

2021-2022 Plan Year

Complete Guide to Your

Employee Benefits



MEDICAL

DENTAL

VISION

FSA

HSA

LIFE

DISABILITY



July 2021



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.
- If you require further assistance contact AssuredPartners. Authority Brands has partnered with AssuredPartners as our benefits administrator for expert assistance with benefit related questions, plan procedures, life events and claim issues.
- **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	Group #	Web	Phone / Email
Medical UMR / UnitedHealthcare Choice Plus National Network	76-414010	www.umar.com	1-800-826-9781
Prescription Express Scripts		www.express-scripts.com	1-866-832-9260
Health Savings Account Optum Bank	76-414010	www.optumbank.com	1-866-234-8913
Flexible Spending Account AssuredPartners Hours: M-F 8am-5:30pm ET		https://apbenefitadvisors.wealthcareportal.com	1-800-535-6539, opt. 4 410-229-8356 (fax) AuthorityBrands@AssuredPartners.com
Dental Lincoln Dental Connect	00001D039539	www.LincolnFinancial.com	1-800-423-2765 claims@lfg.com
Vision Vision Service Plan	30091392	www.vsp.com	1-800-877-7195
Basic Life/AD&D Insurance Voluntary Life Insurance Lincoln Financial	10253493 00040FF01000- 00082	www.lfg.com	1-800-423-2765
FMLA: Absence Management (#1+SSN to connect) Short-Term Disability Long-Term Disability Lincoln Financial	FMLA: Authority Brands, LLC STD: 10253495 LTD: 10253494	www.lfg.com	1-800-423-2765
Employee Assistance Program (EAP) EmployeeConnect		www.guidanceresources.com User Name: LFGsupport Password: LFGsupport1	1-888-628-4824
Emergency TravelConnect		www.mysearchlightportal.com ID: LFGTravel123	1-866-525-1955
LifeKey Services		www.guidanceresources.com Web ID: LifeKeys	1-855-891-3684
AssuredExcellence			1-888-856-4317 assuredexcellence@apbenefitadvisors.com
Authority Brands Benefits Helpline Hours: M-F 8am-5:30pm ET		www.authoritybrands.bswift.com	1-800-535-6539, opt. 4 AuthorityBrands@AssuredPartners.com



Welcome to your 2021 Employee Benefits!

Authority Brands is pleased to offer a wide range of benefits to its employees and their families. These company sponsored benefits are an important part of a total compensation package. They represent both a valuable asset to our employees and to their families, and demonstrate an investment by Authority Brands in our employees. We are proud of our compensation and benefits program and are committed to continuously improving the plans that make up our benefits offerings.

This guide was created to answer some of the questions you may have about your benefits. Please read it carefully along with any supplemental materials you receive.

If you have any benefits related questions or concerns, please do not hesitate to call the Authority Brands Benefits Helpline.

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PLEASE NOTE: This booklet provides a summary of the benefits available, but is not your Summary Plan Description (SPD). Authority Brands 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.

Employee Benefits Helpline

 **1-800-535-6539, opt. 4**

 **AuthorityBrands@AssuredPartners.com**

How to Enroll

Open Enrollment Period

Authority Brands's annual enrollment period will be held **May 18 through June 4, 2021**.

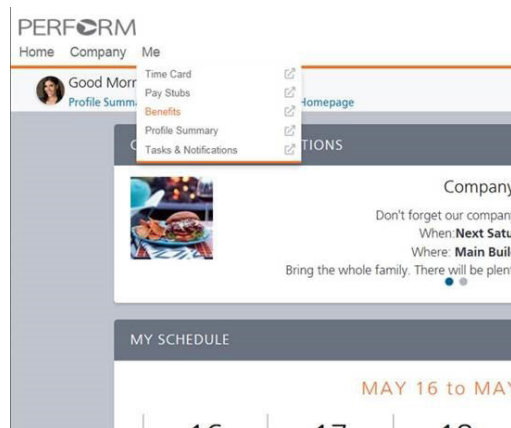
This year's Open Enrollment is active, all employees need to complete the online enrollment to make their benefit plan elections of Flexible Spending Accounts or Health Savings Account. You must make a new election to participate in all Flexible Spending Accounts (FSAs) and/or Health Savings Accounts (HSAs) for 2021. FSA and/or HSA elections do not carry over from year to year.



Have social security numbers and birth dates for all dependents and beneficiaries available prior to logging on.

Minimum Browser Requirements:

- Internet Explorer 11.0
- Firefox 35.0
- Google Chrome 39.0.2171.99 m
- Safari 10.0
- You must have Cookies, JavaScript, and Style Sheets enabled.
- The system will automatically log you out if left idle for more than 30 minutes.



Members can access bswift through their payroll (Paycor) utilizing single sign on.

Go to "Me", then select "Benefits". It will take them directly into bswift.

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. Coverage, if elected, will begin on the first of the month following 30 days from your date of hire, provided you enroll online within **30 days from your benefits effective date**.

Enrolling In Your Benefits

Please review this guide to gain a full understanding of the plans being offered. Be sure to go online to review your current benefits and make any changes for the upcoming plan year. Our plan year is July 1st through June 30th.

www.authoritybrands.bswift.com

- **Username** - AB + last name + last 4 digits Social Security Number (ABsmith1234)
- **Password** - Date of Birth (01021977)

Passwords are reset prior to Open Enrollment every year and you will be prompted to change your password upon login.

The enrollment process will be broken down into 4 steps:

- **Your Information**
Employee - Verify accuracy of all information.
Family - You may add new dependent information as necessary. Please remember to include social security numbers and add date of birth for all dependents.
- **Your Benefits** - You will be automatically enrolled in benefits that are company-paid (Basic Life/AD&D, STD and LTD). These benefits will be checked off as completed. The first incomplete benefit will open up and guide you through the enrollment process.
- **Enroll** - You will be asked to assign beneficiaries, confirm other coverage, do a final review of your elections and confirm.
- **Complete** - After you have made your benefit elections and verified them for accuracy, click **"COMPLETE ENROLLMENT."** You will then have the option to e-mail and/or print a copy of the Confirmation Statement for your records.

You can make changes to your selections prior to the enrollment deadline by logging back into the system and clicking on "Change My Elections."

Eligibility

Full-time employees with a schedule of **30 hours per week** are eligible for the benefits described in this guide, unless otherwise stated.

When Benefits Become Effective

Coverage for most benefit plans becomes effective on the first day of the month following 30 days of continuous employment. Part-time, seasonal, temporary, internship, and contracted employees are not eligible to participate.

Eligible Dependents

Your dependents are eligible to participate in Authority Brands' benefit plans. Your eligible dependents include*:

- A spouse to whom you are legally married.
- A dependent child under age 26. Coverage will terminate at the end of the month of the dependent's 26th birthday. Coverage for medical, dental, and vision may be extended past the age of 26 for disabled dependents. Dependent children can include natural, adopted 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 enrollment even if choosing to waive coverage in order to provide beneficiary information for your company-paid life insurance.



