North Central Health Care

Person centered. Outcome focused.

YOU Benefit

A COMPREHENSIVE BENEFIT RESOURCE GUIDE
FOR NORTH CENTRAL HEALTH CARE EMPLOYEES

2020 **GUIDE**

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YOUR NCHC BENEFITS

Voluntary Benefits

General Information

Welcome to the ***YOU Benefit 2020 Guide***, a comprehensive resource containing information about the benefit package offered by North Central Health Care (NCHC). These benefits are some of the most competitive available in Central Wisconsin. North Central Health Care's benefits package is an important part of your total compensation package, adding value and giving you peace of mind.

Each of the plans detailed on these pages have been carefully researched and negotiated. You can enroll in your benefits with the assurance that your benefits needs are a priority at North Central Health Care.

OFFICE HOURS AND LOCATIONS

Human Resources
Wausau Campus
1100 Lake View Dr.
Wausau, WI 54403
715.848.4419

8:00 a.m. – 4:30 p.m. Monday – Friday

BENEFIT INFORMATION ON THE WEB

For benefit plan information, including eligibility and monthly rates please visit the North Central Health Care's Intranet page at http://intranet/nchc.aspx or; online and accessible from work, home and all electronic devices: http://www.norcen.org/EmployeeBenefits.

The benefit information presented in this book describes only the highlights of the plans and does not constitute official plan documents. Additional terms and conditions apply. If there are any discrepancies between the information contained herein and the official plan documents, the plan documents will govern. This benefit overview is not intended to give rise to any right to employment, continued employment, or any benefit with or from North Central Health Care. To view official plan documents, go to http://intranet/nchc.aspx or contact NCHC Human Resources.

LIMITATIONS

North Central Health Care, in its sole discretion may modify, amend, or terminate the benefits provided in this booklet with respect to any individual receiving benefits, including active employees, retirees, and their dependents. Nothing in these materials gives any individual the right to continue benefits beyond the time North Central Health Care modifies, amends, or terminates the benefit, unless required by law. Anyone seeking or accepting any of the benefits provided will be deemed to have accepted the terms of the benefit programs and North Central Health Care's right to modify, amend or terminate them.

Paying for Your Benefits

North Central Health Care makes a substantial investment in your benefits by paying a significant portion of the cost. You pay any balance through automatic deductions from your pay check. You are responsible for making sure that your pay check can cover the cost of the benefits you choose.

COST OF YOUR BENEFIT PLANS

Each benefit plan has its own rate structure. The cost of each benefit for which you are eligible is generally outlined in this guide or can be obtained by contacting the Human Resources office.

FREQUENCY OF DEDUCTIONS

If you participate in the benefits plans, bi-weekly payroll deductions will be taken in equal installments from the first two paychecks of each month. If there are three paychecks in a month, Wisconsin Retirement contributions are the only benefit deductions that will be taken from the third paycheck.

PAYROLL DEDUCTIONS FOR NCHC STAFF

Certain benefits are paid for by payroll deduction from your salary on a pre-tax basis (before taxes are calculated). The benefit plans with pre-tax deductions are:

- Health Plan
- Dental Plan
- Vision Plan
- Flexible Spending Account
- Wisconsin Retirement Contributions
- Pre-tax 457(b) Deferred Compensation (Voya and WI Deferred Compensation)
- Health Savings Account Contributions

The plans with after-tax deductions are:

- Roth 457(b) Deferred Compensation (Voya and WI Deferred Compensation)
- Short-Term Disability, Accident, Critical Illness
- Income Continuation Insurance (ICI)
- Pet Insurance
- ID Guard

Your Responsibilities

REVIEW BENEFIT INFORMATION AND ENROLL WITHIN YOUR DEADLINES

It is important that you review the benefit information, make your benefit selections, and enroll within 30 days of a qualifying event or during the open enrollment time period. Instructions for enrolling in your benefits are on page 9. There is a separate process used to enroll in voluntary benefits (short-term disability, accidental and critical illness insurance, pet insurance and ID guard).

CHECK YOUR BENEFIT STATEMENT

Review the benefits statement provided at the beginning of the open enrollment process to verify the benefits you are currently enrolled in. When you enroll online during open enrollment, you will receive a benefit statement at the end of your enrollment that outlines what benefits you elected for 2020. During the remainder of the year you can verify your benefits on the Ulti-Pro Employee Self-Service (ESS) website under the Myself tab, then under Benefits, Benefits Summary, or by viewing your NCHC pay stub.

CHECK YOUR DEDUCTIONS

Verify your benefit deductions on each pay stub to be sure they match the coverage you requested. You can view your paystub online through ESS. If you find an error in your deductions, call Human Resources immediately. Human Resources will not credit overpayments for benefits retroactively.

UPDATE YOUR ADDRESS

It is your responsibility to notify Human Resources immediately if your address changes. A paper designation, phone call or email, are all acceptable ways to communicate your address change.

UPDATE YOUR BENEFICIARY DESIGNATIONS

It is important to update your beneficiary designations whenever your circumstances change. You may change your beneficiary designation at any time. Please contact Human Resources to make any changes.

EMERGENCY CONTACT INFORMATION

North Central Health Care encourages you to keep your emergency contact information updated. Please contact Human Resources to make any changes.

KNOW YOUR RIGHTS AND RESPONSIBILITIES UNDER FEDERAL LAW

North Central Health Care is required to provide you with important information and notices about federal laws and acts that affect your coverage. These notices can be found on pages 65-71. While these notices do not cover all the details of these laws and acts, they do give you and your family information about your rights and protections under these laws and acts. You are encouraged to carefully review these notices.

Benefit Plans Summary

This section provides information on the benefit plans offered by North Central Health Care. The plans and options available to you and your dependents depend upon your job status and hours worked.

HEALTH PLAN COVERAGE *Pages 12–19*

North Central Health Care offers two Health Plans that cover the same services but have different cost structures. Both plans are paired with a Health Savings Account (HSA).

PRESCRIPTION DRUG PLAN *Pages 20–24*

If you are enrolled in North Central Health Care's health plan, you are automatically enrolled in the Express Scripts Prescription Drug Plan.

TELADOC *Pages 25–26*

For employees enrolled in North Central Health Care's Health Plans, Teladoc offers 24-7 access to physician consultations. Consultations are provided via phone, video and the internet.

EXERCISE REWARDS *Pages 27–29*

For employees enrolled in North Central Health Care's Health Plans, the Exercise Rewards program rewards you for working out at fitness clubs. It provides a range of prevention, wellness, fitness and speciality health care management programs.

DENTAL PLAN *Pages 30-32*

Administered by Delta Dental, the NCHC Dental Plan gives you access to two of the nation's largest networks of participating dentists–the Delta Dental PPO network and the Delta Dental Premier network.

VISION PLAN *Page 33*

Vision Service Plan (VSP) offers a comprehensive vision care plan to you and your eligible family members.

FLEXIBLE SPENDING ACCOUNTS *Pages 34–35*

Enrolling in the Medical, Dependent Care or Limited Purpose Flexible Spending Account allows you to pay certain allowable expenses with tax-free money.

GROUP TERM LIFE INSURANCE *Pages 36-37*

North Central Health Care offers group term life insurance to employees that are eligible for the Wisconsin Retirement System. You can elect insurance up to five times your annual salary. Dependent and spouse coverage is also available.

WI RETIREMENT SYSTEM SAVING PLAN *Page 38*

The Wisconsin Retirement System (WRS) is a tax deferred defined benefit plan. In 2020 you contribute 6.75% of your eligible wages and NCHC contributes a match of that same 6.75% for a total of 13.5%. Eligibility varies by hire date. If you meet requirements you will automatically be enrolled in the Wisconsin Retirement System.

Benefit Plans Summary *(continued)*

RETIREMENT SAVINGS ACCOUNTS 457(B) - DEFERRED COMPENSATION *Page 39*

In addition to the Wisconsin Retirement System you may also participate in a 457(b) Deferred Compensation Plan.

INCOME CONTINUATION INSURANCE *Pages 40–41*

North Central Health Care employees can elect this insurance coverage which provides income replacement to an eligible employee who is unable to work due to a non work related disabling illness or injury. Benefits are paid at 75% of the employee's average monthly earnings after a 30 calendar day elimination period.

SHORT-TERM DISABILITY *Page 42-46*

Short-Term Disability (STD) is an optional coverage that protects your income. You can protect a portion of your salary to be paid to you in the event that you cannot work due to a disability. Benefits are paid at 66 2/3% of the employee's average monthly earnings after a seven calendar day elimination period.

CRITICAL ILLNESS INSURANCE *Page 47-52*

Critical Illness coverage pays you a direct benefit if you have a serious illness, like a heart attack, cancer, or stroke. This lump-sum cash benefit you can use any way to meet your needs.

ACCIDENT INSURANCE *Page 53-61*

Pays a benefit directly to you if you have a covered injury like an accident or broken bone.

PET INSURANCE *Page 62*

You can protect yourself when unexpected health care costs arise for your dog or cat with Pet Insurance from Nationwide. Learn more about the available wellness plans and other features.

ID GUARD *Page 63*

Identity theft is one of the fastest growing crimes in America, costing individuals and companies billions of dollars each year. To ensure that our employees have access to the latest identity protection services, Identity Guard is there to help.

EMPLOYEE DISCOUNTS & NCHC SwagShop *Page 64*

North Central Health Care provides employees discounts from local and national businesses and retailers including restaurants, cell phone carriers, car rental, massage and wellness, gym memberships, moving and miscellaneous discounts. You can also shop online for NCHC-branded apparel at the SwagShop.

WORKPLACE RESOURCES, TUITION REIMBURSEMENT AND EMPLOYEE REFERRAL PROGRAMS *Page 74-77*

NCHC offers several programs and resources just for our employees like Employee Assistance Program (EAP), *News You Can Use*, Tuition Reimbursement and Employee Referral Bonus Programs.

Eligibility

Your eligibility for benefits at North Central Health Care is based on your designated Full-time Equivalent (FTE) and hours worked. Generally the minimum status an employee can work and be eligible for benefits is 0.5 FTE which is at least 40 hours per pay period. Eligibility for health insurance is based on the number of hours worked in the last year. If you work over 1,560 hours between October 1st and September 30 of each year, you will be eligible for the health plan and pay the same contributions as full-time employees for the entire following plan year.

NEW HIRE/NEWLY ELIGIBLE

If you are a new hire or newly eligible for benefits, your benefits will take effect the first day of the month following your date of hire. Exceptions to this will be designated by eligible Qualifying Events.

MARRIED SAME-SEX COUPLES

Effective January 1, 2015, coverage on our benefit plans was extended to provide benefits eligibility to same-sex couples. Normal documentation requirements (i.e., marriage certificate) are required to add additional participants to our plan. On August 29, 2014, the U.S. Department of the Treasury and the Internal Revenue Service (IRS) released guidance clarifying that same-sex couples who are legally married in jurisdictions or countries that recognize their marriages will be treated as married for all federal tax purposes, regardless of whether the same-sex couple resides in a state or jurisdiction that recognizes same-sex marriages. The State of Wisconsin has also made similar changes for state taxation purposes. This means a same-sex couple legally married in a state that recognizes same-sex marriage will be treated as married for federal and state tax purposes and is now eligible to receive the same tax free benefits. This applies to medical, dental and vision benefits, when your covered spouse and/or your spouse's children are enrolled in these benefits. Employees may be reimbursed under a Dependent Care (FSA) on a pre-tax basis for daycare expenses that are necessary to allow the employee or the spouse to work, look for work (with income during the year), or for the spouse to attend school full time.

Note that the IRS guidance has no impact on the federal tax treatment of OQAs, civil unions, domestic partnerships, or other variations of domestic partnerships – only couples legally married under state law will be treated as married for federal and state tax purposes.

If you wish to enroll your same-sex spouse and his or her children on your benefits, contact Human Resources by calling 715.848.4419 for assistance or enroll them using our ESS enrollment.

MAKE DEPENDENT COVERAGE CHANGES PROMPTLY

Every year, changes affect the personal status of employees who are enrolled in any of North Central Health Care benefit plans. Marriages, births, adoptions, divorces, and loss of coverage from another source are examples of qualified events that may allow eligible employees the opportunity to make mid-year changes to their current benefits enrollment. If any of these changes occur, you must act within 30 days of the qualified event. Otherwise, you will have to wait for the next Open Enrollment period and have the change(s) become effective January 1, of the following plan year.

ADDING A DEPENDENT – REQUIRED INFORMATION	
Spouse	NCHC requires: • Copy of marriage certificate • Social Security Number • Date of Birth
Dependent Children Age 26 and under (Biological child, stepchild, adopted child)	NCHC requires: • Social Security Number • Date of Birth • AND Birth Certificate OR Adoption Agreement OR Medical Child Support Order

Enrollment

WHEN TO ENROLL

Generally, there are four times when you can enroll or to change your benefits at North Central Health Care:

- As a newly hired/rehired or newly eligible employee;
- After experiencing an FTE change;
- After experiencing a qualifying event; and
- During Open Enrollment.

ENROLLMENT DEADLINES

- 2020 Open Enrollment - October 21st – November 1st
- Family status change or job status change – within 30 days following the date of the change
- Newly hired/rehired eligible employee – within 30 days following hire/rehire date

EFFECTIVE DATE OF BENEFIT ELECTIONS

For the following benefits plans, coverage begins for new hires and newly eligible employees on the first of the month following your date of hire or at the start of the plan year if enrollment occurs during open enrollment, unless noted below.

- Health, Prescription Drug, Flexible Spending, Dental, Vision, Pet Insurance, ID Guard, Short-Term Disability, Critical Illness, Accident Coverages
- Life Insurance – the effective date will be one month from your hire date or initial eligibility.
- Income Continuation Insurance – the effective date will be six months from your hire date and requires WRS eligibility.

JOB OR FAMILY STATUS CHANGE

- If you have a job status change that impacts your eligibility for benefits, you will receive a notification.
- If you have a qualified family status change, you must act within 30 days of the qualifying event for the change to be accepted by North Central Health Care. Otherwise you will have to wait for the next Open Enrollment period to make the change to your benefits. Questions about mid-year changes affecting your North Central Health Care benefits should be directed to the Human Resources Department. Change forms are available in Human Resources.

DURING OPEN ENROLLMENT

Open Enrollment is an annual event (usually in October or November) during which you can enroll in new benefits or change current benefits enrollments for the upcoming year effective January 1. Open Enrollment for the 2020 calendar year will be October 21st - November 1st, 2019.

WHERE DO I ENROLL DURING OPEN ENROLLMENT?

ONLINE ENROLLMENT (Using Employee Self Service)	ONLINE ENROLLMENT WITH VENDOR (page listed below for instructions)
Health Insurance	Pet Insurance (see page 62)
Dental Insurance	ID Guard (see page 63)
Vision Insurance	
Flexible Spending Account (FSA)	
Health Savings Account	

Your NCHC Benefits

The following pages will introduce you to the comprehensive benefit package offered by NCHC. This benefits package is an important part of your total compensation package, adding value and giving you peace of mind.

If you have general questions about your benefits, please contact the NCHC Human Resources Office at 715.848.4419.

For more specific questions, refer to page 79 for contact information.

Health Plan Coverage

Administered by Aspirus Arise

North Central Health Care offers two competitive health plan options. Each health plan offers different levels of coverage based on the providers and hospitals you use.

ELIGIBILITY

To be eligible for Health Insurance you will need to work a minimum of a 0.5 FTE status. North Central Health Care has two different levels of premium contribution: 0.5 – 0.74 FTE and 0.75 – 1.0 FTE. Please review each plan for the two different rates based on your FTE status.

ENROLLMENT DEADLINES

To ensure that you and your eligible dependents have health coverage, you must enroll within 30 days of your date of hire or newly eligible date, during open enrollment period, or as specified by your qualifying event date. If you do not enroll within the deadline, you will not receive health or prescription drug coverage.

EFFECTIVE DATE

If you enroll within 30 days of the qualifying event, coverage is effective on the date of your qualifying event. Newly hired employees coverage is effective the first of the month following your hire date. Any applicable retroactive employee contribution amounts will be deducted from your paycheck. Deductions are retroactive to the event date if the event date is the first of the month. If the event date is after the first of the month, deductions begin on the first full pay period after the event date. To minimize the impact of retroactive deductions, it is recommended that you make your benefits elections as soon as possible.

SERVICES BEFORE YOU GET YOUR ID CARD

Contact Aspirus Arise to find out how to receive services before your health plan ID cards arrive at your home. Phone numbers for plan companies are listed on page 79. Until you receive your health plan ID cards, you may have to pay for services and/or prescriptions in full. Contact Aspirus Arise to find out its reimbursement procedure. Be sure to save all your receipts.

TEMPORARY CARDS

You can receive temporary cards in the event you need services before your actual insurance card arrives at your home. Please visit Aspirus Arise website at www.AspirusArise.com to register your user name and password. Once you are logged into the site there is an ID card tab on the website that you can click on and this will let you view your current ID card. You can print this if you would like to use this as your temporary ID card.

PHYSICIAN AND HOSPITAL PLAN PARTICIPATION

Plan participating physicians and participating hospitals are always subject to change. Contract renewal dates between plans and their doctors and hospitals vary, and renewal is at the option of either party.

In the event your provider's affiliation with the North Central Health Care Health Plan ends, you will need to select another provider within your plan's service area. North Central Health Care's plan does not require you to designate an In-Network provider, however, you will always receive a greater benefit and less out-of-pocket costs, if your care is received at the In-Network benefit. Before receiving services, check the provider directory to make sure it includes a doctor and hospital of your choice. You can find provider information on the Aspirus Arise's website, or call the health plan's customer service number list.

Summary of Benefit and Coverage (SBC) are available that detail coverages more specifically.

Health Plan 1

Benefit Coverage		In-Network Aspirus Arise Network	Out of Network (Includes Ascension & Marshfield Clinic)
Deductible	Per Person Family	$1,400 $2,800	$2,800 $5,600
Coinsurance		80%	50%
Annual Employee Out-of Pocket Maximum (Includes Deductible	Per Person Family	$2,800 $5,600	$5,600 $11,200
Lifetime Maximum		Unlimited	
Preventive Care		100% (Deductible Waived for Coded Services)	50%
Pharmacy/Prescription Drug Coverage*		$5 / $30 /$ 75 Copays after Deductible Requiring Generic RX when possible	
Emergency Room		$150 Copay After Deductible	
HSA Employer Annual Deposit	Single Employee + Child(ren) Employee + Spouse Family	$350 $700 $700 $900	

*If more than one person is covered on the plan, the full family deductible has to be met.

