2023

EMPLOYEE BENEFITS GUIDE

Berkowitz Pollack Brant Advisors +CPAs

PROVENANCE WEALTH ADVISORS

BayBridge Capital Advisors

BayBridge REAL ESTATE CAPITAL

CONTENTS

DIRECTORY

HUMAN RESOURCES DEPARTMENT

Gabe Bevilacqua

Payroll & Benefits Administrator

hrpayrollbenefits@bpbcpa.com

(305) 960-8857

EMPLOYEE BENEFITS TEAM

Rachel Sapoznik

Principal

rachels@sapoznik.com

Mary Kreischer

Benefits Consultant

maryk@sapoznik.com

1100 NE 163 Street

North Miami Beach, FL 33162

Telephone: (877) 948-8887

www.sapoznik.com

MEDICAL

UnitedHealthcare | Neighborhood Health Partnership
www.myuhc.com
NHP: (844) 651-3833
UHC: (866) 633-2446

GAP INSURANCE

Transamerica
For customer service, contact Amwins:
(800) 476-4491
www.webtpa.com

DENTAL

Lincoln Financial Group
DHMO: (888) 877-7828 | www.ldc.lfg.com
DPPO: (800) 423-2765 | www.lfg.com

VISION

Lincoln Financial Group
www.lvc.lfg.com
(800) 440-8453

LIFE | AD&D | DISABILITY

Lincoln Financial
www.lincoln4benefits.com
(800) 423-2765

SUPPLEMENTAL INSURANCE

Colonial Life
www.coloniallife.com
(800) 325-4368

FLEXIBLE SPENDING ACCOUNT

Employee Benefits Corporation
www.ebcflex.com
(800) 346-2126

PLEASE NOTE: This Employee Benefits Guide is solely intended as a high-level overview and general reference guide on your employee benefits. This booklet is NOT your Summary of Benefits and Coverage (SBC) document required by the Affordable Care Act of 2010. As an enrollee, your actual SBC will be provided under separate cover, by your health carrier.

WELCOME

TO YOUR EMPLOYEE BENEFITS ENROLLMENT

The firm strives to provide you and your family with a comprehensive and valuable benefits package. We want to make sure you're getting the most out of your benefits - that's why we've put together this enrollment guide.

Elections you make during open enrollment will become effective **January 1, 2023**. If you are a new hire, elections will be effective **the first of the month following 30 days after date of hire**.

Who is eligible?

If you're a full-time employee, you're eligible to enroll in the benefits outlined in this guide. Full-time employees are those who work **30 full-time** hours or more per week. In addition, the following members are eligible for medical, dental and vision coverage.

- Your spouse or Domestic Partner
- A child under the age of 26* who is your natural child, stepchild, legally adopted child, or child for whom you have obtained legal guardianship.
- An unmarried child over the age of 26 who is not able to support themselves due to mental disability, physical disability, mental illness, or developmental disability.

**Employers may choose to expand the definition of child dependent to include children older than 26; age limits vary by plan and state. Please see your human resource department for your state law requirement.*

How to make changes

While you are generally only allowed to change your benefits elections during the open enrollment period each year, certain life events provide an exception. The following are examples of types of qualifying events that may allow you to change your benefit elections during a plan year:

- Birth/adoption
- Marriage/divorce/legal separation*
- Change in insurance coverage
- Moving to a new zip code or county
- Change in employment status
- Death in the family (spouse, child or other qualified dependent)
- Dependent child reaches limiting age
- Loss of other coverage

* *if applicable in state of residence*

You must notify your Human Resources department within 30 days of qualifying event to request a special enrollment.

AVAILABLE BENEFITS

- Medical
- GAP
- Dental
- Vision
- Employer Paid Basic life and AD&D
- Voluntary life and AD&D
- Voluntary Short-Term Disability
- Employer Paid Long-Term Disability
- Supplemental insurance
- Flexible Spending Account

Annual Enrollment Effective Date:

January 1, 2023

New Hire Enrollment Effective Date:

The first of the month following 30 days after date of hire

HIPAA Special Enrollment Rights

To make health coverage more portable, the Health Insurance Portability and Accountability Act (HIPAA) requires group health plans to provide special enrollment opportunities outside of the plans' regular enrollment periods in certain situations.

This notice is being provided to make certain that you understand your right to apply for group health coverage. You should read this notice even if you plan to waive health coverage at this time.

Special enrollment must be provided in these situations:

- **Loss of coverage**
- **Marriage, birth or adoption**
- **Medicaid or CHIP**

Please see federal laws and disclosures section for more information.

Open Enrollment Terms

Coinsurance: The percentage of costs for a covered Healthcare service that you pay after you've paid your deductible.

Copayment: A flat fee that you pay toward the cost of covered medical services.

Deductible: The amount you pay for covered Healthcare service before your insurance plan starts to pay. Under some plans, the deductible is waived for certain services.

Premium: The amount you pay for a health plan in exchange for coverage.

Out-of-Pocket Maximum: The highest amount paid for covered services during a benefit period.

Out of Network: Healthcare you receive without a physician referral, or services received by a non-network service provider.

In Network: Healthcare received from your primary care physician or from a specialist within an outlined list of Healthcare practitioners.

Primary Care Physician (PCP): A doctor that is selected to coordinate treatment under your health plan.

Doctor network: NHP HMO/POS Access

In-network clinical lab: Quest Diagnostics and LabCorp

Plan Name	CRWA-M (NHP HMO 2022 (OA)-Fusion) Rx Plan: NH42
Network	**Choice NHP HMO**
In Network	
Deductible: Single	$5,000
Deductible: Family	$10,000
Deductible Type	Embedded
Co-Insurance	100%
Out-of-Pocket Limit: Single*	$8,150
Out-of-Pocket Limit: Family*	$16,300
Inpatient Facility**	$500 After Ded
Outpatient Surgery***	$250 / Ded ($500 / Ded Hosp)
Copays	
PCP	$0
Specialist	Desig: $75 / Net: $75 / Ded
Urgent Care***	$50
ER***	$500 After Ded
Other Services	
Diagnostic Lab / X-Ray***	$25 / $75
MRI & CT Scan***	$250 / Ded (Non-DDP $500 / Ded)
Prescription Drugs	
Prescription Ded	-
Rx Tiers	$10/75/175/350; Adv PDL Natl
Out of Network	
Deductible: Single	-
Deductible: Family	-
Co-Insurance	-
Out-of-Pocket Limit: Single	-
Out-of-Pocket Limit: Family	-
Inpatient Facility	-
Outpatient Surgery	-

SPECIAL NOTE: *The above is a brief summary of benefits and does not constitute a contract. Please refer to your Certificate of Insurance for further information on your Employee Benefits. In the case of error or omission, the carrier policy will govern.*

Doctor network: Choice Plus

In-network clinical lab: Quest Diagnostics and LabCorp

Plan Name	CRZV-M (UHC INS 2022-Fusion) Rx Plan: D00
Network	**Choice+ Legacy Insurance**
In Network	
Deductible: Single	$5,000
Deductible: Family	$10,000
Deductible Type	Embedded
Co-Insurance	100%
Out-of-Pocket Limit: Single*	$7,500
Out-of-Pocket Limit: Family*	$15,000
Inpatient Facility**	$500 After Ded
Outpatient Surgery***	$250 / Ded ($500/ Ded Hosp)
Copays	
PCP	$0
Specialist	Desig: $75 / Net: $75 / Ded
Urgent Care***	$50
ER***	$500 After Ded
Other Services	
Diagnostic Lab / X-Ray***	$25 (Non-DDP $100) / $75
MRI & CT Scan***	$250 / Ded (Non-DDP $500 /Ded)
Prescription Drugs	
Prescription Ded	-
Rx Tiers	$10/75/175/350; Adv PDL Natl
Out of Network	
Deductible: Single	$10,000
Deductible: Family	$20,000
Co-Insurance	50%
Out-of-Pocket Limit: Single	$20,000
Out-of-Pocket Limit: Family	$40,000
Inpatient Facility	50% After Ded
Outpatient Surgery	50% After Ded

