

# Taylor Corporation Companies

## Benefit Plan Legal Notices 2020/2021

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### IMPORTANT NOTICE

This packet includes a notice regarding how the plan’s prescription drug coverage compares to Medicare Part D. If you or a covered family member is also enrolled in Medicare Parts A or B, but not Part D, you should read the Medicare Part D notice carefully. It is titled, “Important Notice From Taylor Corporation Companies About Your Prescription Drug Coverage and Medicare.”

## TAYLOR CORPORATION – PPO Plus Plan

Summary of Benefits and Coverage: What this [Plan](#) Covers & What You Pay For Covered Services

Coverage Period: Beginning on or after 01/01/2021

Coverage for: Individual/Family | [Plan](#) Type: PPO



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be [provided](#) separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit [www.bluecrossmn.com/taylor](http://www.bluecrossmn.com/taylor) or call toll-free 1-866-289-5154. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copay](#), [deductible](#), [provider](#), or other [underlined](#) terms see the Glossary.

You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> or call toll-free 1-866-873-5943 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall <a href="#">deductible</a> ?	<p>\$1,500 individual medical <a href="#">in-network</a></p> <p>\$3,000 family medical <a href="#">in-network</a></p> <p>\$4,000 individual medical <a href="#">out-of-network</a></p> <p>\$8,000 family medical <a href="#">out-of-network</a></p>	<p>Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay.</p> <p>This <a href="#">plan</a> has an embedded <a href="#">deductible</a>. If you have other family members on the <a href="#">plan</a>, each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a>.</p>
Are there services covered before you meet your <a href="#">deductible</a> ?	<p>Yes. Well-child care, prenatal care and <a href="#">in-network preventive care</a> services are covered before you meet your <a href="#">deductible</a>.</p>	<p>This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copay</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a>. See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</p>
Are there other <a href="#">deductibles</a> for specific services?	<p>No</p>	<p>You don't have to meet <a href="#">deductibles</a> for specific services.</p>
What is the <a href="#">out-of-pocket limit</a> for this plan?	<p>\$6,600 individual medical and drug <a href="#">in-network</a></p> <p>\$13,200 family medical and drug <a href="#">in-network</a></p> <p>\$12,700 individual medical and drug <a href="#">out-of-network</a></p> <p>\$25,400 family medical and drug <a href="#">out-of-network</a></p>	<p>The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services.</p> <p>This <a href="#">plan</a> has an embedded <a href="#">deductible</a>. If you have other family members on the <a href="#">plan</a>, each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a>.</p>

What is not included in the <b>out-of-pocket limit</b> ?	<b>Premiums</b> , <b>balance-billed</b> charges, and health care this <b>plan</b> doesn't cover.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
Will you pay less if you use an <b>in-network provider</b> ?	Yes. See <a href="https://www.bluecrossmn.com/taylor">https://www.bluecrossmn.com/taylor</a> or call toll-free 1-866-289-5154 for a list of <b>in-network providers</b> .	This <b>plan</b> uses a <b>provider network</b> . You will pay less if you use a <b>provider</b> in the <b>plan's network</b> . You will pay the most if you use an <b>out-of-network provider</b> , and you might receive a bill from a <b>provider</b> for the difference between the <b>provider's</b> charge and what your <b>plan</b> pays ( <b>balance billing</b> ). Be aware your <b>in-network provider</b> might use an <b>out-of-network provider</b> for some services (such as laboratory work). Check with your <b>provider</b> before you get services.
Do you need a <b>referral</b> to see a <b>specialist</b> ?	No.	You can see the <b>specialist</b> you choose without a <b>referral</b> .



All **copay** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What you Will Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury	\$25 office visit <b>copay</b> ; <b>deductible</b> does not apply to services subject to a <b>copay</b> ; 20% <b>coinsurance</b> for all other services	40% <b>coinsurance</b>	None
	<b>Specialist</b> visit	\$35 office visit <b>copay</b> ; <b>deductible</b> does not apply to services subject to a <b>copay</b> ; 20% <b>coinsurance</b> for all other services	40% <b>coinsurance</b>	None
	<b>Preventive care/screening/immunization</b>	No charge	40% <b>coinsurance</b> for adult <b>preventive</b> services 40% <b>coinsurance</b> for well-child care services	You may have to pay for services that aren't <b>preventive</b> . Ask your <b>provider</b> if the services needed are <b>preventive</b> . Then check what your <b>plan</b> will pay for.

<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
<b>If you need drugs to treat your illness or condition. A retail pharmacy is any licensed pharmacy that you can physically enter to obtain a <a href="#">prescription drug</a>. A mail service pharmacy dispenses <a href="#">prescription drugs</a> through the U.S. Mail. More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.caremark.com">www.caremark.com</a></b>	Preferred generic drugs	\$10 <a href="#">copay</a> /retail \$25 <a href="#">copay</a> /90dayRx retail	\$10 <a href="#">copay</a> /retail \$25 <a href="#">copay</a> /90dayRx retail	Participant pays full price for prescriptions up to the deductible. Covers up to a 30-day supply (retail prescription); no coverage for mail service pharmacy drugs from Out-of-Network providers.
	Preferred brand drugs	20% <a href="#">coinsurance</a> /retail; \$40 minimum \$80 maximum 20% <a href="#">coinsurance</a> /90dayRx retail; \$100 minimum \$200 maximum	20% <a href="#">coinsurance</a> /retail; \$40 minimum \$80 maximum 20% <a href="#">coinsurance</a> /90dayRx retail; \$100 minimum \$200 maximum	
	Non-preferred drugs	50% <a href="#">coinsurance</a> /retail; \$60 minimum \$120 maximum 50% <a href="#">coinsurance</a> /90dayRx retail; \$150 minimum \$300 maximum	50% <a href="#">coinsurance</a> /retail; \$60 minimum \$120 maximum 50% <a href="#">coinsurance</a> /90dayRx retail; \$150 minimum \$300 maximum	
	<a href="#">Specialty drugs</a>	20% <a href="#">coinsurance</a> ; \$75 minimum \$150 maximum	20% <a href="#">coinsurance</a> ; \$75 minimum \$150 maximum	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
	<a href="#">Urgent care</a>	\$25 office visit <a href="#">copay</a> ; <a href="#">deductible</a> does not apply to services subject to a <a href="#">copay</a> ; 20% <a href="#">coinsurance</a> for all other services	40% <a href="#">coinsurance</a>	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	Physician/surgeon fee	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None



If you need mental health, behavioral health, or substance use services	Outpatient services	\$25 office visit <a href="#">copay</a> ; <a href="#">deductible</a> does not apply to services subject to a <a href="#">copay</a> ; 20% <a href="#">coinsurance</a> for all other services	40% <a href="#">coinsurance</a>	Services for marriage/couples counseling are not covered.
	Inpatient services including residential adult mental health treatment	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
If you are pregnant	Office visits	Prenatal care: 20% <a href="#">coinsurance</a> for non-preventive services Postnatal care: \$25 physician or \$35 specialist office visit <a href="#">copay</a> ; <a href="#">deductible</a> does not apply to services subject to a <a href="#">copay</a> ; 20% <a href="#">coinsurance</a> for all other services	Prenatal care: 40% <a href="#">coinsurance</a> Postnatal care: 40% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, other <a href="#">cost sharing</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Combined <a href="#">in-network</a> and <a href="#">out-of-network</a> : 100 visits per benefit period.
	<a href="#">Rehabilitation services</a>	\$25 <a href="#">copay</a> ; <a href="#">deductible</a> does not apply for occupational therapy \$25 <a href="#">copay</a> ; <a href="#">deductible</a> does not apply for physical therapy \$25 <a href="#">copay</a> ; <a href="#">deductible</a> does not apply for speech therapy	40% <a href="#">coinsurance</a> for occupational therapy 40% <a href="#">coinsurance</a> for physical therapy 40% <a href="#">coinsurance</a> for speech therapy	None
	<a href="#">Habilitation services</a>	\$25 <a href="#">copay</a> ; <a href="#">deductible</a> does not apply for occupational therapy \$25 <a href="#">copay</a> ; <a href="#">deductible</a> does not apply for physical therapy \$25 <a href="#">copay</a> ; <a href="#">deductible</a> does not apply for speech therapy	40% <a href="#">coinsurance</a> for occupational therapy 40% <a href="#">coinsurance</a> for physical therapy 40% <a href="#">coinsurance</a> for speech therapy	

	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Combined <a href="#">in-network</a> and <a href="#">out-of-network</a> : 90 days per benefit period.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
	<a href="#">Hospice service</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge	40% <a href="#">coinsurance</a>	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

### Excluded Services & Other Covered Services:

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

- Routine eye care (adult)
- Private-duty nursing
- Long-term care
- Routine foot care
- Dental care (except as specified in plan benefits)
- Cosmetic surgery (except as specified in plan benefits)
- Weight loss programs

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

- Chiropractic care
- Bariatric surgery
- Infertility treatment
- Acupuncture (except as specified in plan benefits)
- Non-emergency care when traveling outside the U.S.
- Hearing aids (external only & subject to coverage limitations)

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Minnesota Department of Commerce, Attention: Consumer Concerns/Market Assurance Division, 85 7th Place East Suite 280, St. Paul, MN 55101-2198, or call 1 800-657-3602; for group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa>; or, Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323, extension 61565 or <http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/>. Other coverage options may be available to you too, including buying individual insurance coverage through MNSure/the Marketplace. For more information about MNSure/the Marketplace, [visit www.mnsure.org](http://www.mnsure.org) or call 1 855 366 7873.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a grievance or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Customer Service at [www.bluecrossmnonline.com](http://www.bluecrossmnonline.com) or call 1-888-279-4210 or the Minnesota Department of Commerce by calling (651) 539-1600 or toll-free 1 800-657-3602. For group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa>. If you are covered under a [plan](#) offered by the State Health [plan](#), a city, county, school district, or Service Coop, you may contact the Department of Health and Human Services Health Insurance team at 1-888-393-2789.

### Does this [plan](#) provide Minimum Essential Coverage? Yes.

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

## Does this plan meet Minimum Value Standards? Yes.

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

## Notice of Nondiscrimination Practices

**Effective July 18, 2016**

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or gender. Blue Cross does not exclude people or treat them differently because of race, color, national origin, age, disability, or gender.

