Amazon and Subsidiaries
Full-Time In-House Temporary Staffing (ITS) Associates
Working 30+ Hours Per Week

ITS

Benefits Enrollment Guide

2017 – 2018

FOR PLAN YEAR APRIL 1, 2017 – MARCH 31, 2018

amazon

mybenefits

Welcome to Your Benefits

As a Full-Time ITS associate, you have access to a range of benefits. You also have some decisions to make. This Benefits Enrollment Guide* provides information about your choices and can help answer your questions. Use the guide now to enroll, and keep it as a reference to use throughout the year.

Write in your date of hire (as shown on your Offer Letter)		
Basic Life and AD&D + 30 calendar days from date of hire	**+30**	**This date is your benefits effective date**
Medical and Prescription Drug + 90 calendar days from date of hire	**+90**	**This date is your benefits effective date**

Questions?

In addition to this guide, these resources are available to help you choose the right benefits for you and your family.

- Watch the 2017-2018 videos at **amznsubsbenefits.com/itsft** to learn about your benefits.
- If you have questions about your benefits, call the Benefits Service Center at **1-855-331-9745**, Monday through Friday, 5 a.m. to 6 p.m. Pacific Time.
- Find additional resources and full details about all your plans on the Benefits Enrollment Tool. From the Amazon network, go to **benefits.amazon.com**. From outside the network, go to **amazon.ehr.com**.

*This document provides a general summary of benefits for which you may be eligible. It is not the plan document or a Summary Plan Description (SPD). To the extent any description herein conflicts with the terms of the applicable plan document or SPD, the plan document or SPD will control.

What's Inside

What Benefits Do I Get and When?

Here are the benefits available to you as a Full-Time ITS associate.

These benefits start right away:

- Medical Advice Line
- Amazon's Health Marketplace Tool
- Holiday Overtime Pay (time-and-a-half if you work on a holiday)
- Employee Assistance Program
- Support for Children with Developmental Disabilities
- Child, Elder, and Pet Care Referral Service
- Survivor Support and Transitional Support Financial Counseling

This benefit starts 30 days after your date of hire:

- Basic Life and AD&D Insurance for you

This benefit starts after you've worked 320 hours:

- Paid Time Off (hours are earned over time)

This benefit starts 90 days after your date of hire:

- Medical and Prescription Drug coverage for you*

You are automatically enrolled for employee only coverage in the Premera Blue Cross Health Savings Plan and Prescription drug coverage with Express Scripts 90 days after your date of hire, unless you decline coverage.

It's important for you to note the day that these benefits begin so that you can get the most from your benefits – such as setting up an appointment with your doctor for a check-up.

If you're still working at Amazon on your benefits effective date, and need to see a doctor but haven't received your Medical Plan ID card, call Premera Blue Cross at **1-877-995-2696**.

IMPORTANT: If you or your dependents have Medicare or will become eligible for Medicare in the next 12 months, the Medicare Prescription Drug program gives you more choices for your prescription drug coverage. Please see page 19 for more details. Please keep this booklet for your records.

*You can choose to cover eligible dependents, if you pay for their coverage. You can also decline coverage for yourself if you do not want it.

Paying to Cover Your Eligible Dependents*

Can I add my family members to my Medical and Prescription Drug coverage?

Yes. There are three important things to know if you want to cover family members.

1. **If you are a new hire, you must enroll eligible dependents within 60-90 days from your date of hire or during Open Enrollment.** Otherwise, you will be able to add eligible dependents only with a Qualifying Change in Status. For more information see page 5.
2. **You can cover only eligible dependents, including:**
   - **Spouse**. An eligible spouse is the person who is legally married to an eligible employee under the laws of any state or the District of Columbia, any territory or possession of the U.S., or any foreign jurisdiction having the legal authority to sanction marriages.
   - **Domestic partner (opposite or same sex)**. For benefits eligibility purposes, a domestic partner is someone with whom you live and share an enduring legal or personal relationship but are not joined to by a state or federally recognized marriage. Your domestic partner may be of the same or opposite sex, but you must be in an exclusive, committed relationship similar to marriage. You must verify your domestic partnership when you enroll. For the full definition of domestic partner, please go to the Benefits Enrollment Tool or call the Benefits Service Center.
   - **Your child(ren) up to age 26** (including children of a domestic partner, foster children, adopted children, stepchildren, and natural born children).
   - **Your disabled child(ren) age 26 or older**. The child must have become disabled before reaching age 26 and you must provide for 50% of his or her support.
3. **You will pay for eligible dependents' Medical and Prescription Drug coverage through paycheck contributions.**

Paycheck Contributions

If you cover eligible dependents, you will pay for their coverage through paycheck contributions. The contribution rates below are effective from April 1, 2017, to March 31, 2018.

Weekly Paycheck Contributions	
Employee Only (paid in full by Amazon)	**$0**
Employee + Spouse/Domestic Partner	**$55.81**
Employee + Child(ren)	**$43.20**
Employee + Family	**$99.01**

Paying for Domestic Partner Benefits

If you cover your non-tax dependent domestic partner and/or his or her children, the IRS considers both your and Amazon's contribution toward the cost of coverage as taxable income to you.

*The definitions of eligible dependents provided above are general in nature. For the definition applicable for a specific benefit, see the Summary Plan Description (SPD) for that benefit – available on the Benefits Enrollment Tool.

Who Pays for What?

Here's what Amazon pays for:

- Your premiums for Medical and Prescription Drug coverage (for employee only)
- Your premiums for Basic Life and AD&D Insurance (for employee only)
- Medical Advice Line
- Access to Amazon's Health Marketplace Tool
- Paid Time Off
- Holiday Overtime Pay
- Employee Assistance Program for you and any family members living with you
- Access to Support for Children with Developmental Disabilities
- Your membership in the Child, Elder, and Pet Care Referral Service
- Survivor Support and Transitional Support Financial Counseling

Here's what you pay for:

- Premiums for Medical and Prescription Drug coverage for eligible dependents you choose to cover
- Any out-of-pocket costs for the medical care and prescription drugs you and your dependents receive (see page 8 for more information)
- Doctor consultations via the Medical Advice Line*
- Any plans you purchase through Amazon's Health Marketplace Tool
- Any services you purchase through the Child, Elder, and Pet Care Referral Service

Health Insurance Marketplace Premium Subsidy and Tax Credit Reminder

You are not eligible to receive a premium subsidy or health insurance tax credit for medical coverage purchased from a Health Insurance Marketplace if you are eligible for an Amazon-sponsored medical plan. In general, only individuals who are ineligible for employer-sponsored group health plan coverage or who are eligible for such coverage but that coverage is determined to be unaffordable or does not meet certain required minimum standards are eligible for a premium subsidy or tax credit for coverage purchased through the Health Insurance Marketplace. Because Amazon's medical plan options all satisfy these requirements, you are not eligible to receive a premium subsidy or tax credit for medical coverage even if you elect not to participate in an Amazon-sponsored medical plan and purchase medical coverage from the Health Insurance Marketplace.

