2023

EMPLOYEE BENEFITS GUIDE

Welcome to BeneComm!

BeneComm offers you and your eligible family members a comprehensive and valuable benefits program.

This guide has been developed to assist you in learning about your benefit options and how to enroll. We encourage you to take the time to educate yourself about your options and choose the best coverage for you and your family.

Inside This Guide

Enrolling in Benefits
What You Need to Know

When Does Coverage begin?

Coverage will be effective the first of the month following 30 days of employment, provided you complete your enrollment within 45 days of your hire date.

Who is Eligible to Elect Benefits?

If you are a benefits-eligible employee (regular full-time employee scheduled to work a minimum of 30 hours per week), you can enroll in the benefits described in this Guide. Please remember that only eligible dependents can be enrolled. Eligible dependents include: an employee's spouse or civil union partner; if under the age of 26, a natural child, adopted child, foster child, stepchild or grandchild (if court-ordered custody); or a disabled dependent.

Medical, Dental and Vision coverage is available for employees with same-sex domestic partnerships in states that do not recognize civil union partnerships. However, the domestic partnership must be legally recognized by the state and the employee would need to present a certificate to certify such. Opposite -sex domestic partnerships are not covered.

Required Documentation

BeneComm requires documentation of dependent status. Please contact the Member Advocacy Team for a list of acceptable documentation and provide the appropriate copies to Conner Strong & Buckelew within 45 days of your date of hire.

You may send your documentation to:

BeneComm
Attn: HR Department
Fax: 856.123.4567
Email: enrollments@benecomm.com

Enrollment Timeline

You MUST enroll online through our enrollment system benefitsConnect. Instructions for accessing benefitsConnect can be found on page 5 of this guide.

You will have 45 days from your date of hire to log on and complete your benefits enrollment. If you do not enroll within this timeframe, you will not be able to enroll until our next open enrollment, unless you experience a qualifying life event.

Qualifying Life Events

IRS Section 125 prohibits you from changing your enrollment during the plan year unless you experience a qualifying life event, such as: marriage, divorce, death of a spouse, civil union partner or a dependent, birth or adoption of a child, termination or commencement of employment for your spouse/civil union partner, a change in employment status (full-time to part-time or part-time to full-time) for you or your spouse/civil union partner that affects benefits eligibility, or taking an unpaid, medical leave of absence by either you or your spouse/civil union partner.

Online Enrollment System

benefitsConnect

Enrollment Instructions

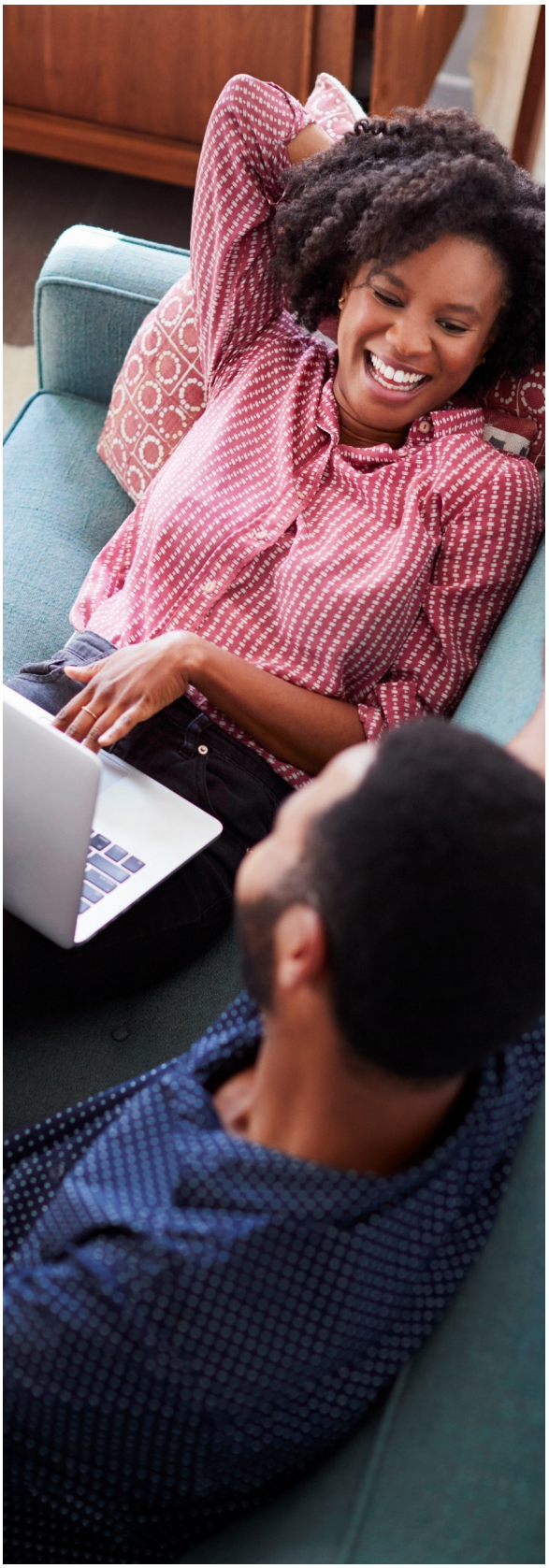
When you are ready to enroll in or make changes to your benefits, you MUST enroll online through our online enrollment system, ***benefits*CONNECT**.

