Your Wellness is Important!

Southeast Petro

Employee Health Benefits Guide

January 1 – December 31, 2017

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

01/26/2017

TABLE OF CONTENTS

WELCOME !

M&R Enterprises, Inc. and Affiliates recognizes the importance of healthcare benefits by offering a cost-effective and comprehensive benefits package suitable for your individual and family needs. This guide provides an overview of the options available to you as well as informational tools to optimize your coverage. As you consider your insurance needs, please take this once a year opportunity to choose the best benefit options for you and your family.

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

ENROLLMENT CHECKLIST

- ✓ Review your benefit options
- ✓ Verify your physician is a participating provider
- ✓ Verify your dentist is a participating provider
- ✓ Verify your eye care professional is a participating provider
- ✓ Complete the enrollment form including information for dependents and beneficiaries (Per Health Care Reform (HCR), dependent social security number (SSN) is required for all enrolled in health coverage)
- ✓ Complete Evidence of Insurability (EOI), if applicable
- ✓ Submit your completed enrollment form(s)

OPEN ENROLLMENT

Each year, during the open enrollment period, you will have the opportunity to enroll in or make changes to your benefit elections and dependents without a qualifying event. Once you have made your elections you will not be able to change them until the next open enrollment period, unless you experience a qualifying event.

MAKING CHANGES TO YOUR BENEFITS DURING THE PLAN YEAR (QUALIFYING EVENT)

Per IRS code Section 125, once your benefits are effective you may not make changes to your benefits until the next open enrollment period unless you experience a qualifying event. Qualifying events that permit mid-year changes include:

- Marriage
- Death of spouse, child or other qualified dependent
- Birth or adoption of child
- Loss of other group coverage
- Change in employment status (employee, spouse, or dependent)
- Change in residence due to an employment transfer
- Divorce
- Legal Separation
- Change of dependent status

If you do not make changes within 30 days of the 'qualifying event,' you must wait until the following open enrollment period. It is <u>your</u> responsibility to notify Human Resources within 30 days of the qualifying event.

WHO IS ELIGIBLE?

Full-time employees (working 30+ hours per week)

If you are a new hire, you are eligible for benefits on the 1st of the month following 60 days of employment

Family members eligible for dependent coverage include:

- Legal spouse
- Natural, adopted, foster or step child(ren)
- Child(ren) for whom court appointed or legal guardianship has been awarded

Eligible dependent children may be covered until:

- <u>Medical</u>: The first of the following year once the dependent child reaches the age of 30.
- <u>Dental</u>: The first of the following month once the dependent child reaches the age of 26.
- <u>Vision</u>: The first of the following month once the dependent child reaches the age of 26.
- <u>Voluntary Child Life</u>: The first of the following month once the dependent child reaches the age of 22.

A handicapped dependent child may continue coverage beyond the age limit if determined to meet plan requirements.

MEDICAL INSURANCE

Health First Health Plans – www.myhfhp.org

Participating provider information can be found on the carrier's website.

	5000/65 HMO 6150		HF24 5000 PPO 6132		HF4 HMO 6030	
IN-NETWORK						
Plan Coinsurance	35%		20%		20%	
Calendar Year Deductible						
Individual / Family	$5,000 / $10,000		$2,500 / $5,000		$0 / $0	
Out of Pocket Max						
Individual / Family	$6,600 / $13,200		$5,000 / $10,000		$4,000 / $8,000	
Deductible Applies To Out of Pocket	Yes		Yes		N/A	
Medical Copays Apply To Out of Pocket	Yes		Yes		Yes	
RX Copays Apply To Out of Pocket	Yes		Yes		Yes	
Office Charges						
Office Visit	$30 Copay		$20 Copay		$20 Copay	
Specialist Visit	$60 Copay		$40 Copay		$40 Copay	
Preventive	No Charge		No Charge		No Charge	
Facility Charges						
Inpatient Hospital	35% after Deductible		$250/Day (Days 1-5)		$200/Day (Days 1-5)	
Outpatient Hospital	35% after Deductible		20% after Deductible		$250 Copay	
Physician Fees	35% after Deductible		20% after Deductible		No Charge	
Independent Facility Charges						
Labs	No Charge		No Charge		No Charge	
X-rays	35% after Deductible		20% after Deductible		20% after Deductible	
Complex Diagnostic Imaging	35% after Deductible		$250 Copay		$100 Copay	
Ambulance	35% after Deductible		$150 Copay		No Charge	
Urgent Care	35% after Deductible		$50 Copay		$30 Copay	
Emergency Room (In or out of network)	35% after Deductible		20% after Deductible		$200 Copay	
Mental Health						
Inpatient	35% after Deductible		$200/Day (Days 1-5)		$200/Day (Days 1-5)	
Outpatient	$60 Copay		$20 Copay		$20 Copay	
Durable Medical Equipment	35% after Deductible		20% after Deductible		20% after Deductible	
Prescription Drugs:						
Deductible	None		None		None	
Tier 1	$2		$2		$2	
Tier 2	$15		$15		$15	
Tier 3	$45		$45		$45	
Tier 4	$90		$90		$90	
Mail Order - 90 day supply	3x		3x		3x	
OUT-OF-NETWORK						
Plan Coinsurance			30%			
Calendar Year Deductible						
Individual / Family			$5,000 / $10,000			
Out of Pocket Max	No Coverage				No Coverage	
Individual / Family			$10,000 / $20,000			
Balance Billing			Yes			
Office / Facility Charges			30% after Deductible			
WEEKLY DEDUCTIONS	**WEEKLY**	**BI-WEEKLY**	**WEEKLY**	**BI-WEEKLY**	**WEEKLY**	**BI-WEEKLY**
Employee	$23.55	$47.10	$59.66	$119.32	$64.78	$129.56
Employee + Spouse	$127.95	$255.91	$224.32	$448.64	$243.57	$487.14
Employee + Child(ren)	$87.17	$174.35	$159.89	$319.78	$173.61	$347.21
Employee + Family	$183.84	$367.67	$312.62	$625.23	$339.44	$678.89

