
WesternUnion WU
YOUR HEALTH BENEFITS
COBRA Benefits Guide

INSIDE THIS GUIDE

3 Key Words to Know

4 Medical Benefits

5 Cigna Medical Plans at a Glance

6 Cigna Prescription Drug Benefits

7 Kaiser Medical Plans at a Glance

8 Kaiser Prescription Drug Benefits

9 Mercer Marketplace 365+ HUB

10 Dental and Vision

11 Employee Assistance Program (EAP)

12 Other Important Health-related Information

19 Contact Information

KEY WORDS TO KNOW

COBRA: A federal law that may allow you to temporarily keep health coverage after your employment ends, you lose coverage as a dependent of the covered employee, or another qualifying event. If you elect COBRA coverage, you pay 100% of the premiums, including the share the employer used to pay, plus a small administrative fee.

Copay: This is a fixed amount that you are required to pay for medical services at the time of each visit. It does not apply toward the deductible. The copays are only applicable if you elect the 900 Deductible Plan.

Deductible: The amount you pay before the plan begins to pay.

Out-of-Pocket Costs: Expenses you pay yourself, such as deductibles, copays, coinsurance and non-covered services.

Out-of-Pocket Maximum: The plan protects you financially by limiting the total amount you will pay each year for medical care. As long as you use in-network providers, once you meet your out-of-pocket maximum, the plan pays 100% of your eligible expenses for the remainder of the year. (For out-of-network providers, the plan will pay 100% of the "usual and customary" charge. You are responsible for any amount in excess of the usual and customary charge.) Note that if you choose Kaiser, there is no coverage for out-of-network services. The out-of-pocket maximum will vary based on which plan you choose.

Coinsurance: Once the deductible is met, you and the plan will each pay a designated percentage of the cost for care, which is called coinsurance. The coinsurance will vary based on which plan you choose.

Prescription Drugs: When you enroll in a medical plan, you automatically receive prescription drug benefits. The amount you pay depends on whether your prescription drug is a generic (tier 1), brand name formulary (tier 2), or brand name non-formulary (tier 3), as shown below:

TIER	YOU PAY	WHAT'S COVERED
1	Lowest Cost Sharing	**Most Generic Prescription Drugs** Generic prescription drugs use the same active ingredients as brand-name prescription drugs and work the same way. Generic drugs are equivalent to a brand product in dosage form, strength, quality and intended use.
2	Second Lowest Cost Sharing	**Preferred Brand Name Drugs** Drugs sold under a specific trade name that are favorably priced by the pharmacy plan.
3	Highest Cost Sharing	**Non-Preferred Brand Name Drugs** Drugs sold under a specific trade name that have a reasonable, more cost-effective alternative on Tier 1 or Tier 2.

Telehealth

With all Western Union medical plans, you have access to quality health care and mental health providers via the phone or online consultations, available 24/7/365 through the use of telehealth services.

The telehealth provider will vary depending on which carrier you choose. Cigna uses MDLIVE and other virtual providers. Most Kaiser providers offer the ability to have a visit via phone/video, so you schedule a virtual visit with your existing provider.

When to Use Telehealth:

» If you are considering the ER or urgent care center for a non-emergency medical issue
» Your primary care physician is not available
» Traveling and in need of medical and mental health care
» During or after normal business hours, nights, weekends and even holidays

Each time you utilize this program you will be charged a fee (amount varies by plan — see Medical Plans at a Glance for information).

MEDICAL BENEFITS

Nothing is more important than your health — that is why we offer medical and prescription drug coverage.

CHOICE OF PLANS AND NETWORKS

You can choose different medical plan options through Cigna or Kaiser. Each provides a range of coverage levels and costs, giving you the flexibility to select the plan that is right for you.

Medical plan offerings include:

» 900 Deductible Plan
» 1850 Deductible Plan
» 2850 Deductible Plan

The network will vary depending on which carrier and which plan you choose. Your monthly costs and out-of-pocket costs will vary depending on which plan you choose.

PLAN FEATURES

The plans include the following features:

» 100% covered in-network preventive medical care for all plans. Preventive care is covered fully with no deductible and no copay or coinsurance, as long as you receive this care from in-network providers.
» Annual deductible if you elect the 1850 or the 2850 Deductible Plans. You pay for your initial costs out-of-pocket until you meet your annual deductible. If you elect the 900 Deductible Plan, you may be responsible for the cost of some services until you meet your annual deductible. The deductible will vary based on which plan you choose.

CIGNA MEDICAL PLANS AT A GLANCE

This chart summarizes the coverage available under each Cigna medical plan.

