

Benefits Enrollment Guide

Mitchell Titus LLP

2021



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Great care has been taken to ensure that this guide is accurate. However, oversights can occur or condensed summaries can be misinterpreted. If there is a difference between this overview and the SPD or official plan documents governing the plan, the plan documents will be followed. The company reserves the right to amend or terminate the program in whole or in part at any time.

Welcome

Mitchell Titus is proud to offer a comprehensive program of benefits designed to serve the diverse needs of our unique workforce, and we are committed to continually enhancing and expanding our offerings. The information in this document is meant to familiarize you with the benefits and programs currently in place.

Full-time partners & employees are eligible for the Mitchell Titus benefits program. You are considered full-time if you are scheduled to work 24 or more hours per week.

- Full-time partners & employees are eligible for coverage on the first of the month coinciding with or following date-of-hire

Deductions for Flexible Spending Accounts, Health Savings Account, Medical, Dental and Vision insurance are generally pretax; all other deductions are after-tax.

Dependents eligible for coverage under the medical, dental and vision plans are your spouse (or domestic partner* as described below) and your children. Children can be covered for medical up to age 29 regardless of student, dependent or marital status for medical. For dental and vision, dependent children can be covered up to age 26 regardless of student status. For the Supplemental Life and Supplemental Accidental Death and Dismemberment insurance plan, you can add coverage for your unmarried dependent children under age 19 (or under age 25 only for an unmarried full-time student).

Overview

The information in this guide can help you by providing an overview of the benefits. This booklet also contains information on how to enroll in each benefit plan. Your medical, dental and vision plan payroll deductions are through a pre-tax plan. The plan provides tax savings by reducing employee medical premiums from gross salary prior to calculation of federal income and Social Security taxes. Your medical, dental and vision premiums will automatically be taken as pre-tax deductions. To enroll, you will need to make your benefit elections in Ascentis employee self-service portal in a timely manner.

Below are the Core Benefits & Voluntary Benefits that are available to you:

Core Benefits	Voluntary Benefits
Medical	Legal Plan
Dental	Flexible Spending Account
Vision	Transit & Parking
Group Life/AD&D	Supplemental Life/AD&D
Group Short-Term Disability	Pet Insurance
Group Long-Term Disability	Unum Accident, Critical Illness, and Hospital Plans

Enrollment Checklist

Use this checklist to help you through the enrollment process. Mitchell Titus annual enrollment period usually occurs during the month of December of each year. Changes are effective on January 1st.

Before Enrollment:

Before enrollment begins, take the time to educate yourself on all of the benefit options that are available to you. Benefit plan summaries and resources can be accessed online at Ascentis ESS portal.

- ☐ Review this Benefits Guide carefully as you consider your plan choices.
- ☐ Read the benefit certificate, which provides a more detailed overview of the coverage.
- ☐ Attend Annual Benefits Enrollment Meeting to hear benefits consultant explain the details of each plan and give you an overview of all benefit programs.
- ☐ Decide if you want to enroll in a Flexible Spending Account (Healthcare and / or Dependent Day Care). Remember: You must actively enroll each year.
- ☐ HSA Plan members, decide if you want to make a contribution to your Health Savings Account.

During Enrollment:

For New Hires

- ☐ Actively enroll within 31 days of your eligibility period
- ☐ Once you have completed your enrollment online, save or print a copy of your confirmation, review it for accuracy and retain it for your record.

For Existing Employees (During the annual enrollment period)

- ☐ If you are currently enrolled and would like to make a change to your benefit elections, you will need to make your new elections online.
- ☐ If you are currently enrolled and do not want to make any changes to your benefit elections, you will still need to confirm your elections online.
- ☐ If you are an existing employee and wish to enroll for the first time, you will need to complete your elections online.
- ☐ HR team will send out new communications if there are changes to the enrollment process and will provide new information on how to enroll.

After Enrollment:

- ☐ Verify your benefits elections by visiting by log on to the insurance company's member services portal. If you notice any errors, notify the HR team. Most elections cannot be changed except within 31 days of a family status change.

Important Reminders for New Hires

Before Enrollment:

Before enrollment begins, take the time to educate yourself on all of the benefit options that are available to you. Review this Benefits Guide carefully as you consider your plan choices.

If you are electing to cover your dependents on your medical, dental or vision benefits, proof of dependent eligibility may be required. These documents must accompany your paperwork, or your dependents will not be added. Acceptable documentation can be found on page 26 of this guide.

During Enrollment:

Be sure to make your elections within 31 days after your eligibility date. If you do not make elections, then you may not be able to get coverage until the next open enrollment period.

Enrollment in the critical illness, hospital and/or accident plan occur once a year. You would only be able to elect coverage during the company annual open enrollment period.

You can elect additional life/AD&D coverages without providing proof of good health during your first 31 days of eligibility up to the guarantee issue amount.

After Enrollment:

Medical coverage: If you elect coverage, you will receive an ID card in the mail that you should use for all medical and prescription services.

Your ID card contains important information about you, your employer group and the benefits to which you are entitled. Always remember to carry your ID card with you, present it when receiving health care services or supplies, and make sure your provider always has an updated copy of your ID card.