Health Plan 2

Benefit Coverage		In-Network Aspirus Arise Network	Out of Network (Includes Ascension & Marshfield Clinic)
Deductible	Per Person Family	$2,800 $5,600**	$5,600 $11,200
Coinsurance		90%	70%
Annual Employee Out-of Pocket Maximum (Includes Deductible	Per Person Family	$3,100 $6,200	$6,200 $12,400
Lifetime Maximum		Unlimited	
Preventive Care		100% (Deductible Waived for Coded Services)	70%
Pharmacy/Prescription Drug Coverage		Co-Insurance after Deductible Requiring Generic RX when Possible	
Emergency Room		Co-Insurance After Deductible	
HSA Employer Annual Deposit	Single Employee + Child(ren) Employee + Spouse Family	$1,000 $1,500 $1,500 $2,000	

**Family deductible applies if employee plus one or more dependents are covered

EMPLOYEE CONTRIBUTION RATES

Health Plan 1
Premium is based on Full Time Employee Rate (>0.75)

Employee Only	Per Pay Period
0.75 – 1.0 FTE	$111.63
0.5 – 0.74 FTE	$194.32

Employee + Spouse	Per Pay Period
0.75 – 1.0 FTE	$255.75
0.5 – 0.74 FTE	$445.20

Employee + Child(ren)	Per Pay Period
0.75 – 1.0 FTE	$200.94
0.5 – 0.74 FTE	$349.78

Family	Per Pay Period
0.75 – 1.0 FTE	$304.45
0.5 – 0.74 FTE	$529.96

Health Plan 2
Premium is based on Full Time Employee Rate (>0.75)

Employee Only	Per Pay Period
0.75 – 1.0 FTE	$58.66
0.5 – 0.74 FTE	$117.31

Employee + Spouse	Per Pay Period
0.75 – 1.0 FTE	$134.39
0.5 – 0.74 FTE	$268.78

Employee + Child(ren)	Per Pay Period
0.75 – 1.0 FTE	$105.58
0.5 – 0.74 FTE	$211.16

Family	Per Pay Period
0.75 – 1.0 FTE	$159.36
0.5 – 0.74 FTE	$318.71

HOW TO FIND A PROVIDER

Members can search for a provider by following these instructions:
1. Go to www.AspirusArise.com
2. Click the Find A Doctor button in the upper right corner of the screen.
3. Enter your group number as shown on your Aspirus Arise ID card and click GO.
4. Enter your search criteria and then click Search. A list of doctors and/or facilities will appear for your review.

Primary Care Physicians (PCPs) are participating providers who practice in any of the following areas: internal medicine, family practice, general practice, pediatrics, and obstetrics/gynecology.

You may also call Aspirus Arise Customer Service at 1.715.972. 8140.

Preventive Services

Aspirus Arise puts an emphasis on keeping you healthy. We include a 100% benefit for preventive services when performed by a participating provider. This means no deductible, copay, or maximum dollar limit for routine exams and preventive services. We are proud to offer a range of services to our members, including all preventive services rated A or B by the United States Preventive Services Task Force (USPSTF). For a complete listing of covered preventive services, please see your Certificate of Coverage or contact our Member Services team at 1-800-332-6290.

Preventive Services	Participating Providers	Non-Participating Providers
Routine physical exams (Including pelvic exams, pap smears, and related routine diagnostic services)	100% coverage, deductible waived	No benefits
Well baby care (Including related routine diagnostic services)	100% coverage, deductible waived	No benefits
Routine immunizations As recommended by the Advisory Committee on Immunization Practices. Immunizations for travel purposes are not covered.	100% coverage, deductible waived	100% coverage, deductible waived on POS plans only
Mammograms Covered expenses include one routine screening exam per calendar year. A routine screening mammogram is a specific procedure performed for detection of a clinically unrevealed disease. A diagnostic mammogram is a specific procedure performed when the covered person has a symptom or history of breast abnormality or cancer. Diagnostic mammograms are subject to the covered person's deductible and coinsurance.	100% coverage, deductible waived	Subject to your deductible and coinsurance on POS plans only
Screening colonoscopies/sigmoidoscopy/fecal occult blood testing Covered expenses include routine screening exam for covered persons age 50 and over, subject to appropriate time intervals provided in the most current guidelines from the USPSTF. A routine screening colonoscopy is a procedure performed for detection of a clinically unrevealed disease. A diagnostic colonoscopy is a procedure performed when the covered person has a symptom or history of colon abnormality, polyps, or cancer. Diagnostic colonoscopies are subject to the covered person's deductible and coinsurance. Colorectal cancer is the second-leading cause of cancer death in the United States. Colorectal cancer is most frequently diagnosed among adults ages 65 to 74 years; the median age at death from colorectal cancer is 68 years. Adults ages 50 to 75 years: The USPSTF recommends screening for colorectal cancer starting at age 50 and continuing until age 75. The risks and benefits of different screening methods vary. Stool-based test should be done on an annual basis with the stool-based DNA screening on a 1-3 year basis. Direct Visual Tests include Colonoscopy every 10 years, CT Colonography every 5 years, Flexible Sigmoidoscopy every five years, and Flexible Sigmoidoscopy with DNA testing every 10 years.	100% coverage, deductible waived	Subject to your deductible and coinsurance on POS plans only
Bone density test to screen for osteoporosis Covered expenses include routine screening exam for covered persons age 65 and over	100% coverage, deductible waived	No benefits
Routine hearing screening exam	100% coverage, deductible waived	No benefits

Preventive Services	Participating Providers	Non-Participating Providers
Screening tests for lead exposure	100% coverage, deductible waived	No benefits
Abdominal aortic aneurysm screening	100% coverage, deductible waived	No benefits
Pregnancy screenings including, but not limited to: • Hepatitis • Asymptomatic bacteriuria • Rh incompatibility • Syphilis • Iron deficiency anemia • Gonorrhea • Chlamydia	100% coverage, deductible waived	No benefits
Screening and intervention services (including counseling and education) for: • Genetic testing for breast and ovarian cancer • Breastfeeding • Tobacco use and diseases caused by tobacco use • Alcohol use	100% coverage, deductible waived	No benefits
Preventive care drug Means a prescription drug whose routine use is rated A or B by the USPSTF. These drugs require a written prescription order from a practitioner and are limited to the following: • Aspirin for the prevention of cardiovascular disease and after 12 weeks of gestation in women who are at high risk for preeclampsia • Fluoride supplements for children older than 6 months • Iron supplements for asymptomatic children aged 6-12 months • Folic acid for women planning or capable of pregnancy • Oral contraceptives, contraceptive patches, contraceptive vaginal rings, and contraceptive devices • Nicotine replacements and covered drugs used for smoking cessation if the covered person is age 18 or over • Vitamin D if the covered person is age 65 or over and is at an increased risk for falls • Risk-reducing medications, such as tamoxifen or raloxifene, for women who are at increased risk for breast cancer and at low risk for adverse medication effects	100% coverage, deductible waived	No benefits
Preventive services for women, as recommended by the Health Resources and Services Administration: • Screening for gestational diabetes in pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes; • High-risk human papilloma virus DNA testing in women age 30 and older with normal cytology results. Screening is limited to once every three years • Annual counseling on sexually transmitted infections for all sexually active women • Annual counseling and screening for HIV infection for all sexually active women • All FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity • Comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment • Annual screening and counseling for interpersonal and domestic violence	100% coverage, deductible waived	No benefits

The above preventive services are covered subject to the terms and conditions set forth in your Aspirus Arise Certificate of Coverage. Age-appropriate screenings are set by the United States Preventive Services Task Force and are subject to change. For further questions, please contact Aspirus Arise Member Services at 1-800-332-6290.
Note: For HMO Plans, no Preventive Services are covered if you utilize Non-Participating Providers.

Aspirus Arise Network Map

In Wisconsin

Top-quality network offers easy access

Convenient access to Aspirus Network health care providers plus a long list of health care professionals and hospitals in your area.

Aspirus Network includes

50 primary and specialty care clinics

Wisconsin Wrap Network offers

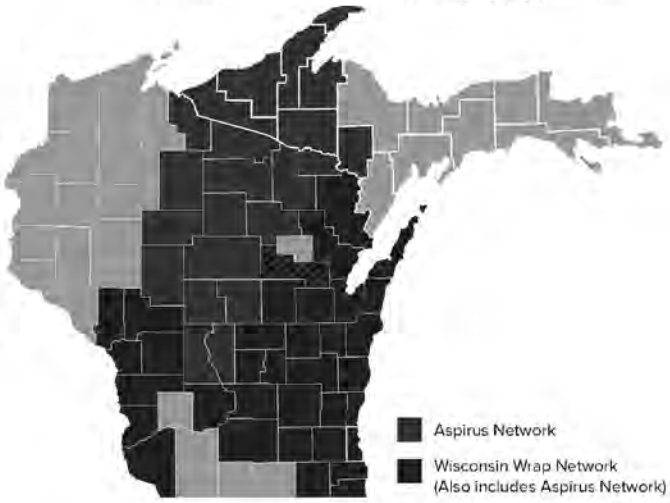
7,000+ health care providers

Members and dependents get in-network benefits in 50 Wisconsin counties.

Note: Aspirus Arise markets products to individuals who reside and businesses domiciled in the green Wisconsin counties and in Shawano County in ZIP code areas beginning with 544 only.

Wisconsin Wrap Network providers include:

- Aurora Health Care
- Bellin Health
- Gundersen Health System
- Holy Family Memorial
- ProHealth Care
- ThedaCare
- UW Health



Where can I go if I need care outside of Wisconsin for myself or a dependent?

First Health Wrap Network

In-network benefits in all 49 states outside Wisconsin allow members and dependents to get health care at in-network benefit levels.

More than

1 million

health care service locations

5,000 hospitals

90,000 ancillary facilities

Aspirus Arise is the best choice for Aspirus patients

If you would like to select an Aspirus primary care practitioner, please call 833-811-4176.

For help locating a participating provider, you can use our online Find a Doctor tool or call Customer Service at the number shown on your ID card, Monday through Friday, 7:30 a.m. to 5 p.m., CT. Providers can leave or enter the network at any time. It is recommended that you check the network status of your provider on a regular basis.

Employee Health and Wellness Center

EASY ACCESS TO QUALITY HEALTH CARE

The Aspirus Clinic at the Employee Health and Wellness Center provides convenient, high-quality, cost effective health care for North Central Health Care Employees and their dependants covered by the NCHC health plan.

HOURS AND LOCATION

North Central Health Care Wausau Campus / Door 25
1100 Lake View Dr., Wausau, WI 54403

For appointments
715.843.1256 or myaspirus.org

Monday, Wednesday, & Friday: 8:00 am - 4:30 pm
Tuesday: 6:30 am – 3:00 pm
Thursday: 10:00 am – 6:30 pm

HEALTH AND WELLNESS SERVICES

- **Annual Physicals:** Women's health, men's health.
- **Chronic Condition Support:** Hypertension, diabetes, asthma, anxiety, depression, thyroid disorders and prescriptions.
- **Health Monitoring:** Blood pressure, cholesterol, blood sugar, weight management, routine lab test and gynecological concerns.
- **Common Health Issues:** Colds, sore throat, earaches, influenza, sinus infection, stomach disorders, nausea, skin problems, rashes, bug bites, minor wounds, suturing, strains, sprains, urinary tract infections.
- **Wellness Center:** Health screening, prevention education, general fitness assessment, goal setting and routine wellness advice.
- **Lab Services and Procedures:** Rapid strep test, urine dip stick, flu screens, pregnancy test, and procedures such as mole and skin tag removal are all provided at the on-site clinic.

APPOINTMENTS AND SAME-DAY CARE

Clinic appointments are encouraged and can be made online by visiting MyAspirus.org or by calling the Employee Health & Wellness Center at 715.843.1256. Same day appointments may be possible based upon the schedule for that day. Clinic Walk-Ins will also be taken if the schedule permits.

CONFIDENTIALITY

All medical information provided to Aspirus will be confidential and not shared with North Central Health Care, or other health care providers without your written consent.

FEES

Aspirus will directly bill your Aspirus Arise Health Plan for the $20 per office visit fee. Additional medical care or lab testing beyond the scope of listed services will also be billed to your insurance. Aspirus will file your health insurance claims. Please remember to bring your insurance card to each appointment.

You are responsible for any charges not covered under your insurance plan. If you have questions about fees, please do not hesitate to discuss them with us.

Health Savings Account (HSA)

HEALTH SAVINGS ACCOUNT (HSA) – HEALTH PLAN 1

Eligible employees who enroll in North Central Health Care's health insurance Plan 1 (HSA) are provided an Employer-funded Health Savings Account contribution to pay a portion of the deductible. Employees in the HSA Plan will have the option to set up their HSA bank account set up with Associated Bank or Marathon County Employees Credit Union. Employees are eligible to contribute to the Health Savings Account and any remaining contributions, both employee and employer contributions, remain in your HSA bank account and roll over year to year. There is no "use it or lose it" rule.

	Total HSA Annual Maximum Contribution (Employee + Employer)	Employer HSA Contribution	Employee Annual Maximum HSA Contribution
Employee Only	$3,550	$350	$3,200
EE + Spouse	$7,100	$700	$6,400
EE + Child(ren)	$7,100	$700	$6,400
Family	$7,100	$900	$6,200

*New Hires only: Contribution is prorated based on # of months of employment.

HEALTH SAVINGS ACCOUNT (HSA) – HEALTH PLAN 2

Eligible employees who enroll in North Central Health Care's health insurance Plan 2 (HSA) are provided an Employer-funded Health Savings Account contribution to pay a portion of the deductible. Employees in the HSA Plan will have the option to set up their HSA bank account set up with Associated Bank or Marathon County Employees Credit Union. Employees are eligible to contribute to the Health Savings Account and any remaining contributions, both employee and employer contributions, remain in your HSA bank account and roll over year to year. There is no "use it or lose it" rule.

	Total HSA Annual Maximum Contribution (Employee + Employer)	Employer HSA Contribution	Employee Annual Maximum HSA Contribution
Employee Only	$3,550	$1,000	$2,550
EE + Spouse	$7,100	$1,500	$5,600
EE + Child(ren)	$7,100	$1,500	$5,600
Family	$7,100	$2,000	$5,100

*New Hires only: Contribution is prorated based on # of months of employment.

For both HSA Plans, individuals 55+ can contribute an additional $1,000 annually. All contributions are made pre-tax.

IMPORTANT TAX REMINDERS FOR ALL HSA

This notice is a reminder of the IRS personal tax filing requirements for all HSA participants. Whether you participate in an HSA offered through our company or your spouse's plan, the IRS requirements are the same.

Who Must File?
Along with your personal tax return, you must also file the one-page HSA form in order to determine your deduction, if any of the following applies:

- you, or someone on your behalf, including your employer, made HSA contributions to your HSA
- you received HSA contributions
- you acquired an interest in an HSA because of the death of the account beneficiary

Which IRS Form Do I Use?
Form 8889. The financial institution that you have your Health Savings Account with provides Form 8889 to you for your tax reporting purposes.

RECORD KEEPING FOR HSA

Should the HSA account holder keep receipts? **YES!**

Please note the following:

- You may need to prove to the IRS that distributions from your HSA were for medical expenses and not otherwise reimbursed.
- Not all medical expenses paid out of the HSA have to be charged against the deductible.
- If the IRS requests receipts for verification purposes, failure to provide those receipts could result in having to pay a penalty.

ADDITIONAL RULES WITH HSA ACCOUNTS

- Cannot be covered under Flex plan for any medical expenses at the same time as covered under HSA, including spouse's FSA.
- Employee cannot have secondary coverage if plan is not a qualified HDHP
- Employees can withdraw funds for non-medical expenses at age 65 without 20% penalty, but withdrawal will be considered taxable income
- Employee keeps account/funds upon termination of employment

IMPORTANT NOTES ON HSA

HSA balances roll over year after year and can be saved for future medical expenses or your retirement. Funds withdrawn for qualified medical, dental and vision expenses are tax-free. Funds used for non-qualified expenses are subject to income tax and a 20% penalty. We recommend keeping your receipts of your qualified expenses in case of an IRS audit.

******If you enroll in the Health Savings Account, you are <u>not</u> allowed to enroll in the Medical Flexible Spending Account (FSA) however you may enroll in a Limited Purpose FSA Account, to be used for qualified dental and visions expenses only. See pages 34-35 for details on FSA.***

Who is <u>not</u> eligible to open and contribute to a HSA Bank Account?

- Employees who are enrolled in Medicare Part A, Tri-Care or VA Benefits
- If you or your spouse are enrolled in a regular medical FSA.
- Anyone who has dual coverage (HSA participant covered by another plan not HSA compatible)

Prescription Drug Plan

Administered by Express Scripts

North Central Health Care provides a Prescription Drug Plan for employees administered by Express Scripts. The prescription drug co-pay varies based on several factors including whether the drug is a generic, a preferred brand, or a non-preferred brand, and whether it is dispensed by a retail pharmacy, mail-order, or the In-House pharmacy. For more information on the Express Scripts and the In-House pharmacy service, see North Central Health Care's Intranet site at: http://intranet/nchc.aspx.

ELIGIBILITY AND ENROLLMENT

When you enroll in North Central Health Care's health plan, you will automatically be enrolled in the Express Scripts plan. You cannot elect the Express Scripts Plan without enrolling in North Central Health Care's health insurance plan. You can have access to North Central Health Care's in-house pharmacy without enrolling in North Central Health Care's benefit plan.

PLAN FEATURES

The Prescription Drug Plan provides a consistent benefit and scope of coverage for all members, including:

Access to local and national chain pharmacies with up to 90-day supplies are available for most medications. Participants can fill prescriptions for 1 to 30-day supplies for one co-pay, 31 to 60-day supplies for two co-pays, or 61 to 90-day supplies for three co-pays.

Mail-order pharmacy is provided by Express Scripts as an alternative to retail pharmacies. Use of the mail-order service is a win-win that results in savings to you and to North Central Health Care. Express Scripts provides convenient, secure deliveries to your home. This is particularly convenient for participants who take certain maintenance medications. Participants save a third of their out-of-pocket co-pay for a 90-day supply of medication through mail-order.

> *Note: Certain drugs may not be available through mail service because there may be medical reasons for not dispensing large quantities, or because of federal or state laws that prohibit dispensing certain drugs through the mail. Contact Express Scripts Pharmacy Services at 855-505-8107 if you have any questions about drugs available through the mail service program. Prescription drugs cannot be mailed outside the United States when using the North Central Health Care Plan.*

In-House Pharmacy is a benefit that employees and their dependents can choose. Participants can fill prescriptions for 1 to 90-day supplies for one co-payment. North Central Health Care also offers price savings if the In-House pharmacy can dispense the medication at a lower cost than the co-payment, North Central Health Care will allow you to pay the lower co-payment if applicable. Diabetic Insulin, needles, and syringes are available to all participants in the North Central Health Care Plan at zero ($0) co-pay at the In-House pharmacy.

TERMS YOU NEED TO KNOW

Formulary
A formulary is an extensive list of available prescription drugs offered by the plan to serve the pharmaceutical needs of patients requiring self-administered drug therapy on an outpatient basis. In addition, there may be drugs covered but not listed on the formulary, as formulary decisions are both clinical and financial. Inclusions (or exclusions) of drugs on the formulary are determined by the clinical judgment of Express Scripts and pharmacists as well as published medical evidence in the diagnosis and treatment of disease. Drug lists are subject to change.

Generic Drugs/Tier 1
The Generic Drug co-pay level offers the opportunity to take advantage of generic drugs. Generic drugs are approved by the United States Food and Drug Administration (FDA) and contain the same active ingredients as their brand-name equivalents. Therefore, the use of generic drugs often offers an effective and safe alternative to help reduce prescription drug costs for both you and North Central Health Care.

