



Part-Time
Employees

BENEFITS GUIDE

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Dear NOVA Parks Colleague:

NOVA Parks cares about the health and well-being of you and your family, and we are dedicated to providing you with a comprehensive benefits package. We encourage you and your dependents to become familiar with the resources and providers listed in this benefits guide.

As an active, part-time employee of NOVA Parks, you are eligible for health insurance as well as dental and vision benefits. Premiums for all health, dental, and vision benefits are deducted on a bi-weekly, pre-tax basis over 24 pay periods. In months where there are three paychecks, health, dental, and vision premiums will not be deducted from the third paycheck.

Consider your benefit options carefully before you make your benefit elections. The benefits you choose will be in place from your eligibility date through the end of the calendar year, unless you have an IRS qualifying event during the year such as marriage, birth, death, etc. It is the employee's responsibility to notify Human Resources of any mid-year qualifying events that affect their coverage within 30 days of the event.



MEDICAL



**KAISER
PERMANENTE®**

KAISER PERMANENTE INSURANCE PLANS

NOVA Parks offers two Kaiser Permanente insurance plans; the HMO Signature and HMO Select. These plans only provide in-network coverage — **no out-of-network benefits are available.**

The HMO Select plan has the same benefits as the HMO Signature plan, but offers a larger network of doctors to choose from. In other words, the HMO Select plan does not require you or your dependents to visit a Kaiser Permanente medical facility for care, while the HMO Signature plan is a local HMO medical center based design.

Visit www.kp.org or call 1.855.249.5018 for a list of network providers.

HMO SIGNATURE

HMO SELECT

BENEFIT	IN-NETWORK ONLY		IN-NETWORK ONLY	
Primary Care Physician (PCP)	\$10 copay ¹		\$10 copay ¹	
Specialty Care	\$20 copay		\$20 copay	
Annual Deductible	None		None	
Out-of-Pocket Maximum	\$3,500 Individual \$9,400 Family		\$3,500 Individual \$9,400 Family	
Preventive Care—All Ages Routine Preventive Care Immunizations Mammogram, PAP, PSA Tests	No charge		No charge	
Inpatient Hospital Facility	\$100 per admission		\$100 per admission	
Outpatient Hospital Facility	\$50 per visit		\$50 per visit	
Outpatient Professional Service	\$50 copay		\$50 copay	
Chiropractic Care	Not covered		Not covered	
Hearing Aids	Not covered		Not covered	
Emergency Room	\$50 copay ²		\$50 copay ²	
Urgent Care Facility	\$20 copay		\$20 copay	
TMJ, Surgical and Non-Surgical Physician’s Office	Copay costs vary based on location of service		Copay costs vary based on location of service	
In-Patient Mental Health & Substance Abuse Treatment	\$100 per admission ³		\$100 per admission ³	
Annual Prescription Drug Deductible	None		None	
Annual Prescription Drug Out-of-Pocket Maximum	Combined with medical		Combined with medical	
Prescription Drug Kaiser Pharmacy 30 day supply	Generic: \$10 copay Preferred Brand: \$20 copay Non-Preferred: \$35 copay Mail Order ⁴ : \$20/\$40/\$70		Generic: \$10 copay Preferred Brand: \$20 copay Non-Preferred: \$35 copay Mail Order ⁴ : \$20/\$40/\$70	
Prescription Drug Community Pharmacy 30 day supply	Generic: \$20 copay Preferred Brand: \$40 copay Non-Preferred: \$55 copay		Generic: \$20 copay Preferred Brand: \$40 copay Non-Preferred: \$55 copay	
BI-WEEKLY CONTRIBUTIONS	EMPLOYEE	NOVA PARKS	EMPLOYEE	NOVA PARKS
Employee Only	\$42.32	\$239.82	\$44.19	\$250.44
Employee + 1 Dependent	\$141.07	\$423.22	\$147.31	\$441.94
Employee + Family	\$204.55	\$613.67	\$213.60	\$640.81

¹ No charge for children under 5 years old

² Copay waived if admitted

³ Outpatient: \$10 per individual visit / \$5 per group visit

⁴ 90 day supply

DENTAL



METLIFE DENTAL

NOVA Parks offers two MetLife dental plans; the low plan and high plan. To locate a dentist, visit www.metlife.com/dental or call 1.800.275.4638.