Dental coverage: If you elect coverage, you will receive an ID card and it will only say the subscribers' name. For dental services, coverage will be tied to the employee's social security number. Be sure that you and any dependents give this to the provider at the time of service.

Vision coverage: If you elect coverage, you will not receive an ID card. For vision services, coverage will be tied to employee's social security number. Be sure to give this to your provider at time of service.

General:

The plan year is a calendar year - January 1 through December 31.

Our plans are pre-tax, which means you save money, and you can only make future changes to your elections during Open Enrollment or if you have a qualifying life event. Choose your new-hire elections carefully.

As long as you enroll within 31 days of your eligibility date, new hires are not required to provide proof of good health to enroll in Voluntary Life insurance up to the guarantee issue amount.

Eligibility and Enrollment

All full-time partners & employees working an average of at least 24 hours per week are eligible to enroll themselves and their eligible dependents for the first of the month coinciding with or following date of hire effective date. For example, employees hired on October 3, 2020 will be eligible November 1, 2020.

In order to continue eligibility throughout the year, you must maintain at least 24 eligible hours per week.

Eligible Dependents may include:

- Your legal spouse, domestic partner
- Your child who is less than age 26 (Up to age 29 for medical)
- Court ordered eligible dependents with legal guardianship

If you are electing to cover your dependents on your medical, dental or vision benefits, proof of dependent eligibility may be required. These documents must accompany your paperwork, or your dependents will not be added. Acceptable documentation can be found on page 26 of this guide.

Changing Benefit Elections

You have a variety of benefits that are offered to you. Be sure to consider your choices before you make your benefit decisions. The reason is that once you make your elections, most will remain in effect until the next open enrollment period, unless you have incurred a life event. Examples of life events include:

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

Medical Insurance

The medical plans cover a wide range of services, from preventive and routine care, to hospitalization and surgery. The medical plans include a prescription drug benefit, which covers prescriptions at participating pharmacies and mail-order maintenance drugs.



United Healthcare PPO Plan (Choice Plus Direct)

If you enroll in the Mitchell Titus PPO Plan, you may use any provider for your care. However, when you see a provider in the PPO network, your out-of-pocket costs are limited to a \$20 copay for primary care office visits / \$40 for specialists. Out of network care is also covered, but you will pay more for your care. Most out of network costs are subject to an annual deductible and then are reimbursed at 40% of the reasonable and customary charge.

	In-Network	Out-of-Network
Can I go to any doctor and receive plan benefits?	Yes	Yes
Do I pay less if I see certain doctors?	Yes. You will pay less out-of-pocket when you use preferred network doctors.	
Do I need a referral to see a specialist?	No. You can always go directly to a specialist. However, you will receive out-of-network benefits if the specialist is not in the preferred network.	
Can I use mail-order for prescription drugs I use regularly?	Yes. For Certain Drugs*	In-Network Benefit Only
Do reasonable and customary limits apply? Will I receive balance due bills?	Only if you see a doctor outside the network. If the charge is above reasonable and customary, you will receive a balance due bill. Preferred doctors charge a negotiated fee, which is always lower than reasonable and customary.	

* Must meet criteria for therapeutic classes.

Medical Insurance

This is not a complete list of covered services. For more details please refer to the summary of benefits coverage (SBC) or certificate of coverage (COC).



You will be opened a Health Savings Account through Optum Bank. Mitchell Titus will contribute to your H.S.A.

	United Healthcare HDHP (Choice Plus Network)	
	In-Network	Out-of-Network
Annual Deductible* Individual / Family	\$2,000 / \$4,000	\$5,000 / \$10,000
Annual Out-of-pocket Maximum* Individual / Family	\$6,750 / \$13,500 (includes deductible)	\$15,000 / \$30,000 (includes deductible)
Coinsurance	10% after deductible	40% after deductible
Maximum Policy Benefit	No Maximum Benefit	
Office Visit PCP / Specialist	10% after deductible	40% after deductible
Preventive Care / Well-women Care Routine Physical Exams / Immunizations (Adult and Child)	No charge	40% after deductible
Lab, X-Ray or Other Preventive Tests	100% covered, deductible doesn't apply	40% after deductible
Lab, X-Ray and Major Diagnostics CT, PET, MRI, and Nuclear Medicine Outpatient	Freestanding/Office: 10% coinsurance after deductible Hospital based: 30% coinsurance after deductible	Not Covered
Emergency Health Services– Outpatient	10% after deductible	40% after deductible
Hospital – Inpatient Stay Pre-Service Notification	10% after deductible	40% after deductible
Ambulance Pre-Service Notification for Non-emergency	10% after deductible	40% after deductible
Urgent Care Facility	10% after deductible	40% after deductible
Mental Health Inpatient	10% after deductible	40% after deductible
Mental Health Outpatient	10% after deductible	40% after deductible
Prescription Drugs Retail (31-day supply)	Annual medical deductible applies	
Generic	\$10 copay	\$10 copay
Preferred-Brand	\$30 copay	\$30 copay
Brand	\$50 copay	\$50 copay
Mail-Order (90-day supply)		
Generic	\$25 copay	In Network Benefit Only
Preferred-Brand	\$75 copay	
Brand	\$125 copay	

* Annual Deductible and Out-of-pocket Maximums reset every January 1st.

