2018-2019

Employee Benefits Guide

Eastern Standard – Branch Line – Row 34 - Island Creek Oyster Bar – The Hawthorne

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Eligibility and Enrollment

Your restaurant offers you and your eligible family members a comprehensive and valuable benefits program. We encourage you to take the time to educate yourself about your options and choose the best coverage for you and your family.

Each year during the Open Enrollment period, you have the opportunity to choose the plans and level of coverage that best meet the needs of you and your family. Please read the information in the booklet to learn about your benefits and how to make your elections. Please make sure to take advantage of the benefits that your restaurant offers you.

You are eligible to enroll in the benefits program if you are a Full-Time employee working at least 30 or more hours. The date of eligibility is 90 days following the date of hire.

Eligible Dependents may include:

- Any lawful spouse
- Your biological, adopted, step, or foster children who have not reached the age of 26.
- Dependents who are 26 or more years old, primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap. Requires approval from underwriting. Form to be completed by subscriber/dependents physician.

Changing Benefit Elections

As an employee who is eligible for benefits, you are allowed to make changes to your plan choices during the annual open enrollment period. After the open enrollment period ends, you will not be allowed to make changes to your elections unless you experience a qualifying event. Some qualifying events include:

- Change in marital status (marriage, death of spouse, divorce, legal separation)
- Change in number of dependents (birth, death, adoption, eligibility status, child support order)
- Change in employment status for you or your spouse (new employment, termination, leave of absence, full-time to part-time or vice versa
- Special enrollment rights under HIPAA
- Medicare coverage

If you have a qualifying event, you must notify Human Resources within 30 days of the change. Depending on the type of event, you may need to provide proof of this change (for example: a marriage or birth certificate). If you do not notify Human Resources within 30 days, you will have to wait until the next Open Enrollment period or a subsequent qualifying life event to make benefit changes.

How to Enroll

If you are enrolling in your benefits for the first time or want to make changes to your current elections please see Human Resources for enrollment forms. If you are looking to keep your current elections, your benefits will automatically roll over to the next year.

Open enrollment begins March 12th for the benefit year of April 1, 2018 – March 31, 2019.

Your 2018 - 2019 Benefits

We remain committed to offering a comprehensive health insurance plan to our employees. The health and welfare of our employees and their families is essential to our success as an organization. We are pleased to report the following:

2018 - 2019 Benefits	
Medical	We will be renewing our coverage with BCBS of MA, with some changes to both the HMO and PPO plans and the addition of an HSA-eligible HMO plan. Please refer to your BCBS Summary of Benefits and Coverage for more detailed plan information.
Dental	We will be renewing our dental coverage with BCBS of MA, with some changes to the plan. For detailed plan information please refer to your Summary of Benefits from BCBS.
Vision	We will be renewing our vision plan with BCBS of MA with no changes to the plan.
Accident	We will be replacing the availability of this coverage previously through Aflac with very similar policy options at better pricing through The Hartford. These plans are effective May 1, 2018
Short Term Disability	We will be replacing the availability of this coverage previously through Aflac with very similar policy options at better pricing through The Hartford. These plans are effective May 1, 2018

Your Cost for Health & Welfare Benefits in 2018 - 2019

At Eastern Standard et al, we are committed to providing our employees with the best health coverage, while trying to minimize the impact of potential cost increases. It is also our goal to maintain a rich, equitable benefit program for all employees and their families. For these reasons Eastern Standard et al will continue to pay a portion of the medical premiums.

Questions & Answers

Changes that can be made during open enrollment or due to a qualifying event:

- Change medical plan election (HMO or PPO)
- Enroll in medical, dental and/or vision plan
- Add or drop dependents from the medical, dental and/or vision plan

Actions to be completed:

- Even if you are not making any changes to your current elections, you must re-elect your coverage or renew your Opt Out status on eStratex.

When do I need to take action?

- All enrollment must be completed on the eStratex portal 30 days from your eligibility date or during the Open Enrollment window

Who do I contact with questions?

- You can contact Molly Hopper in HR at mhopper@easternstandardboston.com

The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the 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 your Guide, contact Human Resources.***

Definitions

Below are some key terms and definitions that will help you understand your insurance.

Affordable Care Act (ACA): The Patient Protection and Affordable Care Act, commonly called the Affordable Care Act (ACA) is a United States federal statute signed into law by President Obama in March 2010. The law puts in place comprehensive health insurance reforms.

Annual Maximum: Total dollar amount a plan pays during a calendar year toward the covered expenses of each person enrolled.

Out-of-Pocket Maximum: The maximum amount of coinsurance a Plan member must pay towards covered medical expenses in a calendar year for both network and non-network services. Once you meet this out-of-pocket maximum, the Plan pays the entire coinsurance amount for covered services for the remainder of the calendar year. Deductibles and copays apply to the annual out-of-pocket maximum.

Copayment: A set dollar amount you pay for network doctors' office visits, emergency room services and prescription drugs.