Preferred Brand-Name Drugs/Tier 2
Brand-name drugs are patent-protected and product-trademarked. For each drug class (i.e., cardiovascular, depression), there may be several drugs produced by different manufacturers with different prices that are equal in therapeutic value. The Preferred Drug List (PDL) includes brand-name and generic drugs that are compiled and periodically updated by Express Scripts, who reviews all FDA-approved drugs. Preferred brand-name drugs are selected on the basis of therapeutic effectiveness, safety, and cost relative to other brand-name drugs used to treat the same conditions.

Non-Preferred Drugs (Brand-Name)/Tier 3
Drugs on the third co-pay tier are FDA-approved drugs that Express Scripts have not designated as "preferred" and are subject to higher co-pays and may have a product selection penalty. These products often are in drug classes that include several similar alternative brand-name or generic options.

PRESCRIPTION SCHEDULE OF BENEFITS
Express Scripts for HSA Health Plan 1
Effective: 01-01-2020

All Pharmacy costs are subject to the same health plan deductible.
You pay the full cost for each prescription up until you reach your deductible on the Health Savings Account (HSA) Plan 1.
Once your deducible is met, you pay 20% coinsurance and copays on any medication up to your out of pocket maximum.
Refer to pages 13-19. Health Savings Account contributions can be used to pay prescription drug costs.

PRESCRIPTION SCHEDULE OF BENEFITS
Express Scripts for HSA Health Plan 2
Effective: 01-01-2020

All Pharmacy costs are subject to the same health plan deductible.
You pay the full cost for each prescription up until you reach your deductible on the Health Savings Account (HSA) Plan 2.
Once your deducible is met, you will be subject to coinsurance on any medication up to your out of pocket maximum.
Refer to pages 13-19. Health Savings Account contributions can be used to pay prescription drug costs.

$0 Drug List

NOTE: For plans having a prescription drug copay (non-HSA Qualified), all drugs listed are a $0 copay. For HSA-Qualified plans, only the drugs highlighted are $0/first dollar (as preventive) due to IRS regulations. The others listed would be subject to deductible/coinsurance.

CARDIOVASCULAR			
Chapter name	**Drug name**		
Antiarrhythmic agents	Amiodarone	Disopyramide phosphate	Disopyramide phosphate CR
	Flecainide acetate	Mexiletine HCL	Pacerone
	Procainamide HCL	Propafenone HCL	Quinidine gluconate
	Quinidine sulfate	Sorine	Sotalol HCL
	Sotalol HCL AF	—	—
Cardiac glycosides	Digoxin	—	—
Nitrates	Isosorbide dinitrate	Isosorbide mononitrate	Nitroglycerin
	Nitroglycerin ointment	Nitroglycerin patch	Nitroglycerin SR
Anticoagulant agents	Warfarin sodium	Jantoven	—
Antiplatelet drugs	Cilostazol	Clopidogrel	Dipyridamole
	Ticlopidine	—	—
Thiazide and related diuretics	Amiloride HCL	Amiloride HCL/Hydrochlorothiazide	Bumetanide
	Chlorothiazide	Chlorthalidone	Eplerenone
	Furosemide	Hydrochlorothiazide	Indapamide
	Methyclothiazide	Metolazone	Spironolactone
	Spironolactone/Hydrochlorothiazide	Torsemide	Triamterene/Hydrochlorothiazide
Beta blockers	Acebutolol HCL	Atenolol	Betaxolol HCL
	Bisoprolol fumerate	Carvedilol	Labetalol HCL
	Metoprolol succinate	Metoprolol tartrate	Nadolol
	Pindolol	Propranolol	Propranolol LA
	Propranolol XL	Timolol maleate	—
Calcium channel blockers	Amlodipine besylate	Cartia XT	Diltiazem HCL
	Diltiazem HCL CD	Diltiazem HCL SR	Diltiazem HCL, sustained release
	Felodipine	Felodipine ER	Isradipine
	Matzim LA	Nicardipine	Nifediac CC
	Nifedipine	Nifedipine CC	Nifedipine XL
	Nimodipine	Nisoldipine	Taztia XT
	Verapamil HCL	Verapamil HCL PM	Verapamil HCL SR
	Verapamil HCL, 24 hour	—	—
ACE inhibitors	Benazepril HCL	Captopril	Enalapril maleate
	Fosinopril sodium	Lisinopril	Moexipril HCL
	Perindopril	Quinapril HCL	Ramipril
	Trandolapril	—	—
Adrenergic antagonists and related drugs	Clonidine HCL	Clonidine HCL patch	Doxazosin mesylate
	Guanabenz acetate	Guanfacine HCL	Methyldopa
	Prazosin HCL	Reserpine	Terazosin
Other antihypertensive combinations	Amlodipine besylate/Benazepril HCL	Atenolol/Chlorthalidone	Benazepril HCL/ Hydrochlorothiazide
	Bisoprolol fumerate/ Hydrochlorothiazide	Captopril/Hydrochlorothiazide	Enalapril maleate/ Hydrochlorothiazide
	Fosinopril sodium/ Hydrochlorothiazide	Hydralazine HCL/ Hydrochlorothiazide	Lisinopril/Hydrochlorothiazide
	Methyldopa/Hydrochlorothiazide	Metoprolol tartrate/ Hydrochlorothiazide	Moexipril HCL/Hydrochlorothiazide
	Propranolol HCL/ Hydrochlorothiazide	Quinapril HCL/Hydrochlorothiazide	Trandolapril/Verapamil

$0 Drug List (continued)

CARDIOVASCULAR			
Chapter name	**Drug name**		
Angiotensin II receptor blockers and renin inhibitors	Candesartan	Candesartan/Hydrochlorothiazide	Eprosartan
	Irbesartan	Irbesartan/Hydrochlorothiazide	Losartan potassium
	Losartan potassium/ Hydrochlorothiazide	Telmisartan	Valsartan
	Valsartan/Hydrochlorothiazide	—	—
Lipid/cholesterol lowering agents	Amlodipine besylate/Atorvastatin	Atorvastatin	Cholestyramine light
	Cholestyramine	Colesevelam	Fenofibrate
	Fenofibric acid	Fluvastatin	Gemfibrozil
	Lovastatin	Niacin	Pravastatin
	Simvastatin	—	—
Potassium	Potassium bicarbonate/Citric acid	Potassium chloride	Potassium chloride cap
	Potassium chloride liquid	Potassium chloride packet	Potassium chloride sustained
	Potassium chloride/Potassium bicarbonate/Citric acid	—	—

DIABETES			
Chapter name	**Drug name**		
Non-insulin oral hypoglycemic agents	Acarbose	Acetohexamide	Chlorpropamide
	Glimepiride	Glipizide	Glipizide ER
	Glipizide XL	Glipizide/Metformin	Glyburide
	Glyburide/Metformin	Glyburide, micronized	Metformin
	Metformin ER	Nateglinide	Pioglitazone
	Pioglitazone/Metformin	Repaglinide	Tolazamide
	Tolbutamide	—	—
Insulins	Humalog	Humalog mix	Humulin 50-50
	Humulin 70-30	Humulin N	Humulin R
	Lantus	Lantus Solostar	Levemir
Non-insulin injectable hypoglycemic agents	Bydureon	Byetta	Symlin
	SymlinPen	—	—

RESPIRATORY			
Chapter name	**Drug name**		
Xanthines	Aminophylline	Theophylline anhydrous	Elixophylline
Beta agonist oral	Albuterol sulfate	Metaproterenol sulfate	Terbutaline sulfate
Beta agonist inhalers	Albuterol	Albuterol sulfate	Levalbuterol
	Metaproterenol sulfate	Arcapta Neohaler	Foradil
	Perforomist	ProAir HFA	Serevent Diskus
	Ventolin HFA	—	—
Inhaled steroids	Budesonide	Asmanex	Pulmicort 1mg/2mL
	Pulmicort Flexhaler	Qvar	—
Miscellaneous pulmonary agents	Acetylcysteine	Cromolyn sodium ampules	Ipratropium/Albuterol sulfate
	Ipratropium bromide solution	Montelukast	Zafirlukast
	Advair Diskus	Atrovent HFA	Combivent
	Dulera	Intal	Spiriva
	Symbicort	Tudorza Pressair	—

This list is subject to change. Please visit our website for up-to-date information: go to **AspirusArise.com** and click on **Resources**. Under the **My Pharmacy Benefits** heading, click on **Drug Formulary**.

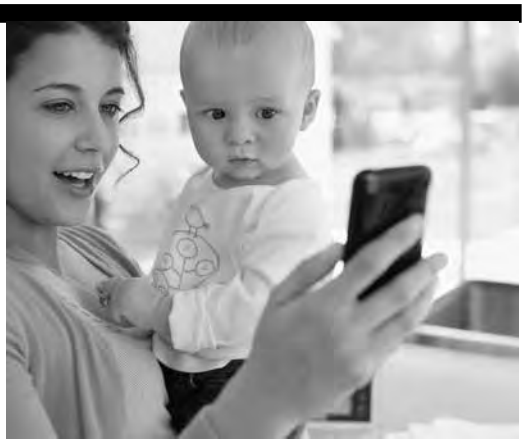
Additional $0 Drug List

Note: These drugs are covered at $0/first dollar (as preventive) in addition to the drugs highlighted on the Aspirus Arise $0 Drug List

Antipsychotics
Clozapine
Fluphenazine
Haloperidol
Loxapine
Olanzapine
Perphenazine
Quetiapine
Risperidone
Thiothixene
Trifluoperazine
Asthma and COPD
Adviar Diskus
Advair HFA
Cancer
Anastrozole
Exemestane
Letrozole
Raloxifene
Tamoxifen
Cardiovascular /Heart Disease
Anticoagulants
ASA/Dipyridamole
Cilostazol
High Blood Pressure
Bumetanide
Carvedilol
Furosemide
Hydralazine
Irbesartan
Olmesartan
Prazosin hcl
Ramipril
Sotalol AF
Torsemide

Cardiovascular/Heart Disease (continued)
High cholesterol
Rosuvastatin
Diabetes
Insulin
Novolin
Novolog
Novolog Mix
Non-insulin
Glimepiride
Supplies
Blood Glucose Test Strips ****only available at NCHC pharmacy at $0 cost***
Multiple Sclerosis
Copaxone
Osteoporosis
Alendronate
Calcitonin spray
Transplant
Azathioprine
Cyclosporine
Cyclosporine modified
Mycophenolate
Mycophenolic DR
Tacrolimus cap

Teladoc – 24/7 Physician Access



NCHC employees who participate in the NCHC Health Plan, will have access to Teladoc, a national network of U.S. board-certified physicians who use electronic health records, telephone consultations and online video consultations to diagnose, recommend treatment and write short-term, non-DEA-controlled prescriptions, when appropriate.

Physicians are available 24 hours a day, 365 days a year. Members of any age can conveniently access quality care from their home, work or on-the-go as opposed to more expensive and time-consuming alternatives like the doctor's office or emergency room. After you request a medical consultation, the average time for a return call from a Teladoc physician is less than one hour – oftentimes in fewer than 30 minutes. Teladoc guarantees a return call within one hour or the medical consultation is free.

For more information about Teladoc or to register, visit https://www.teladoc.com or 1.800.Teladoc (1.800.835.2362)

HOW DOES TELADOC WORK?

Registration:
- The member completes an online medical history disclosure (MHD)
- Teladoc builds a portable, HIPAA compliant electronic health record (EHR)
- It is recommended to register in advance at https://www.teladoc.com There is no cost to register an account.

Consultation by Phone
- The member calls Teladoc to request a consultation.
  Note – consultations may also be requested via the member's online account
- The Teladoc member is placed in the consult queue for pickup by a U.S.-based, board-certified physician. The physician reviews the EHR, including the medical history, before placing a call to the member
- The physician concludes the consult and documents notes into the member's EHR. If appropriate, a Teladoc nurse will call in a prescription into the member's pharmacy of choice

Consultation by Online Video
(Requires a computer, Internet connection and web cam)
- The member calls Teladoc to request a consultation. *Note* – consultations may also be requested via the member's online account
- The member is placed in the consult queue for pickup by a U.S.-based, board-certified physician
- An appointment reminder notification will be sent prior to the consultation
- The physician reviews the EHR, including the medical history, before placing a call to the member
- The member accesses the consult through their Teladoc online account and telephone
- If appropriate, a Teladoc nurse will call in a prescription into the member's pharmacy of choice

Post Consultation
- The physician updates the member's medical record
- Teladoc generates a customer survey via email or mail within three days

WHAT DOES A TELADOC CONSULTATION COST?

The cost of a consultation with a Teladoc physician is $45, which does apply to your health plan deductible. After you reach your deductible, Teladoc is subject to co-insurance and copays until you meet your out-of-pocket maximum.

TELADOC.

Talk to a doctor anytime

Teladoc gives you 24/7/365 accessto U.S. board-certified doctors through the convenience of phone, video or mobile app visits. It's an affordable alternative to costly urgent care and ER visits when you need care now.

MEET OUR DOCTORS

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

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

GET THE CARE YOU NEED

Teladoc doctors can treat many medical conditions, including:

- **Cold & flu symptoms**
- **Allergies**
- **Sinus problems**
- **Ear infection**
- **Urinary tract infection**
- **Respiratory infection**
- **Skin problems**
- **And more!**

WHEN CAN I USE TELADOC?

Teladoc does not replace your primary physician it is a convenient and affordable option for quality care:

- When you need care now
- If you're considering the ER or urgent care for a non-emergency issue
- On vacation, on a business trip, or away from home
- For short term prescription refills

Talk to a doctor anytime for a $45 fee !

($45 fee applies to your plan's deductible, coinsurance, and out-of-pocket maximum)

Teladoc is just a click or call away!

Teladoc.com

1-800-Teladoc

Available on the iPhone App Store

Google play

ExerciseRewards®

Administered by Aspirus Arise

1. **Q: What is the ExerciseRewards™ program, and what is the benefit to me?**
   A: The ExerciseRewards program rewards you for working out at fitness centers. Aspirus Arise members are eligible to participate.
2. **Q: Who provides the ExerciseRewards program?**
   A: The ExerciseRewards program is provided by American Specialty Health Fitness, Inc. (ASH Fitness), a subsidiary of American Specialty Health Incorporated (ASH). ASH is one of the nation's leading health services companies. It provides a wide range of musculoskeletal provider network, fitness and exercise, and health management programs to health plans, employer groups, insurance carriers, and trust funds to improve the health of their members or employees.

   Its mission is to empower individuals to live longer, healthier lives. ASH does this through a variety of population management programs, created through innovation, scientific evidence, and state-of-the-art technology, and measured against the highest industry standards.
3. **Q: How does the program work?**
   A: You need to work out at least 10 times per month at an acceptable fitness center/YMCA to receive your $30 reward each month. You can receive credit for one fitness center visit per calendar day (with at least 8 hours between visits).
4. **Q: How can I track fitness center visits?**
   A: There are 3 ways you can track your fitness center visits. You can use any or all of the 3 methods. You are not limited to just one method.

   1) ASHConnect™ app on your smartphone—Track your workouts at thousands of fitness centers nationwide. For the app to count your visit, your workout should be at least 30 minutes long. This is another efficient method that uses GPS data for real-time tracking. Search for "ASHConnect" in your app store.
   2) Paper log—Submit your completed **Visit Submission Form**. Please make sure the form is complete and legible to earn credit for each visit.
   3) The Active&Fit Direct™ program—Choose from 9,000+ fitness centers and select YMCAs nationwide for $25 a month (plus a $25 enrollment fee and applicable taxes). Once enrolled, you don't need to do anything else—the Active&Fit Direct fitness centers will submit your visits for you automatically for a hassle-free way to earn visits toward your reward goal. You can quickly and easily enroll in the Active&Fit Direct program by visiting www.ExerciseRewards.com. Please note, you can participate in the ExerciseRewards program without using the Active&Fit Direct program to track your fitness center visits.

   You can log on to the ExerciseRewards website to track your progress toward your reward.
5. **Q: How do I register?**
   A: Simply go to www.ExerciseRewards.com and register for an online account. You can also use a Visit Submission Form to track your workouts at your fitness center and submit for credit. You don't need online access to participate in this way.

ExerciseRewards®

6. **Q: What are some of the website features?**
   A: The website has some great features, including:
   - Fitness center search—Find participating fitness centers that automatically report visits and may offer guest passes through the Active&Fit Direct program.
   - Quarterly online newsletters covering health and exercise topics.
   - Online classes.

7. **Q: How can I enroll in the Active&Fit Direct program?**
   A: You may enroll in the Active&Fit Direct program by going to www.exerciserewards.com. Once you choose a participating fitness center, a $25 enrollment fee, $25 for the current month (regardless of the enrollment date within that month), and $25 for the next month will be due when you enroll. Each month's fee is $25.

   After a 3-month commitment, participation is month-to-month. Once enrolled, you may view or print your fitness card. Payment will be charged on the closest day within the same month (e.g., if you enroll January 30, the recurring payment is February 28, the last day of the month).

8. **Q: What should I do if I already go to a fitness center but I want to enroll into an Active&Fit Direct fitness center?**
   A: Active&Fit Direct network fitness centers allow you to cancel or suspend current memberships so you may enroll in the Active&Fit Direct program at no penalty. If you decide to cancel your Active&Fit Direct enrollment, and the original fitness center membership was suspended (and not canceled), your original membership should be reinstated.

9. **Q: What do I need to send in to the ExerciseRewards program if I am manually tracking my activity on the Visit Submission Form?**
   A: If you choose to attend an acceptable fitness center that does not submit visits and you're not enrolled in the Active&Fit Direct program or using the ASHConnect app, then you'll need to keep track of your workouts on a paper log.

   Complete the Visit Submission Form, which documents your fitness center visits. A fitness center staff member must sign or stamp the log for each visit, or you can submit a computer printout of your workouts from the fitness center. Please ensure the form is complete and legible to process your reward.

   Submissions must be received no later than 90 days after the end of each month.

   The Visit Submission Form is available at www.ExerciseRewards.com or by calling 877.810.2746.

10. **Q: What do I need to do to get rewarded?**
    A: You need to complete at least 10 fitness center visits in each month timeframe. Activity can be tracked on www.ExerciseRewards.com when you:
    - » Use the ASHConnect app.
    - » Enroll in the Active&Fit Direct program and attend a contracted fitness center. Visits will be added to your account after they are received and processed, approximately one month after you visit the participating fitness center.

    If you submit paper logs of your workouts, the visits will be added to your online account when your log is received and processed.

11. **Q: How do I redeem my reward?**
    A: You will be able to see your reward information on the website. Once your visit requirement is met and processed, you will receive a redemption email (if on file) advising you to log in to www.ExerciseRewards.com. Go to the Rewards page and click "Available to redeem" and select your incentive period. Confirm your mailing address and click "Redeem." If you are unable to redeem your reward, ExerciseRewards will automatically redeem your reward approximately 30 days after the calendar month in which you earned your reward.

12. **Q: When should I expect to receive my reward?**
    A: All rewards are processed within 7 – 10 days of a member redeeming their reward on the website.

    If you are submitting paper logs, and you submit incomplete or invalid documentation, your reward will not be processed. The reason your reward was not processed will be posted to your account on the ExerciseRewards website within 30 days of receipt of your submission.