* The benefit will be paid at the in-network level and is covered as any other office visit. All office visits are subject to your annual deductible, copays/coinsurance, and out-of-pocket maximums.

When Your Benefits End

Your benefits end on the Saturday of or following your last day at Amazon.

- If your last day at work is a Saturday, your coverage ends that day.
- If your last day at work is a Sunday or any day Monday through Friday, your coverage ends the following Saturday.

If you are paying premiums to cover eligible dependents, those payments will stop on the last day of the pay period that falls on or after your last day at Amazon.

Are Changes Allowed During the Year?

You can make changes to some of your benefit elections during the year if you have a Qualifying Change in Status, such as marriage or the birth or adoption of a child. Any event that changes your legal marital status or your or your spouse's employment status would also qualify.

For the full list of qualifying life events, visit the Benefits Enrollment Tool and review the Amazon.com Section 125 plan document.

Please note: You have 60 calendar days starting on the date the event occurred to make changes to your benefit elections. To make a change, log in to the Benefits Enrollment Tool or contact the Benefits Service Center at **1-855-331-9745**.

What Happens If You Miss the Enrollment Deadline?

If you are a new associate and you take no action, you will be automatically enrolled in Basic Life and Accidental Death and Dismemberment (AD&D) Insurance and Medical/Prescription Drug coverage. Your coverage for Basic Life and AD&D Insurance will start 30 days after your date of hire. Your coverage for Medical/Prescription Drug coverage for ITS associate only will start 90 days after your date of hire. Your eligible dependents will not have Medical/Prescription Drug coverage.

Enrolling Is Quick and Easy

Get Started:

- From the Amazon network, go to **benefits.amazon.com**.
- From outside the network, go to **amazon.ehr.com**.

Enroll:

1. Enter your **Amazon Login ID** and your unique **password**. If this is your first time enrolling or you have forgotten your password, see "Create or Reset Your Password."
2. On the Welcome page, select "Get Started." You will be guided through your enrollment choices.
3. As you make your elections in the Benefits Enrollment Tool, you'll see each benefit get added to your cart as you go.
4. Click "Checkout" to complete your enrollment and print your confirmation page.

Create or Reset Your Password:

1. At the login page, click "Create or reset your Benefits Enrollment Tool password."
2. On the Account Registration page, enter your **Amazon Login ID**, the last four digits of your Social Security Number, your home ZIP code as listed in PeoplePortal, and your birth date.
3. On the Account Setup page, create a unique **password**.

Questions?

If you have questions, visit the Benefits Enrollment Tool (**benefits.amazon.com** from the Amazon network; **amazon.ehr.com** from outside the network) or call the Benefits Service Center at **1-855-331-9745**.

Health Benefits

Medical and Prescription Drug Coverage

Once you're covered, you pay nothing for preventive care services provided by an in-network provider, like an annual check-up, immunizations, and certain health screenings.

For other medical services and prescription drugs, you will pay the full cost until the total you've paid reaches a certain amount. This amount is called a deductible. After you meet the deductible, you will pay just 10% of the cost for most care you receive from providers in the plan's network.

Your Medical and Prescription Drug Coverage Starts Automatically 90 Days After Your Date of Hire

If you want Medical and Prescription Drug coverage just for yourself...

You don't have to do anything. We've already signed you up for this benefit, and Amazon will pay your premiums (for ITS associate only)! Your coverage will start 90 days after your date of hire.

If you don't want Medical and Prescription Drug coverage for yourself...

You have to tell us you want to decline coverage before the coverage starts (within your 30 day enrollment window, which begins 60 days after your hire date).

If you want to add eligible dependents to your coverage...

You have to tell us within your 30 day enrollment window, which begins 60 days after your hire date. If you miss this deadline, you can add eligible dependents only if you have a Qualifying Change in Status or during annual Open Enrollment.

Remember, Amazon pays premiums for your coverage, but you must pay to cover any eligible dependents with paycheck contributions that are deducted from your pay. To see how much coverage would cost for eligible dependents, see page 3.

The Health Savings Medical Plan is an HSA-qualified plan

This Health Savings Plan qualifies for use with a Health Savings Account (HSA), but does not come with an HSA. You can choose to open an HSA on your own and use it with this plan. If you're interested in an HSA, talk to your bank or other financial institution.

Medical Advice Line

You and your family have access to Amazon's Medical Advice Line at **1-877-995-2696** – 24 hours a day, 7 days a week. The Medical Advice Line can connect you to a doctor.

Doctors are available around-the-clock to resolve many of your medical issues and prescribe medication – and you don't even have to leave home.

You can speak with a doctor who can:

- **Diagnose an illness**
- **Recommend treatment**
- **Prescribe short-term prescriptions**

The cost to speak with a doctor is much less than the cost to visit an urgent care facility or emergency room. The benefit is covered as any other office visit. All office visits are subject to your annual deductible, copays/coinsurance, and out-of-pocket maximums.

Health Savings Plan - Premera Blue Cross

The Premera Blue Cross Health Savings Plan is a high-deductible health plan. When you receive care or prescription drugs, you have to meet the deductible before the plan starts paying. If you cover one or more dependents on this plan, the entire family must meet the deductible before the plan covers a share of the cost. It can be met by one individual or the entire family in combination. After that, you will pay 10% of the cost for most in-network care and prescription drugs. You don't pay for preventive services, such as annual exams or immunizations — the plan pays 100%.

Health Savings Plan Summary – What You Pay

PLAN BASICS	
Out-of-network coverage*	Yes
Need referral to see a specialist?	No
Who pays first?	You pay 100% of cost until your deductible is met
Deductible	**For medical and prescription drug expenses:** $1,500/employee $3,000/employee + spouse/ domestic partner or child(ren) $4,500/family
Type of deductible***	Combined
Annual out-of-pocket maximum (including deductible and coinsurance)	**For medical and prescription drug expenses:** $3,000/person $6,000/employee + spouse/ domestic partner or child(ren) ($3,000/person max) $9,000/family ($4,500/person max)
Preventive care (plan pays 100% in-network)	$0
PRESCRIPTION DRUGS	
Retail (30-day supply)	10% after deductible
Mail order (90-day supply)	10% after deductible
OUTPATIENT MEDICAL SERVICES**	
Primary care office visit	**In-network:** 10% after deductible **Out-of-network:*** 30% after deductible
Specialist office visit	
Mental health outpatient visit	
Substance abuse outpatient visit	
Outpatient surgery	
INPATIENT HOSPITAL SERVICES	
Inpatient admission (room and board and other charges related to a hospital stay)	**In-network:** 10% after deductible **Out-of-network:*** 30% after deductible

