MERIDIAN
HEALTHCARE

2024-25 plan year

Employee Benefits Guide

Good health is good business.

MERIDIAN
HEALTHCARE

Questions, Problems or Concerns

Our goal is to make certain that you receive the correct coverage under the benefits plan. We are here to help with any issues that may arise. If you require assistance, have your ID number or Social Security Number available and follow these steps:

- **FOR CLAIMS ASSISTANCE** call the applicable insurance carrier. Have your ID number, date of service, and provider name available.
- **DO YOU NEED AN ID CARD?** If you do not have an ID card, please contact the insurance carrier to order your ID card or go online to the carrier's site to download an ID card.

Important Contact Information

Carrier	Web/Email	Phone
Medical United Healthcare	www.myuhc.com	888-842-4571
Dental Sun Life	www.sunlife.com/account	800-733-7879 / 247-6875
HSA Optum Bank	www.optumbank.com	866-234-8913
Vision United Healthcare	www.myuhcvision.com	800-638-3120
Life and LTD Prudential	http://www.prudential.com/mybenefits	888-598-5671
Group STD, Accident, Critical Illness, Cancer, Hospital AFLAC- Clete Alford	www.AFLAC.com	352-817-2487
Employee Assistance Program GuidanceResources	www.guidanceresources.com	800-311-4327
Pet Insurance Nationwide	www.PetsNationwide.com	877-738-7874
LegalShield/IDShield Steve Baker	www.legalshield.com	310-663-4735
Human Resources Manuel Peruga	manuel_peruga@mbhci.org	352-374-5600 x8327

A Note from our Leadership

Meridian Behavioral Healthcare, Inc. is pleased to offer a wide range of benefits to its employees and their families. These company sponsored benefits are an important part of the total compensation package. They represent a valuable asset to our employees and to their families, and demonstrate an investment by Meridian Behavioral Healthcare, Inc. in our employees. We are committed to continuously strive to provide affordable, competitive benefits to meet the needs of our employees and their families.

This guide is a resource to provide you with information on the benefits offered as well as answer some of the questions you may have about those benefits. Please read it carefully along with any supplemental materials you receive.

Our plan year is July 1, 2024 through June 30, 2025.

What's Inside

PLEASE NOTE: This booklet provides a summary of the benefits available, but is not your Summary Plan Description (SPD). The Company reserves the right to modify, amend, suspend, or terminate any plan at any time, and for any reason without prior notification. The plans described in this book are governed by insurance contracts and plan documents, which are available for examination upon request. We have attempted to make the explanations of the plans in this booklet as accurate as possible. However, should there be a discrepancy between this booklet and the provisions of the insurance contracts or plan documents, the provisions of the insurance contracts or plan documents will govern. In addition, you should not rely on any oral descriptions of these plans, since the written descriptions in the insurance contracts or plan documents will always govern.

Eligibility

As a Meridian employee, you are eligible for the benefits program if you are a full-time active employee working at least 30 hours per week, unless otherwise stated. Benefits are effective on the first of the month following 60 days from date of hire.

Eligible Dependents

Your dependents are eligible to participate in Meridian's benefit plans. Your eligible dependents include*:

- A spouse to whom you are legally married.
- A dependent child under age 19. Coverage will terminate at the end of the month of the dependent's 19 birthday (Medical coverage terminates at the end of the month of the dependent's 26th birthday). Coverage may be extended past the age of 26 for disabled dependents. Dependent children include biological (must be added within 30 days of birth), adopted, foster children, and stepchildren.

Coverage for eligible dependents generally begins on the same day your coverage is effective. Completed enrollment serves as a request for coverage and authorizes any payroll deductions necessary to pay for that coverage.

*Additional carrier conditions may apply and may vary by state.

Newly Hired/Eligible Employees

New hires and newly eligible employees MUST complete online enrollment even if choosing to waive coverage in order to provide beneficiary information for your company-paid life insurance.

Your elected coverages will begin on the first of the month following 60 days from date of hire.

For all benefits, you must enroll within 30 days from your date of hire.

Pre-Tax Benefits: Section 125

Meridian's benefit plans utilize Section 125. This enables you to elect to pay premiums for health, dental, vision and flexible spending account coverage on a pre-tax basis. When you use pretax dollars, you will reduce your taxable income and have fewer taxes taken out of your paycheck. Under Section 125, you can actually have more spendable income than if the same deductions were taken on an after tax basis.

Pre-tax Note: When you pay for your dependent's benefits on a pre-tax basis you are certifying that the dependent meets the IRS' definition of a dependent. [IRC §§ 152, 21 (b)(1) and 105(b)]. Children/spouses that do not satisfy the IRS' definition will result in a tax liability to you, such as changing that dependent's election to a post-tax election, or receiving imputed income on your W-2 for the dependent's coverage that should not have been taken on a pre-tax basis.

Benefit Election Changes

You must notify Human Resources within 31 days of the life event in order to make a change in your benefit selections.

The benefit elections you make during open enrollment or as a new hire will remain in effect for the entire plan year. You will not be able to change or revoke your elections once they have been made unless a life event status change occurs.

For purposes of health, dental, and vision, you will be deemed to have a life event status change if:

- your marital status changes through marriage, the death of your spouse, divorce, legal separation, or annulment;
- your number of dependents changes through birth, adoption, placement for adoption, or death of a dependent;
- you, your spouse or dependents terminate or begin employment;
- your dependent is no longer eligible due to attainment of age;
- you, your spouse or dependents experience an increase or reduction in hours of employment (including a switch between part-time and full-time employment; strike or lock-out; commencement of or return from an unpaid leave of absence);
- gain or loss of eligibility under a plan offered by your employer or your spouse's employer;
- a change in residence for you, your spouse or your dependent resulting in significant network disruption.

In order to be permitted to make a change of election relating to your health, dental, and vision coverage due to a life event status change, the change must result in you, your spouse or dependent gaining or losing eligibility for health, dental or vision coverage under this plan or a plan sponsored by another employer by whom you, your spouse or dependent are employed. The election change must correspond with that gain or loss of eligibility.

You may also be permitted to change your elections for health coverage under the following circumstances:

- a court order requires that your child receive accident or health coverage under this plan or a former spouse's plan;
- you, your spouse or dependent become entitled to Medicare or Medicaid;
- you have a Special Enrollment Right;
- there is a significant change in the cost or coverage for you or your spouse attributable to your spouse's employment.

For purposes of all other benefits under the plan, you will be deemed to have a life event status change if the change is on account of and consistent with a change in status, as determined by the plan administrator, in its discretion, under applicable law and the plan provisions.

Medical Coverage

Meridian Behavioral Healthcare, Inc. offers three medical plans contracted with United Healthcare. Choose the plan that meets your needs and those of your family. Each plan includes comprehensive health care benefits, including free preventive care services and coverage for prescription drugs. Each plan's cost is shared by Meridian Behavioral Healthcare, Inc. and the employee.

United Healthcare	HSA PLAN 70S		TRADITIONAL PLAN 2FZ		FLEX PLAN BWL4 RX C96
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Only
Annual Deductible					
Individual	$2,000	$4,000	$1,500	$3,000	$4,000
Family	$4,000	$8,000	$3,000	$6,000	$12,000
Coinsurance	**20%**	**40%**	**20%**	**40%**	**30%**
Out-Of-Pocket Maximum					
Individual	$4,000	$9,000	$6,350	$12,700	$7,150
Family	$6,850	$18,000	$12,700	$25,400	$14,300
Preventive Care - provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. If a diagnosis is made, any services provided as part of that diagnosis may require a copay, coinsurance or deductible.					
Routine Adult /Well Woman Exam	Covered 100%	40%	Covered 100%	40%	Covered 100%
Routine Mammograms	Covered 100%		Covered 100%		Covered 100%
Routine Well Child Exams	Covered 100%	40%	Covered 100%	40%	Covered 100%
Independent Clinical Lab	Covered 100%	40%	Covered 100%	40%	Covered 100%
Office Visits					
Physician	Deductible + Coinsurance		$30 copay	40%	**No copay per visit for the first 3 visits in a year; then 30% after deductible
Specialist	Deductible + Coinsurance		$60 copay	40%	***No copay per visit for the first 3 visits in a year; then 30% after deductible
Emergency Care					
Emergency Room	Deductible + Coinsurance		$500 copay		$250 per occurrence, then 30% after Deductible
Urgent Care	Deductible + Coinsurance		$75 copay		Deductible + Coinsurance
Hospital Services					
Hospitalization	Deductible + Coinsurance		Deductible + Coinsurance		$250 per occurrence, then 30% after Deductible
Prescription Drugs - *Mail Order: up to 90-day supply*					
Retail	Deductible then $10 / $35 / $60	40%	$10 / $35 / $60	40%	$10 / $45 / $80 / $125
Mail Order	Deductible then 2.5 times copay	40%	2.5 times copay	40%	2.5 times copay

***Flex plan - The number of visits for which a copay will apply are combined with any Specialist office visits.*
****Flex plan – The number of visits which a copay will apply are combined with any Primary Care Physician office visits.*

This Summary is for informational purposes only. For specific benefit information, please refer to the applicable Insurance Contract.