Doctor network: Choice Plus

In-network clinical lab: Quest Diagnostics and LabCorp

Plan Name	AQUQ (UHC INS 2022-HSA) Rx Plan: 570-HSA
Network	**Choice+ Legacy Insurance ***
In Network	
Deductible: Single	$4,000
Deductible: Family	$8,000
Deductible Type	Embedded
Co-Insurance	100%
Out-of-Pocket Limit: Single*	$6,400
Out-of-Pocket Limit: Family*	$12,800
Inpatient Facility**	100% After Ded
Outpatient Surgery***	100% After Ded
Copays	
PCP	100% After Ded
Specialist	100% After Ded
Urgent Care* **	100% After Ded
ER* **	100% After Ded
Other Services	
Diagnostic Lab / X-Ray* **	100% / Ded (Non-DDP 50%) / 100% / Ded
MRI & CT Scan* **	100% / Ded (Non-DDP 50%)
Prescription Drugs	
Prescription Ded	Med Ded
Rx Tiers	$10/35/70; Adv PDL Std Prev Natl
Out of Network	
Deductible: Single	$5,000
Deductible: Family	$10,000
Co-Insurance	50%
Out-of-Pocket Limit: Single	$10,000
Out-of-Pocket Limit: Family	$20,000
Inpatient Facility	50% After Ded
Outpatient Surgery	50% After Ded

Doctor network: Choice Plus

In-network clinical lab: Quest Diagnostics and LabCorp

Plan Name	BWMD (UHC INS 2022-Traditional) Rx Plan: 560
Network	**Choice+ Legacy Insurance ***
In Network	
Deductible: Single	$5,000
Deductible: Family	$10,000
Deductible Type	Embedded
Co-Insurance	70%
Out-of-Pocket Limit: Single*	$6,350
Out-of-Pocket Limit: Family*	$12,700
Inpatient Facility**	70% After Ded
Outpatient Surgery***	70% After Ded
Copays	
PCP	$30
Specialist	$55
Urgent Care***	$60
ER***	$350
Other Services	
Diagnostic Lab / X-Ray***	70% / Ded (Non-DDP 50%) / 70% / Ded
MRI & CT Scan***	70% / Ded (Non-DDP 50%)
Prescription Drugs	
Prescription Ded	-
Rx Tiers	$10/60/100; Adv PDL Natl
Out of Network	
Deductible: Single	$10,000
Deductible: Family	$30,000
Co-Insurance	50%
Out-of-Pocket Limit: Single	$20,000
Out-of-Pocket Limit: Family	$40,000
Inpatient Facility	50% After Ded
Outpatient Surgery	50% After Ded

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GAP INSURANCE

TRANSAMERICA

Amins Customer Service: (800) 476-4491 ● www.webtpa.com

Medical gap insurance is a supplemental health plan that acts as a cushion for people who carry high-deductible Healthcare plans. The main purpose of medical gap insurance is to lower your overall out-of-pocket costs by providing funds to pay for a large deductible and other out-of-pocket costs until your main insurance policy kicks in.

$4,000 Gap Plan

HELPING WITH YOUR MEDICAL COSTS

***TransConnect* for Florida, underwritten by Transamerica Life Insurance Company**

Andrea was involved in a serious car accident. After the whirlwind of the ambulance ride, ER, surgery, and hospital stay, she's nervous about how much her major medical insurance will pay. It's a relief to remember that she signed up for *TransConnect* which can pay for out-of-pocket expenses like deductibles, co-insurance, and co-payments.

TRANSCONNECT WITH OUTPATIENT LAB RIDER FOR FLORIDA SUPPLEMENTAL MEDICAL EXPENSE INSURANCE

INPATIENT HOSPITAL BENEFITS $4000

Your policy pays benefits for inpatient hospital stays, inpatient procedures, inpatient physician charges, and even routine nursery care for dependent children. Your employer determines your calendar year maximum benefit (multiplied by three for an insured family).

OUTPATIENT HOSPITAL BENEFITS WITH OUTPATIENT LAB RIDER $4000

Your policy also pays benefits (separate from the inpatient hospital benefits) for:

- Radiological diagnostic testing performed in a hospital outpatient facility or a magnetic resonance imaging (MRI) facility
- Radiation therapy or chemotherapy authorized by a radiologist, chemotherapist, or an oncologist for outpatient cancer treatment
- Outpatient surgery performed in a hospital facility, free-standing surgery center, or physician's office
- MRIs, CT scans, PET scans, diagnostic ultrasounds, and electrocardiogram (EKG) tests performed in a physician's office (X-rays and lab fees are not included)
- Cardiac catheterizations and stress tests
- Accident, injury, or emergency condition treatment in a hospital ER or urgent care center
- Laboratory tests performed on an outpatient basis in an independent laboratory (a lab that is independent of both an attending or consulting physician's office and of a hospital).

Visit:
transamerica.com

Customer Service:
888-763-7474

ACCIDENT-ONLY AMBULANCE BENEFIT $1000

This benefit is payable when ambulance transportation (ground or air) is required to a hospital or emergency center for injuries sustained in an accident. Ambulance transportation must be within 72 hours of the accident and must be provided by a licensed professional ambulance company.

ELIGIBILITY

You must be actively employed qualifying as an eligible insured (defined by the employer) and have an employer's basic, major medical, or comprehensive medical plan.

TRANSAMERICA

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TRANSCONNECT WITH OUTPATIENT LAB RIDER FOR FLORIDA SUPPLEMENTAL MEDICAL EXPENSE INSURANCE

INPATIENT HOSPITAL BENEFITS $5000

Your policy pays benefits for inpatient hospital stays, inpatient procedures, inpatient physician charges, and even routine nursery care for dependent children. Your employer determines your calendar year maximum benefit (multiplied by three for an insured family).

OUTPATIENT HOSPITAL BENEFITS WITH OUTPATIENT LAB RIDER $5000

Your policy also pays benefits (separate from the inpatient hospital benefits) for:

- Radiological diagnostic testing performed in a hospital outpatient facility or a magnetic resonance imaging (MRI) facility
- Radiation therapy or chemotherapy authorized by a radiologist, chemotherapist, or an oncologist for outpatient cancer treatment
- Outpatient surgery performed in a hospital facility, free-standing surgery center, or physician's office
- MRIs, CT scans, PET scans, diagnostic ultrasounds, and electrocardiogram (EKG) tests performed in a physician's office (X-rays and lab fees are not included)
- Cardiac catheterizations and stress tests
- Accident, injury, or emergency condition treatment in a hospital ER or urgent care center
- Laboratory tests performed on an outpatient basis in an independent laboratory (a lab that is independent of both an attending or consulting physician's office and of a hospital).

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888-763-7474

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ELIGIBILITY

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TRANSAMERICA

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ONLINE REGISTRATION AND MOBILE APP

UnitedHealthcare

www.myuhc.com

Get answers about your benefits, claims and more by registering at myuhc.com today. Download the Health4Me App, it makes the online pharmacy experience simple and possible. Get access today by following the simple steps listed below.

Registration is quick and simple at MyUHC.com

(1) Go to myuhc.com.

(2) Click the **"Register Now"** button.

(3) Enter your name, date of birth and the account numbers from your health plan ID card. Or, enter your Social Security number and date of birth.

(4) Create a username and password.

(5) Enter your email address and optional phone numbers, and choose security questions.

(6) Review and agree to the website policies, and be sure to keep the email opt-in checked so you get relevant news and wellness information

(7) By registering, you will also get Explanations of Benefits (EOB), claim letters, regulatory notices and other important information by email. You may choose to get paper communications at any time by changing your mailing preferences.

On myuhc.com , you can:

- Check past and current statements and claim status.
- Review eligibility and look up benefits.
- Find a hospital or doctor, including UnitedHealth Premium® designated physicians.
- Print a temporary health plan ID card or request a replacement card.
- Take a health assessment and participate in online programs designed to help you set goals toward your health objectives.
- Learn about health conditions, symptoms and the latest treatment options.
- Use the Personal Health Record to organize and store your health data in one convenient, confidential place.