Before you begin, make sure you have your Social Security Number. If you are changing or enrolling your dependents, make sure you also have their birth dates and Social Security Numbers.

A link to ***benefits*CONNECT** will be available on BenePortal. Your username for ***benefits*CONNECT** is (up to) the first 6 letters of your last name, followed by the first letter of your first name, followed by your month and date of birth in mmdd format. Your initial password is your Social Security number.

For example: Jane Dovebar (Social Security number is **123-45-6789** and date of birth **12/10/1969**) would enter the following:

Username: dovebaj1210
Password: 123456789



Member Advocacy Team
Conner Strong & Buckelew

Employee benefits can be complex, making it difficult to fully understand your coverage and use it properly. Member Advocacy allows you to speak to a specially trained Member Advocate, who can answer your questions and help you get the most out of your benefits.

You Can Contact Member Advocacy for Assistance if You:

- Believe your claim was not paid properly
- Need clarification on information from the insurance company
- Have a question regarding a bill from a doctor, lab or hospital
- Are unclear on how your benefits work
- Need information about adding or deleting a dependent
- Need help to resolve a problem you've been working on

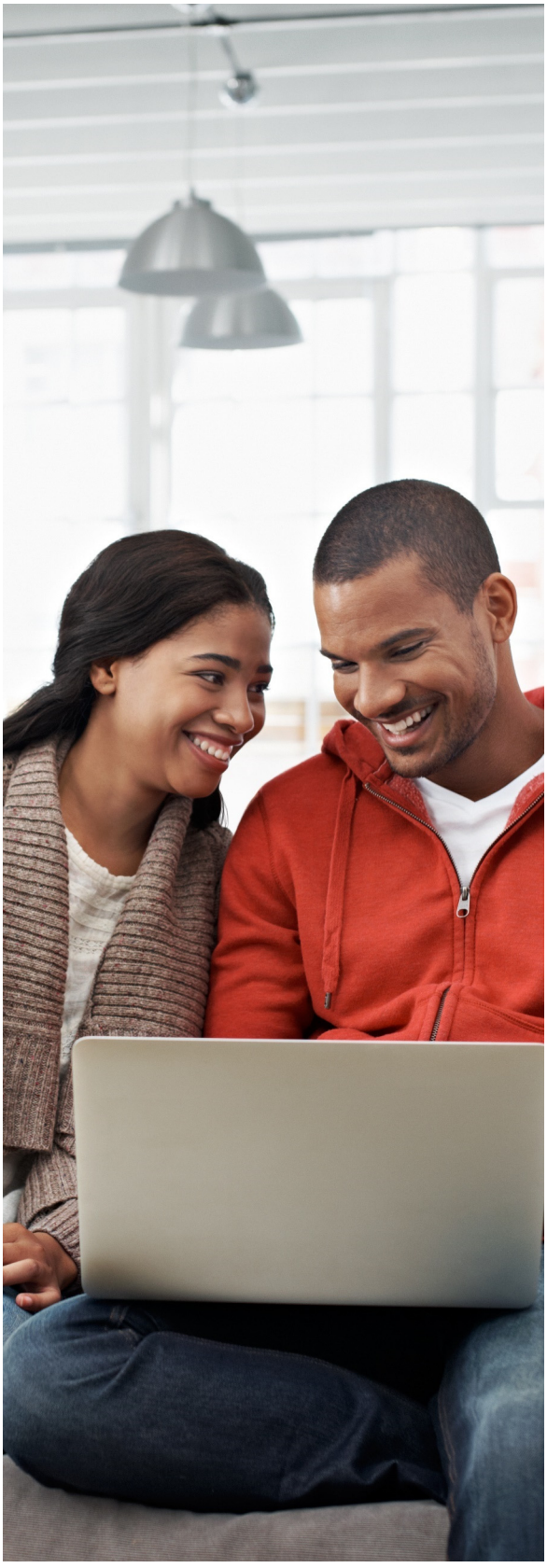
Member Advocates are available Monday through Friday, 8:30am to 5:00pm (Eastern Time). After hours, you will be able to leave a message with a live representative and receive a response by phone or email during business hours within 24 to 48 hours of your inquiry.

How To Contact Member Advocacy?