Medical Coverage *cont.*

Employee Cost - Without Wellness Credit

Bi-weekly payroll (24) deductions will be as shown	HSA Plan 70S	Traditional Plan 2FZ	Flex Plan
Employee Only	$25.00	$132.18	$25.00
Employee + Spouse	$283.21	$483.64	$250.93
Employee + Child(ren)	$220.90	$398.82	$190.38
Family	$479.12	$750.28	$441.32

**Twice a year when three payrolls fall in the same month, the third payroll will not include premium deductions.*

UHC Rewards

Earn Cash for Wellness Activities

GOOD NEWS — your health plan comes with a new way to earn up to ***$300***.
UnitedHealthcare Rewards is included in your health plan at no additional cost.

Earn up to
$300

There's so much good to get

With UHC Rewards, a variety of actions — including many things you may already be doing — lead to rewards. The activities you go for are up to you — same goes for ways to spend your earnings. Here are some ways you can earn:

Reach daily goals

- Track 5,000 steps or 15 active minutes each day, or double it for an even bigger reward
- Track 14 nights of sleep

Complete one-time reward activities

- Go paperless
- Get a biometric screening
- Take a health survey
- Connect a tracker

Personalize your experience by selecting activities that are right for you — and look for new ways of earning rewards to be added throughout the year.

There are 2 ways to get started

On the UnitedHealthcare® app

- Scan this code to download the app
- Sign in or register
- Select the Menu tab and choose UHC Rewards
- Activate UHC Rewards and start earning
- Though not required, connect a tracker and get access to even more reward activities

On myuhc.com®

- Sign in or register
- Select UHC Rewards
- Activate UHC Rewards
- Choose reward activities that inspire you — and start earning

How to Find a PCP

Choose a PCP and you'll have a doctor in your corner

A primary care provider (PCP)is the doctor who knows you best — they're the first person you call with medical questions and issues. PCPs help guide you to the care you need — and may help avoid cost surprises, save time and make the best use of your health care.

Select a PCP to help manage your health

With your new health plan taking effect, it's a good idea to choose a PCP who's in your network — even if your plan doesn't require one. The doctors and facilities in the network have agreed to provide services at a discount, so staying in network makes sense — especially when visiting an out-of-network provider could end up costing you a lot more for care.

A PCP can help you by:

- Getting to know your health history and health goals
- Providing routine care, such as annual checkups, which may catch potential health issues earlier
- Advising you when to see a specialist and providing referrals if needed

Here's how to find a network PCP

Sign in to myuhc.com®, then select **Find Care > Medical Directory > People > Primary Care > All Primary Care Physicians**. Only doctors in your network are visible when you're signed in and you can choose any family practitioner, internist, pediatrician or general medicine physician.

Let the hearts be your guide

The UnitedHealth Premium® program can help you find doctors who meet benchmarks — based on national standards — for quality and cost efficiency. You can locate Premium Care Physicians by looking for the blue hearts near doctors' names.

Questions to ask yourself when looking for a PCP:

- Is the doctor I'm considering in my network?
- Do my friends or family have recommendations?
- Are the office hours and location convenient?
- Does the doctor have a UnitedHealth Premium designation for quality, cost-efficient care?
- Does the doctor meet my specific needs? For example: treat people with my condition, speak my language, etc.

Keep up on preventive care

It's a good idea to see your PCP for an annual checkup and other preventive care, such as recommended screenings and immunizations. Preventive care is covered by most UnitedHealthcare plans at no additional cost when you see network providers.

Schedule a PCP visit

Choose the PCP that best meets your needs, make an appointment —and make sure they're a good fit —and then start seeing the benefits of having a helping hand in your health care.

Find a network PCP
Visit myuhc.com or download the UnitedHealthcare® app

$0 cost for certain medications*

We're making medications that may be essential to your health more affordable.

The new UnitedHealthcare Vital Medication Program offers certain drugs at **no additional cost.*** This means there may be no out-of-pocket costs for preferred insulins and certain other medications, including:

- ✔ **Insulin** – rapid, short and long-acting
- ✔ **Epinephrine** – allergic reactions
- ✔ **Glucagon** – hypoglycemia (low blood sugar)
- ✔ **Naloxone** – opioid overuse
- ✔ **Albuterol** – asthma

To see if you're eligible for no out-of-pocket costs on preferred insulins and other prescription drugs, sign in to myuhc.com/rx

United Healthcare

*Available to eligible members. Check your coverage details at **myuhc.com/rx.**

If you are not currently enrolled with UnitedHealthcare pharmacy benefit coverage, you may access your health plan's member website for additional information during your open enrollment period or you may contact your employer or health plan for additional information.

Medications are categorized by common therapeutic conditions in this reference guide for ease of reference only. These categories do not determine coverage for the medication for your condition. Your benefit plan determines how these medications may be covered for you.

Where differences are noted between this reference guide and your benefit plan documents, the benefit plan documents will govern. This document applies to commercial group members of UnitedHealthcare plans.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates, and UnitedHealthcare Service LLC in NY. Health plan coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Stop-loss insurance is underwritten by All Savers Insurance Company (except CA, MA, MN, NJ and NY), UnitedHealthcare Insurance Company in MA and MN, UnitedHealthcare Life Insurance Company in NJ, UnitedHealthcare Insurance Company of New York in NY, and All Savers Life Insurance Company of California in CA. Optum Rx® is an affiliate of United HealthCare Insurance Company.

Compare options, help keep costs down

Getting care at the place that may best fit your condition or situation may save you up to $2,500 compared to an emergency room (ER) visit.*

Care options to consider	START HERE **Primary care provider (PCP)** The provider who may know you best	**24/7 Virtual Visits** A care provider over the phone or by video	**Convenience care** Nurse practitioners and physician assistants at retail pharmacy clinics	**Urgent care** Physicians and care teams at walk-in clinics	**Emergency room** Physicians and care teams at hospital emergency departments
Average cost*	**In-person: $175 Virtual: $99 or less****	**$54*****	**$100**	**$185**	**$2,700**
Allergies	✓	✓			
Bladder infection/UTI	✓			✓	
Broken bone				✓	✓
Bronchitis	✓	✓		✓	
Chest pain					✓
Cough	✓	✓	✓		
COVID-19 symptoms	✓			✓	
Earache	✓	✓	✓		
Fever	✓	✓			
Flu/common cold	✓	✓	✓		
Migraine/headache	✓	✓			
Muscle ache/sprain	✓			✓	
Pinkeye	✓	✓			
Shortness of breath					✓
Sinus infection	✓	✓			
Skin rash	✓	✓	✓		
Sore throat	✓	✓			
Stomach pain (nausea, vomiting, diarrhea)	✓			✓	
Yeast infection	✓	✓			

✓ **Indicates the care option to consider for the common conditions listed**

Learn more

Visit **uhc.com/quickcare**

United Healthcare®

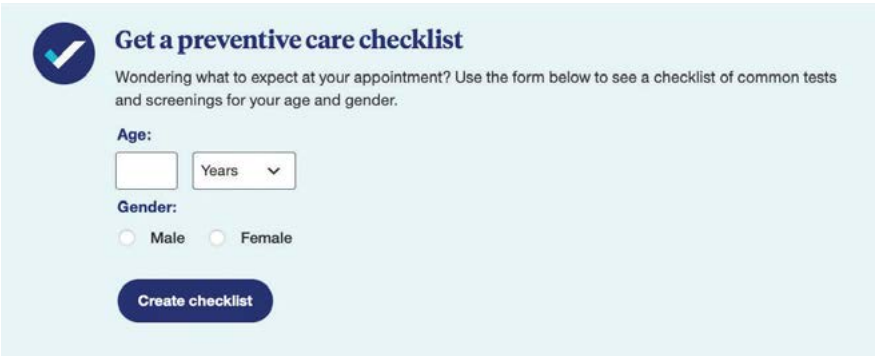
The importance of preventive health care

A yearly wellness exam is a good way to make sure everything checks out. Checking in on your health and getting recommended preventive care may help paint a more accurate picture of your overall health. That's one of the many reasons that preventive care is important.

Keep up on preventive care

Preventive care — such as routine wellness exams and certain recommended screenings and immunizations — is covered by most of our plans at no additional cost when you see network providers. A preventive care visit may be a good time to help establish your relationship and create a connection for future medical services.

Find your age/gender recommended preventive care checklist, access current preventive care guidelines and more at **uhc.com/health-and-wellness/preventive-care.**



Visit **uhc.com/health-and-wellness/preventive-care** or sign in to **myuhc.com®** to learn more.

