



2018 BENEFITS GUIDE

A Guide to Your Health and Welfare Benefits

Medical | Dental | Vision

BENEFITS FOR YOUR LIFE





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“It is important for our employees to understand the value of their benefits and to be better consumers of all benefits.”

Benefits Guide Overview

Fresenius Medical Care North America is committed to providing you with quality benefit programs that address your individual needs. We have prepared this enrollment guide to help you understand the terms and conditions under which your employee welfare benefits are offered. Please review each plan carefully to determine what coverage is right for you before electing coverage.

This guide is an overview of the benefits available to the employees of the Fresenius Travel Nurses Program, and is not to be confused with the corporate benefits program available to employees of Fresenius Medical Care North America.

This guide is only a summary and is not a substitute for the official plan documents. If there is a discrepancy between the official plan documents and this summary, the official plan documents will govern.

Medical



Fresenius Medical Care North America offers quality health care coverage through United Healthcare®.

forms, FAQs, and prescription UHC® drug lists can be found on the UHC® website, www.myuhc.com. The UHC® provider network is Choice Plus.

Plan Features and Benefits

The medical plan covers services within a network of contracted hospitals, doctors, specialists, clinics, and therapists. Benefits received from network providers are payable at a higher level than those benefits received from non-network providers.

Medical Contributions & Plan Summary

Please see the adjacent grid for your cost to participate and page 4 for a summary of the medical plan. Additional information, such as detailed plan descriptions, member

2018 Employee Contribution

United Healthcare® Medical	
Enrollment Type	Per Pay Period
Employee Only	\$144.01
Employee + Spouse	\$462.56
Employee + Child(ren)	\$272.48
Family	\$564.23



Medical Plan Summary

UHC® Choice Plus

Benefits	In-Network	Out-of-Network
Deductible¹		
Individual	\$2,500	\$5,000
Family	\$5,000	\$10,000
Out-of-Pocket	(includes medical and Rx copays and deductible)	
Individual	\$4,500	\$11,000
Family	\$9,000	\$22,000
Lifetime Maximum	Unlimited	
Office Visit		
Preventive Care	100% coverage	Deductible then 40%
PCP	\$30	Deductible then 40%
Specialist	\$30	Deductible then 40%
Diagnostics		
Lab	100% coverage	Deductible then 40%
X-Ray	100% coverage	Deductible then 40%
Scans	Deductible then 20%	Deductible then 40%
Hospital		
Inpatient	Deductible then 20%	Deductible then 40%
Outpatient	Deductible then 20%	Deductible then 40%
Prescription Drug		
Tier 1	\$10	Not covered
Tier 2	\$30	
Tier 3	\$60	
Mail Order (90-day supply)	2.5 x retail	
Emergency	\$500 copay	
Ambulance	Deductible then 20%	
Urgent Care	\$45 copay	Deductible then 40%
Chiropractic	\$30 copay	Deductible then 40%
	(20 visits per calendar year)	

¹Deductible runs on a policy-year basis accumulating from April 1–March 31.

Dental & Discount Vision



Dental

Fresenius Medical Care North America offers dental benefits through MetLife®. The dental plan has in and out-of-network coverage with the ability to choose any dentist; however, you will receive the best benefits available on the plan by choosing a contracted dentist who participates in the network.

The cost to participate is provided below as well as a summary of the dental benefits. For additional information, including FAQs, claim forms, and provider directories, visit MetLife® online at www.metlife.com.

MetLife® Dental Premier Plan Costs	
Enrollment Type	Per Pay Period
Employee Only	\$17.45
Employee + Spouse	\$34.15
Employee + Child(ren)	\$32.68
Family	\$55.21

Discount Vision

In addition to your Dental benefits, Fresenius Medical Care North America has also partnered with MetLife® to offer you Vision benefits at a discounted rate. The MetLife® VisionAccess program provides access to thousands of highly qualified, credentialed, private practice ophthalmologists and optometrists participating in the network. Enjoy 20% off eye exams, lenses and lens options, and non-prescription sunglasses, as well as 25% off frames and discounts on laser vision correction.

To obtain your discount, provide your program code, **MET2020**, when making an appointment or receiving services or materials from a participating MetLife VisionAccess program provider. To review benefits or find a participating provider, visit www.metlife.com/mybenefits. For all other information, please contact Human Resources.