Medical Insurance

This is not a complete list of covered services. For more details please refer to the summary of benefits coverage (SBC) or certificate of coverage (COC).



	United Healthcare EPO (Choice Network)	
	In-Network	Out-of-Network
Annual Deductible* Individual / Family	\$0 / \$0	-
Annual Out-of-pocket Maximum* Individual / Family	\$7,900 / \$15,800 (includes deductible)	-
Coinsurance	20% after deductible	-
Maximum Policy Benefit	No Maximum Benefit	
Office Visit PCP / Specialist	\$20 / \$40	-
Preventive Care / Well-women Care Routine Physical Exams / Immunizations (Adult and Child)	No charge	-
Lab, X-Ray or Other Preventive Tests	No charge	-
Lab, X-Ray and Major Diagnostics CT, PET, MRI, and Nuclear Medicine Outpatient	Freestanding/Office: No Charge	-
	Hospital based: 20% coinsurance	
Emergency Health Services – Outpatient	\$300 copay	-
Hospital – Inpatient Stay Pre-Service Notification	No Charge	-
Ambulance Pre-Service Notification for Non-emergency	No Charge	-
Urgent Care Facility	\$75 copay	-
Mental Health Inpatient	No Charge	-
Mental Health Outpatient	\$40 copay	-
Prescription Drugs Retail (31-day supply)		
Generic	\$10 copay	-
Preferred-Brand	\$30 copay	-
Brand	\$50 copay	-
Mail-Order (90-day supply)		
Generic	\$25 copay	In Network Benefit Only
Preferred-Brand	\$75 copay	
Brand	\$125 copay	

* Annual Deductible and Out-of-pocket Maximums reset every January 1st.

Medical Insurance

This is not a complete list of covered services. For more details please refer to the summary of benefits coverage (SBC) or certificate of coverage (COC).



United Healthcare POS (Choice Plus Network)		
	In-Network	Out-of-Network
Annual Deductible* Individual / Family	\$0 / \$0	\$2,000 / \$4,000
Annual Out-of-pocket Maximum* Individual / Family	\$7,900 / \$15,800 (includes deductible)	\$15,000 / \$30,000 (includes deductible)
Coinsurance	20% after deductible	30% after deductible
Maximum Policy Benefit	No Maximum Benefit	
Office Visit PCP / Specialist	\$20 / \$40	30% after deductible
Preventive Care / Well-women Care Routine Physical Exams / Immunizations (Adult and Child)	No charge	30% after deductible
Lab, X-Ray or Other Preventive Tests	No charge	30% after deductible
Lab, X-Ray and Major Diagnostics CT, PET, MRI, and Nuclear Medicine Outpatient	Freestanding/Office: No Charge Hospital: 20% coinsurance	30% after deductible
Emergency Health Services – Outpatient	\$300 copay	\$250 copay
Hospital – Inpatient Stay Pre-Service Notification	No charge	30% after deductible
Ambulance Pre-Service Notification for Non-emergency	No charge	30% after deductible
Urgent Care Facility	\$75 copay	30% after deductible
Mental Health Inpatient	No charge	30% after deductible
Mental Health Outpatient	\$40 copay	30% after deductible
Prescription Drugs Retail (31-day supply)		
Generic	\$10 copay	\$10 copay
Preferred-Brand	\$30 copay	\$30 copay
Brand	\$50 copay	\$50 copay
Mail-Order (90-day supply)		
Generic	\$25 copay	In Network Benefit Only
Preferred-Brand	\$75 copay	
Brand	\$125 copay	

* Annual Deductible and Out-of-pocket Maximums reset every January 1st.

A Health Savings Account (HSA)

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



Eligibility Requirements:

- Must be enrolled in a High Deductible Health Plan
- Must not be enrolled in Medicare, TRICARE
- Must not be covered by other medical insurance(s) such as a general purpose health FSA, HRA and other ‘first dollar’ coverage
- Must not have received VA medical benefits at any time in the past three months
- Spouse not contributing to / participating in a general-purpose FSA through his / her employer

Maximum tax-deductible contribution to an HSA for 2021:

- \$3,600 for an individual medical insurance plan
- \$7,200 for employee plus one and family medical insurance plan
- Catch up provision for anyone over the age of 55 is \$1,000

Debit Card

An HSA debit card will be provided to all new participants. Your HSA card can be used to pay for qualified medical expenses billed from an insurance company, a physician’s office and a pharmacy.

Employer Contributions to HSA

As a Mitchell Titus employee, should you elect the High Deductible Health Plan (HDHP) paired with a Health Savings Account (HSA), the company will provide you with the below annual contributions to your HSA based on your tier.

- Employee Only: \$1,000
- Employee/Spouse: \$2,000
- Employee/Child(ren): \$2,000
- Family: \$2,000

Refer to the H.S.A quick guide for addition information on the Health Savings Account.