Deductible: Total dollar amount, based on the allowed amount, you must pay out of pocket for covered medical expenses each calendar year before the plan pays for most services. The deductible does not apply to network preventive care and any services where you pay a copayment rather than coinsurance. Some of your dental options also have an annual deductible, generally for basic and major dental care services.

Brand Formulary Drugs: The brand formulary is an approved, recommended list of brand-name medications. Drugs on this list are available to you at a lower cost than drugs that do not appear on this preferred list.

Generic Drugs: These drugs are usually most cost-effective. Generic drugs are chemically identical to their brand-name counterparts. Purchasing generic drugs allows you to pay a lower out-of-pocket cost than if you purchase formulary or non-formulary brand name drugs.

Maintenance Drugs: Prescriptions commonly used to treat conditions that are considered chronic or long-term. These conditions usually require regular, daily use of medicines. Examples of maintenance drugs are those used to treat high blood pressure, heart disease, asthma and diabetes.

Non-Formulary Drugs: These drugs are not on the recommended formulary list. These drugs are usually more expensive than drugs found on the formulary. You may purchase brand-name medications that do not appear on the recommended list, but at a significantly higher out-of pocket cost.

PDP Fee: PDP Fee refers to the fees that participating PDP dentists have agreed to accept as payment in full, subject to any copayments, deductibles, cost sharing and benefits maximums.

Pre-tax Plan: A plan for active employees that is paid for with pre-tax money. The IRS allows for certain expenses to be paid for with tax-free dollars. The state takes premiums out of your check before taxes are calculated, increasing your spendable income and reducing the amount you owe in income taxes. Consequently, the IRS has tax laws that require you to stay in the plans you select for a full plan year (January through December). You can only make changes during Open Enrollment or if you have a qualifying event.

Primary Care Physician (PCP): The health care professional who monitors your health needs and coordinates your overall medical care, including referrals for tests or specialists.

Provider: Any type of health care professional or facility that provides services under your plan.

Network: A group of health care providers, including dentists, physicians, hospitals and other health care providers, that agrees to accept pre-determined rates when serving members.

Qualifying Event: an occurrence that qualifies the Subscriber to make an insurance coverage change outside of the Open Enrollment

Specialty Drugs: prescription medications that require special handling, administration or monitoring. These drugs may be used to treat complex, chronic and often costly conditions.

Medical Insurance – Blue Cross Blue Shield (BCBS of MA)

As an employee, you have access to comprehensive medical coverage through BCBS of MA to protect you and your family. In this section, you will find information on the medical plan offered by your restaurant. Take the time to understand how the plan works, the coverage provided, and how to use the plan to best meet the needs of you and your family. For a complete list of all benefits and coverage offered through BCBSMA, please refer to the BCBSMA eKit

Preferred Blue PPO $2,000 w/ 80%

Bi-Weekly Cost	
Individual	$84.57
Family	$298.73

	Preferred Blue PPO $2,000 w/ 80%	
Deductible	**In-Network**	**Out-of-Network**
Individual	$2,000	**$4,000**
Family	$4,000	**$8,000**
Type (Calendar Year/Plan Year)	Plan Year	
Out of Pocket Max		
Medical (Ind / Fam)	$5,450 / $10,900	**$13,300 / $26,600**
RX (Ind / Fam)	$1,000 / $2,000	**$1,000 / $2,000**
Routine Physicals:	Covered at 100%	Ded., then covered at 100%
Office Visits:	$25 copay	Ded., then covered at 80%
Specialist Visits:	$25 copay	Ded., then covered at 80%
***Chiropractic:**	$25 copay	Ded., then covered at 80%
***Physical/Occupational Therapy:**	$25 copay	Ded., then covered at 80%
Imaging		
High Tech (MRI, CT, PET):	Ded., then covered at 80%	Ded., then covered at 60%
Diagnostic (X-ray & lab):	Ded., then covered at 80%	Ded., then covered at 60%
Durable Medical Equipment:	Ded., then covered at 80%	Ded., then covered at 60%
Emergency Room:	**$350 copay**	
Inpatient Hospital:	Ded., then 80% coverage	Ded., then covered at 60%
Day Surgery:	Ded., then $250 copay	Ded., then covered at 60%
Prescription Drug Deductible:	None	
Retail (30 days):	**$15 / $30 / $50 / $75 / $100**	**$30 / $60 / $100**
Mail Order (90 days):	**$30 / $60 / $100**	All Charges Apply

The changes to the PPO plan from the 2017-18 benefit year are highlighted in bold above and summarized below.

Service / Feature	2017-18	2018-19
Out of Network Deductible	Was combined with In-Network	Separated, but cross accumulated
Out of Network Out of Pocket Maximum	Was combined with In-Network	Separated, but cross accumulated
Emergency Room Visit	$150 copay	$350 copay
Prescription Drugs	*3 Tiers*	*5 Tiers*
Tier 1 Rx	No Change	
Tier 2 Rx	No Change	
Tier 3 Rx	No Change	
Tier 4 Rx	N/A	$75 copay
Tier 5 Rx	N/A	$100 copay

Access Blue NE $1,500

The Access Blue NE $1,500 plan is an HSA-Eligible HMO plan. Enrollment in this plan enables employees to also open and contribute to a Health Savings Account (HSA). More information on HSAs can be found further in this Guide.