	900 DEDUCTIBLE	1850 DEDUCTIBLE	2850 DEDUCTIBLE
Provider Network	A large network: Cigna Open Access Plus Network	A large network: Cigna Open Access Network	A narrow† network: Cigna LocalPlus Network
Office Visit **Plan pays…** **In-Network**	100% after $40 primary care physician copay/ $80 specialist copay	80% after deductible	70% after deductible
Out-of-Network*	60% after deductible	60% after deductible	50% after deductible
Deductible (Individual/Family) **In-Network** **Out-of-Network***	$900/$1,800 $3,000/$6,000	$1,850/$3,700** $3,700/$7,400**	$2,850/$5,700** $5,700/$11,400**
Annual Out-of-Pocket Maximum (Individual/Family)*** **In-Network** **Out-of-Network***	$3,000/$6,000 $6,000/$12,000	$3,500/$6,500 $7,000/$13,000	$5,500/$11,000 $11,000/$22,000
Preventive Care**** **Plan pays…** **In-Network** **Out-of-Network***	100% no copay 60% after deductible	100% no deductible 60% after deductible	100% no deductible 50% after deductible
Coinsurance Plan pays… **In-Network** **Out-of-Network***	80% after deductible 60% after deductible	80% after deductible 60% after deductible	70% after deductible 50% after deductible
Cigna Telehealth	$40 copay	Full cost of visit, generally a fixed fee of around $50, until deductible is met, then coinsurance applies	Full cost of visit, generally a fixed fee of around $50, until deductible is met, then coinsurance applies
Emergency Room Plan pays… **In-Network** **Out-of-Network***	80% after deductible 80% after deductible	80% after deductible 80% after deductible	70% after deductible 70% after deductible

* Out-of-network expenses are subject to reasonable and customary limits.
** You pay the full cost of your medical and prescription drug expenses until your deductible has been met.
*** Out-of-Pocket Maximum includes the deductible; once your out-of-pocket maximum is reached.
**** Health care reform requires that all medical plans cover a specified list of preventive care services at 100% when received in-network (list subject to change based on recommendations from federal guidelines). Cost sharing may apply for network visits when preventive care services are provided in conjunction with an office visit.
† See callout box below.

What is a Narrow Network?

Your 2850 Deductible Plan is unique in that it features a narrow network, the Cigna LocalPlus network. Unlike a broader network, a narrow network features a coordinated care team dedicated to your treatment. Your primary doctor works directly with specialists to implement your treatment plan, with the result being that the care you receive is typically more consistent, efficient and cost effective.

Since a narrow network typically has a smaller number of doctors, specialists, hospitals, etc. that are considered in-network, it is important that you review the network providers prior to enrolling in the 2850 Deductible Plan. If you find that the narrow network does not have providers in your area, the 2850 plan is not an option for you to elect.

CIGNA PRESCRIPTION DRUG BENEFITS

When you enroll in a Cigna Medical Plan, you automatically receive prescription drug benefits. The amount you pay depends on:

- Which medical plan you choose
- Where you purchase the prescription (retail drug store or home delivery)
- Whether your prescription drug is a generic, brand name formulary, or brand name non-formulary.

With the 1850 and 2850 Deductible Plans, you must pay for your prescription drugs out-of-pocket, until you reach your deductible.

Once you've reached your deductible, the plan will pay 80% or 70%, respectively, of the cost of your prescription medications. With the 900 Deductible Plan, you pay copay and coinsurance amounts.

You have two options for filling your prescriptions:

1. Fill prescriptions at a participating retail pharmacy. You can find a list of participating pharmacies by using Cigna's online provider directory, which you can access through **Cigna.com**.
2. Fill long-term prescriptions (31- to 90-day supply) by getting a 90-day supply at one of the 90-day retail pharmacies in your plan's new network*, or through Cigna Home Delivery Pharmacy℠.

CIGNA 90 NOW℠

If you are on maintenance medications, you'll have more flexibility with Cigna 90 Now. Your plan limits the number of fills you'll receive to a 30-day supply. After you have received one fill of your 30-day prescription, you must switch to a 90-day supply, or you'll have to pay the full cost of your medication out of your own pocket, and what you pay won't count towards your plan's deductible or out-of-pocket maximum. With Cigna 90 Now, your maintenance medications will have to be filled in a 90-day supply, but you'll have more choice on where you can get your medication: either at one of the 90-day retail pharmacies in your plan's new network, or through Cigna Home Delivery Pharmacy℠.

* Refer to **Cigna.com/Rx90network** for a list of pharmacies in your plan's new network.

Dispense as Written

The active ingredient(s) in generic drugs are exactly the same as in brand name drugs and will perform the same as the brand name. If your doctor prescribes a brand name medication, you would need to pay the generic copay and difference in cost.

Therapeutic Class drugs: There will be an exclusion of Therapeutic Class drugs if there is an over-the-counter option available.