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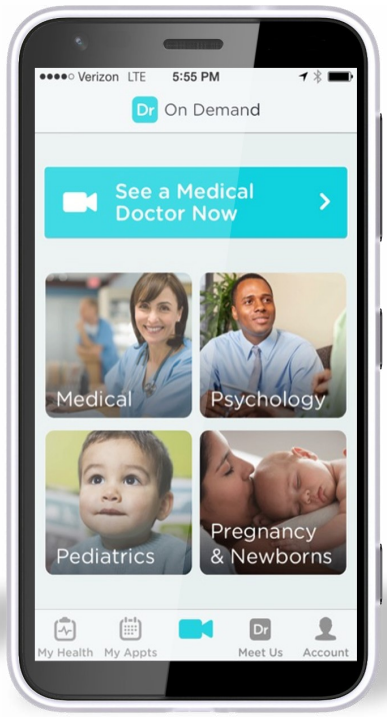
VIRTUAL VISITS

UnitedHealthcare

www.myuhc.com

A virtual visit lets you see and talk to a doctor from your mobile device or computer without an appointment. Most visits take about 10-15 minutes and doctors can write a prescription*, if needed, that you can pick up at your local pharmacy.

Get access to care online. Any where. Any time.



AmWell.com

doctorondemand.com

Note: Doctor on Demand does not support any version of Internet Explorer®.

A Virtual Visit lets you see and talk with a doctor from your laptop or mobile device.

You have access to a network of virtual visit provider groups. To learn more about virtual visits and our network please log into myuhc.com® or the UnitedHealthcare Health4Me® app.

Once you choose a virtual visit provider group you'll be directed to their website from myuhc.com or their app from Health4Me. You also have the option of going directly to their website or app to access care. You can download their app directly from Google Play or the Apple® App Store®.

Virtual visits are covered under your health plan benefits either way you decide to access care.

App Store Google play

Tips for registering:

Locate your member ID number on your health plan ID card

Or look up your number on myuhc.com.

Have your primary care provider name and medical history ready.

Choose a pharmacy that's open in case you're given a prescription.

When to use virtual visits:

- Your doctor is not available
- You become ill while traveling
- You are considering visiting a hospital emergency room for a non-emergency health condition

Not good for:

- Anything requiring an exam or test
- Complex or chronic conditions
- Injuries requiring bandaging or sprains/ broken bones

ENROLLMENT GUIDE

The BESTflex™ Plan

Enroll in the BESTflex℠ Plan and you'll pay less for eligible health care and daycare expenses.

Use *tax-free dollars* to pay for eligible health care and daycare expenses.

Tax-Free Dollars

The BESTflex Plan is an easy way for you to set aside a portion of your earnings, and use it to pay for insurance, health care and daycare expenses. The money you set aside in the BESTflex Plan is free from payroll taxes, so you save approximately 30 percent* in taxes for each dollar you contribute.

A Prescription for Savings

Whether your prescription medicine helps calm your allergies after snuggling with your cat, suppress heartburn after your favorite meal, breathe through your asthma – or something else entirely – the BESTflex Plan lets you pay less for it.

The plan saves you approximately 30 percent* in taxes on your eligible prescriptions and prescription co-payments, meaning a $20 prescription expense amounts to about $14.

Smile!

When you go out to socialize with your friends and meet new people, you trust in your bright smile to lend yourself confidence. It's no surprise, then, that you like to keep your smile in tip-top shape, despite how expensive it can be.

The BESTflex Plan helps you save approximately 30 percent* on your dental expenses, and keep your smile healthy and bright. A dental exam and cleaning might cost you $100 – or more, depending on your provider. Using funds in the BESTflex Plan, you essentially pay around $70. That's a savings that's likely to bring a smile to your face.

Daycare Relief

You know how the hundreds of dollars you spend on daycare each month can pinch your finances. The BESTflex Plan dulls the pinch. By saving you around 30 percent* on your daycare expenses, a week of care at $150 is, in essence, closer to $105.

FLEXIBLE SPENDING ACCOUNT (FSA)

Employee Benefits Corporation

(800) 346-2126 ● www.ebcflex.com

The BESTflex Plan

Why pay more than you have to?

The BESTflex Plan makes it easy for you to set aside a portion of your earnings and use it to pay for certain insurance, medical and dependent care expenses. Because dollars you place in the BESTflex Plan are exempt from Federal, State and FICA taxes, you'll save approximately 30 percent* in taxes for each dollar you contribute.

Direct those tax savings toward your eligible BESTflex Plan expenses and a **$20 prescription could cost $14.** A week of daycare could cost $70 instead of $100 and your $30 health insurance premium could cost you $21.

Our online videos explain where extra FSA dollars come from, the difference between FSA account types, and how to submit claims. ***Watch them now!*** *Visit our website at www.ebcflex.com.*

My **Mobile** Account Assistant

Smart, Simple, Secure and Mobile!

- File a claim
- Attach receipts
- Check balances
- View payment history

Visit www.ebcflex.com to learn more.

Available on the App Store

Google play

How the BESTflex Plan Works

When you enroll in the BESTflex Plan, you set aside the portion of your pay you'll spend annually on eligible health and dependent care expenses. Throughout the year, these elections are deducted bit by bit from your paychecks and placed in flexible spending accounts (FSAs). The usual payroll taxes do not apply to your BESTflex Plan contributions, saving you from paying approximately 30 percent* in taxes on each dollar you contribute to the BESTflex Plan.

Just a Fraction of the Eligible Expenses

These savings can be applied to a variety of expenses. Prescription medicines, dental expenses, vision expenses – including contact lens solution, contact lenses and prescription eyeglasses – day care expenses and co-payments are just a few of the common expenses on which the BESTflex Plan helps you save money.

Enrollment in the BESTflex Plan

We help you set aside the right amount of money for eligible health care and dependent care expenses. Referencing your *Eligible Expenses List* and using the worksheets we've created, you'll arrive at a solid estimate of how much money you should contribute to the plan and help alleviate concerns about forfeiting any contributions.

Reimbursement From the BESTflex Plan

To get back the pre-tax money that's deducted from your pay and deposited in your FSA(s), simply submit a *Claim Form*, along with documentation, such as an itemized receipt, for the eligible expense. We quickly process your form and mail you a reimbursement check or deposit the payment into your bank account.

Filing Claims

We make filing claims easy and we offer three options: **Mobile, Online** or via a paper **Claim Form**

My Mobile Account Assistant lets you file a claim and scan and submit a receipt – at the pharmacy, your provider or anywhere you have access to a 3G or wireless internet connection. Filing a claim for any eligible health care or dependent care expense doesn't get any easier than this. Complete a few lines on a simple form, upload your receipt using your phone's camera and tap "Submit." My Mobile Account Assistant makes filing claims smart, simple, secure and mobile!

Participant Support

If you have questions or need information regarding your account, you can call our in-house Participant Services team at **800 346 2126** for one-on-one support, or access our convenient Telephone Account Assistant, which provides you with basic account details. We are also available via email at **participantservices@ebcflex.com.**

Download information regarding The BESTflex Plan and your FSAs by activating then logging in to My Account Assistant at www.ebcflex.com.

*These tax examples are broad approximations of tax liability. You should consult a tax advisor for help with your own situation. Current IRS tax laws control all BESTflex Plan matters.