Blue Cross provides resources to access information in alternative formats and languages:

- Auxiliary aids and services, such as qualified interpreters and written information available in other formats, are available free of charge to people with disabilities to assist in communicating with us.
- Language services, such as qualified interpreters and information written in other languages, are available free of charge to people whose primary language is not English.

If you need these services, contact us at 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711.

If you believe that Blue Cross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or gender, you can file a [grievance](#) with the Nondiscrimination Civil Rights Coordinator

- by email at: [Civil.Rights.Coord@bluecrossmn.com](mailto:Civil.Rights.Coord@bluecrossmn.com)
- by mail at: Nondiscrimination Civil Rights Coordinator  
Blue Cross and Blue Shield of Minnesota and Blue Plus - M495  
PO Box 64560  
Eagan, MN 55164-0560
- or by telephone at: 1-800-509-5312

[Grievance](#) forms are available by contacting us at the contacts listed above, by calling 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711. If you need help filing a [grievance](#), assistance is available by contacting us at the numbers listed above.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights

- electronically through the Office for Civil Rights Complaint Portal, available at: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>
- by telephone at: 1-800-368-1019 or 1-800-537-7697 (TDD)
- or by mail at: U.S. Department of Health and Human Services  
200 Independence Avenue SW  
Room 509F, HHH Building  
Washington, DC 20201

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

## Language Access Services:

This information is available in other languages. Free language assistance services are available by calling the toll free number below. For TTY, call 711.

Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al 1-855-903-2583. Para TTY, llame al 711.

Yog tias koj hais lus Hmoob, muaj kev pab txhais lus pub dawb rau koj. Hu rau 1-800-793-6931. Rau TTY, hu rau 711.

Haddii aad ku hadasho Soomaali, adigu waxaad heli kartaa caawimo luqad lacag la'aan ah. Wac 1-866-251-6736. Markay tahay dad maqalku ku adag yahay (TTY), wac 711.

နမ့်ကတိကညိကိာ်း, တာ်ကဟ့ၣ်နကိာ်းတၢ်မၤစၢၤကလိတဖၣ်န့ၣ်လိၤ. ကိး 1-866-251-6744 လၢ TTYအဂီၢ်, ကိး 711 တက့ၢ်.

إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. اتصل بالرقم 1-866-569-9123. للهااتف النصي اتصل بالرقم 711.

Nếu quý vị nói Tiếng Việt, có sẵn các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Gọi số 1-855-315-4015. Người dùng TTY xin gọi 711.

Afaan Oromoo dubbattu yoo ta'e, tajaajila gargaarsa afaan hiikuu kaffaltii malee. Argachuuf 1-855-315-4016 bilbilaa. TTY dhaaf, 711 bilbilaa.

如果您說中文，我們可以為您提供免費的語言協助服務。請撥打 1-855-315-4017。聽語障專 (TTY)，請撥打 711。

Если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Звоните 1-855-315-4028. Для использования телефонного аппарата с текстовым выходом звоните 711.

Si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Appelez le +1-855-315-4029. Pour les personnes malentendantes, appelez le 711.

አማርኛ የሚናገሩ ከሆነ፣ ነጻ የቋንቋ አገልግሎት እርዳ አለሎት። በ 1-855-315-4030 ይደውሉ ለ TTY በ 711።

한국어를 사용하시는 경우, 무료 언어 지원 서비스가 제공됩니다. 1-855-904-2583 으로 전화하십시오. TTY 사용자는 711 로 전화하십시오.

ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອພາສາໃຫ້ເຈົ້າຟຣີ. ໃຫ້ໂທຫາ 1-866-356-2423 ສ່າລັບ. TTY, ໃຫ້ໂທຫາ 711.

Kung nagsasalita kayo ng Tagalog, mayroon kayong magagamit na libreng tulong na mga serbisyo sa wika. Tumawag sa 1-866-537-7720. Para sa TTY, tumawag sa 711.

Wenn Sie Deutsch sprechen, steht Ihnen fremdsprachliche Unterstützung zur Verfügung. Wählen Sie 1-866-289-7402. Für TTY wählen Sie 711.

ប្រសិនបើអ្នកនិយាយភាសាខ្មែរមិន អ្នកអាចរកបានសេវាជំនួយភាសាឥតគិតថ្លៃ។ ទូរស័ព្ទមកលេខ 1-855-906-2583។ សម្រាប់ TTY សូមទូរស័ព្ទមកលេខ 711។

Diné k'ehjí yáníłt'i'go saad bee yát'i' éi t'áájíík'e bee níká'a'doowołgo éi ná'ahoot'i'. Kojì éi béésh bee hodiíłnih 1-855-902-2583. TTY biniiyégo éi 711 jì' béésh bee hodiíłnih.

—————*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next page.*—————

**PRA Disclosure 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 **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather 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.

About these Coverage Examples:



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

**Peg is Having a Baby**  
(9 months of [in-network](#) prenatal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$1,500
- [Specialist copay](#) \$35
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

**This EXAMPLE event includes services like:**

- [Specialist](#) office visits (*prenatal care*)
- Childbirth/delivery professional services
- Childbirth/delivery facility services
- [Diagnostic tests](#) (*ultrasounds and blood work*)
- [Specialist](#) visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
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<a href="#">Deductibles</a>	\$1,500
<a href="#">Copays</a>	\$10
<a href="#">Coinsurance</a>	\$2,200

<b><i>What isn't covered</i></b>	
----------------------------------	--

Limits or exclusions	\$60
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<b>The total Peg would pay is</b>	<b>\$3,770</b>
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**Managing Joe's type 2 Diabetes**  
(a year of routine [in-network](#) care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$1,500
- [Specialist copay](#) \$35
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

**This EXAMPLE event includes services like:**

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

<b>Total Example Cost</b>	<b>\$5,600</b>
---------------------------	----------------

**In this example, Joe would pay:**

<i>Cost Sharing</i>	
---------------------	--

<a href="#">Deductibles</a>	\$800
<a href="#">Copays</a>	\$500
<a href="#">Coinsurance</a>	\$20

<b><i>What isn't covered</i></b>	
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Limits or exclusions	\$20
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<b>The total Joe would pay is</b>	<b>\$1,340</b>
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**Mia's Simple Fracture**  
([in-network](#) emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$1,500
- [Specialist copay](#) \$35
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

**This EXAMPLE event includes services like:**

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

<b>Total Example Cost</b>	<b>\$2,800</b>
---------------------------	----------------

**In this example, Mia would pay:**

<i>Cost Sharing</i>	
---------------------	--

<a href="#">Deductibles</a>	\$1,500
<a href="#">Copays</a>	\$200
<a href="#">Coinsurance</a>	\$100

<b><i>What isn't covered</i></b>	
----------------------------------	--

Limits or exclusions	\$0
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<b>The total Mia would pay is</b>	<b>\$1,800</b>
-----------------------------------	----------------

The total patient would pay amount assumes the patient is not using funds from a Flexible Spending Account (FSA), Health Savings Account (HSA), or an integrated Health Reimbursement Account (HRA), including an integrated HRA funded through a Voluntary Employee Beneficiary Association (VEBA-HRA). Account balances may provide you funds to help cover out-of-pocket expenses.

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please refer to your plan document.

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



## TAYLOR CORPORATION – PPO Plan

Summary of Benefits and Coverage: What this [Plan](#) Covers & What You Pay For Covered Services

Coverage Period: Beginning on or after 01/01/2021

Coverage for: Individual/Family | [Plan](#) Type: PPO



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be [provided](#) separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit [www.bluecrossmn.com/taylor](http://www.bluecrossmn.com/taylor) or call toll-free 1-866-289-5154. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copay](#), [deductible](#), [provider](#), or other [underlined](#) terms see the Glossary.

You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> or call toll-free 1-866-873-5943 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall <a href="#">deductible</a> ?	<p><b>\$2,500</b> individual medical <a href="#">in-network</a></p> <p><b>\$5,000</b> family medical <a href="#">in-network</a></p> <p><b>\$5,000</b> individual medical <a href="#">out-of-network</a></p> <p><b>\$10,000</b> family medical <a href="#">out-of-network</a></p>	<p>Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay.</p> <p>This <a href="#">plan</a> has an embedded <a href="#">deductible</a>. If you have other family members on the <a href="#">plan</a>, each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a>.</p>
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. Well-child care, prenatal care and <a href="#">in-network preventive care</a> services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copay</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this plan?	<p><b>\$6,600</b> individual medical and drug <a href="#">in-network</a></p> <p><b>\$13,200</b> family medical and drug <a href="#">in-network</a></p> <p><b>\$12,700</b> individual medical and drug <a href="#">out-of-network</a></p> <p><b>\$25,400</b> family medical and drug <a href="#">out-of-network</a></p>	<p>The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services.</p> <p>This <a href="#">plan</a> has an embedded <a href="#">deductible</a>. If you have other family members on the <a href="#">plan</a>, each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a>.</p>

<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<u>Premiums</u> , <u>balance-billed</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use an <u>in-network provider</u>?</b>	Yes. See <a href="https://www.bluecrossmn.com/taylor">https://www.bluecrossmn.com/taylor</a> or call toll-free 1-866-289-5154 for a list of <u>in-network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware your <u>in-network provider</u> might use an <u>out-of-network provider</u> for some services (such as laboratory work). Check with your <u>provider</u> before you get services.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All copay and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What you Will Pay		Limitations, Exceptions, & Other Important Information
		<u>In-network Provider</u> (You will pay the least)	<u>Out-of-network Provider</u> (You will pay the most)	
<b>If you visit a health care <u>provider's</u> office or clinic</b>	Primary care visit to treat an injury	\$40 office visit <u>copay</u> ; <u>deductible</u> does not apply to services subject to a <u>copay</u> ; 20% <u>coinsurance</u> for all other services	40% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$60 office visit <u>copay</u> ; <u>deductible</u> does not apply to services subject to a <u>copay</u> ; 20% <u>coinsurance</u> for all other services	40% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge	40% <u>coinsurance</u> for adult <u>preventive</u> services 40% <u>coinsurance</u> for well-child care services	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	