MetLife® Dental Premier Plan Benefits		
Items	In-Network	Out-of-Network ¹
Annual Maximum	\$1,500 per person	
Calendar Year Deductible	Type B and C services only	
Individual	\$50	
Family Maximum	\$150	
Type A—Preventive: Oral Examinations, Full Mouth X-Rays, Bitewing X-Rays, Cleanings, Topical Fluoride Applications	100%	100%
Type B—Basic Restorative: Amalgam & Composite Fillings, Simple Extractions, Surgical Extractions, Other Oral Surgery, Bridges, Emergency Palliative Treatment, General Anesthesia, Consultations, Sealants, Space Maintainers, Endodontics, Periodontics	80%	80%
Type C—Major Restorative: Crowns, Inlays, Onlays, Prefabricated Stainless Steel & Resin Crowns, Denture Repairs, Rebases/Relines, Bridges, Implants	50%	50%
Type D—Orthodontia	Not covered	

¹ Out-of-Network reimbursement limited to 90th percentile usual & customary allowances.

Travel Employees E-benefits Enrollment

Log into FMC4me.fmca.com and select PeopleSoft HRMS. You do not have to be on a Fresenius computer to log in. Use your single sign on to log into PeopleSoft.

The screenshot shows the FMC4ME website interface. At the top, there is a navigation bar with the Fresenius Medical Care logo and the text 'FMC4ME'. Below this is a search bar and a navigation menu with categories like HOME, CORPORATE & HUMAN RESOURCES, OPERATIONS & FACILITIES, PATIENT & CLINICAL SUPPORT, PRODUCTS, PHARMA & SPECTRA, IT SYSTEMS LIBRARY, and TRAINING & EDUCATION. A sidebar on the right contains 'Quick Links' with several options: PeopleSoft HRMS, Training & Education, PeopleSoft LMS (Learning Center), Doctors Corner, Compliance, Reports, and Clinical Services. A blue arrow points to the 'PeopleSoft HRMS' link.

In PeopleSoft, under My Benefits, click on 2018 Open Enrollment–Make your Elections.

The screenshot shows the 'My Benefits' page in PeopleSoft. The page has a header 'My Benefits' and a navigation bar. The main content area is divided into two columns. The left column contains links for 'Life Event Benefit Elections', 'Newly Benefits Eligible Employees', and 'Acquisition Employees Enroll'. The right column contains a red heading 'TRAVELING NURSE OPEN ENROLLMENT 2018' with subtext 'Enrollment dates 3/1/18 - 3/31/2018.' and a link '2018 Open Enrollment-Make your Elections'. A blue arrow points to this link.

Please note:

Travel Employees do not need to submit dependent verification documents. You do not need to click on document upload. Also, you may receive a prompt asking if you are a smoker. Please follow the prompts, but the smoker surcharge fees do NOT apply to travelers. If you have any questions regarding your enrollment, please call the Employee Service Center for assistance. 855-362-6247.

Travel Employees E-benefits Enrollment, cont.

Benefits Enrollment

Open Enrollment 2018

- If you are not making changes for 2018, you do not need to enroll, your current elections will roll over, we suggest you verify the information on file is correct.
- Benefits email address – you will be asked to enter a benefit email address. This email will be used to send any benefit related emails. Enrollment information is private and confidential.
- You can enroll, make changes or cancel your coverage during open enrollment.
- Plans remain the same for 2018: United Health Care Medical with prescription coverage, Met Life Dental with Vision discount program. There is no separate vision plan.
- Domestic Partner coverage is not available.
- Enrollments will be effective 04/01/2018.
- Please ignore any reference to document upload.

Open Benefit Events			
Event Description		Event Date	Event Status
Open Enrollment		04/01/2018	Open



After you use the Select button, it will take a few seconds for your benefits enrollment information to load.

Follow the prompts and read the text carefully.

On the Open Enrollment screen, it will show your current elections, if you have any. Once you enroll, it will also show your new elections and the biweekly deductions that will be taken.

To enroll in or update your medical coverage, click the Enroll button beside the Medical coverage. Same for Dental.

Benefits Enrollment

Open Enrollment

Please review the following important information.

Review and compare your "current" elections versus your "new" elections in the list below. If "new" reflects "waive" and you want the benefit in the new year, enrollment is needed.

To make your elections, click "Enroll" next to the plan you wish to update.

