CHRIST ABOVE ALL

BRYAN COLLEGE

2022 BENEFITS OVERVIEW

WELCOME TO YOUR 2022 BENEFITS!

It's time to enroll in your 2022 employee benefits!

Don't miss your once-a-year opportunity to make new benefit elections for you and your family.

The elections you make will be in place from January 1 - December 31, 2022.

Employees will use the BenefitFirst system to elect benefits online this year. The system will be open from December 6 - December 10, 2021.
See page 13 for instructions on using this system.

We appreciate your daily contributions to Bryan College and we value your continued commitment. Our goal is to provide a benefits package that is competitive, while giving you the protection and peace of mind you deserve. The health care claims we incur directly affect the cost of coverage for you and the college - health care costs have made a significant impact on our budget. They have likely also affected your personal budget.

We view health care as a shared responsibility. Bryan College carefully manages the plans and provides you with the tools you need to make informed benefit decisions. Your role is to use your benefits wisely, manage your expenses carefully, and make an effort to live a healthy lifestyle. Together, we can steady our costs and keep the comprehensive benefits package we offer you sustainable long-term. Take a look inside this guide for details about your benefits and the enrollment process.

WHAT'S INSIDE

This guide is designed to provide a general overview of your benefits at Bryan College. It is not a contract or an official interpretation of the benefit plans. For more detailed information, please refer to your summary plan descriptions or the legal plan documents.

Should any questions or conflicts arise, the plan documents will be the final authority in determining your benefits. Bryan College reserves the right to modify or discontinue the plans at any time. This document was prepared exclusively for full-time employees of Bryan College. Unauthorized reproduction is strictly prohibited.

Please contact Human Resources if you have any questions regarding your benefits plan.

ENROLLMENT CHANGES

Changes to your enrollment may be made annually during open enrollment each year. Mid-year changes may be made for the following qualifying events such as marriage/ divorce, birth/adoption, death, change in job status of yourself or your spouse, and or change in Medicaid/CHIP eligibility.

However, all changes must be made within 30 days (with the exception of Medicaid/CHIP which gives you up to 60 days) of your qualifying event. You must notify Human Resources immediately when you experience a qualifying event.

SECTION 125 PLAN PREMIUM CONVERSION

Section 125 Premium Conversion Plan lets you exclude your Medical, Dental and Vision premiums from your taxable income, meaning your premiums will come out of your income pre-tax. This lowers your taxable income. By default, your premiums will be deducted pre-tax, increasing your take-home pay anywhere from a couple hundred dollars to a thousand or more annually.

You may elect to have your premiums deducted after-tax. If you wish to have your premiums deducted after-tax, please see Human Resources.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see the Annual Notices for more details.

MEDICAL BENEFITS

Cigna | 1-800-997-1654 | www.cigna.com | Group Number: 631740

Bryan College's medical benefits are provided through Cigna.

Bryan College offers plan options in the Open Access Plus and Local Plus networks. In these networks, you have the flexibility to go to any provider that you choose; however, anytime you select an in-network physician or facility, you will see significant discounts and savings.

If you select an out-of-network physician or facility, you will be subject to higher deductible and out-of-pocket maximums. You are also responsible for the difference between billed charges and the maximum allowable charge. It definitely works to your advantage to go in network whenever possible.

To find an in-network provider near you, go to www.cigna.com and click on "Find A Doctor, Dentist or Facility." Please be sure to consult either the online directory or the Cigna customer service department to confirm that your provider participates in the network.

MONTHLY PREMIUMS	PPO - Option 1 *Open Access Plus*	PPO - Option 2 *Local Plus*	HSA - Option 3 *Open Access Plus*	HSA - Option 4 *Local Plus*
Employee Only	$149.00	$118.00	$16.00	$5.00
Employee + One	$465.00	$404.00	$205.00	$170.00
Employee + Family	$594.00	$505.00	$218.00	$180.00

HEALTH SAVINGS ACCOUNT

Health Equity | 1-866-889-8583 | www.myhealthequity.com

If you are enrolled in the High Deductible Health Plan, you are eligible to participate in a Health Savings Account (HSA) through Health Equity.

An HSA is established to pay for future qualified medical, dental and vision expenses that are incurred by you or your dependents enrolled in the plan, allowing you to set aside money pre-tax.

Your contributions to the HSA will be payroll deducted and the funds deposited into a HSA account. When a qualified expense is incurred, you use your Health Savings Account debit card or request reimbursement for the expense. Unused account dollars are yours to keep, even if you retire or leave the company.

Please note: If you can't claim a child as a dependent on your tax returns, then you may not spend HSA dollars on services provided to that child.