<p><b>If you need drugs to treat your illness or condition. A retail pharmacy is any licensed pharmacy that you can physically enter to obtain a <a href="#">prescription drug</a>. A mail service pharmacy dispenses <a href="#">prescription drugs</a> through the U.S. Mail. More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.caremark.com">www.caremark.com</a></b></p>	Preferred generic drugs	\$10 <a href="#">copay</a> /retail \$25 <a href="#">copay</a> /90dayRx retail	\$10 <a href="#">copay</a> /retail \$25 <a href="#">copay</a> /90dayRx retail	<p>Participant pays full price for prescriptions up to the deductible. Covers up to a 30-day supply (retail prescription); no coverage for mail service pharmacy drugs from Out-of-Network providers.</p>
	Preferred brand drugs	20% <a href="#">coinsurance</a> /retail; \$40 minimum \$80 maximum 20% <a href="#">coinsurance</a> /90dayRx retail; \$100 minimum \$200 maximum	20% <a href="#">coinsurance</a> /retail; \$40 minimum \$80 maximum 20% <a href="#">coinsurance</a> /90dayRx retail; \$100 minimum \$200 maximum	
	Non-preferred drugs	50% <a href="#">coinsurance</a> /retail; \$60 minimum \$120 maximum 50% <a href="#">coinsurance</a> /90dayRx retail; \$150 minimum \$300 maximum	50% <a href="#">coinsurance</a> /retail; \$60 minimum \$120 maximum 50% <a href="#">coinsurance</a> /90dayRx retail; \$150 minimum \$300 maximum	
	<a href="#">Specialty drugs</a>	20% <a href="#">coinsurance</a> ; \$75 minimum \$150 maximum	20% <a href="#">coinsurance</a> ; \$75 minimum \$150 maximum	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
	<a href="#">Urgent care</a>	\$40 office visit <a href="#">copay</a> ; <a href="#">deductible</a> does not apply to services subject to a <a href="#">copay</a>	40% <a href="#">coinsurance</a>	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	Physician/surgeon fee	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None

If you need mental health, behavioral health, or substance use services	Outpatient services	\$40 office visit <a href="#">copay</a> ; <a href="#">deductible</a> does not apply to services subject to a <a href="#">copay</a> ; 20% <a href="#">coinsurance</a> for all other services	40% <a href="#">coinsurance</a>	Services for marriage/couples counseling are not covered.
	Inpatient services including residential adult mental health treatment	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
If you are pregnant	Office visits	Prenatal care: 20% <a href="#">coinsurance</a> for non-preventive services Postnatal care: \$40 physician or \$60 specialist office visit <a href="#">copay</a> ; <a href="#">deductible</a> does not apply to services subject to a <a href="#">copay</a> ; 20% <a href="#">coinsurance</a> for all other services	Prenatal care: 40% <a href="#">coinsurance</a> Postnatal care: 40% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, other <a href="#">cost sharing</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Combined <a href="#">in-network</a> and <a href="#">out-of-network</a> : 100 visits per benefit period.
	<a href="#">Rehabilitation services</a>	\$40 <a href="#">copay</a> ; <a href="#">deductible</a> does not apply for occupational therapy \$40 <a href="#">copay</a> ; <a href="#">deductible</a> does not apply for physical therapy \$40 <a href="#">copay</a> ; <a href="#">deductible</a> does not apply for speech therapy	40% <a href="#">coinsurance</a> for occupational therapy 40% <a href="#">coinsurance</a> for physical therapy 40% <a href="#">coinsurance</a> for speech therapy	None
	<a href="#">Habilitation services</a>	\$40 <a href="#">copay</a> ; <a href="#">deductible</a> does not apply for occupational therapy \$40 <a href="#">copay</a> ; <a href="#">deductible</a> does not apply for physical therapy \$40 <a href="#">copay</a> ; <a href="#">deductible</a> does not apply for speech therapy	40% <a href="#">coinsurance</a> for occupational therapy 40% <a href="#">coinsurance</a> for physical therapy 40% <a href="#">coinsurance</a> for speech therapy	

	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Combined <a href="#">in-network</a> and <a href="#">out-of-network</a> : 90 days per benefit period.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
	<a href="#">Hospice service</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge	40% <a href="#">coinsurance</a>	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

### Excluded Services & Other Covered Services:

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

- Routine eye care (adult)
- Private-duty nursing
- Long-term care
- Routine foot care
- Dental care (except as specified in plan benefits)
- Cosmetic surgery (except as specified in plan benefits)
- Weight loss programs

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

- Chiropractic care
- Bariatric surgery
- Infertility treatment
- Acupuncture (except as specified in plan benefits)
- Non-emergency care when traveling outside the U.S.
- Hearing aids (external only & subject to coverage limitations)

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Minnesota Department of Commerce, Attention: Consumer Concerns/Market Assurance Division, 85 7th Place East Suite 280, St. Paul, MN 55101-2198, or call 1 800-657-3602; for group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa>; or, Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323, extension 61565 or <http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/>. Other coverage options may be available to you too, including buying individual insurance coverage through MNsure/the Marketplace. For more information about MNsure/the Marketplace, [visit www.mnsure.org](http://www.mnsure.org) or call 1 855 366 7873.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a grievance or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Customer Service at [www.bluecrossmnonline.com](http://www.bluecrossmnonline.com) or call 1-888-279-4210 or the Minnesota Department of Commerce by calling (651) 539-1600 or toll-free 1 800-657-3602. For group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa>. If you are covered under a [plan](#) offered by the State Health [plan](#), a city, county, school district, or Service Coop, you may contact the Department of Health and Human Services Health Insurance team at 1-888-393-2789.

### Does this [plan](#) provide Minimum Essential Coverage? Yes.

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

## Does this plan meet Minimum Value Standards? Yes.

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

## Notice of Nondiscrimination Practices

**Effective July 18, 2016**

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or gender. Blue Cross does not exclude people or treat them differently because of race, color, national origin, age, disability, or gender.

Blue Cross provides resources to access information in alternative formats and languages:

- Auxiliary aids and services, such as qualified interpreters and written information available in other formats, are available free of charge to people with disabilities to assist in communicating with us.
- Language services, such as qualified interpreters and information written in other languages, are available free of charge to people whose primary language is not English.

If you need these services, contact us at 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711.

If you believe that Blue Cross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or gender, you can file a [grievance](#) with the Nondiscrimination Civil Rights Coordinator

- by email at: [Civil.Rights.Coord@bluecrossmn.com](mailto:Civil.Rights.Coord@bluecrossmn.com)
- by mail at: Nondiscrimination Civil Rights Coordinator  
Blue Cross and Blue Shield of Minnesota and Blue Plus - M495  
PO Box 64560  
Eagan, MN 55164-0560
- or by telephone at: 1-800-509-5312

[Grievance](#) forms are available by contacting us at the contacts listed above, by calling 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711. If you need help filing a [grievance](#), assistance is available by contacting us at the numbers listed above.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights

- electronically through the Office for Civil Rights Complaint Portal, available at: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>
- by telephone at: 1-800-368-1019 or 1-800-537-7697 (TDD)
- or by mail at: U.S. Department of Health and Human Services  
200 Independence Avenue SW  
Room 509F, HHH Building  
Washington, DC 20201

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

## Language Access Services:

This information is available in other languages. Free language assistance services are available by calling the toll free number below. For TTY, call 711.

Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al 1-855-903-2583. Para TTY, llame al 711.

Yog tias koj hais lus Hmoob, muaj kev pab txhais lus pub dawb rau koj. Hu rau 1-800-793-6931. Rau TTY, hu rau 711.

Haddii aad ku hadasho Soomaali, adigu waxaad heli kartaa caawimo luqad lacag la'aan ah. Wac 1-866-251-6736. Markay tahay dad maqalku ku adag yahay (TTY), wac 711.

နမ့်ကတိကညိကိာ်း, တာ်ကဟ့ၣ်နကိာ်းတၢ်မၤစၢၤကလိတဖၣ်န့ၣ်လိၤ. ကိး 1-866-251-6744 လၢ TTYအဂီၢ်, ကိး 711 တက့ၢ်.

إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. اتصل بالرقم 1-866-569-9123. للهااتف النصي اتصل بالرقم 711.

Nếu quý vị nói Tiếng Việt, có sẵn các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Gọi số 1-855-315-4015. Người dùng TTY xin gọi 711.

Afaan Oromoo dubbattu yoo ta'e, tajaajila gargaarsa afaan hiikuu kaffaltii malee. Argachuuf 1-855-315-4016 bilbilaa. TTY dhaaf, 711 bilbilaa.

如果您說中文，我們可以為您提供免費的語言協助服務。請撥打 1-855-315-4017。聽語障專 (TTY)，請撥打 711。

Если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Звоните 1-855-315-4028. Для использования телефонного аппарата с текстовым выходом звоните 711.

Si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Appelez le +1-855-315-4029. Pour les personnes malentendantes, appelez le 711.

አማርኛ የሚናገሩ ከሆነ፣ ነጻ የቋንቋ አገልግሎት እርዳ አለሎት። በ 1-855-315-4030 ይደውሉ ለ TTY በ 711።

한국어를 사용하시는 경우, 무료 언어 지원 서비스가 제공됩니다. 1-855-904-2583 으로 전화하십시오. TTY 사용자는 711 로 전화하십시오.

ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອພາສາໃຫ້ເຈົ້າຟຣີ. ໃຫ້ໂທຫາ 1-866-356-2423 ສ່າລັບ. TTY, ໃຫ້ໂທຫາ 711.

Kung nagsasalita kayo ng Tagalog, mayroon kayong magagamit na libreng tulong na mga serbisyo sa wika. Tumawag sa 1-866-537-7720. Para sa TTY, tumawag sa 711.

Wenn Sie Deutsch sprechen, steht Ihnen fremdsprachliche Unterstützung zur Verfügung. Wählen Sie 1-866-289-7402. Für TTY wählen Sie 711.

ប្រសិនបើអ្នកនិយាយភាសាខ្មែរមិន អ្នកអាចរកបានសេវាជំនួយភាសាឥតគិតថ្លៃ។ ទូរស័ព្ទមកលេខ 1-855-906-2583។ សម្រាប់ TTY សូមទូរស័ព្ទមកលេខ 711។

Diné k'ehjí yáníłt'i'go saad bee yát'i' éí t'áájíík'e bee níká'a'doowołgo éí ná'ahoot'i'. Kojì éí béésh bee hodiíłnih 1-855-902-2583. TTY biniiyégo éí 711 jì' béésh bee hodiíłnih.

—————*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next page.*—————

**PRA Disclosure 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 **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather 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.



