ASKAR BRANDS

HELPING YOU UNDERSTAND
Your Benefit Choices

STORES

2021

This is a high-level benefits guide of certain benefits your employer offers. The information in this booklet is intended as a general outline of the benefits offered under your employers benefits program and should not be considered legal, investment or other benefits advice. Specific details and plan limitations are provided in the Summary Plan Descriptions (SPD), which is based on the official Plan Documents that may include policies, contracts and plan procedures. The SPD and Plan Documents contain all the specific provisions of the plans. In the event that the information in this brochure differs from the Plan Documents, the Plan Documents will prevail. Benefit plans are subject to change, amendment, or termination without notice to or the agreement of any employee/participant. All protected health information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Guide, contact Human Resources.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see the "Notices" Section in the back of this benefits booklet.

**This guide may or may not be applicable to union employees.*

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CONTENTS

4	PLAN YEAR NEWS
5	GROUP INSURANCE ELIGIBILITY
6	MEDICAL INSURANCE
8	PRESCRIPTION DRUG COVERAGE | Rx
9	VIRTUAL VISITS
12	HEALTH SAVINGS ACCOUNTS (HSA)
14	DENTAL INSURANCE
16	VISION INSURANCE
18	BASIC LIFE AND AD&D INSURANCE
19	SUPPLEMENTAL LIFE INSURANCE
20	DISABILITY BENEFITS
21	REQUIRED NOTICES & IMPORTANT INFORMATION
Last Page	PROVIDER CONTACT INFORMATION

WELCOME

BENEFITS MENU | ENROLLMENT

BENEFITS OFFERED

MY HEALTH

Medical | **Blue Cross Blue Shield of Michigan (BCBSM)**
Dental | **MMA / MetLife**
Vision | **MMA / MetLife**

MY LIFE

Life and AD&D | **Principal**
Supplemental Life **| Unum**
Disability | **Principal**

MY EXTRAS

Virtual Visits | **BCBSM Online Visits**

Your Benefit Period

AUGUST 1, 2021 – JULY 31, 2022

ENROLLMENT INSTRUCTIONS

1. Review the information in this guide and benefit plan summaries.
2. You must complete and sign an enrollment form, even if you are waiving coverage.
3. You will not be allowed to make changes after the open enrollment window closes, unless you experience a qualifying life event.

IMPORTANT

You must notify HR and change elections within 30 days of the event.

Helpful Tips To Consider Before You Enroll

1. **Do you plan to enroll an *eligible dependent(s)*?**
   If so, make sure to have their social security numbers and birthdates available. You cannot enroll your dependent(s) without this information.
2. **Have you recently been *married/divorced or had a baby*?**
   If so, remember to add or remove any dependent(s) and/or update your beneficiary designation.
3. **Did any of your covered children reach their 26th birthday this *year*?**
   If so, they may no longer be eligible for benefits, unless they meet specific criteria.

ELIGIBILITY
RULES | REQUIREMENTS

EMPLOYEE ELIGIBILITY

You are eligible to participate if you are full-time and work a minimum of 30 hours per week.

OFFICE LEVEL STAFF:
- Executive: Date of Hire
- Director: On your 31st day
- Manager: On your 61st day
- Coordinator: On your 91st day
- Clerk: On your 91st day

STORE LEVEL STAFF:
- Director/Market Leader/FLM/MUM: On your 31st day
- General/Restaurant Manager: On your 61st day
- Assistant Manager: On your 91st day
- Shift Leader/Manager: On your 91st day
- Inside Crew Member/Driver: On your 91st day

DEPENDENT ELIGIBILITY

You may also enroll eligible dependents for benefits coverage. A **'dependent'** is defined as the **legal spouse, legal domestic partner** and/or '**dependent child(ren)'** of the plan participant or the spouse.

The term 'child' refers to any of the following:
- A natural (biological) child;
- A stepchild; legally adopted child; foster child;
- A child for whom legal guardianship has been awarded to the participant or the participant's spouse/domestic partner; or
- Disabled dependents may be eligible if requirements set by the plan are met.

The chart provided below explains who is eligible for coverage under each benefit plan type:

Line of Coverage	When coverage ends
Medical,	The last day of the calendar year the child turns age 26
Dental, Vision	The day the child turns age 26
Child Life Insurance	The day the child turns age 26 (if full-time student)

Qualifying Life Events

If you have a Qualifying Life Event and want to request a mid-year change, you must notify Human Resources and complete your election changes within 30 days following the event. Be prepared to provide documentation to support the Qualifying Life Event.

Common life events include; Marriage, Divorce, New Dependent, Loss/gain of available coverage by you or any of your dependents.

A full list of qualifying events can be found in the 'Required Notices' section of this benefits guide.

IMPORTANT

You cannot make changes to these elections during the year unless you experience a qualified family status change, which must be reported to Human Resources within 30 days of the event.

If you separate from employment, COBRA continuation of coverage may be available as applicable by law. COBRA Continuation details can be found in the notices section of this employee benefit guide.

HEALTH
MEDICAL | PRESCRIPTION DRUGS

COMMON INSURANCE TERMS

A **PREMIUM** is the amount you pay for insurance, using pre-tax or post-tax dollars.