Pre-Tax Benefits: Section 125

Authority Brands 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 Changes

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, vision and flexible spending accounts, 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 a gain or loss of eligibility.

In order to be permitted to make a change of election relating to your health, dental or 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. This is not applicable for Health Care FSAs.

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.

Please note: You must notify the Authority Brands Benefit Helpline of the birth/adoption of child on the date of the event. All other life events, 1st of the month following the date of the event.

You must notify the Authority Brands Benefits Helpline within 30 days of the life event status change in order to make a change in your benefit selections, unless otherwise stated.



Benefit Changes continued...

Event	Action Required	Results If Action Not Taken
New Hire:	Make elections within 30 days of the benefit coverage effective date. Confirm dependents are eligible.	You and your dependents are not eligible until the next annual Open Enrollment.
Marriage:	Your new spouse must be added to your elections on the 1st of the month following the date of marriage. A copy of the marriage certificate must be presented.	Your spouse is not eligible until the next annual Open Enrollment period.
Divorce:	The former spouse must be removed on the 1st of the month following the date of the divorce. Proof of the divorce will be required. A copy of the divorce decree must be presented.	Benefits are not available for the divorced spouse and will be recouped if paid erroneously.
Birth or adoption of a child:	The new dependent must be enrolled on the date of the birth and adoption, even if you already have family coverage. A copy of the birth certificate, footprints, or hospital discharge papers must be presented. Once you receive the child's Social Security Number, be sure to contact AssuredPartners to update your child's insurance information record.	The new dependent will not be covered on your health insurance until the next annual Open Enrollment period.
Death of a spouse or dependent:	Remove the dependent from your elections on the 1st of the month following the date of death. Death certificate must be presented.	You could pay a higher premium than required and you may be overpaying for coverage.
Your spouse gains or loses employment that provides health benefits:	Add or drop health benefits from your elections on the 1st of the month following the event date. A letter from the employer or insurance company must be presented.	You need to wait until the next annual Open Enrollment period to make any change.
Loss of coverage with a spouse:	Change your elections on the 1st of the month following the date of the loss of coverage. A letter from the employer must be provided.	You will be unable to enroll in the benefits until the next annual Open Enrollment period.
Changing from full-time to part-time employment (without benefits) or from part-time to full-time (with benefits):	Change your elections on the 1st of the month following the date of the employment status change in order to receive COBRA information or to enroll in benefits as a full-time employee. Documentation from the employer must be provided.	Benefits may not be available to you or your dependents if you wait to enroll in COBRA. Full-time employees will have to wait until the annual Open Enrollment period.

If you Experience a Life Event Status Change

Contact the Authority Brands Benefits Helpline to add or drop dependents from your coverage if you experience a life event status change.

You must update your elections within 30 days of your life event status change or you will not be able to make changes until the next annual open enrollment. If adding or removing dependents, you are required to submit specific documents to AssuredPartners. The change will be inactive until proper documentation is received and approved. For assistance processing life event status changes, you can call the Benefits Helpline at 1-800-535-6539, opt. 4 or e-mail AuthorityBrands@AssuredPartners.com.

Medical Coverage

Authority Brands is proud to offer you a choice between three different medical plans through UMR. Your network of providers will be the National United Healthcare Choice Point of Service network.

You are not required to select a primary care physician. Referrals to see a specialist are not needed, but we encourage all members to utilize in-network providers to avoid balance billing.

Coverage under these plans includes comprehensive medical care and prescription drug coverage. The plans also offer many resources and tools to help you maintain a healthy lifestyle.

\$4,000 Deductible Plan - Point of Service Program

\$2,000 QHDP - Qualified High Deductible Plan (QHDP)

\$1,000 Deductible Plan - Point of Service Program

\$4,000 Deductible Plan - Non-QHDP

- Carries a higher deductible and no deductible for primary/specialist card and pharmacy
- Preventive services are paid at 100% and not subject to deductible or coinsurance
- Some services are covered after the annual deductible is met then plan pays 70% coinsurance for in-network services

\$2,000 QHDP

- If covering a family, the full family deductible must be met.
- This is a Qualified High Deductible Plan (QHDP) and qualifies for a Health Savings Account (HSA), a tax-advantaged account that you can pay for and build savings for future medical expenses
- Preventive services are paid at 100% and not subject to deductible or copay
- All services (except preventive care) services, including prescription drugs, are covered after the annual deductible is met, then plan pays 80% coinsurance. Employer makes a prorated monthly HSA contributions for eligible employees (not enrolled in Medicare/Tricare and under age 65).

\$1,000 Deductible Plan (Non-QHDP)

- Preventive services is also paid at 100% and not subject to deductible or copay
- Some services are covered after the annual deductible is met then the plan pays 80% coinsurance for in-network providers



Build a Strong Relationship with Your Primary Care Physician

Most doctors went into the practice of medicine so that they could build strong emotional bonds with patients and guide them through health challenges.

Here are 3 tips to building a strong relationship with a new primary care physician, or improving the bond with your current one:

1. Know what's important to you in a physician.

If you're looking for a new doctor, be sure this is someone with whom you will have good interpersonal chemistry, that they're committed to your well-being, and that their office is well organized.

2. Get your doctor familiar with your health history.

Help your doctors to get to know you better by collecting your medical records, writing down your family's health history, and sharing this information with every new physician you meet.

3. Ask the right questions to build rapport and get on the road to better health.

To maximize the time you have together, write down your health questions for your physician beforehand.

Medicare Part D Notice:

If you have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see page 24 for more details.

GoodRx Mobile App



Regardless of which plan you decide to enroll in, we encourage you to download and use the GoodRx Mobile App to help you save on your prescription drug costs. Prices for prescription drugs vary widely between pharmacies. The cost of a prescription may differ by more than \$100 between two pharmacies across the street from each other.

GoodRx doesn't sell the medications, they will tell you where you can get the best deal on them. GoodRx will show you prices, coupons, discounts and savings tips for your prescription at pharmacies near you.

Employee Cost Per Pay	\$4000 Deductible		\$2000 QHDP		\$1000 Deductible	
	Biweekly	Weekly	Biweekly	Weekly	Biweekly	Weekly
Employee	\$10.20	\$5.10	\$25.51	\$12.76	\$63.78	\$31.89
Employee & Spouse	\$28.07	\$14.03	\$61.23	\$30.61	\$135.21	\$67.61
Employee & Child(ren)	\$22.96	\$11.48	\$48.47	\$24.24	\$122.45	\$61.23
Family	\$40.82	\$20.41	\$89.29	\$44.65	\$178.58	\$89.29

Medical Plan Comparison

Effective July 1, 2021, the pharmacy plan will be through Express Scripts. You will receive a single medical and prescription card to use at your doctor's office and the pharmacy. You will still be required to use the Express Scripts mail order pharmacy to fill your maintenance medications.