2021 IRS Limits	Employer Contribution	Maximum Employee Contribution
Employee Only: \$3,600	Employee Only: \$1,000	Employee Only: \$2,600
Family: \$7,200	Family: \$2,000	Family: \$5,200

Flexible Spending Accounts

We offer health care and dependent care flexible spending accounts (FSAs), administered by WageWorks, which allow you to pay for eligible health and dependent care expenses with pretax dollars.



Please note that if you have currently elected an FSA, you must re-elect coverage for the new plan year to continue participating, even if you do not change your election amount.

If you have signed up for a Health Savings Account (H.S.A), you cannot elect Health Care FSA

Health Care FSAs

You may elect to defer from \$500 to \$2,750 of your salary into a health care FSA. The \$2,750 limit applies individually. Any unused funds up to \$500 will get to rollover to the next year. Employees are able to incur expenses until 12/31/2021 and submit claims until 03/31/2022.

Dependent Care FSAs

You may elect to defer from \$5,000 of your salary into a dependent care FSA per household. If you are a highly compensated employee (HCE), defined by the IRS as an employee with annual compensation greater than \$130,000, your election will be capped at \$2,500 and may be reduced during the year, if necessary, to ensure that the plan passes required discrimination testing.

Please note that for expenses to qualify for reimbursement, both you and your spouse (if applicable) must be working, looking for work or attending school fulltime during the period for which you are requesting reimbursement.

Dental Insurance

Our dental plans encourage early detection of dental problems by paying the most toward diagnostic and preventive services, such as routine check-ups and cleanings.



Mitchell Titus PPO INO (In-Network Only) Plan

If you elect the PPO Plan, you can go to any dentist you want. This plan includes child orthodontia coverage with a lifetime maximum of \$2,000 per member. Preventive and orthodontic care are exempt from the deductible.

Plan Details	PPO Plan	
	When you use a PPO dentist, you pay	When you do not use a network dentist, you pay
Annual Deductible (Single / Family)		\$0 / \$0
Calendar Year Maximum		\$2,000
Class I Preventive & Diagnostic	No Charge	Not Covered
Class II Basic Restorative Care	10%	Not Covered
Class III Major Restorative Care	40%	Not Covered
Class IV Orthodontia	50%	Not Covered
Orthodontia Lifetime Maximum (Adult & Child)	\$2,000	Not Covered

Dental Insurance

Our dental plans encourage early detection of dental problems by paying the most toward diagnostic and preventive services, such as routine check-ups and cleanings.



Mitchell Titus PPO Plan (With Out of Network Coverage)

If you elect the PPO Plan, you can go to any dentist you want. Most expenses are subject to an annual deductible and a \$1,500 per member annual maximum applies. This plan includes child orthodontia coverage with a lifetime maximum of \$1,500 per member. Preventive and orthodontic care are exempt from the deductible.

Plan Details	PPO Plan	
	When you use a PPO dentist, you pay	When you do not use a network dentist, you pay
Annual Deductible (Single / Family)		\$50 / \$150
Calendar Year Maximum		\$1,500
Reimbursement Levels	Negotiated Rate	UCR 90th
Class I Preventive & Diagnostic		No charge
Class II Basic Restorative Care	20%	20%
Class III Major Restorative Care	50%	50%
Class IV Orthodontia	50%	50%
Orthodontia Lifetime Maximum (Child Only Up to Age 19)		\$1,000

Vision Insurance

Participation in UHC vision plan is also available to all full-time partners and employees. The most liberal benefits are paid when you use a doctor in the UHC network. The plan helps you pay for a wide range of vision-related services and products as shown below.



Benefit	Frequency (based on your last date of service)	Copay	UHC Doctor	Out-of-Network Provider
Exam	12 months	\$10	Covered after Copay	Reimbursed up to \$40
Lenses	12 months	\$25	Covered after Copay	Reimbursed up to \$40 / single vision Reimbursed up to \$60 / bifocal Reimbursed up to \$80 / trifocal & lenticular
Frames	24 months	None	Covered up to \$130	Reimbursed up to \$45
Contact Lenses	12 months	\$25 (Therapeutic), None (Elective)	Covered after Copay (Therapeutic), Covered up to \$105 (Elective)	Reimbursed up to \$210 (Therapeutic), Reimbursed up to \$105 (Elective)

Disability Plans

Mitchell Titus offers Short-Term Disability (STD) and Long-Term Disability (LTD) through Unum. These disability coverages work in conjunction with one another to provide continuous income replacement in the event of a sudden income loss.



Short-Term Disability Benefit Highlights

This policy will pay you a monthly benefit if you are unable to work due to a disabling accident or sickness. There is a waiting period from when you become ill and when your benefits will begin.

All employees (excluding partners), will have the short-term disability benefit paid for by Mitchell Titus.

STD Coverage Type	STD Benefits
Short-Term Disability (STD)	- Covers accidents and sicknesses for up to 13 weeks. - Weekly benefits are 70% of your weekly earnings. - Maximum benefits are \$1,500 per week. - Benefits begin on the 8th day for accidents and on the 8th day for sickness.