United Healthcare

AssuredExcellence

Low to No Cost Access to **Leading National Providers**

Your company has partnered with **the AssuredExcellence program** to connect you and your dependents[1] with ***high quality health care at minimal to no cost.***[2] The program includes benefits for a broad range of services such as:

- ✓ Orthopedic Procedures
- ✓ Cardiac Surgeries
- ✓ Cancer Diagnosis Confirmation Program
- ✓ Some Cancer Procedures
- ✓ Organ Transplant
- ✓ Gallbladder Surgery
- ✓ Substance Abuse & Mental Health Treatment
- ✓ Treatments for Various Bleeding and Clotting Disorders
- ✓ High-Cost Medications
- ✓ Pediatric Orthopedics
- ✓ Other Treatments are Available

How can I begin the process?

1. Call the AssuredExcellence team to check eligibility.
2. Complete an application; provider will review.
3. Provider will gather and review medical records.
4. Consultation, surgery, or services are scheduled.
5. A stipend is paid to you to assist with lodging & transportation.

If you are interested in learning more about the program, checking to see if it includes benefits for the services you need and/or receiving an application, please contact AssuredExcellence at **888-856-4317** or via e-mail at **AssuredExcellence@AssuredPartners.com**.

[1] *Patients must be over age 18 for certain services.*

[2] *Employees enrolled in a high deductible/HSA Qualified Plan will be responsible for the balance required to meet the IRS minimum deductible. There is no patient liability for covered services for all other program participants.*

To ensure that you receive the maximum benefits available you MUST contact the AssuredExcellence team to initiate the process.

1-888-856-4317 | AssuredExcellence@AssuredPartners.com

Participating Partners:

BayCare

Cleveland Clinic

Goldfinch Health

Hazelden Betty Ford Foundation

Johns Hopkins Medicine

Midlands Orthopaedics & Neurosurgery

Midwest Orthopaedics at Rush
A division of OrthoMidwest®

PRICEMDs Cost Containment Solutions™

Shriners Children's™

See next page for more details

AssuredExcellence

Why is this program being offered?

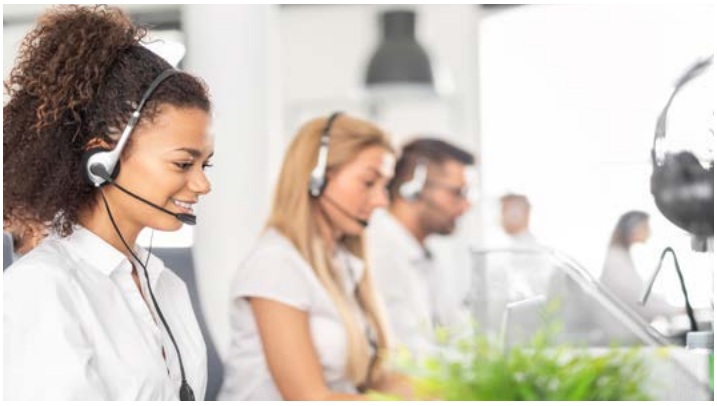
The health and well being of our employees and their families is of paramount importance, and we feel strongly about helping you get care at the best facilities across the country.

How much does it cost?

For most health plans, all treatments at these providers will be at ***NO COST*** to you. Diagnostic procedures required prior to your treatment will go through your regular insurance.

Do I have to travel?

You may, but there are stipends built into the program that are generally enough to cover your travel and more.



Please contact the AssuredExcellence team to discuss any questions or concerns you may have and/or to receive an application to initiate the process.

Procedure Group	Travel Stipend
Bladder Cancer Surgery	up to $3,000
Bone Marrow Transplant	up to $5,500
Cancer Diagnosis Confirmation	up to $750
Some Cancer Surgeries (not all types are covered)	up to $3,000
Cardiac/Heart Surgery	up to $3,500
Colorectal Cancer Surgery	up to $3,000
Gall Bladder Surgery	up to $2,000
Organ Transplant	up to $5,500
Hemophilia/Medications	up to $2,000
Lymph Node Surgery	up to $2,000
Neck and Spine Surgery	up to $2,000
Orthopedic Surgery	up to $2,000
Pancreatic Cancer Surgery	up to $3,000
Prostate Cancer Surgery	up to $2,000
Stem Cell Transplant	up to $5,500
Substance Abuse/Rehab	100% of bundled cost
Thyroid Surgery	up to $2,500
RA / PA Medications	Not Needed
Crohns / UC Medications	Not Needed
Multiple Sclerosis Medications	Not Needed
Rare Disorder / Specialty Medications	Up to $1,000 for first fill only

Travel stipend is determined by the necessary procedure and the AssuredExcellence provider you choose.

To find out what reimbursement you might be eligible to receive, please call AssuredExcellence.

Not every participating provider offers all the AssuredExcellence services. 5.24AssuredPartners does not recommend, endorse or make any representation about the efficacy, appropriateness or suitability of any specific tests, products, procedures, treatments, services, opinions, health care providers or other information that may be contained on or available through AssuredExcellence.

AssuredPartners

1-888-856-4317

AssuredExcellence@AssuredPartners.com

AssuredExcellence

Plan Enhancement!

Specialty Medications at **no cost!**

PRICEMDs
Cost Containment Solutions™

Meridian Behavioral Healthcare has partnered with PriceMDs to provide you with a source of specialty medications at no cost! ***No travel required, no copays, just free meds!***

Are you currently taking specialty medications for a disease or chronic condition? Examples include medications for crohn's disease, ulcerative colitis, rheumatoid arthritis, multiple sclerosis, or a variety of other conditions.

AssuredExcellence, your source for no-cost surgeries and transplants can now assist in sourcing no-cost medications.

You will receive a stipend payment for your first fill of a 90-day supply!

$1,000 *on medications >$10,000...*

or ***$500*** *on medications $3,000–$9,999...*

or ***$250*** *on medications <$3,000.*

- Over 600 medications available and counting.
- Two fills required before engaging with PriceMDs.
- Members that qualify will be connected with a PriceMDs nurse.
- No change in your physician required!
- You may be required to do a tele-health visit with a US-trained and board-certified doctor.
- PriceMDs may require your doctor to submit lab results, or have you get bloodwork done.
- Once approved the PriceMDs nurse will arrange shipping of 90-day supply of meds direct to you!
- Member participation requires a valid passport. No travel required.

If you are enrolled in a Qualified High Deductible Health Plan, you may be subject to charges at the end of the plan year.

If you're on specialty medications and want to find out if your medication is covered, contact an AssuredExcellence representative today!

(888) 856-4317 AssuredExcellence@AssuredPartners.com

AssuredPartners

Health Savings Account (HSA)

The Health Savings Account benefit is only available to those enrolled in the HSA PLAN. HSA's are financial accounts that you can use to accumulate tax-free funds to pay for qualified health care expenses, as defined by the Internal Revenue Service.

The account acts like a regular savings account with a debit card and accrues interest. The money in the account is owned by you and is fully portable. Funds can accumulate over time and roll over each year. If you use the funds for qualified health care expenses, you will pay no taxes. If you use the money for other expenses, you will pay a tax and a penalty fee.

You will receive a debit card that will allow you to access your money to pay for services.

Please note: HSA account funds cannot be used to pay or reimburse expenses for Over the Counter (OTC) medicines or drugs unless a prescription is obtained. There is an exception to this rule for insulin, which can be purchased and reimbursed without a prescription.

How you save with an HSA

As an HSA user, you will save in several ways:

- HSA contributions are not taxed
- You earn tax-free interest on HSA balances
- HSA funds used for qualified medical expenses are not taxed

HSA funds remain yours to grow

With an HSA, you own the account and all contributions. Unlike flexible spending accounts (FSAs), the entire HSA balance rolls over each year and remains yours even if you change health plans, retire or leave the company.

Supplement your retirement

Once your HSA balance reaches a certain point, you may invest your funds for increased earning potential that is also tax-free. After age 65, you can use your HSA much like a 401(k) and withdraw funds for any purpose. Qualified medical expenditures remain tax-free even into retirement.

You can win with an HSA

Regardless of your personal medical situation, an HSA can empower you to maximize savings while building a reserve for the future.

Using your HSA for qualified medical expenses

HSA funds can be used for a variety of qualified medical, dental and vision expenses; for yourself, your spouse, and your qualified dependents. Eligible expenses include:

- Birth control
- Chiropractor
- Contact lenses
- Dental treatment
- Prescription eyeglasses
- Hearing aids
- Physical exams
- Prescriptions
- Stop-smoking programs
- Surgery (non-cosmetic)
- Therapy
- and more...

2024 HSA Annual Contribution Limit:

$4,150 for individual coverage

$8,300 for all other coverage tiers

You can choose to contribute to your HSA on a before-tax basis, up to the IRS annual maximums. If you are or will be age 55 or over during the calendar year, you may also make a "catch-up" HSA contribution of an additional $1,000 each year.