A **COPAYMENT (COPAY)** is a fixed amount you pay to receive services. Your co-payment(s) will count towards your out-of-pocket maximum but not your deductible. (e.g., $30 for every visit to the doctor), while your insurance company pays the rest.

A **DEDUCTIBLE** is the amount of money you are responsible for paying each year before the plan begins to pay for covered services, with the exception of preventive care services, which are covered at 100% In-Network.

COINSURANCE This is your share of the expense of covered services after your deductible has been paid when the company plan is paying a percentage. The coinsurance rate is usually a percentage.

OUT-OF-POCKET (OOP) MAXIMUM is the most you pay per Plan Year for health care expenses and applies to deductibles, flat-dollar copays and coinsurance for all covered services – including cost-sharing amounts for prescription drugs.

Once this limit is met, the plan will cover all in-network services at 100% until the end of the plan year.

***OUT-OF-NETWORK** charges in the above plans are subject to reasonable and customary limitations, which means you are responsible for charges over this amount in addition to separate deductible and coinsurance. Any services received from an out-of-network provider, with the exception of a true emergency, will not be covered.

PPO | In-Network & Out-of-Network Benefits

The PPO option offers the freedom to see any provider when you need care. When you use providers from within the PPO network, you receive benefits at the discounted network cost. Most expenses, such as office visits, emergency room and prescription drugs are covered by a copay. Other expenses are subject to a deductible and coinsurance.

PPO HSA | In-Network & Out-of-Network Benefits

The HDHP is similar to the PPO Plan in that you have the option to choose any provider when you need care. However, in exchange for a lower per-paycheck cost, you must satisfy a higher deductible that applies to almost all health care expenses, including those for prescription drugs.

All expenses are your responsibility until the deductible is reached, with the exception of preventive care, which is covered at 100% when you visit a physician in the network. Once the deductible is met, you are responsible for coinsurance for medical expenses and a copay for prescription drug expenses.

Enrolling in this plan allows you to contribute tax free dollars to a health savings account (HSA). Any dollars that you (and your employer) wish to contribute can be used towards any eligible medical, Rx, dental and vision expenses that you may incur while covered under the plan. See HSA section of this guide for additional details.

Did You Know?

- ✓ **Preventive Services** are c**overed at 100% In-Network** and copays & deductibles do not apply.
- ✓ You **pay less** out of pocket if you receive care from an **In-Network provider.**

How do I find an In-Network Provider?

In-Network providers can be found on your provider's website (BCBSM.com) under "Find a Doctor". Select Group Health Plans and choose the network based on the plan type you are choosing. You can also download the BCBSM Mobile App!

MEDICAL
HEALTH | PLAN COMPARISON

Blue Cross Blue Shield of Michigan

	Gold Option	Silver Option	Bronze Option
IN-NETWORK BENEFITS	**Simply Blue PPO 1500**	**Simply Blue PPO 4000**	**Simply Blue HSA PPO 6900**
DEDUCTIBLE (Calendar Year)			
Single Deductible	$1,500	$4,000	$6,900
Two Person/Family Deductible	$3,000	$8,000	$13,800
COINSURANCE *(applies after deductible is met)*			
Member Cost Share %	20% up to	30% up to	0% up to
Single Maximum	$1,000	Out-of-Pocket Maximum	Out-of-Pocket Maximum
Two Person/Family Maximum	$2,000	Out-of-Pocket Maximum	Out-of-Pocket Maximum
Health Savings Account			
Eligible Plan for HSA	No	**No**	**Yes**
MEMBER COPAYMENT(S)			
Primary Care (PCP) - Office Visit	$30 copay	$40 copay	0% after deductible
Virtual Visit	Covered 100%	Covered 100%	0% after deductible
Specialist - Office Visit	$50 copay	$60 copay	0% after deductible
Urgent Care Facility	$60 copay	$60 copay	0% after deductible
Emergency Room Visit	$250 copay	$250 copay	0% after deductible
OUT-OF-POCKET MAXIMUM (OOPM)			
Single Maximum	$6,600	$8,300	$6,900
Two Person/Family Maximum	$13,200	$16,600	$13,800

Your Care Options and When to Use Them.

Primary Care Physician (PCP)

For routine, primary/preventive care, or non-urgent treatment, we recommend going to your doctor's office for medical care. Your doctor knows you and your health history, and has access to your medical records. You may also pay the least amount out-of-pocket when you receive care in your doctor's office.

Urgent Care Centers vs. Freestanding Emergency Rooms

Freestanding emergency rooms look a lot like the urgent care centers you are likely used to, but the costs and services are drastically different. In general, consider an urgent care center as an extension of your PCP, while freestanding emergency rooms should be used for health conditions that require a high level of care. Research the options in your area and determine which ones are covered by your insurance plan's network; note that balance billing may apply. Choosing an urgent care center for everyday health concerns could save you hundreds of dollars.

PRESCRIPTION DRUGS

Rx | PLAN COMPARISON

TRADITIONAL DRUGS

TIER 1 (GENERIC) | Lowest copay: Most drugs in this category are generic drugs. Members pay the lowest copay for generics, making these drugs the most cost-effective option for treatment.

TIER 2 | Higher copay: This category includes preferred, brand name drugs that don't yet have a generic equivalent. These drugs are more expensive than generics, and a higher copay.