 **Important: Your enrollment will not be complete until you submit your elections.**

Enrollment Summary			
	Before Tax	After Tax	Enroll
Medical			
Current: UHC Traveling Nurses Medical:You Only			
New: UHC Traveling Nurses Medical:Emp+Child	272.48		
Dental			
Current: Metlife:You Only			
New: Metlife:Emp+Child	32.68		

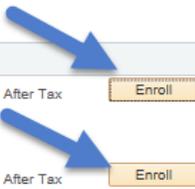
This table summarizes estimated costs for your new benefit elections. (The "Employer" column displays the amount the Company is contributing to subsidize the cost of your benefits.)

Election Summary				
Summarized estimates for new Benefit Elections	Total	Before Tax	After Tax	Employer
Costs	305.16	305.16	0.00	134.21
Your Costs	305.16	305.16	0.00	



Select the Update and Continue button to submit your final elections.

 **Important: Your enrollment will not be complete until you Submit your elections.**



Travel Employees E-benefits Enrollment, cont.

Benefits Enrollment

Medical

All of our medical plan choices offer employees a comprehensive health program for you and your family.

i Important! Your current coverage is: UHC Traveling Nurses Medical with You Only coverage. If you do not make a choice, your coverage will be: UHC Traveling Nurses Medical with Employee + Child(ren) coverage

Select an Option

Here Are Your Available Options With Your Costs.

Overview of all Plans

Select one of the following plans:

UHC Traveling Nurses Medical

Coverage Level	Your Costs	Tax Class
You Only	\$144.01	Before-Tax
Associate + Spouse	\$462.56	Before-Tax
Employee + Child(ren)	\$272.48	Before-Tax
You & 2 or More Dependents	\$564.23	Before-Tax

Waive

Enroll Your Dependents

The following list displays all individuals who are eligible to be your dependents. Use the Add/Review Dependents button to add new dependents to your list.

You may enroll any of the following individuals for coverage under this plan by checking the Enroll box next to the dependent's name.

Select the "Add/Review Dependents" button to review the entire list of dependent and beneficiary information we have on file. If one of your dependents is listed as a "Beneficiary Only" and you would like to enroll the dependent, please contact the Employee Service Center at 855-362-6247 to have your records updated.

Please ignore the Document Upload button below.

Dependent Beneficiary			
Enroll	Name	Relationship	Dependent Verification Status
<input checked="" type="checkbox"/>	Mary Jones	Child	UnVerified*

Add/Review Dependents

Document Upload

Update and Continue

Discard Changes

Document Upload not necessary

You can add or remove dependents from your coverage.

Travel Employees E-benefits Enrollment, cont.

Dependent/Beneficiary Personal Information

SSN (without dashes) is required when dependent(s) is 6 months of age or older. Select save once you have added your Dependent/Beneficiary's personal information.

Personal Information	
*First Name	<input type="text"/>
Middle Name	<input type="text"/>
*Last Name	<input type="text"/>
Name Prefix	<input type="text"/>
Name Suffix	<input type="text"/>
*Date of Birth	<input type="text"/>
*Gender	<input type="text" value="Male"/>
SSN	<input type="text"/>
(Social Security Number)	
*Relationship to Employee	<input type="text"/>
*Dependent Beneficiary	<input type="text" value="Dep/Benef"/>
Relationship: Spouse or Child Only	
Status Information	
*Marital Status	<input type="text" value="Single"/>
As of	<input type="text"/>

Once you have completed your elections click the Submit button and print a copy of your confirmation for your records.

Benefits Enrollment

Submit Benefit Elections

If you have no further changes, click the Submit button on this page to complete your benefit elections.

Click Cancel if you are not ready to submit your choices and wish to return to the Enrollment Summary to review your benefits elections.

Please Note - You may save your elections throughout the enrollment process by clicking "Update and Continue". Prior to submitting, you may return to the Enrollment Summary page and make election changes. You can make changes to your elections any time before Open Enrollment closes on 03/31/2018.

Authorize Election

By submitting your benefit elections you are authorizing the company to take deductions from your paycheck to pay your benefit costs. You are also authorizing your personal information to be sent to your selected providers to initiate and support your coverage.

Benefit Elections Summary

To finalize your 2018 Open Enrollment elections you must:
Print the Confirmation Statement and keep for your records.