Note: As a taxpayer, it is your responsibility to ensure that your HSA contributions do not exceed the maximum possible for your specific tax situation. Please consult your attorney, CPA or tax adviser about your specific tax situation before deferring monies to your Health Savings Account. The benefits of an HSA, who is qualified to have an HSA, etc. can be found in IRS Publication 969, beginning on page 2. https://www.irs.gov/pub/irs-pdf/p969.pdf

Dental Coverage

NEW ENHANCED DENTAL COVERAGE!!!
Check out what's updated for you!!!

Meridian Behavioral Healthcare continues to provide two dental plan options. **New for 2024 the PPO plan option has enhanced benefits.** Basic services are now covered at 90% and Major services are now covered at 60% of In Network Provider negotiated pricing. The DHMO Plan offers benefits only through a network of plan dentists. When you enroll, treatments you receive from your selected plan dentist will be provided at reduced fees called copayments. There is no deductible, no waiting period and no annual maximum. It includes Orthodontic copayments. Refer to the DHMO copayment reference sheet, available from HR, for information on this plan. You can buy up to a PPO plan with in-network and out-of-network coverage. Outlined below are the benefits for the PPO plan.

PPO stands for Preferred Provider Organization. A PPO is a network of participating dentists who agree to provide services at a negotiated discount. With a PPO plan, you can see any dentist you choose, but you will receive a discount when you see a dentist within the PPO network.

DHMO stands for Dental Health Maintenance Organization. A DHMO or prepaid plan has a network of participating dentists who agree to accept a copayment for services covered by the plan. With a DHMO/prepaid dental plan, you know exactly what you are going to pay out of pocket when you go to the dentist, but you are required to select and be assigned to a dentist within the network. A DHMO/prepaid plan is not the same thing as a discount plan.

PPO plan offer:	DHMO/prepaid plan offer:
Deductibles, benefit maximums and waiting periods	No deductibles, maximums or waiting periods
Freedom to choose dentists both in and out of the network	You must select a dentist who is in the network
Coinsurance for covered services—this means you pay a percentage of the provider's fee	Copayment schedule for covered services—this means you know costs up-front and pay at time of service
Some exclusions for pre-existing conditions	Benefits are payable for pre-existing dental conditions within the copayment schedule

Sun Life Dental	PPO SUMMARY - YOUR COST
Annual Deductible - Applies to basic and major services only	
Individual / Family	$50 / $150
Yearly Maximum	**$1,500**
Preventive - Preventive services do not reduce the $1,500 annual maximum.	
Oral Exams	covered in full (out-of-network based on in-network fee schedule).
Routine Cleanings	
X-rays	
Basic	
Fillings	10% in-network; 40% out-of-network based on in-network fee schedule
Major	
Crowns	40% in-network; 60% out-of-network based on in-network fee schedule
Root Canals	
Oral Surgery	
Orthodontia	**Not Covered**

This Summary is for informational purposes only. For specific benefit information, please refer to the applicable Insurance Contract.

Bi-weekly payroll (24) deductions	DHMO	PPO
Employee Only	$5.57	$11.74
Employee + Spouse	$9.38	$25.50
Employee + Child(ren)	$12.62	$28.48
Family	$16.59	$42.71

To register online for claim and benefit information, go to **www.sunlife.com/oaregister**.

Vision Coverage

Meridian Behavioral Healthcare, Inc. offers its employees the opportunity to purchase Vision coverage at their own expense. This plan is being offered through UHC Vision. If you utilize the services of a provider listed in the Preferred Provider Directory, your benefits include routine vision exams paid at 100% after a $10 co-pay, and preferred pricing on a large selection of frames, lenses, and lens options after a $25 co-pay. You may replace lenses every 12 months under this plan and frames every 24 months.

UHC Vision has updated their contact lens formulary to include some of the most popular disposable lenses available. The non-formulary allowance is $200.

Bi-weekly payroll (24) deductions	Vision
Employee Only	$4.04
Employee + Spouse	$7.67
Employee + Child(ren)	$8.05
Family	$13.37

Register online for claim and benefit information at **www.myuhcvision.com**

Employee Assistance Program

GuidanceResources is a company-sponsored service that is available to you and your dependents, at no cost, to provide confidential support, resources and information to get through life's challenges.

- **Confidential Counseling on Personal Issues** - staffed by experienced clinicians, allows unlimited telephonic support from a counselor who can provide immediate help with issues of concern and help connect you with support groups and resources in your community for ongoing help.
- **Legal Information, Resources and Consultation** - attorneys are available to provide confidential support with practical, understandable information and assistance. If you require representation, you can also be referred to a qualified attorney in your area for a free 30-minute consultation with a 25% reduction in customary legal fees thereafter.
- **Financial Information, Resources and Tools** - financial professionals are here to discuss your concerns and provide you with the tools and information you need to address your finances
- **Online Information, Tools and Services** - GuidanceResources® Online is your one stop for expert information to assist you with the issues that matter to you, from personal or family concerns to legal and financial concerns. Create your own account by going to **www.guidanceresources.com**. Each time you return to the site, you will find personalized, relevant information based on your individual life needs.

Call or visit online - 24 hours a day, seven days a week! **800-311-4327**

www.GuidanceResources.com
Web ID: GEN311

Now provided by United HealthCare when you're enrolled in medical coverage:

- **Behavioral Health -**
  Behavioral health is about more than just mental health: It includes addiction issues, anger management, coping with grief, dealing with stress and other challenges. It's an important part of your overall well-being — because how you feel matters, and caring support from behavioral health providers is a part of your plan.

  Self Care from AbleTo - For on-demand support to help with stress, anxiety and depression.
  Visit **ableto.com/begin** and follow the steps to begin your self-care program

  Employee Assistance Program (EAP) - Your EAP offers up to 3 provider visits for $0 by phone and in-person counseling sessions for short-term support and advice to help with:
  • Stress, anxiety and depression • Personal challenges, including substance abuse and relationships • Work/life balance, including legal and financial support
  Call **1-888-887-4114** for 24/7 in-the-moment phone support or to schedule in-person counseling with a masters-level EAP specialist

  Behavioral health provider
  Connect virtually or in-person with a licensed therapist, counselor, psychologist or psychiatrist for ongoing support to help.
  Answer a few questions and find support at **myuhc.com/mh-recommendations**

Basic Life and AD&D Insurance

Meridian Behavioral Healthcare, Inc. provides employees with group life and accidental death and dismemberment (AD&D) insurance calculated at 1 times your annual salary. There is no cost to the employee for this coverage. To update your beneficiary information, log into the Datis system, click on ***MYe3*** on the top menu bar and then select ***Benefits***.

Plan Cost: 100% Employer Paid

Voluntary Life and AD&D Insurance

Employees who want to supplement their group life insurance benefits may purchase additional coverage through Prudential. When you enroll yourself and/or your dependents in this benefit, you pay the full cost through bi-weekly payroll deductions. You can purchase coverage on yourself and your spouse in $10,000 increments. Minimum coverages are $10,000 and maximum coverage is 5x your annual earnings or $500,000.

If you are enrolling in Voluntary Life for the first time during the 2024 Open Enrollment session, EOI is waived for any amounts elected up to the guarantee amount of $150,000. Evidence of Insurability (EOI) forms are required to be completed for amounts over $150,000. Visit **https://gi.prudential.com/POGH/Controller/standalone?VR=eFRVNlhyL2RtamtMdU00UzJyY3ZlZz09** to access the form.

Age reductions will apply. Rates are based on employee age.

Plan Cost: 100% Employee Paid

	Semi-Monthly Life Rate	
Age	**Employee Rate per $10,000 of coverage**	**Spouse Rate per $5,000 of coverage**
Under 35	$0.26	$0.15
35 - 39	$0.41	$0.23
40 - 44	$0.71	$0.38
45 - 49	$1.11	$0.58
50 - 54	$2.16	$1.13
55 - 59	$3.51	$1.78
60 - 64	$3.91	$1.98
65 - 69	$6.96	$3.50
70 - 74	$17.56	$8.80
70 - 100	$69.41	$34.73

Dependent Children	**$10,000 of coverage**
	$1.00 (covers all children)

Note: If you did not enroll when initially eligible or are requesting a coverage increase, you will be asked to complete an Evidence of Insurability form and be approved for the coverage.

Long-Term Disability

Meridian Behavioral Healthcare, Inc. provides employees with long-term disability income benefits, and pays the full cost of this coverage. In the event you become disabled from a non work-related injury or sickness, long term disability benefits are provided as a source of income.