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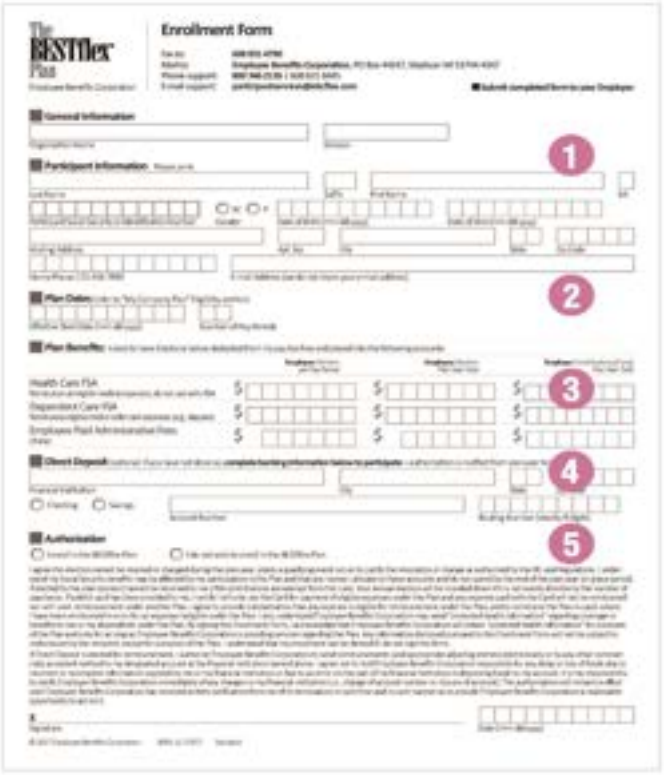
FLEXIBLE SPENDING ACCOUNT (FSA)

Employee Benefits Corporation

(800) 346-2126 ● www.ebcflex.com

How to Enroll in the BESTflex Plan:



(Sample Enrollment Form shown; your form may differ slightly)

Follow enrollment instructions from your employer. If you receive an enrollment form, complete these steps:

1. **Enter General and Personal Information.** All of it, including your email address, if you have one. Email is how we prefer to contact you.
2. **Enter Plan Dates.** Enter the date you start the plan (the Effective Start Date) and the number of paychecks per year from which your elections are deducted (Number of Pay Periods). Enrollment is for one plan year, usually consisting of 12 calendar months or less.
3. **Enter BESTflex Plan Benefits.** Use the mini-worksheet on the *Enrollment Form* to enter your annual election. Choose the amount you'd like deducted from each paycheck (Employee Deduction per Pay Period) and multiply that amount by the Number of Pay Periods to determine your Plan Year Total. Do this for each FSA in which you are enrolling and total the form.

   If you receive contributions from your employer, add the Employer Contribution Plan Year Total.
4. **Complete Direct Deposit Information.** You have the option of having your reimbursement check mailed to you or deposited directly at your bank, credit union or other financial institution. To authorize the direct deposit feature of the BESTflex Plan, provide the financial account information requested on the enrollment form. If you already have direct deposit information on file with us, it is not necessary to provide it again. The direct deposit feature will carry over to your new plan year.
5. **Authorize Enrollment and Direct Deposit.** First, indicate whether you want to participate in the BESTflex Plan. Then sign and date the form and return it to your employer.

   If you choose to not enroll in the BESTflex Plan FSAs, you must sign and date the form anyway. Your eligible employer-provided insurance premiums will still be deducted from your pay on a pre-tax basis.

What Happens After I Enroll?

Your employer transfers the amounts you elected on the *Enrollment Form* to your Health and/or Dependent Care FSA. Check your pay stub to ensure these amounts are correct.

Once your plan year starts, visit our website at **www.ebcflex.com.** You can activate your online account and access My Account Assistant, where you'll see your account information and be able to download useful materials to help you make the most of your plan.

Review My Company Plan

My Company Plan, the appendix to your *Summary Plan Description (SPD)*, describes the specific details and features of your company's BESTflex Plan. Use the information in *My Company Plan* to aid in completing your enrollment.

My Company Plan Contains:

A. BESTflex Plan Dates, including the date your employer started its BESTflex Plan (Original Plan Date) and the start and end dates of your employer's current BESTflex Plan (My Company's Plan Year)

B. Eligibility definitions

C. Group Insurance Premiums, the types of premiums deducted from your paycheck on a pre-tax basis

D. The Health Care and Dependent Care FSA contribution limits, the maximum amount you can contribute to each account

E. Plan Amendments, if any

F. Company Information regarding who to contact within your Company

G. Legal Information defining the relationship between your employer and Employee Benefits Corporation

My Company Plan is available online at www.ebcflex.com by logging onto My Account Assistant.

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FLEXIBLE SPENDING ACCOUNT (FSA)

Employee Benefits Corporation

(800) 346-2126 ● www.ebcflex.com

Employee Benefits Corporation's Website

Once you enroll in the BESTflex Plan, our website makes it easy to view your claims and reimbursements. Get started at www.ebcflex.com.

My Account Assistant

As a BESTflex Plan participant, it's important to monitor the status of the claims you've submitted, stay aware of your FSA balances, be mindful of the deadlines for submitting claims, and have a place to find the latest BESTflex Plan forms and materials.

Once you enroll in the BESTflex Plan, our website makes all of this easy with **My Account Assistant,** your online account management portal.

Using My Account Assistant, you can:

- File claims
- Review account balance(s)
- Review when a claim was processed and when the reimbursement was mailed or direct deposited
- Download BESTflex Plan forms and information regarding the operation of your plan
- Update personal information
- View a detailed account history

In order for you to view your account, you activate it by entering a valid email address and receiving a password. You can then log-in and view your account using your Social Security Number and your password.

SPECIAL NOTE: *The above is a brief summary of benefits and does not constitute a contract. Please refer to your Certificate of Insurance for further information on your Employee Benefits. In the case of error or omission, the carrier policy will govern.*

DENTAL INSURANCE

Lincoln Financial Group

Provider Network: LDCS500B / Solstice

DHMO Telephone: (888) 877-7828
www.ldc.lfg.com

Provider Network: PPO / Lincoln Dental Connect

DPPO Telephone: : (800) 423-2765
www.lfg.com

Plan Name	LDCS500B	DPPO LOW		DPPO HIGH	
Network Access	In Network Only	In Network	Out of Network	In Network	Out of Network
Deductible	No Ded $0 Office Visits	$50/$150	$50/$150	$50/$150	$50/$150
Ded waived for Preventive	None	Yes	Yes	Yes	Yes
Preventive	Some procedures Covered 100%	100%	100%	100%	100%
Basic	Co-Pays Apply	90%	90%	90%	90%
Major	Co-Pays Apply	60%	60%	60%	60%
Periodontics / Endodontics	Co-Pays Apply	Major Simple Extractions & Oral Surgery - Basic		Basic	
Annual Maximum Benefit	None	$2,500	$2,500	$2,500	$2,500
Out of Network Reimbursement Lev-el	In Network Only	Fee	Fee	Fee	UCR
Orthodontic	Co-Pays Apply	50%		50%	
Orthodontic Eligibility	Adult & Child	Child(ren) to age 19		Child(ren) to age 19	
Orthodontic Maximum	None	$1,500		$1,500	

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VISION INSURANCE

Lincoln Financial Group®

(800) 440-8453 ● www.lvc.lfg.com

Doctor network: **Spectera Vision**

NO VISION ID CARDS Use your Social Security Number and say Spectera Vision.

Plan Name	**LVC10**	
Network Access	In Network Allowance	Out of Network Reimbursement
Eye Care Co-pay		
Eye Exam	$20	Up to $40
Frequency	**12 Months**	
Materials Co-pay	$20	N/A
Lenses		
Single	$0 After Co-pay	Up to $40
Bifocal	$0 After Co-pay	Up to $60
Trifocal	$0 After Co-pay	Up to $80
Lenticular	$0 After Co-pay	Up to $80
Frequency	**12 Months**	
Frames		
Frames	Up to $130 + 30% off Balance	Up to $45
Frequency	**24 Months**	
Contact Lens Co-pay	**In lieu of any other eyewear benefits**	
Elective	Up to $125	Up to $125
Medically Necessary	$0 After Co-pay	Up to $210
Frequency	**12 Months**	

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LIFE AND AD&D INSURANCE

(800) 423-2765 ● www.lincoln4benefits.com

Life insurance can help provide for you and your loved one if something where to happen to you. If you have people who depend on you for financial support, it's important to make an educated decision about life insurance options.