About these Coverage Examples:



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

**Peg is Having a Baby**  
(9 months of [in-network](#) prenatal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$2,500
- [Specialist copay](#) \$60
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

**This EXAMPLE event includes services like:**

- [Specialist](#) office visits (*prenatal care*)
- Childbirth/delivery professional services
- Childbirth/delivery facility services
- [Diagnostic tests](#) (*ultrasounds and blood work*)
- [Specialist](#) visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
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<a href="#">Deductibles</a>	\$2,500
<a href="#">Copays</a>	\$10
<a href="#">Coinsurance</a>	\$2,000

<b><i>What isn't covered</i></b>	
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Limits or exclusions	\$60
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<b>The total Peg would pay is</b>	<b>\$4,570</b>
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**Managing Joe's type 2 Diabetes**  
(a year of routine [in-network](#) care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$2,500
- [Specialist copay](#) \$60
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

**This EXAMPLE event includes services like:**

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

<b>Total Example Cost</b>	<b>\$5,600</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
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<a href="#">Deductibles</a>	\$800
<a href="#">Copays</a>	\$700
<a href="#">Coinsurance</a>	\$20

<b><i>What isn't covered</i></b>	
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Limits or exclusions	\$20
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<b>The total Joe would pay is</b>	<b>\$1,540</b>
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**Mia's Simple Fracture**  
([in-network](#) emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$2,500
- [Specialist copay](#) \$60
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

**This EXAMPLE event includes services like:**

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

<b>Total Example Cost</b>	<b>\$2,800</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
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<a href="#">Deductibles</a>	\$2,100
<a href="#">Copays</a>	\$300
<a href="#">Coinsurance</a>	\$0

<b><i>What isn't covered</i></b>	
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Limits or exclusions	\$0
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<b>The total Mia would pay is</b>	<b>\$2,400</b>
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The total patient would pay amount assumes the patient is not using funds from a Flexible Spending Account (FSA), Health Savings Account (HSA), or an integrated Health Reimbursement Account (HRA), including an integrated HRA funded through a Voluntary Employee Beneficiary Association (VEBA-HRA). Account balances may provide you funds to help cover out-of-pocket expenses.

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please refer to your plan document.

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

## TAYLOR CORPORATION – HSA Plan

Summary of Benefits and Coverage: What this [Plan](#) Covers & What You Pay For Covered Services

Coverage Period: Beginning on or after 01/01/2021

Coverage for: Individual/Family | [Plan](#) Type: HSA



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be [provided](#) separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit [www.bluecrossmn.com/taylor](http://www.bluecrossmn.com/taylor) or call toll-free 1-866-289-5154. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copay](#), [deductible](#), [provider](#), or other [underlined](#) terms see the Glossary.

You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> or call toll-free 1-866-873-5943 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall <a href="#">deductible</a> ?	<p><b>\$6,600</b> individual medical and drug <a href="#">in-network</a></p> <p><b>\$13,200</b> family medical and drug <a href="#">in-network</a></p> <p><b>\$12,700</b> individual medical and drug <a href="#">out-of-network</a></p> <p><b>\$25,400</b> family medical and drug <a href="#">out-of-network</a></p>	<p>Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay.</p> <p>This <a href="#">plan</a> has an embedded <a href="#">deductible</a>. If you have other family members on the <a href="#">plan</a>, each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a>.</p>
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. Well-child care, prenatal care and <a href="#">in-network preventive care</a> services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copay</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this plan?	<p><b>\$6,600</b> individual medical and drug <a href="#">in-network</a></p> <p><b>\$13,200</b> family medical and drug <a href="#">in-network</a></p> <p><b>\$12,700</b> individual medical and drug <a href="#">out-of-network</a></p> <p><b>\$25,400</b> family medical and drug <a href="#">out-of-network</a></p>	<p>The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services.</p> <p>This <a href="#">plan</a> has an embedded <a href="#">out-of-pocket limit</a>. If you have other family members in this <a href="#">plan</a>, they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.</p>



<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<u>Premiums</u> , <u>balance-billed</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use an <u>in-network provider</u>?</b>	Yes. See <a href="https://www.bluecrossmn.com/taylor">https://www.bluecrossmn.com/taylor</a> call toll-free 1-866-289-5154 for a list of <u>in-network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware your <u>in-network provider</u> might use an <u>out-of-network provider</u> for some services (such as laboratory work). Check with your <u>provider</u> before you get services.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All copay and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What you Will Pay		Limitations, Exceptions, & Other Important Information
		<u>In-network Provider</u> (You will pay the least)	<u>Out-of-network Provider</u> (You will pay the most)	
<b>If you visit a health care <u>provider's</u> office or clinic</b>	Primary care visit to treat an injury	0% <u>coinsurance</u>	0% <u>coinsurance</u>	None
	<u>Specialist</u> visit	0% <u>coinsurance</u>	0% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge	0% <u>coinsurance</u> for adult <u>preventive</u> services 0% <u>coinsurance</u> for well-child care services	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	0% <u>coinsurance</u>	0% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	0% <u>coinsurance</u>	0% <u>coinsurance</u>	

<p><b>If you need drugs to treat your illness or condition. A retail pharmacy is any licensed pharmacy that you can physically enter to obtain a <a href="#">prescription drug</a>. A mail service pharmacy dispenses <a href="#">prescription drugs</a> through the U.S. Mail.</b></p> <p>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.caremark.com">www.caremark.com</a></p>	Preferred generic drugs	0% <a href="#">coinsurance</a> /retail 0% <a href="#">coinsurance</a> /90dayRx retail	0% <a href="#">coinsurance</a> /retail 0% <a href="#">coinsurance</a> /90dayRx retail	Participant pays full price for prescriptions up to the deductible. No coverage for mail service pharmacy drugs from <a href="#">out-of-network providers</a>
	Preferred brand drugs	0% <a href="#">coinsurance</a> /retail 0% <a href="#">coinsurance</a> /90dayRx retail	0% <a href="#">coinsurance</a> /retail 0% <a href="#">coinsurance</a> /90dayRx retail	
	Non-preferred drugs	0% <a href="#">coinsurance</a> /retail 0% <a href="#">coinsurance</a> /90dayRx retail	0% <a href="#">coinsurance</a> /retail 0% <a href="#">coinsurance</a> /90dayRx retail	
	<a href="#">Specialty drugs</a>	0% <a href="#">coinsurance</a>	Not covered	No coverage for mail service pharmacy drugs from <a href="#">out-of-network providers</a>
<p><b>If you have outpatient surgery</b></p>	Facility fee (e.g., ambulatory surgery center)	0% <a href="#">coinsurance</a>	0% <a href="#">coinsurance</a>	None
	Physician/surgeon fees	0% <a href="#">coinsurance</a>	0% <a href="#">coinsurance</a>	None
<p><b>If you need immediate medical attention</b></p>	<a href="#">Emergency room care</a>	0% <a href="#">coinsurance</a>	0% <a href="#">coinsurance</a>	None
	<a href="#">Emergency medical transportation</a>	0% <a href="#">coinsurance</a>	0% <a href="#">coinsurance</a>	None
	<a href="#">Urgent care</a>	0% <a href="#">coinsurance</a>	0% <a href="#">coinsurance</a>	None
<p><b>If you have a hospital stay</b></p>	Facility fee (e.g., hospital room)	0% <a href="#">coinsurance</a>	0% <a href="#">coinsurance</a>	None
	Physician/surgeon fee	0% <a href="#">coinsurance</a>	0% <a href="#">coinsurance</a>	None
<p><b>If you need mental health, behavioral health, or substance use services</b></p>	Outpatient services	0% <a href="#">coinsurance</a>	0% <a href="#">coinsurance</a>	Services for marriage/couples counseling are not covered.
	Inpatient services including residential adult mental health treatment	0% <a href="#">coinsurance</a>	0% <a href="#">coinsurance</a>	None

If you are pregnant	Office visits	Prenatal care: 0% <a href="#">coinsurance</a> Postnatal care: 0% <a href="#">coinsurance</a>	Prenatal care: 0% <a href="#">coinsurance</a> Postnatal care: 0% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, other <a href="#">cost sharing</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	0% <a href="#">coinsurance</a>	0% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	0% <a href="#">coinsurance</a>	0% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	0% <a href="#">coinsurance</a>	0% <a href="#">coinsurance</a>	Combined <a href="#">in-network</a> and <a href="#">out-of-network</a> : 100 visits per benefit period.
	<a href="#">Rehabilitation services</a>	0% <a href="#">coinsurance</a> for occupational therapy 0% <a href="#">coinsurance</a> for physical therapy 0% <a href="#">coinsurance</a> for speech therapy	0% <a href="#">coinsurance</a> for occupational therapy 0% <a href="#">coinsurance</a> for physical therapy 0% <a href="#">coinsurance</a> for speech therapy	None
	<a href="#">Habilitation services</a>	0% <a href="#">coinsurance</a> for occupational therapy 0% <a href="#">coinsurance</a> for physical therapy 0% <a href="#">coinsurance</a> for speech therapy	0% <a href="#">coinsurance</a> for occupational therapy 0% <a href="#">coinsurance</a> for physical therapy 0% <a href="#">coinsurance</a> for speech therapy	
	<a href="#">Skilled nursing care</a>	0% <a href="#">coinsurance</a>	0% <a href="#">coinsurance</a>	Combined <a href="#">in-network</a> and <a href="#">out-of-network</a> : 90 days per benefit period.
	<a href="#">Durable medical equipment</a>	0% <a href="#">coinsurance</a>	0% <a href="#">coinsurance</a>	None
	<a href="#">Hospice service</a>	0% <a href="#">coinsurance</a>	0% <a href="#">coinsurance</a>	None
	If your child needs dental or eye care	Children's eye exam	No charge	0% <a href="#">coinsurance</a>
Children's glasses		Not covered	Not covered	None
Children's dental check-up		Not covered	Not covered	None

## Excluded Services & Other Covered Services:

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

- Routine eye care (adult)
- Private-duty nursing
- Long-term care
- Routine foot care
- Dental care (except as specified in plan benefits)
- Cosmetic surgery (except as specified in plan benefits)
- Weight loss programs

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

- Chiropractic care
- Bariatric surgery
- Infertility treatment
- Acupuncture (except as specified in plan benefits)
- Non-emergency care when traveling outside the U.S.
- Hearing aids (external only & subject to coverage limitations)

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Minnesota Department of Commerce, Attention: Consumer Concerns/Market Assurance Division, 85 7th Place East Suite 280, St. Paul, MN 55101-2198, or call 1 800-657-3602; for group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa>; or, Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323, extension 61565 or <http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/>. Other coverage options may be available to you too, including buying individual insurance coverage through MNSure/the Marketplace. For more information about MNSure/the Marketplace, [visit www.mnsure.org](http://www.mnsure.org) or call 1 855 366 7873.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a grievance or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Customer Service at [www.bluecrossmnonline.com](http://www.bluecrossmnonline.com) or call 1-888-279-4210 or the Minnesota Department of Commerce by calling (651) 539-1600 or toll-free 1-800-657-3602. For group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa>. If you are covered under a [plan](#) offered by the State Health [plan](#), a city, county, school district, or Service Coop, you may contact the Department of Health and Human Services Health Insurance team at 1-888-393-2789.