- Benefits Begin - After 90 day elimination period
- Benefits Payable - ADEA I - with Social Security Normal Retirement Age
- Percentage of Income Replaced - 66 2/3% of gross monthly earnings
- Maximum Benefit - $6,000 monthly

Register online at **http://www.prudential.com/mybenefits** to check status of a claim or evidence of insurability. Customer support for claims is **800-524-0542** for Life and Disability is **800-842-1718**.

Plan Cost: 100% Employer Paid

Open enrollment planning isn't complete until you have Aflac

New AFLAC group plans now available with enhanced benefits at guaranteed group pricing with payroll deductions. A special enrollment site has been created and your plans will be payroll deducted. Be on the look out for dates/times/ locations the AFLAC rep will be available for one on one enrollment assistance.

Anyone enrolled in the Accident, Hospital, or Critical Care(Specified Event) Plans make sure you stop by to see your Aflac Team to learn about plan upgrades that should save you per deduction on these lines.

For Anyone currently enrolled in the Cancer Plan and/or Short Term, you may continue these plans thru Payroll deduction or Look at increasing your Coverage in the new Short Term Disability.

Who hasn't been blindsided by an unexpected medical bill? That's why there's Aflac. We can help take care of the expenses health insurance doesn't cover, so you can take care of everything else.

Aflac supplemental benefits

Our product portfolio is as broad as your needs, with group plans that help cover the expected – and unexpected – that's sure to come life's way.

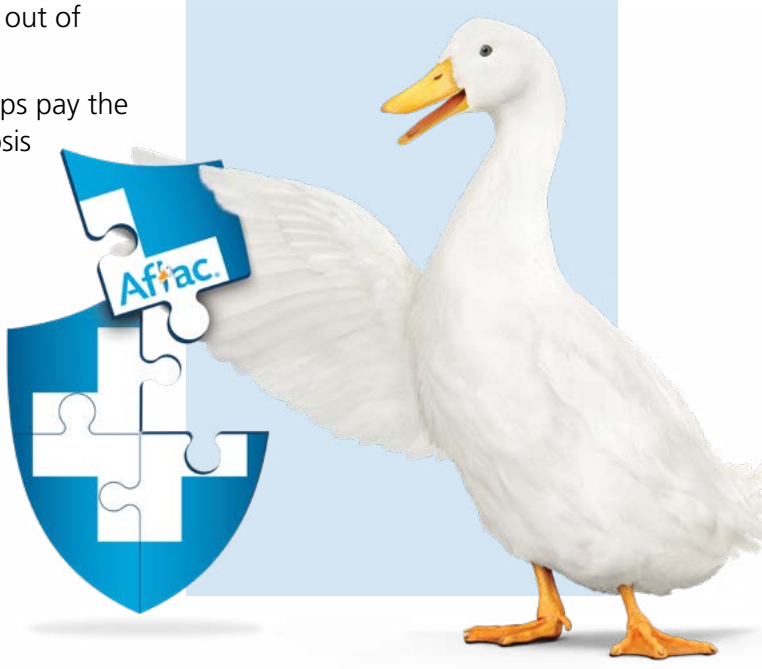
Group Disability: Group disability insurance helps protect your income in the event that you are unable to work.

Group Accident: Group Accident insurance helps pay for out of pocket costs that arise from covered accidents.

Group Critical Illness: Group Critical Illness insurance helps pay the expected and unexpected expenses that arise from diagnosis of a covered critical illness.

Group Hospital Indemnity: Group Hospital Indemnity insurance helps pay the out of pocket costs associated with a covered hospital stay.

Please see your Aflac Team led by Clete Alford.
Contact him at:
(352)-817-2487
Jeremy_Alford@us.aflac.com



Voluntary Short-Term Disability

Disability can be expensive - especially if you are unable to work. Having an income can help you cover bills, pay for your home and provide for your family. But if you got sick or injured and couldn't work, how long could you afford life without a paycheck? Would your finances become disabled if you lost your paycheck? Voluntary Short Term Disability coverage from AFLAC pays a monthly cash benefit to employees only for disabilities due to non-occupational sickness or injury. The monthly cash benefit can range from

$700 to $4,000, subject to income requirements. Guaranteed Issue! Benefit period of up to 90 days; Waiting period: (Accident/Sickness): 14/14 days

Plan Cost: 100% Employee Paid

Monthly Benefit Premium	Income Required	0/7 Days Waiting Bi-Weekly Premium	
		18 - 49	50 – 64
$1,000	$20,000	$7.60	$8.24
$1,200	$24,000	$9.12	$9.88
$1,400	$28,000	$10.64	$11.53
$1,600	$32,000	$12.16	$13.18
$1,800	$36,000	$13.68	$14.83
$2,000	$40,000	$15.20	$16.47

Voluntary Hospital Indemnity

Pays $1000 upon hospital admission to the employee. Pays Hospital Confinement, Hospital Intensive Care, and Health Screening Benefit.

	AFLAC Hospital Indemnity			
	Employee $1,000	Employee + Spouse $1,000 / each	Employee + Children $1,000 / each	Family $1,000 / each
	$11.22	$21.41	$17.27	$27.46

Voluntary Critical Illness Insurance

If you suffer a critical illness like a heart attack, chances are you'll recover. However, your bank account might not spring back as quickly. It's true that your medical insurance can help cover the cost of care and treatment. But there are other expenses you may face beyond those resulting from a loss of income. These costs may include deductibles, copays or prescriptions; rehabilitation, alternative treatments; and/or transportation to health facilities, and family travel for visits.

Voluntary Critical Illness Insurance pays you a lump sum benefit at first diagnosis of a covered critical illness, and can be used however you choose. So you can focus on getting better – not on your bills!

Maximum Benefit by Category

Employee - up to $30,000 GI

Spouse - Up to $30,000 GI

Dependent Child - Up to 50% of the face amount elected by employee

Plan Cost: 100% Employee Paid

Below is a partial list of the benefits included.

- Heart Attack
- Major Organ Transplant
- Stroke
- Coronary Artery Bypass*
- Cancer
- Carcinoma In-Situ*
- Renal (Kidney) Failure

** Paid at 25% Face Amount*

Voluntary Accident Insurance

Voluntary Accident Insurance pays benefits for accidents on and off the job, plus some benefits that correspond with medical care. Because accident insurance is supplemental, it pays in addition to other coverage the insured may already have in place. This coverage pays a benefit up to a specified amount for covered injuries resulting from accidents 24/7. Benefits can also help with deductibles and copays. The chart below is a partial list of the benefits included. Accident coverage is guarantee issue!

Incident	Payable
ER and Physician Visits	$175 / $100
Hospital Admission Benefit	$1,000
Hospital Confinement	$300 per day
Broken Bones and Dislocation	$240 - $6,000
Physical Therapy	$50 per visit up to 10 per accident
Follow-up Visits	$50 per visit up to to 6 per accident
Ambulance	$400 ground; $1,200 air
Accidental Death	Up to $50,000 Employee; Up to $25,000 Spouse; Up to $10,000 Child
Dismemberment	Up to $100,000 Employee; Up to $50,000 Spouse; Up to $20,000 Child

Wellness Benefit: The AFLAC Accident Plan includes a Wellness Benefit that pays $50 per covered person per year.

Bi-weekly payroll (24) deductions	AFLAC Accident
Employee Only	$7.06
Employee + Spouse	$11.39
Employee + Child(ren)	$13.92
Family	$18.25

Voluntary Personal Cancer Care Insurance

According to the American Cancer Association, one out of three Americans will be diagnosed with Cancer. Traditional health insurance covers only 34% of those expenses. Plan pays $4000 upon initial diagnosis of internal cancer (initial diagnosis benefit grows by $500 per year), $200 per day Hospital Confinement, radiation, Chemotherapy, Experimental treatments, Skin cancer benefit, Surgery, Lodging, Travel expenses, $75 Annual Wellness benefit, also a rider for benefits covering 32 additionally diseases and more.

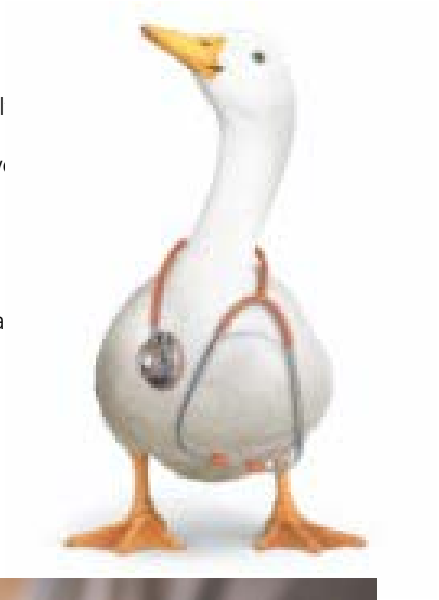
Bi-weekly payroll (24) deductions	AFLAC Cancer Care
Individual	$22.02
One-Parent Family	$22.02
Two-Parent Family	$39.96

Value Added Services

Increase enrollment engagement with enhanced resources

As a valued covered memeber of AFLAC, when you elect one or more of the available AFLAC plans, these Added Value Services are available to you and your families. Please contact your AFLAC benefits representative for more information or with any additional questions you may have.