	\$4,000 Deductible In-Network, You Pay:	\$2,000 QHDP In-Network, You Pay:	\$1,000 Deductible In-Network, You Pay:
In-Network Deductible¹ Plan Year 7/1 - 6/30 (Individual / Family)	\$4,000 / \$8,000	\$2,000 / \$4,000 Full Family Deductible must be met	\$1,000 / \$2,000
ER Contribution to HSA (Individual / Family)	N/A	\$360 / \$720 Annually (prorated per pay)	N/A
In-Network Out-Of-Pocket Maximum* (Individual / Family)	\$7,900 / \$15,800	\$5,000 / \$10,000 \$5,000 individual/\$5,000 individual covered under family plan/\$10,000 family	\$4,000 / \$8,000
Preventive Services (age appropriate guidelines may apply) Well-Child Care Adult Physical Examination Breast Cancer Screening Pap Test	No charge	No charge	No charge
Office Visits	\$30 copay PCP \$60 copay Specialist	20% after deductible	\$25 copay PCP \$50 copay Specialist
Urgent Care Centers	\$60 copay	20% after deductible	\$50 copay
Lab, X-Ray, Diagnostic (non-hospital)	30% after deductible	20% after deductible	20% after deductible
Emergency Room Care	\$500 copay,	20% after deductible	\$300 copay,
Hospital Services Inpatient Outpatient	30% after deductible 30% after deductible	20% after deductible 20% after deductible	20% after deductible 20% after deductible
Maternity Delivery and Facility Services	30% after deductible	20% after deductible	20% after deductible
	Out-of-Network, You Pay:	Out-of-Network, You Pay:	Out-of-Network, You Pay:
Out-of-Network Deductible* (Individual / Family)	\$8,000 / \$16,000	\$4,000 / \$8,000 (full family deductible must be met)	\$2,000 / \$4,000
Out-of-Network Out-Of-Pocket Maximum* (Individual / Family)	\$10,000 / \$20,000	\$10,000 / \$20,000	\$8,000 / \$16,000
Most Out-of-Network Services	50% after deductible	50% after deductible	50% after deductible
Prescription Drug	Retail / Maintenance Mail Order Copays		
Combined Medical Deductible	No	Yes	No
Generic	\$15 / \$30	20% after deductible	\$15 / \$30
Preferred	\$40 / \$80	20% after deductible	\$40 / \$80
Non-Preferred	\$75 / \$150	20% after deductible	\$75 / \$150
Specialty	\$150 for 30 day supply through BrivoaRX mail order	20% after ded. for 30 day supply through Brivoa RX mail order	\$150 for 30 day supply through BrivoaRX mail order

Some medications will require a Prior Authorization. Additional information about the pharmacy is included in the bswift library, including the Express Script Basic Formulary Drug Listing.

Retail - up to 31-day supply. **Mandatory Maintenance Mail Order** - up to 90-day supply. Members can obtain two refills at the retail pharmacy; thereafter they must utilize the Express Scripts Mail Order to have the medication covered the plan. Specialty meds must be dispensed through Express Scripts' Specialty Pharmacy (30 day clinical supply per month).

This Summary is for informational purposes only. For specific benefit information, please refer to the applicable Benefits Summary. The Benefit Summary contains exclusions and limitations that are not shown here. The out-of-network deductible is a separate accumulator than the in-network deductible.

How to Find Providers and Facilities

Making it easier for you to find a network provider.

Simply log in to **umr.com**® to find a physician, clinic, hospital or lab based on location, specialty condition, estimated cost of services, hours of operation and more. You can even see patient ratings and compare quality and costs before choosing services. Network physicians, hospitals, clinics and labs charge discounted rates, which typically saves you money. Even though the plan provides coverage for care outside the network, be aware that it could cost you more.

Choosing a primary care physician (PCP).

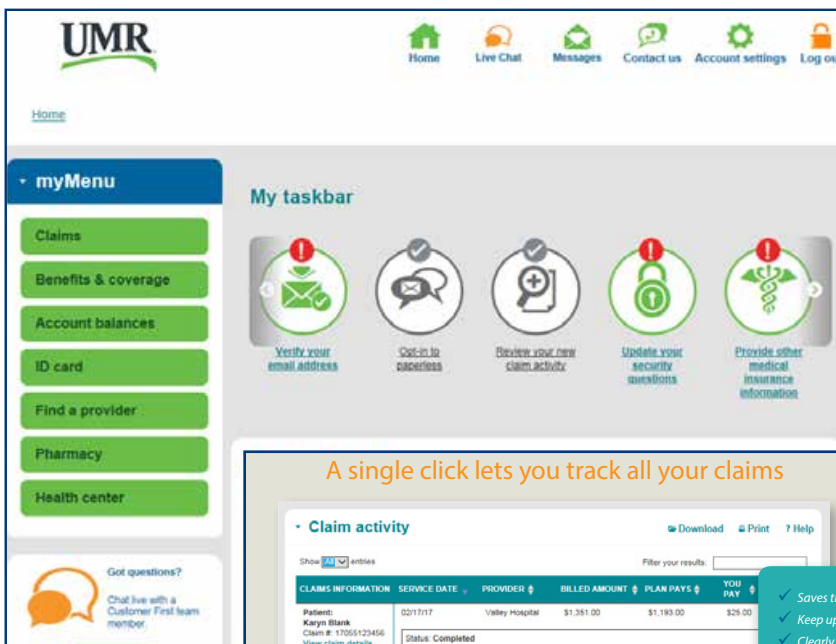
If you do not select a PCP, one will be selected for you. Your PCP:

- Knows your history.
- Helps guide you on the best path of care.
- Can advise you when to see a specialist and provide referrals.
- Can determine which hospital in your network can meet your medical or surgical needs if you need hospital care.

Make umr.com your first stop

At umr.com, you'll find everything you want to know – and need to do – as soon as you log in.

- View **My taskbar**, your personalized benefits to-do list
- Check your benefits and see what's covered
- Look up what you owe and how much you've paid
- Find a doctor in your network
- Learn about medical conditions and your treatment options
- Access tools and trusted resources to help you live a healthier life



A single click lets you track all your claims

Claim activity

Download Print Help

Show 20 entries Filter your results:

CLAIMS INFORMATION	SERVICE DATE	PROVIDER	BILLED AMOUNT	PLAN PAYS	YOU PAY
Patient: Karyn Blank Claim #: 17056123456 View claim details View EOB	02/17/17	Valley Hospital	\$1,381.00	\$1,180.00	\$20.00
Status: Completed					
Patient: Code Blank Claim #: 17054123456 View claim details View EOB	02/15/17	Hon. Gregory, Dr.	\$359.20	\$0.00	\$0.00
Status: Completed					
Patient: Elizabeth Blank Claim #: 17061123456 View claim details View EOB	02/03/17	Hon. Gregory, Dr.	\$290.00	\$0.00	\$0.00
Status: Denied - Accident info needed from pt. Action needed! Click here					
Patient: Code Blank Claim #: 17061123456 View claim details View EOB	01/29/17	Moore, John, Dr.	\$370.00	\$0.00	\$215.95
Status: Completed					
Patient: Code Blank Claim #: 17061123456 View claim details View EOB	01/23/17	Hon. Gregory, Dr.	\$745.00	\$69.30	\$675.70

Fictionalized data

Hassle-free access when you need it

Check in at your convenience to see if a claim has been processed and what you might owe. To get more details on a specific claim, click view claim details or view EOB. This will tell you the type of services provided, the amount billed and the amount paid, if any, and whether there's any action that needs to be taken before the claim can be processed.