You may contact the Member Advocacy Team in any of the following ways:

- Via phone: 800.563.9929, Monday through Friday, 8:30 am to 5:00 pm (Eastern Time)
- Via the web: www.connerstrong.com/memberadvocacy
- Via fax: 856.685.2253

BenePortal
Online Benefits Resource



BenePortal

At BeneComm, you have access to a full-range of valuable employee benefit programs. You are able to review your current employee benefit plan options online, 24 hours a day, 7 days a week! By using BenePortal, our online tool that houses our benefit program information, you can:

- Review medical/prescription drug/vision and dental plan options
- Explore additional voluntary employee benefit programs available to you
- Find links to insurance carriers' websites
- Download plan designs, affidavits, etc.

You and your family can access BenePortal anytime at: www.samplebenefitsportal.com

Medical Benefits

Cigna

	OA POS Elite Plan	*OA POS High Plan*	*OA POS Mid Plan*	*HSA-Qualified HDHP*
IN-NETWORK BENEFITS				
Deductible Individual/Family	None	$250/$500	$500/$1,000	$1,350/$2,700**
Firm HSA Funding Individual/Family	N/A	N/A	N/A	$650/$1,300
Out-of-Pocket Maximum Individual/Family	$2,500/$5,000	$3,000/$6,000	$4,000/$8,000	$6,550/$13,100***
Preventive Care Services	Covered 100%	Covered 100%	Covered 100%	Covered 100%
PCP Office Visit	$15 copay	$30 copay	Plan pays 80%*	Plan pays 80%*
Specialist Office Visit	$30 copay	$60 copay	Plan pays 80%*	Plan pays 80%*
Diagnostic Laboratory	Covered 100%	Plan pays 90%	Plan pays 80%*	Plan pays 80%*
Diagnostic X-Ray/Imaging (MRI, CT-Scan)	$100 copay	$100 copay	Plan pays 80%*	Plan pays 80%*
Emergency Room	$150 copay	$150 copay	Plan pays 80%*	Plan pays 80%*
Urgent Care Center	$50	$50	Plan pays 80%*	Plan pays 80%*
Inpatient Hospital	$250 copay per admission	Plan pays 90%*	Plan pays 80%*	Plan pays 80%*
Outpatient Surgery	Covered 100%	Plan pays 90% *	Plan pays 80%*	Plan pays 80%*
OUT-OF-NETWORK BENEFITS (SUBJECT TO BALANCE BILLING)				
Deductible Individual/Family	$500/$1,500	$1,500/$3,000	$2,500/$5,000	$3,000/$6,000**
Out-of-Pocket Maximum Individual/Family	$5,000/$15,000	$5,000/$15,000	$10,000/$20,000	$6,550/$13,100
Coinsurance	Plan pays 70%*	Plan pays 70%*	Plan pays 60%*	Plan pays 50%*

* After deductible

** Full Family Deductible: The family deductible must be met if employee covers self and one or more dependent.

*** Once any one individual meets the individual out-of-pocket maximum, their expenses are covered at 100% for the balance of the plan year, all other family members must collectively meet the family out-of-pocket maximum before the plan pays 100%.

Medical Benefits

Preventive Care

What are Preventive Services?

Preventive services typically include yearly check-ups, screenings, and immunizations that can help you and your family members stay healthy, avoid or delay health problems, and lower your out-of-pocket medical costs..

Are These Services Always Covered With No Cost Sharing?

To be covered without any member cost-sharing, the designated preventive tests, examinations, and other medical services you receive must be billed by the in-network provider as preventive care and not be part of a diagnostic procedure or ongoing treatment for an existing condition. If a procedure is considered preventive, there is no cost-sharing. If a procedure is not considered preventive, or you don't fall within the coverage guidelines, charges may apply.

Covered preventive services for adults generally include:

- Cancer screenings of the breast, cervix, and colon
- Screening for vitamin deficiencies during pregnancy
- Screenings for diabetes, high cholesterol, and high blood pressure
- Medication and supplements for people with certain conditions
- Immunizations (doses, recommended ages, and recommended populations vary)

Covered preventive services for children generally include:

- Annual pediatrician visits
- Pediatric vision and hearing screening
- Developmental assessments for young children
- Screening and counseling to address childhood obesity
- Immunizations (from birth to age 18 - doses, recommended ages, and recommended populations vary)

Prescription Benefits

Cigna

If you are enrolled in one of the medical plans, you are automatically enrolled in the corresponding prescription drug plan through Cigna.