MEDICAL BENEFITS CHART

EMPLOYEE AMOUNTS*		PPO Option 1- *Open Access Plus* Option 2- *Local Plus*	HSA Option 3- *Open Access Plus* Option 4- *Local Plus*
Benefit Plan Features			
Deductible	Individual / Family	$2,750 / $5,500	$5,500 / $11,000
Out-of-Pocket Max	Individual / Family	$5,200 / $10,400	$6,000 / $12,000
Preventive Care			
Preventive Care Visits		100%*	
Office Visits			
Primary Care Provider		$40 copay	30% after deductible
Specialist		$80 copay	30% after deductible
Physical, Occupational, Speech, Audiology and Cognitive Therapy		30% after deductible	30% after deductible
Outpatient and Group Therapy		30% after deductible	30% after deductible
Imaging Services			
Physician's Office (x-ray, ultrasound)		30% after deductible	30% after deductible
Non-Hospital, Independent Facility Advanced Imaging (MRI, CAT, PET)		30% after deductible	30% after deductible
Hospital Outpatient Advanced Imaging (MRI, CAT, PET)		30% after deductible	30% after deductible
Surgery			
Non-Hospital, Independent Facility Surgery		30% after deductible	30% after deductible
Outpatient or Inpatient Hospital Surgery		30% after deductible	30% after deductible
Emergency Care			
Emergency Care (Includes urgent care centers at a hospital. Copay waived for inpatient hospital admissions)		30% after deductible	30% after deductible
Other Services			
Home Health Care, Durable Medical Equipment, Prosthesis, and Most Other Covered Services		30% after deductible	30% after deductible
Pharmacy			
Generic		$10	30% after deductible
Preferred		$75	30% after deductible
Non-Preferred		$150	30% after deductible

*Review plan documents for out-of-network rates, prior authorization requirements, limits on the number of visits per year and service restrictions.

FLEXIBLE SPENDING ACCOUNT

HRPro | www.hrpro.com

Bryan College offers employees the option to defer money on a pre-tax basis for use on approved medical and dependent care expenses. This is NOT insurance. This is simply a way for you to save on your medical (FSA) or day-care expenses (DCA) by setting money aside from your gross income, pre-tax for expenses that you anticipate for the plan year.

Medical FSA: With the Medical FSA, the total dollar amount set aside for the plan year is eligible for withdrawal from the account on day one of your first payroll deduction towards the account. The maximum medical FSA annual contribution amount is $2,850. If you are a new hire and enroll in the plan midyear, your rates will be prorated for the annual amount you select.

Dependent Care Account (DCA): You may elect to set money aside to use for your approved childcare services, provided at a day-care facility, in your home, or in someone else's residence through a DCA. Certain requirements must be satisfied for the services to be approved for reimbursement. The maximum DCA annual contribution amount is $5,000 per family (if you are head of household or married and file a joint tax return) or $2,500 (if you are married and file a separate tax return).

Without FSA	VS	With FSA
$30,000	**Gross Income**	$30,000
$0	**FSA Contributions**	$2,750
$30,000	**Gross Income**	$27,250
	Estimated Taxes	
$2,550	**Federal***	$1,770
$900	**State****	$747
$2,295	**FICA**	$1,906
$24,255	**After-Tax Earnings**	**$22,827**
$3,000	**Eligible Out-of-Pocket Medical / Dependent Care Expenses**	$350
$21,255	**Remaining Spendable Income**	$22,477
$ -	**Spendable Income Increase**	**$1,222**

This example is for illustrative purposes only. Every situation varies and it is recommended you consult a tax advisor for all tax advice.

* Assumes standard deductions and four exemptions

** Varies, assumes 3 percent

Note: You can only deduct what is in your account for Dependent Care. By setting aside money pre-tax into either a FSA or DCA, you save on taxes and take home more spendable income!

Please contact customer service or Human Resources for a list of eligible medical and dependent care expenses.

****Important- We are moving from TASC to HRPro for flex plan. Please spend down any remaining funds in your TASC flex account. December 31st will be the last day to file claims with TASC. Remaining funds up to $550 will rollover to HRPro but will not be available until summer 2022.**

FINDING A DOCTOR OR DENTIST IN OUR DIRECTORY IS EASY

Is your doctor, dentist or hospital in the Cigna network? Cigna's online directory makes it easy to find who (or what) you're looking for.

SEARCH OUR NETWORK IN FOUR SIMPLE STEPS

Step 1

Go to **Cigna.com**, and click on "Find a Doctor" at the top of the screen. Then, under "Not a Cigna Customer Yet?" select "Plans through your employer or school."

(If you're already a Cigna customer, log in to **myCigna.com** or the myCigna® app to search your current network. To search other networks, use the **Cigna.com** directory.)

Step 2

Enter the location in which you want to search.

Step 3

Optional – Select one of the plans offered by your employer during open enrollment.

Step 4

Type in who or what you are looking for.
Or browse the A-to-Z glossary of providers and procedures or keywords option.

That's it! You can also refine your search results by distance, years in practice, specialty, languages spoken and more.

Search first. Then choose Cigna.

There are so many things to love about Cigna. Our directory search is just the beginning.

After you enroll, you'll have access to **myCigna.com** – your one-stop source for managing your health plan, anytime, just about anyplace. On **myCigna.com**, you can estimate your health care costs, manage and track claims, learn how to live a healthier life and more.

Questions? Call **1-866-494-2111**

Cigna®

Offered by: Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company or their affiliates.

Providers and facilities that participate in the Cigna network are independent practitioners solely responsible for the treatment provided to their patients. They are not agents of Cigna. Product availability may vary by location and plan type and is subject to change. All group health insurance policies and health benefit plans contain exclusions and limitations. For costs and details of coverage, see your plan documents.