CIGNA PLANS	900 DEDUCTIBLE	1850 DEDUCTIBLE	2850 DEDUCTIBLE
PRESCRIPTION DRUGS			
Retail (up to 30-day supply) Plan pays...	100% after $10 copay for Tier 1, 70% (min $25 / max $50) for Tier 2, 55% (min $40 / max $80) for Tier 3	80% after deductible	70% after deductible
Mail order (31- to 90-day supply) Plan pays...	100% after $25 copay for Tier 1, 70% (min $62.50 / max $125) for Tier 2, 55% (min $100 / max $200) for Tier 3	80% after deductible	70% after deductible

KAISER MEDICAL PLANS AT A GLANCE

This chart summarizes the coverage available under each Kaiser medical plan. **Kaiser Plans provide coverage only with in-network providers with the exception of emergency and urgent care.**

	900 DEDUCTIBLE	1850 DEDUCTIBLE	2850 DEDUCTIBLE
Provider Network	Kaiser Permanente	Kaiser Permanente	Kaiser Permanente
Office Visit Plan pays… In-Network	100% after $40 primary care copay/$80 specialist copay	80% after deductible primary care physician and specialist	70% after deductible primary care physician and specialist
Deductible (Individual/Family) In-Network	$900/$1,800	$1,850/$3,700*[1]	$2,850/$5,700*
Annual Out-of-Pocket Maximum (Individual/ Family) In-Network**	$3,000/$6,000	$3,500/$6,500[2]	$5,500/$11,000
Preventive Care* Plan pays… In-Network**	100% no copay	100% no deductible	100% no deductible
Coinsurance Plan pays… In-Network	80% after deductible	80% after deductible	70% after deductible
Telehealth Consultations	Applicable copay	80% after deductible	70% after deductible
Emergency Room Plan pays… In-Network	80% after deductible	80% after deductible	70% after deductible

Note: Out-of-network expenses are not covered under the plan.
* You pay the full cost of your medical and prescription drug expenses until your deductible has been met.
** Out-of-Pocket Maximum includes the deductible.
*** Health care reform requires that all medical plans cover a specified list of preventive care services at 100% when received in-network (list subject to change based on recommendations from federal guidelines). Cost sharing may apply for network visits when preventive care services are provided in conjunction with an office visit.
[1] In California, deductible is embedded and 3 tiers. $1,850 for Self-Only coverage; $2,800 for any one member within a Family enrollment; and $3,700 for the entire family.
[2] In California, out-of-pocket maximum is embedded. $5,500 for Self-Only coverage; $3,500 for any one member within a Family enrollment; and $6,500 for the entire family.

Kaiser Plans

- The plans will be offered to employees in the following regions: California (northern and southern), Colorado (Colorado Springs, Denver/Boulder, Northern Colorado and Pueblo), Georgia, Mid-Atlantic region (Washington D.C., Maryland and Virginia), Washington (Seattle/Spokane) and Idaho
- Benefits may differ slightly across the Kaiser regions due to state mandated benefits
- In-Network Only coverage (except for ER and urgent care visits) means you must see a Kaiser provider
- For Kaiser Hawaii, you will have a different medical plan (just one plan) that will be provided in the COBRA enrollment packet from WEX

KAISER PRESCRIPTION DRUG BENEFITS

When you enroll in a Kaiser Medical Plan, you automatically receive prescription drug benefits. The amount you pay depends on:

- Which medical plan you choose
- Where you purchase the prescription (retail drug store or home delivery)
- Whether your prescription drug is a generic, brand name formulary, or brand name non-formulary.

With the 1850 and 2850 Deductible Plans, you must pay for your prescription drugs out-of-pocket until you reach your deductible.

Once you've reached your deductible, the plan will pay 80% or 70%, respectively, of the cost of your prescription medications. With the 900 Deductible Plan you pay the appropriate copay.

You have two options for filling your prescriptions:

1. Fill prescriptions at a local Kaiser retail pharmacy. You can find a list of Kaiser locations by using Kaiser's online provider directory, which you can access through **www.kp.org**.
2. Fill long-term prescriptions (31- to 90-day supply) by utilizing the Kaiser Mail Order program. More information can be found at **www.kp.org** where you can easily set this benefit up.

KAISER PLANS	900 DEDUCTIBLE	1850 DEDUCTIBLE	2850 DEDUCTIBLE
PRESCRIPTION DRUGS			
Retail* (up to 30-day supply) Plan pays...	100% after $10 copay for Tier 1, 70% (min $25 / max $50) for Tier 2, 55% (min $40 / max $80) for Tier 3	80% after deductible; deductible waived for some medications	70% after deductible; deductible waived for some medications
Mail order* (31- to 90-day supply) Plan pays...	100% after $25 copay for Tier 1, 70% (min $62.50 / max $125) for Tier 2, 55% (min $100 / max $200) for Tier 3	80% after deductible; deductible waived for some medications	70% after deductible; deductible waived for some medications

*Amounts may vary by Kaiser region.

DISPENSE AS WRITTEN

The active ingredient(s) in generic drugs are exactly the same as in brand name drugs and will perform the same as the brand name. If your doctor prescribes a brand name medication, you would need to pay the generic copay and difference in cost.