	OA POS Elite, High, & Mid Plans	*HSA-Qualified HDHP*
RETAIL PHARMACY (UP TO A 30-DAY SUPPLY)		
Generic	$20 copay	Plan pays 80%*
Preferred Brand	$40 copay	Plan pays 80%*
Non-Preferred Brand	$60 copay	Plan pays 80%*
MAIL ORDER PHARMACY (UP TO A 90-DAY SUPPLY)		
Generic	$40 copay	Plan pays 80%*
Preferred Brand	$80 copay	Plan pays 80%*
Non-Preferred Brand	$120 copay	Plan pays 80%*

* After medical deductible

Cigna 90-Day Prescription for Maintenance Medications

Maintenance medications must be filled in a 90-day supply at a retail pharmacy or Home Delivery pharmacy to be covered under your plan. Maintenance medications are those medications that are taken regularly, over time, to treat an ongoing health condition, such as diabetes, high blood pressure, cholesterol or asthma.

Effective July 1, 2023, you will be able to receive three 30-day fills before your maintenance medication is not covered. **If you haven't switched to a 90-day supply after three fills, your plan won't cover the cost of the medication.**

Having a 90-day supply of your medication on-hand typically means you're less likely to miss a dose.

Where you can fill a 90-day prescription

Your plan also offers a new retail pharmacy network that gives you more choice in where you can fill your 90-day prescriptions. There are thousands of retail pharmacies in the network.

For more information about your new pharmacy network, you can go to www.Cigna.com/Rx90network.

Prescription Benefits

Cigna

Save on your prescriptions with Mail Order: Cigna Home Delivery Pharmacy

When you use the Cigna Home Delivery Pharmacy to fill your maintenance drug prescriptions, you will receive a 90-day (3-month) supply for two retail copays. In addition to the savings, your prescriptions will be delivered right to your home.

To learn more about using mail order, simply visit
www.cigna.com

How much can you save when you use Mail Order?
Compare for yourself...

RETAIL PHARMACY	MAIL ORDER	ANNUAL SAVINGS
Preferred Brand-Name **$40**	Preferred Brand-Name **$80**	**$160**
Annual cost *($40 x 12 fills per year)* **$480**	Annual cost *($80 x 4 fills per year)* **$320**	

GoodRx

Stop paying too much for prescriptions! Good Rx allows you to simply and easily search for retail pharmacies that offer the lowest price for specific medications. The cost for the same medications vary drastically from one drug store to the next.

Use Good Rx to compare drug prices at local and mail-order pharmacies and discover free coupons and savings tips. Find huge savings on drugs not covered by your insurance plan – you may even find savings versus your typical co-payment!

Start saving on your prescriptions today at
connerstrong.goodrx.com

Dental Benefits

Cigna

Below is a summary of the dental plans available to you effective July 1, 2023.

	Core PPO		*Buy-Up PPO*	
	IN-NETWORK	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
Calendar Year Deductible Individual/Family	$50/$150	$75/$225	$50/$150	$75/$225
Calendar Year Maximum (per patient)	$1,250	$1,250	$2,250	$2,250
Preventive & Diagnostic Services • Exams • Cleanings • Bitewing X-rays (each twice in a calendar year) • Fluoride Treatment (once in a calendar year, children to age 19)	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Basic Services • Fillings, Extractions • Endodontics (root canal) • Periodontics, Oral Surgery • Sealants	Plan pays 100% after deductible	Plan pays 80% after deductible	Plan pays 100% after deductible	Plan pays 80% after deductible
Major Services • Crowns • Gold Restorations • Bridgework • Full and Partial Dentures	Plan pays 60% after deductible	Plan pays 50% after deductible	Plan pays 60% after deductible	Plan pays 50% after deductible
Orthodontia Benefits (children age 19 and below)	Plan pays 50%	Plan pays 50%	Plan pays 50%	Plan pays 50%
Orthodontia Lifetime Maximum (per patient)	$2,000	$2,000	$2,000	$2,000

* After medical deductible

Vision Benefits

Cigna

Eligible employees and their eligible family members may enroll in the VSP Vision plan.

To find doctors in your neighborhood, visit www.vsp.com or call 800.877.7195.