You can choose to receive a secure e-mail any time you have a new EOB. And if you're not ready to give up paper completely, you can print out copies from our claims center.

Helpful apps, calculators, videos and health information all in one place

Online health information: up-to-date and ad-free

- Search your health symptoms
- Understand your treatment options
- Learn about drug interactions
- Find first aid information

Our top picks for healthy eating and exercise

- Get the essentials on men's, women's & kids' health
- Watch step-by-step recipe videos
- Log your exercise and activity

Free tools, apps and calculators

- Calculate your body-mass index (BMI)
- Download apps to help you stay healthy
- Track your nutrition and fitness goals

Visit **umr.com** on your desktop or tablet device. If it's your first time visiting us, click the **Login/Register** button in the upper-right corner to open an account. Make sure you have your ID card handy and follow the steps to get started.

Health Savings Accounts

Only \$2,000 QHDP Participants are Eligible

If you enroll in the **\$2,000 QHDP**, you will have access to an HSA through Optum Bank. HSAs are financial accounts that you can use to accumulate tax-free funds to pay for qualified health care expenses. **Authority Brands will make an annual contribution to your HSA, up to \$360 for individual coverage and \$720 for family coverage on a per paycheck basis** (employer funding will be prorated for new hires). Employees age 65 and older are not eligible. To qualify for an HSA, you must be covered under a QHDP; have no other health insurance coverage; may not be enrolled in Medicare A, B or D or TriCare; or claimed as a dependent on someone else's tax return. See IRS publication 969 for additional information.

The account acts like a regular savings account with a debit card. 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.



How you save with an HSA

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

- HSA contributions are not taxed, *can vary by state*
- 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 \$2,000, 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.

You must first enroll in the \$2,000 QHDP to start saving with an HSA. A welcome kit will be sent to you within 10 business days of the account opening. You also have the option to access the welcome kit online. You cannot use your HSA to reimburse yourself for medical expenses you had before your account was established. Optum Bank will not accept a P.O. Box as a home address. Optum Bank may contact you to verify information as required under the Patriots Act.

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 | • Prescription eyeglasses | • Stop-smoking programs | <ul style="list-style-type: none"> • View a complete list of qualified medical expenses on IRS.gov. |
| • Chiropractor | • Hearing aids | • Surgery (non-cosmetic) | |
| • Contact lenses | • Physical exams | • Therapy | |
| • Dental treatment | • Prescriptions | | |

NEW for 2021: Over the counter medicines & menstrual products are now eligible under CARES Act.

HSA Annual 2021 Contribution Limit (includes the ER HSA contributions):

\$3,600 for individual coverage **\$7,200** 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, you may also make a "catch-up" HSA contribution of an additional \$1,000 each year.

As a taxpayer, it is your responsibility to ensure that your Health Savings Account (HSA) contributions do not exceed the maximum possible for your specific tax situation. Please consult your attorney, CPA or tax advisor about your specific tax situation before deferring monies to your HSA. The benefits of an HSA, who is qualified to have an HSA, etc. can be found in IRS Publication 969, beginning on page 2. For example, you cannot have a HSA if you are enrolled in Medicare A and/or B, D or TriCare.

Dental Coverage

Lincoln DentalConnect PPO

The Lincoln DentalConnect plan allows employees and their dependents to select the dentist of his or her choice — each time he or she goes to the dentist.

In-Network benefits are payable when you receive treatment from a dentist who is participating in the dental network. With the DentalConnect plan, employees can save in several ways:

- Negotiated discounts from participating dentists
- The plan includes a higher level of reimbursement when you visit a participating dentist (no balance billing)

Directory of Participating/Contracting Dentist

You can look up a dentist at www.lincolnfinancial.com/findadentist, or the Lincoln Mobile App by accessing LincolnDentalConnect® - the online dental information tool providing health information, ask a dentist, and a dental cost estimator.

Find a dentist: LincolnFinancial.com/FindaDentist

If your dentist currently does not participate in the network, you can nominate them through Lincoln's website. Lincoln will review the dentists credentials and if they qualify, Lincoln will contact them about becoming a participating provider. Employees can nominate a dentist by visit www.lincolnfinancial.com/findadentist.

Benefit	In-Network	Out-of-Network*
Plan Year Deductible Applies to: Individual / Family	Type II & III \$50 / \$150	Type II & III \$50 / \$150
Type I - Diagnostic & Preventive - Routine Oral Examinations & Routine Cleanings - up to 2 per year - Bitewing X-rays - 1 set per year - Fluoride Treatments - through age 15; 1 per year - Space Maintainers - through age 15; 1 per lifetime - Sealants - through age 15; 1 per 60 months	100%	100%
Type II - Basic Services - Complete full-mouth or panoramic X-rays - 1 per 5 years - Other dental X-rays (including periapical films) - 6 per year - Palliative Treatment (including emergency relief of dental pain) - Fillings - 1 per 24 months (includes composite fillings on posterior teeth) - Prefabricated Stainless Steel and Resin Crowns - Simple extractions - Prosthetic repair and recementation services - Periodontal Maintenance procedures - up to 2 per year	80%	80%
Type III - Major Services - Surgical extractions, Oral surgery - General anesthesia and I.V. sedation - Endodontics (including Root Canal Treatment) - Non-surgical Periodontal Therapy - Scaling and Root Planing - 1 per 24 months - Full-mouth Debridement - 1 per lifetime - Periodontal Surgery - 1 per 36 months - Bridges - 1 per 8 years - Full and partial dentures - 1 per 5 years - Denture Reline and Rebase services - Crowns, Inlays, Overlays and related services - age 16 and above; 1 per 8 years - Treatment of disorders of the Temporomandibular Joint	50%	50%
Type IV - Orthodontia for Family - Orthodontic Treatment - including exams, X-rays, extractions	50%	50%
Maximum Benefit Types I, II, and III combined, per year / Type IV	\$1,700 / \$1,500	\$1,700 / \$1,500

*Out-of-network reimbursement (non participating providers is 80% percentile of Usual and Customary).

Employee Cost	Biweekly per Pay	Weekly per Pay
Employee	\$7.37	\$3.69
Employee & Spouse	\$14.67	\$7.34
Employee & Child(ren)	\$18.28	\$9.14
Family	\$28.30	\$14.15

Vision Coverage

The **VSP Choice Plan** is a full-service plan that offers low costs, a focus on health, and choice of providers. Medical eye conditions are covered under the medical plan.