You may choose either an in or out-of-network dentist. However, if you choose an out-of-network dentist, your out-of-pocket costs may be higher. Before receiving service, MetLife recommends that you request a pre-treatment estimate for services in excess of \$300. Your dentist can submit a request online at www.metdental.com or can call 1.877.MET.DDS9. You and your dentist will receive a benefit estimate for most procedures while you are still in the office!



LOW PLAN

HIGH PLAN

BENEFIT	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible	Individual: \$50 Family: \$150	Individual: \$50 Family: \$150	Individual: \$50 Family: \$150	Individual: \$50 Family: \$150
Annual Maximum	\$1,000		\$1,750	
Diagnostic & Preventive Services Prophylaxis (Cleanings, up to 4 per plan year); Oral Examinations; Topical Fluoride (up to age 14); Bitewing; X-rays	100%	60%	100%	80%
Basic Services Problem Focused Examinations; Fillings; Extractions; Oral Surgery; Endodontics; Scaling, Root Planning, and Periodontal Surgery; Anesthesia; Repairs; Sealants and Space Maintainers (up to age 14)	80%*	40%*	80%*	80%*
Major Services Bridge and Dentures; Crowns, Inlays, Onlays, Implants; Consultations	50%*	10%*	50%*	50%*
Orthodontia Services	Not Covered		Not Covered	
BI-WEEKLY CONTRIBUTIONS	EMPLOYEE		EMPLOYEE	
Employee Only	\$17.13		\$23.61	
Employee + 1 Dependent	\$35.03		\$48.07	
Employee + Family	\$60.57		\$81.30	

* After deductible



AVESIS VISION

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Eye Exam	\$10 copay	Up to \$35 reimbursement
Frequency Exam/Lenses or Contact Lenses/Frames	12 /12 /24 months	
Frames	\$120 allowance ¹	Up to \$45 reimbursement
Lenses Single Vision Lenses Bifocal Vision Lenses Trifocal Vision Lenses	Covered in full after \$15 copay Covered in full after \$15 copay Covered in full after \$15 copay	Up to \$25 reimbursement Up to \$40 reimbursement Up to \$50 reimbursement
Contact Lenses² Standard Contact Lens Fitting & Follow-up Elective Contact Lenses Medically Necessary Contact Lenses ³	\$50 maximum copay \$110 allowance Covered in full	n/a Up to \$85 reimbursement Up to \$250 reimbursement
BI-WEEKLY CONTRIBUTIONS		
	EMPLOYEE	
Employee Only	\$3.00	
Employee + Spouse	\$5.66	
Employee + Child(ren)	\$6.17	
Employee + Family	\$7.94	

¹ Up to 20% discount above frame allowance

² In lieu of frame and spectacle lenses

³ Prior authorization is required for medically necessary contacts

KP VISION

BENEFIT	IN-NETWORK ONLY
Eye Exam	\$10-20 copay ¹
Frames Frames from KP	No charge ²
Lenses Single Vision Lenses Bifocal Vision Lenses	No charge ² No charge ²
Contact Lenses Lenses from KP Medically Necessary Lenses	1 pair covered in full 2 pair covered in full
Frequency Exam Frames/Lenses or Contact Lenses	12 months 12 months

¹ Optometrist \$10 copay / Ophthalmologist \$20 copay

² Some limitations apply

VISION



AVĒSIS VISION

To locate in-network providers in your area, call 1.800.828.9341 or visit www.avesis.com. Members who use an out-of-network provider must pay the provider in full at the time of service and submit a claim to Avēsis for reimbursement



KAISER PERMANENTE (KP) VISION

If your dependents under age 19 are enrolled in the Kaiser Permanente insurance plan offered by NOVA Parks, they have vision benefits included. You and your dependents over the age of 19 do not have vision benefits included in the plan, but may be eligible to receive a discount on your eyeglass lenses and frames. Visit www.kp.org for more information.