TIER 3 | Highest copay: In this category are non-preferred brand name drugs for which there is either a generic alternative or a more cost-effective preferred brand. These drugs have the highest copay. **Make sure to check for mail order discounts that may be available.**

SPECIALTY DRUGS

TIER 4 | Lowest specialty drug copay: Tier 4 specialty drugs are generally more effective and less expensive than non-preferred specialty drugs in tier 5.

TIER 5 | Highest specialty drug copay: These drugs have the highest copay for specialty drugs, usually because there may be a more cost-effective generic or preferred brand available.

WHERE CAN I FIND A DRUG LIST?

Typically, a full listing of covered drugs is found on your provider's website. A drug list, also called a formulary, is a list of generic and brand-name drugs covered by a health plan. Although a drug may be on the drug list, it might not be covered under every plan. Review the plan materials for details on specific benefits.

You can use drug lists to see if a medication is covered by your health insurance plan. You can also find out if the medication is available as a generic, needs prior authorization, has quantity limits and more.

Blue Cross Blue Shield of Michigan

In-Network Rx Copays	Simply Blue PPO 1500	Simply Blue PPO 4000	Simply Blue HSA PPO 6900
TIER 1 (Generic)	$20	$30	0% after deductible
TIER 2	$60	$60	0% after deductible
TIER 3	$80 or 50% (whichever is greater) but no more than $100	$80 or 50% (whichever is greater) but no more than $100	0% after deductible
TIER 4	20% up to $200	20% up to $200	0% after deductible
TIER 5	25% up to $300	25% up to $300	0% after deductible
MAIL ORDER	3X Retail Copay less $10	3X Retail Copay less $10	0% after deductible

Prescription Drug Discount Program (Pillar Rx)

Only applies to NON HSA plans.

Prescription drug manufacturers provide coupon programs for certain medications. Your benefit plan allows you to take advantage of BCBSM-approved coupon programs for select medications. This benefit may lower the cost sharing typically required for these drugs. Your out-of-pocket expense will be no more than your benefit cost sharing. When a manufacturer coupon is used, only the amount you paid for the prescription will apply towards your annual out-of-pocket maximum. NOTE: Adjustments may be required to accurately reflect your annual out of-pocket maximum to reflect your true out-of-pocket cost. This program may be discontinued at any time if it is no longer supported by the vendor. As long as you take advantage of the coupon's you will likely get a better benefit (i.e. lower copay); however, if you do not take advantage of the coupon, it may impact the costs of your prescription.

Save Money With Generic (Tier 1) Drugs

Ask your doctor if it's appropriate to use a generic drug rather than a brand.

Generic drugs are less expensive, and according to the FDA, they contain the same active ingredients and are identical in dose, form and administrative method as a brand name.

Helpful Rx Cost Savings Tools & Tips:

MAIL ORDER - Many drugs are available in a 90 day supply, rather than the 30 day retail supply. Typically, you will pay less if you choose to get a mail order 90 day supply.

GOOD Rx - There are many tools online that you can use in order to save on prescription costs. One being GoodRx.com, an online Rx database that allows you to find what pharmacy is the cheapest for your specific prescription. Additionally, you may be able to find a coupon that will greatly reduce your cost. It is important to remember that many of the coupons can only be used outside of your plan (will not count towards your maximums).

ASK YOUR DOCTOR – Make sure to ask if there are cost savings alternatives to the prescription they are providing. Many times there are generic or different manufacturers that will save you money at the pharmacy.

ONLINE HEALTHCARE

24/7 | VIRTUAL DOCTOR VISITS

No crowded waiting rooms. No Driving. See a doctor when you need a doctor.

A virtual visit lets you see and talk to a doctor from your mobile device or computer. When you use one of the provider groups in our virtual visit network, you have benefit coverage for certain non-emergency medical conditions. Costs must be paid by you at the time of the virtual visit and will apply toward your deductible and out-of-pocket maximum.

For questions regarding online health care, contact: **1-844-606-1608** or **bcbsmonlinevisits.com**

WHEN CAN I USE A VIRTUAL VISIT?

When you have a non-emergency condition and:

- your doctor is not available;
- you become ill while traveling;
- When you are considering visiting a hospital emergency room for a non-emergency health condition.

**Your covered children may also use Virtual Visits when a parent or legal guardian is present for the visit.*

Examples of Non-Emergency Conditions:

- ✓ Bladder infection
- ✓ Bronchitis
- ✓ Diarrhea
- ✓ Fever
- ✓ Pink eye
- ✓ Rash
- ✓ Seasonal flu
- ✓ Sinus
- ✓ Sore throat
- ✓ Stomach

HOW DOES IT WORK?

The first time you use a Virtual Visits provider, you will need to set up an account with that Virtual Visits provider group. You will need to complete the patient registration process to gather medical history, pharmacy preference, primary care physician contact information, and insurance information.

Each time you have a virtual visit, you will be asked some brief medical questions, including questions about your current medical concern. If appropriate, you will then be connected using secure live audio and video technology to a doctor licensed to deliver care in the state you are in at the time of your visit. You and the doctor will discuss your medical issue, and, if appropriate, the doctor may write a prescription* for you.

Virtual Visits doctors use e-prescribing to submit prescriptions to the pharmacy of your choice. Costs for the virtual visit and prescription drugs are based on, and payable under, your medical and pharmacy benefit. They are not covered as part of your Virtual Visits benefit.