Your coverage with a VSP Provider

Benefit	Description	Copay	Frequency
WellVision Exam	Focuses on your eyes and overall wellness	\$20	Every calendar year
Prescription Glasses		\$25	See frame and lenses
Frame	\$150 allowance for a wide selection of frames \$170 allowance for featured frame brands 20% savings on the amount over your allowance \$80 Costco® or Walmart® frame allowance	Included in Prescription Glasses	Every other calendar year
Lenses	Single vision, lined bifocal, and lined trifocal lenses Polycarbonate lenses for dependent children	Included in Prescription Glasses	Every calendar year
Lens Enhancements	Standard progressive lenses Premium progressive lenses Custom progressive lenses Average savings of 20-25% on other lens enhancements	\$0 \$95 - \$105 \$150 - \$175	Every calendar year
Contacts (instead of glasses)	\$150 allowance for contacts; copay does not apply Contact lens exam (fitting and evaluation)	Up to \$60	Every calendar year
Diabetic Eyecare Plus Program	Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details.	\$20	As needed
Extra Savings	Glasses and Sunglasses Extra \$20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam. Retinal Screening No more than a \$39 copay on routine retinal screening as an enhancement to a WellVision Exam Laser Vision Correction Average 15% off the regular price/5% off the promotional price; discounts available from contracted facilities		

Using your VSP benefit is easy.

Create an account at vsp.com. Once your plan is effective, review your benefit information.

Find an eye doctor who's right for you. Visit vsp.com or call 800-877-7195.

At your appointment, tell them you have VSP. There's no ID card needed. If you'd like a card as a reference, you can print from vsp.com.

That's it! We'll handle the rest—there are no claim forms to complete when you see a VSP provider.

Choice in Eyewear From classic styles to the latest designer frames, you'll find hundreds of options. Visit vsp.com to find a Premier Program location near you. Plus, save up to 40% on popular lens enhancements. Prefer to shop online? Go to eyeconic.com®, VSP's preferred online eyewear store.

Provider Look-Up

www.vsp.com, type in desired zip code and search in Find a Doctor field:

FIND A DOCTOR

Zip Code

Coverage with a participating retail chain may be different. Once your benefit is effective, visit vsp.com for details.

Employee Cost	Biweekly per Pay	Weekly per Pay
Employee	\$1.20	\$0.60
Employee & Spouse	\$2.39	\$1.20
Employee & Child(ren)	\$2.56	\$1.28
Family	\$4.09	\$2.05

AssuredExcellence

The Assured Excellence program is designed to connect employees and their dependents¹ with high quality health care at minimal to no cost.² The program includes benefits for a broad range of services including:

- orthopedic procedures,
- surgical cardiac and cancer procedures,
- organ transplant,
- bariatric surgery,
- gallbladder surgery,
- treatments for various bleeding and clotting disorders,
- anorexia
- other treatments are also available

Employees can begin the process by completing an application that includes basic information. Applications are reviewed by the prospective

provider of care and, if it is determined that the applicant is a candidate for services, the provider will gather and review medical records. Following this review the provider will contact applicants who remain eligible for services to schedule a consultation, surgery or services depending on the medical issue being addressed. A stipend is paid to the employee to assist with lodging and/or transportation expenses associated with traveling (**if necessary**) to the designated Center of Excellence.

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..

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. If you are covered under a qualified High Deductible Health Plan (also known as an "HSA Qualified Plan"), once you satisfy your minimum IRS deductible, these services are available 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.

How do I get started?

Step 1:

Contact the AssuredExcellence team to discuss your condition and possible procedure requirements

Step 2:

Complete an application with your pertinent information so the AssuredExcellence service team can determine the AssuredExcellence provider that is best suited for your treatment

Step 3:

The AssuredExcellence provider will gather the relevant medical records and following the review of the records will contact you to schedule services

Step 4:

You will automatically receive the travel reimbursement stipend after treatment

Procedure Group	Travel Stipend
Bariatric Surgery*	up to \$1,800
Bladder Cancer Surgery	up to \$2,800
Bone Marrow Transplant	up to \$5,300
Cancer Surgery	up to \$2,800
Cardiac/Heart Surgery	up to \$2,800
Colorectal Cancer Surgery	up to \$2,800
Gall Bladder Surgery	up to \$1,800
Heart Transplant	up to \$5,300
Hemophilia/Medications	up to \$2,000
Kidney Transplant	up to \$5,300
Liver Transplant	up to \$5,300
Lung Transplant	up to \$5,300
Lymph Node Surgery	up to \$1,800
Neck and Spine Surgery	up to \$1,800
Orthopedic Surgery	up to \$1,800
Pancreas Transplant	up to \$5,300
Pancreatic Cancer Surgery	up to \$2,800
Prostate Cancer Surgery	up to \$2,800
Stem Cell Transplant	up to \$5,300
Thyroid Surgery	up to \$1,800

*If covered by plan, 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.



(888) 856-4317



assuredexcellence@apbenefitadvisors.com

Flexible Spending Accounts

Eligibility Based on Medical Plan Election

Flexible Spending Accounts (FSA's) offer another way to save money on health care and dependent care expenses. You may submit expenses incurred by any of your dependents, whether or not they are covered by the insurance plans you have through your employer. Employees need not be enrolled in either medical plan to participate in FSAs.

If you enroll, you fund the accounts via a payroll deduction each pay period. Money that you contribute to your FSAs is not subject to social security taxes, federal, and in most cases, state income taxes.

Please note: The CARES Act was recently signed into law and permits plan participants to purchase OTC medicines and products with their HCFSAs (excludes Limited Healthcare FSA). This feature was lost to plan participants in 2011, when the Affordable Care Act ("ACA") limited the purchase of OTC products to plan participants with a prescription. Now that the CARES Act is law, you may begin to use your HCFSAs monies for these OTC purchases. Further, the CARES Act extended the list/category of included items to include menstrual care products.

Reimbursements for purchases made on or after December 31, 2020 are eligible for reimbursement through paper submissions, web-submissions, or app-based claims-submissions and are subject to all the usual claims submission deadlines, rules, etc. If you previously filed a claim and were denied for lack of a prescription, etc., please submit a new claim at this time.

Account	HSA Participants	Non-HSA Participants	How it works
Healthcare FSA	✗	✓	Employee-funded. Can use funds for all healthcare related expenses. Federal regulations do not allow participation in an HSA and this type of account.
Limited Healthcare FSA	✓	✗	Employee-funded. Employees can enroll in this program for eligible dental and vision expenses.
Dependent Care FSA	✓	✓	Employee-funded. Can use funds for all dependent care related expenses such as day care, nursery school, or elder care.

HCFSAs Annual Contribution Limit:
\$2,750

Health Care Flexible Spending Account (HCFSAs)

Federal regulations do not allow participation in an HSA and this type of account. Eligible health care expenses include many of the out-of-pocket expenses you pay to maintain your health and well-being. These include deductibles and coinsurance expenses not covered by your medical plan, expenses for glasses or contact lenses, and more.

Limited HCFSAs:
\$1,000

Limited HCFSAs

Eligible to pay dental and vision expenses.

DCFSA Annual Contribution Limit:
\$5,000
Or \$2,500 if you are married and file a separate tax return.

Dependent Care Flexible Spending Account (DCFSA)

You may use pre-tax dollars from your DCFSA to pay expenses for care when the services enable you and your spouse to work outside of the home. These include expenses for the care of a dependent child, spouse or elderly parent inside your home. Also included are baby-sitters, nursery schools, and day care centers.