FAMILY PLANNING/MATERNITY CARE**	
Prenatal/maternity care – office visit	**In-network:** 10% after deductible **Out-of-network:*** 30% after deductible
Prenatal/maternity hospital birth and delivery	
Infertility treatment (up to $15,000 lifetime maximum benefit)	
EMERGENCY MEDICAL SERVICES	
Ambulance (travel to nearest hospital where treatment can be obtained)	**In-network:** 10% after deductible **Out-of-network:*** 10% after deductible
Emergency room	**In-network:** 10% after deductible **Out-of-network:*** 10% after deductible
Urgent care visit	**In-network:** 10% after deductible **Out-of-network:*** 30% after deductible
MISCELLANEOUS SERVICES	
Chiropractic visit (20 visits maximum per plan year)	**In-network:** 10% after deductible **Out-of-network:*** 30% after deductible
Outpatient rehabilitation (physical, occupational, and speech therapy, 60 visits maximum per plan year)	**In-network:** 10% after deductible **Out-of-network:*** 30% after deductible
Alternative care benefit (licensed massage therapist, licensed acupuncturist services, 18 visits maximum per plan year)	**In-network:** 10% (deductible waived) **Out-of-network:*** 10% (deductible waived)
Transgender surgery	**In-network:** 10% after deductible **Out-of-network:*** 30% after deductible
Applied Behavioral Analysis (ABA) Therapy	**In-network:** 10% after deductible **Out-of-network:*** 10% after deductible
Medical Care Outside the United States	**In-network:** 10% after deductible **Out-of-network:*** 10% after deductible

* Subject to allowed amounts. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. Please go to the Benefits Enrollment Tool for the applicable Summary Plan Description.
** To the extent the visit or any services provided during the visit constitute preventive care, the plan pays 100% and you pay $0.
*** For deductible definitions see page 18.

Prescription Drug Plan - Express Scripts

You are automatically enrolled in the pharmacy plan when you are enrolled in the Premera Blue Cross Health Savings Plan. Your prescription drug coverage is managed and administered by Express Scripts. See the Health Savings Plan Summary on the previous page for more information about what you pay under Prescription Drug coverage.

Express Scripts provides access to a nationwide network of pharmacies, as well as mail order and specialty pharmacy services through Accredo. Your costs are based on the types of drugs you purchase and where you buy them. For more information visit **express-scripts.com/amazon**.

Ways to Save on Prescription Drugs

You pay for your prescription based on the type of drug you're taking. Tier 1 drugs are the least expensive and Tier 3 drugs are the most expensive. Here are the three basic types of prescription drugs

- **Generic (Tier 1):** These are lower cost alternatives to brand-name drugs. They are just as effective as brand-name drugs and must meet the same federal quality and safety requirements as their brand name counterparts. Ask your doctor if a generic alternative is right for you.
- **Preferred brand-name (Tier 2):** These drugs are preferred based on their safety, effectiveness, and cost. These are generally brand-name drugs that don't have generic substitutes.
- **Non-preferred brand-name (Tier 3):** These are brand-name drugs for which generic alternatives are available. These drugs will typically cost you the most.

If you are taking a medication that is not on the preferred list, ask your doctor to consider prescribing a lower-cost generic or preferred brand-name drug. To find out which drugs are preferred, log in to **express-scripts.com/amazon** or call Express Scripts at **1-844-626-9387**. When maintenance medication is needed (medication used long-term to treat a chronic condition), consider Express Scripts Home Delivery. It is convenient and cost-effective.

Unless your doctor indicates "dispense as written" when prescribing you a brand-name drug, you may receive a generic drug if one is available. If your doctor does not indicate "dispense as written" and you request the brand-name drug when a generic alternative is available, you will pay the difference in cost between the brand-name and the generic drug. More information on drug costs under your plan can be found at www.express-scripts.com/amazon using the 'Compare prescription medication costs' tool.

Your pharmacy and ESI will coordinate in real-time and may even contact your provider to ensure that your prescriptions are appropriate and safe based on your medical history. If you take medications for certain conditions, such as migraines, diabetes, high blood pressure, or asthma, your pharmacy may need to coordinate with ESI and your health care provider before your prescription is covered.

The plan provides each member up to four early refills per year as needed for personal or business travel. Please call Express Scripts at **1-844-626-9387** to request an early refill prior to submitting your prescription refill request by mail order or at a retail pharmacy.

To see if your prescription requires pre-approval or prior authorization, visit express-scripts.com/amazon, or call Express Scripts at **1-844-626-9387**.

Specialty Medications

Specialty medications are usually self-injected and very expensive drugs that are used to treat complex conditions.

These drugs are limited to a 30-day supply and will be covered after the second fill only if purchased through Accredo Specialty Pharmacy. Specialty drug coverage and pricing information is available at **express-scripts.com/amazon** or by calling **1-844-626-9387**.

For questions, contact Accredo Health Group (an Express Scripts company) at **1-877-244-2995**.

Summary Plan Description (SPD)

The Summary Plan Description (SPD) is the official source for all information about our Medical and Prescription Drug coverage. You can get a copy of the SPD on the Benefits Enrollment Tool at **amazon.ehr.com** or by calling the Benefits Service Center at **1-855-331-9745**.

Amazon's Health Marketplace Tool

The Affordable Care Act requires most Americans to have medical insurance coverage for themselves and their dependents. If you don't have this coverage, you may have to pay a penalty when you file your taxes. If you become ineligible for Amazon benefits or choose to buy health insurance coverage through the Marketplace, Amazon's Health Marketplace Tool is a resource for you and your family.

While you may be eligible for health insurance coverage through Amazon's Medical/ Prescription Drug plan, you can find other options also available to you that meet all requirements under the Affordable Care Act.

The Amazon Health Marketplace Tool is your online resource to:

1. **Learn.** Check out quick, helpful videos and information on the Affordable Care Act and how it impacts you.
2. **Calculate**. See if you are eligible for Medicaid or a federal subsidy and identify which coverage options are available to you.
3. **Enroll**. Compare plans and find affordable coverage for you and your family.

Visit the Amazon Health Marketplace Tool at **healthcoverageresources.com/amazon/home** or call **1-844-730-8915**. Learn about federal subsidies, health care laws and how they can affect you.

How to Find a Doctor

To find a doctor or other medical provider in the network, go to the Find a Doctor tool at **premera.com/amazon**.

You can also find in-network providers using the free Premera Blue Cross mobile app. In Washington State, the network is called Heritage and Heritage Plus 1. Everywhere else, it's called the BlueCard® PPO network.

Financial Security Benefit

Financial security benefits are designed to protect your income and save you money.

Basic Life and Accidental Death and Dismemberment (AD&D) Insurance underwritten by Securian Life

The Company provides you with Basic Life and Accidental Death and Dismemberment (AD&D) Insurance at no cost to you. This insurance can help your loved ones financially if you are seriously injured due to an accident or die.

Basic Life pays your beneficiary $25,000 upon your death. AD&D pays an additional benefit up to $25,000 to your beneficiary if you die, or to you if you suffer an injury due to a covered accident. If your death is the result of a covered accident, both Basic Life and AD&D pay benefits to your beneficiary. Benefits for Life and AD&D are reduced to 65% at age 65 and to 50% at age 70.