**Prescription services may not be available in all states.*

HOW DO I GET ACCESS?

Learn more about Virtual Visits and access direct links to provider sites by logging into your www.BCBSMonlineVisits.com

Blue Cross Blue Shield Blue Care Network of Michigan

Blue Cross Online Visits℠

DOWNLOAD THE APP

Get the information you need on the go by downloading the BCBSM Online Visits App from the App Store for AppleSM products or on the Google Play™ Store for Android products.

Download on the App Store

GET IT ON Google Play

POWER TO

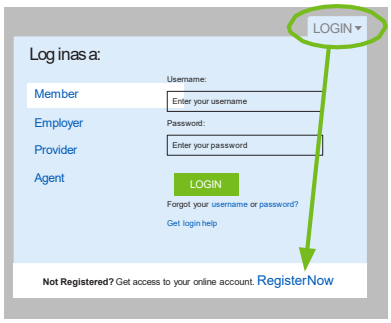
know. compare. choose.

How to register at bcbsm.com | computer

Your online member account gives you the power to get the most from your health care plan. Use it to check your claims, coverage and much more.

Have your Blue Cross or BCN ID card handy:

1. Go to bcbsm.com.
2. In the upper-right corner of the home page, click the ***LOGIN*** tab.
3. In the pop-up menu below the login fields, click ***Register Now***.



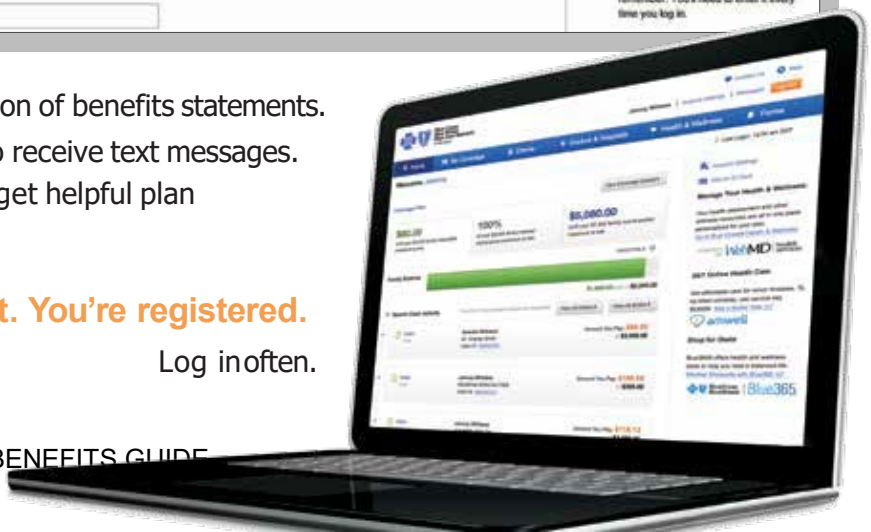
As you go through the registration screens, carefully:

- Type your information correctly.
- Read the privacy policy.
- Set up security questions and answers that you can easily remember.
- Create a strong password with a minimum of eight characters, using at least one uppercase letter, one lowercase letter and one number.

Passwords
Strong: I@mBlue32!
Weak: Abcd1234 ⚠

Go digital:

- Sign up for paperless explanation of benefits statements.
- Register your phone number to receive text messages.
- Sign up to receive emails, and get helpful plan information online.



That's it. You're registered.

Log in often.

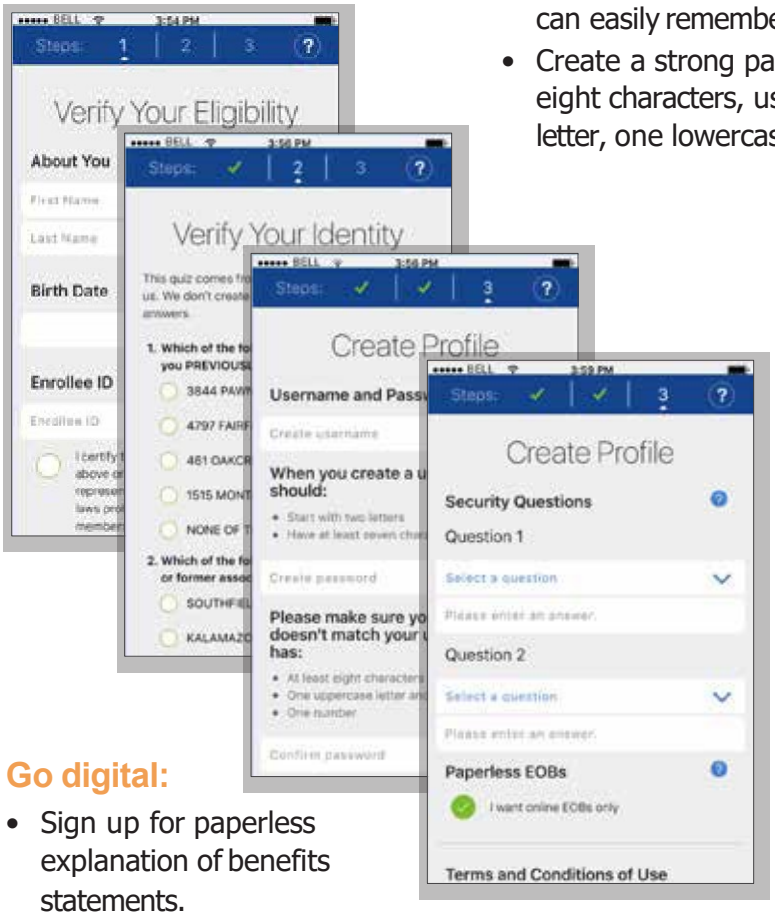
Your online member account gives you the power to get the most from your health care plan. Use it to check your claims, coverage and much more.