### Does this [plan](#) provide Minimum Essential Coverage? Yes.

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

### Does this [plan](#) meet Minimum Value Standards? Yes.

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

### Notice of Nondiscrimination Practices

**Effective July 18, 2016**

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or gender. Blue Cross does not exclude people or treat them differently because of race, color, national origin, age, disability, or gender.

Blue Cross provides resources to access information in alternative formats and languages:

- Auxiliary aids and services, such as qualified interpreters and written information available in other formats, are available free of charge to people with disabilities to assist in communicating with us.
- Language services, such as qualified interpreters and information written in other languages, are available free of charge to people whose primary language is not English.

If you need these services, contact us at 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711.

If you believe that Blue Cross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or gender, you can file a [grievance](#) with the Nondiscrimination Civil Rights Coordinator

- by email at: [Civil.Rights.Coord@bluecrossmn.com](mailto:Civil.Rights.Coord@bluecrossmn.com)
- by mail at: Nondiscrimination Civil Rights Coordinator  
Blue Cross and Blue Shield of Minnesota and Blue Plus - M495  
PO Box 64560  
Eagan, MN 55164-0560
- or by telephone at: 1-800-509-5312

[Grievance](#) forms are available by contacting us at the contacts listed above, by calling 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711. If you need help filing a [grievance](#), assistance is available by contacting us at the numbers listed above.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights

- electronically through the Office for Civil Rights Complaint Portal, available at: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>
- by telephone at: 1-800-368-1019 or 1-800-537-7697 (TDD)
- or by mail at: U.S. Department of Health and Human Services  
200 Independence Avenue SW  
Room 509F, HHH Building  
Washington, DC 20201

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

### Language Access Services:

This information is available in other languages. Free language assistance services are available by calling the toll free number below. For TTY, call 711.

Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al 1-855-903-2583. Para TTY, llame al 711.

Yog tias koj hais lus Hmoob, muaj kev pab txhais lus pub dawb rau koj. Hu rau 1-800-793-6931. Rau TTY, hu rau 711.

Haddii aad ku hadasho Soomaali, adigu waxaad heli kartaa caawimo luqad lacag la'aan ah. Wac 1-866-251-6736. Markay tahay dad maqalku ku adag yahay (TTY), wac 711.

နမ့်ကတိကညီကိုင်နိး, တံကဟ့နကိုင်တံမစေးကလိတဖှ်န့လိ. ကိး 1-866-251-6744 လာ TTYအဂီၢ်, ကိး 711 တက့ၢ်.

.711 إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. اتصل بالرقم 1-866-569-9123. للهاتف النصي اتصل بالرقم 711.

Nếu quý vị nói Tiếng Việt, có sẵn các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Gọi số 1-855-315-4015. Người dùng TTY xin gọi 711.

Afaan Oromoo dubbattu yoo ta'e, tajaajila gargaarsa afaan hiikuu kaffaltii malee. Argachuuf 1-855-315-4016 bilbilaa. TTY dhaaf, 711 bilbilaa.

如果您說中文，我們可以為您提供免費的語言協助服務。請撥打 1-855-315-4017。聽語障專 (TTY)，請撥打 711。

Если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Звоните 1-855-315-4028. Для использования телефонного аппарата с текстовым выходом звоните 711.

Si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Appelez le +1-855-315-4029. Pour les personnes malentendantes, appelez le 711.

አማርኛ የሚናገሩ ከሆነ፣ ነጻ የቋንቋ አገልግሎት እርዳ አለሎት። በ 1-855-315-4030 ይደውሉ ለ TTY በ 711።

한국어를 사용하시는 경우, 무료 언어 지원 서비스가 제공됩니다. 1-855-904-2583 으로 전화하십시오. TTY 사용자는 711 로 전화하십시오.

ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອພາສາໃຫ້ເຈົ້າຟຣີ. ໃຫ້ໂທຫາ 1-866-356-2423 ສໍາລັບ. TTY, ໃຫ້ໂທຫາ 711.

Kung nagsasalita kayo ng Tagalog, mayroon kayong magagamit na libreng tulong na mga serbisyo sa wika. Tumawag sa 1-866-537-7720. Para sa TTY, tumawag sa 711.

Wenn Sie Deutsch sprechen, steht Ihnen fremdsprachliche Unterstützung zur Verfügung. Wählen Sie 1-866-289-7402. Für TTY wählen Sie 711.

ប្រសិនបើអ្នកនិយាយភាសាខ្មែរមិន អ្នកអាចរកបានសេវាជំនួយភាសាឥតគិតថ្លៃ។ ទូរស័ព្ទមកលេខ 1-855-906-2583។ សម្រាប់ TTY សូមទូរស័ព្ទមកលេខ 711។

Diné k'ehjí yáníłt'i'go saad bee yát'i' éí t'áájíík'e bee níká'a'doowołgo éí ná'ahoot'i'. Kojí éí béésh bee hodííłnih 1-855-902-2583. TTY biniiyégo éí 711 jí' béésh bee hodííłnih.

————— *To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next page.* —————

**PRA Disclosure 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 **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather 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.



About these Coverage Examples:



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

**Peg is Having a Baby**  
(9 months of [in-network](#) prenatal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$6,600
- [Specialist copay](#) \$0
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

**This EXAMPLE event includes services like:**

- [Specialist](#) office visits (*prenatal care*)
- Childbirth/delivery professional services
- Childbirth/delivery facility services
- [Diagnostic tests](#) (*ultrasounds and blood work*)
- [Specialist](#) visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700</b>
<b>In this example, Peg would pay:</b>	
<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$6,600
<a href="#">Copays</a>	\$0
<a href="#">Coinsurance</a>	\$0
<b><i>What isn't covered</i></b>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$6,660</b>

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

- The [plan's](#) overall [deductible](#) \$6,600
- [Specialist copay](#) \$0
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

**This EXAMPLE event includes services like:**

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

<b>Total Example Cost</b>	<b>\$5,600</b>
<b>In this example, Joe would pay:</b>	
<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$5,400
<a href="#">Copays</a>	\$0
<a href="#">Coinsurance</a>	\$0
<b><i>What isn't covered</i></b>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$5,420</b>

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

- The [plan's](#) overall [deductible](#) \$6,600
- [Specialist copay](#) \$0
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

**This EXAMPLE event includes services like:**

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

<b>Total Example Cost</b>	<b>\$2,800</b>
<b>In this example, Mia would pay:</b>	
<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$2,800
<a href="#">Copays</a>	\$0
<a href="#">Coinsurance</a>	\$0
<b><i>What isn't covered</i></b>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,800</b>

The total patient would pay amount assumes the patient is not using funds from a Flexible Spending Account (FSA), Health Savings Account (HSA), or an integrated Health Reimbursement Account (HRA), including an integrated HRA funded through a Voluntary Employee Beneficiary Association (VEBA-HRA). Account balances may provide you funds to help cover out-of-pocket expenses.

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please refer to your plan document.

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



## **Important Notice From Taylor Corporation (the Company) About Your Prescription Drug Coverage and Medicare**

### **Notice Pertains To The Following Health Plans: PPO Plus, PPO and HSA Plan**

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Company and about your options under Medicare's prescription drug coverage. 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. This information can help you decide whether or not you want to join a Medicare drug plan. 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 prescription 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. The Company has determined that the prescription drug coverage offered by your employer through the Taylor Corporation Self-Insured Hospitalization Welfare Plan – PPO, PPO Plus, and HSA Plans 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 on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

### **When Can You Join A Medicare Drug Plan?**

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

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

If you decide to join a Medicare drug plan, your current coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current Company coverage, be aware that you and your dependents might not be able to get this coverage back, depending on your employer's eligibility policy. This may affect your medical coverage as well, so be sure to contact HRConnect at 877-252-9861, [HRConnect@taylorcorp.com](mailto:HRConnect@taylorcorp.com).

### **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 the Company and do not 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 percent of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19 percent 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 pharmacy vendor at the telephone number listed on the back of your pharmacy member card.

**NOTE:** You will receive this notice each year. You will also receive it before the next period you can join a Medicare drug plan and if this coverage through the Company changes. You may request a copy of this notice anytime.

### **For More Information About Your Options Under Medicare Prescription Drug Coverage...**

- Visit [www.medicare.gov](http://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, or
- 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](http://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 you are required to pay a higher premium (a penalty).**

Date: 10/07/2020

## 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](http://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](http://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](http://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	CALIFORNIA – Medicaid
Website: <a href="http://myalhipp.com/">http://myalhipp.com/</a> Phone: 1-855-692-5447	Website: <a href="https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_ont.aspx">https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_ont.aspx</a> Phone: 916-440-5676
ALASKA – Medicaid	COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)
The AK Health Insurance Premium Payment Program Website: <a href="http://myakhipp.com/">http://myakhipp.com/</a> Phone: 1-866-251-4861 Email: <a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a> Medicaid Eligibility: <a href="http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx">http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx</a>	Health First Colorado Website: <a href="https://www.healthfirstcolorado.com/">https://www.healthfirstcolorado.com/</a> Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: <a href="https://www.colorado.gov/pacific/hcpf/child-health-plan-plus">https://www.colorado.gov/pacific/hcpf/child-health-plan-plus</a> CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): <a href="https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program">https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program</a> HIBI Customer Service: 1-855-692-6442
ARKANSAS – Medicaid	FLORIDA – Medicaid
Website: <a href="http://myarhipp.com/">http://myarhipp.com/</a> Phone: 1-855-MyARHIPP (855-692-7447)	Website: <a href="https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html">https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html</a> Phone: 1-877-357-3268