Employer Paid Basic Life and AD&D	Benefit reduction:	Other Benefits include:
Berkowitz Pollack Brant Advisors and Accountants provides employer paid life insurance and AD&D to all full-time employees eligible for benefits in the amount of: **$10,000**	• 33% at age 70 • 17% at age 75	• Conversion Privilege • Accelerated Benefits • Accidental Death and Dismemberment will match your life amount.

Voluntary Life and AD&D

Employee Benefits	Spouse Benefits	Dependent Child Benefit
Benefit Amount: • Choice of $10,000 Increments • Not to exceed 5 times your annual salary • Maximum Amount $500,000 **Guarantee Issue:** • Up to $150,000, *at initial enrollment* **Other Benefits Included:** • Living Care/ Accelerated Death Benefit • Waiver of Premium • Portability • Conversion	**Benefit Amount:** • Choice of $10,000 Increments • Not to exceed 50% of employee's selected amount • Employee must elect coverage in order to enroll spouse **Guarantee Issue:** • Up to $30,000, at initial enrollment	• $250 child: 14 days to 6 months • 6 months to age 19 (to age 25 if full-time student): $10,000 • Newborn children to age 14 days are not eligible for a benefit • Employee must elect coverage in order to enroll children

Accidental Death and Dismemberment (AD&D)

Principal Sum Amount paid for Loss of Life due to an accident or loss of 2 or more members (Hand, Foot, Eye) 1/2 Principal Sum Amount paid for Loss of One Member (Hand, Foot, Eye) *Accidental Death and Dismemberment benefit amount will match your Life Benefit amount*

Definitions and Requirements

Program Effective Date: The effective date of your coverage will begin upon completion of your new hire waiting period. Late entrants are required to complete satisfactory Evidence of Insurability.

Eligibility Requirements: You must be a full-time active employee working at least 30 hours per week. You must also be a permanent employee and be actively at work* on the coverage effective date.

*Actively at work means the full-time performance of all customary duties of your occupation.

If Spouses and Dependent Children are in a 'Period of Limited Activity'* their effective date will not take effect until the day after: (1) his or her final discharge from the Healthcare facility; or (2) resuming the normal activities of a healthy person of the same age and sex.

**Period of Limited Activity means a period when a spouse or child is confined in a Healthcare facility; or, whether confined or not, is unable to perform the regular and usual activities of a healthy person of the same age and sex.*

SPECIAL NOTE: *The above is a brief summary of benefits and does not constitute a contract. Please refer to your Certificate of Insurance for further information on your Employee Benefits. In the case of error or omission, the carrier policy will govern.*

SHORT-TERM AND LONG-TERM DISABILITY

Lincoln Financial Group

(800) 423-2765 ● www.lincoln4benefits.com

Disability insurance is coverage that provides you with income protection should you lose time on the job due to an injury or illness. With disability coverage, you receive partial replacement of lost income.

Voluntary Short-Term Disability

Maximum Weekly Benefit

60% Of Your Salary Up To $1,500

This is the amount of benefit you will receive when you are disabled.

Elimination Period

14th Day Accident and 14th Day Sickness

This is the amount of benefit you will receive when you are disabled.

Benefit Duration

11 weeks

This is the period of time that benefits will continue to be paid to you during a period of disability.

Employer Paid Long-Term Disability

Class 1 & 2: All Active FT Directors & Managers
Class 3: All Other Active FT Employees

Maximum Monthly Benefit

Class 1 & 2: 60% Of Your Salary Up To $25,000
Class 3: 60% Of Your Salary Up To $15,000

This is the amount of benefit you will receive when you are disabled.

Elimination Period

90 Days

This is the amount of benefit you will receive when you are disabled.

Benefit Duration

Later of Age 65 or Social Security Normal Retirement Age

This is the period of time that benefits will continue to be paid to you during a period of disability.

Own Occupation

End of Max Benefit Period

This is the period of time that the employee need only be disabled from his/her own occupation

Pre-existing Period

3 months prior / 12 months after

This is the period of time you must wait to receive benefits due to a condition that you had prior to coverage.

DEFINITIONS & REQUIREMENTS

Definition of Disability: Disability means you are unable to perform the main duties of your occupation on a full-time basis due to a non-work related injury or sickness. Please see the summary of benefits for more detail.

Program Effective Date: The effective date of your coverage will begin upon completion of your new hire waiting period. Late entrants are required to complete satisfactory Evidence of Insurability.

Eligibility Requirements: You must be a permanent employee regularly scheduled to work at least 30 hours per week; be actively at work* on the coverage effective date.

* Actively at work means the full-time performance of all customary duties of your occupation.

SUPPLEMENTAL INSURANCE

Colonial Life

(800) 325-4368 • www.coloniallife.com

Voluntary benefits provide critical support to employees when the unexpected happens – whether it's an accident, illness or injury. Protect your income and provide financial security for you and your family.

Accident Insurance (Pre-tax)

Accidents can happen anytime, anywhere. In your lifetime, which of these accidental injuries have happened to you or someone you know?

• Sports-related accidental injury • Broken bone • Burn • Concussion • Laceration • Back or knee injuries

Accident Insurance from Colonial Life & Accident Insurance Company can help protect you, your spouse or your children from the unexpected expense of an accident.

Features:

- You are paid benefits to help you with the care and treatment of a covered accidental injury
- Your benefits are paid directly to you (unless you specify otherwise)
- You are paid benefits regardless of any other insurance you may have with other insurance companies.
- Your coverage is portable; you can take it with you if you change jobs or retire.

Cancer Insurance (Pre-tax)

How will you pay for what your health insurance won't? If diagnosed with cancer, would you have the money to cover:

• Out-of-network treatments • Experimental treatments • Rehabilitation • Travel expenses to and from treatment centers

• Childcare expenses

Cancer Insurance from Colonial Life & Accident Insurance Company helps guard against financial hardship if you or a loved one is diagnosed with cancer

Features:

- Helps pay some of the direct and indirect costs related to cancer diagnosis and treatment.
- Helps fill the gaps in your health insurance by helping to pay deductibles and coinsurance.
- Pays an annual benefit for specified cancer screening tests.

Critical Illness Insurance (Post-tax)

...so you can better deal with the cost of an illness. If you were to suffer a heart attack, stroke or other critical illness, would you have the money to cover:

• Deductibles and co-insurance not covered by health insurance • Home Healthcare needs • Travel expenses to and from treatment centers • Lost income • Rehabilitation expenses • Childcare expenses

Even those of us who plan for the unexpected with life, disability and health insurance may discover that some expenses can still remain unpaid. Without adequate protection, sufferers of critical illness might have to pull from their savings or rely on the financial aid of family members in their time of need.

Specified Critical Illness insurance from Colonial helps preserve your lifestyle in the event of a specified critical illness. It pays money that you can use however you need it most.

Features:

- Pays a benefit if you are diagnosed with a covered specified critical illness
- Coverage is available for you and your family members.

Medical Bridge (Pre-tax)

(Hospital Confinement Indemnity Insurance)

You may have health insurance… But are you really covered? Colonial Life's Group Medical Bridge Insurance helps fill in the gaps when you have unexpected health care expenses. These benefits are available for you, your spouse and eligible dependent children.

Features:

- Benefits are paid directly to you for hospital confinements, outpatient surgeries, and diagnostic procedures. Benefits are paid regardless of any other insurance you many have with other insurance companies.

Whole life Insurance (Post-tax)

You like to think that you'll be there for your family in the years to come but…

if something happened to you, would your family have the income it needs?

Whole life insurance can help provide protection for you and those who depend on you.

Features:

- Your premiums will never increase because of changes in your health or age
- Plan is Guaranteed Issue up to $18 per week to a maximum benefit of $75,000.