Have your Blue Cross or BCN ID card handy:

1. Go to the Apple® App Store or Google Play™, and search for **BCBSM**.
2. Download the app.
3. Tap the app icon.
4. Tap ***Register***.

As you go through the registration screens, carefully:

- Type your information correctly.
- Read the privacy policy.
- Set up security questions and answers that you can easily remember.
- Create a strong password with a minimum of eight characters, using at least one uppercase letter, one lowercase letter and one number.



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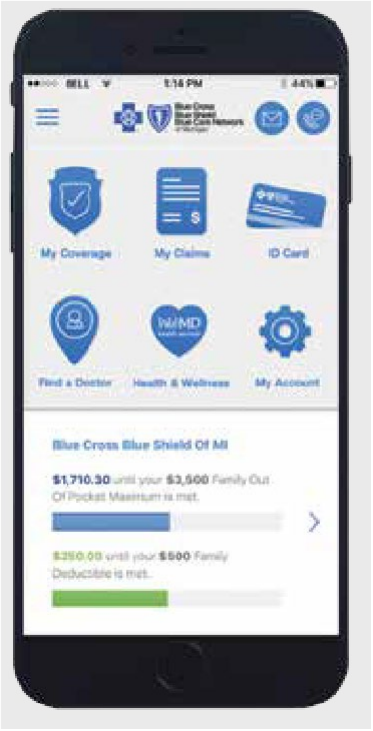

That's it. You're registered.

Tap the app anytime, anywhere.

Get the app.

Download on the App Store

GET IT ON Google Play

SEARCH BCBSM.

Blue Cross Blue Shield of Michigan and Blue Care Network are nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association.

CF 13544 JAN 17 R063827

HEALTH SAVINGS ACCOUNT

HSA | TAX SAVING VEHICLE

ENROLLED IN A HSA ELIGIBLE HEALTH PLAN?

Take charge of your health care spending with a Health Savings Account (HSA). Contributions to an HSA are tax-free, and no matter what, the money in the account is yours!

A Health Savings Account (HSA) is a tax-free savings account is owned by you, is 100% vested from day one, and let's you build up savings for future needs. The funds may be used to pay for qualifying healthcare expenses not covered by insurance or any other plan for yourself, your spouse, or tax dependents. You decide how much you would like to contribute, when and how to spend the money on eligible expenses, and how to invest the balance.

HealthEquity

UNDERSTANDING YOUR HSA

- Pre-tax contributions are deducted through payroll and deposited into your HSA account;
- You can use your HSA available funds to pay for qualified medical expenses tax-free;
- HSA funds can be used for non-eligible expenses, but will be subject to regular income taxes and a 20% excise tax penalty.
- Unused funds remain in your account for future use and roll over each calendar year;
- HSAs remain with you even if you change health plans or companies. If you open an HSA and later become ineligible to make contributions, you can still use your remaining funds; and
- You can change your HSA contribution at any time during the plan year for any reason.

2021 | HSA FUNDING LIMITS

Each year, the IRS places a limit on the maximum amount that can be contributed to HSA accounts.

HSA Contribution Limits	
Employee	**$3,600**
Two Person/Family	**$7,200**

HSA "Catch-Up" Contributions	
Age 55 or older	**$1,000 a year**

Source: IRS, Rev. Proc. 2020-30

HEALTH SAVINGS ACCOUNT

HSA | TAX SAVING VEHICLE

HSA ELIGIBILITY REQUIREMENTS

To have an HSA and make contributions to the account, you must meet several basic qualifications.

- ✓ To be eligible to open and contribute to an HSA, you must have coverage under a qualified High Deductible Health Plan (HDHP).
- ✓ Participants cannot be covered by any other health insurance plan (this exclusion does not apply to certain other types of insurance, such as dental, vision, disability or long-term care coverage);
- ✓ Participants cannot participate in a Healthcare FSA or spouse/domestic partner's Healthcare FSA or Health Reimbursement Account (HRA).
- ✓ Participants cannot be enrolled in Medicare or Medicaid.
- ✓ You cannot be eligible to be claimed as a dependent on someone else's tax return.
- ✓ You have not received Department of Veterans Affairs Medical benefits in the past 90 days, unless the Veteran has a disability rating. (*There may be additional special circumstances, check with your tax preparer*).

MAINTAINING RECORDS

To protect yourself in the event that you are audited by the IRS, keep records of all HSA documentation and itemized receipts for at least as long as your income tax return is considered open (subject to an audit), or as long as you maintain the account, whichever is longer.

The IRS requires HSA funds to be used for qualified expenses only. If you use HSA funds for non-eligible expenses, you will be subject to regular income taxes and an additional 20% excise tax penalty.