MEMBER LOGIN

Using the website below, register for your personal access to Health First.

www.myhfhp.org

My Health First Health Plans

*Required Fields

***User Name**

***Password**

***If you DO NOT have a login and password – Click on "I need to sign up" and follow the steps**

Login to My Health First Health Plans to:

- Find information about your eligibility, dependents, benefits, deductibles, claims and authorizations
- Find a Doctor
- Print Temporary ID card or request a new one
- Change your contact information
- Check year-to-date expenses applied toward deductible
- See total expenses applied toward your annual maximums
- Find costs of tests and doctor visits
- See Pharmacy benefit information

SAVINGS TIPS

Below are a few ideas on how to spend your dollars or save on prescriptions and medications.

Pharmacy discount programs. Before you pay for your next prescription check to see if they are available for free or at a low cost. Pharmacies such as Wal-Mart, Target and Costco offer prescription discount programs that allow you to purchase medications for as low as $4 for a 30-day supply. Publix pharmacies offer select free antibiotics and diabetes medications.

Walmart Publix TARGET COSTCO WHOLESALE

www.NeedyMeds.org is a national non-profit organization that maintains a website of free information on programs that help people who need assistance with the cost of medications and healthcare costs.

Some resources available through *NeedyMeds* are:

- Patient Assistance Programs
- Free / Low Cost Clinics
- Diagnosis – Based Assistance
- State Programs
- Free Drug Discount Card

Urgent Care vs Emergency Room (ER). The Emergency Room is meant for true emergencies such as life threatening illnesses and injuries. The ER costs an average of three times more than a visit to the urgent care. In a non-life threatening situation, you can most likely be treated at an urgent care. Urgent Care centers are available for non-life threatening immediate care.

Emergency Room Examples:

- Chest Pain
- Broken Bones
- Allergic Reactions
- Continuous Bleeding
- Head Injury
- Severe Shortness of Breath
- Deep Wounds

Urgent Care Examples:

- Coughs and Sore Throat
- Minor Injuries and Burns
- Ear / Sinus Infections
- Flu and Cold
- Sprains and Strains
- Fever
- Vaccinations

Convenience Care Clinic. Don't pay more if you don't have to. Convenience care clinics are walk-in clinics located in a supermarket, pharmacy or retail store, where available, such as CVS Caremark, Target, Walgreens and Walmart. Services may be provided at a lower out-of-pocket cost compared to urgent or emergency care as they are subject to primary care office visit co-pays, and/or coinsurance. Convenience care clinics are available for non-life threatening immediate care.

healthcare clinic at select Walgreens
CVS CAREMARK
The Clinic at Walmart
minute clinic

Convenience Care Clinic Examples:

- Common Infections (e.g.: ear, bladder, pink eye, strep throat)
- Flu Shots
- Minor Skin Conditions
- Pregnancy Tests
- Allergies
- Immunizations
- School Physicals

DENTAL INSURANCE

Guardian – www.guardiananytime.com

Participating provider information can be found on the carrier's website.