Make Sure Your Benefit Goes to the Right Person!

Your beneficiary is the person who receives your Life Insurance and AD&D benefits if you die. Naming your beneficiary ensures the money will go to the right person. You can designate more than one beneficiary, and you can change your beneficiaries at any time. You can also name a trust, charity, or estate to receive your benefit.

To choose a beneficiary, log in to the Benefits Enrollment Tool at **amazon.ehr.com** or call the Benefits Service Center at **1-855-331-9745**.

Coverage starts 30 days after your date of hire

We've already signed you up for this benefit.

Important Reminder

Any material omission or misrepresentation in answering questions when enrolling or making changes, or any misrepresentation or abuse of participation in any program, may result in denial of benefits, termination of coverage and enrollment for you and your dependents and/or disciplinary action including and up to termination of your employment.

Work/Life Benefits

The Company cares about your health and well-being, both on and off the job. Your work/life balance benefits are here to help make life a little bit easier, at no cost to you.

Paid Personal Time (PPT)

After you've worked 320 hours, you'll receive five hours of PPT. After that, you'll earn another five hours of PPT for every 320 hours you work. At the time clock, you can review your PPT balance and request time off. Once you begin earning PPT, be sure to check your balance so that you can use your PPT. When you leave Amazon, you will not be paid for unused PPT unless required by law.

Holiday Overtime Pay

If you work on any of these Amazon holidays, you'll earn time and a half.

- New Year's Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Christmas Day

Employee Assistance Program (EAP)

Too much to do, and too little time to get it all done? Work, family, relationships, even planning vacation travel can add up to too much stress in your life. That's where GuidanceResources®, Amazon's Employee Assistance Program (EAP), can help.

GuidanceResources is administered by ComPsych and gives you free, confidential support, resources, and referrals for every aspect of your work and personal life. GuidanceResources is available 24 hours a day, 7 days a week for you and family members living with you.

Call the EAP for resources and referrals for counseling services related to bereavement, marital issues, depression, anxiety, stress, and other concerns. Additionally, GuidanceResources can assist with legal and financial questions, finding child or elder care, moving, and other personal needs. Up to three counseling sessions are available for each issue

Visit **guidanceresources.com** or call **1-855-435-4333**. Use Company ID "AmazonEAP" when registering online for the first time.

Did You Know?

The Employee Assistance Program (EAP) provides legal and financial services in addition to counseling services.

Support for Children with Developmental Disabilities

Rethink Benefits is a program to help children who have autism and/or other developmental disabilities build the skills they need to reach their fullest potential. Families can access a variety of resources and support at no cost, including:

- Live clinical support
- An innovative online library of over 1,500 video-based lessons based on proven applied behavior analysis (ABA) teaching techniques
- Research-based assessments, which help guide parents and service providers in building unique treatment plans individualized for the particular needs of their child
- Rethink's Training Center, which helps train parents and service providers in ABA teaching techniques and strategies for implementing lessons
- Data collection tools to help monitor your child's progress and guide instruction

These comprehensive resources have been developed by a team of experienced, caring clinicians and are continually updated to offer you the latest treatment techniques and research. To access Rethink Benefits, register online at **amazon.rethinkbenefits.com** or call **1-877-988-8871.**

Survivor Support and Transitional Support Financial Counseling

A life-threatening illness or death of a loved one can be one of life's most overwhelming events. Crucial decisions will likely have to be made that can affect your family's financial well-being over the long term. To help you and your family during such a difficult time, you have access to objective and professional guidance from Ayco – a leading expert in financial counseling services. Ayco's TransitionalSupport℠ and SurvivorSupport® services can help you make benefit plan decisions, update or initiate estate planning documents, and settle a family member's estate. For more information, please go to the Survivor documents on the Benefits Enrollment Tool under the Benefits tab or call **1-800-235-3417**.

Child, Elder, and Pet Care Referrals and Assistance

Through Care Advantage you have free* memberships to **Sittercity** (babysitters, nannies, special needs caregivers, pet sitters, etc.) and **Years Ahead** (senior care needs, access to in-home health care, companion care, assisted living facilities, and nursing homes). To activate your Care Advantage membership, visit **careadvantage.com/amazon** or call **1-844-858-8336.**

Sittercity

Sittercity.com connects you with babysitters, nannies, special needs caregivers, pet sitters, and other household help. You can search by location or other qualifications or post a job on the site so available caregivers can apply directly to you. Review caregiver profiles that include photos, biographies, experience, hourly rates, reviews by other members, and references to find the perfect caregiver for your care needs. You can instantly run standard background checks on potential caregivers at no extra charge to you.

Years Ahead

Years Ahead is a comprehensive solution for your senior care needs. You can take a needs assessment to help determine the level of care needed for your loved one, or you can call and speak with a Certified Senior Care Advisor that can help you through the process. Years Ahead provides access to both in-home health care and companion care, as well as specialized care facilities, including assisted living facilities and nursing homes.

* The Company pays for website access while you pay for the actual care you need.

Important Notices

The following are some of the required notices that must be distributed to enrollees in the Amazon Corporate LLC Group Health & Welfare Plan (the "Plan"). Please refer to the Summary Plan Description (SPD) for the component medical benefit under the Plan in which you participate for further information about your benefits, including other required notices. SPDs are available through the Benefits Service Center at **1-855-331-9745** and on the Benefits Enrollment Tool (benefits.amazon.com from an Amazon computer or network; amazon.ehr.com from any other computer or network). You also have the right to request a printed copy of your SPD. If you would like to do so, please contact the Benefits Service Center at **1-855-331-9745**.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep Amazon informed of any changes in your or your family members' addresses. You should also keep a copy of any communication you send to Amazon.

Important Notices About Health Care Reform

Waiving Coverage

You may choose to waive coverage under the medical benefit options under the Plan, but before you do, keep in mind that the Affordable Care Act — also known as "health care reform" — requires most individuals to pay a tax penalty unless they have health care coverage that satisfies certain minimum standards. Because each of the Plan's medical benefit options satisfies the applicable minimum standards, individuals enrolled in medical benefits under the Plan will not be subject to the penalty. See the section "Health Care Reform Update" below for more information.

Summary of Benefits and Coverage (SBC)

You have access to a Summary of Benefits and Coverage (SBC). This document includes key provisions, limitations, cost-sharing and examples explaining how your medical benefit works. The SBC is available on the Benefits Enrollment Tool at amazon.ehr.com. You may also receive a paper copy on request. If you would like to do so, please contact the Benefits Service Center at **1-855-331-9745**.

Value of Health Plan on W-2

As required by health care reform, the full dollar value of your health plan will be noted on your W-2. This is being provided for informational purposes only. The value of your health plan is not taxable income unless special circumstances apply.