<b>GEORGIA – Medicaid</b>	<b>MASSACHUSETTS – Medicaid and CHIP</b>
Website: <a href="https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp">https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp</a> Phone: 678-564-1162 ext 2131	Website: <a href="http://www.mass.gov/eohhs/gov/departments/masshealth/">http://www.mass.gov/eohhs/gov/departments/masshealth/</a> Phone: 1-800-862-4840
<b>INDIANA – Medicaid</b>	<b>MINNESOTA – Medicaid</b>
Healthy Indiana Plan for low-income adults 19-64 Website: <a href="http://www.in.gov/fssa/hip/">http://www.in.gov/fssa/hip/</a> Phone: 1-877-438-4479 All other Medicaid Website: <a href="https://www.in.gov/medicaid/">https://www.in.gov/medicaid/</a> Phone 1-800-457-4584	Website: <a href="https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp">https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp</a> Phone: 1-800-657-3739
<b>IOWA – Medicaid and CHIP (Hawki)</b>	<b>MISSOURI – Medicaid</b>
Medicaid Website: <a href="https://dhs.iowa.gov/ime/members">https://dhs.iowa.gov/ime/members</a> Medicaid Phone: 1-800-338-8366 Hawki Website: <a href="http://dhs.iowa.gov/Hawki">http://dhs.iowa.gov/Hawki</a> Hawki Phone: 1-800-257-8563	Website: <a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a> Phone: 573-751-2005
<b>KANSAS – Medicaid</b>	<b>MONTANA – Medicaid</b>
Website: <a href="http://www.kdheks.gov/hcf/default.htm">http://www.kdheks.gov/hcf/default.htm</a> Phone: 1-800-792-4884	Website: <a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP">http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP</a> Phone: 1-800-694-3084
<b>KENTUCKY – Medicaid</b>	<b>NEBRASKA – Medicaid</b>
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: <a href="https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx">https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx</a> Phone: 1-855-459-6328 Email: <a href="mailto:KIHIPP.PROGRAM@ky.gov">KIHIPP.PROGRAM@ky.gov</a>  KCHIP Website: <a href="https://kidshealth.ky.gov/Pages/index.aspx">https://kidshealth.ky.gov/Pages/index.aspx</a> Phone: 1-877-524-4718  Kentucky Medicaid Website: <a href="https://chfs.ky.gov">https://chfs.ky.gov</a>	Website: <a href="http://www.ACCESSNebraska.ne.gov">http://www.ACCESSNebraska.ne.gov</a> Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
<b>LOUISIANA – Medicaid</b>	<b>NEVADA – Medicaid</b>
Website: <a href="http://www.medicaid.la.gov">www.medicaid.la.gov</a> or <a href="http://www.ldh.la.gov/lahipp">www.ldh.la.gov/lahipp</a> Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: <a href="http://dhcfp.nv.gov">http://dhcfp.nv.gov</a> Medicaid Phone: 1-800-992-0900
<b>MAINE – Medicaid</b>	<b>NEW HAMPSHIRE – Medicaid</b>
Enrollment Website: <a href="https://www.maine.gov/dhhs/ofi/applications-forms">https://www.maine.gov/dhhs/ofi/applications-forms</a> Phone: 1-800-442-6003 TTY: Maine relay 711  Private Health Insurance Premium Webpage: <a href="https://www.maine.gov/dhhs/ofi/applications-forms">https://www.maine.gov/dhhs/ofi/applications-forms</a> Phone: 1-800-977-6740. TTY: Maine relay 711	Website: <a href="https://www.dhhs.nh.gov/oi/hipp.htm">https://www.dhhs.nh.gov/oi/hipp.htm</a> Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218

<p align="center"><b>NEW JERSEY – Medicaid and CHIP</b></p> <p>Medicaid Website:  <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a>  Medicaid Phone: 609-631-2392  CHIP Website: <a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a>  CHIP Phone: 1-800-701-0710</p>	<p align="center"><b>SOUTH DAKOTA - Medicaid</b></p> <p>Website: <a href="http://dss.sd.gov">http://dss.sd.gov</a>  Phone: 1-888-828-0059</p>
<p align="center"><b>NEW YORK – Medicaid</b></p> <p>Website: <a href="https://www.health.ny.gov/health_care/medicaid/">https://www.health.ny.gov/health_care/medicaid/</a>  Phone: 1-800-541-2831</p>	<p align="center"><b>TEXAS – Medicaid</b></p> <p>Website: <a href="http://gethipptexas.com/">http://gethipptexas.com/</a>  Phone: 1-800-440-0493</p>
<p align="center"><b>NORTH CAROLINA – Medicaid</b></p> <p>Website: <a href="https://medicaid.ncdhhs.gov/">https://medicaid.ncdhhs.gov/</a>  Phone: 919-855-4100</p>	<p align="center"><b>UTAH – Medicaid and CHIP</b></p> <p>Medicaid Website: <a href="https://medicaid.utah.gov/">https://medicaid.utah.gov/</a>  CHIP Website: <a href="http://health.utah.gov/chip">http://health.utah.gov/chip</a>  Phone: 1-877-543-7669</p>
<p align="center"><b>NORTH DAKOTA – Medicaid</b></p> <p>Website:  <a href="http://www.nd.gov/dhs/services/medicalserv/medicaid/">http://www.nd.gov/dhs/services/medicalserv/medicaid/</a>  Phone: 1-844-854-4825</p>	<p align="center"><b>VERMONT– Medicaid</b></p> <p>Website: <a href="http://www.greenmountaincare.org/">http://www.greenmountaincare.org/</a>  Phone: 1-800-250-8427</p>
<p align="center"><b>OKLAHOMA – Medicaid and CHIP</b></p> <p>Website: <a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a>  Phone: 1-888-365-3742</p>	<p align="center"><b>VIRGINIA – Medicaid and CHIP</b></p> <p>Website: <a href="https://www.coverva.org/hipp/">https://www.coverva.org/hipp/</a>  Medicaid Phone: 1-800-432-5924  CHIP Phone: 1-855-242-8282</p>
<p align="center"><b>OREGON – Medicaid</b></p> <p>Website: <a href="http://healthcare.oregon.gov/Pages/index.aspx">http://healthcare.oregon.gov/Pages/index.aspx</a>  <a href="http://www.oregonhealthcare.gov/index-es.html">http://www.oregonhealthcare.gov/index-es.html</a>  Phone: 1-800-699-9075</p>	<p align="center"><b>WASHINGTON – Medicaid</b></p> <p>Website: <a href="https://www.hca.wa.gov/">https://www.hca.wa.gov/</a>  Phone: 1-800-562-3022</p>
<p align="center"><b>PENNSYLVANIA – Medicaid</b></p> <p>Website:  <a href="https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx">https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx</a>  Phone: 1-800-692-7462</p>	<p align="center"><b>WEST VIRGINIA – Medicaid</b></p> <p>Website: <a href="http://mywvhipp.com/">http://mywvhipp.com/</a>  Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)</p>
<p align="center"><b>RHODE ISLAND – Medicaid and CHIP</b></p> <p>Website: <a href="http://www.eohhs.ri.gov/">http://www.eohhs.ri.gov/</a>  Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)</p>	<p align="center"><b>WISCONSIN–Medicaid and CHIP</b></p> <p>Website:  <a href="https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm">https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm</a>  Phone: 1-800-362-3002</p>
<p align="center"><b>SOUTH CAROLINA – Medicaid</b></p> <p>Website: <a href="https://www.scdhhs.gov">https://www.scdhhs.gov</a>  Phone: 1-888-549-0820</p>	<p align="center"><b>WYOMING – Medicaid</b></p> <p>Website:  <a href="https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/">https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/</a>  Phone: 1-800-251-1269</p>

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](http://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](http://www.cms.hhs.gov)  
1-877-267-2323, Menu Option 4, Ext. 61565

### **Paperwork Reduction Act Statement**

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

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

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

## Special Enrollment Provisions

### Life Events

**Loss of Other Coverage.** If you decline enrollment for yourself or for an eligible dependent because you had other group health plan coverage or other health insurance, you may be able to enroll yourself and your dependents in the Plan if you or your dependents lose eligibility for that coverage, or if the other employer stops contributing toward your or your dependents' other coverage. You must request enrollment within 30 days after you or your dependents' other coverage ends, or after the other employer stops contributing toward the other coverage.

**New Dependent by Marriage, Birth, Adoption, or Placement for Adoption.** If you gain a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents in the Plan. You must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. In the event you acquire a new dependent by birth, adoption or placement for adoption, you may also be able to enroll your spouse in the Plan, if your spouse was not previously covered.

**Enrollment Due to Medicaid/CHIP Events.** If you or your eligible dependents are not already enrolled in the Plan, you may be able to enroll yourself and your eligible dependents in the Plan if: (1) you or your dependents lose coverage under a state Medicaid or children's health insurance program (CHIP); or (2) you or your dependents become eligible for premium assistance under state Medicaid or CHIP. You must request enrollment within 60 days from the date of the Medicaid/CHIP event.

### Contact Information

If you have any questions about this Notice or about how to enroll in the Plan, please contact HRConnect at 877-252-9861, [HRConnect@taylorcorp.com](mailto:HRConnect@taylorcorp.com), or by writing to:

Taylor Corporation HRConnect  
1725 Roe Crest Drive  
P.O. Box 3728  
North Mankato, MN 56002-3728

### Notice Availability

A copy of this notice is available at our internal website at <http://newcompass.tc.inet>, HRConnect – Benefits page. Additional information regarding your rights to enroll in the Plan are found in the applicable Summary Plan Description(s) for the Plan, or you may contact HRConnect as provided above.

**Action Requested:**

If you are enrolled in your companies Health, Dental, Vision, Flexible Benefits, Life Insurance, and/or Long-term Disability plans, please review these Summary Annual Reports and file for future reference.

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**SUMMARY ANNUAL REPORTS**

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**FOR TAYLOR CORPORATION SELF-INSURED HOSPITALIZATION WELFARE PLAN**

This is the summary annual report for the Taylor Corporation Self-Insured Hospitalization Welfare Plan, EIN 41-0852411, Plan number 503 for the period January 1, 2019 to December 31, 2019. The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Taylor Corporation has committed itself to pay the following types of claims incurred under the terms of the plan: medical and dental

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**FOR TAYLOR CORPORATION FLEXIBLE BENEFIT PLAN**

This is the summary annual report for the Taylor Corporation Flexible Benefit Plan, EIN 41-0852411, Plan number 501 for the period January 1, 2019 to December 31, 2019. The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Taylor Corporation has committed itself to pay the following types of claims incurred under the terms of the plan: medical, dental, and vision

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**FOR TAYLOR CORPORATION VISION PLAN**

This is the summary annual report for the Taylor Corporation Vision Plan, EIN 41-0852411, Plan number 504 for the period January 1, 2019 to December 31, 2019. The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

**Insurance Information**

The plan has a contract with Vision Service Plan to pay vision claims incurred under the terms of the plan. Total premiums paid during the plan year were \$1,149,747.

