Cape Abilities℠
Creating Opportunity

BENEFITS GUIDE

01.01.2021 – 12.31.2021

PROVIDED BY
ROGERS | GRAY

CONTENTS

Benefit Summaries, Enrollment Forms, and other materials which empower you to get the most value from your benefits can be found on the ADP Homepage

WELCOME!

Cape Abilities is proud to offer you and your eligible family members a comprehensive, competitive, and valuable benefits package to protect your health, your family, and your way of life. We believe the health and welfare of our employees and their families is essential to our success as an organization. Your benefits are also an important part of your overall compensation. We encourage you to take the time to educate yourself about the available options and choose the best coverage for you and your family. This guide answers some of the basic questions that you may have about your benefits. Please read this guide carefully, along with any supplemental materials provided.

Below you will find a brief description of the employee benefits package for the 2021 plan year.

MEDICAL

- In an effort to maintain the lowest possible premiums for the company and the best available benefits for our employees, we will be offering our medical insurance through United Health Care.

DENTAL

- Our dental coverage will be offered through Blue Cross Blue Shield.

VISION

- Our vision insurance will be offered through EyeMed.

FLEXIBLE SPENDING ACCOUNT (FSA & DCA)

- United Health Care will administer accounts as enrolled in this plan.

GROUP LIFE/AD&D AND PAID FAMILY/MEDICAL LEAVE INSURANCE

- These are company sponsored and offered through Equitable. Employees pay a portion of the PFML coverage, which is a state-mandated benefit.

VOLUNTARY LIFE INSURANCE, CRITICAL ILLNESS, AND ACCIDENTAL INSURANCE

- These are offered as an optional benefit through Colonial Life.

CONTACT INFORMATION

Below you will find a list of our carriers' names and their member services phone numbers. Please refer to this list when you have a question regarding your benefits, or you need to check if a provider is in-network. If you have a question about a claim-specific or coverage-specific question, you will be best and most quickly served by contacting the carrier directly.

COVERAGE	CARRIER	PHONE	WEBSITE
MEDICAL, FSA & DCA	UNITED HEALTH CARE	*MEMBER SERVICES* 866.414.1959	UHC.COM
DENTAL	BLUE CROSS BLUE SHIELD OF MA	800.262.2583	BCBSMA.COM
VISION	EYEMED	844.225.3107	EYEMED.COM
LIFE/AD&D, PFML	EQUITABLE	877.222.2144	EQUITABLE.COM
SUPPLEMENTAL LIFE, SHORT-TERM DISABILITY, CRITICAL ILLNESS & ACCIDENT	COLONIAL LIFE	800.325.4368	COLONIALLIFE.COM

ELIGIBILITY

You are eligible for benefits if you are a full-time employee (working 30+ hours per week). You may also enroll your eligible family members under certain plans that you choose for yourself.

ELIGIBLE FAMILY MEMBERS INCLUDE:

- Your legally married spouse
- Your children who are your biological children, stepchildren, adopted children, or children for whom you have legal custody (age restrictions may apply). Disabled children age 26 or older who meet certain criteria may continue on your health coverage.

WHEN COVERAGE BEGINS

NEW HIRES: You must complete the enrollment process within 30 days of your date of hire. If you enroll on time, coverage is effective on your date of hire for Medical, Dental, Vision and FSA/DCA elections. If you fail to enroll on time, you will NOT have benefits coverage (except for company-paid benefits). You are automatically enrolled in the company-paid Life and Disability coverages effective on your date of hire.

OPEN ENROLLMENT: The open enrollment period is open from November 20th through November 25th, 2020. You must schedule a 1:1 consultation with our enrollment consultants, New England Enrollment Strategies, during this time, whether you are electing or declining coverage. The benefits you elect during open enrollment will be effective from January 1, 2021 through December 31, 2021.

HOW TO ENROLL

The first step is to review your current benefit elections. Verify your personal information and decide upon any changes. To enroll in or decline all coverages, you will need to schedule a 1:1 call with our enrollment consultants, New England Enrollment Strategies. Remember that FSA elections cannot rollover from year to year; you must re-elect this benefit and your contribution amount annually.

CHOOSE CAREFULLY

Due to IRS regulations, you cannot change your elections until the next annual Open Enrollment period, unless you experience a qualifying life event during the year. Change requests due to qualifying events must be reported within 30 days of the event and are effective the date of the event.