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company (CHLIC), Connecticut General Life Insurance Company, Cigna Behavioral Health, Inc., and HMO or service company subsidiaries of Cigna Health Corporation and Cigna Dental Health, Inc., including Cigna HealthCare of Arizona, Inc., Cigna HealthCare of California, Inc., Cigna HealthCare of Colorado, Inc., Cigna HealthCare of Connecticut, Inc., Cigna HealthCare of Florida, Inc., Cigna HealthCare of Georgia, Inc., Cigna HealthCare of Illinois, Inc., Cigna HealthCare of Indiana, Inc., Cigna HealthCare of St. Louis, Inc., Cigna HealthCare of North Carolina, Inc., Cigna HealthCare of New Jersey, Inc., Cigna HealthCare of South Carolina, Inc., Cigna HealthCare of Tennessee, Inc. (CHC-TN), Cigna HealthCare of Texas, Inc., Cigna Dental Health Plan of Arizona, Inc., Cigna Dental Health of California, Inc., Cigna Dental Health of Colorado, Inc., Cigna Dental Health of Delaware, Inc., Cigna Dental Health of Florida, Inc., a Prepaid Limited Health Services Organization licensed under Chapter 636, Florida Statutes, Cigna Dental Health of Kansas, Inc., Cigna Dental Health of Kentucky, Inc., Cigna Dental Health of Maryland, Inc., Cigna Dental Health of Missouri, Inc., Cigna Dental Health of New Jersey, Inc., Cigna Dental Health of North Carolina, Inc., Cigna Dental Health of Ohio, Inc., Cigna Dental Health of Pennsylvania, Inc., Cigna Dental Health of Texas, Inc., and Cigna Dental Health of Virginia, Inc. Policy forms: Medical: OK - HP-APP-1 et al., OR - HP-POL38 02-13, TN - HP-POL43/HC-CER1V1 et al. (CHLIC); GSA-COVER, et al. (CHC-TN). Dental (CHLIC): OK – Indemnity/DPPO: HP-POL99, DHMO: POL115; OR - Indemnity/DPPO/DEPO: HP-POL68, DHMO: HP-POL121 04-10; TN – Indemnity/DPPO/DEPO: HP-POL69/HC-CER2V1 et al., DHMO: HP-POL134/HC-CER17V1 et al. The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc.

TELADOC

Teladoc | 1-800-835-2362 | www.teladoc.com

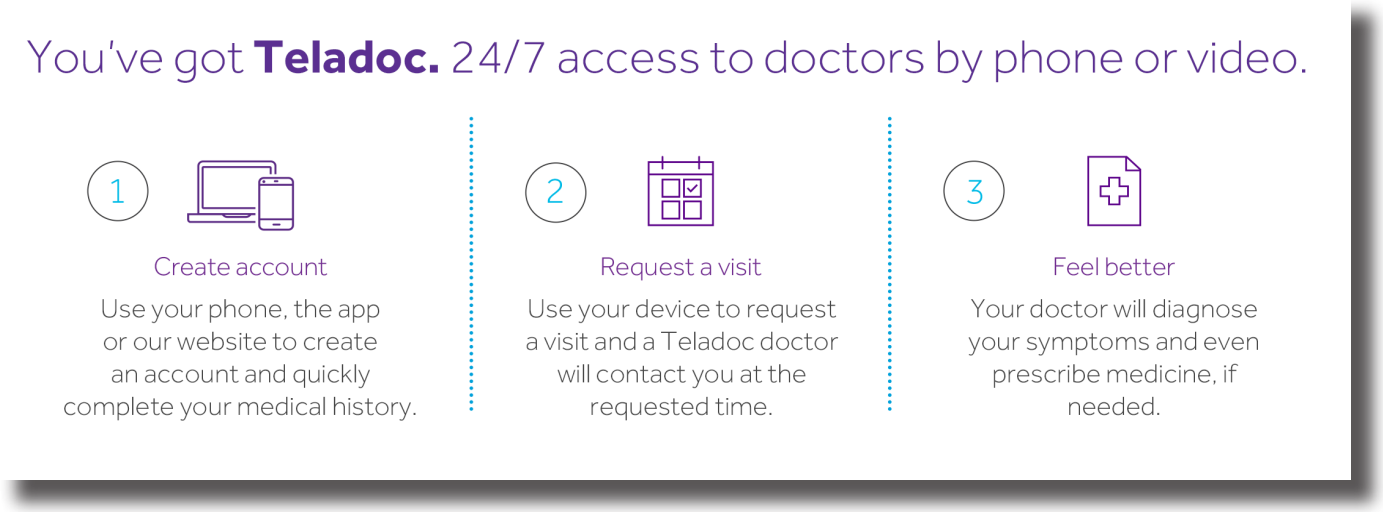
Bryan College is proud to offer Teladoc to all full-time employees and their dependents. Teladoc is a national network of board certified physicians providing telephonic consultations 24/7 when your primary care physician is not available.

Teladoc doctors are U.S. board certified in Internal Medicine, Family Practice, or Pediatrics. They average 15 years practice experience, are licensed in your state, and incorporate Teladoc into their day-to-day practice as a way to provide people with convenient access to quality medical care.

Teladoc does not replace your primary care physician. Teladoc should be used when you need immediate care for non-emergent medical issues. It is an affordable, convenient alternative to urgent care and ER visits.

You can talk with a Teladoc doctor via a phone consult, video consult within the secure member portal, or video consult within the Teladoc mobile app. To request a consult, visit the Teladoc website, log into your account and click “Request a Consult”. You can also call Teladoc to request a consult by phone, or request a consult through the Teladoc mobile app. A doctor will call you back in 16 min, on average.