MERCER MARKETPLACE 365+ HUB

Have you needed help finding the right doctor or getting an appointment scheduled with your doctor during regular business hours? Can you locate a lower cost provider that's convenient for you for X-rays, MRIs and other medical services that you or a family member needs? Do you think you might need a second opinion from an expert to review your diagnosis or treatment plan? Ever had a claim issue with your insurance that you can't resolve on your own and you don't know where to turn?

Now you can get personalized support with all of this and more by enrolling in the Mercer Marketplace 365+ HUB. The Mercer Marketplace 365+ HUB is a destination of services, information and tools that can help you improve the quality and cost of your care, and it's always just a phone call away!

Take advantage of all of your health care benefits

Once you are enrolled in a medical plan, you are eligible to elect the Marketplace 365+ HUB. Simply call us at 1-866-385-8032 to talk to a dedicated Personal Health Advocate. You can get help with everything from finding a doctor for your condition to claim and billing resolution to clinical support and even support for eldercare and special needs.

Get help finding doctors who provide high quality care for your needs

With the Mercer Marketplace 365+ HUB, you can review the quality scores of doctors in your area based on your condition and need. Quality matters! Especially when it comes to you and your family's health, you'll be more likely to get the care you need to recover faster and save money. In-network physicians are ranked by data-driven quality scores for easy selection.

Find the best price for the health care services you need

The cost of health care can vary widely, even within the same area. You share in the cost of health care services, so it's important to know how much a service can cost in advance. Use the Mercer Marketplace 365+ HUB to help you save money on your health care.

Get an expert second opinion for peace of mind

Take charge of your health care. Don't hesitate to get another opinion, especially if it's for a concerning or serious condition. The Mercer Marketplace 365+ HUB gives you and your covered family members access to world-class specialists that will review your case and give you an expert opinion on your diagnosis and treatment plan. About 40% of people receive an improved diagnosis and 99% recommend this service. It's peace of mind at a time when you may need it most. Mercer Marketplace 365+ HUB accepts all cases and sticks with you every step of the way.

DENTAL AND VISION

Health is about more than just medical coverage. Investing time to develop good dental and vision practices is relatively easy and can make a lasting difference in your overall health.

The TeleDentists

Consult with a dentist from the convenience of your home 24/7 if you are experiencing dental pain, oral sores, lesions, swelling or infections.

DENTAL

Healthy teeth and gums are an essential part of your general health and well-being. You can choose between three dental options: an Enhanced Plan, Basic Plus Plan and DHMO.

With the Enhanced and Basic Plus plan, you may see any provider you would like, although you will pay less for a provider in the Cigna network and will not have to file a claim for services. You must meet a deductible each year for basic and major care, after which the plan pays a percentage of covered services. Preventive care is free under both plans.

With the DHMO plan, you must choose a primary care dentist from Cigna's network to receive coverage. That dentist will coordinate any specialty work you may need.

	ENHANCED	BASIC PLUS	DHMO
	WHAT THE PLANS PAY (IN-NETWORK/OUT-OF-NETWORK)		
Annual Deductible (individual)	$50/$50	$50/$50	N/A
Annual Deductible (family)	$150/$150	$150/$150	N/A
Calendar Year Maximum	$2,000 (in-network and out-of-network)	$1,000 (in-network and out-of-network)	See **Benefit Schedule**
Preventive Services	100%	100%	See **Benefit Schedule**
Basic Services	80%	70%	See **Benefit Schedule**
Major Services	50%	50%	See **Benefit Schedule**
Orthodontia	50%, up to a $1,500 maximum (children less than 19 years of age)	NA	See **Benefit Schedule** (adult & child)

Dental ID Cards

You will only receive a dental ID card if you enroll in the DHMO plan. You will not receive one under the Cigna Enhanced or Basic Plus plans.

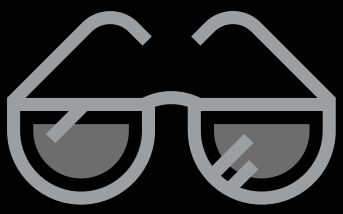
Finding Cigna Providers Is Easy!

To search for providers in the Cigna network once you are a member, visit **mycigna.com** and log in. If you are not a member, visit **cigna.com** and select Find a Doctor, Dentist, or Facility.

VISION

An annual eye exam is one of the best ways to make sure you are keeping your eyes healthy. The Enhanced Plan is administered by Vision Service Plan (VSP) and is designed to save you money on eligible vision care expenses such as eye exams, glasses, and contact lenses. You also have the option to enroll in the Materials Only plan (also administered by VSP), which provides the same coverage as the Enhanced Plan, but has lower paycheck premiums and does not cover yearly exams.