Bi-Weekly Cost	
Individual	$90.32
Family	$313.89

	Access Blue NE Saver $1,500
Deductible	**In-Network**
Individual	$1,500
Family	$3,000
Type (Calendar Year/Plan Year)	Plan Year
Out of Pocket Max	
Medical (Ind / Fam)	$6,450 / $12,900
RX (Ind / Fam)	
Routine Physicals:	Covered at 100%
Office Visits:	Ded., then $15 copay
Specialist Visits:	Ded., then $25 copay
***Chiropractic:**	Ded., then $25 copay
***Physical/Occupational Therapy:**	Ded., then $25 copay
Imaging	
High Tech (MRI, CT, PET):	Ded., then covered at 100%
Diagnostic (X-ray & lab):	Ded., then covered at 100%
Durable Medical Equipment:	Ded., then covered at 80%
Emergency Room:	Ded., then $150 copay
Inpatient Hospital:	Ded., then covered at 100%
Day Surgery:	Ded., then covered at 100%
Prescription Drug Deductible:	**Medical Deductible applies, then:**
Retail (30 days):	$10 / $25 / $45
Mail Order (90 days):	$20 / $50 / $135

HMO Blue NE $500

Bi-Weekly Cost	
Individual	$128.28
Family	$413.97

	HMO Blue NE $500
Deductible	**In-Network**
Individual	$500
Family	$1,000
Type (Calendar Year/Plan Year)	Plan Year
Out of Pocket Max	
Medical (Ind / Fam)	$3,000 / $6,000
RX (Ind / Fam)	$1,000 / $2,000
Routine Physicals:	Covered at 100%
Office Visits:	$20 copay
Specialist Visits:	$35 copay
***Chiropractic:**	$35 copay
***Physical/Occupational Therapy:**	Ded., then $35 copay
Imaging	
High Tech (MRI, CT, PET):	Ded., then covered at 100%
Diagnostic (X-ray & lab):	Ded., then covered at 100%
Durable Medical Equipment:	Ded., then covered at 80%
Emergency Room:	**$350 copay**
Inpatient Hospital:	Ded., then covered at 100%
Day Surgery:	Ded., then covered at 100%
Prescription Drug Deductible:	None
Retail (30 days):	**$15 / $30 / $50 / $75 / $100**
Mail Order (90 days):	**$30 / $60 / $100**

The changes to the HMO plan from the 2017-18 benefit year are highlighted in bold above and summarized below.

Service	2017-18	2018-19
Emergency Room Visit	$150 copay	$350 copay
Prescription Drugs	*3 Tiers*	*5 Tiers*
Tier 1 Rx	No Change	
Tier 2 Rx	No Change	
Tier 3 Rx	No Change	
Tier 4 Rx	N/A	$75 copay
Tier 5 Rx	N/A	$100 copay

Dental Insurance

Good dental health is important to your overall well-being. It is for this reason that your restaurant offers eligible employees a comprehensive dental plan through BCBSMA. There is a rollover benefit with an accumulated maximum rollover benefit of $350. Be sure to refer to your Summary Plan Description for a more complete description of plan benefits.

Bi-Weekly Cost	
Individual	$17.81
Family	$51.78

	Dental Blue	
	Participating Providers	Non-Participating Providers
Calendar Year Deductible		
Individual	$50	
Family	$150	
Calendar Year Maximum		
	$1,000	
Preventive Services	100% coverage	
Basic Services	80% coverage after deductible	
Major Services	**50% coverage after deductible**	
Orthodontic Services	Not covered	

The changes to the Dental plan from the 2017-18 benefit year are highlighted in bold above and summarized below.

Service	2017-18	2018-19
Major Services	30% coverage after deductible	50% coverage after deductible

Vision Insurance

The voluntary Blue 20/20 vision plan provides significant benefits and cost savings for your vision care. Be sure to refer to your Summary Plan Description for a more complete description of plan benefits.

Bi-Weekly Cost	
Individual	$3.57
Ind. + 1	$6.88
Family	$10.65

	Blue 20/20 Vision	
	In-Network	Out-of-Network
Exam (1 every 12 months)	$10 copay	Reimbursed up to $50
Lenses (1 every 12 months)	$25 copay (some lenses enhancements will cost extra)	Reimbursed up to $42 copay (some lenses enhancements will cost extra)
Frames (1 every 24 months)	Up to $130 retail allowance then 20% discount on balance over $130	Reimbursed up to $104
Contact Lenses (1 every 12 months)	Up to $130 allowance, then 15% discount off balance over $130	Up to $130 elective; up to $210 medically necessary

Telehealth

What is Telehealth, and why should I use it?