Long-Term Disability Benefit Highlights

All employees (excluding partners), will have the long-term disability benefit paid for by Mitchell Titus.

LTD Coverage Type	LTD Benefits
Long-Term Disability	- Income replacement begins after 90 days of sickness or disability - Offers a 60% (All employees) / 66.667% (Partners) income replacement of monthly earnings - Maximum of \$5,000 (All employees) / \$10,000 (Partners) per month of income replacement

Life/AD&D Insurance

Your family depends on your income for a comfortable lifestyle and for the resources necessary to make their dreams – such as a college education – a reality. Like anyone, you don't like to think of the scenario where you're no longer there for your family. However, you do need to ensure their lives and dreams can continue if the worst should occur.



Basic Life Insurance

Mitchell Titus life Insurance plan pays benefits if you die or are seriously injured.

All employees (excluding partners), will have the long-term disability benefit paid for by Mitchell Titus.

Basic Life	\$50,000
Basic Accidental Death and Dismemberment	Matches Basic Life coverage
Life Benefit Reduction	65% at age 65, 50% at age 70
Portability	If you retire, reduce your hours or leave your employer, you can take this coverage with you.

Voluntary Life and Voluntary Accidental Death & Dismemberment

You have the freedom to select adequate levels of life insurance coverage to protect the well-being of your family. Mitchell Titus offers Voluntary Life and Voluntary Accidental Death & Dismemberment through Renaissance Life & Health Insurance Co. of NY. These premiums are paid 100% by you.

Supplemental Life and AD&D Insurance Coverage	Coverage Amount
For Yourself	An amount between \$25,000 and \$400,000, in increments of \$25,000 not to exceed 5 times your salary. Guarantee issue amount Under Age 65 - \$50,000 Age 65-69 - \$25,000 Age 70 and over – Health questionnaire form is required
For Spouse	An amount between \$12,500 and \$200,000, in increments of \$12,500. Guarantee issue amount Under Age 65 – Health questionnaire form is required Age 65 & over – Health questionnaire is required
For Eligible Children	A child from 15 days to under 6 months, \$800; A child 6 months and above, \$4,000 Your eligible dependent children will be provided coverage on a guarantee issue basis as long as you apply on a timely basis

MetLaw Legal Plan

Services listed are covered and/or paid in full only when working with an in-network attorney. The services listed below are a sampling of the coverage provided. Additional information is available for review upon request.

MetLaw provides a call center assistance to refer participants to network attorney's in their area. To use your Legal Plan, visit www.legalplans.com or call MetLaw Hyatt Legal Plans' Client Service Center at 1-800-821-6400.

Network Attorneys	14,000+
Document Review	Paid in full for review of any personal legal document
Document Preparation	Affidavits, Deeds, Demand Letters, Mortgages, Promissory Notes
Purchase or Sale of Real Estate	Paid in full
Living Will	Paid in full
Power of Attorney	Paid in full
Driving Privilege Restoration Excluding DUI-related	Paid in full

PetsBest Pet Insurance

Pet insurance reimburses you for vet bills when your pet is sick or injured, to help take the financial worry out of vet visits. Simply use the discount code “MITCHELLTITUS” and you will get pet insurance at a discounted rate by being a Mitchell Titus employee. Cats and dogs are covered pets.

- Fast claims processing and payment
- Optional direct deposit and direct vet pay options
- Use any veterinarian in the United States – including specialty and emergency clinics
- Exclusive employee discount on a BestBenefit plan
- Optional coverage for routine care
- Access to 24/7 pet helpline powered by whiskerDocs

HOW PET INSURANCE WORKS



Get Treatment

When your pet becomes ill or injured, get treatment from any licensed veterinarian in the US or Canada.



File a Claim

Use your mobile app or file a claim online, there is no need to send us medical records unless we request them.



Get Paid Fast

Fast claims processing and payment, and we can reimburse you directly into your bank account.

Mitchell Titus LLP Employees

To begin, enroll at www.petsbest.com/mitchelltitus

or call **888-984-8700**

reference discount code: **MITCHELLTITUS**

Unum Critical Illness

How does it work?

If you're diagnosed with an illness that is covered by this insurance you can receive a benefit payment in one lump sum. You can use the money however you want.

Why is this coverage so valuable?

- The money can help you pay out-of-pocket medical expenses, like co-pays and deductibles.
- You can use this coverage more than once. Even after you receive a payout for one illness, you're still covered for the remaining conditions or categories. If you have a different condition later, you can receive another benefit.

What's covered?

- Category 1
 - Heart attack
 - Stroke
 - Coronary artery disease (pays at 25% of lump sum benefit)
- Category 2
 - Benign brain tumor
 - Major organ failure
 - End stage renal (kidney) failure
- Category 3
 - Cancer coverage
- Coverage is also included for:
 - Cancer
 - Carcinoma in situ – pays 25% of your coverage amount. (Carcinoma in situ is defined as cancer that involves only cells in the tissue in which it began and that has not spread to nearby tissues.)
 - Skin cancer – pays a \$250 benefit per covered person per lifetime. Not part of the 100% payout.