	ENHANCED (IN-NETWORK)	MATERIALS ONLY (IN-NETWORK)
Exam (once every 12 months)	$10 copay	Not covered
Lenses (once every 12 months)	$10 copay for single vision, lined bifocal, and lined trifocal (copay applies to lenses and frame)	
Lens Options	Standard progressive lenses covered in full	
	All other most popular lens options are covered in full with a copay, saving members an average of 20–25%	
Frame (once every 12 months)	Retail allowance of $175	
	20% discount on any amount over the retail allowance	
Contact Lenses (once every 12 months, instead of frame and lenses)	Covered up to $175 allowance	
	Contact lens exam (fitting and evaluation) covered in full with a copay, not to exceed $60	



Finding VSP Providers Is Easy!

To search for providers in the VSP vision network, go to **www.vsp.com.**

Select "Find a Doctor" on the left-hand side of the screen.

Then select "Search as Guest."

EMPLOYEE ASSISTANCE PROGRAM (EAP)

The EAP offers free, confidential, and professional counseling for you and your household members—even those not enrolled in a Western Union health plan. When you need help with a personal or work-related problem, the EAP is available 24/7 at no cost to you.

Coverage is automatic, and you do not need to enroll.

Your benefits include:

» Up to 5 face-to-face sessions per year—expert assistance for grief, relationship challenges, parenting, substance abuse, and more.

» Unlimited work/life benefits and personal services—referrals and resources for child care, emotional health, and more.

Reach out to the EAP

Sometimes just talking about a problem with someone who has a fresh, unbiased view can help you cope with life's challenges. You can contact the EAP by calling **800-424-4485**, or visit **www.MagellanAscend.com.**

OTHER IMPORTANT HEALTH-RELATED INFORMATION

LEGAL NOTICE

THE WESTERN UNION COMPANY RESERVES THE RIGHT TO CHANGE, AMEND OR TERMINATE ANY BENEFITS PLAN AT ANY TIME FOR ANY REASON. PARTICIPATION IN A BENEFITS PLAN IS NOT A PROMISE OR GUARANTEE OF FUTURE EMPLOYMENT. RECEIPT OF BENEFITS DOCUMENTS DOES NOT CONSTITUTE ELIGIBILITY. THESE NOTICES DO NOT APPLY TO ANY BENEFITS YOUR EMPLOYER OFFERS OUTSIDE OF MERCER MARKETPLACE 365+.

The COBRA Benefits Guide, combined with these legal notices, provides an overview of the benefits available to eligible COBRA beneficiaries. In all cases, the official plan documents govern and this COBRA Benefits Guide is not, and should not be relied upon as a governing document. In the event of a discrepancy between the information presented in the COBRA Benefits Guide and official plan documents, the official plan documents will govern.

IMPORTANT NOTICE FROM THE WESTERN UNION COMPANY ABOUT CREDITABLE PRESCRIPTION DRUG COVERAGE AND MEDICARE

The purpose of this notice is to advise you that the prescription drug coverage listed below under The Western Union Company medical plan is expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2022. This is known as "creditable coverage."

Why this is important: if you or your covered dependent(s) are enrolled in any prescription drug coverage during 2022 listed in this notice and are or become covered by Medicare, you may decide to enroll in a Medicare prescription drug plan later and not be subject to a late enrollment penalty — as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment. You should keep this notice with your important records.

If you or your family members aren't currently covered by Medicare and won't become covered by Medicare in the next 12 months, this notice doesn't apply to you.

Please read the notice below carefully. It has information about prescription drug coverage with The Western Union Company and prescription drug coverage available for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

NOTICE OF CREDITABLE COVERAGE

You may have heard about Medicare's prescription drug coverage (called Part D), and wondered how it would affect you. Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans also offer more coverage for a higher monthly premium.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible, and each year from October 15 through December 7. Individuals leaving employer/union coverage may be eligible for a Medicare Special Enrollment Period.

If you are covered by one of The Western Union Company prescription drug plans listed below, you'll be interested to know that the prescription drug coverage under the plan is, on average, at least as good as standard Medicare prescription drug coverage for 2022. This is called creditable coverage. Coverage under one of these plans will help you avoid a late Part D enrollment penalty if you are or become eligible for Medicare and later decide to enroll in a Medicare prescription drug plan.

- Cigna – 900, 1850 or 2850 Deductible Plan
- Kaiser Permanente – 900, 1850 or 2850 Deductible Plan

If you decide to enroll in a Medicare prescription drug plan and you are an active employee or family member of an active employee, you may also continue your employer coverage. In this case, The Western Union Company plan will continue to pay primary or secondary as it had before you enrolled in a Medicare prescription drug plan. If you waive or drop The Western Union Company coverage, Medicare will be your only payer. You can re-enroll in the employer plan at annual enrollment or if you have a special enrollment event for The Western Union Company plan, assuming you remain eligible.