IN-NETWORK BENEFITS	DHMO Plan		PPO Plan	
Dental Network	***Managed DentalGuard***		***DentalGuard Preferred***	
Co-Insurance				
Preventive	Copay Schedule		100%	
Basic	Copay Schedule		80%	
Major	Copay Schedule		50%	
Deductible (Individual / Family)	$5 Office Visit Copay		$50 / $150	
Waived for Preventive Services	N/A		Yes	
Calendar Year Maximum	Unlimited		$1,500	
SCHEDULE OF BENEFITS				
Routine Exams	Preventive		Preventive	
Cleaning	Preventive		Preventive	
X-Rays				
Bitewing	Preventive		Preventive	
Full Mouth	Preventive		Preventive	
Sealants	Preventive		Preventive	
Fillings				
Amalgam	Basic		Basic	
Composite Resin	Basic		Basic	
Oral Surgery (Co-insurance based on complexity of procedure)	Basic		Basic	
Repairs	Basic		Basic	
Root Canal	Basic		Basic	
Periodontal Maintenance and/or Surgery (Co-insurance based on complexity of procedure)	Basic		Basic	
Crowns	Major		Major	
Fixed Bridges	Major		Major	
Full And Partial Dentures	Major		Major	
OUT-OF-NETWORK BENEFITS				
Co-Insurance	No Coverage			
Preventive			100%	
Basic			80%	
Major			50%	
Benefits Based on			Fee Schedule	
Balance Billing			Yes	
Deductible Individual / Family (Waived for Preventive Services)			$50 / $150	
Calendar Year Maximum			$1,500	
PAYROLL DEDUCTIONS	**WEEKLY**	**BI-WEEKLY**	**WEEKLY**	**BI-WEEKLY**
Employee	$3.02	$6.05	$7.25	$14.51
Employee + Spouse	$6.05	$12.11	$15.11	$30.23
Employee + Child(ren)	$6.72	$13.45	$16.28	$32.57
Employee + Family	$9.75	$19.50	$23.36	$46.72

DENTAL MAXIMUM ROLLOVER

Guardian

By enrolling in either dental plan offered by Guardian you can take advantage of the dental maximum rollover benefit.

Guardian will rollover a portion of your unused annual maximum amount into your personal Maximum Rollover Account (MRA). If you reach your Plan Annual Maximum in future years, you can use money from your MRA. To qualify, you must have a paid claim (such as cleaning or filling) and must not have exceeded the paid claims threshold during the plan year. You can view your annual MRA statement detailing your account and those of your dependents on the carrier website. You and your insured dependents maintain separate MRAs based on your own claim activity.

Calendar Year Maximum	Threshold	Maximum Rollover Amount	In-Network Only Rollover Amount	Maximum Rollover Account Limit
$1000	$500	$250	$350	$1000
Maximum claims reimbursement	Claims amount that determines rollover eligibility	Additional dollars added to Plan Annual Maximum for future years	Additional dollars added to Plan Annual Maximum for future years if only in-network providers were used during the benefit year	Plan Annual Maximum plus Maximum Rollover cannot exceed $2,000 in total

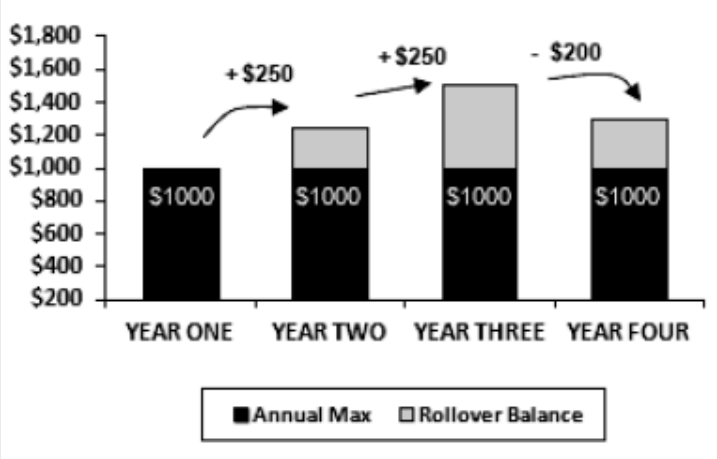
HERE'S HOW THE BENEFITS WORK:

YEAR ONE: Jane starts with a $1,000 Plan Annual Maximum. She submits $150 in dental claims. Since she did not reach the $500 Threshold, she receives a $250 rollover that will be applied to Year Two.