Telehealth is a powerful new benefit included at no additional charge. Whenever your employees and covered family members have urgent health concerns or when in-person visits are not convenient, Telehealth can be an effective alternative to face-to-face visits. Video visits will enable you and your family to have a brief medical or behavioral health visit with a doctor or therapist in a fast and convenient manner using a computer, tablet, or mobile device. Telehealth is an end-to-end solution that facilitates access and simplifies care. It's a state-of-the-art convenient, connected, and efficient way to see a doctor or therapist.

Telehealth benefits include:

- Real-time interactive access to have a visit with a doctor or therapist through our local and national provider networks. It is simple to use and makes quality care easily accessible.
    - You can use your own participating provider, or check the BCBSMA website's Find a Doctor tool to identify providers in the network who offer Telehealth care.
    - Visit bluecrossma.com/telehealth to connect to our Telehealth services powered by American Well's national network of online doctors and therapists.
- On-demand medical professional consultations, available 24/7/365. Telehealth medical appointments usually take about 10 minutes, while behavioral health appointments can be 30+ minutes.
- With Telehealth care, doctors can review patient history, answer questions and, at their discretion, diagnose, treat, and even prescribe medication. Prescriptions can be sent directly to your pharmacy of choice.
- Web and mobile visits supported

Medical Convenience Care	
Examples of Treatable Conditions	**When to Use**
• Bronchitis • Ear infections • Eye infections • Skin conditions like poison ivy and ringworm • Strep throat	Patients see a doctor online for a range of issues, from minor illnesses and injuries, chronic conditions, and even general health and wellness concerns. Often, reasons include time savings, alternative to ER or Urgent Care, Doctor's office is closed, or following up with an existing doctor
Behavioral Health	
Examples of Treatable Conditions	**When to Use**
• Depression • Anxiety • Stress Management • Sleep difficulties • Relationship challenges • Child behavior difficulties • Coping with chronic health problems • Weight Management • Smoking Cessation	Telehealth provides reliable and convenient limited therapy visits with trained and certified professionals. Patients see therapists for a variety of reasons. Often, these reasons include not wanting to be seen waiting outside a therapist's office or experiencing any of the examples to the left.

Seeking Urgent Care vs Emergency Care

If you think you're having a medical emergency, call 911 or go to the nearest emergency room. If you need medical care and your primary care provider's office isn't open, you have options other than the ER through Convenient Care Clinics/Minute Clinic and Urgent Care Centers. Not only will seeking services from these providers save you time, they will also save you money in comparison to seeking treatment from an ER.

- To find the nearest CVS Minute Clinic near you, visit; www.cvs.com/minuteclinic
- To find urgent care clinics near you, visit; http://www.urgentcarelocations.com

Please see below for an overview on the benefits of using an Urgent Care Center and what services can be treated.

Convenience Care Center *walk-in, retail clinics like CVS Minute Clinic in MA*	
Common Symptoms	**Pros & Cons**
• Bronchitis • Ear infections • Eye infections • Skin conditions like poison ivy and ringworm • Strep throat	• Walk-in care for common illnesses that typically require straightforward treatment • Staffed by board-certified nurse practitioners • Open seven days a week, including evenings and weekends • Lower-cost alternative to ER care – typical office visit cost-sharing applies
Urgent Care Center *freestanding facility not affiliated with a hospital*	
Common Symptoms	**Pros & Cons**
• Burns, rashes, bites, cuts and bruises • Infections • Coughs, cold and flu • Minor injuries • Respiratory infections • Sprains and strains	• Offers medical treatment for illnesses or injuries that require immediate attention but are not life threatening • Same-day appointments and walk-in service • Nurse practitioners, physician assistants and nurses typically provide most care with doctor overseeing clinic • Extended hours, including evenings and weekends* • Shorter waiting times than the ER • Lower-cost alternative to ER care-typical office visit cost-sharing applies
Emergency room (ER) *part of a local hospital*	
Common Symptoms	**Pros & Cons**
Symptoms to go to ER include, but are not limited to: • Choking • Convulsions • Heart attack • Loss of consciousness • Major blood loss • Seizures • Severe head trauma • Shock • Stroke	• Open 24/7 • Doctors on-site • Longer waiting periods due to life-threatening emergencies being treated first • Costs more than urgent or retail care centers • You will typically pay a higher copay than an office visit and services would cost • Deductible will apply

Health Savings Accounts (HSAs)

A Health Savings Account (HSA) allows members to put money aside to pay for current and future qualified medical expenses using pre-tax dollars. An HSA allows dollars to "roll over" annually. Your HSA provides a triple tax advantage; contributions are tax deductible, balances grow tax free, and all withdrawals for qualified expenses are tax free.

Eligibility Requirements:

- Must be enrolled in a High Deductible Health Plan such as the Access Blue NE Saver $1,500 plan
- Must not be enrolled in Medicare
- Must not be covered by other medical insurance(s)
- Must not have received VA medical benefits at any time in the past three months
- Spouse not contributing to/participating in a general-purpose FSA through his/her employer

Maximum tax-deductible contribution to an HSA for 2016-2017

- $3,450 for individual medical insurance coverage
- $6,850 for family medical insurance coverage
- Catch up provision for anyone over the age of 55 is $1,000

Debit Card

Once you enroll in the Access Blue NE Saver $1,500 plan and elect your HSA contribution amount, a debit card will be sent to you from HealthEquity. Your HSA card can be used to pay for qualified medical expenses billed from an insurance company, a physician's office and a pharmacy. Upon receipt of the card, you will need to follow the instructions included in the mailing to activate the card.