13. **Q: If a fitness center is not in the ExerciseRewards network, how will I know if it is acceptable to use for this program?**
    A: For a fitness center to qualify, it must be in the 50 U.S. states or District of Columbia; offer regular cardiovascular, flexibility, and/or resistance training exercise programs or may include instructor-led classes (such as Zumba®, Pilates, "step" classes, yoga, aquatics, etc.); must have staff oversight; and must offer a membership agreement.

    Examples of excluded centers that do not qualify for rewards include, but are not limited to, the following:

    - Services and activities such as rehabilitation services, physical therapy services, country clubs, social clubs, or sports teams and leagues
    - Dues or fees for participating in aerobic/fitness activities not in an acceptable fitness center, as well as fees for personal training, lessons (e.g., tennis and swimming), coaching, and exercise equipment or clothing purchases
    - Exercise sessions at fitness centers where there is no staff oversight (e.g., centers in apartment buildings, hotels, and sports clubs)

    Because these excluded fitness centers are not eligible for rewards, they will not appear in the ASHConnect app and are not in the Active&Fit Direct network.

Dental Plan

Administered by Delta Dental

North Central Health Care provides dental coverage that is administered by Delta Dental for eligible North Central Health Care employees. Delta Dental PPO is Delta Dental's national preferred provider organization program that gives you access to two of the nation's largest networks of participating dentists–the Delta Dental PPO network and the Delta Dental Premier network. Although you can go to any licensed dentist anywhere, your out-of-pocket costs are likely to be lower if you go to a dentist who participates in one of these networks.

ELIGIBILITY

To be eligible for Dental Insurance you will need to work a minimum of a 0.5 FTE status. North Central Health Care has two different levels of premium contribution.

- **0.5 – 0.74 FTE** has a premium contribution of 30% employer paid premium and 70% employee paid premium
- **0.75 – 1.0 FTE** has a premium contribution of 65% employer paid premium and 35% employee paid premium

2020 EMPLOYEE CONTRIBUTION RATES

FTE	SINGLE Per Pay Period	FAMILY Per Pay Period
0.5–0.74	$13.78	$36.74
0.75-1.0	$6.89	$18.37

HOW DOES THE DELTA DENTAL PPO PROGRAM WORK?

The Delta Dental plan offers two provider networks: Delta Dental PPO and Delta Dental Premier. With two dentist networks available, which one is right for you? The Delta Dental PPO network delivers the greatest savings, but fewer dentists belong. The Delta Dental Premier network is the largest dentist network, but the savings aren't as significant as with a Delta Dental PPO provider. Both networks save you money, and seeing either a Delta Dental PPO dentist or Delta Dental Premier dentist will ensure that treatments are guaranteed, claims are directly paid, and no balance-billing can occur.

WHAT IF I GO TO A NON-PARTICIPATING DENTIST?

Out-of-network dentists have not agreed to a fee schedule with Delta Dental. If a non-participating dentists charges more for a service, than the maximum Delta Dental allows for a procedure, then the dentist can balance bill you for the difference between the maximum allowable fee and what they charge.

HOW CAN I FIND A PARTICIPATING DENTIST?

To find the names of participating dentists near you, use the Delta Dental provider search on their website www.deltadentalwi.com, or you can call Delta Dental's Customer Service department toll-free, at: 800-236-3712.

DELTA DENTAL

Your Dental Benefits

Specially Prepared for the Employees of *North Central Health Care*

The summary below does not cover all plan details. Further information can be found in the summary plan description or dental benefit handbook. That document provides a thorough explanation of your dental plan, including any limitations or exclusions that might apply. If there are any discrepancies between information found here and the group contract, the group contract shall govern.

Benefit Plan Design		Delta Dental PPO When you see a Delta Dental PPO dentist	Delta Dental Premier When you see a Delta Dental Premier or any other dentist
Individual Annual Maximum		$1,500	$1,500
Deductible	**Individual**	$50	$50
	Family	$150	$150
Dependent Eligibility Dependents are eligible through the end of the month in which they attain age 26 and full-time students through the end of the month in which they attain age 26; except as noted for orthodontics			
Diagnostic & Preventive Services			
Exams		100%	100%
Cleanings		100%	100%
Fluoride treatments		100%	100%
X-rays		100%	100%
Space maintainers		100%	100%
Sealants		100%	100%
Deductible applies		No	No
Basic & Major Services			
Emergency treatment to relieve pain		80%	80%
Fillings		80%	80%
Endodontics – nonsurgical		50%	50%
Endodontics – surgical		50%	50%
Periodontics – nonsurgical		50%	50%
Periodontics – surgical		50%	50%
Extractions - nonsurgical		50%	50%
Extractions - surgical and other oral surgery		50%	50%
Crowns, inlays, onlays		50%	50%
Bridges and dentures		50%	50%
Repairs and adjustments to bridges and dentures		50%	50%
Implants		50%	50%
Deductible applies		Yes	Yes
Orthodontic Services			
Coverage copayment		50%	50%
Individual lifetime maximum		$1,200	$1,200
Dependents eligible to age		19	19
Full-time students eligible to age		19	19
Adult ortho		No	No
Deductible applies		Yes	Yes
Special Plan Provisions **(see following page for more information)**			
CheckUp Plus		Yes	Yes

DELTA DENTAL

Specially prepared for the employees of North Central Health Care

Special Plan Provisions

Your group dental plan from Delta Dental of Wisconsin includes one or more special features designed to encourage good oral health and promote overall health. Details of these provision(s) are addressed in the policy amendments provided with your dental plan handbook. Below is a brief summary.

CheckUp Plus™ Promoting wellness

- CheckUp Plus™ lets you obtain diagnostic and preventive services - including examinations, X-rays, regular cleanings and other related treatments - without the costs of those services applying to your individual annual maximum.
- The full value of your annual maximum is applied to the benefits you receive for basic and major restorative services.
- CheckUp Plus™ promotes regular visits to the dentist for exams and cleanings, which can improve your oral health and overall health.

HOW DOES DELTA DENTAL COORDINATE COVERAGE WITH ANOTHER PLAN WHEN DELTA IS THE SECONDARY PAYER?

After benefits have been determined under the primary plan, the secondary plan will determine its allowable benefit, and pay a benefit up to the full amount of the claim. The two programs together will not pay more than 100% of covered expenses.

PREDETERMINATION OF DENTAL BENEFITS

Whenever you have a question about whether a dental procedure will be covered, you and/or your dentist should contact Delta Dental before you begin treatment. Ask your dentist to send Delta Dental a request for a predetermination of covered benefits anytime your dental work is expected to exceed $200.

WHERE CAN I FIND ADDITIONAL INFORMATION REGARDING THE DENTAL PLAN?

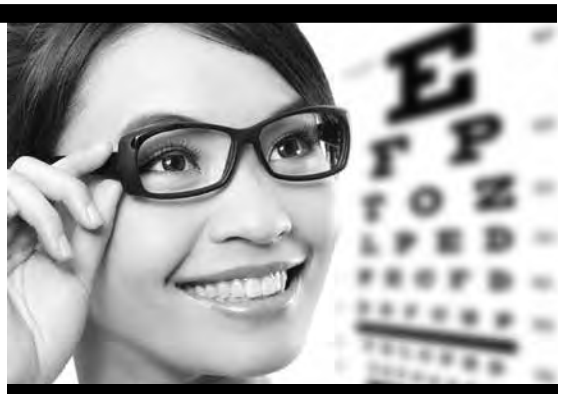
Several resources are available to find out what your dental plan covers:
- Refer to the Dental Plan Booklet that is available for viewing in the Human Resources office.
- Call Delta Dental's Customer Service department at: 800-236-3712

NOTE: You may enroll in the Limited Purpose FSA (Flexible Spending Account) for your dental expenses. See pages 34-35 for details.

Vision Plan

Administered by Vision Service Plan (VSP)

Vision Service Plan (VSP) has been contracted by your group to offer a comprehensive vision care plan to you and your eligible family members.



ELIGIBILITY

To be eligible for Vision Insurance you will need to work a minimum of a 0.5 FTE status. The vision premium contribution is 100% employee paid premium.

2020 EMPLOYEE CONTRIBUTION RATES

SINGLE Per Pay Period	FAMILY Per Pay Period
$2.69	$5.78

HOW VSP WORKS

- **When you enroll in VSP, you will not receive a member card.**
- **Notify your eye care provider that you are an NCHC Employee and enrolled in VSP. All records are accessed electronically.**

HOW TO FIND A PROVIDER

Members can search for network vision providers by following these instructions:

1. Go to www.vsp.com
2. Find the "Find a VSP Doctor" on the log in page
3. Enter your zip code and click on the green "Search button"
4. You can refine your search if you choose with the "Refine your Search" tool on the left side of the screen

To verify your benefit eligibility prior to calling or visiting your eye care provider, please visit our website at www.vsp.com or contact VSP's Member Services toll-free at 800.877.7195.

Benefit	Description	Copay	Frequency
	Your Coverage with a VSP Provider		
WellVision Exam	• Focuses on your eyes and overall wellness	$10	Every calendar year
Prescription Glasses		$25	See frame and lenses
Frame	• $130 allowance for a wide selection of frames • $150 allowance for featured frame brands • 20% savings on the amount over your allowance • $70 Costco® frame allowance • $70 Walmart frame allowance	Included in Prescription Glasses	Every other calendar year
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children	Included in Prescription Glasses	Every calendar year
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 20-25% on other lens enhancements	$55 $95 - $105 $150 - $175	Every calendar year
Contacts (instead of glasses)	• $130 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every calendar year
Extra Savings	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam. **Retinal Screening** • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam **Laser Vision Correction** • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		

Your Coverage with Out-of-Network Providers

Get the most out of your benefits and greater savings with a VSP network doctor. Your coverage with out-of-network providers will be less or you'll receive a lower level of benefits. Visit **vsp.com** for plan details.

Exam	up to $45	Lined Bifocal Lenses	up to $50	Progressive Lenses	up to $50
Frame	up to $70	Lined Trifocal Lenses	up to $65	Contacts	up to $105
Single Vision Lenses	up to $30				

Coverage with a participating retail chain may be different. Once your benefit is effective, visit vsp.com for details. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc. is the legal name of the corporation through which VSP does business.

NOTE: You may enroll in the Limited Purpose FSA for your vision expenses. See pages 34-35 for details.

Flexible Spending Accounts

Administered by Diversified Benefits Services

Flexible Spending Accounts (FSAs) allow you to pay for out-of-pocket medical and dependent care expenses with pre-tax dollars. Your contributions are subtracted from your paycheck before federal, state, and FICA taxes are calculated on your pay, so you save money on taxes. Because you don't pay taxes on the money you contribute to your account, you gain an easy way to save money while paying for expenses you expect to incur. Contributions for FSAs do not reduce your pay for purposes of determining your life insurance or retirement benefits provided by North Central Health Care.

NCHC offers two FSA's Accounts:

Medical FSA—Use this account to cover the cost of health, dental, vision and hearing expenses which are not covered under an insurance plan for you, your spouse or dependents (including children up to age 26) which are considered eligible healthcare FSA expenses. You may contribute up to $2,700 per year. ***If you or your spouse are on any HSA Plan, you cannot be enrolled in the Medical FSA at the same time, per IRS guidelines.***

Dependent Care FSA—Use this account to cover the cost of dependent care while you work. You may use this for expenses for the care of a child under age 13 or a disabled spouse, child or parent. If you are married, your spouse must be employed or attending classes full time for you to use the Dependent Care Spending Account. You may contribute up to $5,000 per year per household to this account or $2,500 per year if you are married and file your taxes separately. Eligible dependent care expenses include qualified daycare centers for children or qualified adults as well as care inside or outside your home.

Limited Purpose FSA—Use this account to cover the cost for out-of-pocket dental and visions expenses for you, your spouse or dependents (including children up to age 26). If you enroll in the Health Savings Account, you are only allowed to enroll in the Limited Purpose FSA, meaning you can only use the FSA money for qualified dental and vision expenses. You may contribute up to $2,700 per year.

For more information please visit www.dbsbenefits.com

Eligible Medical FSA Expenses Include:

- Deductibles, coinsurance, and copays
- Prescription drug copays
- Over-the-counter medicines, if prescribed by a doctor
- Medical care items that are not prescription drugs, such as equipment (crutches), supplies (bandages and contact lens solution), and diagnostic devices (blood sugar testing kits)
- Dental expenses, including orthodontia
- Vision expenses, including eye exams, glasses, and contact lenses
- Hearing expenses, including hearing aids and exams
- Mental health expenses (does not include marriage counseling)
- Orthopedic expenses
- Weight loss programs (if medically necessary)
- Medical expenses for certain procedures not covered by your plan, such as laser vision correction

Eligible Dependent Care FSA Expenses Include:

- Child or adult care center that complies with State and Local regulations (not including nursing homes)
- Sitter inside or outside the home
- Day care during school vacation, provided it is not primarily for educational purposes
- Nursery school, even if the school provides educational services
- Relative who cares for eligible dependents, as long as that relative is not your dependent and is age 19 or older

Limited Purpose FSA Expenses Include:

- Dental expenses (cleanings, x-rays, fillings, caps, crowns, braces, bridges)
- Vision expenses (eye exams, glasses, frames, lenses, contact lenses, saline solutions, LASIK surgery)

For a list of covered expenses, visit the DBS website at: www.dbsbenefits.com. Contact DBS at: 262-367-3300 if you have questions about whether a particular expense is eligible.

HOW THE ACCOUNTS WORK

FSAs are simple. Here is how they work:

- You decide whether to participate in account.
- You decide how much you want to deposit during the calendar year.
- The money you allocate to the account is automatically deducted from your pay each pay period, before taxes are taken out.
- For dependent care claims, save the itemized receipts from your day care provider and submit a claim form with your receipts to DBS.

THINGS TO CONSIDER FOR DEPENDENT CARE FSAS

There are some IRS rules you should be aware of before you decide to participate in an FSA.

- Your 2020 contributions for Dependent Care FSA must be used for eligible expenses you incur between January 1, 2020 and March 15, 2021.
- You incur an expense on the date the service is provided—not when you are billed or when you pay for it.
- By plan rule, any unclaimed money remaining in your 2020 account(s) that is not used in the grace period is forfeited and will not be returned to you. This is known as the "use it or lose it" rule.
- Expenses reimbursed through an FSA cannot be used as a deduction or credit on your federal income taxes.
- For a Dependent Care Flexible Spending Account, you can only be reimbursed up to the amount available in your account. Claims for expenses exceeding that amount will be reimbursed as additional funds accumulate in your account.
- The contribution amount you elect during Open Enrollment is in effect until the end of the plan year. You may change your contribution amount during the plan year only if you experience a qualified family status change.

CLAIMS PROCESSING

An external vendor, Diversified Benefits Services (DBS), will process claims for reimbursement from your Dependent Care. DBS is a national provider of health care and benefits management services. A manual claim is needed for the Dependent Care claim process.

Group Term Life Insurance

Administered by Securian

North Central Health Care offers group life insurance through the Wisconsin Retirement System to eligible staff. This plan can be up to five times your annual salary. Spouse and dependent coverage is also available.

ELIGIBILITY

You may enroll if you are a Wisconsin Retirement System participant at the time of hire or when you first become eligible.

HOW TO ENROLL IN THE GROUP TERM LIFE INSURANCE

- Newly hired, if you are immediately eligible 30 days from your hired date. Coverage is effective on the 1st of the month following your hire date.
- The first of the month following date of hire under the WRS if you are a new employee or previously withdrew your retirement money.
- Evidence of Insurability will be required if you are outside of the open enrollment period or did not initially enroll on your hire date. The Evidence of Insurability Application form (Et-2305) must be received by Securian prior to your 70th birthday for Basic, and Supplemental Coverages. Evidence of Insurability is required in order to add or increase your Spouse or Dependent Coverage from one unit to two units of coverage. The Evidence of Insurability form is available from Human Resources or http://etf.wi.gov.

APPLICATION FORM

The application form is available from the ETF website at http://etf.wi.gov or in the Human Resources office.

WHAT YOU PAY FOR YOUR GROUP TERM LIFE INSURANCE

Group term life insurance may be purchased in amounts from one to five times your annual salary rounded to the next higher thousand dollars. Employee's cost per month for each $1,000 of basic life insurance is listed below. These rates are effective until June 30, 2020, at that time the premiums are subject to change.

Optional Employee Life Insurance Rates

AGE	RATES PER $1,000
0-29	$0.05
30-34	$0.06
35-39	$0.07
40-44	$0.08
45-49	$0.12
50-54	$0.22
55-59	$0.39
60-64	$0.49
65-69	$0.57
70-99	See HR

Dependent and Spouse Life Insurance Rates

AGE	1 UNIT	2 UNITS
Spouse	$10,000	$20,000
Each Dependent	$5,000	$10,000

Dependent and Spouse Plan premiums are $1.75 per unit, per month

YOUR BENEFICIARY

When you elect life insurance coverage of any kind for the first time, you must complete the beneficiary designation available in Human Resources.

You are automatically the beneficiary for any dependent life insurance for your spouse, other qualified adult (OQA), or eligible children.

You may choose any beneficiary you wish, such as a family member, a friend, a trust, or an organization. You can name a single beneficiary or you can name two or more joint beneficiaries to receive the insurance payment.

You may change your beneficiary at any time. If you do not designate a beneficiary, or if none of the beneficiaries you name survives you, death benefits will be paid to the first of the following:

- Your surviving spouse/OQA
- Surviving children in equal shares
- Surviving parents in equal shares
- Surviving siblings in equal shares
- Estate

TERMINATION OF COVERAGE

You can terminate Group Life Insurance or dependent/spouse coverage at any time. To do so, complete a Cancelation Form available from Human Resources.

Dependent spouse or other qualified adult plan coverage terminates when the employee retires, terminates employment with the North Central Health Care for any reason, or dies.

Coverage for your eligible dependent child ends at the end of the month in which the child turns age 25.

NCHC Retirement Plan - Wisconsin Retirement System

North Central Health Care participates in the Wisconsin Retirement System (WRS). The WRS is a defined benefit retirement program that is commonly referred to as a pension plan. Combined with Social Security benefits (where applicable) and personal retirement savings accounts, WRS benefits can help provide financial security during retirement. Contribution amounts are listed below. Employee contributions are mandatory.

2020 CONTRIBUTION RATES

Employee Category	Employee Contribution for 2020	Employer Contribution for 2020	Total Contribution 2020
General Employees	6.75%	6.75%	13.5%

Participation and Eligibility for employees hired prior to July 1, 2011 requires that:

1. An employee is expected to work at least one-third of what is considered full-time employment, which equates to working 600 hours or more during the year.
2. An employee is expected to be employed for at least one year, (365 consecutive dates, 366 in leap year) from the employee's date of hire.

Participation and Eligibility for employees hired on or after July 1, 2011:

1. An employee is expected to work at least two-thirds of what is considered full-time employment, which equates to working 1200 hours or more during the year.
2. An employee is expected to be employed for at least one year, (365 consecutive dates, 366 in leap year) from the employee's date of hire.

Once the employer sets the expectation that the employee will work the applicable required hours or an employee works the required hours, the employee is enrolled in the WRS and does not need to work the required hours every year to remain in the WRS. Once enrolled in the WRS, an employee can not opt-out of participation.

VESTING REQUIREMENTS

You may have to meet one of two vesting requirements depending on when you first began WRS employment. If neither vesting law applies, you were vested when you first began WRS employment.