SOME EXAMPLES OF COMMON QUALIFYING LIFE EVENTS ARE:

- Marriage
- Divorce
- Birth or adoption of a child
- Child reaching the maximum age limit
- Death of a spouse, child, or yourself
- Loss of coverage
- Gaining access to state coverage under Medicaid or CHIP

Required Information: When you enroll, you will be required to enter a Social Security number (SSN) for yourself and all covered dependents. The Affordable Care Act (ACA) requires the company to report this information to the IRS each year to show proof of coverage. This information will be securely submitted to the IRS and remain confidential.

MEDICAL | UNITED HEALTH CARE

We are proud to offer you a choice of two medical plans which provide comprehensive medical and prescription drug coverage. The plans also offer many resources and tools to help you maintain a healthy lifestyle. Following are a brief description of the plans.

MEDICAL PLAN OVERVIEWS

	Choice (EPO) $2k / $4k	Choice (EPO) $3k / $6k
Deductible	**In-Network**	**In-Network**
Individual	$2,000	$3,000
Family	$4,000	$6,000
Type (Calendar/Plan Year)	Plan Year	Plan Year
Out of Pocket Max	*Individual / Family*	*Individual / Family*
Medical Rx	$6,450 / $12,900	$6,450 / $12,900
Routine Physicals	No cost	No cost
Office Visits	$20 copay	$20 copay
Specialist Visits	$35 copay	$35 copay
*Physical/Occupational Therapy	$20 copay	$20 copay
Testing		
High Tech Imaging (MRI, CT, PET)	Ded., then no cost	Ded., then no cost
X-ray	Ded., then no cost	Ded., then no cost
Diagnostic Lab Work	Ded., then no cost	Ded., then no cost
Emergency Room	$150 copay	$150 copay
Inpatient Hospital	Ded., then no cost	Ded., then no cost
Day Surgery	Ded., then no cost	Ded., then no cost
Prescription Drugs	*Tier 1 / 2 / 3*	*Tier 1 / 2 / 3*
Rx Deductible	None	None
Retail Copays (30 days)	$15 / $30 / $50	$15 / $30 / $50
Mail Order Copays (90 days)	$37.50 / $75 / $125	$37.50 / $75 / $125

Please refer to the UHC Summary of Benefits & Coverage for complete details regarding network access, covered benefits, and member cost share.

BI-WEEKLY COST OF COVERAGE

Your contributions toward the medical premium are deducted pre-tax from your bi-weekly paycheck.

COVERAGE TIER	EPO $2,000 / $4,000	EPO $3,000 / $6,000
INDIVIDUAL	$207.08	$48.50
FAMILY	$543.52	$509.22

FLEXIBLE SPENDING ACCOUNT | UNITED HEALTH CARE

We provide you with the opportunity to participate in a flexible spending account (FSA) administered by United Health Care. FSAs allow you to set aside a portion of your income, before taxes, to pay for qualified health care expenses. Because that portion of your income is not taxed, you pay less in federal income, Social Security and Medicare taxes.

2021 FSA MINIMUM CONTRIBUTION	$240
2021 FSA MAXIMUM CONTRIBUTION	$2,750

You can use your FSA to pay for qualified expenses for yourself and your dependents. Some examples of qualified expenses include:

Copays
Deductible expenses
Prescription Drugs
Dental services
Orthodontia
Bandages
Contact solution
Sunscreen
Diabetic supplies

FSA funds unused at the end of the plan year are forfeited, with the exception of a maximum rollover amount of $550.

For a complete list of FSA-eligible expenses, visit www.irs.gov/pub/irs-pdf/p502.pdf
IRS REGULATION: The IRS regulates this benefit and has the right to request your receipts if you were to be audited on your taxes. As a result, you are encouraged to keep all FSA-related receipts.

DEPENDENT CARE ACCOUNT | UNITED HEALTH CARE

We provide you with the opportunity to participate in a dependent care account (DCA) administered by United health Care. DCAs allow you to set aside a portion of your income, before taxes, to pay for qualified child-care expenses. Because that portion of your income is not taxed, you pay less in federal income, Social Security and Medicare taxes.

2021 DCA MINIMUM CONTRIBUTION	$240
2021 DCA MAXIMUM CONTRIBUTION	$5,000 per household

You can use your DCA to pay for qualified childcare expenses for your dependents. Generally, qualifying expenses are those that you incur to allow for yourself or your legal spouse to work. Some examples of qualified expenses include:

Day care
Before-school care
After-school care

DCA funds unused at the end of the plan year are forfeited. There is no rollover provision on the DCA.