ELIGIBLE HSA EXPENSES*

- Acupuncture
- Alcoholism treatment
- Ambulance
- Artificial limb
- Automobile modifications for a physically handicapped person
- Birth control pills
- Blood pressure monitoring device
- Braille books & magazines
- Chiropractic care
- Christian science practitioner
- COBRA premiums
- Contact lenses & related materials
- Crutches
- Dental treatment
- Dentures
- Diagnostic services
- Drug addiction treatment
- Eye examination
- Eye glasses & related materials
- Fertility treatment
- Flu shot
- Guide dog or other animal aide
- Hearing aids
- Hospital services
- Immunization
- Insulin
- Laboratory fees
- Laser eye surgery
- Long-term care premiums or expenses
- Medical testing device
- Nursing services
- Obstetrical expenses
- Organ transplant
- Orthodontia (not for cosmetic reasons)
- Oxygen
- Physical exam
- Physical therapy
- Prescription drugs
- Psychiatric care
- Retiree medical insurance premiums
- Smoking cessation program
- Surgery
- Transportation for medical care
- Weight loss program
- Wheelchairs and more*.

A full list of qualified expenses can be found in IRS Publication 502 at www.irs.gov.

DENTAL
COVERAGE OVERVIEW

COMMON TERMS

PRE-TREATMENT ESTIMATE
If your dental care is extensive and you want to plan ahead for the cost, you can ask your dentist to submit a pre-treatment estimate. While it is not a guarantee of payment, a pre-treatment estimate can help you predict your out-of-pocket costs.

DUAL COVERAGE
You might have benefits from more than one dental plan, which is called dual coverage. In this situation, the total amount paid by both plans can't exceed 100% of your dental expenses. And in some cases, depending on the specifics of the plans, your coverage may not total 100%.

LIMITATIONS AND EXCLUSIONS
Dental plans are intended to cover part of your dental expenses, so coverage may not extend to your every dental need. A typical plan has limitations such as the number of times you can receive a cleaning each year. In addition, some procedures may be not be covered under your plan, which is referred to as an exclusion.

PREVENTION FIRST!

Your dental health is an important part of your overall health. Make sure you take advantage of your preventive dental visits.

Preventive care services are covered at 100% if you visit an In-Network provider. They are also not subject to the annual deductible.

You have the freedom to select the dentist of your choice; however when you visit a participating in-network dentist, you will have lower out-of-pocket costs, no balance billing, and claims will be submitted by your dentist on your behalf.

Michigan Manufacturers Association | MetLife

	PPO Network	Out-of-Network
PLAN FEATURES		
Network Details	PDP Plus	Dentists who do not participate in either network.
Benefit Period	**Calendar Year**	
DEDUCTIBLE		
Single	**$25** In-network / **$25** out of network	
Two Person	**$50** In-network / **$50** out of network	
Family	**$75** In-network / **$75** out of network	
When does it apply?	When receiving Basic or Major services (Does not apply for Preventive services)	
COVERED SERVICES		
CLASS I: Preventive Services *Routine oral exams and cleanings, x-rays, sealants & fluoride treatments*	**Covered at 100%**	**Covered at 100%** *With possible balance billing*
CLASS II: Basic Services *Periodontics (surgical & non-surgical), endodontics (root canals), oral surgery, fillings, prosthetic maintenance*	**Covered at 80%**	**Covered at 80%** *With possible balance billing*
CLASS III: Major Services *Prosthodontics, crowns, inlays/onlays, dentures, implants & bridges*	**Covered at 50%**	**Covered at 50%** *With possible balance billing*
CLASS IV: Orthodontia *Dependent children (Up to age 19)*	**Covered at 50%** Lifetime max $1,500	**Covered at 50%** Lifetime max $1,500 *With possible balance billing*
ANNUAL MAXIMUM		
Maximum Benefit *Allowed per Benefit Period*	**$2,500 per covered individual**	

How do I find an In-Network Provider?

This dental plan offers deeper discounts when you visit a provider that is In-Network. In-Network providers can be found on www.metlife.com > Click "Dentist", enter your ZIP Code, and select your network "PDP Plus".

PEDIATRIC DENTAL

COVERAGE OVERVIEW

Pediatric members are age 18 or younger on the plan's effective date, and will remain pediatric members through the end of the calendar year in which they turn 19.

Michigan Manufacturers Association MetLife

PLAN FEATURES	PPO NETWORK	OUT-OF-NETWORK
	MMA/MetLife	
Network Details	In-Network	Dentists who do not participate in network.
Benefit Period	**Calendar Year**	
DEDUCTIBLE		
Single	**$75**	**$200**
When does it apply?	When receiving Preventive, Basic or Major services	
COVERED SERVICES		
CLASS I: Preventive Services *Routine oral exams/evaluations; routine prophylaxes; fluoride treatment; sealants; bitewing x-rays; oral brush biopsy*	**Covered at 100%**	**Covered at 100%**
CLASS II: Basic Services *Amalgam fillings, resin composite fillings, sedative fillings, pulp vitality, diagnostic photographs and bacteriological studies*	**Covered at 50%**	**Covered at 50%** *With possible balance billing*
CLASS III: Major Services *Major restorative services; oral surgery services; surgical endodontic services; surgical periodontic services; prosthodontic services;*	**Covered at 50%**	**Covered at 50%** *With possible balance billing*
OUT OF POCKET MAXIMUM		
This out-of-pocket maximum is separate from the annual out-of-pocket maximum that applies under your hospital and medical coverage.	**$350 for one pediatric member** **$700 for two or more pediatric members**	**$400 for one pediatric member only**

VISION
COVERAGE OVERVIEW

Under this plan, you may use the eye care professional of your choice. However, when you visit a participating in-network provider, you receive higher levels of coverage. If you choose to receive services from an out-of-network provider, you will be required to pay that provider at the time of service and submit a claim form for reimbursement.