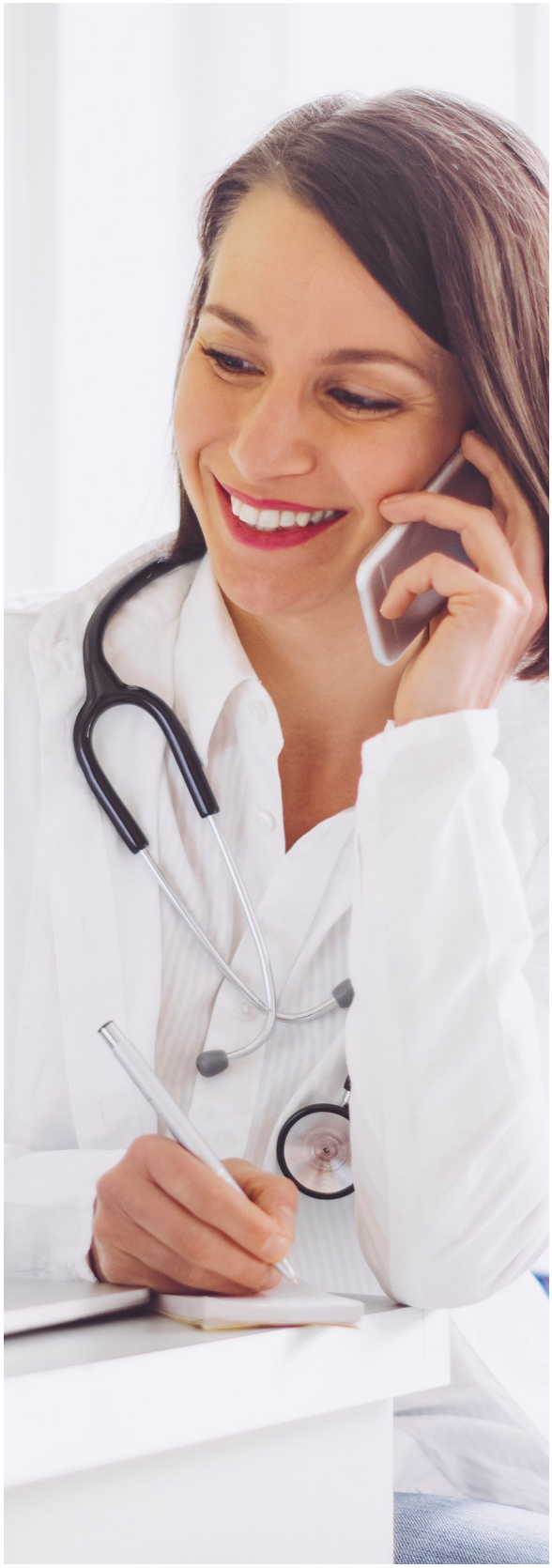
VSP Vision Plan

	IN-NETWORK	OUT-OF-NETWORK
Exam	$20 copay	Reimbursed up to $45
Frames	$130 allowance, 20% off amount over your allowance	Reimbursed up to $47
Lenses • Single Vision Lenses • Bifocal Lenses • Trifocal Lenses	Combined with Exam	Reimbursed up to $45 Reimbursed up to $65 Reimbursed up to $85
Contact Lenses (in lieu of eyeglasses)	$130 allowance	Reimbursed up to $105
Frequency • Vision Exam • Lenses • Frames	 12 months 12 months 24 months	 12 months 12 months 24 months

TeleMedicine
MDLive

If you are enrolled in a BeneComm medical plan, you and your dependents have access to a telemedicine benefit through MDLive.

MDLive is a national network of U.S. board-certified doctors available on-demand 24/7/365 to diagnose, treat and prescribe medication, if necessary, for many of your medical issues. It's quality care when you need it.



Talk to a Doctor Anytime

With MDLive, plan members can conveniently consult with board-certified physicians through phone or video consults. A wide range of common non-emergency conditions may be treated, including:

- Allergies or allergic reactions
- Cold and flu
- Constipation
- Cough
- Diarrhea
- Ear problems
- Fever
- Headaches
- Insect bites
- Pink eye
- Rashes and other skin irritations
- Respiratory problems
- Sore throat
- Urinary tract infections
- Vomiting

To access your telehealth benefit in one of three ways:

- Call **1.877.764.6605**
- Download the free MDLIVE mobile phone app
- Visit **www.mdlive.com**

Life & AD&D Benefits

Unum

This year BeneComm has enhanced the Life Insurance and Accidental Death and Dismemberment (AD&D) benefit by adding a Basic Life Benefit of $50,000. This benefit is provided to you at no cost - BeneComm pays 100% of the basic life premium. The Voluntary Life and AD&D plan allows you to purchase additional life insurance for yourself and your dependents.

Basic Term Life and AD&D

Eligibility	All active, full-time salaried and office hourly employees working at least 30 hours per week
Life/AD&D Benefit	$50,000
Benefit Age Reduction	67% at age 70
Guaranteed Issue Amount	100%

Voluntary Life and AD&D

Eligibility	All active, full-time salaried and office hourly employees working at least 30 hours per week
Life/AD&D Benefit	The lesser of 5 times your base annual earnings or $500,000 ($10,000 increments)
Spouse	$5,000 increments to a maximum of $100,000; not to exceed 100% of the employee benefit amount
Dependent Child(ren)*	$2,000 units up to a maximum of $10,000
Benefit Age Reduction	67% at age 70
Guaranteed Issue Amount Employee/Spouse/Child	$150,000/$25,000/$10,000

* Please note: dependents are covered to age 19 and full-time students are covered to age 23.