Health Equity Portal / BCBSMA My Blue Portal

Log on to your BCBSMA My Blue portal from the BCBSMA website, and click "Go to My Health Equity Account". You will need to establish unique credentials for the Health Equity member portal.

Health Equity Mobile App

Use the HealthEquity mobile app to:

- Get on-the-go access
- Take a photo of documentation and link it to claims
- Send payments and reimbursements from HSA
- View claims status

Accident Insurance

With Accident insurance, you'll receive payment(s) associated with a covered injury and related services. You can use the payment in any way you choose – from expenses not covered by your major medical plan to day-to-day costs of living such as the mortgage or your utility bills. This insurance provides benefits when injuries, medical treatment and/or services occur as the result of a covered accident.

Coverage Information

You have a choice of two accident plans, which allows you the flexibility to enroll for the coverage that best meets your needs. Unless otherwise noted, the benefit amounts payable under each plan are the same for you and your dependent(s). The table below gives a brief overview of the two plan options. To learn more about Short Term Disability Insurance, visit The Hartford's Employee Benefits site or view the MyTomorrow video through eStratex.

Emergency, Hospital & Treatment Care Package			
Treatment / Service	**Detail (Per covered person)**	**Plan 1**	**Plan 2**
ACCIDENT FOLLOW-UP	Up to 3 Treatments/accident within 90 Days	$50	$75
ACUPUNCTURE	Up to 10 visits/accident within 365 Days	$25	$25
AMBULANCE – AIR	Once/accident within 72 Hours	$600	$900
AMBULANCE – GROUND	Once/accident within 90 Days	$200	$300
CHIROPRACTIC CARE	Up to 10 visits/accident within 365 Days	$25	$25
DAILY HOSPITAL CONFINEMENT	Up to 365 Days/lifetime (Total daily and ICU)	$100	$200
DAILY ICU CONFINEMENT	Up to 30 Days/accident (Subject to 365 Days/lifetime)	$300	$400
EMERGENCY DENTAL – EXTRACTION	Highest benefit once/accident within 90 Days	$50	$100
EMERGENCY ROOM	Once /accident within 72 Hours	$100	$150
HOSPITAL ADMISSION	Once/accident within 90 Days	$500	$1,000
PHYSICAL THERAPY	Up to 10 Visits/accident within 90 Days	$25	$25
REHABILITATION FACILITY	Up to 15 Days/lifetime within 90 Days	$50	$100
TRANSPORTATION	Up to 3 Trips/accident	$200	$300
X-RAY	Once/accident within 90 Days	$50	$50
Specified Injury & Surgery Benefit Package			
Treatment / Service	**Detail (Per covered person)**	**Plan 1**	**Plan 2**
ABDOMINAL/THORACIC SURGERY	Once/accident within 90 Days	$1,000	$1,500
ARTHROSCOPIC SURGERY	Once/accident within 90 Days	$200	$300
BURN – 2ND DEGREE (≥ 34% OF BODY SURFACE)	Highest benefit once/accident within 72 Hours	$500	$1,000
BURN – 3RD DEGREE (≥ 18IN2 OF BODY SURFACE)	Highest benefit once/accident within 72 Hours	$5,000	$10,000
JOINT REPLACEMENT	Once/accident within 90 Days	$1,500	$2,000
Specified Injury & Surgery Benefit Package Dislocations (dollar amounts shown are for Open Surgical injuries)			
Treatment / Service	**Detail (Per covered person)**	**Plan 1**	**Plan 2**
ANKLE, FOOT BONES (EXCEPT TOES)	Once/joint/lifetime (Open or closed)	$500	$1,000
KNEE	Once/joint/lifetime (Open or closed)	$1,000	$1,800

Short Term Disability Insurance

A disability can happen to anyone. A back injury, pregnancy, or serious illness can lead to months without a regular paycheck. If you're unable to work for a short period of time due to a non-work-related condition, illness or injury, short-term disability insurance offers financial protection by paying you a portion of your earnings.

Coverage Information

You have a choice of four disability plans, which allows you the flexibility to enroll for the coverage that best meets your needs. The table below gives a brief overview of the four options. To learn more about Short Term Disability Insurance, visit The Hartford's Employee Benefits site or view the MyTomorrow video through eStratex

	Option 1	Option 2	Option 3	Option 4
Benefit Amount				
You have the choice of electing your weekly benefit. Benefits are in $100 increments, not to exceed 60% of your weekly earnings.	$100 - $500	$100 - $500	$100 - $500	$100 - $500
Injury & Sickness Benefit Starts				
You have the choice of when you want your benefit for injury to start.	8 days	8 days	15 days	15 days
Benefit Duration				
You have the choice of how long you want to receive benefits.	13 weeks	26 weeks	13 weeks	26 weeks

Fitness Reimbursement Form[1]

To verify this reimbursement is within your plan, please log on to Member Central at **www.bluecrossma.com/membercentral** or call the Member Service number on your ID card. Submit this form once per calendar year, no later than March 31 of the following year.