YEAR TWO: Jane now has an increased Plan Annual Maximum of $1,250. This year, she submits $50 in claims and receives an additional $250 rollover added to her Plan Annual Maximum.

YEAR THREE: Jane now has an increased Plan Annual Maximum of $1,500. This year, she submits $1,200 in claims. All claims are paid due to the amount accumulated in her Maximum Rollover Account.

YEAR FOUR: Jane's Plan Annual Maximum is $1,300 ($1,000 Plan Annual Maximum + $300 remaining in her Maximum Rollover Account).



VISION INSURANCE

Guardian – www.guardiananytime.com

Participating provider information can be found on the carrier's website.
Vision Network: VSP Choice Network

IN-NETWORK BENEFITS		
Vision Examination	$10 Copay	
Single Lenses	$25 Copay	
Bifocal Lenses	$25 Copay	
Trifocal Lenses	$25 Copay	
Frame	$130 Maximum Allowed	
Contact Lens Exam & Fitting	15% Off UCR	
Contact Lenses (Elective) – *In lieu of frames*	$130 Maximum Allowed	
Contact Lenses (Medically Necessary) – *In lieu of frames*	$25 Copay	
OUT-OF-NETWORK BENEFITS	**Reimbursement up to**	
Vision Examination	$39	
Single Lenses	$23	
Bifocal Lenses	$37	
Trifocal Lenses	$49	
Frame	$46	
Contact Lenses (Elective)	$100	
Contact Lenses (Medically Necessary)	$210	
FREQUENCY *(Rolling 12 months)*		
Exams	12 Months	
Lenses / Contacts – *In lieu of frames*	12 Months	
Frames	24 Months	
WEEKLY PAYROLL DEDUCTIONS	**WEEKLY**	**BI-WEEKLY**
Employee	$1.33	$2.65
Employee + Spouse	$2.28	$4.56
Employee + Child(ren)	$2.33	$4.66
Employee + Family	$3.73	$7.45

VOLUNTARY LIFE INSURANCE

Benefits:

- **For you:**

  An Amount between $10,000 and $500,000, in increments of $10,000. Limited to 5 times your annual salary. Guaranteed Issue Amount is $150,000.

- **For your spouse:**

  An Amount between $5,000 and $200,000, in increments of $5,000. Guaranteed Issue Amount is $50,000. *You must elect Voluntary Life coverage for yourself in order to cover your spouse.*

- **For your dependent child(ren):**

  An amount of $10,000. *You must elect Voluntary Life coverage for yourself in order to cover your dependent child(ren).*

Features of the Plan

- The plan also includes many special features including LifeKeys and TravelConnect.

How to Enroll:

- Once you have selected the amount of the coverage that's right for you, your spouse and your child(ren), simply complete the Voluntary Life section on the enrollment form. Please submit the enrollment form along with any Evidence of Insurability form (if required).

About Evidence of Insurability

- Evidence of Insurability – also called "proof of good health" – is required if:
  - o You decline coverage during initial eligibility period and want to enroll at a later date
  - o You apply for Voluntary Life in excess of the Guaranteed Issue Amount.
  - o All "Late Entrants" require Evidence of Insurability.
  - o Coverage *will not* go into effect *until* Lincoln approves the application.

Voluntary Life cost illustration (Weekly Pay Period)

EMPLOYEE

Weekly RATE Per $1,000	AGE	$10,000	$20,000	$30,000	$40,000	$50,000	$60,000	$70,000	$80,000	$90,000	$100,000
0.0138	<25	$0.14	$0.28	$0.41	$0.55	$0.69	$0.83	$0.97	$1.10	$1.24	$1.38
0.0138	25-29	$0.14	$0.28	$0.41	$0.55	$0.69	$0.83	$0.97	$1.10	$1.24	$1.38
0.0162	30-34	$0.16	$0.32	$0.49	$0.65	$0.81	$0.97	$1.13	$1.30	$1.46	$1.62
0.0254	35-39	$0.25	$0.51	$0.76	$1.02	$1.27	$1.52	$1.78	$2.03	$2.29	$2.54
0.0462	40-44	$0.46	$0.92	$1.39	$1.85	$2.31	$2.77	$3.23	$3.70	$4.16	$4.62
0.0715	45-49	$0.72	$1.43	$2.15	$2.86	$3.58	$4.29	$5.01	$5.72	$6.44	$7.15
0.1085	50-54	$1.09	$2.17	$3.26	$4.34	$5.43	$6.51	$7.60	$8.68	$9.77	$10.85
0.1708	55-59	$1.71	$3.42	$5.12	$6.83	$8.54	$10.25	$11.96	$13.66	$15.37	$17.08
0.2838	60-64	$2.84	$5.68	$8.51	$11.35	$14.19	$17.03	$19.87	$22.70	$25.54	$28.38
0.4708	65-69	$6,500	$13,000	$19,500	$26,000	$32,500	$39,000	$45,500	$52,000	$58,500	$65,000
		$3.06	$6.12	$9.18	$12.24	$15.30	$18.36	$21.42	$24.48	$27.54	$30.60
0.9092	70-74	$5,000	$10,000	$15,000	$20,000	$25,000	N/A	N/A	N/A	N/A	N/A
		$4.55	$9.09	$13.64	$18.18	$22.73	N/A	N/A	N/A	N/A	N/A
0.9092	75-79	$5,000	$10,000	$15,000	$20,000	$25,000	N/A	N/A	N/A	N/A	N/A
		$4.55	$9.09	$13.64	$18.18	$22.73	N/A	N/A	N/A	N/A	N/A
0.9092	80-84	$5,000	$10,000	$15,000	$20,000	$25,000	N/A	N/A	N/A	N/A	N/A
		$4.55	$9.09	$13.64	$18.18	$22.73	N/A	N/A	N/A	N/A	N/A