Only the portion of expenses which enable you to remain employed are eligible. Educational expenses are not eligible.



The FSA Plan Year is July 1st through June 30th.

Flexible Spending Accounts continued...

Eligible Dependents

In regards to your Dependent Care FSA, the IRS defines an eligible dependent as:

- A child under the age of 13 and may be claimed as a deduction for personal exemption under Code Section 151(c).
- A spouse who is physically or mentally incapable of self-care.
- A disabled person who is physically or mentally incapable of self-care who you provide more than 50% support, and who qualifies as your dependent under Code Section 152.



FSA Debit Card

An FSA debit card is provided to all HCFA participants (no debit card for the Dependent Care plan). The debit card is similar to a bank account debit card that allows you to remove funds from your FSA at a merchant payment terminal. By using the debit card to purchase eligible expenses, you avoid paying for a purchase with money out of your pocket. Remember, you still must keep your receipts even when you use the debit card. Periodically, the IRS requires proof of purchase.

A debit card will be mailed to your home within 7 to 10 business days from your effective date. The envelope will appear generic so please make sure you do not discard.

Changing Your Contribution Amount

Federal regulations prohibit you from changing your enrollment or the amount of your election during the plan year. You are only eligible to change your elections during the year if you have a qualifying life event status change. Only benefit changes consistent with the change in status are permitted. Life event status changes that may warrant a change in benefit elections are described on page 4 and 5 of this guide.

FSA Claims & Reimbursements

Current Account Users

Requests for reimbursement from your FSA may be made online at <https://apbenefitadvisors.wealthcareportal.com> or by completing a claim form. Claim forms can be faxed to AssuredPartners at 410-771-9487, along with proof of expenses (i.e. receipts from your dependent care provider) detailing provider name, date expense incurred, and description of service. Reimbursements are generally distributed through payroll.

New Account Users

1. Please visit <https://apbenefitadvisors.wealthcareportal.com> to register for the FSA web site.
2. Enter a User Name meeting the minimum requirements.
3. Enter a Password meeting the minimum-security requirements. Please do not use your name in the password.
4. Confirm Password.
5. Enter your First Name and Last Name as they were provided to your employer at enrollment. No suffixes or commas.
6. Provide an Email Address.
7. For Registration ID use the Employer's ID, which is **CRWAUTHORITY**.
8. Enter your Employee ID (your Social Security Number).
9. Click I accept Terms of Use.
10. Click Next.

Go to the "Communication" Tab, then click "Communication Preference" in the drop down.



AssuredPartners' FSA Mobile App

Get your benefits on the go! Save time and hassles with AssuredPartners' FSA Mobile App. The app provides the following features:

- Account balances and details
- Upload Claims and Submit Receipts
- Recent Transactions and Details
- View all email and SMS alerts
- View Profile Details
- View Dependents
- View Card Details
- View Card PIN
- and more...

Search for "**AssuredPartners FSA**" on your mobile device to download!

Basic Life and AD&D Insurance

Life insurance provides financial protection for your family in the event of your death. Authority Brands offers all employees life and accidental death and dismemberment insurance through Lincoln Financial with an issue amount of 1 times your base annual salary* rounded to the next higher \$1,000 and up to \$400,000. Employees are responsible for paying imputed income on the coverage amount in excess of \$50,000.

The Basic AD&D amount is equal to the life amount. Your benefit amount for the Life and AD&D will reduce by 35% at age 65, additional 15% at age 70 and terminates at retirement.

***Non Commissioned Employees:** Base annual salary (excluding overtime / bonus / commissions)

Commissioned Employees: Greater of \$41,600 or prior year W-2 earnings.



Plan Cost: 100% Employer Paid

Voluntary Life and AD&D Insurance

Limited Open Enrollment: During this open enrollment period, you can increase or elect (unless previously declined) your life insurance up to a maximum of \$20,000 (in \$10,000 increments) and up to \$10,000 (in \$5,000 increments) for your spouse without providing proof of good health. If you wish to elect coverage in excess of the limited open enrollment amount, you need to complete the online Evidence of Insurability form and Lincoln needs to approve.

You may elect life insurance coverage for yourself, your spouse and your dependent children – all at an affordable group rate provided by Lincoln Financial. Please review Voluntary Life and AD&D elections during your Open Enrollment. Voluntary Life coverage is updated in the enrollment system. This coverage comes in the following increments:

Employee Voluntary Life/AD&D

- **Benefit Amount:** increments of \$10,000, max of 5 times annual salary (excludes overtime, bonus and commissions) rounded to the next higher \$10,000
- **Non-Medical Maximum Benefit:** \$200,000
- **Maximum Benefit:** up to \$500,000
- **New Employees (age 70+):** maximum coverage is \$50,000
- Same age reduction as Basic Life

Spousal Voluntary Life/AD&D

- **Benefit Amount:** increments of \$5,000 up to \$250,000, not to exceed 100% of employees Voluntary Life amount
- **Non-Medical Maximum Benefit:** \$50,000
- **Maximum Benefit:** 100% of employee's amount or \$250,000, which ever is less
- Same age reduction as Basic Life

Employee must have Voluntary Life before Spousal Voluntary Life and Dependent Child Life can be elected. Spouse rates are based on the employees age as of the coverage effective date. Rates are adjusted on each plan anniversary (7/1).

Dependent Child Voluntary Life (ONLY)

Benefit Amount: flat \$10,000

Non-Medical Maximum Benefit: \$10,000

From age 14 days to 26 years. Employees with current coverage in excess of \$10,000 are grandfathered. Child amount cannot exceed spouse amount.

Monthly Rates Per \$1,000

Age	Uni-Smoker
< 25	0.093
25 - 29	0.093
30 - 34	0.101
35 - 39	0.140
40 - 44	0.212
45 - 49	0.314
50 - 54	0.497
55 - 59	0.768
60 - 64	1.057
65 - 69	1.931
70 - 74	3.199
75 - 79	3.199
80 - 89	3.199

Dependent Child Life: \$2 per month, regardless of number of eligible children

Short-Term Disability



To ensure your income will continue if you are unable to work due to a disability, Authority Brands provides short-term disability (STD) through Lincoln Financial. Benefits are payable for a non-occupational injury or illness that keep you from performing the normal duties of your job. If a medical condition is job-related, it is considered Workers' Compensation rather than STD.

Benefits Start After: 14 day illness/injury (elimination period)

Benefit Amount: 60% of base weekly earnings up to \$2,500 / week

Maximum Benefit Duration: 13 weeks (including 14 day elimination period), no pre-existing conditions



Plan Cost: 50% Employer Paid

Long-Term Disability

Long-Term Disability (LTD) insurance helps replace a portion of your income for an extended period of time. Authority Brands provides LTD benefits through Lincoln Financial.

Benefits Start After: 90 days

Benefit Amount: 60% of predisability base monthly earnings up to \$10,000 / month*

Maximum Benefit Duration: The later of your SSNRA*, age 65, or recovery.

***Non Commissioned Employees:** Base annual salary (excluding overtime / bonus / commissions)

Commissioned Employees: Greater of \$41,600 or prior year W-2 earnings.