You should know that if you waive or leave coverage with The Western Union Company and you go 63 days or longer without creditable prescription drug coverage (once your applicable Medicare enrollment period ends), your monthly Part D premium will go up at least 1% per month for every month that you did not have creditable coverage. For example, if you go 19 months without coverage, your Medicare prescription drug plan premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll in Part D.

You may receive this notice at other times in the future — such as before the next period you can enroll in Medicare prescription drug coverage, if The Western Union Company coverage changes, or upon your request.

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. Medicare participants will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. Here's how to get more information about Medicare prescription drug plans:

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

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at **www.socialsecurity.gov** or call 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in a Medicare prescription drug plan after your applicable Medicare enrollment period ends, you may need to provide a copy of this notice when you join a Part D plan to show that you are not required to pay a higher Part D premium amount.

For more information about this notice or your prescription drug coverage, contact:

The Western Union Company Benefits Department
7001 E. Belleview Avenue
Denver, Colorado 80237
Phone: 720-332-1000
Email: **wubenefits@westernunion.com**

HIPAA SPECIAL ENROLLMENT NOTICE

NOTICE OF SPECIAL ENROLLMENT RIGHTS FOR HEALTH PLAN COVERAGE

If you have declined enrollment in The Western Union Company health plans for you or your dependents (including your spouse) because of other health insurance coverage, you or your dependents may be able to enroll in some coverages under these plans without waiting for the next Open Enrollment period, provided 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 eligible dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

The Western Union Company will also allow a special enrollment opportunity if you or your eligible dependents either:

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or
- Become eligible for a state's premium assistance program under Medicaid or CHIP.

For these enrollment opportunities, you will have 60 days – instead of 30 – from the date of the Medicaid/CHIP eligibility change to request enrollment in The Western Union Company group health plan. Note that this 60-day extension does not apply to enrollment opportunities other than due to the Medicaid/CHIP eligibility change.

Note: If your dependent becomes eligible for special enrollment rights, you may add the dependent to your current coverage or change to another medical plan.

To request a HIPAA special enrollment based on the events described above or obtain more information, contact the below or submit a ticket in the **People Services** portal.

The Western Union Company Benefits Department
7001 E. Belleview Avenue
Denver, Colorado 80237
Phone: 720-332-1000

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA) 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 medical carrier at the phone number listed on the back of your ID card.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT 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). If you would like more information on maternity benefits, call your medical carrier at the phone number listed on the back of your ID card.

TAXATION OF BENEFITS

The taxation of certain benefits may vary at the local, state and federal level. You should consult your tax advisor if you have any questions about the proper treatment of any benefits.

STATEMENT OF MATERIAL MODIFICATIONS

This enrollment guide constitutes a Summary of Material Modifications (SMM) or Summary of Material Reductions (SMR), as applicable, to The Western Union Company summary plan description (SPD). It is meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.

SUMMARY OF BENEFITS COVERAGE

A Summary of Benefits Coverage (SBC) for each of The Western Union Company-sponsored medical plans is provided by WEX with your COBRA enrollment packet. You may also request a paper copy by calling Mercer Marketplace 365+ at 866-867-6898.

MERCER'S ROLE AND COMPENSATION

Mercer Health & Benefits LLC facilitates the placement of insurance coverage on behalf of its clients.

Mercer is compensated through commissions that are calculated as a percentage of the insurance premiums charged by insurers. This compensation may include payment from insurers for marketing related expenses, technology investments or service fees. Our compensation may vary depending on the type of insurance purchased, the insurer selected and other factors such as the volume, growth and/or retention of Mercer's book of business with the insurer or service provider.

You may obtain additional information regarding our compensation by sending an email to **mercermarketplace.compensation@mercer.com**.

PAPERWORK REDUCTION ACT STATEMENT

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

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20220 or email **ebsa.opr@dol.gov** and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 12/31/2019)

PHYSICIAN DESIGNATION NOTICE

The Kaiser plans generally allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Kaiser Permanente at **www.kp.org**.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Kaiser Permanente or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Kaiser Permanente at **www.kp.org**.

THE WESTERN UNION COMPANY HIPAA PRIVACY NOTICE

Please carefully review this notice. It describes how medical information about you may be used and disclosed and how you can get access to this information.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on the use and disclosure of individual health information by The Western Union Company health plans. This information, known as protected health information, includes almost all individually identifiable health information held by a plan — whether received in writing, in an electronic medium or as an oral communication. This notice describes the privacy practices of these plans: All Cigna health plans as well as all Health Care Flexible Spending Accounts offered by The Western Union Company. The plans covered by this notice may share health information with each other to carry out treatment, payment or health care operations. These plans are collectively referred to as the Plan in this notice, unless specified otherwise.

THE PLAN'S DUTIES WITH RESPECT TO HEALTH INFORMATION ABOUT YOU

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. If you participate in an insured plan option, you will receive a notice directly from the Insurer. It's important to note that these rules apply to the Plan, not The Western Union Company as an employer — that's the way the HIPAA rules work. Different policies may apply to other The Western Union Company programs or to data unrelated to the Plan.