This is an estimate of premium cost. Actual deductions may vary slightly due to rounding and payroll frequency.

Example:
Use this formula to calculate premium for benefit amounts over $100,000

Age	Weekly Rate per $1,000	X	Benefit in $1,000's	=	Weekly Cost
35	$0.0254	x	150	=	$3.81
		x		=	

DEPENDENT CHILDREN

Dependent Children Benefit	Weekly Rate
$10,000	$0.46

Premium covers all dependent children regardless of the number of children.

Voluntary Life cost illustration (Weekly Pay Period)

SPOUSE

Weekly RATE Per $1,000	AGE	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
0.0138	<25	$0.07	$0.14	$0.21	$0.28	$0.35	$0.41	$0.48	$0.55	$0.62	$0.69
0.0138	25-29	$0.07	$0.14	$0.21	$0.28	$0.35	$0.41	$0.48	$0.55	$0.62	$0.69
0.0162	30-34	$0.08	$0.16	$0.24	$0.32	$0.41	$0.49	$0.57	$0.65	$0.73	$0.81
0.0254	35-39	$0.13	$0.25	$0.38	$0.51	$0.64	$0.76	$0.89	$1.02	$1.14	$1.27
0.0462	40-44	$0.23	$0.46	$0.69	$0.92	$1.16	$1.39	$1.62	$1.85	$2.08	$2.31
0.0715	45-49	$0.36	$0.72	$1.07	$1.43	$1.79	$2.15	$2.50	$2.86	$3.22	$3.58
0.1085	50-54	$0.54	$1.09	$1.63	$2.17	$2.71	$3.26	$3.80	$4.34	$4.88	$5.43
0.1708	55-59	$0.85	$1.71	$2.56	$3.42	$4.27	$5.12	$5.98	$6.83	$7.69	$8.54
0.2838	60-64	$1.42	$2.84	$4.26	$5.68	$7.10	$8.51	$9.93	$11.35	$12.77	$14.19
0.4708	65-69	$3,250	$6,500	$9,750	$13,000	$16,250	$19,500	$22,750	$26,000	$29,250	$32,500
		$1.53	$3.06	$4.59	$6.12	$7.65	$9.18	$10.71	$12.24	$13.77	$15.30
0.9092	70-74	$2,500	$5,000	$7,500	$10,000	$12,500	$15,000	$17,500	$20,000	$22,500	$25,000
		$2.27	$4.55	$6.82	$9.09	$11.37	$13.64	$15.91	$18.18	$20.46	$22.73

This is an estimate of premium cost. Actual deductions may vary slightly due to rounding and payroll frequency.

Example:
Use this formula to calculate premium for benefit amounts over $50,000

Age	Weekly Rate per $1,000	X	Benefit in $1,000's	=	Weekly Cost
35	$0.0254	x	75	=	$1.91
		x		=	

SHORT TERM DIS. INSURANCE

Manage your benefits
Contact Lincoln at 1.800.423.2765; reference ID: SPETRO www.lincolnfinancial.com

CARRIER		Lincoln
		Short Term Disability
Short Term Disability	**Benefit Highlights**	
	Coverage Amount	60% of weekly salary up to $1,500 per week
	Maximum payment period	26 weeks
	Accident benefits begin	Day 1
	Illness benefits begin	Day 8
	Pre-existing conditions	6 months look back; 12 months after from effective date
	Premium waived if disabled	Yes
	Additional Benefits	Progressive Income, Family Care Expense, Survivor Income, Employee Assistance Program and Portability