Prescriptions. Teladoc doctors can prescribe short term medication for a wide range of conditions when medically appropriate. Teladoc doctors do not prescribe substances controlled by the DEA, nontherapeutic and/or certain other drugs which may be harmful because of their potential abuse. When you go to your pharmacy of choice to pick up the prescription, you may use your health/prescription insurance card to help pay for the medication. You will be responsible for the co-pay based on the type of medication and your plan benefits.



DENTAL BENEFITS

Cigna | 1-800-997-1654 | www.cigna.com | Group Number: 631740

Your dental benefits at Bryan College are provided by Cigna. This dental plan is a PPO (similar to your medical plan), in that you may visit any provider that you choose, however, you will most likely see increased benefit levels if you go to a provider in network.

MONTHLY PREMIUMS	Basic	Deluxe
Employee Only	$15.00	$19.00
Employee + One	$35.00	$43.00
Family	$66.00	$80.00

DENTAL BENEFITS	Basic	Deluxe
Deductible: (Aggregate) Individual / Family	$25 / $75	$25 / $75
Benefits Paid by the Plan		
Calendar Year Maximum	$1,000	$1,500
Preventive - Includes exams, cleanings (2 per year), sealants, x-rays	100%	100%
Basic - Fillings, periodontic services, minor oral surgery	80%	100%
Major - Root Canals, periodontic surgery, crowns, dentures, bridges, anesthesia	50%	80%

To find a provider in the network, visit www.cigna.com and click on "Find A Doctor, Dentist or Facility."

VISION BENEFITS

Cigna | 1-800-997-1654 | www.cigna.com | Group Number: 631740

Your vision plan is provided by Cigna. When using in-network providers, this PPO plan covers most exams, eyeglass and medically necessary contacts in full. Discounts are available for upgrades on covered frames and lenses, as well. To find an in-network provider or surgery center, call customer service or go to www.cigna.com and click on "Find A Doctor, Dentist or Facility."

MONTHLY PREMIUMS	
Employee Only	$7.08
Employee + One	$12.52
Family	$19.66

VISION BENEFITS	In-Network	
	Frequency	Details
Vision Exam	Once every 12 months	$10 copay
Prescription Glasses		
Frames	Once every 24 months	$0 copay up to $120 allowance, 20% off balance over allowance
Lenses	Once every 12 months	$10 copay
Contact Lenses (instead of glasses)		
Conventional	Once every 12 months	$0 copay up to $120 allowance, 15% off balance over allowance
Disposable		$0 copay up to $120 allowance
Medically Necessary		Paid in Full

Should you choose to see an out-of-network provider, Cigna will reimburse you up to a specified amount. Please see the plan document for the out-of-network reimbursement schedule.

BASIC AND VOLUNTARY LIFE

Guardian | 1-800-627-4200 | www.guardianananytime.com | Group Number: 564733

BASIC LIFE/AD&D INSURANCE

At Bryan College, Basic Life/Accidental Death and Dismemberment (AD&D) Insurance is a provided benefit at no cost to you through Guardian. The coverage amount is $50,000.

AD&D insurance pays an additional amount based on a specific list of losses such as loss of life, limb, or sight due to an accident. Please remember to contact Human Resources when you need to update your beneficiaries. Amounts are subject to age reductions beginning at age 70.

VOLUNTARY LIFE INSURANCE

You have the option to purchase Voluntary Term Life through Guardian. You may purchase:

- Employee coverage is up to $500,000. Newly hired employees may purchase the first $150,000 without evidence of good health.
- Spousal coverage is up to $150,000, and not to exceed 50% of employee amount. Newly hired employees may purchase the first $30,000 without evidence of good health.
- Child(ren) coverage, the full amount is available without evidence of good health. You may purchase up to $10,000 of coverage on child(ren) age 6 months to 26 years (if a full-time student).

Benefits are subject to age reduction beginning at age 70.

DISABILITY PRODUCTS

Guardian | 1-800-627-4200 | www.guardianananytime.com | Group Number: 564733

VOLUNTARY LONG-TERM DISABILITY (LTD) INSURANCE

LTD Insurance can protect your income in case of a long-term injury or illness. This coverage is provided through Guardian and paid entirely by you. Your LTD benefits are equal to 60% of your basic monthly earnings not to exceed $5,000 for Class 1 and $2,500 for Class 2 employees per month and start after you have been deemed disabled for 90 days. Pre-existing condition limitations may apply.

***Pre-Existing Condition**: No benefit (or increase in benefit) is payable for a disability that is the result of a pre-existing injury or illness, including pregnancy, if the disability begins during the first 12 months of coverage or increase in coverage, unless the insured is treatment free for 3 consecutive months of coverage.*

VOLUNTARY PRODUCTS

Guardian | 1-800-627-4200 | www.guardianananytime.com | Group Number: 564733

CRITICAL ILLNESS

Critical Illness insurance is a supplemental policy for people who already have health insurance. It provides you with an additional payment to cover expenses like deductibles, treatments and living costs. You may choose a lump sum benefit of $5,000 to $20,000 in increments of $2,500 for yourself. You may choose a lump sum benefit of $2,500 to $10,000 in increments of $1,250 for your spouse. You may elect 25% of the employee benefit for your children.