HOW THE PLAN MAY USE OR DISCLOSE YOUR HEALTH INFORMATION

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care treatment, payment activities and health care operations. Here are some examples of what that might entail:

- **Treatment** includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plan may share your health information with physicians who are treating you.
- **Payment** includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations, and provide reimbursement for health care. This can include determining eligibility, reviewing services for medical necessity or appropriateness, engaging in utilization management activities, claims management, and billing; as well as performing "behind the scenes" plan functions, such as risk adjustment, collection or reinsurance. For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan to coordinate payment of benefits.
- **Health care operations** include activities by this Plan (and, in limited circumstances, by other plans or providers), such as wellness and risk assessment programs, quality assessment and improvement activities, customer service and internal grievance resolution. Health care operations also include evaluating vendors; engaging in credentialing, training and accreditation activities; performing underwriting or premium rating; arranging for medical review and audit activities; and conducting business planning and development. For example, the Plan may use information about your claims to audit the third parties that approve payment for Plan benefits.

The amount of health information used, disclosed or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purposes, as defined under the HIPAA rules. If the Plan uses or discloses PHI for underwriting purposes, the Plan will not use or disclose PHI that is your genetic information for such purposes.

HOW THE PLAN MAY SHARE YOUR HEALTH INFORMATION WITH THE WESTERN UNION COMPANY

The Plan, or its health insurer or HMO, may disclose your health information without your written authorization to The Western Union Company for plan administration purposes. The Western Union Company may need your health information to administer benefits under the Plan. The Western Union Company agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. Benefits, payroll and finance staff are the only employees who will have access to your health information for plan administration functions.

Here's how additional information may be shared between the Plan and The Western Union Company, as allowed under the HIPAA rules:

- The Plan, or its insurer or HMO, may disclose "summary health information" to The Western Union Company, if requested, for purposes of obtaining premium bids to provide coverage under the Plan or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants' claims information, from which names and other identifying information have been removed.
- The Plan, or its insurer or HMO, may disclose to The Western Union Company information on whether an individual is participating in the Plan or has enrolled or dis-enrolled in an insurance option or HMO offered by the Plan.

In addition, you should know that The Western Union Company cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by The Western Union Company from other sources — for example, under the Family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation programs — is not protected under HIPAA (although this type of information may be protected under other federal or state laws).

OTHER ALLOWABLE USES OR DISCLOSURES OF YOUR HEALTH INFORMATION

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information about your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made — for example, if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative. The Plan also is allowed to use or disclose your health information without your written authorization for the following activities:

- **Workers' compensation:** Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with the laws
- **Necessary to prevent serious threat to health or safety:** Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (or to the target of the threat); includes disclosures to help law enforcement officials identify or apprehend an individual who has admitted participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody
- **Public health activities:** Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects
- **Victims of abuse, neglect, or domestic violence:** Disclosures to government authorities, including social services or protected services agencies authorized by law to receive reports of abuse, neglect or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk)
- **Judicial and administrative proceedings:** Disclosures in response to a court or administrative order, subpoena, discovery request or other lawful process (the Plan may be required to notify you of the request or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)
- **Law enforcement purposes:** Disclosures to law enforcement officials required by law or legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosures about a death that may have resulted from criminal conduct; and disclosures to provide evidence of criminal conduct on the Plan's premises
- **Decedents:** Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties
- **Organ, eye or tissue donation:** Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death
- **Research purposes:** Disclosures subject to approval by institutional or private privacy review boards, subject to certain assurances and representations by researchers about the necessity of using your health information and the treatment of the information during a research project
- **Health oversight activities:** Disclosures to health agencies for activities authorized by law (audits, inspections, investigations or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws
- **Specialized government functions:** Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates
- **HHS investigations:** Disclosures of your health information to the Department of Health and Human Services to investigate or determine the Plan's compliance with the HIPAA privacy rule

Except as described in this notice, other uses and disclosures will be made only with your written authorization. For example, in most cases, the Plan will obtain your authorization before it communicates with you about products or programs if the Plan is being paid to make those communications. If we keep psychotherapy notes in our records, we will obtain your authorization in some cases before we release those records. The Plan will never sell your health information unless you have authorized us to do so. You may revoke your authorization as allowed under the HIPAA rules. However, you can't revoke your authorization with respect to disclosures the Plan has already made. You will be notified of any unauthorized access, use, or disclosure of your unsecured health information as required by law.

The Plan will notify you if it becomes aware that there has been a loss of your health information in a manner that could compromise the privacy of your health information.

YOUR INDIVIDUAL RIGHTS

You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right. See the Contact section at the end of this notice for information on how to submit requests.