DISCLOSURES

SPECIAL ENROLLMENT RIGHTS (HIPAA)

If you have previously declined enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. 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, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

NO GUARANTEE ON TAX CONSEQUENCES

Neither the Administrator nor the Company makes any commitment or guarantee that any amounts paid to or for the benefit of an Employee under any Plan will be excludable from the Employee's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Employee. An Employee shall indemnify and reimburse the Company for any liability it may incur for failure to withhold federal or state income tax or social security tax from such payments or reimbursements.

NEWBORNS & MOTHERS HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section.

However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

MICHELLE'S LAW

Michelle's Law permits seriously ill or injured college students to continue coverage under a

group health plan when they must leave school on a full-time basis due to their injury or illness and would otherwise lose coverage.

The continuation of coverage applies to a dependent child's leave of absence from (or other change in enrollment) a postsecondary educational institution (college or university) because of a serious illness or injury, while covered under a health plan. This would otherwise cause the child to lose dependent status under the terms of the plan.

Coverage will be continued until:

1. One year from the start of the medically necessary leave of absence, or
2. The date on which the coverage would otherwise terminate under the terms of the health plan; whichever is earlier.

MEDICARE PART D NOTICE OF CREDITABLE COVERAGE

Written notice stating whether or not the expected amount of paid claims under a group health plan's prescription drug coverage is at least as much as the expected amount of paid claims under the standard drug benefit under Medicare Part D. Must be sent to participants and beneficiaries eligible for Medicare Part D.

The notice must be provided by (1) October 15th each year; (2) prior to an individual's individual enrollment period for Part D; (3) prior to the effective date of coverage for any Part D eligible individual who enrolls in the employer's prescription drug coverage; (4) when the plan no longer provides drug coverage or when the coverage is no longer creditable; and (5) upon request.

JANET'S LAW WOMEN'S HEALTH AND CANCER RIGHT'S ACT OF 1998

On October 21, 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. As required by this law, annual notice of the mandated post-mastectomy benefits must be provided to all covered persons. Please review this information carefully. If your spouse is covered under a health plan sponsored by your employer, please make certain that she or he also has the opportunity to review this information.

The Women's Health and Cancer Rights Act of 1998 requires that all group health plans that

provide medical and surgical benefits for a mastectomy also must provide coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and coverage for any complications in all stages of mastectomy, including lymphedemas.

The Act requires that coverage be provided in a manner that is consistent with other benefits provided under the plan. The coverage may be subject to annual deductibles and coinsurance provisions.

The Act prohibits any group health plan from:

- Denying a participant or a beneficiary eligibility to enroll or renew coverage under the plan in order to avoid the requirements of the Act;
- Penalizing, reducing, or limiting reimbursement to the attending provider (e.g., physician, clinic or hospital) or to induce (monetary or otherwise) the provider to provide care inconsistent with the Act.

CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT (CHIPRA)

Effective April 1, 2009 employees and dependents who are eligible for coverage, but who have not enrolled, have the right to elect coverage during the plan year under two circumstances:

- The employee's or dependent's state Medicaid or CHIP (Children's Health Insurance Program) coverage terminates because the individual cease to be eligible.
- The employee or dependent becomes eligible for a CHIP premium assistance subsidy under state Medicaid or CHIP (Children's Health Insurance Program).

Employees must request this special enrollment within 60 days of the loss of coverage and/or within 60 days of when eligibility is determined for the premium subsidy.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008

This act expands the mental health parity requirements in the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Services Act by imposing new



DISCLOSURES

mandates on group health plans that provide both medical and surgical benefits and mental health or substance abuse disorder benefits. Among the new requirements, such plans (or the health insurance coverage offered in connection with such plans) must ensure that: the financial requirements applicable to mental health or substance abuse disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance abuse disorder benefits.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employers who provide medical coverage to their employees to offer such coverage to employees and covered family members on a temporary basis when there has been a change in circumstances that would otherwise result in a loss of such coverage [26 USC §4980B]. This benefit, known as “continuation coverage,” applies if, for example, dependent children become independent, spouses get divorced, or employees leave the employer.