Health Care Reform Update

Under the Affordable Care Act, most individuals will be required to pay a "shared responsibility" penalty unless they have health care coverage that satisfies certain minimum standards. This rule is also known as the individual coverage mandate. Unless you're exempt from this mandate, you may be subject to penalties if you fail to maintain such health care coverage for yourself, your nonexempt spouse with whom you file a joint tax return and your nonexempt tax dependents, which may include certain domestic partners. Please see your tax advisor for more details.

Because each of Amazon's medical benefit options satisfies or exceeds the applicable minimum standards, individuals enrolled in medical benefits under the Plan will not be subject to the penalty. This means that, in most cases, Amazon provides better coverage at a lower cost to you than the health plan options available in the Health Insurance Marketplace. When you are covered by one of the Plan's medical options, Amazon pays most of your premium and you pay for your share of the premium on a pre-tax basis, which benefits you.

Medical Coverage for Non-Benefit Eligible Employees

Each year Amazon will evaluate eligibility for Amazon-sponsored medical coverage for part-time and other non-benefit eligible employees who are not currently covered under one of the medical benefit options under the Plan using the "lookback measurement method." The Affordable Care Act requires employers like Amazon to offer medical benefits to employees who work 30 or more hours per week. Amazon measures actual hours worked by all non-benefit eligible employees to determine whether any such employee has worked sufficient hours to become eligible. Employees who become eligible for benefits under this method will be notified of their eligibility.

Health Insurance Marketplace

The Health Insurance Marketplace (also known as the health insurance "exchange") allows individuals to compare and purchase private health insurance plans. Some individuals may be eligible for a premium subsidy from the federal government to assist in paying for such plans.

Amazon's Health Marketplace Tool is a resource for you and your family to learn about federal subsidies, health care laws and how they can affect you.

Visit the Amazon Health Marketplace Tool at **healthcoverageresources.com/amazon/home** or call **1-844-730-8915**.

Please note that if you purchase coverage through the Marketplace despite being eligible for Amazon's medical Plan:

- You will not receive a contribution from Amazon to help you pay the cost of that coverage.
- You will not be able to pay for that coverage on a pre-tax basis.
- You will not be eligible for any federal premium subsidies or tax credits to assist you in paying for the cost of the Marketplace coverage – because all of our medical options under the Plan exceed the federally required standards for "minimum value" and "affordability."

Social Security Number Requirement

Insurance companies and plan sponsors of self-insured group health plans are federally mandated to obtain Social Security Numbers (SSNs) for all employees and covered dependents and to report SSNs

to certain federal agencies in connection with health care coverage. The Centers for Medicare & Medicaid Services require this information to determine the primary payer between Medicare and the Amazon Medical Plan and to avoid processing errors. Additionally, SSNs are necessary for reporting to the IRS whether an employer-sponsored group health plan provides minimum essential coverage to all of its full-time employees and their dependents under the Affordable Care Act. You may be prompted to provide the SSN of a dependent upon enrollment of such dependent in the Plan.

Notice of Special Enrollment Rights

THIS NOTICE DESCRIBES SPECIAL CIRCUMSTANCES WHICH MAY ALLOW YOU AND YOUR ELIGIBLE DEPENDENTS TO ENROLL IN AMAZON HEALTH COVERAGE DURING THE YEAR. PLEASE REVIEW IT CAREFULLY.

Amazon sponsors a group health plan (the "Plan") to provide coverage for health care services for our employees and their eligible dependents. Our records show that you are eligible to participate, which requires that you complete enrollment in the Plan and pay your portion of the cost of coverage through payroll deductions or decline coverage. A federal law called the Health Insurance Portability and Accountability Act ("HIPAA") requires we notify you about your right to later enroll yourself and eligible dependents for coverage in the Plan under "special enrollment provisions" described below.

Special Enrollment Provisions

- Loss of Other Coverage. If you decline enrollment for yourself or for an eligible dependent because you had other group health plan coverage or other health insurance, you may be able to enroll yourself and your dependents in the Plan if you or your dependents lose eligibility for that other coverage, or if the other employer stops contributing toward your or your dependents' other coverage. You must request enrollment within 60 days after you or your dependents' other coverage ends, or after the other employer stops contributing toward the other coverage. Please contact the Benefits Service Center at **1-855-331-9745** for details, including the effective date of coverage added under this special enrollment provision (contact information provided below).

- New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you gain a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents in the Plan. You must request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption. In the event you acquire a new dependent by birth, adoption, or placement for adoption, you may also be able to enroll your spouse in the Plan, if your spouse was not previously covered. Please contact the Benefits Service Center at **1-855-331-9745** for details, including the effective date of coverage added under this special enrollment provision (contact information provided below).

- Enrollment Due to Medicaid/CHIP Events. If you or your eligible dependents are not already enrolled in the Plan, you may be able to enroll yourself and your eligible dependents in the Plan if: (i) you or your dependents lose coverage under a state Medicaid or children's health insurance program (CHIP), or (ii) you or your dependents become eligible for premium assistance under state Medicaid or CHIP. You must request enrollment within 60 days from the date of the Medicaid/CHIP event. Please contact the Benefits Service Center at **1-855-331-9745** for details, including the effective date of coverage added under this special enrollment provision (contact information provided below).

Contact Information

If you have any questions about this notice or about how to enroll in the Plan, please contact the Benefits Service Center at **1-855-331-9745**.

Mental Health Parity and Addiction Equity Act Notice

Amazon's group medical plans provide and administer mental health and substance abuse benefits as required by the Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"). For more information about Amazon's group medical plans and their compliance under the MHPAEA, please contact the Benefits Service Center at **1-855-331-9745**.

Women's Health and Cancer Rights Act Notice

The Women's Health and Cancer Rights Act is a Federal law. It protects breast cancer patients who elect breast reconstruction due to a mastectomy. Health care plans must cover reconstructive surgery following a mastectomy, as determined in consultation with the attending physician and the patient. Reconstructive benefits must include 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
- Prosthesis and physical complications at all stages of mastectomy, including lymphedemas

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan. Call the Benefits Service Center at 1-855-331-9745 for more information.

Newborns' and Mothers' Health Protection Act (NMHPA)

Maternity Stays

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).

HIPAA Privacy Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY THE SELF-INSURED BENEFIT COMPONENTS OF THE PLAN AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Summary: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires health plans to notify plan participants and beneficiaries about its policies and practices to protect the confidentiality of their health information. This document is intended to satisfy HIPAA's notice requirement with respect to all health information created, received, or maintained by the self-insured components of the Amazon Corporate LLC Group Health & Welfare Plan (the "Plan"), as sponsored by Amazon (the "Company").

The Plan needs to create, receive, and maintain records that contain health information about you to administer the Plan and provide you with health care benefits. This notice describes the Plan's health information privacy policy with respect to your medical and prescription drug benefits. The notice tells you the ways the Plan may use and disclose health information about you and describes your rights and the obligations under the Plan regarding the use and disclosure of your health information. However, it does not address the health information policies or practices of your health care providers.