Critical illnesses include cancer, heart attack, stroke and Parkinson's disease as well as other illnesses. You are eligible to enroll in this benefit each year at annual open enrollment. Rates can be found on the open enrollment portal on Benefit*first*.

ACCIDENT

You may elect accident coverage for yourself and your dependents. Accident insurance pays you a lump sum benefit after you suffer an accident. A detailed list of services and procedures can be found on the open enrollment portal on Benefit*first* as well as rates for you and your dependents. You are eligible to enroll in this benefit each year at annual open enrollment.

HOSPITAL INDEMNITY

Hospital Indemnity insurance can cover some of the cost associated with a hospital stay, letting you focus on recovery. This benefit will pay $1,000 per admission to a max of 1 admission per year per insured and to a maximum of 3 admissions per year per covered family. If you are admitted to a hospital for a covered sickness or injury, you will receive payments that can be used to cover deductibles and travel to and from the hospital for treatment. You are eligible to enroll in this benefit each year at annual open enrollment. Rates and benefits can be found on the open enrollment portal on Benefit*first*.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Guardian®

Employee Assistance Program

We all need a little support every now and then.

Guardian's Employee Assistance Program gives you and your family members access to confidential personal support, across everything from stress management and nutrition to handling legal or financial issues.

The services available include consultations with experts, as well as access to resources and discounts designed to help you in a variety of different ways.

How it can help

Consultative services are available to provide direct support and assistance

Work/life assistance that can help you save money and balance commitments

Access legal and financial assistance and resources – including WillPrep Services

How to access

To access the WorkLifeMatters Employee Assistance Program, you'll need a few personal details.

Visit
ibhworklife.com

User ID
Matters

Password
wlm70101

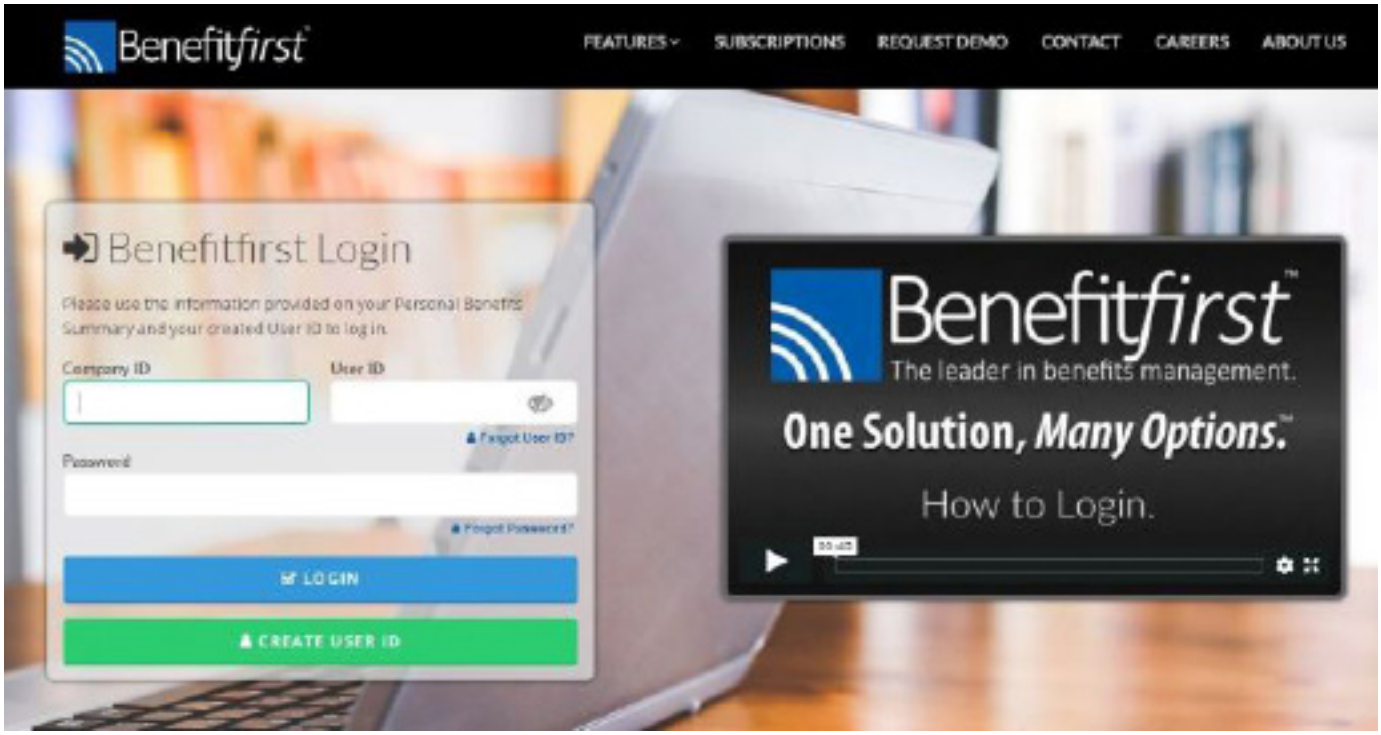
For more information or support, you can reach out by phoning **1800 386 7055**. The team is available 24 hours a day, 7 days a week[1].

This service is only available if you purchase qualifying lines of coverage. See your plan administrator for more details.