Additional Voluntary Benefits

Allstate

All Full-Time and Part-Time benefit eligible employees may choose to participate in any of the following benefits.

Universal Life Insurance

- Weekly Benefit Percent: 60%
- Maximum Weekly Benefit: $1,000
- Elimination Period (day on which benefits will be payable for your disability): 1st day for Accidents & 8th day for Illness
- Maximum Duration of Benefit (subject to approval): 13 weeks (includes elimination period)

Accident Insurance

- Weekly Plan pays lump sum dollar amount to you in the event of an accidental injury including accidental life insurance, hospitalization and ICU, ambulance services and other medical related expenses.
- Benefit pays $50 for each visit, by a covered insured, to any doctor visit outside of a hospital. Benefit pays a maximum of 2 times per year for individual coverage and a maximum of 4 times per year for individual/spouse, individual/child(ren) or family coverage.
- Individual, individual/spouse, individual/child(ren) and family coverage is available.

Short-Term Disability Insurance

The plan offers income protection should you be disabled due to sickness, accident or maternity leave. Elect up to 60% of your gross monthly salary and choose an elimination and benefit period to meet your specific needs.

All Full-Time and Part-Time employees are eligible for voluntary short term disability through Allstate.

The Allstate Cancer Insurance at BeneComm will be discontinued as of July 1, 2023. Employees currently enrolled in the Allstate Cancer Insurance may keep the policy in place. No new enrollments will be accepted.

For additional information regarding the Allstate benefits, please contact the BenAware Call Center between June 13th and June 20th at 866.591.7328 Monday through Friday, 8:30am to 5:00pm EST.

Flexible Spending Accounts (FSA)

benefitExpress

The BeneComm Flexible Spending Accounts are administered by benefitExpress.

Flexible Spending Accounts (FSAs) provide a tax-advantaged way to help you pay for certain out-of-pocket expenses. An FSA lets you set aside money on a pre-tax basis to pay for eligible out-of-pocket health care expenses, dependent care expenses or both. You can enroll in the following accounts:

Health Care FSA

You use this account to pay for eligible unreimbursed health care, dental, vision and prescription drug expenses for you and/or your dependents with pre-tax dollars. You can contribute up to **$2,700 in 2023**.

Dependent Care FSA

You may use this account to pay for eligible dependent care expenses (not for dependents' health care expenses). You can contribute up to $5,000 a year or $2,500 if you are married but file separate tax returns.

Limited Purpose FSA

Those who enroll in the HDHP with an HSA can participate in a Limited Purpose FSA. Funds in this account can be used for qualified reimbursements for dental and vision expenses only.

Make Sure You Plan Your FSA Contributions Carefully

It's important that you plan your contributions to the FSAs carefully. Consider how much you expect to spend on out-of-pocket health care and prescription drug and/or dependent-care expenses in 2023, recognizing that your needs may have changed from the previous year.

Once you have elected your contribution amount and the plan year begins, you cannot change your contributions or stop contributing during the year unless you have a qualifying status change, such as gaining or losing a dependent. In addition, FSAs have a "use-it-or-lose-it" provision. If you do not use the funds set aside, you will lose the money in your account, except for up to $500 that can be rolled over into the next calendar year. It is important to estimate your out-of-pocket expenses carefully, so you do not forfeit money left in your account. cards will be issued to all employees that enroll in an FSA for 2023.

Health Savings Account (HSA)

BeneComm

What is an HSA?

If you participate in the HDHP medical plan, you may be eligible to participate in a Health Savings Account (HSA). An HSA is a tax-exempt savings account that can be used for eligible healthcare expenses (an expense which pays for care as described in Section 213 (d) of the Internal Revenue Code).

- You may contribute pre-tax dollars to the HSA. Interest accumulates tax-free and funds are tax-free to withdraw for eligible medical expenses.
- You can use the money in your HSA to pay for eligible medical expenses and prescriptions. The HSA funds can be used to help you satisfy your plan's annual deductible.
- HSAs are available through most banks and financial institutions

You may contribute to an HSA if you:

- Have coverage under an HSA-qualified HDHP medical plan.
- Have no other first-dollar medical coverage.
- Are not enrolled in Medicare.
- Cannot be claimed as a dependent on someone's tax return.

Contributions to an HSA are limited annually by the IRS. For 2023, the contribution limits are:

- **Single coverage:** $3,500
- **Family Coverage:** $7,000

Individuals 55 and older can also contribute an additional $1,000 per year as a catch-up contribution.

Discount Programs

GlobalFit

Save money and achieve your fitness goals with GlobalFit!

CHOOSE from over 10,000 gyms, including big chains (Bally, Curves, etc.), regional chains and your local favorites.

SAVE with GlobalFit's Lowest Price Guarantee! If the gym publishes a lower price on the same membership, we will beat that price.