- If you first began WRS employment after 1989 and terminated employment before April 24, 1998, then you must have some WRS creditable service in five calendar years.
- If you first began WRS employment on or after July 1, 2011, then you must have five years of WRS creditable service.

LEARN MORE ABOUT THE WISCONSIN RETIREMENT SYSTEM

Specific details about WRS benefits, including benefit estimates, may be obtained at the Department of Employee Trust Funds Plan Website: www.etf.wi.gov
Customer service number: (877) 533-5020

Retirement Savings Accounts Section 457(b)-Deferred Compensation

Administered by Empower Or Voya

North Central Health Care provides employees an additional way to save for retirement through the Section 457b Deferred Compensation Plans, administered through two providers. These plans are designed to be a supplement to an employee's WRS benefits and Social Security. These funds are fully funded by you. North Central Health Care does not contribute to these plans. You choose the amount to be deducted from your paycheck on a pre-tax or post-tax basis and the type of investment options that suit your financial plan. North Central Health Care's deferred compensation providers are:

- State of Wisconsin Deferred Compensation (Administered by Empower)
- Voya

Representatives from these companies can be contacted directly by using the telephone numbers located on page 79.

FUND MANAGEMENT FEES AND PLANS

Investment carriers pay for operational expenses, portfolio management, record keeping, quarterly statements, general administration, and customer service by assessing fees on its investment funds. The fees are subtracted from the investment returns or earnings of those funds, with the net return being credited to participant accounts. The prospectus of each fund summarizes its various fees and is available on the provider website. The combination of these fees will generally equal a fund's expense ratio. The expense ratio is reported as a percent of assets under management.

ROTH AFTER-TAX OPTION

Contributions to the 457(b) plans have historically been tax-deferred; that is, you reduce your taxable income now, and pay the taxes later upon withdrawal. You also have the option to make contributions with after-tax dollars, with the incentive that qualified withdrawals in retirement are completely tax-free. After-tax Roth accumulations are still subject to the same eligibility criteria to elect a cash withdrawal, rollover or loan.

When you make your 457(b) elections through North Central Health Care, you have the option to make your contributions all pre-tax, all after-tax, or a combination. Your combined tax-deferred and after-tax Roth contributions cannot exceed IRS limits. If you have an existing 457(b) account at WI Deferred Compensation or Voya, your investment company will track your after-tax contributions and associated earnings separately within the same account.

IRS 457(B) CONTRIBUTION LIMITS

You may contribute up to $19,000 per year if you are under age 50; if you are age 50 or older the limit is $25,000.

Voluntary Benefits Available to NCHC Employees

North Central Health Care offers a variety of voluntary benefits to provide income protection during a short-term disability, critical illness or accident. There are also options available for pet insurance and identity monitoring. We contract with a variety of insurers to provide these coverages. If you have any questions about the following benefits or would like to enroll, contact details are listed with each voluntary benefit. Voluntary benefits are available for:

- Income Continuation Insurance (ICI)
- Short-Term Disability
- Critical Illness with Cancer Coverage
- Accident
- Pet Insurance
- Identity Guard

Income Continuation Insurance

Administered by The Hartford

WHAT IS AN INCOME CONTINUATION INSURANCE (ICI) BENEFIT?

The Income Continuation Insurance (ICI) benefit is an "income replacement" benefit payable if you become disabled. This insurance is available to all NCHC employees who are eligible in the Wisconsin Retirement System. ICI provides replacement income for disabilities which are short- and long-term. The benefit usually lasts until you are no longer disabled or you reach age 65 (with some exceptions), whichever is sooner.

Note: ICI Standard Coverage is FREE to all eligible NCHC employees who participate in the WI Retirement System.
You must enroll within 30 days of date of hire by submitting a paper form to receive this benefit.

COVERAGE

The benefit provides up to 75% of your average monthly earnings based on your previous calendar year earnings rounded to the next highest $1,000 and divided by 12 (for newly hired employees, your projected annual salary is rounded to the next highest $1,000 and divided by 12).

- **Standard Coverage**—Covers up to $64,000 of annual earnings. The maximum benefit is $4,000 per month. The premiums are waived for both the employer and employee.

- **Supplemental Coverage**—Provides an additional benefit of up to $3,500 to employees whose annual salary exceeds $64,000. Covers between $64,001 and $120,000 of annual earnings. The maximum combined benefit is $7,500 per month. You must have standard coverage to apply for supplemental coverage. The premiums are paid entirely by the employee. Please see HR for information pertaining to the rates.

HOW IT WORKS?

Before the benefit starts, you must serve your elimination period. An elimination period is the number of calendar days in which you must be completely off work. You may select an elimination period of up to 180 days.

ICI benefits will not duplicate benefits available from other WRS programs, the Social Security Administration, workers' compensation, unemployment compensation or certain other sources. You will be required to repay duplicate benefits back to the ICI program.

Note: The Local ICI program is currently under a premium holiday. The premium holiday covers Standard and supplemental coverage.

INCOME CONTINUATION INSURANCE ENROLLMENT

Initial Enrollment
You have 30 days from your date of employment or your newly benefits-eligible job to enroll in the Income Continuation Insurance program. New hires would be offered the opportunity to enroll upon their initial eligibility.

When will coverage be effective?
- NCHC employees: Coverage is effective on the first day of the month on or after your date of employment or your newly benefits-eligible job.

DEFERRED ENROLLMENT

If you do not enroll in Income Continuation Insurance when you are initially eligible, you may have an opportunity to enroll through underwriting. Underwriting may include such items as an individual questionnaire, lab work or documentation from your physician. It is extremely beneficial to enroll when you are first eligible. As there will be no cost for employees in 2020, we recommend that employees who are benefit eligible enroll in ICI. Should a cost become necessary in the future, NCHC employees who are enrolled will be allowed to drop or change their elections into the program. You will also be given the opportunity to select supplemental ICI coverage if you are eligible.

EVIDENCE OF INSURABILITY

If you do not enroll in ICI during your initial 30-day enrollment period, you may apply for coverage at any time through Evidence of Insurability (acceptance not guaranteed). Coverage is effective on the first of the month on or following the approval of your application by the plan's underwriter.

WHEN ARE BENEFITS PAYABLE?

The elimination period begins on the first full day that you are continuously and completely absent from work due to disability. If you return to work during your elimination period, even to perform incidental work at your employer's request, your elimination period may be extended. Before performing any work during your elimination period you should discuss the issue with your claims representative at The Hartford.

HOW TO FILE A CLAIM

You may file a claim up to 30 days before your anticipated last day worked but no more than 12 months from your last day in pay status. Contact The Hartford at 1-800-960-0052 to begin your claims process. See the Plan Brochure for more information.

PREMIUMS

For Income Continuation Insurance premiums, see the Premiums page. Currently the local plan is on a premium free holiday from January 1, 2014. If an employee makes over $64, 001 and would like to purchase additional supplement salary the premium cost would be the employee responsibility.

Specific details about Income Continuation Insurance, may be obtained by contacting The Hartford at 1.800.960.0052.

Short-Term Disability

Administered by The Standard

You work hard to earn a paycheck to cover your daily expenses such as your house payment, car payment and utility bills. If an unexpected illness or accident were to happen short-term disability will protect a portion of your income so you can make sure your bills are paid.

ENROLLMENT

You may enroll in the Short-Term Disability benefit if you work a minimum of a 0.5 FTE status.
You have 30 days from your date of employment or your newly benefits-eligible job to enroll.

Your health insurance helps pay medical bills. Short Term Disability insurance pays you. It can replace part of your paycheck if you can't work due to a qualifying disability.

Disability insurance helps protect your income if you're unable to work.

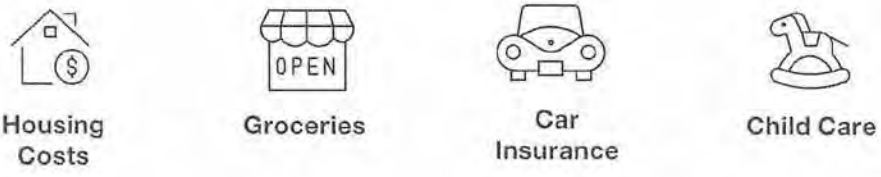
Short Term Disability insurance can help pay benefits if you become disabled and can't work for a short amount of time.

This coverage replaces a portion of your income when you can't work because of a qualifying disability, including injury, physical disease, pregnancy or mental disorder

You may receive weekly benefits that replace a specified percentage of your eligible earnings. Benefits begin after the short benefit waiting period explained below.

You may also receive help returning to work if you need accommodations.

Even if you're healthy now, it's important to protect yourself and the people who count on your income. **If you can't work, Short Term Disability insurance may help you pay for ongoing expenses:**



Short Term Disability Insurance

What Your Benefit Provides This is the benefit you'd receive if you suffer a qualifying disability. Eligible earnings are your weekly insured predisability earnings, as defined by the group policy. Your benefit amount will be reduced by deductible income; see the Important Details section for a list of deductible income sources.	66 2/3 percent of your eligible earnings, up to a maximum benefit of $1,000 per week. Plan minimum $15 per week.
Benefit Waiting Period If you suffer a qualifying disability, your benefit waiting period is the length of time you must be continuously disabled before you can begin receiving your weekly benefit.	• 0 days for accidental injury • 7 days for physical disease, pregnancy or mental disorder
Extended Benefit Waiting Period This applies to you if you opted out of coverage on July 1, 2019, if you do not apply for this coverage within 31 days of becoming eligible, or if your insurance ends because you failed to pay your premium and is later reinstated.	60 days for any qualifying disability caused by physical disease, pregnancy or mental disorder occurring during the first 12 months of coverage.
How Long Your Benefits Last This is the maximum length of time you could be eligible to receive a weekly disability benefit.	90 days

See the Important Details section for more information, including requirements, exclusions, limitations and definitions.

Short-Term Disability (continued)

Additional Features

Return to Work Incentive	Your disability benefit will not be reduced by any work earnings you receive until the combined amount of the benefit, earnings and other sources of income exceeds 100 percent of your pre-disability earnings.
Help With Returning To Work	If a worksite modification would enable you to return to work, we can help your employer make approved modifications by covering some or all of the cost.

Not being able to work also means not being able to earn a paycheck.

As you consider Short Term Disability insurance, think about the expenses you would need to cover if you became disabled:

- Housing costs
- Utilities
- Groceries
- Medical bills
- Car insurance
- Child care costs

To estimate your insurance needs, you'll need to consider your unique circumstances. Use our online calculator at **standard.com/disability/needs.**

How Much Your Coverage Costs

Because this insurance is offered through North Central Health Care, you'll have access to competitive group rates that may be more affordable than those available through individual insurance. You'll also have the convenience of having your premium deducted directly from your paycheck.

How much your premium costs depends on a number of factors, such as your age and your benefit amount.

Use this formula to calculate your premium payment:

_____	x 0.6667	x	_____	÷ 10 =	_____
Enter your weekly earnings (cannot be more than $1,500)			Enter your rate from the rate table.		This amount is an estimate of how much you'd pay each month.

Your Age (as of July 1)	Rate per $10 of weekly benefit
<0-24	$0.587
25-29	$0.587
30-34	$0.597
35-39	$0.597
40-44	$0.618
45-49	$0.731
50-54	$0.906
55-59	$1.112
60-64	$1.164
65+	$1.318

Important Details

Here's where you'll find the nitty-gritty details about the plan.

Eligibility Requirements

A minimum number of eligible employees must apply and qualify for the plan before the coverage can become effective. If this requirement is not met, this plan will not become effective.

To be eligible for coverage, you must be:

- A regular employee of North Central Health Care actively working at least 20 hours per week
- A citizen or resident of the United States or Canada

Temporary and seasonal employees, full-time members of the armed forces, leased employees and independent contractors are not eligible.

Employee Coverage Effective Date

To become insured, you must:

- Meet the eligibility requirements listed above
- Serve an eligibility waiting period,*
- Apply for coverage and agree to pay premium
- Receive medical underwriting approval (if applicable)
- Be actively at work (able to perform all normal duties of your job) on the day before the scheduled effective date of insurance

If you become a member after the group policy effective date, you are eligible on the first day of the calendar month following the date you become a member.

If you are not actively at work on the day before the scheduled effective date of insurance, your insurance will not become effective until the day after you complete one full day of active work as an eligible employee.

Definition of Disability

You will be considered disabled if, as a result of physical disease, injury, pregnancy or mental disorder:

- You are unable to perform with reasonable continuity the material duties of your own occupation, and
- You suffer a loss of at least 20 percent in your predisability earnings when working in your own occupation.

You are not considered disabled merely because your right to perform your own occupation is restricted, including a restriction or loss of license.

Exclusions

Subject to state variations, you are not covered for a disability caused or contributed to by any of the following:

- Your committing or attempting to commit an assault or felony, or your active participation in a violent disorder or riot
- An intentionally self-inflicted injury, while sane or insane
- War or any act of war (declared or undeclared, and any substantial armed conflict between organized forces of a military nature)
- The loss of your professional or occupational license or certification
- An activity arising out of or in the course of any employment for wage or profit

Short-Term Disability (continued)

Limitations
Short Term Disability benefits are not payable for any period when you are:

- Not under the ongoing care of a physician in the appropriate specialty, as determined by The Standard
- Not participating in good faith in a plan, program or course of medical treatment or vocational training or education approved by The Standard, unless your disability prevents you from participating
- Confined for any reason in a penal or correctional institution
- Able to work and earn at least 20 percent of your predisability earnings in your own occupation but you elect not to
- Receiving sick-leave pay, annual or personal leave pay, severance pay or other salary continuation (including donated amounts) from your employer
- Eligible to receive benefits for your disability under a workers' compensation law or similar law

When Your Benefits End
Your Short Term Disability benefits end automatically on the date any of the following occur:

- You are no longer disabled
- Your maximum benefit period ends
- Long term disability benefits become payable to you under a long term disability plan
- Benefits become payable under any other disability insurance plan which you become insured through employment during a period of temporary recovery
- You fail to provide proof of continued disability and entitlement to benefits
- You pass away

Deductible Income
Your benefits will be reduced if you have deductible income, which is income you receive or are eligible to receive while receiving Short Term Disability benefits. Deductible income includes:

- Amounts under unemployment compensation law
- Amounts because of your disability from any other group insurance
- Any retirement or disability benefits received from your employer's retirement plan which are not attributable to your contributions
- Amounts under any state disability income benefit law or similar law
- Earnings from work activity while you are disabled, plus the earnings you could receive if you work as much as your disability allows
- Earnings or compensation included in your predisability earnings which you receive or are eligible to receive while Short Term Disability benefits are payable
- Amounts due from or on behalf of a third party because of your disability, whether by judgment, settlement or other method
- Any amount you receive by compromise, settlement or other method as a result of a claim for any of the above

Group Insurance Certificate
If coverage becomes effective, and you become insured, you will receive a group insurance certificate containing a detailed description of the insurance coverage, including the definitions, exclusions, limitations, reductions and terminating events. The controlling provisions will be in the group policy. The information presented in this summary does not modify the group policy, certificate or the insurance coverage in any way.

When Your Insurance Ends
Your insurance ends automatically when any of the following occur:

- The date the last period ends for which a premium was paid
- The date your employment terminates
- The date the group policy (or your employer's coverage under the group policy) terminates
- The date you cease to meet the eligibility requirements (insurance may continue for limited periods under certain circumstances)
- The date North Central Health Care ends participation in the group policy

Critical Illness with Cancer Coverage

Administered by The Standard

Critical illness with cancer insurance coverage helps with the financial burden that can come along when cancer, heart attack, stroke and multiple other diseases strike a family unexpectedly. This coverage pays a lump sum if one of the covered diseases happens to your family. The money comes to you and can be used any way you choose.

ENROLLMENT

You may enroll in the Critical Illness with Cancer Coverage benefit if you work a minimum of a 0.5 FTE status.
You have 30 days from your date of employment or your newly benefits-eligible job to enroll.

You may have medical insurance. But that doesn't mean you're covered for all of the expenses resulting from a serious illness that you probably haven't budgeted for — things like copays, deductibles, loss of income, child care and travel expenses. Group Critical Illness insurance helps fill the gap caused by these out-of-pocket costs, creating a financial safety net for you and your family.

Cancer patients carry rising burdens of health care-related out-of-pocket expenses: 42 percent reported a significant subjective financial burden and 46 percent used savings to defray out-of-pocket expenses.[1]

70 percent of people who had difficulty paying medical bills in 2012 had some kind of health insurance.[2]

1 "The Financial Toxicity of Cancer Treatment: A Pilot Study Assessing Out-of-Pocket Expenses and the Insured Cancer Patient's Experience," The Oncologist Express, Feb. 26, 2013, theoncologist.alphamedpress.org/content/18/4/381.full

2 "Medical Debt Among People With Health Insurance," Kaiser Family Foundation, 2012 National Health Interview Survey (NHIS) data, Jan. 7, 2014, http://kff.org/private-insurance/report/medical-debt-among-people-with-health-insurance/

Help ensure your financial plans stay healthy even when you're not.

Critical Illness insurance is an affordable way to make up the difference between what your medical insurance covers and what you'd owe out of pocket if you or a family member were to be diagnosed with a covered critical illness. It's protection that's also convenient: Your premium payments are deducted directly from your paycheck.

Critical Illness (continued)

An Extra Layer of Protection

Critical Illness insurance can make a big difference in your ability to pay out-of-pocket expenses associated with a serious illness. It pays a lump-sum benefit directly to you upon diagnosis of a covered illness, regardless of your treatment costs or what's covered by your medical insurance. Elect coverage in $5,000 increments between $10,000 and $30,000.*

With Critical Illness insurance, you can:

- **Update your coverage as needed.** As your life circumstances change, increase* or decrease your coverage.
- **Lock in your rate.** For example, if you're 35 when your coverage becomes effective, you'll pay a 35-year-old's rate for as long as you have the coverage. If you increase your coverage amount at age 45, you will continue to pay a 35-year-old's rate for that increased coverage amount for so long as you have that increased coverage amount.
- **Take it with you.** If you leave your job, you can take your coverage with you.
- **Pick and choose how to spend your benefit.** Spend your lump-sum benefit however you want.
- **Protect your loved ones.** Cover your spouse up to $15,000. Your kids are automatically covered at 25 percent of the amount elected for yourself for the same critical illnesses that you are. Kids are also covered for 21 additional childhood diseases, including cystic fibrosis, Down syndrome, muscular dystrophy, spina bifida and cerebral palsy.
- **Receive a benefit for taking care of your health.** You and your covered loved ones receive a Health Maintenance Screening benefit of $75 once per calendar year when visiting the doctor for a covered wellness exam, such as a cholesterol screening (part of a lipid panel) or mammogram — routine preventive visits that typically cost you nothing under your medical insurance.
- **Receive additional benefits.** If you are diagnosed with a covered illness again after a treatment-free period of 6 months, you will receive 50 percent of the original benefit amount. If you are diagnosed with a different and subsequent covered illness at least 90 days after the diagnosis of the first critical illness, you will receive an additional Critical Illness insurance benefit.

Chances are good that a family member, friend or colleague of yours has endured a critical illness. You may have even seen that person struggle to pay the bills. Think of Critical Illness insurance as financial peace of mind, so you don't have to choose between paying for medical bills and helping send your daughter to the college of her dreams.