Restrictions on Plan's Disclosing Your PHI to Your Family

Due to legal requirements, in most circumstances the Plan cannot reveal protected health information ("PHI") about you to other members of your family. There are three major exceptions:

1. In most situations, you (or your spouse/domestic partner) can receive PHI about your child, if your child is a minor. For example, you could call to inquire about the basis for the Plan's denying payment of expenses for care provided to your three-year-old daughter.

2. The Plan will permit you and your spouse or qualifying domestic partner to receive a limited amount of information about each other or other adult family members. This exception would not allow other persons to receive your PHI. For example, under this exception, the Plan could not provide information about a retiree's claim to an adult child of the retiree.

    - The information that the employee or retiree and his or her spouse/domestic partner can receive is information about the family member's eligibility for the Plan, enrollment in the Plan, whether a claim has been paid, and the amount paid. To receive information about another family member's claim, you (or your spouse or qualifying domestic partner) may be asked some questions to determine whether you have been asked to find out about the claim. For example, the caller should be familiar with information such as the service date, the name of the provider, and the type of provider.

    - If the claim has been denied, the Plan can tell you (or your spouse or domestic partner) only the general reason why the claim has not been paid. For example, the Plan could tell your spouse or qualifying domestic partner that your claim was denied because the deductible has not been satisfied, because an annual or lifetime limit has been reached, or because the expense is not a covered expense under the Plan.

    - Additional information such as the medical diagnosis, the type of service performed, or the name or specialty of the provider cannot be provided. The service recipient must call to get that information.

3. You (or the other adult family member) may directly communicate your agreement to release your PHI. For example, if you wanted your spouse/domestic partner to call your plan provider and ask about the reimbursement of certain medical expenses, you could join the first part of the call and tell provider that you agree to your spouse's receiving PHI as he or she inquires about your claim. However, your spouse could not simply say that you had agreed. You must provide that information yourself. The family member whose PHI would be discussed may provide a written authorization allowing the Plan to discuss his or her PHI with any other person. There are detailed requirements for an authorization. Contact your medical plan provider for a copy of a model authorization that you can use for this purpose.

The Plan's Pledge Regarding Health Information Privacy

The privacy policy and practices of the Plan protect confidential health information that identifies you or could be used to identify you and relates to a physical or mental health condition or the payment of your health care expenses. This individually identifiable health information is known as protected health information ("PHI"). Your PHI will not be used or disclosed without a written authorization from you, except as described in this notice or as otherwise permitted by federal and state health information privacy laws.

Privacy Obligations of the Plan

The Plan is required by law to:

- Make sure health information that identifies you is kept private
- Give you this notice of the Plan's legal duties and privacy practices with respect to health information about you
- Follow the terms of the notice that are currently in effect
- Notify you following a breach of unsecured PHI

How the Plan May Use and Disclose Health Information About You

The following are the different ways the Plan may use and disclose your PHI. Note that receipt of a written authorization from you is a precondition for most uses and disclosures of psychotherapy notes (when these notes are maintained by the Plan), uses and disclosures of PHI for marketing purposes, and disclosures that constitute the sale of PHI.

- **For Treatment**. The Plan may disclose your PHI to a health care provider who renders treatment on your behalf. For example, if you are unable to provide your medical history as the result of an accident, the Plan may advise an emergency room physician about the types of prescription drugs you currently take.

- **For Payment**. The Plan may use and disclose your PHI so claims for health care treatment, services, and supplies you receive from health care providers may be paid according to the Plan's terms. For example, the Plan may receive and maintain information about surgery you received to enable the Plan to process a hospital's claim for reimbursement of surgical expenses incurred on your behalf.

- **For Health Care Operations**. The Plan may use and disclose your PHI to enable it to operate more efficiently or to make certain all of the Plan's participants receive their health benefits. For example, the Plan may use your PHI for case management or to perform population-based studies designed to reduce health care costs. In addition, the Plan may use or disclose your PHI to conduct compliance reviews, audits, actuarial studies, and/or for fraud and abuse detection. The Plan may also combine health information about many Plan participants and disclose it to the

Company in summary fashion so it can decide what coverages the Plan should provide. The Plan is prohibited from using or disclosing PHI that is genetic information for underwriting purposes (with the exception of PHI that is genetic information). The Plan may remove information that identifies you from health information disclosed to the Company so it may be used without the Company learning who the specific participants are.

- **To the Company**. The Plan may disclose your PHI to designated Company personnel so they can carry out their Plan-related administrative functions, including the uses and disclosures described in this notice. Such disclosures will be made only to those Company employees who require the information in order to perform their Plan administrative services or functions. These individuals will protect the privacy of your health information and ensure it is used only as described in this notice or as permitted by law. Unless authorized by you in writing, your health information:

  1. May not be disclosed by the Plan to any other Company employee; and

  2. Will not be used by the Company for any employment-related actions and decisions or in connection with any other employee benefit plan sponsored by the Company.

- **To a Business Associate**. Certain services are provided to the Plan by third parties known as "business associates." For example, the Plan may input information about your health care treatment into an electronic claims processing system maintained by the Plan's business associate so your claim may be paid. In so doing, the Plan will disclose your PHI to its business associate so it can perform its claims payment function. However, the Plan will require its business associates, through contract, to appropriately safeguard your health information.

- **Treatment Alternatives**. The Plan may use and disclose your PHI to tell you about possible treatment options or alternatives that may be of interest to you.

- **Health-Related Benefits and Services**. The Plan may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you.

- **Individual Involved in Your Care or Payment of Your Care**. The Plan may disclose PHI to a close friend or family member who is involved in or who helps pay for your health care. The Plan may also advise a family member or close friend about your condition, your location (for example, that you are in the hospital), or your death.

- **As Required by Law**. The Plan will disclose your PHI when required to do so by federal, state, or local laws, including those that require the reporting of certain types of wounds or physical injuries.

Special Use and Disclosure Situations

The Plan may also use or disclose your PHI under the following circumstances:

- **Lawsuits and Disputes**. The Plan may disclose your PHI in response to a court or administrative order, a subpoena, warrant, discovery request, or other lawful due process, subject to certain conditions.

- **Law Enforcement**. The Plan may release your PHI if asked to do so by a law enforcement official, for example, to identify or locate a suspect, material witness, or missing person or to report a crime, the crime's location or victims, or the identity, description, or location of the person who committed the crime.

- **Workers' Compensation**. The Plan may disclose your PHI to the extent authorized by and to the extent necessary to comply with workers' compensation laws and/or other similar programs.

- **Military and Veterans**. If you are or become a member of the U.S. Armed Forces, the Plan may release medical information about you as deemed necessary by military command authorities.

- **To Avert Serious Threat to Health or Safety**. The Plan may use and disclose your PHI when necessary to prevent a serious threat to your health and safety, or to the health and safety of the public or another person.