SPECIAL NOTE: *The above is a brief summary of benefits and does not constitute a contract. Please refer to your Certificate of Insurance for further information on your Employee Benefits. In the case of error or omission, the carrier policy will govern.*

BENEFITS EDUCATION, WELLNESS, AND YOUR RIGHTS: FEDERAL LAWS

Making better Healthcare decisions

KNOW YOUR BENEFITS

- Prescription savings
- Preventative Care
- Where to go for care

Get started on your

WELLNESS JOURNEY

- Getting started: annual doctor visits
- Eat a well-balanced diet
- Water: are you getting enough?
- Starting an exercise program
- Don’t forget to stretch
- Prioritizing Sleep
- Managing Stress

Know your rights

FEDERAL LAWS & DISCLOSURES

- Notice of Patient Protections
- Medicare Part-D
- Section 125 and HIPAA Special Enrollment
- Newborns Act, WHCRA, Medicaid/CHIP
- Continuation coverage right under COBRA

Making better Healthcare decisions
KNOW YOUR BENEFITS

SAVE ON PRESCRIPTIONS

Generic vs. Brand Name

Some people think that generic versions of their prescription drugs are inferior, but the FDA requires that generic drugs meet the same standards as their brand name counterparts.

The difference between the two involves the research, development and marketing investment that went into the original brand name product. When "generic equivalents" become available, they have the same active ingredients and chemical purity as the brand-name drugs they imitate. Other ingredients such as tablet fillers, binders, coatings or flavors may differ. Because their development costs are less, generic drugs are often priced substantially lower.

When you receive a prescription from your doctor, ask if a generic equivalent is available. Many health plans charge a lower copay for patients who choose generics.

Pharmacy Convenience Starts Here

Having access to a discount prescription program can be an enormous benefit to anyone who has a chronic condition. When you have to buy the same medications regularly, it makes a huge difference to save as much money as possible each and every time.

We encourage you to use local pharmacy discount programs available through your local pharmacy. When you do, it's important to remind the pharmacist *NOT* to process your prescription through your medical plan.

Visit your nearest drugstore to start saving on your generic prescriptions today.

Store	Generic Medication Programs	Website
Publix Pharmacy*	Free Antibiotics*	www.publix.com/pharmacy
CVS & CVS at Target	$11.99 / 90 day supply	www.cvs.com/pharmacy
Walmart Pharmacy	$4 / 30 Day Supply $10 / 90 Day Supply	www.walmart.com/pharmacy

*check with Publix for selections

GoodRx

GoodRx is the #1 medical app for iOS and Android. Get prescription drug prices on-the-go, with coupons built unto the app.

- Login at **www.goodrx.com**
- Type your drug name (like Lipitor, Gabapentin, etc.)
- Set your location
- Compare prices, print coupons, save up to 80%

Preventative Care Covered 100% - What does that mean for you?

Depending on your age and your health plan type, you may have easier access to services such as:

- Counseling from your Healthcare provider on topics such as quitting smoking, losing weight, eating better, treating depression and reducing alcohol use
- Routine vaccines for diseases such as measles, polio and meningitis
- Flu and pneumonia shots

Healthy Pregnancy Services

Pregnant women have access to certain services to help ensure a healthy pregnancy, such as:

- Screening for conditions that can harm pregnant women or their babies, including iron deficiency, hepatitis B, a pregnancy-related immune conditions called Rh incompatibility and a bacterial infection called bacteriuria.
- Pregnancy-tailored counseling from a doctor that will help pregnant women quit smoking and avoid alcohol use
- Counseling to support breast-feeding and help nursing mothers

Preventing Heart Disease and Obesity

Some of the covered services that help prevent and control heart disease and obesity include:

- Screening for obesity, and counseling from your doctor and other professionals to promote sustained weight loss, including dietary counseling
- Blood pressure screening, tests to screen for high cholesterol and diabetes
- Counseling on the daily use of aspirin to reduce the risk of stroke

Cancer Prevention Services

A variety of cancer prevention tools are covered, including:

- Annual mammograms for women over age 40, referrals to genetic counseling and discussion of chemoprevention for certain women at increased risk
- Regular Pap smears to screen for cervical cancer and coverage for the HPV vaccine that can prevent cases of cervical cancer
- Tobacco cessation interventions including counseling or medication to help individuals quit
- Screening tests for colon cancer for adults over age 50

Source: www.healthcare.gov

For a full list of preventive services available to adults, visit www.healthcare.gov.

Making better Healthcare decisions
KNOW YOUR BENEFITS

PREVENTATIVE CARE

Examples of covered preventative care services.

Adults	Women	Men	Children	Medicare
• Physical Examination • Immunizations • Screening for obesity and counseling, including dietary counseling • Blood pressure and test for high cholesterol and diabetes • Counseling on the daily use of aspirin to reduce the risk of stroke • Counseling from your healthcare provider on topics such as, quitting smoking, treating depression, and reducing alcohol use. • HIV and STD screenings	• Well-women visits • Anemia screenings • Breast cancer genetic test counseling (BRCA) for women at higher risk of breast cancer • Mammograms every one to two years for women over 40 • Cervical cancer screening • Osteoporosis screening for women over age 60 depending on risk factors • Domestic violence screening and counseling • Contraceptive and counseling • Multiple test for pregnant women	• Prostate Cancer Screening— Men over the age of 50 should have yearly prostate exam and screening test. • Testicular Cancer Screening—All teenage and adult males should have exam every time they visit the doctor for physical exam. • Colorectal Cancer Screening—Men should have colorectal screenings after the age of 50 • Skin Cancer Screenings—A skin exam by a dermatologist or other health professional should be part of a routine check up.	• Physical examination and height, weight and body mass index measurements • Vision and hearing screening • Oral health risk assessments • Supplements for children without fluoride in their water source • Dyslipidemia screening for children at a higher risk of lipid disorders • Iron supplements for children ages 6 to 12 months at a risk for anemia • Phenylketonuria (PKU) screening for newborns • Alcohol and drug use assessments for adolescents • *Immunizations* : Vaccines for children from birth to age 18	• Mammograms every 12 months • Cardiovascular disease screenings • Colorectal cancer screenings • Cervical cancer screenings • Cholesterol screenings • Diabetes screenings • Medical nutrition therapy to manage diabetes or kidney disease • Prostate cancer screening • Annual Flu shot and Hep B vaccine • Bone mass measurement • HIV screening tests

Under the ACA, many private health plans must provide coverage for a range of preventative services. These plans may not change any copayments, deductibles or co-insurance to patients receiving preventative care. The preventative care requirements do not apply to grandfathered plans.

Making better Healthcare decisions
KNOW YOUR BENEFITS

WHERE TO GO FOR CARE

Compare quick care options to help keep costs down.




	PCP	Virtual Visits	Convenience Care	Urgent Care	Emergency Room
	Care from the doctor who knows you best.	See a doctor whenever, wherever.	Basic Conditions that aren't life-threatening	Serious Conditions that aren't life-threatening	Life and limb-threatening emergencies
Average Cost	Varies by plan type	less than $50	$90	$170	$2,000
✓ Indicates the recommended place for care for the following conditions:					
Broken Bones				✓	✓
Chest Pain					✓
Cough	✓	✓	✓		
Fever	✓	✓	✓		
Muscle Strain	✓		✓		
Pinkeye	✓	✓	✓		
Shortness of Breath					✓
Sinus Problems	✓	✓	✓		
Sore Throat	✓	✓	✓		
Sprain	✓		✓	✓	
Urinary Tract Infection	✓	✓	✓		

Call 911 or go to an emergency room (ER) if you have a life-threatening condition

The following pages should be used for informational purposes only and should not be considered medical advice. Please consult a doctor with any questions and before making changes to your lifestyle.

A well-balanced diet is a key component in living a healthy life because it helps you fuel your body with the vitamins, minerals and nutrients it needs.

EAT A WELL-BALANCED DIET

Eating healthy can help you fight off chronic conditions, boost your immunity, give you energy, improve your sleep and support brain function. Although it may seem daunting to make the switch to a well-balanced diet, the truth is that it's easier than you think.

What's Included in a Well-balanced Diet?

Unlike fad diets, which often cut out or severely limit certain food groups like carbs and fats, a well-balanced diet includes all recommended dietary food groups. Making sure that you're getting your daily dose of essential macronutrients, such as fats or carbohydrates, is crucial to your overall health. A diet with balance provides the body with the proper proportions of carbohydrates, fats, proteins, vitamins, minerals and liquids.