*Evidence of good health may be necessary in some cases; see the Important Details section for more information.

Here's how it works:

John has $10,000 of Critical Illness insurance coverage. He makes an appointment with his doctor after feeling off for the past few weeks. Diagnosis: cancer, with a good prognosis but a long road ahead. Within days of making a claim, John receives his Critical Illness insurance benefit paid directly to him. As John undergoes intensive treatment over the next few months, he can use the benefit for any purpose, including to pay for things that his medical insurance does not cover. Things like the deductible, copays, child care, certain medications, time away from work, alternative treatments and a special diet.

SAMPLE OUT-OF-POCKET EXPENSES

Medical insurance deductible	$1,300
Out-of-pocket expenses over the course of six months	$5,000
Lost wages	$4,500
Alternative treatments and diets not covered by medical plan	$4,500
TOTAL OUT-OF-POCKET EXPENSES	**$15,300**
CRITICAL ILLNESS BENEFIT	$10,000
OUT-OF-POCKET EXPENSES	$5,300

Costs are hypothetical. Actual costs will vary by state, cancer type, stage at diagnosis, treatments received and personal factors.

Critical Illness insurance can make a big difference in your ability to pay out-of-pocket expenses associated with a serious illness that are not covered by medical insurance.

Covered Conditions

Receive 100 percent of your coverage amount for:

- Heart attack
- Stroke
- Cancer
- End stage renal (kidney) failure
- Major organ failure
- Coma
- Paralysis of two or more limbs
- Loss of sight
- Occupational HIV
- Occupational hepatitis

Receive 25 percent of your coverage amount for:

- Severe coronary artery disease with recommendation for bypass surgery
- Carcinoma in situ (cancer that has not metastasized)

Initial diagnosis and initial recommendation must occur after your coverage becomes effective.

Critical Illness (continued)

Affordable Group Rates

Because you'll be buying this insurance through North Central Health Care, you'll have access to affordable group rates. You'll also have the convenience of having your premium deducted directly from your paycheck. Your rates will not increase as you grow older – meaning you'll have the same monthly payment for as long as you have your coverage.

The semimonthly premiums you would pay for Critical Illness insurance benefits are based on your age for both you and your spouse and whether or not you or your spouse use tobacco. The rates below are not combined rates for you and your spouse, rather they are the rates for each of you individually. Please note that coverage can be purchased in $5,000 increments.

Coverage for...	Coverage Amount...
You	$10,000-$30,000 in increments of $5,000
Your spouse	$5,000-$15,000 in increments of $5,000, as long as it's not more than your coverage amount
Your child(ren) through age 25	Automatically covered at 25% of your coverage amount

See the Important Details section for more information, including requirements, exclusions, age reductions and definitions.

Non Tobacco Semimonthly Issue Age Premiums					
Coverage Amount	Age Band				
	< 30	30-39	40-49	50-59	60-70
5,000	$1.58	$2.70	$4.58	$8.85	$16.03
10,000	$3.15	$5.40	$9.15	$17.70	$32.05
15,000	$4.73	$8.10	$13.73	$26.55	$48.08
20,000	$6.30	$10.80	$18.30	$35.40	$64.10
25,000	$7.88	$13.50	$22.88	$44.25	$80.13
30,000	$9.45	$16.20	$27.45	$53.10	$96.15

Tobacco Semimonthly Issue Age Premiums					
Coverage Amount	Age Band				
	< 30	30-39	40-49	50-59	60-70
5,000	$2.10	$4.28	$8.53	$18.73	$35.73
10,000	$4.20	$8.55	$17.05	$37.45	$71.45
15,000	$6.30	$12.83	$25.58	$56.18	$107.18
20,000	$8.40	$17.10	$34.10	$74.90	$142.90
25,000	$10.50	$21.38	$42.63	$93.63	$178.63
30,000	$12.60	$25.65	$51.15	$112.35	$214.35

Important Details

Here's where you'll find the nitty-gritty details about Critical Illness Insurance.

Portability

This coverage is portable. That means that you may be able to continue your coverage through direct bill — at the same rate you would pay today — if your employment ends, the group policy terminates or your insurance ends because you no longer meet the eligibility requirements.

Eligibility Requirements

To be eligible for this coverage, you must be a regular employee of North Central Health Care, actively working in the United States at least 20 hours per week and a citizen or resident of the United States. Temporary and seasonal employees, full-time members of the armed forces, leased employees and independent contractors are not eligible.

You can choose to cover your spouse, a person to whom you are legally married, or your domestic partner as recognized by law or by your employer's domestic partnership policy, if applicable. You can also cover your child(ren) from birth through age 25. Your child(ren) cannot be insured by more than one employee. Your spouse or child(ren) must not be full-time member(s) of the armed forces. You cannot be insured as both an individual and a dependent.

A minimum number of eligible employees must apply and qualify for the proposed plan before Critical Illness insurance coverage can become effective.

Your Effective Date

You must satisfy the eligibility requirements listed above, serve an eligibility waiting period, receive evidence of good health underwriting approval (if applicable), agree to pay premium and be actively at work (able to perform all normal duties of your job) on the day before the scheduled effective date of insurance.

If you are not actively at work on the day before the scheduled effective date of insurance, your insurance will not become effective until the day after you complete one full day of active work as an eligible employee.

Please contact your human resources representative or plan administrator for more information regarding the requirements that must be satisfied for your insurance to become effective.

Evidence of Good Health

When you first apply for coverage or reinstatement, you and your spouse will need to provide evidence of good health by completing a brief questionnaire for the following situations:

- All late applications (applying 31 days after becoming eligible), outside North Central Health Care's annual open enrollment period
- Reinstatements, if required
- If you or your spouse were required to provide evidence of good health under a prior period of eligibility and either:
  - Did not provide it, or
  - We did not approve it

Changes in Your Insurance

To increase your or your spouse's insurance, you can apply in writing. Evidence of good health will be required:

- If you or your spouse were required to provide evidence of good health under a prior period of eligibility and either:
  - Did not provide it, or
  - We did not approve it

Reoccurrence Benefit

If you or your dependents receive a benefit for a covered critical illness and are later diagnosed with the same critical illness, a one-time reoccurrence benefit will be paid if you or your dependents have:

- Been continuously insured under the group policy between the initial and subsequent diagnosis or recommendation
- Served a 6-month treatment-free period in connection with the critical illness during which you or your dependents did not:
  - Consult a physician or other licensed medical professional
  - Receive medical treatment, services or advice
  - Undergo diagnostic procedures, including self-administered procedures
  - Take prescribed drugs or medications

Exclusions

Benefits are not payable if a critical illness is caused or contributed to by any of the following:

- War or any act of war
- Attempted suicide or other intentionally self-inflicted injury, while sane or insane
- Committing or attempting to commit an assault, felony or act of terrorism
- Active participation in a violent disorder or riot

Critical Illness (continued)

- The voluntary use or consumption of any poison, chemical compound, drug or alcohol in excess of the legal limit in the state the critical illness occurred, unless used or consumed according to the directions of a physician
- Initial diagnosis outside of the United States or Canada
- Elective surgery or other procedure which:
  - Does not promote the proper function of your or your dependent's body or prevent or treat sickness or injury
  - Is directed at improving your or your dependent's appearance, unless such surgery or procedure is necessary to correct a deformity resulting from a congenital abnormality or disfigurement

  Note: This exclusion will not apply to a critical illness caused or contributed to by your or your dependent's donation of an organ or tissue.

When Your Insurance Ends

Your insurance ends if you notify your employer or policyholder to terminate your coverage, you stop making premium payments, your employment terminates, you reach age 80, you cease meeting the member definition or the group policy terminates.

Child and spouse insurance ends when your insurance ends, they cease to meet the definition of child or spouse, you stop making premium payments for spouse insurance, your spouse reaches age 80, spouse or child insurance is no longer offered under the group policy or the group policy terminates.

Group Insurance Certificate

If coverage becomes effective and you become insured, you will receive a group insurance certificate containing a detailed description of the insurance coverage, including the definitions, exclusions, limitations, reductions and terminating events. The controlling provisions will be in the group policy. The information present in this summary does not modify the group policy, certificate or the insurance coverage in any way.

About Standard Insurance Company

For more than 100 years, we have been dedicated to our core purpose: to help people achieve financial well-being and peace of mind. Headquartered in Portland, Oregon, The Standard is a nationally recognized provider of group employee benefits. To learn more about products from The Standard, visit us at **www.standard.com**.

The Standard is a marketing name for StanCorp Financial Group, Inc. and subsidiaries. Insurance products are offered by Standard Insurance Company of Portland, Oregon, in all states except New York. Product features and availability vary by state and are solely the responsibility of Standard Insurance Company.

IMPORTANT NOTICE TO PERSONS ON MEDICARE: THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some healthcare services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductible or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice
- Outpatient prescription drugs if you are enrolled in Medicare Part D
- Other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before you buy this insurance:

- Check the coverage in all health insurance policies you already have.
- For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from Standard Insurance Company
- For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Accident Plan

Administered by The Standard

This plan protects you and your family against the unexpected costs associated with an accident. This plan pays you cash that can be used to help with your house payment, car payment, groceries, and cell phone payment or even help with out of pocket medical expenses like your deductible. It's your money, you choose where it goes. This plan includes a $200 wellness benefit paid once a year when you complete your annual exam.

ENROLLMENT

You may enroll in the Accident Plan benefit if you work a minimum of a 0.5 FTE status. You have 30 days from your date of employment or your newly benefits-eligible job to enroll.

Having an accident doesn't just hurt you — it can also damage your finances. Your medical insurance will cover some of the expenses, but you'll be left to foot the bills for your copays and deductible. Those can add up fast, especially if you're unable to work while you recover. That's where Group Accident insurance comes in: It helps protect your bank account from the out-of-pocket expenses that can come with an injury — whether you're coping with a broken arm or recovering from a serious car accident.

Medical insurance helps — but it doesn't pay for everything.

Some 31 million people sought care in the emergency room for unintended injuries in 2011.[1]

An estimated 10 million working-aged Americans struggled to pay medical bills in 2013 — even though they had health insurance.[2]

Don't let an accident stop your financial plans.

Accident insurance is an affordable way to make sure you can cover the gap between what your medical insurance covers and what you'd owe out of pocket if you or a family member were to get injured. It's protection that's also convenient: Your premium payments are deducted directly from your paycheck.

Accident Plan (continued)

Here's how it works:

In the event of a covered accident, your Accident insurance will pay a benefit directly to you. You can use this money wherever you need it most — whether that's to help with your deductible, copays and other medical bills, or your daily expenses while you recover.

Let's say your teenage daughter gets injured during tryouts for her school basketball team and goes to urgent care for treatment. Diagnosis: dislocated elbow and fracture of the forearm and wrist. Although surgery isn't necessary, she will need follow-up appointments and physical therapy.

BENEFITS PAID TO YOU

Urgent Care Visit	$50
X-ray	$50
Dislocated Elbow	$800
Arm Fracture	$550
Wrist Fracture	$550
Physician Follow-up Appointment	$50
Physical Therapy Appointment (2 visits)	$100
SUBTOTAL	**$2,150**
Youth Organized Sports Benefit (25% of subtotal)	$538
Total paid directly to you	$2,688

You d get an additional 25% if your child is injured while participating in an organized athletic activity whether it's football practice, a soccer game or dance class.

Imagine that you survive a serious car accident. After a trip to the ER, you stay in the hospital for several days while you recover. In the weeks following the accident, you have a follow-up appointment at a clinic in another city and physical therapy.

BENEFITS PAID TO YOU

Ambulance	$300
Emergency Room Visit	$150
CAT Scan	$200
Hospital Admission Benefit	$1,000
5-Day Hospital Confinement ($200 per day)	$1,000
Right Leg Fracture	$4,000
Knee Cap Fracture	$1,100
Pelvis Fracture	$2,400
Physician Follow-up Appointment	$50
Physical Therapy Appointment	$50
SUBTOTAL	**$10,250**
Transportation Benefit	$150
Lodging (4 days)	$700
Total paid directly to you	$11,100

Because you drove more than 100 miles one way for your follow up appointment, you d receive an extra $150. If your car accident occurred more than 100 miles away from your home and a family member who resides with you traveled to be near you while you were in the hospital, we d pay additional benefits to help cover lodging expenses.

Affordable Group Rates

Because you'll be buying this insurance through North Central Health Care Facilities, you'll have access to affordable group rates. You'll also have the convenience of having your premium deducted directly from your paycheck. Your rates will not increase as you grow older — meaning you'll pay the same premium for the life of the policy, even if you continue your coverage after your employment with North Central Health Care Facilities ends (this is known as portability).

You can get a Health Maintenance Screening Benefit of $200 each year just for going to the doctor for a covered wellness exam, such as a stress test or lipid panel — a routine preventive visit that typically costs you nothing under your medical insurance.

It pays to be well-adjusted. If you need to see a chiropractor while you're recovering from an accident, you can get a benefit of $50 (up to two visits per accident, providing those visits are on different days).

Staying in a hospital can be costly, even with medical insurance coverage. You'll receive a $1,000 benefit if you're admitted — plus $200 for every day you're hospitalized.* And if you're admitted or confined to a critical care unit while you're in the hospital, you'll receive additional critical care unit benefits.

If you or a dependent travel at least 100 miles from your or your dependent's place of residence for treatment, you'll receive a Transportation Benefit of $150 for each day of travel.** We'll pay a $175 Lodging Benefit per day** if you or a dependent travel at least 100 miles from your or your dependent's place of residence for treatment and you, your dependent or another person incurs a lodging expense.

*Up to 365 days per accident.
**Maximum 30 days per accident; 90 days per year.

Coverage for...	Monthly Premium
You	$9.55
You and your spouse	$16.45
You and your children	$17.92
You, your spouse and your children	$28.42

Accident Plan (continued)

These are actual benefits you could receive in the event of a covered accident. Benefits are paid once per covered accident unless otherwise noted:

Emergency Care Benefits	
Ambulance — Air	$800
Ambulance — Ground	$300
Emergency Room Visit	$150
Urgent Care Visit	$50
Initial Care Visit (not payable if Urgent Care or Emergency Room Visit Benefit is payable)	$50
Emergency Dental Care — Crown	$200
Emergency Dental Care — Extraction	$100
Outpatient X-ray	$50
Major Diagnostic Exam (such as CT scan, MRI, EEG)	$200
Transfusion Blood, Plasma or Platelets	$300

Specific Injury Benefits	
Burns	$200-$10,000, depending on severity
Coma	$7,500
Concussion	$150
Eye Injury	$200
Lacerations	$75-$500, depending on size
Skin Graft	25% of burn benefit

Dislocations	Non surgical/Surgical
Ankle, Collarbone (sternoclavicular), Elbow, Foot, Hand, Lower Jaw, Shoulder, Wrist	$800/$1,600
Knee (not including kneecap)	$900/$1,800
Collarbone (acromioclavicular), Spine	$400/$800
Finger, Rib, Toe	$150/$300
Hip	$2,500/$5,000
Partial Dislocation	25% of the associated dislocation listed above (non-surgical)

Fractures	Non surgical/Surgical
Ankle, Arm (shoulder to elbow), Arm (elbow to wrist), Collarbone, Elbow, Foot, Hand, Kneecap, Lower Jaw, Shoulder Blade, Sternum, Wrist	$550/$1,100
Bones of Face, Coccyx, Nose, Vertebrae	$500/$1,000
Rib	$400/$800
Finger, Toe	$100/$200
Hip	$2,500/$5,000
Leg (hip to knee)	$2,000/$4,000
Leg (knee to ankle), Pelvis, Vertebral Column	$1,200/$2,400
Skull (depressed)	$4,000/$8,000
Skull (non-depressed)	$1,500/$3,000
Chip Fracture	25% of the associated fracture listed above (non-surgical)

Surgical Benefits	
Knee Cartilage (Once per covered accident, regardless of whether one or both knees require repair. If both exploratory and repair surgeries are performed, will pay repair benefit amount)	
Exploratory	$200
Repair	$750
Tendon, Ligament, Rotator Cuff (If two or more surgeries are required for the same covered accident, will pay the highest benefit amount)	
Exploratory	$200
Repair of one	$750
Repair of two or more	$1,000
Ruptured Disc	
Repair	$750
Abdominal/Thoracic Surgery (If more than one surgery required for the same covered accident, will pay the highest benefit amount)	
Exploratory	$200
Laparoscopic Repair Surgery	$750
Open Repair Surgery	$1,500
Surgical Facility Benefit	$150

Hospital Benefits	
Hospital Admission (once per covered accident)	$1,000
Daily Hospital Confinement (maximum 365 days per covered accident)	$200 per day
Critical Care Unit Admission* (once per covered accident)	$750
Daily Critical Care Unit Confinement* (maximum 15 days per covered accident)	$200 per day
Daily Rehabilitation Facility (maximum 90 days per covered accident)	$100 per day
* Payable in addition to any Hospital Admission and/or Daily Hospital Confinement Benefit you may be eligible to receive.	

Follow Up Care	
Medical Appliance (e.g., wheelchair, cane or brace)	$100
Chiropractic Care (maximum 2 visits per covered accident, 1 per day)	$50 per day
Physician Follow-up (maximum 2 visits per covered accident, 1 per day)	$50 per day
Hearing Device	$500
Prosthesis	One: $500 Two or more: $1,000
Occupational, Speech or Physical Therapy (maximum 3 visits per covered accident, 1 per day)	$50 per day

Additional Benefits	
Lodging (per day, to a maximum of 30 days per covered accident and a total of 90 days per year)	$175
Transportation (per trip) (per day, to a maximum of 30 days per covered accident and a total of 90 days per year)	$150
Health Maintenance Screening Benefit (once per calendar year)	$200
Youth Organized Sports Benefit	Additional 25% of total benefit payable

IMPORTANT NOTICE TO PERSONS ON MEDICARE: THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some healthcare services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductible or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice
- Outpatient prescription drugs if you are enrolled in Medicare Part D
- Other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before you buy this insurance:

- Check the coverage in all health insurance policies you already have.
- For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from Standard Insurance Company
- For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Accident Plan (continued)

Here's where you'll find the nitty-gritty details about Accident insurance.

Portability

This coverage is portable. That means that you may be able to continue your coverage through direct bill if your employment ends, the group policy terminates or your insurance ends because you no longer meet the eligibility requirements.

Eligibility Requirements

To be eligible for this coverage, you must be a regular employee of North Central Health Care, actively working in the United States at least 20 hours per week and a citizen or resident of the United States. Temporary and seasonal employees, full-time members of the armed forces, leased employees and independent contractors are not eligible.

You can choose to cover your spouse, a person to whom you are legally married. You can also cover your children from birth through age 25. Your children cannot be insured by more than one employee. Your spouse or children must not be full-time member(s) of the armed forces. You cannot be insured as both an individual and a dependent.

A minimum number of eligible employees must apply and qualify for the proposed plan before Accident insurance coverage can become effective.

Your Effective Date

You must satisfy the eligibility requirements listed above, serve an eligibility waiting period, agree to pay premium, and be actively at work (able to perform all normal duties of your job) on the day before the scheduled effective date of insurance.

If you are not actively at work on the day before the scheduled effective date of insurance, your insurance will not become effective until the day after you complete one full day of active work as an eligible employee.