Michigan Manufacturers Association | MetLife

	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
PLAN FEATURES		
Vision Exam	**$10** copay	Up to **$45**
COVERED SERVICES – LENSES / FRAMES		
Single Lenses	**$25** copay	Up to **$30**
Bifocals	**$25** copay	Up to **$50**
Trifocals	**$25** copay	Up to **$65**
Frames	**$130** retail allowance	Up to **$70**
COVERED SERVICES		
Contact Lenses	**$130**	Up to **$105**
Contact Lens Evaluation Fitting	**Up to $60 copay**	Applied to the contact lens allowance
BENEFIT FREQUENCY		
Exams	Once every 12 Months	Once every 12 Months
Lenses	Once every 12 Months	Once every 12 Months
Frames	Once every 12 Months	Once every 12 Months
Contacts	Once every 12 Months *(contacts in lieu of frames/lenses)*	Once every 12 Months

Did you know your eyes can tell an eye care provider a lot about you?

In addition to eye disease, a routine eye exam can help detect signs of serious health conditions like diabetes and high cholesterol. This is important, since you won't always notice the symptoms yourself and since some of these diseases cause early and irreversible damage.

Need to locate a participating In-Network provider?

Visit www.metlife.com > Click "Vision Provider" and enter your ZIP Code, and select your network "Vision PPO".

How to register on MyBenefits for MMA Members

MyBenefits provides you with a personalized, integrated and secure view of your MetLife-delivered benefits. You can take advantage of a number of self-service capabilities as well as a wealth of easy to access information. MetLife is able to deliver services that empower you to manage your benefits. As a first time user, you will need to register on MyBenefits. To register, follow the steps outlined below.

Registration Process for MyBenefits

Access MyBenefits:
www.metlife.com/mybenefits
Enter: Michigan Manufacturers Assoc.
Submit

The Login Screen

On the Home Page, you can access general information. To begin accessing personal plan information, click on **'Register Now'** and perform the one-time registration process. Going forward, you will be able to log-in directly.

Step 1: Enter Personal Information

Enter your first and last name, identifying data and e-mail address.

Step 2: Create a User Name and Password

Then you will need to create a unique user name and password for future access to MyBenefits.

The User Name and Password requirements may vary by company setup. General setup includes a User Name between 8-20 characters, containing at least one letter and one number, and a password between 6-20 characters, containing at least one letter and one number.

Step 3: Security Verification Questions

Now, you will need to choose and answer three identity verification questions to be utilized in the event you forget your password.

Step 4: Terms of Use

Finally, you will be asked to read and agree to the website's Terms of Use.

Step 5: Process Complete

Now you will be brought to the "Thank You" page.

Lastly, a confirmation of your registration will be sent to the email address you provided during registration.

For questions on registering,
please contact MyBenefits at (877) 963-8932.

metlife.com/mybenefits

Metropolitan Life Insurance Company | 200 Park Avenue | New York, NY 10166
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MetLife

In collaboration with

MMA Michigan Manufacturers Association

BASIC LIFE
COVERAGE OVERVIEW

BENEFICIARY(IES)

It's very important to designate beneficiaries. Taking a few minutes to designate your beneficiaries now will help ensure that your assets will be distributed according to your direction.

A Beneficiary is the person you designate to receive your life insurance benefits in the event of your death. It is important that your beneficiary designation is clear so there is no question as to your intentions.

It is also important that you name a **Primary** and **Contingent Beneficiary.** A contingent beneficiary will receive the benefits of your life insurance if the primary beneficiary cannot. You can change beneficiaries at any time.

You should review your beneficiary elections on a regular basis to ensure they are updated as life changes. Even if you are single, your beneficiary can use your Life Insurance to pay off your debts, such as: credit cards, mortgages, and other expenses.

**You designate your beneficiary(ies) when enrolling for your benefits.*

Principal

BASIC LIFE INSURANCE – Offered to Managers and Above

Life insurance is an important part of your financial security. Life insurance helps protect your family from financial risk and sudden loss of income in the event of your death. AD&D insurance is equal to your Life benefit in the event of your death being a result of an accident, and may also pay benefits for certain injuries sustained.

Company Paid Benefit - Provided to you at no cost	
Coverage Amount	Flat **$20,000** Benefit
Accidental Death and Dismemberment (AD&D)	Amount equal to your Life benefit
Benefit Reduction Schedule	Your insurance will reduce at: – 35% of the original amount at age 65 – 50% of the original amount at age 70

ADDITIONAL PLAN PROVISIONS

Portability	If your employment ends or your retire, you may be eligible to continue your term insurance at group rates.
Conversion	When coverage ends under the plan, you can convert to an individual permanent life policy without evidence of insurability.

WHAT WILL MY BENEFICIARY RECEIVE?