PLEASE PRINT ALL INFORMATION CLEARLY

Subscriber Information (Policyholder)

Identification Number (including first 3 letters)	Subscriber's Last Name	First Name	Middle Initial

Address—Number and Street	City	State	Zip Code

Employer's Name

Member and Claim Information

Member's Last Name	First Name	Middle Initial	Date of Birth: Mo. Day Yr.

Mailing Address—Number and Street (if different from subscriber's)	City	State	Zip Code

Gender
☐ Male
☐ Female

Claim is for (check one):
☐ Subscriber (policyholder) ☐ Ex-Spouse ☐ Other (specify) _____
☐ Spouse (of policyholder) ☐ Dependent (up to age 26)

Name, Address, and Phone Number of Qualified Health Club

I am due $_____ for the following reimbursement (check one):
☐ Membership at a qualified health club. My monthly fee is $_____.
☐ Fitness classes at a qualified health club. My fee per class is $_____.

Health Plan Year

Certification and Authorization (This form must be signed and dated below.)

I authorize the release of any information to Blue Cross Blue Shield of Massachusetts about my health club membership. I certify that the information provided in support of this submission is complete and correct and that I have not previously submitted for these services. I understand that Blue Cross may require additional evidence of health club membership and proof of payment for my membership before reimbursement is provided.

Subscriber's or Member's Signature: _____ Date: _____

Questions?

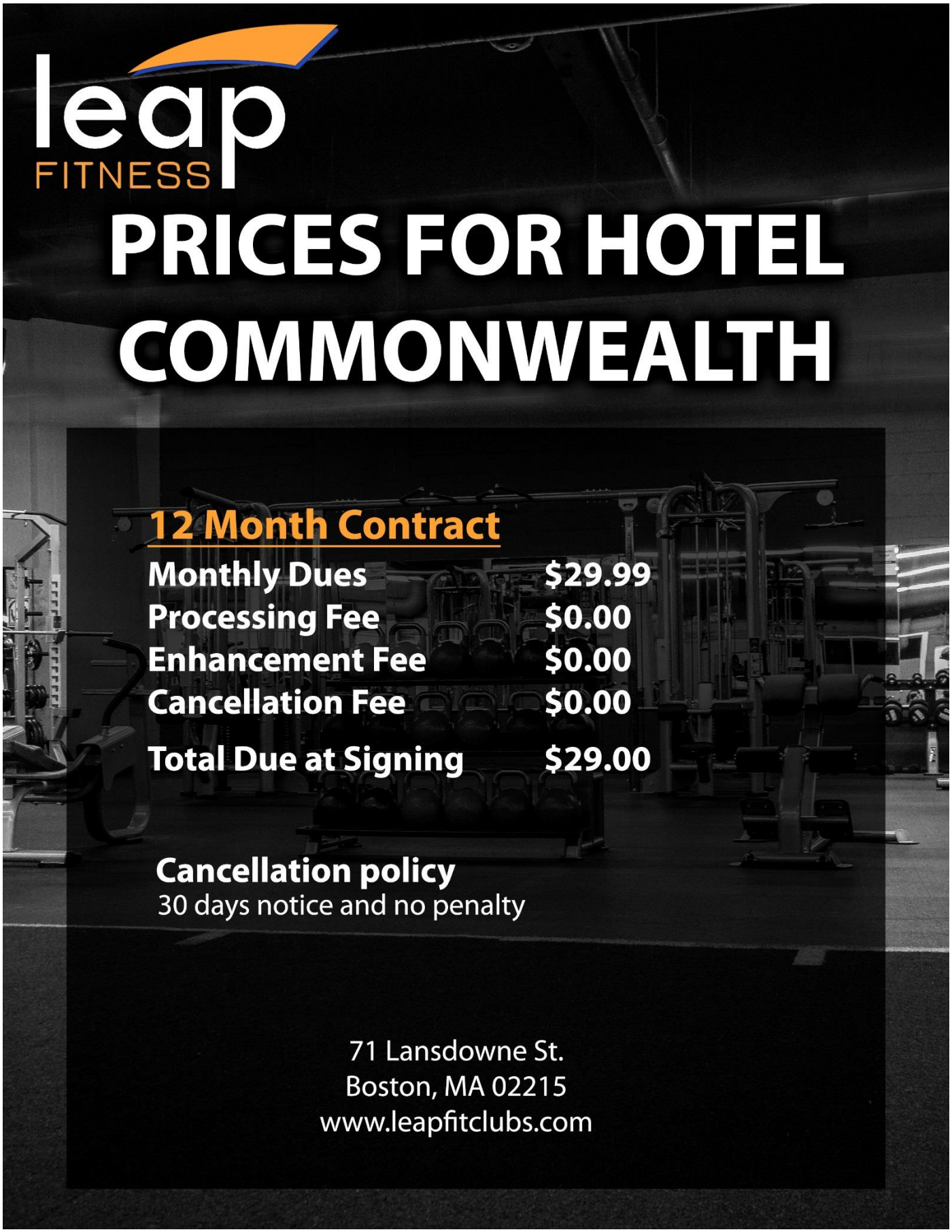
To verify this reimbursement is within your plan or for further information, please log onto the Member Central website at **www.bluecrossma.com/membercentral** or call the Member Service number on the front of your ID card.