For a complete list of FSA-eligible expenses, visit www.irs.gov/pub/irs-pdf/p502.pdf
IRS REGULATION: The IRS regulates this benefit and has the right to request your receipts if you were to be audited on your taxes. As a result, you are encouraged to keep all DCA-related receipts.

DENTAL | BLUE CROSS BLUE SHIELD DENTAL BLUE

The dental plan allows you the freedom and flexibility to seek care from the provider of your choice, but you will maximize your benefits by choosing a provider who participates in the BCBSMA network. In order to earn the maximum rollover, your claims must not exceed $700 for the calendar year. The maximum rollover accumulation is $1,250.

	Dental Blue Program 2
Deductible	**In-Network**
Individual	$25
Family	$75
Calendar Year Maximum	
	$1,500 + rollover maximum of $500
Type I - Preventative Services	
Oral exams, X-rays, Cleanings, Space Maintainers, Sealants	No Cost *deductible does not apply*
Type II - Basic Services	
Fillings, Extractions, Oral Surgery, Endodontics, Periodontics	Ded., then 20% coinsurance
Type III - Major Services	
Onlays, Prosthodontics, Crowns, Initial Installation & Maintenance	Ded., then 50% Coinsurance
Usual & Customary Charges	
Participating	Negotiated Fee
MA Non-Participating	MAC, balance billing may apply
Non-Participating	MAC, balance billing may apply

BI-WEEKLY COST OF COVERAGE

COVERAGE TIER	EMPLOYEE CONTRIBUTION
INDIVIDUAL	$7.87
FAMILY	$22.86

MAC = Maximum Allowable Charge. Please refer to the BCBSMA Summary of Benefits & Coverage for complete details regarding network access, covered benefits, and member cost share.

VISION | EYEMED

The vision plan allows you the freedom and flexibility to seek care from the provider of your choice, but you will maximize your benefits by choosing a provider who participates in the EyeMed network. The contact lens benefit can be utilized in lieu of, but not in addition to, plastic lenses in frames per frequency.

	VSP Choice Plan	
	In-Network	Out-of-Network Reimbursement
Vision Exam	*Frequency: 12 months*	
	$10 copay	Up to $50
Frames	*Frequency: 24 months*	
	$0 copay, $130 allowance 20% off balance over $130	Up to $104
Lenses	*Frequency: 12 months*	
Single Vision	$25 copay	Up to $30
Bifocal	$25 copay	Up to $50
Trifocal	$25 copay	Up to $65
Contact Lenses		
Conventional /Disposable	$130 allowance, 20% off balance over $130	Up to $130
Medically Necessary	No cost	Up to $210

BI-WEEKLY COST OF COVERAGE

COVERAGE TIER	EMPLOYEE CONTRIBUTION
INDIVIDUAL	$3.45
IND. + SPOUSE	$6.54
IND. + CHILD(REN)	$6.89
FAMILY	$10.13

Please refer to the VSP Summary of Benefits & Coverage for complete details regarding network access, covered benefits, and member cost share.

LIFE AND AD&D | EQUITABLE

Preparing for your future requires a lot more than saving, reducing, and controlling expenses. We are pleased to offer life insurance at no cost to you. You are automatically enrolled in this coverage on your date of hire.

BASIC LIFE	$20,000
AD&D *(ACCIDENTAL DEATH AND DISMEMBERMENT)*	Equal to amount of life insurance
AGE REDUCTION	To 65% at age 70, to 50% at age 75
GUARANTEED ISSUE AMOUNT	All Amounts

MA PFML | EQUITABLE

MA PFML is a mandated benefit for anyone who works in Massachusetts and is eligible to take up to 26 weeks of paid leave for medical or family reasons. PFML is separate from both the federally mandated benefits offered by the Family Medical Leave Act (FMLA) and from employer-specific leave benefits.

Cape Abilities' PFML coverage is offered through Equitable, is compliant with legislative requirements, and becomes effective 01.01.2021 for Medical Leave and 07.01.2021 for Family Leave.

ELIGIBLE TYPES OF LEAVE

PAID MEDICAL LEAVE MAY BE TAKEN TO:

- Manage your own serious health condition

PAID FAMILY LEAVE MAY BE TAKEN TO:

- Care for a family member with a serious health condition
- Bond with a child during the first 12 months after the child's birth
- Bond with a child during the first 12 months after adoption or foster care placement
- Manage family affairs when a family member is on or has been called to active duty in the armed forces, including the National Guard or Reserves

VOLUNTARY EMPLOYEE & DEPENDENT LIFE AND AD&D | COLONIAL LIFE

If you determine that you need more than the basic coverage provided at no cost to you, you may purchase additional coverage for yourself and your dependents. The guarantee issue amounts per member only apply during your initial eligibility window. If you apply for coverage after your initial eligibility, you will need to submit evidence of insurability (EOI) along with your application. Coverage amounts which require EOI will not be effective unless approved by the carrier. To learn more about the benefit amounts and cost of coverage, please contact Colonial Life.