Aflac value-added services portfolio



- **Medical Bill Saver®**
  Help support uncovered or out-of-network health care costs with Medical Bill Saver from Heal Advocate. This service offers employees a financial safety net when out-of-pocket, uncovered medical or dental bills reach more than $400. Health Advocate's skilled negotiators work on y employees' behalf to obtain discounts whenever possible.
- **Telehealth**
  Seeking wellness and preventative care solutions to support employee health and alleviate productivity concerns? Walmart Health Virtual Care (WHVC) connects employees and their families with board-certified medical providers or licensed behavioral health providers online a receive personalized treatment anytime, almost anywhere.

LegalShield

As one of the first companies in North America to provide legal expense plans to consumers, we now provide legal services to over 1.5 million families across the U.S. and Canada—representing approximately 4 million people. With over 650 employees dedicated to serving you, our promise remains the same: to provide outstanding legal services by quality law firms at an affordable price.

Even better, members do not have to worry about finding out which attorney to use—we will do that for you. Our experienced attorneys focus specifically on our members and provide 24/7 access for covered emergencies.

Why LegalShield

LegalShield gives you the ability to talk to a lawyer on any personal legal matter without worrying about high hourly costs. That is why, under the protection of LegalShield, you and your family can live your lives worry free.

- Advice on an unlimited number of legal topics
- Letters and phone calls on your behalf
- 24/7 emergency assistance
- Legal document review
- Toll-Free phone consultations
- Trial defense hours
- Forms service center
- Will preparation

Service Level Standards

LegalShield Provider Law Firms adhere to the following service standards for our members:

- Return call from attorney - 8 business hours
- Document review - 3 business days
- Letter or phone call - 3 business days
- Will preparation - 10 business days
- Referrals - 3 business days

Bi-weekly payroll (26) deductions	LegalShield
Family	$8.75

Covered Family Members include: Member, Member's spouse/domestic partner, Never-married dependent children under age 26 living at home, Dependent children under age18 for whom the member is legal guardian, Never married, dependent, children who are full-time college students up to age 26, Physically or mentally disabled children living at home.

IDShield

Identity theft has been the top consumer complaint filed with the FTC for 15 years straight. Victims are spending an exorbitant amount of time and money dealing with it. The criminals are getting smarter. And they're not going away. That's why you need a company that's more than a website. Worry less, live more!

Members have unlimited access to identity consultation services provided by Kroll's Licensed Private Investigators. The Investigator will advise members on best practices for identity management tailored to the member's specific situation. Services include:

- Consultation (Unlimited counseling, sex offender reports, identity alert and more...)
- Restoration ($5M service guarantee, medical & financial fraud, and more...)
- Privacy Monitoring (DOB/SSN, DL, and email monitoring, web surveillance, and more...)
- Security Monitoring (Score tracker, Bank account, credit, credit cards, and more...)

Monitor More of What Matters

We monitor your identity from every angle, not just your Social Security number, credit cards and bank accounts. We ensure everything connected to you is safe, even your social media accounts. If any change in your status occurs, you receive an email update immediately.

Counsel When You Need It

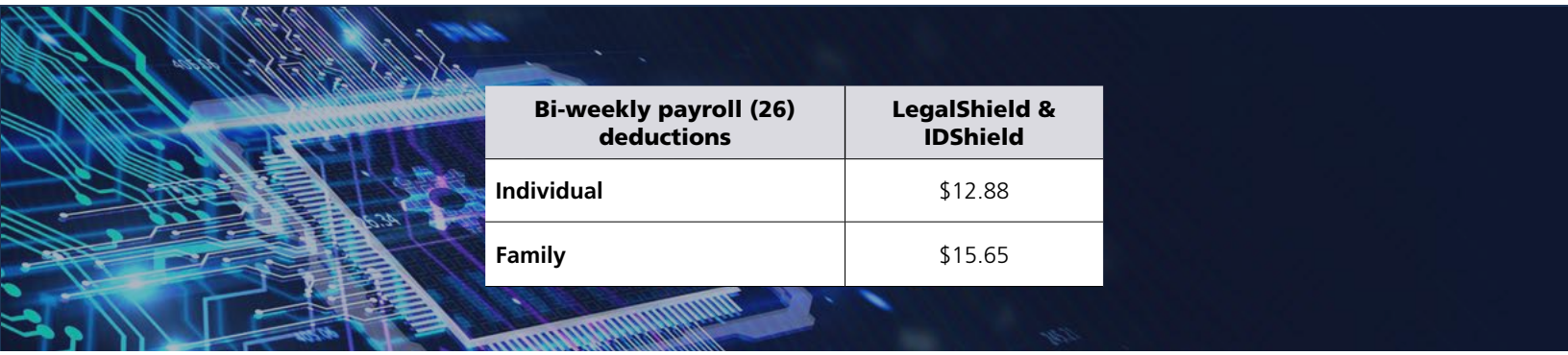
Our identity specialists are focused on protecting you. They are available to provide you with a complete picture of identity theft, walk you through all the steps you can take to protect yourself and answer any questions. Plus, they are available 24 hours a day, every day, in the event of an identity theft emergency. We're always here to help, no matter what.

Restore Your Identity Completely

IDShield is the only company with an exclusive partnership with Kroll, the worldwide leader in theft investigative services. If a compromise occurs, contact your licensed private investigator who will immediately begin restoring your identity to exactly the way it was.

Bi-weekly payroll (26) deductions	IDShield
Individual	$4.13
Family	$8.75

Covered Family Members include: employee, spouse/partner + Up to 8 dependent children up to age 26. (includes consultation/ restoration only, for dependent children age 18 to 26.)



Bi-weekly payroll (26) deductions	LegalShield & IDShield
Individual	$12.88
Family	$15.65

Pet Protection Plans

my pet protection **with wellness**

- $250 annual deductible
- Accidents & illnesses
- Hereditary & congenital
- Cancer
- Dental diseases
- Behavioral treatments
- Rx therapeutic diets & supplements
- Specialty & ER coverage included
- 24/7 Vet Helpline access
- Wellness exams
- Spay or neuter
- Flea & tick
- Preventive dental cleaning & more...

my pet protection

- $250 annual deductible
- Accidents & illnesses
- Hereditary & congenital
- Cancer
- Dental diseases
- Behavioral treatments
- Rx therapeutic diets & supplements
- Specialty & ER coverage included
- 24/7 Vet Helpline access...

90% cash back - use any vet and get 90% back
Open to all ages - one price regardless of pets age
More than just accident/illness - spay/neuter, Rx diet, dental and more
Exclusive to employees - not available to the general public
Easy enrollment - just two questions to get coverage
Employee preferred pricing - special discounts with employers

Plus additional coverage:

- Boarding/kennel fees if a family member hospitalized due to injury/illness
- Advertising/reward fees for pets that go missing during the policy term
- Pet replacement costs if a missing pet is not found within sixty (60) days
- Mortality coverage for euthanization due to illness/injury and cremation/burial fees

Key Points

Enroll anytime throughout the year. Enroll your pet when they're healthy, don't wait until they are sick or hurt!

- Sign up by the 15th of the month, effective date will 1st of the next month. Ex: enroll 2/14, effective date is 3/1.
- Sign up after the 15th of the month, effective date will be 1st of the next following month. Ex: enroll 2/17, effective date is 4/1.
- Each pet has an individual policy. Multiple pet discounts: 2 or 3 pets – 10% total discount. 4 or more pets – 15% total discount.

Easily enroll online at **PetsNationwide.com**. Type in your company name for preferred employee pricing or Call us at **877-738-7874** and speak with a trained representative – Please state your company name for preferred employee pricing.

Contact Information:

Marcy Croyle
Account Executive
(330) 608-0908
croylm1@nationwide.com

New Enrollments
www.PetsNationwide.com
877-738-7874

Policyholder
Customer Care
800-540-2016
Mon-Fri: 5am-7pm PST
Sat: 7am-3:30pm PST

Claims
submitmyclaim@petinsurance.com
https://www.petinsurance.com/submit-claim

Frequently Asked Questions and Answers

1. **Where can I find the Open Enrollment Presentation?** If you missed the live presentation, you can watch a video recording posted on SharePoint. We'll be distributing the link via email.

2. **How do I submit my open enrollment changes?** Log into Datis and click ***Open Enrollment*** on the right-hand side of the homepage. A new window will open with the enrollment wizard. Select or decline each plan and click ***Submit*** on the last page. The Submit button appears only when all pages of the wizard have been completed. If you don't see the Submit button, please read the Summary page of the wizard and complete all the pages.