FREEZE your membership for up to 2 months a year with no billing!

SAVE on various home health and fitness products including Zumba, Total Gym, Schwinn, Stairmaster and more through the GlobalFit store!

FREE Tips and Resources help you stay motivated with articles, tips and recipes from GlobalFit's monthly newsletter, GO.

ENROLLMENT is easy! GlobalFit handles all employee inquiries, enrollments, and billing through their full-service website and call center.No paperwork, no payroll deductions, and no hassle for you!

SET goals and stay motivated! Support is available to you through GlobalFit's US-based call center or 24/7 online.

Learn more about how you can save with GlobalFit by calling 800.294.1500 or visit www.globalfit.com/connerstrong

BenefitPerks

CSB Benefit Perks is a discount and rewards program provided by Conner Strong & Buckelew (CSB) that is available to all employees at no additional cost. The program allows consumers to receive discounts and cash back for hand-selected shopping online at major retailers.

Use the Benefit Perks website to browse through categories such as: Automotive, Beauty, Computer & Electronics, Gifts & Flowers, Health & Wellness and much more! Consumers can also print coupons to present at local retailers and merchants for in-person savings, including movie theatres and other services.

Start saving today by registering online at connerstrong.corestream.com

Carrier Contacts

Carrier Contacts

Benefits/Resources	*Contact*	*Phone number*	*Website*
Medical and Prescription	Cigna	555-555-5555	www.cigna.com
Vision	VSP	800-877-7195	www.vsp.com
Dental	Cigna	800-244-6224	www.mycigna.com
Life/AD&D, STD and LTD	Unum	866-679-3054	www.unum.com
Flexible Spending Accounts and Commuter Benefits	Flores & Associates	704-335-8211	www.flores247.com
Employee Assistance Program (EAP)	IBH	800-395-1616	www.ibhcorp.com User Name: BENECOMM Password: BENECOMM
401(k)	Principal	800-547-7754 Plan Number: 525626	www.principal.com
Member Advocacy	Member Advocacy	800-563-9929	www.connerstrong.com/memberadvocacy
Accident, Critical Illness	Unum	866-679-3054	www.unum.com

Legal Notices

Notice Regarding Special Enrollment

Loss of other Coverage (excluding Medicaid or a State Children's Health Insurance Program)
If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, 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 Company stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of coverage for Medicaid or a State Children's Health Insurance Program
If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program (CHIP).

New dependent by marriage, birth, adoption, or placement for adoption
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 new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If you request a change due to a special enrollment event within the applicable timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment.

Newborns' and Mothers' Health Protection Act

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

Women's Health and Cancer Rights Act

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 benefits.
If you have any questions, please speak with Human Resources.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com
Phone: 1-855-692-5447

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

Legal Notices

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

COLORADO - Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 1-800-221-3943 / State Relay 711
CHP+ Website: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991 / State Relay 711

FLORIDA – Medicaid
Website: http://flmedicaidtplrecovery.com/hipp/
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162 ext 2131

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: http://www.indianamedicaid.com
Phone 1-800-403-0864

IOWA – Medicaid
Website: http://dhs.iowa.gov/Hawki
Phone: 1-800-257-8563

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/
Phone: 1-785-296-3512

KENTUCKY – Medicaid
Website: https://chfs.ky.gov
Phone: 1-800-635-2570

LOUISIANA – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 1-888-695-2447

MAINE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-442-6003
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-862-4840

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

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

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: (855) 632-7633
Lincoln: (402) 473-7000
Omaha: (402) 595-1178

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

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 603-271-5218
Toll-Free: 1-800-852-3345, ext 5218

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

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

NORTH CAROLINA – Medicaid
Website: https://dma.ncdhhs.gov/
Phone: 919-855-4100

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

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm
Phone: 1-800-692-7462

Legal Notices

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 855-697-4347 or 401-462-0311

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

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

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

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

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

VIRGINIA – Medicaid and CHIP
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid
Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/
Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2023, 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

Continuation of Coverage Rights Under COBRA

Federal law requires certain employers sponsoring group health plan coverage to offer their employees (and his or her enrolled family members) the opportunity to elect to extend health coverage should a loss of plan coverage occur due to a qualifying event. You are receiving this notice because you have either (1) recently been hired by Interstate Realty Management, and are enrolled in the Interstate Realty Management Group Health Plan or (2) you recently added a newly eligible dependent to your plan. This notice contains important information about the right you and your covered dependents have under COBRA continuation coverage.

Both you (the employee) and your enrolled dependents (if applicable) should read this notice carefully and keep it with your records.

Introduction
You are receiving this notice because you have recently become covered under Interstate Realty Management (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should either review the Plan's Summary Plan Description or get a copy of the Plan Document from the Plan Administrator.