SUPPLEMENTAL HEALTH PLANS | COLONIAL LIFE

The following benefits are designed to work alongside your medical coverage to help offset out-of-pocket expenses resulting from an accidental injury, or a serious illness. Even if you do not participate in the medical plan offered by Cape Abilities, you are still eligible to enroll in these benefits.

ACCIDENT INSURANCE

- Pays benefits for injuries, initial treatment, hospitalization, and follow-up care related to an accidental injury
- Helps offset copays, deductibles, and other expenses resulting from an accidental injury
- 24/7 coverage, worldwide
- Includes $50 Annual health screening benefit

CRITICAL ILLNESS

- Provides a source of added financial protection when you or a covered family member is diagnosed with a critical illness, including:
    - Cancer
    - Heart attack
    - Stroke
    - Coronary artery bypass
    - Organ failure
    - Blindness,
    - Occupational *HIV/Hepatitis*
- Rates are fixed, do not increase as you age
- Includes $50 Annual health screening benefit

ANNUAL NOTICES

SUMMARY OF MATERIAL MODIFICATIONS TO CAPE ABILITIES HEALTH & WELFARE PLAN

This Summary of Material Modifications ("SMM") modifies some of the information contained in the Summary Plan Description ("SPD") for the Cape Abilities Health and Welfare Plan (the "Plan") that describes the Plan as of 01/01/2021.

Note: In the event of any discrepancy between this SMM and the SPD, the provisions of the SMM will govern.

MODIFICATION(S)

Important changes under the Plan will go into effect on 01/01/2021. In particular, coverage for Medical Plan and Premium Conversion Plan / Pre-Tax Contributions shall be amended as follows:

The medical insurance will now be provided through United Health Care. The FSA and DCA will also be administered by United Health Care. The Basic Life/AD&D coverage and PFML coverage will be provided through Equitable. The worksite and voluntary life/disability coverages will be offered through Colonial Life.

If you have questions about these changes in benefits, please contact Human Resources at 508-778-5040 Extension 827.

HEALTH INSURANCE EXCHANGE NOTICE

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

When key parts of the health care law took effect in 2014, there also became 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:

Human Resources
Cape Abilities
Independence Park
895 Mary Dunn Road
Hyannis, MA 02601
508.778.5040 x827

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.

PART B: INFORMATION ABOUT HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

3. Employer name Cape Abilities	4. Employer Identification Number (EIN) 04-2453166	
5. Employer address 895 Mary Dunn Road	6. Employer phone number 508.778.5040	
7. City Hyannis	8. State Massachusetts	9. ZIP code 02601
10. Who can we contact about employee health coverage at this job? Kathy Hansen		
11. Phone number 508.778.5040 x 827	12. Email address khansen@capeabilities.org	

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.

[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.

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

I. As your employer, we offer a health plan to:

☑ Some employees. Eligible employees are: Active, Full-time employees working 30+ hours per week.

II. With respect to dependents:

☑ We do offer coverage. Eligible dependents are: Spouse and children (up to age 26).

☑ 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.

Note: 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.

NOTICE OF PATIENT PROTECTIONS

The medical plan offered within the Cape Abilities Health and Welfare Plan generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact United Health Care.

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

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).

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.

If you or your dependent(s) lose coverage under a state Children's Health Insurance Program (CHIP) or Medicaid, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the loss of CHIP or Medicaid coverage.

If you or your dependent(s) become eligible to receive premium assistance under a state CHIP or Medicaid, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days of the determination of eligibility for premium assistance from state CHIP or Medicaid.

To request special enrollment or obtain more information, contact Human Resources.

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA) NOTICES

ENROLLMENT NOTICE

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: $3000 deductible (in-network) and 0% coinsurance (in-network). If you would like more information on WHCRA benefits, contact Human Resources.

ANNUAL NOTICE

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

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA) DISCLOSURE

The Mental Health Parity and Addiction Equity Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For information regarding the criteria for medical necessity determinations made under the Cape Abilities Health and Welfare Plan with respect to mental health or substance use disorder benefits, please contact Human Resources.