3. **What changes can I make during open enrollment?** You can enroll, change or terminate individual and/or dependent coverage in the medical, dental, vision, voluntary life and AFLAC plans. All changes you submit will be processed for an effective date of July 1, 2024.

4. **If I have no changes to make, do I need to do anything?** If you are happy with what you are currently enrolled in, then no further action is required. Your enrollment will continue in the same plans you are enrolled in for 2023-2024. The benefits wizard will remain in your Datis landing page until the close of Open Enrollment.

5. **I made changes in Datis but when I go back to review my benefits, they are not showing up.** Datis knows that you are still in plan year 2023-2024. You will not see your 2024 changes until July 1, 2024 as those are future-dated benefits.

6. **When is the deadline to submit changes for 2024?** All changes must be made by May 31, 2024.

7. **Where can I find the enrollment forms?** Benefits open enrollment for medical, dental, vision, and life insurance is done online through Datis. For Aflac, please visit **Employee Navigator** (https://www.employeenavigator.com/benefits/Account/Register) using the company ID MerBehHea2024. Enrollment forms for LegalShield are still used and available through Datis. On the landing page, click "*Forms*" on the right-hand side, download the form, complete, scan, and email to **manuel_peruga@mbhci.org.**

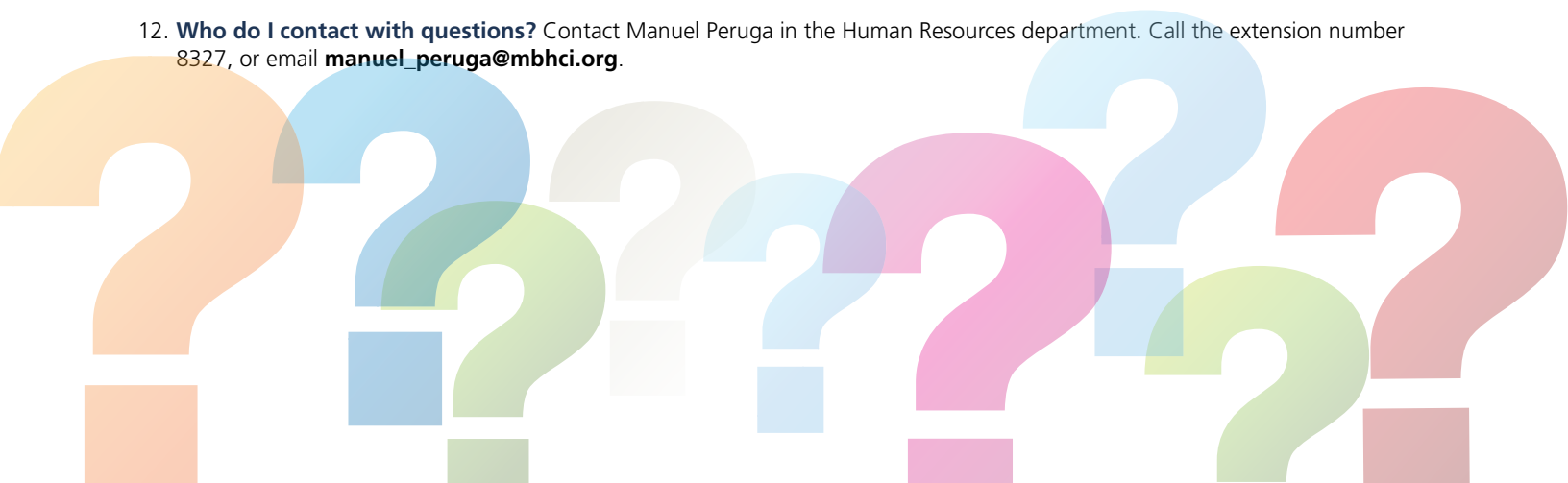
8. **When electing Voluntary Life Insurance, how do I complete the Personal Health Application?** You will receive the form in the next few weeks from HR.

9. **If I change my mind after Open Enrollment ends, when can I make changes to my benefits again?** Once elected, your benefit elections remain in place for the full benefit plan year which runs July 1, 2024 to June 30, 2025. Changes outside of Open Enrollment are only allowed for qualifying life events (e.g., birth of a child, marriage, divorce, etc.). If you experience a qualifying event, you must notify the Payroll Department within 30 days of that event in order to make changes to your benefits.

10. **Can I waive coverage if I have access to insurance elsewhere, such as through my spouse?** Yes, coverage is available on an a-la-carte basis. Employees have the option to elect or decline the coverage that is most suitable for their life situation.

11. **How much does our insurance plans cost?** When you logon into Datis, you will be able to see both the Employee (you) and the Employer (Meridian Behavioral Healthcare, Inc.) cost per month. For basic life, AD&D and long term disability, Meridian Behavioral Healthcare, Inc. pays 100% of the coverage.

12. **Who do I contact with questions?** Contact Manuel Peruga in the Human Resources department. Call the extension number 8327, or email **manuel_peruga@mbhci.org**.



Glossary of Terms

This glossary has many commonly used terms, but it isn't a full list. These are not contract terms. Those can be found in your insurance policy or certificate.

Allowed Amount: Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Appeal: A request for your health insurer or plan to review a decision or a grievance again.

Balance Billing: When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you.

Co-insurance: Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount. (Jane pays 20%, her plan pays 80%.)

Complications of Pregnancy: Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency cesarean section aren't complications of pregnancy.

Co-payment: A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible: The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services. (Jane pays 100%, her plan pays 0%.)

Durable Medical Equipment (DME): Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency Medical Condition: An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm. Emergency Medical Transportation Ambulance services for an emergency medical condition.

Emergency Room Care: Emergency services received in an emergency room.

Emergency Services: Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

Excluded Services: Health care services that your health insurance or plan doesn't pay for or cover.

Grievance: A complaint that you communicate to your health insurer or plan.

Habilitation Services: Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance: A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

Home Health Care: Health care services a person receives at home.

Hospice Services: Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization: Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care: Care in a hospital that usually doesn't require an overnight stay.

In-network Co-insurance: The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network co-insurance usually costs you less than out-of-network co-insurance.

In-network Co-payment: A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network co-payments usually are less than out-of-network co-payments.

Medically Necessary: Health care services or supplies needed to prevent, diagnose or treat an illness, injury, disease or its symptoms and that meet accepted standards of medicine.

Network: The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Non-Preferred Provider: A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.

Out-of-Network Co-insurance: The percent (for example, 40%) you pay of the allowed amount for covered health care services to providers who do not contract with your health insurance or plan. Out-of-network co-insurance usually costs you more than in-network co-insurance.

Out-of-Network Co-payment: A fixed amount (for example, $30) you pay for covered health care services from providers who do not contract with your health insurance or plan. Out-of-network co-payments usually are more than in-network copayments.

Out-of-Pocket Limit: The most you pay during policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit. (Jane pays 0%, her plan pays 100%.)

Physician Services: Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan: A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Preauthorization: A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Preferred Provider: A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium: The amount that must be paid for your health insurance or plan. You and or your employer usually pay it yearly.

Prescription Drug Coverage: Health insurance or plan that helps pay for prescription drugs and medications.

Prescription Drugs: Drugs and medications that by law require a prescription.

Primary Care Physician: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Provider: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

Reconstructive Surgery: Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Rehabilitation Services: Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care: Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist: A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

UCR (Usual, Customary and Reasonable): The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care: Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Health Insurance Marketplace

The Patient Protection Affordability Care Act ("PPACA") was signed into law on March 23, 2010. Under PPACA, individuals are required to have creditable health insurance coverage or pay a penalty (if applicable) to the Internal Revenue Service. This is known as the Individual Mandate. For more information on the details of PPACA please visit **https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-workers-and-families**.