WorkLifeMatters Program services are provided by Integrated Behavioral Health, Inc., and its contractors. Guardian does not provide any part of WorkLifeMatters program services. Guardian is not responsible or liable for care or advice given by any provider or resource under the program. This information is for illustrative purposes only. It is not a contract. Only the Administration Agreement can provide the actual terms, services, limitations and exclusions. Guardian and IBH reserve the right to discontinue the WorkLifeMatters program at any time without notice. Legal services provided through WorkLifeMatters will not be provided in connection with or preparation for any action against Guardian, IBH, or your employer. WorkLifeMatters Program is not an insurance benefit and may not be available in all states.

[1]Office hours: Monday-Friday 6 a.m.–5 p.m. PST.

BENEFITFIRST



Enrolling in Benefit*first* is easy!

You may enroll online at www.benefitfirst.com. Your Company ID is 870.

- Enter your name as it appears on your paycheck and your date of birth in the following format: mm/dd/yyyy.
- Choose a unique, confidential password and click SUBMIT.
- At the Bryan College homepage choose ENROLL NOW!
- If you are a new hire, choose ENROLL IN OR DECLINE BENEFITS AS A NEWLY ELIGIBLE EMPLOYEE.
- If you are an existing employee going through annual enrollment or wanting to make a family status change, choose the appropriate transaction and click CONTINUE.
- Check your personal information for accuracy and click NEXT.
- Add any eligible dependents to the dependent screen and click NEXT.
- Starting with the medical screen, complete your selections. Choose the level of coverage, the plan desired and the dependents to be added.
- When you get to the last enrollment screen, you will be asked to review your elections and certify them by re-entering your password.
- The final step is to click the SUBMIT button. That's it… the entire process can take as little as 4 minutes to complete.

ANNUAL NOTICES

IMPORTANT NOTICES FROM OUR COMPANY REGARDING THE PLAN

The following notices provide important information about the group health plan provided by your employer. Please read the attached notices carefully and keep a copy for your records.

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

Bryan College
Contact: Angie Price, Director of Human Resources
Phone: 423-775-7269
Mailing Address: 721 Bryan Drive, Dayton, TN 37321
Distribution Date: November 2021

HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that we notify you about important provisions in the plan. You have the right to enroll in the plan under its "special enrollment provision" provided that you meet participation requirements, if you marry, acquire a new dependent, or if you decline coverage under the plan for an eligible dependent while other coverage is in effect and later the dependent loses that other coverage for certain qualifying reasons. Special enrollment must take place within 30 days of the qualifying event. If you are declined enrollment for yourself or your dependents (including your spouse) while coverage under Medicaid or a state Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and your dependents in this program if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after you or your dependents' Medicaid or CHIP coverage ends. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or a CHIP program with respect to coverage under this plan, you may be able to enroll yourself and your dependents (including your spouse) in this plan. However, you must request enrollment within 60 days after you or your dependents become eligible for the premium assistance. To request special enrollment or obtain more information, contact the plan administrator indicated in this notice.

HIPAA Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that we maintain the privacy of protected health information, give notice of our legal duties and privacy practices regarding health information about you and follow the terms of our notice currently in effect.

You may request a copy of the current Privacy Practices from the Plan Administrator explaining how medical information about you may be used and disclosed, and how you can get access to this information. As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

You have the right to inspect and copy, right to an electronic copy of electronic medical records, right to get notice of a breach, right to amend, right to an accounting of disclosures, right to request restrictions, right to request confidential communications, right to a paper copy of this notice and the right to file a complaint if you believe your privacy rights have been violated.

SPECIAL ENROLLMENT NOTICE

If you are declining enrollment 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) provided that you meet participation requirements. However, you must request enrollment within 30 days or any longer period that applies under the plan, after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days or any longer period that applies under the plan, after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact the plan administrator mentioned above.

USERRA

The Uniformed Services Employment and Reemployment Rights Act (USERRA), protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

Reemployment Rights

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- You ensure that your employer receives advance written or verbal notice of your service;
- You have five years or less of cumulative service in the uniformed services while with that particular employer;
- You return to work or apply for reemployment in a timely manner after conclusion of service; and
- You have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

Right to Be Free From Discrimination and Retaliation

If you are a past or present member of the uniformed service; have applied for membership in the uniformed service; or are obligated to serve in the uniformed service; then an employer may not deny you: initial employment; reemployment; retention in employment; promotion; or any benefit of employment because of this status. In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

Health Insurance Protection

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military. Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

Enforcement

The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations. For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its website at http://www.dol.gov/vets. An interactive online USERRA Advisor can be viewed at https://webapps.dol.gov/elaws/vets/userra/. If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation. You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

GINA

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to any requests for medical information, if applicable. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Discrimination is Against the Law

The Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Company does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Company:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - •Qualified sign language interpreters
  - •Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - •Qualified interpreters
  - •Information written in other languages

If you need these services, contact the plan administrator.

If your Company has fifteen (15) or more employees and you believe that The Company has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, refer to the Plan Administrator for Grievance Procedures or if you need help filing a grievance can be filed in person, by mail, fax, or email.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

QMCSO (Qualified Medical Child Support Order)

QMCSO is a medical child support order issued under state law that creates or recognizes the existence of an "alternate recipient's" right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An "alternate recipient" is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant is an alternate recipient. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified, and to administer benefits in accordance with the applicable terms of each order that is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer; know the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.

