IMPORTANT NOTICE FROM NURSING PLACEMENT, INC. REGARDING YOUR HEALTH AND WELFARE PLAN FOR THE 2016-2017 PLAN YEAR

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 consolidated notifications. These notices explain your rights and obligations in relation to the health and welfare plan provided by your employer. 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.*

The following is a summary of notices included in this packet:

- ✓ Women's Preventative Health Service
- ✓ Michelle's Law
- ✓ Qualified Medical Child Support Order (QMCSO)
- ✓ Family Medical Leave Act (FMLA)
- ✓ WHCRA Notice
- ✓ NMHPA Notice
- ✓ Mental Health Parity and Addiction Equity Act of 2008 (MHPA/MHPAEA)
- ✓ Health Information Technology for Economic and Clinical Health Act (HITECH)
- ✓ Genetic Information Nondiscrimination Act (GINA)
- ✓ USERRA Notice
- ✓ HIPAA Notice of Privacy Practices
- ✓ HIPAA Special Enrollment Rights Notice
- ✓ Information on Nondiscrimination 105(h) Rules
- ✓ Information on the Uniform Glossary of Health Coverage and Medical Terms

You have the right to request and obtain a paper copy of any document at no charge. If a paper version is available, then you will receive it immediately. You should contact your plan administrator with your request.

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

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WOMEN'S PREVENTIVE HEALTH SERVICES

When plans renew or are effective on or after August 1, 2012, all of the following women's health services will be considered preventive (some were already covered). These services generally will be covered at no cost share, when provided in-network:

- Well-woman visits (annually)
- Prenatal visits (routine preventive visits)
- Screening for gestational diabetes
- Human papillomavirus (HPV) DNA testing
- Counseling for sexually transmitted infections
- Counseling and screening for human immunodeficiency virus (HIV)

- Screening and counseling for interpersonal and domestic violence
- Breastfeeding support, supplies and counseling
- Generic formulary contraceptives, certain brand formulary contraceptives, and FDA-approved, over-the-counter female contraceptives with prescription are covered without member cost share (for example, no copayment). Certain religious organizations or religious employers may be exempt from offering contraceptive services.

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.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

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 is an alternate recipient. 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, and to administer benefits in accordance with the applicable terms of each order that 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; know 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.

FAMILY MEDICAL LEAVE ACT (FMLA)

FMLA Family Medical Leave Act entitles eligible employees of covered employers to take unpaid, job-protected leave for specific family and medical reasons if the employee has been with the company for one year, has worked at least 1250 hours during the prior 12 months and works in an area where there are at least 50 employees within 75 miles. For additional details, visit the Department of Labor FMLA page. Notify the organization when you have a qualifying leave such as birth or adoption of a child, a serious health condition, to care for a spouse, child or parent with a serious medical condition or for reservist or National Guard provisions related to you or an immediate family member leaving for military duty or being injured in active duty.

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA) ANNUAL NOTICE

Your Rights After a Mastectomy

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. Therefore, the deductible and coinsurance you will be subject depends on which health plan you choose.

Call your plan administrator at for more information.

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT (NMHPA) NOTICE

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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Plans may be subject to State law requirements, please refer to the Plan Summary Plan Document for details describing any applicable State law.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OR 2008 (MHPA/MHPAEA)

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 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 the 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. Additional information and details can be found by visiting the Department of Labor's Mental Health Parity webpage located at http://www.dol.gov/ebsa/newsroom/fsmhpaea.html.

HEALTH INFORMATION TECHNOLOGY FOR ECONOMIC AND CLINICAL HEALTH ACT (HITECH)

The Health Information Technology for Economic and Clinical Health Act (HITECH Act) was signed into law on February 17, 2009 as part of the American Recovery and Reinvestment Act of 2009 (ARRA), an economic stimulus bill.

The HITECH Act requires entities covered by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to report data breaches affecting 500 or more individuals to HHS and the media, in addition to notifying the affected individuals.

Following a breach of unsecured protected health information covered entities must provide notification of the breach to affected individuals, the Secretary, and, in certain circumstances, to the media. In addition, business associates must notify covered entities that a breach has occurred.