Because it is a so-called "experience-rated" contract, the premium costs are affected by, among other things, the number and size of claims. Of the total insurance premiums paid for the plan year ending December 31, 2019, the premiums paid under this "experience-rated" contract were \$1,149,747, and the total of all benefit claims paid under the experience-rated contract during the plan year was \$907,506.

**Your rights to additional information**

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report.

- Insurance information including sales commissions paid by insurance carriers

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**FOR TAYLOR CORPORATION LIFE, ACCIDENTAL DEATH AND DISMEMBERMENT PLAN**

This is the summary annual report for the Taylor Corporation Life, Accidental Death and Dismemberment Plan, EIN 41-0852411, Plan number 505 for the period January 1, 2019 to December 31, 2019. The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

**Insurance Information**

The plan has a contract with Reliastar Life Insurance Company (Voya) to pay life and accidental death & dismemberment claims incurred under the terms of the plan. Total premiums paid during the plan year were \$2,718,749.

**Your rights to additional information**

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in



that report.

- Insurance information including sales commissions paid by insurance carriers

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## FOR TAYLOR CORPORATION LONG TERM DISABILITY PLAN

This is the summary annual report for the Taylor Corporation Long Term Disability Plan, EIN 41-0852411, Plan number 506 for the period January 1, 2019 to December 31, 2019. The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

### Insurance Information

The plan has a contract with Reliastar Life Insurance Company (Voya) to pay long term disability claims incurred under the terms of the plan. Total premiums paid during the plan year were \$1,315,364.

### Your rights to additional information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report.

- Insurance information including sales commissions paid by insurance carriers

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## YOUR RIGHTS TO ADDITIONAL INFORMATION

If you participate in the employee benefit plans referred to above, you have the right to receive a copy of the full annual report, or any part thereof, on request. To obtain a copy of any of the full annual reports, or any part thereof, write or call the office of Taylor Corporation, who is the plan administrator, 1725 Roe Crest Drive, North Mankato, MN, 56003, 507-625-2828. For the Self-Insured Hospitalization Welfare Plan and the Flexible Benefit Plan, the charge to cover copying costs will be \$0.75 for the full annual report, or \$0.25 per page for any part thereof. For the Vision, Life / AD&D Insurance and Long Term Disability Insurance plans, the charge to cover copying costs will be \$1.75 for the full annual report, or \$0.25 per page for any part thereof.

You also have the right to receive from the plan administrator, on request and at no charge, a statement of the assets and liabilities of the plan and accompanying notes, or a statement of income and expenses of the plan and accompanying notes, or both. If you request a copy of the full annual report from the plan administrator, these two statements and accompanying notes will be included as part of that report. The charge to cover copying costs given above does not include a charge for the copying of these portions of the report because these portions are furnished without charge.

Plan participants also have the legally protected right to examine the annual report at the main office of the plan: 1725 Roe Crest Drive, North Mankato, MN 56003, and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N-1513, Employee Benefits Security Administration U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210.

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### Paperwork Reduction Act Statement

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

The public reporting burden for this collection of information is estimated to average less than one minute per notice (approximately 3 hours and 11 minutes per plan). Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of the Chief Information Officer, Attention: Departmental Clearance Officer, 200 Constitution Avenue, N.W., Room N-1301, Washington, DC 20210 or email [DOL\\_PRA\\_PUBLIC@dol.gov](mailto:DOL_PRA_PUBLIC@dol.gov) and reference the OMB Control Number 1210-0040.

OMB Control Number 1210-0040 (expires 06/30/2022)



# New Health Insurance Marketplace Coverage Options and Your Health Coverage

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

## PART A: General Information

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

### What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace runs from November 1, 2020 through December 15, 2020 for coverage starting as early as January 1, 2021.

### 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.<sup>1</sup>

**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 [HRConnect@taylorcorp.com](mailto:HRConnect@taylorcorp.com) or 877-252-9861.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [HealthCare.gov](http://HealthCare.gov) for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

<sup>1</sup> 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 Taylor Corporation		4. Employer Identification Number (EIN) 41-0852411	
5. Employer address 1725 Roe Crest Drive		6. Employer phone number 507-625-2828	
7. City North Mankato	8. State MN	9. ZIP code 56003	
10. Who can we contact about employee health coverage at this job? Manager of Benefits			
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:

Full-time employees of Taylor. "Full-time employee" means that you work an average of at least 20 hours per week over the course of the Employer's applicable measurement period.

- With respect to dependents:

We do offer coverage. Eligible dependents are:

Legal Spouse and Dependent Children under 26 years of age.

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

## Notice of Privacy Practices

**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.**

**Taylor Corporation** sponsors a group health plan (the “Plan”) to provide coverage for health care services (including medical, prescription drug, dental and vision plan benefits) for our employees, their dependents and other participants. We provide this coverage through various relationships with third parties that establish networks of providers, coordinate your care, and process claims for reimbursement for the services that you receive. This Notice of Privacy Practices (the “Notice”) describes the legal obligations of **Taylor Corporation**, the Plan and your legal rights regarding your protected health information held by the Plan under HIPAA. Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice to you pursuant to HIPAA. The HIPAA Privacy Rule protects only certain medical information known as “protected health information.” Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, which relates to:

- (1) your past, present or future physical or mental health or condition;
- (2) the provision of health care to you; or
- (3) the past, present or future payment for the provision of health care to you.

### Contact Information

If you have any questions about this Notice or about our privacy practices, please contact the Taylor HIPAA Privacy Officer:

Taylor Corporation  
Attention: HIPAA Privacy Officer  
1725 Roe Crest Drive  
North Mankato, MN 56003  
(507) 625-2828

## **Effective Date**

This Notice as revised is effective September 23, 2013.

## **Our Responsibilities**

We are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices. You may also obtain a copy of the latest revised Notice by contacting our Privacy Officer at the contact information provided above. Except as provided within this Notice, we may not disclose your protected health information without your prior authorization.

## **How We May Use and Disclose Your Protected Health Information**

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose protected health information will fall within one of the categories.

### **For Treatment**

We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is inappropriate or dangerous for you to use.

### **For Payment**

We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

**For Health Care Operations**

We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. The Plan is prohibited from using or disclosing protected health information that is genetic information about an individual for underwriting purposes.

**To Business Associates**

We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with us.

**As Required by Law**

We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

**To Avert a Serious Threat to Health or Safety**

We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

**To Plan Sponsors**

For the purpose of administering the Plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform Plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

**Special Situations**

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category



will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

### **Organ and Tissue Donation**

If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

### **Military and Veterans**

If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

### **Workers' Compensation**

We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

### **Public Health Risks**

We may disclose your protected health information for public health actions. These actions generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

### **Health Oversight Activities**

We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

### **Lawsuits and Disputes**

If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

### **Law Enforcement**

We may disclose your protected health information if asked to do so by a law enforcement official—

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct;
- about criminal conduct; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

### **Coroners, Medical Examiners and Funeral Directors**

We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

### **National Security and Intelligence Activities**

We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

### **Inmates**

If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

### **Research**

We may disclose your protected health information to researchers when:

- (1) the individual identifiers have been removed; or
- (2) when an institutional review board or privacy board has (a) reviewed the research proposal; and (b) established protocols to ensure the privacy of the requested information, and approves the research.

## **Required Disclosures**

The following is a description of disclosures of your protected health information we are required to make.

### **Government Audits**

We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

### **Disclosures to You**

When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide

you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

### **Notification of a Breach.**

We are required to notify you in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information, as defined by HIPAA.

## **Other Disclosures**

### **Personal Representatives**

We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

- (1) you have been, or may be, subjected to domestic violence, abuse or neglect by such person;
- (2) treating such person as your personal representative could endanger you; or
- (3) in the exercise or professional judgment, it is not in your best interest to treat the person as your personal representative.

### **Spouses and Other Family Members**

With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

### **Authorizations**

Other uses or disclosures of your protected health information not described above, including the use and disclosure of psychotherapy notes and the use or disclosure of protected health information for fundraising or marketing purposes, will not be made without your written authorization. You may revoke written authorization at any time, so long as your revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation. You may elect to opt out of receiving fundraising communications from us at any time.

## **Your Rights**

You have the following rights with respect to your protected health information:

### **Right to Inspect and Copy**

You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, submit your request in writing to the Privacy Officer at the address provided above under Contact Information. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may have a right to request that the denial be reviewed and you will be provided with details on how to do so.

### **Right to Amend**

If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at the address provided above under Contact Information. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

### **Right to an Accounting of Disclosures**

You have the right to request an “accounting” of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address provided above under Contact Information. Your request must state a time period of not longer than six years and may not include dates prior to your request. Your request should indicate in what form you want the list (for example, paper or electronic). We will attempt to provide the accounting in the format you requested or in another mutually agreeable format if the requested format is not reasonably feasible. The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

**Right to Request Restrictions**

You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had. We are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you. To request restrictions, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

**Right to Request Confidential Communications**

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

**Right to a Paper Copy of This Notice**

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, telephone or write the Privacy Officer as provided above under Contact Information.

**Complaints**

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, telephone or write the Privacy Officer as provided above under Contact Information. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Rights or with us. You should keep a copy of any notices you send to the Plan Administrator or the Privacy Officer for your records.

## GENERAL COBRA NOTICE

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of healthcare coverage under the plan. 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/or to other members of your family who are covered under the plan when you and/or they would otherwise lose the group health coverage. This notice gives only a summary of your COBRA continuation coverage rights. ***This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.*** For more information about your rights and obligations under the plan and under federal law, you should either review the plan's Summary Plan Description or contact the Plan Administrator. In some cases the plan document also serves as the Summary Plan Description.

***Note you may have other options available to you when you lose group health coverage.*** When you become eligible for COBRA, you may also become eligible for other coverage options not provided by your employer that may cost less than COBRA continuation 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.

### COBRA Continuation Coverage and "Qualifying Events"

COBRA continuation coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and eligible children of employees may be qualified beneficiaries. Certain newborns, newly-adopted children and alternate recipients under qualified medical child support orders may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below. Under the plan, qualified beneficiaries who elect COBRA continuation coverage generally must pay for this continuation coverage.