Please contact your human resources representative or plan administrator for more information regarding the requirements that must be satisfied for your insurance to become effective.

Exclusions

Benefits are not payable if an accident is caused by or contributed to any of the following:

- War or any act of war
- Suicide or other intentionally self-inflicted injury, while sane or insane
- Committing or attempting to commit an assault, felony or act of terrorism
- Active participation in a violent disorder or riot
- The voluntary use or consumption of any poison, chemical compound, drug or alcohol in excess of the legal limit in the state your accident occurred
- Sickness existing at the time of the accident, including any medical or surgical treatment or diagnostic procedure for a sickness
- Travel or flight in or on any aircraft, except as a fare-paying passenger on a commercial aircraft
- Engaging in high-risk sports or activities such as (but not limited to) bungee jumping, parachuting, base jumping, mixed martial arts or mountain climbing
- Practicing for, or participating in, any semiprofessional or professional competitive athletic contests for which any type of compensation or remuneration is received
- Routine eye exams and dental procedures other than a crown or extraction for a tooth or teeth as a result of a covered accident
- Riding in or driving any automobile in a race, stunt show or speed test
- Cosmetic surgery or other procedure to improve appearance, unless it is necessary to correct a deformity or restore bodily function after a covered accident
- An accident that occurs while you or your dependent is incarcerated in a jail or penal or correctional institution

When Your Insurance Ends

Your insurance ends if you notify your employer or policyholder to terminate your coverage, you stop making premium payments, your employment terminates, you cease meeting the member definition or the group policy terminates.

Child and spouse insurance ends when your insurance ends, they cease to meet the definition of child or spouse, you stop making premium payments for child or spouse insurance, spouse or child insurance is no longer offered under the group policy or the group policy terminates.

Group Insurance Certificate

If coverage becomes effective and you become insured, you will receive a group insurance certificate containing a detailed description of the insurance coverage, including the definitions, exclusions, limitations, reductions and terminating events. The controlling provisions will be in the group policy.

Encourage Employee Wellness

Annual Health Screening = A Cash Benefit

Regular health screenings can help employees stay healthy and productive. You can help promote and support wellness by including the Health Maintenance Screening Benefit with group Accident[1], Critical Illness[2] and Hospital Indemnity[3] insurance from The Standard.‡

Employees who purchase coverage can receive a cash benefit each calendar year when they or their covered dependents complete any one of the tests listed below.[4]

20 Approved Tests

- Abdominal aortic aneurysm ultrasound
- Ankle brachial index (ABI) screening for peripheral vascular disease
- Biopsies for cancer
- Bone density screening
- Breast ultrasound
- Cancer antigen 125 (CA 125) blood test for ovarian cancer
- Cancer antigen 15-3 (CA 15-3) for breast cancer
- Carcinoembryonic antigen (CEA) blood test for colon cancer
- Colonoscopy
- Complete blood count (CBC)
- Comprehensive metabolic panel (CMP)
- Electrocardiogram (EKG)
- Hemocult stool analysis
- Hemoglobin A1c
- Human papillomavirus (HPV) vaccination
- Lipid panel
- Mammography
- Pap smears or thin prep Pap test
- Prostate-specific antigen (PSA) test
- Stress test on a bicycle or treadmill

Employees simply undergo a covered health screening test and submit a claim. They will be mailed a check for the cash benefit.

1 This policy does not provide basic hospital, basic medical or major medical insurance as defined by the New York State Department of Financial Services. Important notice. Accident Insurance does not provide coverage for sickness.

2 Critical Illness insurance is called Specified Disease insurance in the states of New York and Vermont.

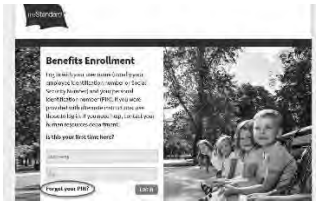
3 These policies do not provide basic hospital, basic medical or major medical insurance as defined by the New York State Department of Financial Services.

4 The benefit is paid only once per calendar year, even if the covered individual receives additional wellness tests during the year.

‡ The Standard is the marketing name for StanCorp Financial Group, Inc. and subsidiaries. Insurance products are offered by Standard Insurance Company of 1100 SW Sixth Avenue, Portland, Oregon, in all states except New York, where insurance products are offered by The Standard Life Insurance Company of New York of 360 Hamilton Avenue, Suite 210, White Plains, New York. Products not available in all states. Product features may vary by state and company and are solely the responsibility of each subsidiary. Each company is solely responsible for its own financial condition. Standard Insurance Company is licensed to solicit insurance business in all states except New York. The Standard Life Insurance Company of New York is licensed to solicit insurance business only in the state of New York.

Short-Term Disability, Critical Illness & Accident Plan Online Enrollment

Logging In/Forgot Login Information



- Open the online portal site at https://standard.benselect.com/NCHC
- Your user name is your 9 digit Social Security Number with no dashes.
- When you first log in, your personal identification number (PIN) will be the last four digits of your SSN followed by the last two digits of your birth year.
- *If you have previously logged in and forgot your password, click "Forgot your PIN?"*

Change PIN

- The first time you log in, you will be prompted to change your PIN. Your personalized pin must be a minimum of eight characters and include at least three of the following: UPPER case letter, lower case letter, number, a special character.
- Answer security questions and enter in your email address.
- Once you have entered your information, click SAVE NEW PIN
- *If you have previously logged in and forgot your password, click "Forgot your PIN?"*

Home Screen

- Once you have logged in, click NEXT. This will guide you through the entire enrollment process.
- Utilize the home screen navigation options to get to the specific thing you would like to do (*ie. change beneficiary).*
- You will be able to logout and re-enter the portal any time to continue the process or modify your enrollments.
- Any changes or elections you make will be saved each time you logout or time out due to in-activity.

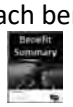
Personal Information

- Verify your personal information is correct. If any information is not correct, follow the instructions on the screen, then click NEXT

Dependents

- Review any dependent information listed.
- You may add a dependent by clicking +, edit an existing dependent by clicking the pencil icon or delete a dependent by clicking the blue x.
- You must have dependents entered on this screen in order to enroll or change any available dependent coverage.

Benefit Elections

- Review the short video about each benefit.
- Choose your benefit elections by selecting a level of coverage for you and your dependents.
- Where applicable, slide the bar to increase or decrease the benefit amount and cost. Click NEXT after making your election.
- To learn more about each benefit, click on the benefit summary link or the icon in the upper right corner of the screen. It may look like 

Beneficiaries

- Click + to add a new beneficiary or click pencil to change an existing beneficiary or X to delete a beneficiary.
- If the beneficiary you would like to designate is already listed, click the check box.
- You may designate more than one beneficiary and allocate different percentages between them.
- Your designation applies to the plan for which you are currently enrolling.
- To change a Beneficiary at a later date; simply login and select "Change my Beneficiary" located on the right side of the screen. Follow the screens as prompted and save your changes.

Navigation

- If at any point you would like to go back to a plan to make a change, you can use the My Benefits at the top to navigate back to any coverage.
- To make a change to the coverage, click the UNLOCK button and continue through the enrollment process.

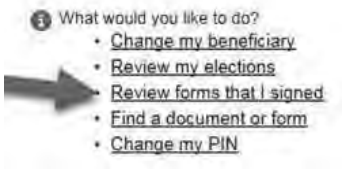
Submit Enrollment

- After verifying your benefit elections, you will be brought to the Submit Your Enrollment screen. Your enrollment is not complete until you have clicked the I AGREE button on the bottom of this screen.

Enrollment Confirmation Statement

You can access your Statement in two ways.

- Upon completion of your enrollment
    - From the Sign/Submit Complete screen, you may obtain copies of your enrollment summary. Scroll to the bottom of the page and click Enrollment Summary.
    - Please note: If you do not advance through the Submit Enrollment screens, you will not have an Enrollment Summary.
- Home Page
    - Log back into the system. On the right side of the screen, select *review forms I signed*



    - Select the Enrollment summary for the period you are looking for.

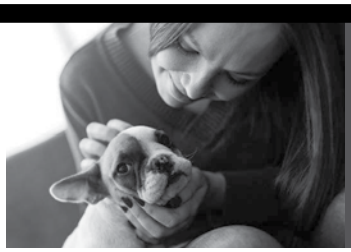
Evidence of Insurability (EOI)

- If you have selected an amount of coverage that exceeds the guarantee issue, you will be prompted to complete a medical history statement. The prompt appears after submitting your enrollment. Please follow the instructions for submitting evidence of insurability.
- Any amount of coverage you've elected over the guarantee issue amount will be pended until the medical review process is complete. You will be notified by The Standard once a decision is made on your application.

Pet Insurance

Administered by Nationwide

North Central Health Care offers pet insurance that provides nose-to-tail coverage for everything from shots to surgeries for as little as $1 a day for your pet. Exclusive group plans are available to you with pricing that is not available to the public. Enrollment is easy and premiums are payroll deducted. Plans are flexible and accepted by all veterinarians everywhere. Policies are portable and renew in full each year.



Choose a plan that's as unique as your pet.

Get back 90% of the vet bill for these items **and more**.[1]

Visit any vet, anywhere

	my pet protection® with wellness	my pet protection®
Accidents, including poisonings and allergic reactions	✓	✓
Injuries, including cuts, sprains and broken bones	✓	✓
Common illnesses, including ear infections, vomiting and diarrhea	✓	✓
Serious/chronic illnesses, including cancer and diabetes	✓	✓
Hereditary and congenital conditions	✓	✓
Surgeries and hospitalization	✓	✓
X-rays, MRIs and CT scans	✓	✓
Prescription medications and therapeutic diets	✓	✓
Wellness exams	✓	
Dental cleaning	✓	
Vaccinations	✓	
Spay/neuter	✓	
Flea and tick prevention	✓	
Heartworm testing and prevention	✓	
Routine blood tests	✓	
Just like all other pet insurers, we don't cover pre-existing conditions. However, we go above and beyond with extra features such as **emergency boarding, lost pet advertising and more**. Plus, both plans have a low $250 annual deductible and a generous $7,500 maximum annual benefit.	**$45.64(dogs) $27.38 (cats)**	**$27.30 (dogs) $16.38 (cats)**

Plans with coverage of getting back 70% and 50% of the vet bill are available. Please call 877-738-7874 for rates.

Easy enrollment

1. Select the species (dog or cat)*
2. Provide your zip code
3. Pick between two plans

*To enroll your bird, rabbit, reptile or other exotic pet, please call 888-899-4874.

vethelpline®

Free service available to all pet insurance members. Unlimited, 24/7 access to a veterinary professional ($150 value). Only from Nationwide®.

HOW IT WORKS

Pay for your pet's treatment at the time of service. Mail or email our claim form along with your vet bill. Get reimbursed according to your plan, after meeting the deductible (if any).

ENROLLMENT

Visit www.PetsNationwide.com, search for your company name and enroll easily online through your company page with your group discount included in the rates. You can also call 1.877.738.7874 and speak with a representative for easy enrollment and receive your group discount policy.

Identity Guard

Administered by Identity Guard

North Central Health Care offers identity protection through Identity Guard®. Identity Guard monitors your valuable credit and identity information, with alerts that can help you respond quickly if certain changes indicating fraudulent activity are detected. With dynamic credit management resources and tools, you will have helpful information as you make better financial and credit decisions.

Id Verification Alert System
Receive near real-time account takeover alerts when your personal information is used to update current accounts or apply for new credit applications. Identity Guard's global network of data sources include near real-time data feeds to help maintain your personal security.

Internet Surveillance
We reduce your risk of identity fraud by searching Internet chat rooms, underground forums, and online "black market"websites for your Social Security number, registered bank account numbers, and credit card numbers.

3-Bureau Credit Monitoring
Always be at the ready by arming yourself with the fastest alerts available from all three credit bureaus. 24/7 monitoring alerts you of early signs of potential identity theft such as new inquiries and account openings.

Address Change Monitoring
Changing the physical address with the U.S Post Office is a common tactic among fraudsters. You receive an alert whenever a change in your address is detected

1-Bureau Credit Report And Score*
Stay up to date on your credit with one-click access to your credit score and credit report from one of the leading credit bureaus.

Credit Score Analyzer
Simulate how your financial decisions may impact your credit. Use this tool to help decide whether or not to make payments, transfer balances, and open or close accounts.

	GOLD PLAN
Identity Protection	
3 Bureau Credit Monitoring	✔
Social Securtity Monitoring	✔
Dark Web Monitoring	✔
Identity Verification Alerts	✔
Address Change Monitoring	✔
Credit Score and Credit Reports	
Credit Scores* and Reports	MONTHLY 1-BUREAU
Credit Scores Analyzer	✔
Credit Inquiry Alerts	✔
Identity Theft Recovery Services	
Dedicated Case Managers	✔
$1 Million Identity Theft Insurance**	✔
Lost Wallet Protection	✔
Education Services	✔
U.S. Based Customer Care	✔
kIDSure Child Identity Protection	WITH CHILDREN AND FAMILY PLANS

Semi-Monthly Rates

Employee Only	$6.00
Employee + Spouse	$11.50
Employee + Children includes kIDSure	$7.50
Employee + Family includes kIDSure	$13.00

Lost Wallet Protection
If your wallet/purse is lost or stolen, just call us to cancel your credit cards, review your credit report for potential fraud, and send you up to $2,000 in emergency cash from one of your accounts.

$1 Million Identity Theft Insurance†
Not just a "Service Guarantee", you receive up to $1 million in identity theft insurance for covered losses due to identity theft to help you get your life back on track.

Id Vault Password Protection
Instead of trying to remember all your user names and passwords, use ID Vault® to securely encrypt and store it all in one place.

PC Keyboard Encryption Software
Encrypt every keystroke you make on your PC using PrivacyProtect®, which makes your typing unintelligible to keyloggers trying to steal your passwords and PINs.

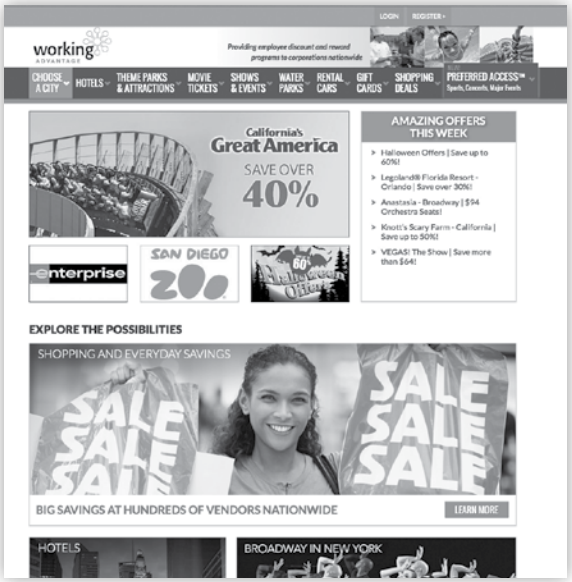
ENROLLMENT

Enroll online at: https://benefits.identityguard.com/northcentralhealthcare/ or call 1.800.452.2541

Employee Discounts

North Central Health Care provides employees discounts from local businesses and retailers including restaurants, cell phone carriers, car rental, massage and wellness, gym memberships, moving and miscellaneous discounts. Our list of partner businesses changes throughout the year. You can find the comprehensive list on the NCHC Intranet. There are also educational discounts offered through various educational institutions. Please contact Human Resources for the most current incentives and discounts at 715.848.4419.

In addition to local discounts, employees have access to Working Advantage discounts. Working Advantage provides employee discount and reward programs to corporations nationwide. When you sign up using the employer number provided on the intranet, you will have access to thousands of discounts from around the country! Hotels, movies, theme parks, attractions, skiing, rental cars, gifts, shopping partner sites.....the list is endless.



HOW TO FIND THE DISCOUNT PAGE ON THE INTRANET

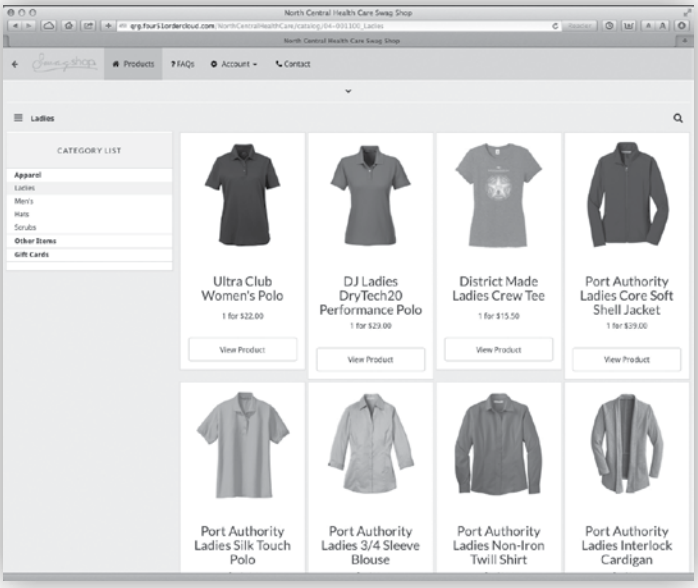
1. Go to any network computer, login and open your internet browser (Internet Explorer, Chrome, Safari, Firefox)
2. Navigate to the intranet by typing in "intranet" on your web browser or this address: http://intranet.co.marathon.wi.us/NCHC.aspx
3. From the NCHC tab at the top click on the following drop down: Departments, Human Resources, Employee Programs, Employee Savings Program. Your discounts await!

WORKING ADVANTAGE ENROLLMENT

Working Advantage provides discounts of up to 60% on a variety of entertainment and shopping opportunities. To enroll, you must register on the Working Advantage website using the NCHC access code found on the Intranet on the Employee Discounts page.

When logging in for the first time, create an account by clicking on "Register" in the upper right corner.

NCHC Swag shop.



www.norcen.org/SwagShop

North Central Health Care offers an online store for employees to shop online for NCHC branded clothing and accessories including scrubs, shirts, hats, jackets, vests, cardigans, polos and much more. From professional to casual, there are options available to ship directly to your home.

Looking for samples?

Visit the Human Resources office on the Wausau Campus to see samples of clothing. General sizing and measurements are available on the website.

Important Federal Notices

SUMMARY OF BENEFITS AND COVERAGE (SBC) AND UNIFORM GLOSSARY

A document called a Summary of Benefits and Coverage (SBC) is a federally-mandated document intended to help individuals across the nation compare health plans. The SBC is also available on the Intranet website. Each health plan is required to issue an SBC for every group health plan it offers. An SBC details deductibles, coinsurance and out-of-pocket limits for various services in a prescribed format. A Uniform Glossary of Health Coverage and Medical Terms to accompany the SBC is also available. You may also call the Human Resources at 715.848.4419 to request printed copies of a specific plan's SBC at no charge.

WOMEN'S HEALTH AND CANCER RIGHTS

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.
- Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and co-insurance applicable to other medical and surgical benefits provided under North Central Health Care's health plan.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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

HIPPA 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 North Central Health Care Human Resources at 715-848-4419.