GENETIC INFORMATION NON-DISCRIMINATION ACT (GINA)

The Genetic Information Nondiscrimination Act of 2008 enacted May 21, 2008, GINA), is designed to prohibit the use of genetic information in health insurance and employment. The Act prohibits group

health plans and health insurers from denying coverage to a healthy individual or charging that person higher premiums based solely on a genetic predisposition to developing a disease in the future. The legislation also bars employers from using individuals' genetic information when making hiring, firing, job placement, or promotion decisions.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA) NOTICE

Your right to continued participation in the Plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA).

Accordingly, if you are absent from work due to a period of active duty in the military for less than 31 days, your Plan participation will not be interrupted.

If you do not elect to continue to participate in the Plan during an absence for military duty that is more than 31 days, you and your covered family members will have the opportunity to elect COBRA Continuation Coverage only under the medical insurance policy for the 24-month period (18-month period if you elected coverage prior to December 10, 2004) that begins on the first day of your leave of absence. You must pay the premiums for Continuation Coverage with after-tax funds, subject to the rules that are set out in that plan.

HIPAA NOTICE OF PRIVACY PRACTICES

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), your health plan recognizes your right to privacy in matters related to the disclosure of health-related information. The Notice of Privacy Practices *(provided in the plan certificate booklet)* details the steps your plan 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 health plan.

HIPAA SPECIAL ENROLLMENT RIGHTS

This notice is being provided so that you understand your right to apply for group health insurance coverage outside of your employer's open enrollment period. You should read this notice regardless of whether or not you are currently covered under your employer's Group Health Plan. The Health Insurance Portability and Accountability Act (HIPAA) requires that employees be allowed to enroll themselves and/or their dependent(s) in an employer's Group Health Plan under certain circumstances, described below, provided that the employee notified the employer within 30 days of the occurrence of any following events:

- Loss of health coverage under another employer plan (including exhaustion of COBRA coverage);
- Acquiring a spouse through marriage; or
- Acquiring a dependent child through birth, adoption, placement for adoption or foster care placement.

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

INFORMATION ON NON-DISCRIMINATION 105(H) RULES

The Affordable Care Act also extended the Section 105(h) rules of the Internal Revenue Code to non-grandfathered fully insured group health plans. Section 105(h) prohibits employers from discriminating in favor of highly compensated individuals (HCIs) relative to other employees in eligibility and benefits under a group health plan.

The Affordable Care Act stated that the 105(h) rules would apply to non-grandfathered fully insured group health plans on their first plan year on or after September 23, 2010. On December 22, 2010, however, the

IRS (with the support of the Departments of Labor and HHS) announced that compliance with the rules will not be required of insured plans until guidance is provided regarding their application. Until that time, sanctions for failure to comply with the rules will not apply. Furthermore, the agencies expect that when such guidance is issued, its effective date will be delayed until plan years beginning a certain time after issuance.

Under 105(h), HCIs generally consist of officers and owners and individuals in the top quartile of employees (when ranked according to compensation). Certain types of non-grandfathered plans, such as class/carve-out plans (that only cover a class of employees that consist primarily of HCIs or cover such class at a higher benefit level than another class that does not include HCIs), are either prohibited or suspect under 105(h). Insured plan sponsors that violate the 105(h) rules are subject to a $100 per day per failure penalty. This penalty would likely apply to each non-HCI who is impermissibly excluded under the plan.

Under the amended grandfather rules, the following fully insured plans are not grandfathered and may be impacted by the 105(h) rules:

- an insured plan sold with a new coverage effective date after March 23 and before November 15, 2010; or
- an insured plan that was grandfathered on March 23, 2010, and subsequently lost its grandfather status due to changes in the plan.

If these non-grandfathered plans are class/carve-out plans as described above, they may face compliance issues under the 105(h) rules, depending on how the future guidance takes shape. Customers that have a fully insured non-grandfathered class/carve-out plan, or have questions about the application of the 105(h) rules to their plan, should review the matter with their tax or legal counsel. Customers concerned that their plans may be considered discriminatory under 105(h) may contact their broker.

INFORMATION ON THE UNIFORM GLOSSARY OF HEALTH COVERAGE AND MEDICAL TERMS

The Affordable Care Act provides employees a resource to help them understand some of the most common but confusing jargon used in health insurance. Insurance companies and group health plans will be required to make available upon request a uniform glossary of terms commonly used in health insurance coverage such as “deductible” and “co-payment”. Please contact your plan administrator for a copy of the uniform glossary or you can visit www.HealthCare.gov or www.dol.gov/ebsa/healthreform.