What else is included?

A Wellness Benefit. Every year, each family member who has a Specified Disease coverage can also receive \$50 for getting a health screening test, such as:

- Blood tests
- Chest x-rays
- Stress tests
- Colonoscopies
- Mammograms
- And other tests listed in your policy

What else is included?

A Wellness Benefit. Every year, each family member who has a Specified Disease coverage can also receive \$50.

Who can get coverage?

You: Choose \$5,000 or \$10,000 of coverage. If you do not sign up now but decide to apply later, you may have to answer medical questions.

Your spouse: Age 17 to 64 can get \$5,000 of coverage

Your children: Newborns to age 26

Unum Hospital Insurance

How does it work?

Hospital insurance helps covered employees and their families cope with the financial impacts of a hospitalization. You can receive benefits when you're admitted to the hospital for a covered accident, illness, or childbirth. The money is paid directly to you – not to a hospital or care provider. The money can also help you pay the out-of-pocket expenses your medical plan may not cover, such as co-insurance, co-pays and deductibles.

Why is this coverage so valuable?

- The benefits in this plan are compatible with a Health Savings Account (HSA).
- You may take the coverage with you if you leave the company or retire, without having to answer new health questions. You will be billed directly.

What's included?

- \$1,500 for each covered hospital admission – once per year
- \$165 for each day of your covered hospital stay, up to 60 days – once per year

Who can get coverage?

You: If you're actively at work

Your spouse: Age 17 to 64

Your children: Dependent children until their 26th birthday regardless of marital or student status

Unum Accident Insurance

How does it work?

Accident Insurance can pay a set benefit amount based on the type of injury you have and the type of treatment you need. It covers accidents that occur on or off the job. And it included a range of incidents, from common injuries to more serious events.

Why is this coverage so valuable?

- It can help you with out-of-pocket costs that your medical plan doesn't cover, like co-pays and deductibles
- You're guaranteed base coverage, without answering health questions
- The cost is conveniently deducted from your paycheck.
- You can keep your coverage if you change jobs or retire. You will be billed directly

Who can get coverage?

You: If you're actively at work

Your spouse: Age 17 to 64

Your children: Dependent children until their 26th birthday regardless of marital or student status

401(k) Savings Plan

There are many features of your employer-sponsored retirement savings plans with which you should become familiar. Below is a summary of some features your Mitchell Titus Fidelity Investments 401 (k) Plan may contain. To learn more about the details of your Plan go to the Associate Portal to find the consecutive Summary Plan Description (SPD), and if appropriate, a Summary of Material Modifications (SMM) to your Plan.

401 (k) Questions		
When am I eligible?	You are eligible to begin contributing to the 401(k) plan following your third month of employment with Mitchell Titus. You will be sent an enrollment packet by Fidelity Investments roughly 30 days before your date of eligibility.	
How much can I contribute before taxes?	The maximum that you are allowed to contribute before taxes (as set by the IRS in 2016) is \$18,000.	
How much can I contribute after taxes?	You will be eligible to designate some or all of your contributions as a Roth Deferral contribution at the time you make your deferral election. If you elect to make Roth Deferral contributions, the amount of your contribution will be included in your income for tax purposes, and the income tax withholding amounts will be deducted from the remainder of your pay, not from the Roth Deferral contribution amount.	
Will Mitchell Titus match any contributions I have made to this plan?	Mitchell Titus will match you dollar for dollar up to 4% at the first of the month following six (6) months of employment. Matching contributions will be made during the period of time in which you are making deferral contributions.	
Is there a vesting option based on your tenure with Mitchell Titus?	Years of Service	Vesting %
	Less than 1 Year	0%
	1 Year	25%
	2 Years	50%
	3 Years	75%
	4 Years	100%
How do I modify my investments?	You may move money among the Plan's investment options or redirect your future contributions online at www.netbenefits.com or by calling toll-free 1-800-294-4015 on any day the New York Stock Exchange is open for business.	

Cost of Coverage

United Healthcare HSA Plan and United Healthcare Pharmacy Plan

Semi-Monthly Deduction	
Employee Only:	\$94.40
Employee + Spouse:	\$370.60
Employee + Child(ren):	\$335.31
Employee + Family:	\$492.50

United Healthcare EPO Plan and United Healthcare Pharmacy Plan

Semi-Monthly Deduction	
Employee Only:	\$106.94
Employee + Spouse:	\$437.90
Employee + Child(ren):	\$396.20
Employee + Family:	\$625.57

United Healthcare PPO Plan and United Healthcare Pharmacy Plan

Semi-Monthly Deduction	
Employee Only:	\$142.02
Employee + Spouse:	\$560.69
Employee + Child(ren):	\$507.29
Employee + Family:	\$818.03

United Healthcare Dental Plan (In-Network Only)

Semi-Monthly Deduction	
Employee Only:	\$5.00
Employee + 1 Dependent:	\$15.00
Employee + Family:	\$28.00