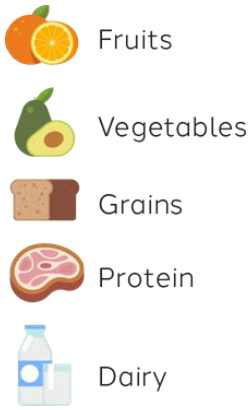
According to the most recent version of the Dietary Guidelines for Americans, a government-provided resource for healthy eating, a well-balanced diet should:

- Emphasize fruits, vegetables, whole grains, and fat-free or low-fat milk and milk products
- Include lean meats, poultry, fish, beans, eggs and nuts
- Be low in saturated fats, trans fats, cholesterol, sodium and added sugars
- Include oils that are rich in fatty acids and vitamin E

Stay within your daily calorie needs, as determined by your doctor. Be sure to talk to your doctor about your specific health needs and how you can achieve them through a well-balanced diet.

MyPlate and the food groups

Although many American adults grew up with the food pyramid as their example for a well-balanced diet, the pyramid has been replaced with MyPlate. The MyPlate format and the dietary guidelines for Americans focus on five food groups as building blocks for a well-balanced diet. The five food groups that MyPlate focus on are:



Explore the MyPlate Food Groups at MyPlate.gov

There are many health benefits from drinking water including weight loss and reduced fluid retention, but above all, the body simply cannot function without it. But how much water do you actually need to drink each day?

WATER: ARE YOU GETTING ENOUGH?

There are many health benefits from drinking water including weight loss and reduced fluid retention, but above all, the body simply cannot function without it. But how much water do you actually need to drink each day?

No Easy Answer

The truth is, your water needs depend on many factors, including your health, how active you are and where you live. No single formula fits everyone, so understanding your body's individual needs is essential in helping to determine how much water you should be drinking each day to maintain optimal health and stay hydrated.

Health Benefits of Water

Understanding how your body and health can benefit from water is the first step to determining how much water you need each day. Water is your body's principal chemical component, comprising, on average, 60 percent of your weight. Every system in your body depends on water. For example, water flushes toxins out of vital organs, carries nutrients to your cells and provides a moist environment for ear, nose and throat tissues. Lack of water can lead to fatigue, dizziness, cramping and other symptoms of dehydration.

Every day you lose water through breathing, perspiration and urine and bowel movements. For your body to function properly, you must replenish its water supply by consuming beverages and foods that contain water.

Recommended Daily Intake

Replacement and simple dietary recommendations can help approximate water needs for an average adult living in a temperate climate. The replacement approach refers to replacing the normal amount of fluids you typically lose each day. On average, two liters of water or other beverages a day (a little more than eight cups) along with your normal diet, will replace lost fluids.

Another approach to staying hydrated is to follow basic dietary recommendations. On average, men should consume three liters (about 13 cups) of liquid a day and women 2.2 liters (about nine cups). As a rule of thumb, if you drink enough fluids to rarely feel thirsty, and always produce colorless or slightly yellow urine, your fluid intake is most likely adequate. It is important to remember, however, that you may need to modify your total fluid intake depending on how active you are, the climate you live in, your health status and whether or not you're pregnant or breastfeeding.

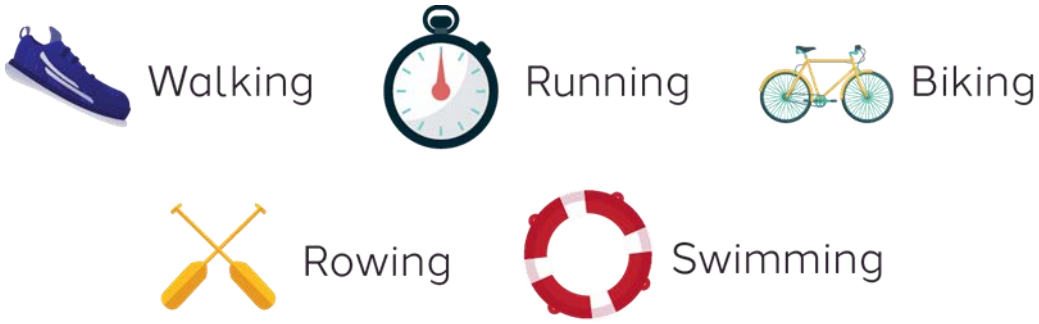
Exercising improves your health by reducing the amount of time you're sitting or sedentary. Sitting or remaining sedentary for extended periods can make you more susceptible to chronic disease. Increasing your exercise level is also likely to help you relax and be more energetic as you go about your day.

ELEMENTS OF AN EXERCISE PROGRAM

Exercise is more than just cardiovascular activity. In fact, a complete exercise regimen should include aerobic exercise, strength training and stretching.

Aerobic Exercise

Aerobic exercise is a type of physical activity that you can sustain for more than a few minutes, with the end goal being improved cardiorespiratory fitness. Commitment to a regular physical activity program is more important than the intensity of your workouts. Choose exercises you're likely to pursue and enjoy, such as these activities:



Walking

If you're looking for an easy and inexpensive way to stay healthy or lose weight, you need nothing more than your own two feet. Walking is an ideal form of exercise—it's free, and you can do it almost anytime and anywhere. Walking is also a great way to maintain a healthy weight or to shed those extra pounds.

You can walk to maintain your health or as part of a weight-loss program. To get moving, experts advise beginners to start with a 15- or 30-minute walk daily, adding five or 10 minutes to the walking session time per week. More specifically:

- To maintain your health, walk 30 minutes a day most days of the week at a "talking" pace, which means you're able to carry on a conversation comfortably while walking.
- If you're walking for weight loss, walk 45 to 60 minutes a day at a medium to fast pace. In addition, don't skip more than two days per week.
- For aerobic and cardiovascular fitness, walk 20 minutes at a very fast pace (you should be breathing hard) three to four days a week.

After walking, gentle stretching can help keep your muscles from being sore. It's also wise to warm up before walking fast or going a long distance.

Getting started on your
WELLNESS JOURNEY

MANAGING STRESS

According to a Gallup poll, 55% of Americans experience stress on a daily basis—making the United States one of the most stressed-out nations in the world. Unfortunately, chronic and long-term stress can greatly increase your risk of developing a serious health condition.

What Is Stress?

Stress is your body's natural response to any type of demand. It's a feeling of emotional or physical tension in response to an event or thought that causes you to be angry, nervous or frustrated. For example, you may feel stressed about meeting a deadline or when traveling.

While short-term instances of stress are not typically harmful, prolonged stress that isn't addressed can become a serious health concern and can lead to burnout. Examples of chronic and long-term stress factors include ongoing financial troubles and heavy workloads. Stress that is left unchecked can contribute to health problems like heart disease, diabetes, high blood pressure and obesity.

What Are the Symptoms of Stress?

Stress affects your mental health, but it can show itself in other ways too. Back pain, poor focus and headaches can all be symptoms of stress. Here are some other signals that you may be feeling stressed:

- Trouble sleeping or fatigue
- Feelings of anxiety, depression, irritability, restlessness or anger
- Upset stomach
- Change in appetite
- Social withdrawal
- Chest pain

Where Can I Learn More?

If you still have trouble coping with stress, talk with your doctor about treatment options. Don't wait too long before seeking help, or you'll risk letting the stress pile up.

How Can You Address Stress?

While it may not be possible to eliminate all the stressors in your life, there are plenty of ways to reduce their effects. Recognizing the signs of stress is the first step to improving your health. Consider these tactics to keep stress at bay:

- Plan and prioritize your most important responsibilities.
- Limit interruptions so you don't have to refocus each time you're distracted. Some ways to limit distractions include using a Do Not Disturb function on your phone or scheduling time on your calendar to finish a project.
- Take breaks away from your workstation to mentally regroup. Consider going for a short walk to reenergize your mind.
- Listen to relaxing music to help you calm down.
- Take time off from work to clear your mind.
- Avoid caffeine, as this stimulant has been proven to worsen feelings of stress.
- Get some exercise to work off your stress. Exercise releases endorphins that can help you relax.
- Try meditating. Meditation is an activity that can calm your mind and keep you focused on the present.
- Learn to say no. Often, we overschedule ourselves, which can lead to feelings of stress. Don't be afraid to say no to taking on a project or going to an event if you need a break or time for yourself.