*SSNRA means the Social Security Normal Retirement Age in effect under the Social Security Act on the Policy Effective Date.

Pre-Existing Condition Limitations - Applicable to Long-Term Disability

The carrier will not pay benefits for any period of Disability caused or contributed to by, or resulting from, a pre-existing Condition. A "Pre-existing Condition" means any Injury or Sickness for which you incurred expenses, received medical treatment, care or services including diagnostic measures, took prescribed drugs or medicines, or for which a reasonable person would have consulted a Physician within 3 months before your most recent effective date of insurance. (A pre-existing condition does not apply if you have not received treatment for the pre-existing condition 6 consecutive months after your effective date.)

The pre-existing Condition Limitation will apply to any added benefits or increases in benefits. This limitation will not apply to a period of Disability that begins after you are covered for at least 12 months after your most recent effective date of insurance, or the effective date of any added or increased benefits.

NOTE: This is not intended to be a complete description of the insurance coverage offered. Controlling provisions are provided in the policy, and this summary does not modify those provisions or the insurance in any way. This is not a binding contract. A certificate of coverage will be made available to you that describes the benefits in greater details. Should there be a difference between this summary and the contract, the contract will govern



Plan Cost: 100% Employee Paid

Employee Assistance Program

EmployeeConnect - Employee Assistance Program

Life brings challenges. EmployeeConnect delivers help. Everyone needs help solving problems sometimes. EmployeeConnect offers confidential assistance to help you and your family meet the challenges that life, work and relationships can bring.

Get help 24/7 with:

- Depression
- Substance abuse
- Legal and financial concerns
- Marital or family difficulties
- Stress management/anxiety
- Child or elder care

Who is eligible?

You and your immediate household family members are eligible to access EmployeeConnect services as part of your long-term disability coverage from Lincoln.

What services can I access?

- Unlimited, 24/7 toll-free phone and online access to:
 - Family and personal information and referrals for topics such as child and elder care, kennels and pet care, vacation planning, relocation, car buying and colleges
 - Legal information and referrals for situations requiring expertise in family law, estate planning, landlord/tenant relations, consumer and civil law, and more
 - Financial information and referrals to assist with concerns such as household budgeting, as well as short- and long-term planning
- In-person help for short-term issues; up to five sessions with a counselor per person, per issue, per year
- In-person consultations with network lawyers, including one free 30-minute in-person consultation per legal issue, and subsequent meetings at a reduced fee
- Web-based resources: Articles, Tutorials, Streaming videos, Interactive tools and assessments such as financial calculators, budgeting spreadsheets and a language translator
 - Articles
 - Tutorials
 - Streaming videos
 - Interactive tools and assessments such as financial calculators, budgeting spreadsheets and a language translator
- Customized information packets to accompany all work-life services

What experience and credentials will my counselors have?

By phone: Your EmployeeConnect counselor is the first point of contact when you call the toll-free line. This individual performs counseling and work-life triage, assessment, intake and referral. All counselors hold master's degrees in counseling, social work or other related majors. In addition, they have broad-based clinical skills and at least three years of experience in assessing and counseling related to a variety of issues.

In person: When you schedule a face-to-face meeting, you will be referred to a fully credentialed, state-licensed clinician. How can I find out more and access the Lincoln EmployeeConnect program?

Online: Visit www.GuidanceResources.com (user name = LFGsupport; password = LFGsupport1),

Phone: 888-628-4824



Value Added Services

TravelConnect

TravelConnect is a comprehensive program that can bring help, comfort, and reassurance if you face a medical emergency while traveling 100 or more miles from home. Whether traveling for business or leisure, if you are enrolled in life and/or AD&D insurance, you and your loved ones can count on TravelConnect for responsive and caring support — 24 hours a day, 7 days a week.

You can count on TravelConnectSM services to:

Coordinate and provide transportation from an initial medical facility that cannot adequately treat the patient due to their condition.

Coordinate travel and airfare for your dependent children. This includes the services, transportation expenses and accommodations of a qualified escort.

TravelConnect will also coordinate and pay for a safe evacuation due to natural disaster, or when a political or security threat occurs.

Medical care, and travel services recovery. Assistant services include, but are not limited to:

- Medical record requests
- Intermediary services
- Recovering lost or stolen documents or luggage
- Medical and dental referrals
- Language translation
- Corrective lenses and medical device replacement
- Arrangements for a deceased traveler

For a complete list of TravelConnectSM services, go to mysearchlightportal.com and enter your group ID: LFGTravel123.

LifeKeys

This program provides life insurance related resources including:

- **EstateGuidance® Will Preparation** - Create your will online, follow a step by step guide through the entire process. Then, use online instructions to execute your will. You can:
 - Name an executor to manage your estate
 - Specify wishes for your property
 - Choose a guardian for your child (ren)
 - Provide funeral and burial instructions
- **GuidanceResources® online** - The place to go for articles, tutorials, streaming videos and "Ask the Expert" personal responses on topics such as:
 - Law and regulations
 - Health and wellness
 - Money and investments
 - Work and education
 - Family and relationships
 - Leisure and home
- **Identity Theft Resources** - This program provides links to essential resources such as credit reporting bureaus, the FBI Internet Crime Complaint Center and ID Theft Resource Center, and more.
- **Beneficiary Services** - Up to one year following the death of a covered individual (up to six {6} face-to-face sessions and unlimited counseling on topics such as grief, stress, anxiety, depression, memorial planning and concerns about children and teens.
- **Legal Support** - For quick legal information, call the in-house attorneys and they will refer you to qualified attorney in your area for in-depth information, guidance or representation.

Website: GuidanceResources.com

(Web ID = LifeKeys) | Phone: 855-891-3684

CyberScout

CyberScout provides award-winning services that give individuals and families the tools and knowledge they need to take control of their personal information and better protect themselves from cyber attacks and related crime. Cyberscout's services help to reduce employees' anxiety by educating them about identity theft risks and protection strategies. Our seasoned experts are advocates who work to guide them through the resolution and recovery process in the event their identity is compromised or they experience data theft or loss.

Cyberscout's long-standing reputation, industry expertise and scalable approach offer businesses and their employees a trusted ally for:

- Identity management
- Breach education, preparation, response and remediation
- Fraud, credit and reputation monitoring
- Cybersecurity and data privacy consulting

The Platinum Plan

Cyberscout's Platinum Plan offers the most comprehensive identity and monitoring coverage, pulling information from all three credit-reporting agencies. The Platinum Plan also offers additional social media monitoring for employees and their children.