- **Public Health Risks**. The Plan may disclose health information about you for public health activities. These activities include preventing or controlling disease, injury, or disability; reporting births and deaths; reporting child abuse or neglect; reporting reactions to medication or problems with medical products; or notifying people of recalls of products they have been using.

- **Health Oversight Activities**. The Plan may disclose your PHI to a health oversight agency for audits, investigations, inspections, and licensure necessary for the government to monitor the health care system and government programs.

- **Research**. Under certain circumstances, the Plan may use and disclose your PHI for medical research purposes.

- **National Security, Intelligence Activities, and Protective Services**. The Plan may release your PHI to authorized federal officials:

  1. For intelligence, counterintelligence, and other national security activities authorized by law

  2. To enable them to provide protection to the members of the U.S. government or foreign heads of state, or to conduct special investigations

- **Organ and Tissue Donation**. If you are an organ donor, the Plan may release information to organizations that handle organ procurement or organ, eye, or tissue transplantation, or to an organ donation bank to facilitate organ or tissue donation and transplantation.

- **Coroners, Medical Examiners, and Funeral Directors**. The Plan may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. The Plan may also release your PHI to a funeral director, as necessary, to enable him or her to carry out his or her duties.

Your Rights Regarding Health Information About You

Your rights regarding the health information the Plan maintains about you are as follows:

- **Right to Inspect and Copy**. You have the right to inspect and copy your PHI. This includes information about your Plan eligibility, claim and appeal records, and billing records, but does not include psychotherapy notes.

To inspect and copy health information maintained by the self-insured medical plan component administered by your provider under the Plan, submit your request, in writing, to your medical plan provider. The Plan may charge a fee for the cost of copying and/or mailing your request. In limited circumstances, the Plan may deny your request to inspect and copy your PHI. Generally, if you are denied access to health information, you may request a review of the denial. If the Plan maintains your PHI electronically, and you request an electronic copy

of information, the Plan will provide access in the electronic form and format you request, if the information is readily producible in that form and format; if it is not readily producible in that form and format, the Plan will produce it in a readable electronic form and format that you and the Plan agree on.

- **Right to Request an Amendment**. If you feel that health information the Plan has about you is incorrect or incomplete, you may ask the Plan to amend it. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, send a detailed request, in writing, to your provider. You must provide reason(s) to support your request. The Plan may deny your request if you ask the Plan to amend health information that was:

  1. Accurate and complete
  2. Not created by the Plan
  3. Not part of the health information kept by or for the Plan
  4. Not information that you would be permitted to inspect and copy

- **Right to an Accounting of Disclosures**. You have the right to request an "accounting of disclosures." This is a list of disclosures of your PHI that the Plan has made to others, except for those necessary to carry out health care treatment, payment, or operations; disclosures made to you; or in certain other situations. To request an accounting of disclosures, submit your request in writing to your provider. Your request must state a time period, which may not be longer than six years prior to the date the accounting was requested.

- **Right to Request Restrictions**. You have the right to request a restriction on the health information the Plan uses or on disclosures about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information the Plan discloses about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that the Plan not use or disclose information about a surgery you had. To request restrictions, make your request in writing to your provider. You must advise us:

  1. What information you want to limit
  2. Whether you want to limit the Plan's use, disclosure, or both
  3. To whom you want the limit(s) to apply

Note: The Plan is not required to agree to your request.

The Plan will notify you if it agrees to a requested restriction on how your PHI is used or disclosed. You should not assume that the Plan has accepted a requested restriction until the Plan confirms its agreement to that restriction in writing. You may request restrictions on our use and disclosure of your confidential information for the treatment, payment and health care operations purposes explained in this Notice. Notwithstanding this policy, the Plan will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to the health plan for purposes of carrying out payment or health care operations (and it is not for purposes of carrying out treatment); and (2) the PHI pertains solely to a health care item or service for which the health care provider has been paid out-of-pocket in full.

- **Right to Be Notified of a Breach**: You have the right to be notified in the event that the Plan (or a Business Associate) discovers a breach of unsecured protected health information.

- **Right to Request Confidential Communications**. You have the right to request that the Plan communicate with you about health matters in a certain way or at a certain location. For example, you can ask that the Plan send you explanation of benefits (EOB) forms about your benefit claims to a specified address. To request confidential communications, make your request, in writing, to your provider. The Plan may, if it wishes, limit its agreement to confidential communications to those instances in which the individual states that he or she will be endangered if the request is not granted. The Plan will make every attempt to accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to a Paper Copy of This Notice**. You have the right to a paper copy of this notice. You may call the Benefits Service Center to request a written copy of this notice at any time.

Changes to This Notice

The Plan reserves the right to change this notice at any time and to make the revised or changed notice effective for health information the Plan already has about you, as well as any information the Plan receives in the future. The Plan will post a copy of the current notice on Inside Amazon at all times and will distribute this notice as required.

Complaints

If you believe your privacy rights under this policy have been violated, you may file a complaint with the U.S. Department of Health and Human Services Office by sending a letter to Centralized Case Management Operations, 200 Independence Avenue, S.W., Washington, D.C. 20201, calling **1-877-696-6775**, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints.**

Note: You will not be penalized or retaliated against for filing a complaint.

Other Uses and Disclosures of Health Information

Other uses and disclosures of health information not covered by this notice or by the laws that apply to the Plan will be made only with your written authorization. If you authorize the Plan to use or disclose your PHI, you may revoke the authorization, in writing, at any time. If you revoke your authorization, the Plan will no longer use or disclose your PHI for the reasons covered by your written authorization; however, the Plan will not reverse any uses or disclosures already made in reliance on your prior authorization.

Contact Information

If you have any questions about this notice, please contact the Benefits Service Center at **1-855-331-9745**.

Notice Effective Date: January 15, 2014

Important Notice from Amazon Corporate LLC Group Health & Welfare Plan About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Amazon Corporate LLC Group Health & Welfare Plan ("Amazon") and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

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

When Can You Join a Medicare Drug Plan?

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

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

If you decide to join a Medicare drug plan, your current Amazon coverage will not be affected, subject to the Medicare Secondary Payer Rules. If you decide to join a Medicare drug plan and you drop your current Amazon prescription drug coverage, be aware that you and your dependents may not be able to get your Amazon prescription drug coverage back until the next Open Enrollment.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

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

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

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

Contact the Benefits Service Center for further information at **1-855-331-9745**. Note: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Amazon changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

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

For more information about Medicare prescription drug coverage:

- Visit **medicare.gov**.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call **1-800-MEDICARE (1-800-633-4227)**. Hearing impaired callers should use the relay system provided by their telephone carrier.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **socialsecurity.gov** or call **1-800-772-1213**. Hearing impaired callers should use the relay system provided by their telephone carrier.

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

Date:	**February 1, 2017**
Name of Entity/Sender:	Amazon Corporate LLC Group Health & Welfare Plan
Contact—Position/Office:	Corporate Benefits Office
Address:	P.O. Box 81226, Seattle, WA 98108
Phone Number:	1-855-331-9745

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2016. Contact your State for more information on eligibility.