Weekly Premium Calculation**

		EXAMPLE
List your weekly earnings (*Maximum covered payroll is $2,500 Weekly)	$_____	$610
Multiply by your premium factor	_____	0.00872
Your Estimated Weekly Premium**	$_____	$5.32

** This is an estimate of premium cost.
Actual deductions may vary slightly due to rounding and payroll frequency.

Composite Rate Factor:
0.00872

LONG TERM DIS. INSURANCE

Manage your benefits
Contact Lincoln at 1.800.423.2765; reference ID: SPETRO www.lincolnfinancial.com

CARRIER		Lincoln
Long Term Disability		Long Term Disability
	Benefit Highlights	
	Coverage Amount	60% of monthly salary up to $6,000 per month
	Maximum payment period	Social Security Normal Retirement Age
	Accident benefits begin	Day 181
	Illness benefits begin	Day 181
	Pre-existing conditions	3 months look back; 12 months from the effective date
	Premium waived if disabled	Yes
	Additional Benefits	Progressive Income, Family Care Expense, Survivor Income, Employee Assistance Program and Portability

Weekly Premium Calculation**			Attained Age	Premium Factor
		EXAMPLE		
		Age 35	<30	0.00016
List your monthly earnings			30-34	0.00030
(*Maximum covered payroll is			35-39	0.00048
$10,000 Monthly)	$_____	$2,643	40-44	0.00076
			45-49	0.00104
			50-54	0.00136
Multiply by your premium factor	_____	$0.00048	55-59	0.00173
			60-64	0.00143
			65-69	0.00113
Your Estimated Weekly Premium**	$_____	$1.27	70-74	0.00099
** This is an estimate of premium cost.			75-99	0.00099
Actual deductions may vary slightly due to rounding and payroll frequency.				

VOLUNTARY SHORT TERM DISABILITY

In the event you become disabled from a non work-related injury or sickness, disability income benefits are provided as a source of income. Employees may purchase Short Term Disability (STD) through payroll deductions. Coverage is offered through Aflac.

ACCIDENT INDEMNITY ADVANTAGE

Aflac pays cash benefits directly to you to help with things like out-of-pocket medical expenses, the rent or mortgage, groceries, or utility bills. This policy has no deductibles and no copayments, no lifetime limit, no network restrictions, and no coordination of benefits. Coverage is offered through Aflac.

CANCER CARE PLAN SELECT

Aflac pays a cash benefit upon initial diagnosis of a covered cancer, with a variety of other benefits payable through cancer treatment. You can use these cash benefits to help pay out-of-pocket medical expenses, the rent or mortgage, groceries, or utility bills. Coverage is offered through Aflac.

You must enroll directly with Aflac to enroll into these benefits.

Individual Mandate

Overview
Beginning in 2014, the Affordable Care Act included a mandate for most individuals to have health insurance or potentially pay a penalty for noncompliance. Individuals are required to maintain minimum essential coverage for themselves and their dependents. Some individuals are exempt from the mandate or the penalty, while others may be given financial assistance to help them pay for the cost of health insurance.

What type of coverage satisfies the individual mandate?
"Minimum essential coverage"

What is minimum essential coverage?
Minimum essential coverage is defined as:

- Coverage under certain government-sponsored plans
- Employer-sponsored plans, with respect to any employee
- Plans in the individual market,
- Grandfathered health plans; and
- Any other health benefits coverage, such as a state health benefits risk pool, as recognized by the HHS Secretary.

Minimum essential coverage does not include health insurance coverage consisting of excepted benefits, such as dental-only coverage.

How does "Minimum Essential Coverage" differ from "Essential Health Benefits"?
Essential health benefits were required to be offered by certain plans starting in 2014 as a component of the essential health benefit package. They are also the benefits that are subject to the annual and lifetime dollar limit requirements.

This is different than minimum essential coverage, which refers to the coverage needed to avoid the individual mandate penalty. Coverage does not have to include essential benefits to be minimum essential coverage.

What is the penalty for noncompliance?
The penalty is determined by calculating the greater amount of either a flat dollar amount or set percentage of income. Beginning in 2017, penalties will increase based on the cost of living.