HIPAA INFORMATION NOTICE OF PRIVACY PRACTICES

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), your employer recognizes your right to privacy in matters related to the disclosure of health related information. The Notice of privacy Practices (provided to you upon your enrollment in the health plan) details the steps your employer has taken to assure your privacy is protected. The Notice also explains your rights under HIPAA. A copy of this Notice is available to you at any time, free of charge, by request through your local Human Resources Department.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

is a medical child support order issued under State law that creates or recognizes the existence of an “alternate recipient’s” right to receive benefits for

which a participant or beneficiary is eligible under a group health plan. An “alternate recipient” is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer on the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.

COVERAGE EXTENSION RIGHTS UNDER THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

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

GENETIC INFORMATION NON-DISCRIMINATION ACT (GINA)

GINA broadly prohibits covered employers from discriminating against an employee, individual, or member because of the employee’s “genetic information,” which is broadly defined in GINA to mean (1) genetic tests of the individual, (2) genetic tests of family members of the individual, and (3) the manifestation of a disease or disorder in family members of such individual.

GINA also prohibits employers from requesting, requiring, or purchasing an employee’s genetic information. This prohibition does not extend to information that is requested or required to comply with the certification requirements of family and

medical leave laws, or to information inadvertently obtained through lawful inquiries under, for example, the Americans with Disabilities Act, provided the employer does not use the information in any discriminatory manner. In the event a covered employer lawfully (or inadvertently) acquires genetic information, the information must be kept in a separate file and treated as a confidential medical record, and may be disclosed to third parties only in very limited circumstances.

CAN CHILDREN STAY ON A PARENT’S PLAN UNTIL AGE 26?

If a plan covers children, they can be added or kept on the health insurance policy until they turn 26 years old.

Children can join or remain on a plan even if they are:

- married
- not living with their parents
- attending school
- not financially dependent on their parents
- eligible to enroll in their employer’s plan

HOW TO GET COVERAGE FOR ADULT CHILDREN

Adult child may be enrolled during a plan’s open enrollment period or during other special enrollment opportunities. The employer or insurance company can provide details.

Under-26-year-olds can be signed up directly in new Marketplace plans. Be sure to include him or her on the list of people to be covered.

Questions? Call 1-800-318-2596, 24 hours a day, 7 days a week. (TTY: 1-855-889-4325)

ADVOCACY



WEBSITE

Stay informed with the latest health news, biometric tools, calculators and information at **benefitsvip.com!**



BLOG

HealthDiscovery.org is a lifestyle blog with wellness articles, tips, quizzes, recipes, and more!

BenefitsVIP
Help starts here.



HELP STARTS HERE

BenefitsVIP is a powerful, one-stop contact center staffed by seasoned professionals. Your dedicated team of employee benefits advocates is ready to help you and your family members resolve your Kaiser, MetLife, and Avēsis benefits issues.

For service that's confidential and responsive, contact:

866.293.9736

Monday—Friday

8:30am—8:00pm (ET)

Fax: 856.996.2755

solutions@benefitsvip.com

QUESTIONS ANSWERED HERE

COMPLETELY CONFIDENTIAL! Your dedicated BenefitsVIP advocates understand your benefit plans and are able to answer benefit questions and quickly resolve claims and eligibility issues. A majority of inquiries are resolved the same day and all calls adhere to privacy best practices.

BenefitsVIP.com

This benefit summary provides selected highlights of the employee benefits program available. It is not a legal document and shall not be construed as a guarantee of benefits nor of continued employment. All benefit plans are governed by master policies, contracts and plan documents. Any discrepancies between any information provided through this summary and the actual terms of such policies, contracts and plan documents shall be governed by the terms of such policies, contracts and plan documents. Our company reserves the right to amend, suspend or terminate any benefit plan, in whole or in part, at any time. The authority to make such changes rests with the Plan Administrator.