If you are a covered ***employee***, you will become a qualified beneficiary if you lose your coverage under the plan because either one of the following qualifying events happens:

- ❖ Your hours of employment are reduced, or
- ❖ Your employment ends for any reason other than your gross misconduct.

If you are the ***spouse of a covered employee***, you will become a qualified beneficiary if you lose your coverage under the plan because any of the following qualifying events happens:



- ❖ 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 enrolled in any part of Medicare (it is extremely rare for coverage of an employee's dependents to be terminated on account of the employee's Medicare enrollment); or
- ❖ You become divorced or legally separated from your spouse. Note that if your spouse cancels your coverage in anticipation of a divorce or legal separation and a divorce or legal separation later occurs, then the divorce or legal separation will be considered a qualifying event even though you actually lost coverage earlier. ***If you notify the Plan Administrator or its designee within 60 days after the divorce or legal separation and can establish that the employee canceled the coverage earlier in anticipation of the divorce or legal separation, then COBRA coverage may be available for a period after the divorce or legal separation (but not for the period between the date your coverage ended, and the date of divorce or legal separation).*** But you *must* provide timely notice of the divorce or legal separation to the Plan Administrator or its designee or you will not be able to obtain COBRA coverage after the divorce or legal separation. See the rules in the box below, under the heading entitled, "Notice Requirements," regarding the obligation to provide notice, and the procedures for doing so.

Your covered ***eligible children*** will become qualified beneficiaries if they lose coverage under the plan because any of the following qualifying events happens:

- ❖ 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 enrolled in any part of Medicare (it is extremely rare for coverage of an employee's dependents to be terminated on account of the employee's Medicare enrollment);
- ❖ The parents become divorced or legally separated; or
- ❖ The child stops being eligible for coverage under the plan as an "eligible child."

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

## Notice Requirements

The plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator or its designee has been *timely notified* that a qualifying event has occurred. When the qualifying event is:

- ❖ 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 employer (if the employer is not the Plan Administrator) must notify the Plan Administrator of the qualifying event within 30 days following the date coverage ends.

## IMPORTANT:

*For the other qualifying events (divorce or legal separation of the employee and spouse or an eligible child's losing eligibility for coverage as an eligible child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the qualifying event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any spouse or eligible child who loses coverage will not be offered the option to elect continuation coverage.*

### NOTICE PROCEDURES:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department, or firm listed below, at the following address:

Sharon Koenig  
Total Rewards Director  
507-625-2828  
skoenig@taylorcorp.com  
1725 Roe Crest Drive  
North Mankato, MN 56003

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- ❖ the ***name of the plan or plans*** under which you lost or are losing coverage,
- ❖ the ***name and address of the employee*** covered under the plan,
- ❖ the ***name(s) and address(es) of the qualified beneficiary(ies)***, and
- ❖ the ***qualifying event*** and the ***date*** it happened.

If the qualifying event is a ***divorce or legal separation***, your notice must include ***a copy of the divorce decree or the legal separation agreement***.

There are other notice requirements in other contexts. See, for example, the discussion below under the heading entitled, "***Duration of COBRA Coverage***." That explanation describes other situations where notice from you or the qualified beneficiary is required in order to gain the right to COBRA coverage.

Once the Plan Administrator or its designee receives *timely 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 for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will

begin on the date of the qualifying event. ***If you or your spouse or eligible children do not elect continuation coverage within the 60-day election period described above, you will lose your right to elect continuation coverage.***

## **Duration of COBRA Coverage**

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in any part of Medicare, your divorce or legal separation, or an eligible child losing eligibility as an eligible child, COBRA continuation coverage lasts for up to **36 months**.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to **18 months**.

There are *three ways* in which the period of COBRA continuation coverage can be extended...

### ***1. Disability extension of 18-month period of continuation coverage.***

If you or anyone in your family covered under the plan is determined by the Social Security Administration to be disabled as of the date of the qualifying event or at any time during the first 60 days of COBRA continuation coverage ***and you notify the Plan Administrator or its designee in writing and in a timely fashion***, you and your entire family can receive up to ***an additional 11 months*** of COBRA continuation coverage, for a total maximum of **29 months**.

***You must make sure that the Plan Administrator or its designee is notified in writing of the Social Security Administration's determination within 60 days after (i) of the date of the determination or (ii) the date of the qualifying event or (iii) the date coverage is lost due to the qualifying event, whichever occurs last. But in any event the notice must be provided before the end of the 18-month period of COBRA continuation coverage.*** The plan requires you to follow the procedures specified in the box above, under the heading entitled "Notice Procedures." In addition, your notice must include

- ❖ the name of the disabled qualified beneficiary,
- ❖ the date that the qualified beneficiary became disabled, and
- ❖ the date that the Social Security Administration made its determination.

Your notice must also include a copy of the Social Security Administration's determination. ***If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee within the required period, then there will be no disability extension of COBRA continuation coverage.***

### ***2. Second qualifying event extension of 18-month period of continuation coverage.***

If your family experiences ***another qualifying event*** while receiving COBRA continuation coverage, the spouse and eligible children in your family can get additional months of COBRA

continuation coverage, up to a maximum of **36 months (including the initial period of COBRA coverage)**.

This extension is available to **the spouse** and **eligible children** if, while they and the covered former employee are purchasing COBRA coverage, the former employee:

- ❖ dies,
- ❖ enrolls in any part of Medicare
- ❖ gets divorced or legally separated.

The extension is also available to an **eligible child** when that child stops being eligible under the plan as an eligible child.

***In all of these cases, you must make sure that the Plan Administrator or its designee is notified in writing of the second qualifying event within 60 days after (i) the date of the second qualifying event or (ii) the date coverage is lost, whichever occurs last.*** The plan requires you to follow the procedures specified in the box above, under the heading entitled “*Notice Procedures.*” Your notice must also ***name the second qualifying event and the date it happened.*** If the second qualifying event is a divorce or legal separation, your notice must include ***a copy of the divorce decree or legal separation agreement.***

***If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee within the required 60-day period, then there will be no extension of COBRA continuation coverage due to the second qualifying event.***

### ***3. Medicare Extension for Spouse and Eligible Children.***

If a qualifying event that is a termination of employment or reduction of hours occurs within 18 months after the covered employee becomes entitled to any part of Medicare, then the maximum coverage period for the spouse and eligible children is **36 months** from the date the employee became entitled to Medicare (but the covered employee’s maximum coverage period will be 18 months). **Shorter Maximum Coverage Period for Health Flexible Spending Accounts**

The maximum COBRA coverage period for a health flexible spending arrangement (health “FSA”) maintained by the employer ends on the last day of the cafeteria or flexible benefits plan “plan year” in which the qualifying event occurred. In addition, if at the time of the qualifying event the employee has withdrawn (during the plan year) more from the FSA than the employee has had credited to the FSA, no COBRA right is available at all.

### **Enrolling in Medicare instead of COBRA after group health plan coverage ends**

In general, if you do not enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- ❖ The month after your employment ends; or
- ❖ The month after group health plan coverage based on current employment ends

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA notice.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit <https://www.medicare.gov/medicare-and-you>

## OTHER RULES AND REQUIREMENTS

***Same Rights as Active Employees to Add New Dependents.*** A qualified beneficiary generally has the same rights as similarly situated active employees to add or drop dependents, make enrollment changes during open enrollment, etc. Contact the Plan Administrator for more information. See also the paragraph below titled, "*Children Born or Placed for Adoption with the Covered Employee During COBRA Period,*" for information about how certain children acquired by a covered employee purchasing COBRA coverage may actually be treated as qualified beneficiaries themselves. ***Be sure to promptly notify the Plan Administrator or its designee if you need to make a change to your COBRA coverage. The Plan Administrator or its designee must be notified in writing within 30 days of the date you wish to make such a change (adding or dropping dependents, for example).*** See the rules in the box above, under the heading entitled, "*Notice Procedures,*" for an explanation regarding how your notice should be made.

***Children Born to or Placed for Adoption with the Covered Employee During COBRA Period.*** A child born to, adopted by, or placed for adoption with a covered employee or former employee during a period of continuation coverage is considered to be a qualified beneficiary provided that, if the covered employee or former employee is a qualified beneficiary, the employee has elected COBRA continuation coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the plan, the child must satisfy the otherwise applicable plan eligibility requirements (for example, age requirements). ***Be sure to promptly notify the Plan Administrator or its designee if you need to make a change to your COBRA coverage. The Plan Administrator or its designee must be notified in writing within 30 days of the date you wish to make such a change.*** See the rules in the box above, under the heading entitled, "*Notice Procedures,*" for an explanation regarding how your notice should be made.

***Alternate Recipients Under Qualified Medical Child Support Orders.*** A child of the covered employee or former employee who is receiving benefits under the plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by the Plan Administrator during the employee's period of employment with the employer is entitled the same rights under COBRA



as an eligible child of the covered employee, regardless of whether that child would otherwise be considered a dependent. ***Be sure to promptly notify the Plan Administrator or its designee if you need to make a change to your COBRA coverage. The Plan Administrator or its designee must be notified in writing within 30 days of the date you wish to make such a change.*** See the rules in the box above, under the heading entitled, “*Notice Procedures,*” for an explanation regarding how your notice should be made.

### **Are there other coverage options besides COBRA Continuation Coverage?**

Yes, other coverage options not sponsored by your employer may be available. 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](http://www.healthcare.gov).

### **If You Have Questions**

Questions concerning your plan or your COBRA continuation rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability or Accountability Act (HIPAA), 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). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).”

### **Keep Your Plan Informed of Address Changes**

***In order to protect your family's rights, you should keep the Plan Administrator or its designee informed of 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 or its designee.

### **Plan Contact Information**

Sharon Koenig  
Total Rewards Director  
507-625-2828  
skoenig@taylorcorp.com  
1725 Roe Crest Drive  
North Mankato, MN 56003

## **WOMEN’S HEALTH AND CANCER RIGHTS NOTICE**

Taylor Corporation Employee Health Care Plan is required by law to provide you with the following notice:

The Women’s Health and Cancer Rights Act of 1998 (“WHCRA”) provides certain protections 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 lymphedemas.

The Taylor Corporation Employee Health Care Plan provide(s) medical coverage for mastectomies and the related procedures listed above, subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, please refer to your or contact your Plan Administrator at:

Manager of Benefits  
507-625-2828