To see if any other states have added a premium assistance program since July 31, 2016, or for more information on special enrollment rights, contact either:

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

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

State	Provider	Phone	Website
Alabama	Medicaid	1-855-692-5447	www.myalhipp.com
Alaska	Medicaid	1-866-251-4861	The AK Health Insurance Premium Payment Program: www.myakhipp.com Medicaid Eligibility: www.dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
Colorado	Medicaid	1-800-221-3943	www.colorado.gov/hcpf
Florida	Medicaid	1-877-357-3268	www.flmedicaidtplrecovery.com/hipp
Georgia	Medicaid	1-404-656-4507	www.dch.georgia.gov/medicaid - Under Third Party Liability, click on Health Insurance Premium Payment (HIPP)
Indiana	Medicaid	1-877-438-4479 1-800-403-0864	Healthy Indiana Plan for low-income adults 19-64: www.hip.in.gov All other Medicaid: www.indianamedicaid.com
Iowa	Medicaid	1-888-346-9562	www.dhs.state.ia.us/hipp
Kansas	Medicaid	1-785-296-3512	www.kdheks.gov/hcf
Kentucky	Medicaid	1-800-635-2570	www.chfs.ky.gov/dms/default.htm
Louisiana	Medicaid	1-888-342-6207	www.dhh.louisiana.gov/index.cfm/subhome/1/n/331
Maine	Medicaid	1-800-442-6003 TTY: Maine relay 711	www.maine.gov/dhhs/ofi/public-assistance/index.html
Massachusetts	Medicaid and CHIP	1-800-462-1120	www.mass.gov/MassHealth
Minnesota	Medicaid	1-800-657-3739	www.mn.gov/dhs/ma
Missouri	Medicaid	1-573-751-2005	www.dss.mo.gov/mhd/participants/pages/hipp.htm
Montana	Medicaid	1-800-694-3084	www.dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Nebraska	Medicaid	1-855-632-7633	www.ACCESSnebraska.ne.gov
Nevada	Medicaid	1-800-992-0900	http://dwss.nv.gov
New Hampshire	Medicaid	1-603-271-5218	http://www.dhhs.nh.gov/oii/documents/hippapp.pdf
New Jersey	Medicaid and CHIP	Medicaid: 1-800-356-1561 CHIP: 1-800-701-0710	Medicaid: www.state.nj.us/humanservices/dmahs/clients/medicaid CHIP: www.njfamilycare.org
New York	Medicaid	1-800-541-2831	www.nyhealth.gov/health_care/medicaid
North Carolina	Medicaid	1-919-855-4100	www.ncdhhs.gov/dma
North Dakota	Medicaid	1-844-854-4825	www.nd.gov/dhs/services/medicalserv/medicaid
Oklahoma	Medicaid and CHIP	1-888-365-3742	www.insureoklahoma.org
Oregon	Medicaid	Medicaid: 1-800-699-9075	www.healthcare.oregon.gov
Pennsylvania	Medicaid	1-800-692-7462	www.dhs.pa.gov/hipp
Rhode Island	Medicaid	1-855-697-4347	www.eohhs.ri.gov
South Carolina	Medicaid	1-888-549-0820	www.scdhhs.gov
South Dakota	Medicaid	1-888-828-0059	www.dss.sd.gov
Texas	Medicaid	1-800-440-0493	www.gethipptexas.com
Utah	Medicaid and CHIP	1-866-435-7414	Medicaid: www.health.utah.gov/medicaid CHIP: www.health.utah.gov/chip
Vermont	Medicaid	1-800-250-8427	www.greenmountaincare.org
Virginia	Medicaid and CHIP	Medicaid: 1-800-432-5924 CHIP: 1-855-242-8282	www.coverva.org/programs_premium_assistance.cfm
Washington	Medicaid	1-800-562-3022 ext. 15473	www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program
West Virginia	Medicaid	1-877-598-5820, HMS Third Party Liability	www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx
Wisconsin	Medicaid and CHIP	1-800-362-3002	www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Wyoming	Medicaid	1-307-777-7531	https://wyequalitycare.acs-inc.com

Terms to Know

Allowed amount: The maximum amount on which our Medical Plan bases payments for covered services. This may also be called "eligible expense," "payment allowance," or "negotiated rate." **If an out-of-network provider charges more than the allowed amount, you may have to pay the difference.**

Coinsurance: The percentage of the charges you are responsible for paying when you get care (for example, the plan pays 90% and you pay 10%).

Combined deductible: For family coverage, the entire family has one deductible that applies to everyone. Once the family, in any combination, reaches that family deductible, the plan begins paying coinsurance for the whole family.

Copay: The flat fee you pay to the provider based on the care or service you receive.

Deductible: The amount you pay for certain services each year before the plan begins to pay benefits.

In-network: The doctors, hospitals, laboratories, pharmacies, etc., that are members of the plan's provider network. When you see an in-network provider, the plan pays a higher benefit.

Out-of-network: The doctors, hospitals, laboratories, pharmacies, etc., that are not members of the plan's provider network. When you see an out-of-network provider, the plan pays a lower benefit (or no benefit if you're in the In-Network Only Plan, except for medical emergencies). If an out-of-network provider charges more than the allowed amount, you may have to pay the difference.

Plan year: The period from April 1, 2017, to March 31, 2018.

Preventive care: Routine visits to your doctor to prevent illnesses and improve your health. Preventive care includes annual check-ups, immunizations, and certain screenings. The plans pay 100% of the cost of in-network preventive care.

Qualifying change in status: A life event that allows you to make changes to some of your benefit elections during the year. Examples include: a change in your marital status, the start or end of a domestic partnership, the death of your spouse/domestic partner, the birth/adoption of a child, or a change to your or your spouse's employment status.

For the full list of qualifying life events, visit the Benefits Enrollment Tool and review the Amazon.com Section 125 plan document.

Contact Information

	CONTACT	PHONE	WEBSITE
IF YOU NEED HELP...			
Employee Assistance Program	GuidanceResources Company ID "AmazonEAP"	1-855-435-4333	**guidanceresources.com**
Medical Advice Line	For Premera Blue Cross members	1-877-995-2696	**N/A**
IF YOU HAVE QUESTIONS ABOUT...			
Your Benefits	The Benefits Service Center (Monday through Friday, 5 a.m. to 6 p.m. Pacific Time)	1-855-331-9745	**amazon.ehr.com**
FOR IMPORTANT PLAN PROVIDER INFORMATION...			
Premera Medical	Premera Blue Cross Group #4000083	1-877-995-2696	**premera.com/amazon**
Express Scripts Prescription Drug Plan	Express Scripts Customer Service	1-844-626-9387	**express-scripts.com/amazon**
Life and AD&D Insurance	Securian Life Group #70004	1-866-293-6047	**amazon.ehr.com**

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