The Plan Administrator is:
BeneComm
123 Somewhere Street
City, State ZIP

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.

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." Specific qualifying events are listed later in the notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of

employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

1) Your hours of employment are reduced; or
2) 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:

1) Your spouse dies;
2) Your spouse's hours of employment are reduced;
3) Your spouse's employment ends for any reason other than his or her gross misconduct;
4) Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
5) 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:

1) The parent-employee dies;
2) The parent-employee's hours of employment are reduced;
3) The parent-employee's employment ends for any reason other than his or her gross misconduct;
4) The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
5) The parents become divorced or legally separated; or
6) The child stops being eligible for coverage under the plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Interstate Realty Management and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan. The plan will offer COBRA continuation 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 enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event. In addition, if the Plan provides retiree health coverage, then commencement of a proceeding in a bankruptcy with respect to the employer is also a qualifying event where the employer must notify the Plan Administrator of the qualifying event.

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator, in writing, within 60 days after the qualifying event occurs. You must send this notice to:

PayFlex Systems USA, Inc.
BENEFIT BILLING DEPARTMENT
P.O. BOX 2239
OMAHA, NE 68103-2239

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 on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin either (1) on the date of the qualifying event or (2) on the date that Plan coverage would otherwise have been lost, depending on the nature of the Plan.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 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 at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can 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. You must notify PayFlex of that fact within 60 days of the later of 1) the SSA's determination of disability (the date of the SSA award letter); 2) the date of your qualifying event; 3) the date of your loss of coverage; or 4) the date you were notified of the requirement (the date of your qualifying event letter). The notification must also be provided before the end of the first 18 months of continuation coverage.

Also, you are required to notify the Plan Administrator of any change in your disabled status. This notice should be sent to:

PayFlex Systems USA, Inc.
BENEFIT BILLING DEPARTMENT
P.O. BOX 2239
OMAHA, NE 68103-2239

Legal Notices

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

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. **In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to:**

PayFlex Systems USA, Inc.
BENEFIT BILLING DEPARTMENT
P.O. BOX 2239
OMAHA, NE 68103-2239

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.

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact PayFlex Systems USA, Inc. or you may contact the nearest Regional or District Office of the U.S Department of Labor's Employee Benefits Security Administration (EBSA). 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 www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website. at http://www.dol.gov/ebsa. For more information about the Marketplace, visit www.HeathCare.gov.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of 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.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) includes some provisions that may affect decisions you make about your participation in the Group Health Plan under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). These provisions are as follows:

1. Under COBRA, if the qualifying event is a termination or reduction in hours of employment, affected qualified beneficiaries are entitled to continue coverage for up to 18 months after the qualifying event, subject to various requirements. Before HIPAA, this 18-month period could be extended for up to 11 months (for a total COBRA coverage period of up to 29 months from the initial qualifying event) if an individual was determined by the Social Security Administration, under the Social Security Act, to have been disabled at the time of the qualifying event and if the plan administrator was notified of that disability determination within 60 days of the determination and before the end of the original 18-month period.
Under HIPAA, if a qualified beneficiary is determined by the Social Security Administration to be disabled under the Social Security Act at any time during the first 60 days of COBRA coverage, the 11-month extension is available to all individuals who are qualified beneficiaries due to the termination or reduction in hours of employment. The disabled individual can be a covered employee or any other qualified beneficiary. However, to be eligible for the 11 -month extension, affected individuals must still comply with the notification requirements in a timely fashion.

2. A child that is born to or placed for adoption with the covered employee during a period of COBRA coverage will be eligible to become a qualified beneficiary. In accordance with the terms of the employer's group health plan (s) and the requirements of Federal law, these qualified beneficiaries can be added to COBRA coverage upon proper notification to the Plan Administrator of the birth or adoption.

3. Under COBRA, your right to continuation coverage terminates if you become covered by another employer's group health plan.

If you have any questions about COBRA, or if you have changed marital status, or you or your spouse have changed addresses, please contact PayFlex Systems USA, Inc. at (800) 359-3921.

PayFlex Systems USA, Inc.
COBRA Compliance Administrator

Insurance Marketplace Notice

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets our needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]
Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution, as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact the insurance carrier's customer service number located on your ID card. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area. To get information about the Marketplace coverage, you can call the government's 24/7 Help-Line at 1-800-318-2596 or go to https://www.healthcare.gov/marketplace/individual/.

PART B: Information about Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer Name		4. Employer Identification Number
5. Employer Address		6. Employer Phone Number
7. City	8. State	9. Zip Code

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

Notes

Notes

BeneComm reserves the right to modify, amend, suspend or terminate any plan, in whole or in part, at any time. The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies, or errors are always possible. In case of discrepancy between the Guide and the actual plan documents, the actual plan documents will prevail. If you have any questions about your Guide, contact Human Resources.