Please complete and mail this form to:
Blue Cross Blue Shield of Massachusetts
Local Claims Department
PO Box 986030
Boston, MA 02298

1. Blue Cross will make a reimbursement decision within 30 calendar days of receiving a completed request for coverage or payment.

130440M 55-0763 (10/14)

MASSACHUSETTS


leap
FITNESS
PRICES FOR HOTEL
COMMONWEALTH
12 Month Contract
Monthly Dues $29.99
Processing Fee $0.00
Enhancement Fee $0.00
Cancellation Fee $0.00
Total Due at Signing $29.00
Cancellation policy
30 days notice and no penalty
71 Lansdowne St.
Boston, MA 02215
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Look up classes online ahead to check your chances of getting in

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Just mention you work for "Row 34 Group"

Available for all employees of ES, ICOB, The Hawthorne, Row 34 and Branch Line

For more information please contact Molly, Krista, and/or Eddy

Required Notices

Newborns' and Mothers' Health Protection Act

Under federal law, health care plans may not restrict any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal 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 and with the mother's consent, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

Women's Health and Cancer Rights Act 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.

Affordable Care Act (ACA) - Frequently Asked Questions
Employees Eligible for the Company-Sponsored Medical Plan

Q. What is the Affordable Care Act?

A: The Patient Protection and Affordable Care Act, commonly called the Affordable Care Act (ACA) is a United States federal statute signed into law by President Obama in March 2010.

The ACA includes subsidies, health insurance exchanges, and mandates, including an individual mandate that, with certain exceptions, requires all individuals beginning January 1, 2014 to have health insurance or pay a penalty. The law includes subsidies to help individuals with low incomes comply with the mandate. Coverage through the health insurance exchange is guaranteed; even if you have a pre-existing medical condition, your cost for coverage will be the same as all other applicants of the same age living in the same geographic location.

Q. Who is required to have health insurance?

A: Beginning January 1, 2014, all Americans – with some exceptions – are required to have medical insurance coverage or incur a penalty. Qualified health insurance plans that meet the ACA requirements may include:

- Government-sponsored plans, such as:
- Medicare or Medicaid
- Children's Health Insurance Program (CHIP)
- TRICARE
- Veterans health care programs
- Employer-based or sponsored health care plans - the Transamerica Limited Benefit *Hospital Indemnity Insurance is NOT considered qualified health insurance*
- Individual private coverage

Q. Will the Company continue to offer medical coverage in 2016-2017?

A: Yes, we will continue to offer medical coverage to eligible employees and their eligible family members in 2016.

Q. What is the health insurance exchange?

A: The health insurance exchange, sometimes called the Exchange or Marketplace, is a resource where individuals can learn about private health coverage options, compare private health insurance plans, and enroll in private health insurance coverage. The health insurance exchange also provides information on programs that help individuals with low to moderate incomes, and resources to pay for private health insurance coverage.

You can get help online at www.healthcare.gov, or call 1-800-318-2596, 24 hours a day, 7 days a week

Summary of Material Modifications

The Eastern Standard et, al Guide to Benefit Enrollment constitutes a Summary of Material of Modifications ("SMM") which describes changes to your health care program effective April 1st.

This SMM is a summary of the changes made to the program and the partial terms of Eastern Standard et al.'s medical or vision, plans. The SMM is not an official plan document. The actual terms of the plans are contained in the plan documents. In the event of any discrepancy, or any conflict between the SMM and the official plan documents, the official plan documents will govern. This SMM should be retained with your other benefits information. Eastern Standard et, al reserves the right to change, amend, or cease these benefits at any time.

Premium Assistance under Medicare 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 January 31, 2017. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**FLORIDA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	IOWA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-462-1120	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website:http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

To see if any other states have added a premium assistance program since January 31, 2017, 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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

OMB Control Number 1210-0137 (expires 12/31/2019)

Important Notice from Eastern Standard et al 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 Eastern Standard et al 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. Eastern Standard et al has determined that the prescription drug coverage offered by Blue Cross Blue Shield MA 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, your current Eastern Standard et al coverage will not be affected. Your options are as follows:

- Retain your existing coverage and choose not to enroll in a Part D plan; or
- Enroll in a Part D plan as a supplement to the other coverage
- If your existing prescription drug coverage is under a Medigap policy, you cannot have both your existing prescription drug coverage and Part D coverage. If you enroll in Part D coverage, you should inform your Medigap insurer of that fact, and the Medigap insurer must remove the prescription drug coverage from the Medigap policy and adjust the premium as of the date the Part D coverage starts. .