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 Wisconsin, you may be eligible for assistance paying your employer health plan premiums. Contact your State for more information on eligibility – Medicaid and CHIP Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.p Phone: 1-800-362-3002

Important Federal Notices *(continued)*

SPECIAL RULES FOR GAIN OR LOSS OF ELIGIBILITY FOR MEDICAID/CHIPRA

When you experience a change that results in a gain or loss of eligibility for Medicaid/CHIP, you may be able to make certain adjustments to your benefits correlating to your status change within 60 days. Effective April 1, 2009, the Children's Health Insurance Program Reauthorization Act of 2009 ("CHIPRA") adds two new special enrollment events. You or your dependent(s) will be permitted to enroll or cancel coverage in NCHC's sponsored health plan coverage in either of the following circumstances:

1. You or your dependent's Medicaid or state Children's Health Insurance Program ("CHIP") coverage is canceled due to a loss of eligibility. You must request to enroll in North Central Health Care's health plan within sixty (60) days from the date you or your dependent loses coverage.
2. You or your dependent(s) enrolls in Medicaid or the state CHIP. You may cancel coverage in North Central Health Care's group health plan within sixty (60) days of your or your dependent's coverage effective date.

To make a change to your benefits plans please complete and submit a Benefits Enrollment/Change Form, available from Human Resources along with your documentation of the change within sixty (60) days after gaining or losing coverage in Medicaid or the state CHIP program. Your change will be effective as of the event date. For further details on Medicaid or Wisconsin's CHIP program, visit the Wisconsin Department of Community Health website or call 800-362-3002 toll-free.

HIPAA NOTICE OF PRIVACY PRACTICES REMINDER

The organization is committed to the privacy of your health information. The administrators of the medical plan use strict privacy standards to protect your health information from unauthorized use or disclosure. The plan's policies protecting your privacy rights and your rights under the law are described in the plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting North Central Health Care Human Resources at 715-848-4419.

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

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 Lynn Wengelski – Compensation & Benefits Analyst. 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.

[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.

Important Federal Notices *(continued)*

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE...*continued*

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: NCHC
4. Employer Identification Number (EIN): 39-1267785
5. Employer address: 1100 Lake View Drive
6. Employer phone number: (715) 848-4438
7. City: Wausau
8. State: WI
9. ZIP code: 54403
10. Who can we contact about employee health coverage at this job? Lynn Wengelski
11. Phone number (if different from above):
12. Email address: LWengelski@norcen.org

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:
- ☒ Some employees. Eligible employees are: Regular full-time employees to a .50 FTE for part-time employees

With respect to dependents:

- ☒ We do offer coverage. Eligible dependents are: spouse, children and step-children to the end of the month that they turn age 26
- ☐ We do not offer coverage.

☒ 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.

Important Federal Notices *(continued)*

IMPORTANT NOTICE FROM NORTH CENTRAL HEALTH CARE 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 North Central Health Care 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. **North Central Health Care has determined that the prescription drug coverage offered by Aspirus Arise 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 15 through December 7.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two 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 **North Central Health Care** coverage will not be affected. You may reference your current Aspirus Arise Summary Plan Description for benefits in place at the current time. Or you may request a copy of the Summary Plan Description from Human Resources or Aspirus Arise if you need to review or clarify the level of benefits currently being administered. See pages 7-9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current North Central Health Care 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 North Central Health Care 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 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information about This Notice or Your Current Prescription Drug Coverage…
Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through North Central Health Care 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).

Important Federal Notices *(continued)*

CONTINUATION 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 who elect COBRA continuation coverage must pay for COBRA continuation 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."

> Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to The NCHC and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

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;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- 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: Lynn Wengelski.

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.

Important Federal Notices *(continued)*

CONTINUATION COVERAGE RIGHTS UNDER COBRA...*continued*

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.

Plan contact information:

Lynn Wengelski, Compensation & Benefits Analyst, 1100 Lake View Drive, Wausau, WI 54403
715-848-4438 LWengelski@norcen.org

Important Federal Notices *(continued)*

NOTICE REGARDING WELLNESS PROGRAM

NCHC Wellness is a voluntary wellness program available to all employees participating in the NCHC's health care plan. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for cholesterol levels, glucose and triglycerides. For a complete list of conditions tested, see Human Resources. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Human Resources at 715-848-4419.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as nutrition or other forms of counseling. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and the NCHC may use aggregate information it collects to design a program based on identified health risks in the workplace, the NCHC's Wellness Program will never disclose any of your personal information, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are Aspirus' physicians, who will only access the information if/when you are seen by the Aspirus physician.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, and no information you provide as part of the wellness program will be used in making any employment decision. The NCHC only receives aggregate information and data – no personally identifying health information is provided to the NCHC by the Wellness contractors. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you in accordance with state and federal law.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Human Resources at 715.848.4419.

Changes to Your Benefits

QUALIFIED FAMILY STATUS CHANGE

Your benefits elections will remain in effect through December 31, 2020. Once you have enrolled, you may not change coverage mid-year unless you have a change in status, as defined by Section 125 of the IRS. Changes that qualify typically include but are not limited to:

- Marriage, divorce, birth, adoption, or death of a spouse or child
- Change in eligibility status for a covered dependent
- Your spouse starts or stops working
- Change from full-time to part-time (or vice versa) work status for you or your spouse
- You or your spouse take an unpaid leave of absence
- Elimination of your spouse's coverage due to an employment change
- You move out of the plan's service area

Different qualifying events allow different benefit changes. Any change you make mid-year must be consistent with your change in status and the event must affect eligibility for coverage under the plan.

DEADLINE FOR REPORTING CHANGES IN FAMILY STATUS

If you have a family status change, you must act within 30 days of the qualifying event to make a corresponding mid-year change to your benefits. Otherwise, you will have to wait for the next Open Enrollment period and have the change(s) become effective January 1 of the following year. In order to make such changes, contact the Human Resources at 715.848.4419 before the 30-day deadline.

REMOVING DEPENDENTS WHO LOSE ELIGIBILITY

If your covered dependent loses eligibility under the North Central Health Care benefit plan coverage due to an event occurring mid-way through the year, it is your responsibility to remove your dependent from your coverage within 30 days of ineligibility. It is especially important to delete any ineligible dependents within that time frame to avoid overpaying premiums that may not be refunded by North Central Health Care. Overpayment of premiums will not be refunded.

AGE 26 DEPENDENT CHILD

Children who turn age 26 in 2020 will be automatically removed from coverage at the end of the month they turn 26, and offered COBRA.

CHANGE IN YOUR FTE STATUS

If at any time your hours decrease to less than 0.5 FTE you become ineligible for health, dental and vision insurance. Health insurance benefit eligibility may remain in place if you worked more than 1,560 hours each year from October 1st to September 30th in the previous year.

LEAVES OF ABSENCE

Questions about leaves of absence should be directed to Human Resources. Leaves of absence are approved by your department and Human Resources. There are several kinds of leaves, and the effect on your benefits may vary. When your leave is approved, you will receive information about benefits continuation at your home address. All leave of absence premiums are due on the first of each month for that month's coverage (i.e., the premium for the month of June is due June 1).

QUESTIONS?

Questions should be directed to the Human Resources at 715.848.4419.

If You Leave North Central Health Care

HEALTH, DENTAL, AND VISION PLANS

Coverage for health care, including prescription drug coverage, the Dental Plan, and the Vision Plan ends on the last day of the month in which your employment terminates. For example, if you terminate employment on August 15, your health care coverage will end on August 31. You are covered up to and including August 31. However, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law that allows you to continue coverage under these plans at your own cost for up to 18 months and in some cases longer. Following your termination, COBRA enrollment materials will be sent to your last known home address. Update your address with Human Resources before your employment end date.

Workplace Resources

EMPLOYEE ASSISTANCE PROGRAM (EAP)

North Central Health Care's Employee Assistance Program is an assessment, referral, consultation and short-term counseling service for the employees and family members of North Central Health Care. All active staff including their immediate families are eligible. The primary purpose of the Employee Assistance Program is to assist in the identification and resolution of personal or work-related issues that may affect productivity and overall satisfaction in the work environment, as well as, the employee's personal well-being.

Important Information:

- 8 Sessions are offered per counseling issue needed for NCHC employees and members of their family
- A wide range of counselors and topics are covered under the EAP program.
  Examples are financial, job/work stress, family issues, marital counseling, etc.
- Counselors are located in the Wausau area and outside of the Wausau area if needed

The EAP contact number is entirely confidential and can be accessed
24 hours a day 365 days per year at 1.800.540.3758.

NEWS YOU CAN USE EMPLOYEE NEWSLETTER

News You Can Use is weekly newsletter created for the employees of North Central Health Care. Current information, recognition, news and events are shared with employees to keep informed and educated about topics you care about. Trainings, competencies and a variety of opportunities are included each week.

You can read the newsletter at anytime by:

- Clicking on the link sent out weekly to all staff via email
- Visiting www.norcen.org/NewsYouCanUse
- Logging on to the intranet http://intranet/nchc.aspx
- From any network computer, log in and go to the folder on the O:Drive > News You Can Use
- Read a printed copy in Human Resources, Communication Boards or staff lounge areas throughout the organization.

To make a submission to the newsletter, email jmeadows@norcen.org or call 1.715.848.4309. You can also text information and photos to 1.715.370.1547.

PARTNERING COMMUNITY ORGANIZATIONS

Opportunities and resources are available to employees from community organization partners, like the United Way, Chamber of Commerce and the Marathon Employees Credit Union. Please contact Human Resources for the latest information.

NCHC Tuition Reimbursement Program

North Central Health Care is committed to providing financial assistance to eligible employees interested in pursuing business related education in order to advance their careers at NCHC. Tuition reimbursement rewards employees for their contributions, adds skills to NCHC's workforce and promotes the shared responsibility between NCHC and employees for individual and organizational success.

TO BE ELIGIBLE TO PARTICIPATE IN THE TUITION REIMBURSEMENT PROGRAM, AN EMPLOYEE MUST:

- Have a minimum of one continuous year of service from your most recent date of hire; and
- Be eligible for benefits by maintaining at least a 0.5 FTE status at the start, through the duration of the educational term and during the repayment required service period; and
- Maintain acceptable job performance, as determined by management, throughout the course of study; and
- Be seeking a degree that is substantially related to their current position or another position within the organization.

REIMBURSEMENT OPPORTUNITIES

Annual (calendar year) maximum reimbursement amounts are available for the following educational opportunities:

- 100% for Certified Nursing Assistant course
- $1,000 – Associated degrees or equivalent
- $2,500 – Bachelor's degree or equivalent
- $5,250 – Master's, Ph.D., NP, OR PA-C degree or equivalent

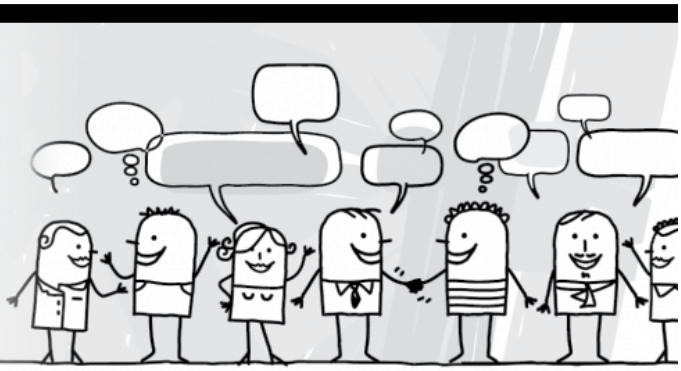
Tuition reimbursement is only for eligible tuition related costs and is not intended to cover books or other ancillary costs of seeking a degree. Only the reimbursement for Certified Nursing Assistant programs will be made in advance.

APPLICATION

Employees interested in applying for tuition reimbursement must apply prior to enrolling in the coursework. Applications will be reviewed by the Senior Executive of the program in conjunction with the Senior Executive – Human Resources. Approval is subject to NCHC sole discretion over applicability of the degree to NCHC criteria, operations and available funding. Review of the application and determination of funding will be made within thirty (30) days.

For the full Tuition Reimbursement Policy and required Request Form, please log in to the Policy Tree at the link on your network computer or at this web address: https://northcentralhealthcare.mypolicies.com
You may also contact Human Resources for assistance.

Employee Referral Program



North Central Health Care believes that it is in the best interest of both the organization and our employees to reward employees for referring qualified candidates for employment. The Employee Referral Program encourages current employees to participate in the recruitment of new employees by offering a referral bonus for the successful referral of a candidate hired at NCHC.

There is no limit to the number of times a referring employee may receive an Employee Referral Bonus, provided the conditions of this policy and the employment stipulations of the referred candidate are met.

Eligible employees will be rewarded a referral bonus when they refer a qualified candidate for successful employment at NCHC. The candidate must be hired into a budgeted full-time equivalent (FTE) position of 0.50 or greater, and remain employed in good standing and in the status of 0.50 or greater. Market sensitive positions can be hired at less than 0.5 FTE and still receive referral bonus.

WHAT DO I NEED TO DO TO EARN A REFERRAL BONUS?

The referring employee being referred must complete and submit the Employee Referral Bonus form to Human Resources BEFORE orientation.

Required Criteria: You and your RN recruit must be in good standing throughout this period.
What does that mean? No written warnings for attendance or other performance.

For the full Employee Referral Program Policy and required Referral Form, please log in to the Policy Tree at the link on your network computer or at this web address: https://northcentralhealthcare.mypolicies.com
You may also contact Human Resources for assistance.

REFERRAL BONUS AMOUNTS

Referral Bonus amounts are as follows:

- $500 - For all positions; or
- $1,000 - For Market Sensitive positions (will be identified by Human Resources at the time the position is posted).

HOW ARE REFERRAL BONUS PAYMENTS MADE?

Referral Bonus payments with be made in two payments: 50% of the Referral Bonus will be paid after ninety (90) days of employment and the remaining 50% after the referred employee has been with NCHC for one year.

Referral bonus amounts are subject to change without notice. The Human Resource Department will be responsible for keeping records of bonus eligibility and payments.

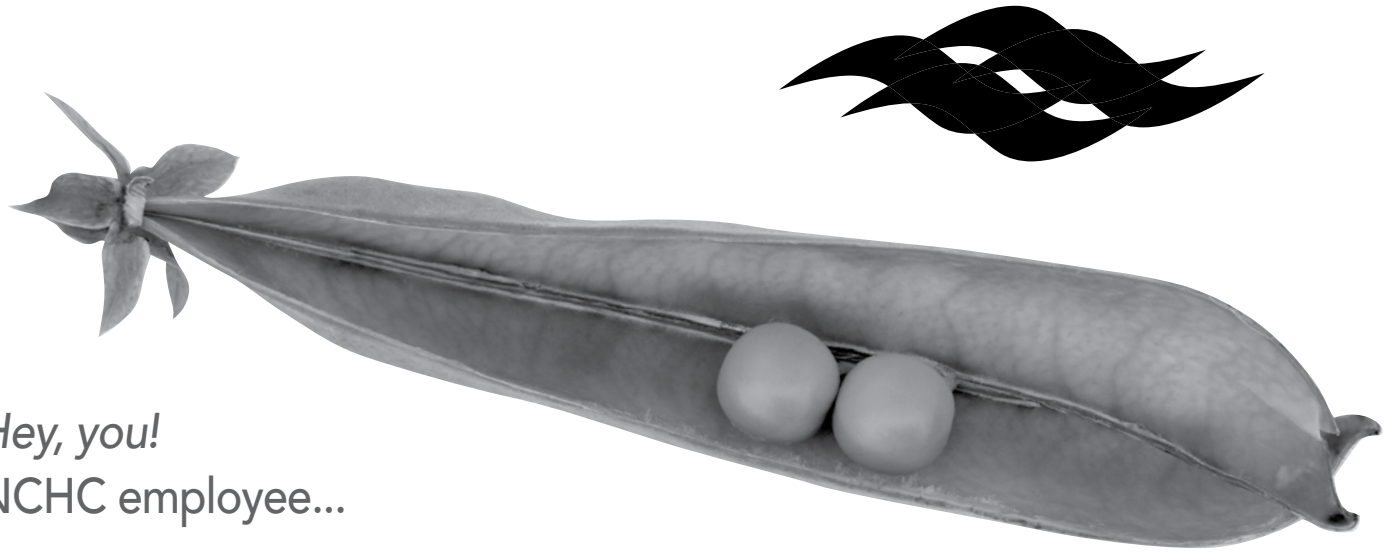
WHO IS NOT ELIGIBLE FOR A REFERRAL BONUS?

- The referral bonus does not apply for in-house transfers, promotions or referring prior employees.
- The referral bonus does not apply for referring former students, contract employees or temporary employees within one year of separation.

Text Your Referral

EMPLOYEE REFERRALS ARE NOW EVEN EASIER!

If you know someone who would like to join the North Central Health Care team, text "Refer" to 715.598.3663 and you will become eligible for a referral bonus when they join our team.



Hey, you!
NCHC employee...

Do YOU know someone who is as awesome as YOU?

Text **"Refer"** to **715.598.3663** and you are eligible for a referral bonus when they join our team!

When we get your text, HR will take it from there. What are you waiting for?!

My Notes, Questions & Answers

Use this page to keep notes, questions and answers about your benefits together in one place. When you contact Human Resources or any of the agencies listed on the following page, you can takes notes below.

Contact Information

NCHC CONTACTS:

Human Resources Office 715.848.4419
Payroll 715.848.4409
Organizational Development 715.841.5162
Employee Assistance Program 1.800.540.3758

NCHC WEB LINKS:

Ulti-Pro (Paystub/Benefit Elections)
(ESS)..... https://nw14.ultipro.com
Intranet ..... http://intranet/nchc.aspx
News You Can Use .....www.norcen.org/NewsYouCanUse
SwagShop..... www.norcen.org/SwagShop

HEALTH INSURANCE

ASPIRUS ARISE
1.800.223.6048
https://www.aspirusarise.com
PO Box 21684, Eagan, MN 55121

TELADOC

TELADOC
1.800.TELADOC (1.800.835.2362)
https://www.teladoc.com

DENTAL INSURANCE

DELTA DENTAL
1.800.236.3712
www.deltadentalwi.com
PO Box 828, Stevens Point, WI 54481-0828

VISION INSURANCE

VISION SERVICE PLAN
1.800.877.7195
https://www.vsp.com

FLEXIBLE SPENDING

DIVERSIFIED BENEFIT SERVICES (DBS)
1.800.234.1229 Fax: 1.262.367.5938
https://www.dbsbenefits.com
PO Box 260, Hartland, WI 53029

WISCONSIN RETIREMENT SYSTEM

EMPLOYEE TRUST FUND (ETF)
1.877.533.5020
http://etf.wi.gov/members/benefits_wrs.htm
801 W. Badger Road, Madison, WI 53713-2526

DEFERRED COMPENSATION PROGRAMS

WISCONSIN DEFERRED COMPENSATION
1.877.457.9327 Option 2

VOYA DEFERRED COMPENSATION
1.800.335.0982
https://www.voya.com

VOLUNTARY BENEFITS

THE HARTFORD (THROUGH WI RETIREMENT SYSTEM)
Income Continuation Insurance
1.800.960.0052

THE STANDARD
1.833.878.8853
Short-Term Disability, Accident, Critical Illness Insurance
https://www.standard.com/

NATIONWIDE PET INSURANCE
1.877.738.7874
www.PetsNationwide.com

IDENTITY GUARD
1.800.452.2541
https://benefits.identityguard.com/northcentralhealthcare/

MARATHON COUNTY EMPLOYEES CREDIT UNION
1.715.261.7680 https://www.mcecu.org

North Central Health Care