WHCRA

The Women's Health and Cancer Rights Act (WHCRA) of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). Call your health insurance issuer for more information.

This notice informs you of the Federal regulation that requires all health plans that cover mastectomies to also cover reconstruction of the removed breast. If you have had or are going to have a mastectomy, you may be entitled to certain benefits. 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 lymphedemas.

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and

Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for: All stages of reconstruction of the breast on which the mastectomy was performed; Surgery and reconstruction of the other breast to produce a symmetrical appearance; Prostheses; and Treatment of physical complications of the mastectomy, including lymphedema. These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator at the number listed above.

NMHPA

Newborns' and Mothers' Health Protection Act requires that group health plans and health insurance issuers who offer childbirth coverage 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). Refer to your plan document for specific information about childbirth coverage or contact your plan administrator.

For additional information about NMHPA provisions and how Self-funded non Federal governmental plans may opt-out of the NMHPA requirements, visit http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/nmhpa_factsheet.html.

RESCISSIONS

The Affordable Care Act prohibits the rescission of health plan coverage except for fraud or intentional misrepresentation of a material fact. A rescission of a person's health plan coverage means that we would treat that person as never having had the coverage. The prohibition on rescissions applies to group health plans, including grandfathered plans, effective for plan years beginning on or after September 23, 2010.

Regulations provide that a rescission includes any retroactive terminations or retroactive cancellations of coverage except to the extent that the termination or cancellation is due to the failure to timely pay premiums. Rescissions are prohibited except in the case of fraud or intentional misrepresentation of a material fact. For example, if an employee is enrolled in the plan and makes the required contributions, then the employee's coverage may not be rescinded if it is later discovered that the employee was mistakenly enrolled and was not eligible to participate. If a mistake was made, and there was no fraud or intentional misrepresentation of a material fact, then the employee's coverage may be cancelled prospectively but not retroactively.

Should a member's coverage be rescinded, then the member must be provided 30 days advance written notice of the rescission. The notice must also include the member's appeal rights as required by law and as provided in the member's plan benefit documents. Please be aware that if you rescind a member's coverage, you must provide the proper notice to the member.

PREVENTIVE CARE

Health plans through our medical carrier will provide in-network, first-dollar coverage, without cost-sharing, for preventative services and immunizations as determined under health care reform regulations. These include, but are not limited to, cancer screenings, well-baby visits and influenza vaccines. For a complete list of covered services, please visit: https://www.healthcare.gov/coverage/preventive-care-benefits/

WOMEN'S PREVENTIVE HEALTH SERVICES

All of the following women's health services will be considered preventive (some were already covered). These services generally will be covered at no cost share, when provided in-network through our medical carrier:

- Well-woman visits (annually)
- Prenatal visits (routine preventive visits)
- Screening for gestational diabetes
- Human papillomavirus (HPV) DNA testing
- Counseling for sexually transmitted infections
- Counseling and screening for human immunodeficiency virus (HIV)
- Screening and counseling for interpersonal and domestic violence
- Breastfeeding support, supplies and counseling
- Generic formulary contraceptives, certain brand formulary contraceptives, and FDA-approved, over-the-counter female contraceptives with prescription are covered without member cost share (for example, no copayment). Certain religious organizations or religious employers may be exempt from offering contraceptive services.

HEALTH AND WELLNESS PROGRAM

Our company and our medical carrier provides a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you may be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You may also be asked to complete a biometric screening, which could include a blood test for blood related conditions such as diabetes. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program may receive an incentive. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive the incentive.

Additional incentives may be available for employees who participate in certain health-related activities or achieve certain health outcomes. If you are unable to participate in any of the health-related activities or achieve any of the health

outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. Please speak with your contact at our company for specific details regarding incentives, participation requirements or to request reasonable accommodations or alternative standards.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

PROTECTIONS FROM DISCLOSURE OF MEDICAL INFORMATION

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and our company may use aggregate information it collects to design a program based on identified health risks in the workplace, the Company's wellness program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) authorized health coaches, nurses or providers in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact your representative with our company.

FMLA

The Family and Medical Leave Act (FMLA) entitles eligible employees of covered employers to take unpaid, job-protected leave for specific family and medical reasons if the employee has been with the company for one year, has worked at least 1250 hours during the prior 12 months and works in an area where there are at least 50 employees within 75 miles. Public agencies as well as public and private secondary schools are covered employers without regard to the number of employees employed. For additional details, visit the Department of Labor FMLA page.

Notify the Company when you have a qualifying leave such as birth or adoption of a child, a serious health condition, to care for a spouse, child or parent with a serious medical condition or for reservist or National Guard provisions related to you or an immediate family member leaving for military duty or being injured in active duty.

If you are on a qualified leave and any of the circumstances pertaining to your leave change, you must notify the company of the change.

MHPA/MHPAEA

Mental Health Parity and Addiction Equity Act (MHPA/MHPAEA) require that group health plans not unfairly restrict treatment with regards to benefits/services applicable to mental health or substance use disorders. Additional information and details can be found by visiting the Department of Labor's Mental Health Parity webpage locate at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity.

PATIENT PROTECTION DISCLOSURE

Our Company generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact our medical provider, listed on the medical benefits page herein.