If you do decide to join a Medicare drug plan and drop your current Eastern Standard et al coverage, be aware that you and your dependents may not be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with Eastern Standard et al 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 Eastern Standard et al 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:	April 1, 2018
Name of Entity/Sender:	Molly Hopper Sandrof
Contact–Position/Office:	Director of People & Staff Development
Address:	700 Congress Street, Suite 204, Quincy, MA 02169
Phone Number:	1-800-258-4674

CMS Form 10182-CC Updated April 1, 2011

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

General Notice of COBRA Continuation Coverage 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;
- Commencement of a proceeding in bankruptcy with respect to the employer;]; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

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

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.

HIPAA 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 towards 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 decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

- To request special enrollment or obtain more information, contact:
- Name: Molly Hopper Sandrof
- Email: mhopper@easternstandard.com
- Address: 528 Commonwealth Avenue, Boston, Massachusetts 02215

Uniformed Services Employment and Reemployment Rights Act (USERRA)

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. The Act also states that if an employee leaves their job to perform military service, they have the right to elect to continue existing employer-based health plan coverage for the employee and their eligible dependents for up to 24 months while in the military. Even if the employee doesn't elect to continue coverage during their military service, they have the right to be reinstated in their employer's health plan when they are reemployed, generally without any waiting periods or exclusions (e.g. pre-existing condition exclusions) except for service-connected illnesses or injuries.

Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of your health and claims records	• You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct health and claims records	• You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
Ask us to limit what we use or share	• You can ask us not to use or share certain health information for treatment, payment, or our operations. • We are not required to agree to your request, and we may say "no" if it would affect your care.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in payment for your care • Share information in a disaster relief situation • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we never share your information unless you give us written permission:	• Marketing purposes • Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Help manage the health care treatment you receive	• We can use your health information and share it with professionals who are treating you.	**Example:** A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.
Run our organization	• We can use and disclose your information to run our organization and contact you when necessary. • We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.	**Example:** We use health information about you to develop better services for you.
Pay for your health services	• We can use and disclose your health information as we pay for your health services.	**Example:** We share information about you with your dental plan to coordinate payment for your dental work.
Administer your plan	• We may disclose your health information to your health plan sponsor for plan administration.	**Example:** Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information? We are allowed or required to share your information in other ways usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues	• We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests and work with a medical examiner or funeral director	• We can share health information about you with organ procurement organizations. • We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Effective: 4/1/2018

This Notice of Privacy Practices applies to: Eastern Standard et al

New Health Insurance Marketplace Coverage Options and Your Health Coverage

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

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution –as well as your employee contribution to employer-offered coverage– is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact _____.

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.

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name		4. Employer Identification Number (EIN)
5. Employer address		6. Employer phone number
7. City	8. State	9. ZIP code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above)	12. Email address	

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

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☐ Some employees. Eligible employees are:
- With respect to dependents:
  - ☐ We do offer coverage. Eligible dependents are:
  - ☐ We do not offer coverage.

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

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

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

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

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

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

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

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Contact Information

Company	Contact	Website / Email	Phone number
Blue Cross Blue Shield of MA *Medical, Dental and Vision Insurance Carrier*	**Pam Berman**	Pamela.Berman@bcbsma.com	617-246-3749
	Member Services	www.bluecrossma.com	800-424-0794
The Hartford *Accident and Disability Insurance Carrier*	**Customer Service**	www.thehartford.com	800-523-2233
Travelers Insurance *Risk Management Plus Online*	**Customer Service**	www.rmplusonline.com	
Health Equity *Health Savings Account Administrator*	**Member Service**	www.healthequity.com	877-694-3938


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BAR
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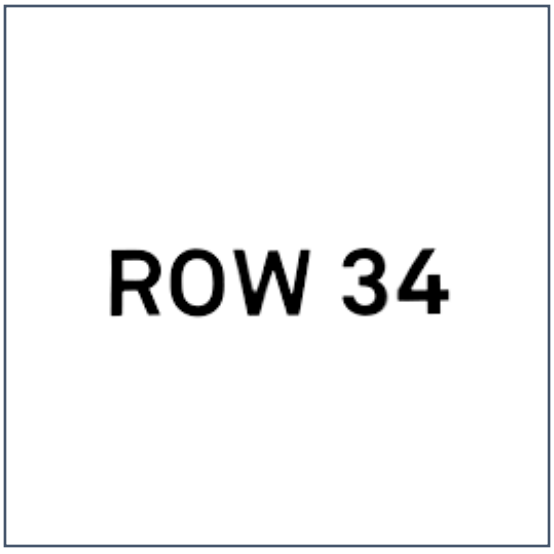
THE HAWTHORNE
500A COMMONWEALTH


BRANCH
LINE


KITCHEN
EASTERN ES STANDARD
DRINKS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