EMPLOYER'S CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) NOTICE

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

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

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

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

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

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

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131

CALIFORNIA – Medicaid	INDIANA – Medicaid
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 916-440-5676	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**MONTANA – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178
KENTUCKY – Medicaid	**NEVADA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://dhcfp.nv.gov/ Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825

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

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

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/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

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

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

MEDICARE PART D CREDITABLE COVERAGE NOTICE

IMPORTANT NOTICE FROM CAPE ABILITIES 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 Cape Abilities and about your options under Medicare's prescription drug coverage. This information can help you decide whether 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. Cape Abilities has determined that the prescription drug coverage offered by the Cape Abilities Health and Welfare Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

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

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

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?

If you decide to join a Medicare drug plan and maintain your current Cape Abilities coverage, your current Cape Abilities coverage will not be affected. However, you should inform Cape Abilities that you also have a Medicare drug plan so that your prescription drug coverage will be coordinated. Please note that your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all your current health and prescription drug benefits as long as you remain an eligible employee. You should carefully research the cost and benefits of maintaining two prescription drug plans before making this decision.

If you do decide to join a Medicare drug plan and drop your current Cape Abilities coverage, be aware that you and your dependents will only be able to get this coverage back under limited circumstances. In order to get this coverage back for you and your dependents, you must be eligible for health plan benefits and you will only be able to enroll yourself and your dependents upon open enrollment of if you have a loss of coverage that qualifies under special enrollment rights.

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 Cape Abilities 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

For further information please contact Human Resources at 508.778.5040 x827.

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 Cape Abilities 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).

Date	11.13.2020
Name of Entity / Sender	Cape Abilities
Contact Position / Office	Human Resources
Address	895 Mary Dunn Road, Hyannis, MA 02601
Phone Number	508.778.5040 x 827

GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 (GINA) DISCLOSURES

The Genetic Information Nondiscrimination Act of 2008 ("GINA") protects employees against discrimination based on their genetic information. Unless otherwise permitted, your Employer may not request or require any genetic information from you or your family members.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

GENERAL NOTICE OF COBRA RIGHTS

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."

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

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

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

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

Cape Abilities
Human Resources
508.778.5040 x827
895 Mary Dunn Road, Hyannis, MA 02601

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

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

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

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

DISABILITY EXTENSION OF 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

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

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

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

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?

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

IF YOU HAVE QUESTIONS

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

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

PLAN CONTACT INFORMATION

Cape Abilities Health and Welfare Plan
Human Resources
895 Mary Dunn Road, Hyannis, MA 02601
508.778.5040 x 827

GENERAL FMLA NOTICE

EMPLOYEE RIGHTS

UNDER THE FAMILY AND MEDICAL LEAVE ACT

THE UNITED STATES DEPARTMENT OF LABOR WAGE AND HOUR DIVISION

Leave Entitlements

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

Benefits & Protections

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

Eligibility Requirements

An employee who works for a covered employer must meet three criteria to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

Requesting Leave

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

Employer Responsibilities

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

Enforcement

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:

1-866-4-USWAGE

(1-866-487-9243) TTY: 1-877-889-5627

www.dol.gov/whd

U.S. Department of Labor | Wage and Hour Division

USERRA NOTICE

YOUR RIGHTS UNDER USERRA

A. THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

B. REEMPLOYMENT RIGHTS

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- You ensure that your employer receives advance written or verbal notice of your service;
- You have five years or less of cumulative service in the uniformed services while with that particular employer;
- You return to work or apply for reemployment in a timely manner after conclusion of service; and
- You have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

C. RIGHT TO BE FREE FROM DISCRIMINATION AND RETALIATION

If you:

- Are a past or present member of the uniformed service;
- Have applied for membership in the uniformed service; or
- Are obligated to serve in the uniformed service; then an employer may not deny you
- Initial employment;
- Reemployment;
- Retention in employment;
- Promotion; or
- Any benefit of employment because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

D. HEALTH INSURANCE PROTECTION

- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

E. ENFORCEMENT

- The U.S. Department of Labor, Veterans' Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its Web site at *http://www.dol.gov/vets.* An interactive online USERRA Advisor can be viewed at *http://www.dol.gov/elaws/userra.htm.*

- If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS and may be viewed on the Internet at this address: *http://www.dol.gov/vets/programs/userra/poster.htm.* Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees. U.S. Department of Labor, Veterans' Employment and Training Service, 1-866-487-2365.