RIGHT TO REQUEST RESTRICTIONS ON CERTAIN USES AND DISCLOSURES OF YOUR HEALTH INFORMATION AND THE PLAN'S RIGHT TO REFUSE

You have the right to ask the Plan to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death — or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. If the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

An entity covered by these HIPAA rules (such as your health care provider) or its business associate must comply with your request that health information regarding a specific health care item or service not be disclosed to the Plan for purposes of payment or health care operations if you have paid out of pocket and in full for the item or service.

RIGHT TO RECEIVE CONFIDENTIAL COMMUNICATIONS OF YOUR HEALTH INFORMATION

If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.

If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

RIGHT TO INSPECT AND COPY YOUR HEALTH INFORMATION

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "designated record set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. The Plan may deny your right to access, although in certain circumstances, you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request (60 days if the health information is not accessible on site), the Plan will provide you with one of these responses:

- The access or copies you requested.
- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint.
- A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

You may also request your health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage. If the Plan doesn't maintain the health information but knows where it is maintained, you will be informed where to direct your request.

If the Plan keeps your records in an electronic format, you may request an electronic copy of your health information in a form and format readily producible by the Plan. You may also request that such electronic health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. Any charge that is assessed to you for these copies must be reasonable and based on the Plan's cost.

RIGHT TO AMEND YOUR HEALTH INFORMATION THAT IS INACCURATE OR INCOMPLETE

With certain exceptions, you have a right to request that the Plan amend your health information in a designated record set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the designated record set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal or administrative proceedings).

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will take one of these actions:

- Make the amendment as requested.
- Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint.
- Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

RIGHT TO RECEIVE AN ACCOUNTING OF DISCLOSURES OF YOUR HEALTH INFORMATION

You have the right to a list of certain disclosures of your health information the Plan has made. This is often referred to as an "accounting of disclosures." You generally may receive this accounting if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the Other Allowable Uses or Disclosures of your Health Information section earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health information for up to six years before the date of your request. You do not have a right to receive an accounting of any disclosures made in any of these circumstances:

- For treatment, payment or health care operations.
- To you about your own health information.
- Incidental to other permitted or required disclosures.
- Where authorization was provided.
- To family members or friends involved in your care (where disclosure is permitted without authorization).
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances.
- As part of a "limited data set" (health information that excludes certain identifying information).

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You'll be notified of the fee in advance and have the opportunity to change or revoke your request.

RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE FROM THE PLAN UPON REQUEST

You have the right to obtain a paper copy of this privacy notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

CHANGES TO THE INFORMATION IN THIS NOTICE

The Plan must abide by the terms of the privacy notice currently in effect. This notice takes effect on date]. However, the Plan reserves the right to change the terms of its privacy policies, as described in this notice, at any time and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this notice, you will be provided with a revised privacy notice.

COMPLAINTS

If you believe your privacy rights have been violated or your Plan has not followed its legal obligations under HIPAA, you may complain to the Plan and to the Secretary of Health and Human Services. You won't be retaliated against for filing a complaint. To file a complaint, contact the below or submit a ticket in the **People Services** portal.

The Western Union Company Benefits Department
7001 E. Belleview Avenue
Denver, Colorado 80237
Phone: 720-332-1000

CONTACT

For more information on the Plan's privacy policies or your rights under HIPAA, contact the below or submit a ticket in the **People Services** portal.

The Western Union Company Benefits Department
7001 E. Belleview Avenue
Denver, Colorado 80237
Phone: 720-332-1000

CONTACT INFORMATION

Have a question? Your answer is a call or a click away.

You may find many details about the Western Union benefit plans on the Mercer Marketplace 365+ website. However, you can use this table if you need to contact a benefit provider directly.

BENEFIT	CARRIER	PHONE	WEBSITE
Mercer Marketplace 365+	Mercer	1-866-867-6898	www.mercermarketplaceplus.com/westernunion
Medical	Cigna	1-800-244-6224	www.cigna.com
Medical	Kaiser	see below	www.kp.org
Prescription Home Delivery	Cigna	1-800-835-3784	www.cigna.com/coachrx
Dental	Cigna	1-800-244-6224	www.cigna.com
The TeleDentists	Cigna		www.theteledentists.com/cigna
Vision	VSP	1-800-877-7195	www.vsp.com
Telehealth	MDLIVE – Cigna	1-877-726-3171	www.cigna.com
Telehealth	Kaiser	1-866-454-8855	www.kp.org/getcare

KAISER PHONE NUMBERS BY REGION	
California	800-464-4000 or TTY 711 800-788-0616 (Spanish) 800-757-7585 (Chinese dialects)
Colorado	800-632-9700
Georgia	888-865-5813 or TTY 711
Hawaii	800-966-5955 or TTY 711
Mid-Atlantic States (DC, Maryland and Virginia)	800-777-7902 or TTY 711
Washington (Idaho and Washington)	888-907-4636 or TTY 711

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