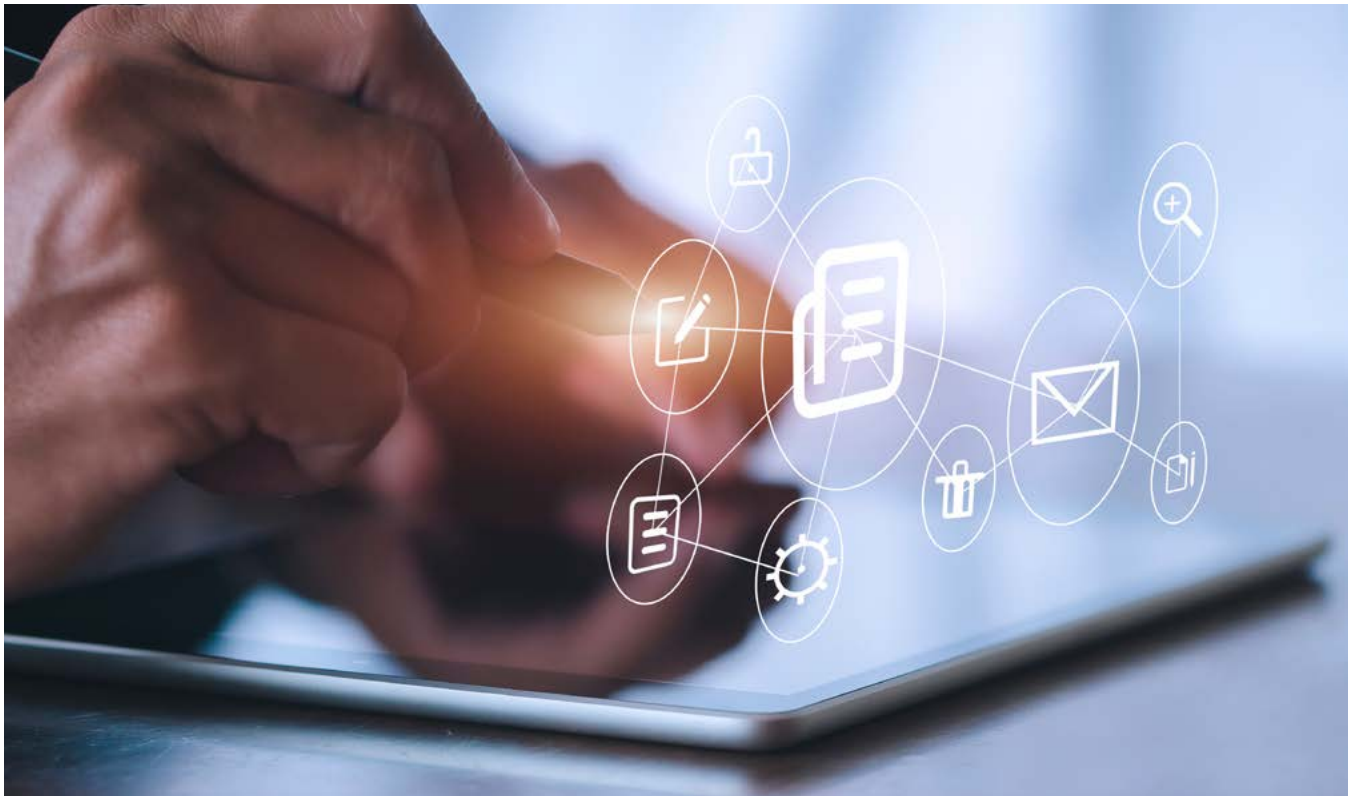
PPACA created a new way to buy health insurance which is called the Health Insurance Marketplace ("Marketplace"), also known as Exchanges. These Marketplaces are established by each individual state, the federal government or as a partnership between the state and the federal government. Through the Marketplaces, individuals can compare and purchase coverage (with a possible premium subsidy for those qualifying as low income; subsidies are made available as a federal tax credit through the Marketplace for individuals that are not eligible for coverage through their employer.

If you are enrolled in the Company's medical plan, then PPACA may have little effect on you. The Company's medical plans meet or exceed the minimum coverage requirements set by PPACA. If you are eligible for our plans, you will not be eligible for federal tax credits. You still have the option to visit the Marketplace to see the coverage options available. If you purchase a health plan through the Marketplace instead of purchasing health coverage offered by the Company, you will lose any contribution your employer makes for your health coverage, and your payments for coverage through the Marketplace will be made on an after-tax basis. (See **https://www.healthcare.gov/have-job-based-coverage/**).

If you are not eligible to enroll in the Company's medical plan, you may have a few options to purchase medical coverage. These options, if applicable, may include but are not limited to: your spouse's medical plan, your parent's medical insurance plan (if you are under age 26), or from several insurance companies offered though the Marketplace. If you shop for coverage through the Marketplace, you may be eligible for a federal tax credit and/or subsidy if you qualify as low income. (See also: **healthcare.gov**).

How Can I Get More Information?

For more information about purchasing medical coverage through the Marketplace please visit **healthcare.gov** or call **800-318-2596**.



Annual Notices

Health Insurance Portability and Accountability Act (HIPAA)

For purposes of the health benefits offered under the Plan, the Plan uses and discloses health information about you and any covered dependents only as needed to administer the Plan. To protect the privacy of health information, access to your health information is limited to such purposes. The health plan options offered under the Plan will comply with the applicable health information privacy requirements of federal Regulations issued by the Department of Health and Human Services. The Plan's privacy policies are described in more detail in the Plan's Notice of Health Information Privacy Practices or Privacy Notice. Plan participants in the Company-sponsored health and welfare benefit plan are reminded that the Company's Notice of Privacy Practices may be obtained by submitting a written request to the Human Resources Department. For any insured health coverage, the insurance issuer is responsible for providing its own Privacy Notice, so you should contact the insurer if you need a copy of the insurer's Privacy Notice.

Newborns' and Mothers' Health Protection Act

Group health plans and health issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours if applicable).

Notice Regarding Special Enrollment

If you are waiving enrollment in the Medical plan for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in the Medical plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

States with Individual Mandate

Taxpayers in CA, DC, MA, NJ, RI, and VT (this list is neither complete nor exhaustive) are reminded that your state imposes an individual mandate penalty (tax) should you, your spouse, and children choose to not have (and keep) medical/rx coverage for each tax year. Please consult your tax advisor for how a non-election for health coverage may affect your tax situation.

Special Enrollment Rights CHIPRA – Children's Health Insurance Plan

You and your dependents who are eligible for coverage, but who have not enrolled, have the right to elect coverage during the plan year under two circumstances:

- You or your dependent's state Medicaid or CHIP (Children's Health Insurance Program) coverage terminated because you ceased to be eligible.
- You become eligible for a CHIP premium assistance subsidy under state Medicaid or CHIP (Children's Health Insurance Program).
- You must request special enrollment within 60 days of the loss of coverage and/or within 60 days of when eligibility is determined for the premium subsidy.

Genetic Nondiscrimination

The Genetic 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, the Company asks Employees not to provide any genetic information when providing or responding to a request for medical information. 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.

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. 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 on 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.

Annual Notices continued

Notice of Required Coverage Following Mastectomies

In compliance with the Women's Health and Cancer Rights Act of 1998, the plan provides the following benefits to all participants who elect breast reconstruction in connection with a mastectomy, to the extent that the benefits otherwise meet the requirements for coverage under the plan:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- coverage for prostheses and physical complications of all stages of the mastectomy, including lymphedemas. The benefits shall be provided in a manner determined in consultation with the attending physician and the patient. Plan terms such as deductibles or coinsurance apply to these benefits

Women's Preventive Health Benefits

The following women's health services are considered preventive. These services generally will be covered at no cost share, when provided in network:

- Well-woman visits (annually and now including prenatal visits)
- Screening for gestational diabetes
- Human papilloma virus (HPV) DNA testing
- Counseling for sexually transmitted infections
- Counseling and screening for human immunodeficiency virus (HIV)
- Screening and counseling for interpersonal and domestic violence
- Breast-feeding support, supplies and counseling
- Generic formulary contraceptives are covered without member cost-share (for example, no copayment). Certain religious organizations or religious employers may be exempt from offering contraceptive services.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

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 (including spouse) for up to 24 months while in the military. Even if you do not 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 for pre-existing conditions except for service-connected injuries or illnesses.

Medicare Part D

The prescription drug benefit is creditable coverage. Medicare-eligible participants need not enroll in a separate Medicare D drug plan.

Mental Health Parity and Addiction Equity Act of 2008

This act expands the mental health parity requirements in the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Services Act by imposing new mandates on group health plans that provide both medical and surgical benefits and mental health or substance abuse disorder benefits. Among the new requirements, such plans (or the health insurance coverage offered in connection with such plans) must ensure that: the financial requirements applicable to mental health or substance abuse disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance abuse disorder benefits.

COBRA

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, COBRA qualified beneficiaries (QBs) generally are eligible for group coverage during a maximum of 18 months for qualifying events 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.

COBRA coverage is not extended for those terminated for gross misconduct. Upon termination, or other COBRA qualifying event, the former employee and any other QBs will receive COBRA enrollment information.

Qualifying events for employees include voluntary/involuntary termination of employment, and the reduction in the number of hours of employment. Qualifying events for spouses or dependent children include those events above, plus, the covered employee becoming entitled to Medicare; divorce or legal separation of the covered employee; death of the covered employee; and the loss of dependent status under the plan rules.

If a QB chooses to continue group benefits under COBRA, they must complete an enrollment form and return it to the Plan Administrator with the appropriate premium due. Upon receipt of premium payment and enrollment form, the coverage will be reinstated. Thereafter, premiums are due on the 1st of the month. If premium payments are not received in a timely manner, Federal law stipulates that your coverage will be cancelled after a 30-day grace period. If you have any questions about COBRA or the Plan, please contact the Plan Administrator.

Please note, if the terms of the Plan and any response you receive from the Plan Administrator's representatives conflict, the Plan document will control.

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