Your plan requires the designation of a primary care provider.

UnitedHealthcare generally requires 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.

Until you make this designation, **UnitedHealthcare** designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact:

UnitedHealthcare

(866) 633-2446
www.myuhc.com

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

Obstetrical or gynecological care

You do not need prior authorization from UnitedHealthcare or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a Healthcare professional in our network who specializes in obstetrics or gynecology.

The Healthcare 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 Healthcare professionals who specialize in obstetrics or gynecology, contact UnitedHealthcare at (866) 633-2446 or online at www.myuhc.com

Important Notice from The Firm 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 The Firm 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 costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

For more information about this notice or your current prescription drug coverage, please contact your human resources department

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

For More Information About Your Options Under Medicare Prescription Drug Coverage. .

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

For more information about Medicare prescription drug coverage:

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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).

Know your rights
FEDERAL LAWS & DISCLOSURES

DISCLOSURE NOTICE: SECTION 125 & HIPAA

SECTION 125

Under certain circumstances, you may be allowed to make changes to your benefits elections during the plan year, such as additions, deletions and cancellations, depending on whether or not you experience an eligible qualifying event as determined by the Internal Revenue Service (IRS) Code, Section 125. You may change a benefit election upon the occurrence of a valid qualifying event only if the event affects your own, your spouse's or your dependent's coverage eligibility.

If you experience a qualifying event, you must report the qualifying event to Human Resources Department within 30 days of the event. Beyond 30 days, additions and deletions will be denied and you may be responsible both legally and financially for any claims and/or expenses incurred as a result of any dependent(s) who continued to be enrolled who no longer meet the entity's eligibility requirements.

If approved, most election changes will be effective on the date of the qualifying event for additions; cancellations will be processed at the end of the month.

Payroll deductions for health, dental, vision and certain supplemental accident insurance premiums, are deducted from your gross income before your income is taxed. The entity's plan is known as a Cafeteria Benefit Plan and is governed by IRS Code, Section 125. This pre-tax benefit means you pay less tax on a per-pay and annual basis. See examples of Qualifying Life Events for allowable enrollment changes as determined by Section 125 of the IRS Code.

QUALIFYING EVENTS

- Change is status *(for example, employee's legal marital status, number of dependents, employment status, dependent eligibility change, change in residence or adoption proceedings);*
- Significant cost changes
- Significant curtailment of coverage
- Change in coverage under other employer's plan
- Addition or significant improvement of benefit package option;
- FMLA leaves of absence
- Loss of group health coverage sponsored by a governmental or educational institution
- COBRA qualifying events
- HIPAA special enrollment events
- Judgement, decree, or court order, such as Qualified Medical Child Support Order (QMCSO)
- Medicare or Medicaid entitlement

HIPAA SPECIAL ENROLLMENT NOTICE

This notice is being provided to ensure that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive coverage at this time.

Loss of Other Coverage

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Example: You waived coverage because you were covered under a plan offered by your spouse's employer. Your spouse terminates his employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under our health plan.

Marriage, Birth or Adoption

If you have a new dependent as a result of a marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth or placement for adoption.

Example: When you were hired by us, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this group health plan. However, you must apply within 30 days from the date of your marriage.

Medicaid or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired by us, your children received health coverage under CHIP and you did not enroll them in our health plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this group health plan if you apply within 60 days of the date of their loss of CHIP coverage.

For More Information or Assistance

To request special enrollment or obtain more information, please contact your human resources department.

DISCLOSURE NOTICE: NEWBORNS & MOTHERS, WHACR, MEDICAID/CHIP

NEWBORNS' AND MOTHER'S HEALTH PROTECTION ACT

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT *Enrollment 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. Therefore, the following deductibles and coinsurance apply:

UNITEDHEALTHCARE	CRWA-M (NHP HMO 2022 (OA)-Fusion) Rx Plan: NH42	CRZV-M (UHC INS 2022-Fusion) Rx Plan: D00	AQUQ (UHC INS 2022-HSA) Rx Plan: 570-HSA	BWMD (UHC INS 2022-Traditional) Rx Plan: 560
Individual	$5,000	$5,000	$4,000	$5,000
Family	$10,000	$10,000	$8,000	$10,000
Co-Insurance	100%	100%	100%	70%

If you would like more information on WHCRA benefits, call your plan administrator.

WOMEN'S HEALTH AND CANCER RIGHTS ACT *Annual Notice*

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator for more information.

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 below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, 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).

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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 January 31, 2022. Contact your State for more information on eligibility –

ALABAMA MEDICAID
Website: http://myalhipp.com **Phone:** 1-855-692-5447

ALASKA MEDICAID
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS MEDICAID
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA MEDICAID
Health Insurance Premium Payment (HIPP) Program
Website: http://dhcs.ca.gov/hipp
Phone: 916-445-8322 | **Fax:** 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO MEDICAID & CHILDREN HEALTH PLAN PLUS CHP+
Health First Colorado: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI):
https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI
Customer Service: 1-855-692-6442

FLORIDA MEDICAID
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/ hipp/index.html
Phone: 1-877-357-3268

GEORGIA MEDICAID
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162 Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party- liability/childrens-health-insurance-program-reauthorization- act-2009-chipra
Phone: 678-564-1162 Press 2

INDIANA MEDICAID
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone: 1-800-457-4584

IOWA MEDICAID AND CHIP (HAWKI)
Medicaid: https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki: http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

KANSAS MEDICAID
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884

KENTUCKY MEDICAID
Kentucky Integrated Health Insurance Premium Payment Program (**KI-HIPP**) **website:**
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328 **Email:** KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA MEDICAID
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline)
1-855-618-5488 (LaHIPP)

MAINE MEDICAID
Enrollment Website:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-442-6003 **TTY:** Maine relay 711

Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 800-977-6740. **TTY:** Maine relay 711

MASSACHUSETTS MEDICAID AND CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840

MINNESOTA MEDICID
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI MEDICID
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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 October 15, 2021. Contact your State for more information on eligibility –

MONTANA MEDICAID
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 800-694-3084

NEBRASKA MEDICAID
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA MEDICAID
Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE MEDICAID
Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 603-271-5218 **TTY:** Maine relay 711
Toll free number for the HIPP program:
1-800-852-3345, ext 5218

NEW JERSEY MEDICAID AND CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK MEDICAID
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA MEDICAID
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA MEDICAID
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA MEDICAID AND CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON—MEDICAID
Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA MEDICAID
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 1-800-692-7462

RHODE ISLAND MEDICAID
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347
or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA—MEDICAID
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA—MEDICAID
Website: http://dss.sd.gov
Phone: 1-888-549-0820

TEXAS MEDICAID
Website: http://gethipptexas.com/
Phone: 1-800-440-0493

UTAH MEDICID
Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT MEDICAID
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA MEDICAID AND CHIP
Website: https://www.coverva.org/en/famis-select
https://www.coverva.org/en/hipp
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-800-432-5924

WASHINGTON MEDICAID
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA MEDICAID AND CHIP
Website: https://dhhr.wv.gov/bms/ | http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699- 8447)

WISCONSIN JERSEY MEDICAID AND CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING MEDICAID
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

DISCLOSURE NOTICE: COBRA CONTINUATION COVERAGE RIGHTS

INTRODUCTION

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

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

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

WHAT IS COBRA CONTINUATION COVERAGE?

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

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

WHEN IS COBRA COVERAGE AVAILABLE?

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

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).
- *If the plan has retirement coverage:* Commencement of a proceeding in bankruptcy with respect to the employer

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to your human resources department.

Keep your Plan informed of address changes.*

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

There is also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or the month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below.

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

1100 NE 163 Street | North Miami Beach, Florida 33162

Telephone: (877) 948-8887 www.sapoznik.com