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

You do not need prior authorization from Our Company or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact our medical provider, listed on the medical benefits page herein.

COBRA NOTICE

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the company 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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. 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.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the plan is lost because of the qualifying event. Under the plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Employees and their qualified dependents are responsible for notifying the Company of any change in address or status (e.g., divorce, insurance eligibility, child becoming ineligible due to age, etc.) within 30 days of the event.

If applicable, your participation in the Health Flexible Spending Account can also continue on an after-tax basis through the remainder of the Plan Year in which you qualify for COBRA. The opportunity to elect the same coverage that you had at the time the qualifying event occurred extends to all qualified beneficiaries.

If you make contributions to the Health Flexible Spending Account for the year in which your qualifying event occurs, you may continue to make these contributions on an after-tax basis. This way, you can be reimbursed for certain medical expenses you incur after your qualifying event, but before the end of the Plan Year.

You may be offered to continue your coverage under the Health Flexible Spending Account if you have not overspent your account. The determination of whether your account for a plan year is overspent or underspent as of the date of the qualifying event depends on three variables: (1) the elected annual limit for the qualified beneficiary for the Plan Year (e.g., $2,550 of coverage); (2) the total reimbursable claims submitted to the Cafeteria Plan for that plan year before the date of the qualifying event; and (3) the maximum amount that the Cafeteria Plan is permitted to require to be paid for COBRA coverage for the remainder of the plan year. The elected annual limit less the claims submitted is referred to as the "remaining annual limit." If the remaining annual limit is less than the maximum COBRA premium that can be charged for the rest of the year, then the account is overspent. You may not re-enroll in the Health Flexible Spending Account during any annual enrollment for any Plan Year that follows your qualifying event.

Supporting documentation like a divorce decree, death certificate, proof of other insurance may be required as proof of a qualifying event.

This general notice does not fully describe COBRA or the plan. More complete information is available from the plan administrator and in the summary plan document.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- 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.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- 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. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), the employee must notify the Plan Administrator of the qualifying event.

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), employees must notify the Plan Administrator within 60 days after the qualifying event occurs.

How is COBRA 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. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA

continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total 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 continuation coverage. Documentation from the Social Security administration certifying a disability will be required.

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

If your family experiences another qualifying event while receiving 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 notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

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.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the plan administrator indicated above or in the summary plan description. 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.

Trinity Advisors | RUSS BLAKELY & ASSOCIATES, LLC
POWERED BY BKS PARTNERS

246 E. 11th Street, Suite 302 Chattanooga, TN 37402
(423) 266-8306 • www.rbabenefits.com
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Important Notice About Your Prescription Drug Coverage and Medicare

If you or any of your eligible dependents are eligible for Medicare, or will soon become eligible for Medicare, please read this notice. If not, you can disregard this notice.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage under the health plan 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. **We have determined that the prescription drug coverage offered by the health plan 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 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.

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 coverage [will or will not] be affected.

Prescription Drug Benefits	PPO - Option 1 OAP	PPO - Option 2 Local Plus	HSA - Option 3 OAP	HSA - Option Local Plus
Generic	$10	$10	30% after deductible	30% after deductible
Preferred	$75	$75	30% after deductible	30% after deductible
Non-Preferred	$150	$150	30% after deductible	30% after deductible

Contact your plan administrator for an explanation of the prescription drug coverage plan provisions/ options under the plan available to Medicare eligible individuals when you become eligible for Medicare Part D. If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents [may or may not] be able to get this coverage back.

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 health plan coverage 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 please contact the plan administrator indicated on the first page of this notice.

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 your current health plan provided by the current insurer 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 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).

Date:	1/1/2022
Name of Entity/Sender	Bryan College
Contact -- Position / Office:	Angie Price -- Director of Human Resources
Address:	721 Bryan Drive Dayton, TN 37321
Phone:	423-775-7269

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

ALABAMA Medicaid	CALIFORNIA Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov
ALASKA Medicaid	**COLORADO Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
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	Health First Colorado Website: 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
ARKANSAS Medicaid	**FLORIDA Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/ hipp/index.html Phone: 1-877-357-3268
GEORGIA Medicaid	**MASSACHUSETTS Medicaid and CHIP**
Website: https://medicaid.georgia.gov/health-insurance- premium-payment-program-hipp Phone: 678-564-1162 ext 2131	Website: https://www.mass.gov/info-details/masshealth- premium-assistance-pa Phone: 1-800-862-4840
INDIANA Medicaid	**MINNESOTA 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	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
IOWA Medicaid and CHIP (Hawki)	**MISSOURI Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a- to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS Medicaid	**MONTANA Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KENTUCKY Medicaid	**NEBRASKA 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	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

LOUISIANA Medicaid	NEVADA Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE Medicaid	**NEW HAMPSHIRE 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	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
NEW JERSEY Medicaid and CHIP	**SOUTH DAKOTA Medicaid**
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	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK Medicaid	**TEXAS Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA Medicaid	**UTAH Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA Medicaid	**VERMONT Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA Medicaid and CHIP	**VIRGINIA Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	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
OREGON Medicaid	**WASHINGTON Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA Medicaid	**WEST VIRGINIA Medicaid**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND Medicaid and CHIP	**WISCONSIN Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA Medicaid	**WYOMING Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and- eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since October 15, 2021, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/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

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