United Healthcare Dental Plan (PPO Plan)

Semi-Monthly Deduction	
Employee Only:	\$8.00
Employee + 1 Dependent:	\$27.00
Employee + Family:	\$46.00

United Healthcare Vision Plan

Semi-Monthly Deduction	
Employee Only:	\$1.00
Employee + Spouse:	\$3.00
Employee + Child(ren):	\$3.00
Employee + Family:	\$5.00

Renaissance Voluntary Life and Accidental Death and Dismemberment Insurance

Employee & Family:	Please refer to the cost calculation worksheet
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MetLaw Legal Plan

	Semi-Monthly Deduction
Employee / Family:	\$7.87

Unum Accident Insurance

	Monthly Deduction
Employee Only:	\$11.38
Employee + Spouse:	\$18.34
Employee + Child(ren):	\$21.22
Employee + Family:	\$28.18

Unum Critical Illness Insurance

Age	Monthly premium for \$10,000 of coverage (Non-tobacco/Tobacco)
0-24	\$7.10/\$10.00
25-29	\$7.90/\$12.00
30-34	\$9.80/\$16.40
35-39	\$12.80/\$23.10
40-44	\$17.60/\$33.00
45-49	\$24.00/\$46.10
50-54	\$31.90/\$62.10
55-59	\$43.00/\$81.80
60-64	\$58.20/\$104.70
65-69	\$75.40/\$126.60
70+	\$94.20/\$143.10

Unum Hospital Indemnity Insurance

Age	Monthly Rates (EE/ES/EC/FAM)
17-49	\$14.24/\$28.52/\$20.92/\$35.20
50-59	\$18.55/\$38.13/\$25.23/\$44.81
60-64	\$25.96/\$53.60/\$32.64/\$60.28
65+	\$39.15/\$81.12/\$45.83/\$87.80

You must wait until the annual enrollment period to elect Unum Accident, Critical Illness and Accident coverage.

Verification of Eligibility

In order to cover your dependents under the medical, dental or vision plan, you may be asked to provide:

Legal spouse	Copy of marriage certificate.
Domestic Partner	Domestic Partnership Certificate or affidavit
Biological child to age 26	Copy of birth certificate or copy of prior year federal tax return showing dependent claimed on taxes.
Step-child to age 26	Copy of birth certificate and copy marriage certificate showing your spouse as the biological parent.
Adopted child to age 26	Copy of papers showing placement of child in your home; or a copy of final adoption papers.
An associate's unmarried child (as described above) age 26 or older, primarily supported by the associate, and is incapable of self-sustaining employment because of mental or physical handicap	Copy of birth certificate or copy of prior year federal tax return showing dependent claimed on taxes and proof of incapacity must be received within 120 days after the date on which the maximum age is attained. Subsequent evidence of disability or dependency may be required as often as reasonably necessary to verify continued eligibility for benefits.

Additional Information

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

Q. What is the Affordable Care Act?

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

The ACA includes, among other things, premium and cost-sharing subsidies for those that qualify, health insurance exchanges, and mandates, including an individual mandate that, with certain exceptions, requires all individuals beginning January 1, 2014, and through the end of 2018, to have health insurance or pay a tax penalty. Under the tax reform law of 2017, the individual mandate penalty tax was repealed beginning in 2019, meaning individuals can forego coverage in 2019 and beyond without having to pay a penalty tax. Beyond that, the ACA includes subsidies to help individuals with low incomes obtain health coverage and comply with the individual mandate. Coverage through the health insurance exchange and any other plan (including an employer-sponsored group health plan), is guaranteed; even if you have a pre-existing medical condition, your cost for coverage will generally be the same as all other applicants of the same age living in the same geographic location.

Q. Who is required to have health insurance?

A. From 2014 through 2018, all Americans – with some exceptions – are required to have medical insurance coverage (called ‘minimum essential coverage’, or ‘MEC’) or incur a tax penalty. MEC includes a governmental plan (such as Medicare, Medicaid, Children’s Health Insurance Program (CHIP), TRICARE and Veterans’ health care programs), an employer-based or sponsored health plan (except for limited benefit and limited indemnity insurance, such as the Transamerica Limited Benefit Hospital Indemnity Insurance) and individual plans (both in the private market and through the exchanges). Beginning in 2019, the individual mandate penalty is repealed, meaning American citizens will not have to pay a penalty tax if they forego health insurance coverage.

Q. Will the Company continue to offer medical coverage in 2021?

A. Yes, we will continue to offer medical coverage to eligible employees and their eligible family members in 2021.

Q. What is the health insurance exchange?

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

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

Required Notices

Newborns' and Mothers' Health Protection Act

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

Women's Health and Cancer Rights Act Enrollment Notice

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

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

These benefits will be provided 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, call your Plan Administrator.

Women's Health and Cancer Rights Act Annual Notice

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

HIPAA Regulations Help to Protect Your Privacy

The privacy provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) help to ensure that your health care-related information stays private. New employees will receive a Privacy Practice Notice which outlines the ways in which the medical plan may use and disclose protected health information (PHI). The notice also describes your rights. For more information, contact the Human Resources Department.