Year	Pay whichever is greater			
	Flat dollar amount		OR	*Percentage of income (over tax filing threshold)*
	Per Adult	*Per Child (under age 18)*		
2015	$325	$162.50 (maximum of $975 per family)		2.0%
2016	$695	$347.50 (maximum of $2,085 per family)		2.5%

Who is exempt from the mandate?
Individuals who have a religious exemption, those not lawfully present in the United States, and incarcerated individuals are exempt from the minimum essential coverage requirement.

Are there other exceptions to when the penalty may apply?
Yes. A penalty will not be assessed on individuals who:

- cannot afford coverage based on formulas contained in the law,
- have income below the federal income tax filing threshold,
- are members of Indian tribes,
- were uninsured for short coverage gaps of less than three months;
- have received a hardship waiver from the Secretary, or are residing outside of the United States, or are bona fide residents of any possession of the United States.

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

Beginning in 2014, there is a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace 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. The initial open enrollment for health insurance coverage through the Marketplace ended on March 31, 2014. You can get coverage through the Marketplace for 2014 if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP). The Marketplace's next open enrollment period begins on Nov. 15, 2014, for coverage starting as early as Jan. 1, 2015.

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 your Human Resources department.

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.

Annual Notices

Women's Health & Cancer Rights Act of 1998

Did you know that your medical plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymph edema)? For more information regarding this benefit, contact customer service at the number listed on the back of your medical ID card.

The Newborns' and Mothers' Health Protection Act (the Newborns' Act)

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

Your Right to Receive a Notice of Privacy Practices

M&R Enterprises, Inc. and Affiliates is subject to the HIPAA privacy rules. In compliance with these rules, it maintains a Notice of Privacy Practices. You have the right to request a copy of its Notice of Privacy Practices by contacting the medical insurance company. (See telephone number on your medical ID card).

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The list of States are current as of July 31, 2015. Contact your State for more information on eligibility.

ALABAMA – Medicaid	**GEORGIA** – Medicaid
Website: www.myalhipp.com Phone: 1-855-692-5447	Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ALASKA – Medicaid	**INDIANA** – Medicaid
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone: 907-269-6529	Website: http://www.in.gov/fssa Phone: 1-800-889-9949
COLORADO – Medicaid	**IOWA** – Medicaid
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
FLORIDA – Medicaid	**KANSAS** – Medicaid
Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268	Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884

Addendum A – Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP) - *CONTINUATION*

KENTUCKY – Medicaid	**OKLAHOMA** – Medicaid and CHIP
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
LOUISIANA – Medicaid	**OREGON** – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075
MAINE – Medicaid	**PENNSYLVANIA** – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	Website: http://www.dhs.state.pa.us/hipp Phone: 1-800-692-7462
MASSACHUSETTS – Medicaid and CHIP	**RHODE ISLAND** – Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.eohhs.ri.gov Phone: 401-462-5300
MINNESOTA – Medicaid	**SOUTH CAROLINA** – Medicaid
Website: http://www.dhs.state.mn.us/id_006254 Click on Health Care, then Medical Assistance Phone: 1-800-657-3739	Website: http://www.scdhhs.gov Phone: 1-888-549-0820
MISSOURI – Medicaid	**SOUTH DAKOTA** – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://dss.sd.gov Phone: 1-888-828-0059
MONTANA – Medicaid	**TEXAS** – Medicaid
Website: http://medicaid.mt.gov/member Phone: 1-800-694-3084	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NEBRASKA – Medicaid	**UTAH** – Medicaid and CHIP
Website: www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633	Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-866-435-7414
NEVADA – Medicaid	**VERMONT** – Medicaid
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
NEW HAMPSHIRE – Medicaid	**VIRGINIA** – Medicaid and CHIP
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218	Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid: Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
NEW JERSEY – Medicaid and CHIP	**WASHINGTON** – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext.15473
NEW YORK – Medicaid	**WEST VIRGINIA** – Medicaid
Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://dhhr.wv.gov/bms/Medicaid%20Expansion/pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
NORTH CAROLINA – Medicaid	**WISCONSIN** – Medicaid and CHIP
Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
NORTH DAKOTA – Medicaid	**WYOMING** – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2015, or for more information on special enrollment rights, you can contact either:

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

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

Addendum B - Medicare Part D Notice of Creditable Coverage

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 Notice from M&R Enterprises, Inc. and Affiliates
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 M&R Enterprises, Inc. and Affiliates 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. M&R Enterprises, Inc. and Affiliates has determined that the prescription drug coverage offered through Health First Health Plans is or are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents will be able to reenroll in our program during the next open enrollment period.

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 M&R Enterprises, Inc. and Affiliates and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE**: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through M&R Enterprises, Inc. and Affiliates 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).