Employee Cost	Biweekly per Pay	Weekly per Pay
Single	\$4.39	\$2.20
Family	\$8.08	\$4.04



visit www.cyberscout.com for more information

Identity Theft Protection

- Auto-on Monitoring
- Bank Account Monitoring
- Credit card and debit card monitoring
- Payday loan monitoring
- Dark Web monitoring
- Email account monitoring
- Change of address monitoring
- Court records monitoring
- Sex offender registry monitoring
- Social security number monitoring
- Active duty military alert
- Data breach notification
- Decreased family member coverage
- Identity risk calculator
- Lost wallet and document replacement
- Mobile app
- Password protector
- Social media reputation monitoring
- Social media account takeover
- Financial account monitoring
- Child social security number monitoring

Credit Monitoring

- One-Bureau credit monitoring and score
- Credit freeze and lock assistance
- Three-bureau credit monitoring
- Three-bureau credit report and scores
- Monthly score tracker

Resolution

- Expense Reimbursement: \$2 million
- Ransomware reimbursement
- Social engineering reimbursement
- Seniors fraud resolution



New Voluntary LifeStyle Benefits!

Includes COVID-19 Coverage

ACCIDENT INSURANCE

When you suffer an accident (on and off-the-job) such as a burn or broken bone, Accident insurance from **MetLife** provides a lump-sum cash benefit based on your injury(s) and the treatment you receive. These benefits are paid on top of what your health insurance covers, and can be used at your own discretion. The plan includes a **\$75 Wellness Benefit** when a defined health assessment is completed; a COVID-19 test, as well as other prevention tests, are covered as a wellness benefit.

Example Benefits*

Ambulance Ground Transportation	\$300
Emergency Room Treatment	\$250
Laceration	\$50 - \$750
Accident Follow-up Visit	\$75
Physical Therapy Benefit	\$25
Major Diagnostic Examination (CT Scan, MRI, etc.)	\$200

*This is not a comprehensive list of covered injuries and treatments. Speak to a benefit counselor for a complete list of covered events. Limitations may apply.

CANCER GUARDIAN

A new and innovative, high touch support program designed to provide an individual and their family with genetic testing that indicates whether you are predisposed to cancer, dedicated resources, and the technology needed to effectively navigate cancer while improving chances of survival. This benefit also includes a dedicated Cancer Guardian support specialist to collect pertinent information needed to source and access financial assistance due to COVID-19.

2021 Voluntary Benefits

Includes COVID-19 Coverage

CRITICAL ILLNESS INSURANCE

No one can be completely prepared for when critical illness strikes, but if you or a loved one is diagnosed with a covered condition such as cancer, stroke, or heart attack, Critical Illness Insurance through **MetLife** provides a lump-sum cash benefit to help pay for out-of-pocket medical expenses or any other bills that need attention, including rent or groceries. **During this enrollment period, you can enroll without answering medical questions!** The plan includes a **\$50 Wellness Benefit** when a defined health assessment is completed; a COVID-19 test, as well as other prevention tests, are covered as a wellness benefit.

HOSPITAL INDEMNITY INSURANCE

Even with health insurance, a stay in the hospital can become very costly very quickly as out-of-pocket charges begin to add up. Hospital Indemnity insurance from **MetLife** can reduce the financial and emotional stress of a hospital stay by providing a lump-sum cash benefit directly to you that can be used however you need, whether that's for coinsurance or childcare. This benefit will also cover a hospital admission or stay due to COVID-19. **Enroll without answering medical questions, even if you have a pre-existing condition or are pregnant.**

Example Benefits*

Hospital Admission Benefit	\$1000; once/year
Daily Hospital Confinement	\$200; Up to 15 days/year
Daily ICU Confinement	\$400; Up to 15 days/year
Benefit paid concurrently with the Confinement benefit when a Covered Person is admitted to ICU	

*This is not a comprehensive list of covered injuries and treatments. Speak to a benefit counselor for a complete list of covered events. Benefit limitations apply.

LIFETIME BENEFIT WITH LONG TERM CARE

LifeTime Benefit Term Insurance with Long Term Care Coverage through **Chubb** provides permanent, flexible protection. The policy's living benefits provide financial support to cover the cost of long term care you might need as a result of an accident, illness, or aging. As life insurance, LifeTime Benefit Term protects your family with money that can be used any way they choose like your mortgage or rent, education for children, retirement, and final expenses. **During this enrollment period, you can enroll without answering medical questions!**

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.

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.

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.



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 canceled 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.

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 January 31, 2020. Contact your State for more information on eligibility –

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

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

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

CALIFORNIA – Medicaid
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx
Phone: 1-800-541-5555

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+: <https://www.colorado.gov/pacific/hcpf/child-health-plan-plus>
CHP+ Customer Service: 1-800-359-1991/ State Relay 711

FLORIDA – Medicaid
Website: <http://flmedicaidprecovery.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/fsa/hip/>
Phone: 1-877-438-4479
All other Medicaid
Website: <http://www.indianamedicaid.com>
Phone 1-800-403-0864

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: <https://dhs.iowa.gov/ime/members>
Medicaid Phone: 1-800-338-8366
Hawki Website: <http://dhs.iowa.gov/Hawki>
Hawki Phone: 1-800-257-8563

To see if any other states have added a premium assistance program since January 31, 2020, or for more information on special enrollment rights, contact either:

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

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

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

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

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/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp> [Under ELIGIBILITY tab, see "what if I have other health insurance?"]
Phone: 1-800-657-3739

MISSOURI – Medicaid
Website: <http://www.dss.mo.gov/gmh/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: <https://dhcfp.nv.gov>
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: <https://www.dhhs.nh.gov/oi/hipp.htm>
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

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

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

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

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

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

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

PENNSYLVANIA – Medicaid
Website: <https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx>
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP
Website: <http://www.eohhs.ri.gov/>
Phone: 855-697-4347, or 401-462-0311 (Direct Rlte Share Line)

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

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

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
Website: <https://www.coverva.org/hipp/>
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid
Website: <https://www.hca.wa.gov/>
Phone: 1-800-562-3022

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://wyequalitycare.acs-inc.com/>
Phone: 307-777-7531

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

Important Notice from Authority Brands, LLC About Your Prescription Drug Coverage and Medicare

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Authority Brands, LLC has determined that the prescription drug coverage offered by the Authority Brands, LLC's Employee Benefits Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current Authority Brands, LLC's coverage will not be affected. Details of the Plan's prescription drug benefits are included in the separate benefits booklet previously provided to you as part of (or along with) the Plan's Summary Plan Description. In addition, keep in mind that your current coverage pays for other health expenses for you and, if applicable, your eligible dependents, in addition to prescription drugs, and you will still be eligible to receive all of your current health and prescription drug benefits even if you choose to enroll in a Medicare prescription drug plan. If you are enrolled in both the Plan and a Medicare prescription drug plan, your prescription coverage under the Plan will be coordinated with the Medicare prescription drug benefit.

If you do decide to join a Medicare drug plan and drop your current Authority Brands, LLC's coverage, be aware that you and your dependents may not be able to get this coverage back.

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

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

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

For More Information about this Notice or Your Current Prescription Drug Coverage:

Contact the person or office listed below for further information.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Authority Brands, LLC changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage:

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	7/1/21
Name of Entity/Sender:	Authority Brands, LLC
Contact Position/Office:	Human Resources Dept.
Address:	7120 Samuel Morse Drive, Suite 300 Columbia, MD 21046
Phone Number:	(410) 794-9080



Your Benefits Helpline:  1-800-535-6539, opt. 4  AuthorityBrands@AssuredPartners.com