Notice to Employees Regarding Employer Contributions to HSAs

This notice explains how you may be eligible to receive contributions from Mitchell Titus if you are covered by a High Deductible Health Plan (HDHP). Mitchell Titus provides contributions to the Health Savings Account (HSA) of each employee who is enrolled in a qualified High Deductible Health Plan (“eligible employee”). If you are an eligible employee, you will be opened a Health Savings Account through Optum Bank. Mitchell Titus will make contributions to your H.S.A based on your medical enrollment tier. Contributions will begin once your H.S.A has been fully established. You can also contribute to your H.S.A. Notify the HR team your annual contribution amount. If you have questions regarding your Health Savings Account, you can contact Cassie Francis Talent Acquisition & Engagement at 212-709-4687 or cfrancis@mitchelltitus.com.

Important Notice from Mitchell Titus About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Mitchell Titus and about your options under Medicare’s prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare’s prescription drug coverage:

Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

Mitchell Titus has determined that the prescription drug coverage offered by Mitchell Titus is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

Carrier: UnitedHealthcare

Pharmacy Cost Share: (All Plans) \$10/\$30/\$50 Retail (per 30-day supply)

When Can You Join A Medicare Drug Plan?

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

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

If you decide to join a Medicare drug plan, your current Mitchell Titus coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current Mitchell Titus coverage, be aware that you and your dependents may not be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with Mitchell Titus and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice or Your Current Prescription Drug Coverage...

Contact the person listed below for further information

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Mitchell Titus changes. You also may request a copy of this notice at any time.

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

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	1/1/2021
Name of Entity / Sender:	Mitchell & Titus LLP
Contact - Position / Office:	HR Team
Address:	80 Pine St, 32 nd Floor, New York, NY 10005
Phone Number:	212-709-4687

HIPAA Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

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

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

To request special enrollment or obtain more information, contact the HR team.

General Notice of COBRA Continuation Coverage Rights

**** Continuation Coverage Rights Under COBRA ****

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When Is COBRA Continuation Coverage Available?

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 30 days after the qualifying event occurs. You must provide this notice to: Cassie Francis.

How Is COBRA Continuation Coverage Provided?

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

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

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

Disability Extension of 18-Month Period of COBRA Continuation Coverage

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

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

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

Are There Other Coverage Options Besides COBRA Continuation Coverage?

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

If You Have Questions

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

Keep Your Plan Informed Of Address Changes

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

Plan Contact Information

Cassie Francis at 212-709-4687 or cfrancis@mitchelltitus.com

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

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

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

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

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

For Medicaid / CHIP contact information, refer to Medicaid / CHIP contact sheet located in Ascentis ESS portal

Definitions

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

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

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

Coinsurance: A percentage of the medical costs, based on the allowed amount, you must pay for certain services after you meet your annual deductible.

Conversion: An Associate changes or “converts” her / his Group Life coverage to an Individual Life Insurance policy without having to answer any medical questions. Conversion is for an Associate who is leaving her / his job, reducing hours, or has reached the age when coverage may be reduced or eliminated, and still wants to maintain the protection that life insurance provides.

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

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

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

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

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

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

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

Portability: An Associate carries or “ports” her / his current Group Life coverage after employment ends, without having to answer any medical questions. Portability is for an Associate who is leaving her / his job and still wants to maintain the protection that life insurance provides.

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

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

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

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

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

Reasonable and Customary Charge (R&C): R&C fee refers to the Reasonable and Customary (R&C) charge, which is based on the lowest of (1) the dentist’s actual charge, (2) the dentist’s usual charge for the same or similar services, or (3) the charge of most dentist’s in the same geographic area for the same or similar services as determined by Metlife.

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

Contact Information

Plan	Group Number	Website	Phone Numbers
Medical – United Healthcare	02Y5943 (EPO), 02Y5945 (HDHP), 02Y5946 (POS)	www.myuhc.com	1-800-980-7513
Dental – United Healthcare	0716201	www.myuhcdental.com	1-877-816-3596
Vision – United Healthcare	0716201	www.myuhcvision.com	1-800-638-3120
Group Life/AD&D - Unum	223131	www.unum.com	1-877-851-7637
Supplemental Life – Renaissance	G000045647-00001	www.renaissancefamily.com	1-888-358-9484
Group STD & LTD - Unum	223131	www.unum.com	1-877-851-7637
Legal Plan - MetLaw	Not Applicable	www.legalplans.com	1-800-821-6400
FSA – WageWorks	018649	www.wageworks.com	1-877-924-3967
Transit & Parking – WageWorks	018649	www.wageworks.com	1-877-924-3967
Pet Insurance – Pets Best	Not Applicable	www.petsbest.com/mitchelltitus	1-888-984-8700
Accident, Critical Illness, & Hospital Plans	115040	www.unum.com	1-877-851-7637
Optum Bank	Your H.S.A account number	www.optumbank.com	1-800-791-9361



80 Pine St, 32nd FL
New York, NY 10005

www.mitchelltitus.com
212.709.4530