Date:	January 1, 2016
Name of Entity/Sender:	M&R Enterprises, Inc. and Affiliates
Contact--Position/Office:	Chrissy Council / HR Manager
Address:	402 High Point Drive
	Cocoa, FL 32926
Phone Number:	321-631-0245

GLOSSARY OF TERMS

Balance Billing – When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you for covered services

Coinsurance – The portion of the cost for care received for which an individual is financially responsible, which is usually calculated as a percentage (such as 20%). Often coinsurance applies after a specific deductible has been met and may be subject to an individual out-of-pocket. For example, if the plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The plan pays the rest of the allowed amount.

Copayment – A payment you make at the time that selected services are rendered and no additional payment is required. Copayments are typically flat amounts (for example, $15), covering such items as office visits, prescriptions, and emergency care.

Covered Expenses – Health Care expenses that are covered under your health plan.

Deductible – The amount of eligible expenses you must pay, out of pocket each plan year, before the plan begins to pay. The deductible may not apply to all services.

Embedded Deductible: An embedded deductible is an individual deductible level within a family contract. For example, if there is a family deductible of $3,000 with an individual embedded deductible of $1,500, when any one individual family member reaches $1,500 in expenses, their benefit plan coverage takes effect.

Non-embedded Deductible: An non-embedded deductible requires that the entire family deductible be met before benefit plan coverage takes effect by any one or combination of family members.

Evidence of Insurability – A medical questionnaire which is used to determine whether an applicant will be approved or declined coverage.

Guarantee Issue - The amount which is available without providing an Evidence of Insurability (EOI). An EOI will be required for any amounts above this, for late enrollees or increases in insurance.

In-Network – Care received from physicians, facilities or suppliers that are contracted with the insurer to provide services on a negotiated discount basis.

Late Entrant – A member that becomes insured more than 30 days after initial eligibility or becomes insured again after previously waiving coverage.

Mandatory Generic – When you request a brand name drug when there is a generic equivalent, you pay the generic copay plus the cost difference between the brand and generic drug. Dispense as written (DAW) may be allowed. With DAW you will not be charged a cost difference.

Out-of-Network – Care received from physicians, facilities or suppliers that are not contracted with the insurer to provide services on a negotiated discount basis.

Out-of-Pocket Expense – Amount you must pay toward the cost of health care services. This may include deductibles, copayment and/or coinsurance.

Out-of-Pocket Maximum – The maximum dollar amount a member is required to pay out of pocket during a benefit period. Plans may vary but deductibles and coinsurance may apply toward meeting the out-of-pocket maximum.

Preferred Provider – A provider who has a contract with your carrier/vendor to provide services to you at a discount.

Pre-existing Condition – Any Injury or Sickness for which you received medical treatment, advice or consultation, care or services including diagnostic measures, or had drugs or medicines prescribed or taken in the X months prior to the day you become insured. *For example: Disabilities that occur during the first 6 months of coverage due to a pre-existing condition that occurred during the 3 months prior to coverage are excluded.*

Provider – A physician (medical, dental or vision), health care professional or health care facility licensed, certified or accredited as required by state law.

Prior Authorization/Pre-Service Notification – The decision by the plan or health insurer that a health care service, treatment plan, prescription drug, medical equipment, or other health care services defined in the certificate of coverage, is medically necessary. The plan may require preauthorization for certain services before receiving them, except in an emergency.

UCR (Usual, Customary & Reasonable) – The amount paid for a service in a geographic area based on what providers in the area usually charge for the same or similar service. The UCR amount is sometimes used to determine the allowed amount.

CONTACTS

Benefit / Contact	Carrier / Resource	Phone	Website / Email
Medical	Health First Health Plans	321-434-5668	www.myhfhp.org
Dental	Guardian	800-627-4200	www.guardiananytime.com
Vision	Guardian	800-627-4200	www.guardiananytime.com
Life and Disability Insurance	Lincoln Financial Group	800-423-2765	www.lfg.com
Beth Fiffie Voluntary Insurance	Aflac	813-421-2384	www.aflac.com bethduck2@gmail.com
Chrissy Council	M&R Enterprises, Inc. and Affiliates	321-631-0245 Ext. 116	Chrissy@southeastpetro.com
Patricia Tilley	Sihle Insurance Group	407-389-3598	PTilley@sihle.com
Online Enrollment	Benefits Connect	727-209-4227 Ext. 0	www.benefitsconnect.net/sepetro

Search and see if your carrier has an app. Download today!

This guide is provided to you by:

Southeast Petro