Be sure to print your confirmation for your records.

Important Notices from FRESENIUS MEDICAL CARE NORTH AMERICA

The Employee Retirement Income Security Act (ERISA), Department of Labor (DOL), Department of Health and Human Services (HHS) and Internal Revenue Service (IRS) require plan administrators and/or Insurers to provide certain information related to their health and welfare benefit plans to plan participants in writing. To satisfy this requirement, please see the attached notifications. These notices explain your rights and obligations in relation to the health and welfare plan provided by FRESENIUS MEDICAL CARE NORTH AMERICA. Please read the attached notices carefully and retain a copy for your records. ***Please note, this is not a legal document and should not be construed as legal advice.***

If you have any questions regarding any of these notices, please contact:

FRESENIUS MEDICAL CARE NORTH AMERICA
Steven Covino
920 Winter St.
Waltham, MA 02451
800-662-1237
Steven.covino@fmc-na.com

Important Notice about Your Prescription Drug Coverage and Medicare

If you or any of your eligible dependents are eligible for Medicare, or will soon become eligible for Medicare, please read this notice. If not, you can disregard this notice.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage under the health plan and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. We have determined that the prescription drug coverage offered by the health plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage.

If your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan. If your plan is **NOT** creditable, it is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan than if you only have prescription drug coverage from the employer's health plan provided by current carrier. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.

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 may be affected. Contact your plan administrator for an explanation of the prescription drug coverage plan provisions/options under the plan available to Medicare eligible individuals when you become eligible for Medicare Part D. If you do decide to join a Medicare drug plan and drop your current 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 health plan coverage 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, Please Contact the Plan Administrator.

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 your current health plan provided by the current insurer 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).

Women’s Health and Cancer Rights Act 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). If you have had or are going to have a mastectomy, you may be entitled to certain benefits. 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, contact your Health Insurance issuer or your plan administrator.

Newborns’ and Mothers’ Health Protection Act

Newborns' and Mothers' Health Protection Act requires that group health plans and health insurance issuers who offer childbirth coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Refer to your plan document for specific information about childbirth coverage or contact your plan administrator.

For additional information about NMHPA provisions and how Self-funded non-Federal governmental plans may opt out of the NMHPA requirements, visit http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/nmhcpa_factsheet.html.

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 are 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 are not eligible for Medicaid or CHIP, you will not 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, you can 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, you can ask the 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 are not 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, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3272).

You may be eligible for assistance paying your employer health plan premiums. Contact your state for further information on eligibility.

ALABAMA – Medicaid	GEORGIA – Medicaid
Website: http://www.myalhipp.com Phone: 1-855-692-5447	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ALASKA – Medicaid	INDIANA – Medicaid

<p>The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPPI.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.asp x</p>	<p>Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864</p>
ARIZONA - Medicaid	IDAHO - Medicaid
<p>Website: https://www.healtharizonaplus.gov/Default/Default.aspx Phone: 1-855-432-7587</p>	<p>Website: http://healthandwelfare.idaho.gov/Medical/Medicaid/PremiumAssistance/tabid/1510/Default.aspx Phone: 1-800-926-2588</p>
ARKANSAS - Medicaid	IOWA – Medicaid
<p>Website: http://myarhipp.com Phone: 1-855-MyARHIPP (855-692-7447)</p>	<p>Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562</p>
COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)	KANSAS – Medicaid
<p>Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711</p>	<p>Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512</p>
FLORIDA – Medicaid	NEW HAMPSHIRE – Medicaid
<p>Website: http://flmedicaidprecovery.com/hipp/ Phone: 1-877-357-3268</p>	<p>Website: http://www.dhhs.nh.gov/oi/hipp.htm Phone: 603-271-5218</p>
KENTUCKY – Medicaid	NEW JERSEY – Medicaid and CHIP
<p>Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570</p>	<p>Medicaid Website: http://www.nj.gov/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/default.aspx CHIP Phone: 1-800-701-0710</p>
LOUISIANA – Medicaid	NEW YORK – Medicaid
<p>Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-342-6207</p>	<p>Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831</p>
MAINE – Medicaid	NORTH CAROLINA – Medicaid
<p>Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-423-4331</p>	<p>Website: https://dma.ncdhhs.gov Phone: 919-855-4000</p>
MASSACHUSETTS – Medicaid and CHIP	NORTH DAKOTA – Medicaid
<p>Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120</p>	<p>Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604</p>
MINNESOTA – Medicaid	OKLAHOMA – Medicaid and CHIP
<p>Website: http://mn.gov/dhs/people-we-serve/adults/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739</p>	<p>Website: http://www.insureoklahoma.org Phone: 1-888-365-3742</p>
MISSOURI – Medicaid	OREGON – Medicaid
<p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>	<p>Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075</p>

MONTANA – Medicaid	PENNSYLVANIA – Medicaid
Website: http://medicaid.mt.gov/member Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	RHODE ISLAND – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Website: http://www.eohhs.ri.gov/ Phone: (855) 632-7633 Phone: 855-697-4347 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
NEVADA – Medicaid	VIRGINIA – Medicaid and CHIP
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH CAROLINA – Medicaid	WASHINGTON – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://www.dshs.wa.gov/altsa/home-and-community-services/medicaid Phone: 1-800-562-3022 ext. 15473
SOUTH DAKOTA - Medicaid	WEST VIRGINIA – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
TEXAS – Medicaid	WISCONSIN – Medicaid and CHIP
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
UTAH – Medicaid and CHIP	WYOMING – Medicaid
Website: https://medicaid.utah.gov CHIP: http://health.utah.gov/chip Phone: 1-866-435-7414	Website: https://wequalitycare.acs-inc.com/ Phone: 307-777-7531
VERMONT– Medicaid	
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	

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

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

HIPAA Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that we maintain the privacy of protected health information, give notice of our legal duties and privacy practices regarding health information about you and follow the terms of our notice currently in effect.

If not attached to this document, you may request a copy of the current Privacy Practices, explaining how medical information about you may be used and disclosed and how you can get access to this information. **As Required by Law.** We will disclose health information when required to do so by international, federal, state, or local law.

You have the right to inspect and copy, right to an electronic copy of electronic medical records, right to get notice of a breach, right to amend, right to an accounting of disclosures, right to request restrictions, right to request confidential communications, right to a paper copy of this notice, and the right to file a complaint if you believe your privacy rights have been violated.

Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, 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 your dependents (including your spouse) while coverage under Medicaid or a state Children's Health Insurance Program (CHIP) 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' Medicaid or CHIP coverage ends. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or a CHIP program with respect to coverage under this plan, you may be able to enroll yourself and your dependents (including your spouse) in this plan. However, you must request enrollment within 60 days after you or your dependents become eligible for the premium assistance.

To request special enrollment or obtain more information, contact your plan administrator.

Mental Health Parity Notice

The Mental Health Parity and Addiction Equity Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance abuse disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.

Continuation Coverage Rights Under COBRA

Introduction

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

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

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

When is COBRA continuation coverage available?

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

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

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

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.



New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
Expires 5-31-2020

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.56% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

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

How Can I Get More Information?

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

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

¹ An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% 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.

1. Employer name Fresenius Medical Care North America		2. Employer Identification Number (EIN) 26-1951557	
3. Employer address 920 Winter St.		4. Employer phone number 800-662-1237	
5. City Waltham	6. State MA	7. ZIP Code 02451	
8. Who can we contact about employee health coverage at this job? Steven Covino			
9. Phone number (if different from above)		10. E-mail address steven.covino@fmc-na.com	

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

- As your employer, we offer a health plan to:

- All employees.
- Some employees. Eligible employees are:

Full-time employees working 30 hours or more per week.

- With respect to dependents:

- We do offer coverage. Eligible dependents are:

Legal spouses and dependent children up to age 26.

- We do not offer coverage.

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

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

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

Resources and Contact Information



Important Phone Numbers and Websites

Medical

United Healthcare

866-844-4864

www.myuhc.com

Dental and Discount Vision

MetLife

800-ASK4MET

www.metlife.com

Human Resources

Fresenius Medical Care North America

Jackie Beaudoin

781-699-4574

jacqueline.beaudoin@fmc-na.com

Employee Benefits Consultants

Cherry Creek Benefits

303-771-2221 or 855-777-5035

Andy Neff, ext. 347 or andy@cherrycreekbenefits.com

All detailed benefit plan information, plan documents, enrollment forms, and summary plan information can be found online at:

www.mybenesite.com

Username: [fresenius](#)

Password: [benefits](#)

Your Employee Benefits Guide was created by:



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