In The Event That Death Occurs:

- Your Basic Life insurance is paid to your beneficiary.
- **If death occurs from an accident:** 100% of the AD&D benefit would be payable to your beneficiary(ies) in addition to your Basic Life insurance.

SUPPLEMENTAL LIFE
COVERAGE OPTIONS FOR YOU & THE FAMILY

SUPPLEMENTAL **LIFE INSURANCE**

Employees have the opportunity to enroll in supplemental Life insurance. If you choose to enroll in employee coverage, this will be in addition to your employer provided Basic Life coverage. Coverage is also available for your spouse and/or child dependents. It is typically required that you elect coverage for yourself in order to be eligible for coverage on your dependents.

PLAN OPTIONS

Cost of Coverage

Premiums are based on age-rated tables and paid by the employee every pay period through a payroll deduction. These premiums are post-tax and benefits payable are tax-free.

Coverage Options

Employee Coverage	Spouse Coverage	Dependent Coverage
Choose in $10,000 increments up to the lesser of 5x your annual salary or $500,000	Choose in $5,000 increments up to the lesser of 100% of the amount you elect for yourself or $500,000	Choose in $2,000 increments up to the lesser of 100% of employee coverage or $10,000

Do I have to take a health exam to get coverage?

If you and your dependents enroll in coverage at your initial eligibility date, you may apply for up to the Guaranteed Issue amounts without medical questions.

Guaranteed Issue

Employee	Spouse	Dependent
$40,000	$15,000	$10,000

PLAN PROVISIONS

Cost Calculation

Age Rated Benefit (Spouse Life based on employee's age)

Benefit Reduction Schedule

Employee Coverage Will Reduce To:
- 65% of the original amount at age 70
- 50% of the original amount at age 75

Spouse Coverage Will Reduce By:
The same amount and at the same time your coverage reduces

Portability

If your employment ends or you retire, you may be eligible to continue your term insurance at group rates.

Conversion

When coverage ends under the plan, you can convert to an individual permanent life policy without evidence of insurability.

*Guaranteed Issue (GI) and Evidence of Insurability (EOI)

When you are first eligible (at hire) for Voluntary Life and AD&D, you may purchase up to the Guaranteed Issue (GI) for yourself and your spouse without providing proof of good health (EOI). Annually, you are able to increase elections 1 increment up to GI without proof of good heath.

Any amount elected over the GI will require EOI. If you elect optional life coverage, and are required to complete an EOI, it is your responsibility to complete the EOI and send to the provider (address will be listed on your form). In addition, your spouse will need to provide EOI to be eligible for coverage amounts over GI, or if coverage is requested at a later date.

DISABILITY
SHORT-TERM | LONG-TERM

Principal

SHORT-TERM DISABILITY (STD) - Offered to Managers and Above

Everyday illnesses or injuries can interfere with your ability to work. Even a few weeks away from work can make it difficult to manage household costs.

Short Term Disability coverage provides financial protection for you by paying a portion of your income, so you can focus on getting better and worry less about keeping up with your bills.

PLAN FEATURES	SHORT-TERM DISABILITY (STD)
Cost of Coverage	**Employer paid benefit** Paid for 100% by Askar
Elimination Period *This is the number of days that must pass between your first day of a covered disability & the day you can begin to receive your disability benefits.*	Benefits begin on the **1st day of an accident** and the **8th day of an illness (including pregnancy)**
Benefit Duration *The maximum number of weeks you can receive benefits while you are sick or disabled.*	**Payments may last up to 26 weeks** You must be sick or disabled for the duration of the waiting period before you can receive a benefit payment.
Coverage Amount	Covers **60% of your weekly income,** up to a maximum benefit of **$1,000 per week.**
What's covered?	**A variety of conditions and injuries.** Typical claims would include: pregnancy, injuries, joint, back and digestive disorders.
Definition of Earnings	**Base Salary**
ADDITIONAL PLAN PROVISIONS	
Benefit Payment Frequency	**Weekly benefit** may be reduced or offset by other sources of income.
Cost Calculation	Composite Rate per $10 of Benefit
Waiver of Premium	If you're disabled and receiving benefit payments, you cost may be waived until you return to work.
Pre-Existing Condition Limitation	You have a pre-existing condition if you have received: medical treatment, consultation, care or services including diagnostic measures for the condition, or took prescribed drugs or medicines for it in the 3 months just prior to your effective date of coverage; and the disability begins in the first 6 months after your effective date of coverage.

Certain exclusions and any pre-existing condition limitations may apply. Please refer to the Provider's detailed benefit summary for details.

ASKAR BRANDS

REQUIRED NOTICES

& FEDERAL MANDATES

2021

REQUIRED NOTICES

Federal regulations require employers to provide certain notifications and disclosures to all eligible employees. This section of your benefit guide is dedicated to those disclosures for 8.1.21 – 7.31.22. If you have any questions or concerns please contact Human Resources

FAMILY MEDICAL LEAVE ACT (FMLA)

The Family and Medical Leave Act (FMLA) of 1993 was designed to provide eligible employees with up to 12 workweeks per year of job-protected leave to address critical personal and family matters. It is the policy of **your employer** and its U.S. subsidiaries to provide eligible employees with a leave of absence in accordance with the provisions of FMLA.

You are eligible for an FMLA leave of absence under this policy if you meet the following requirements:

- You have completed at least 12 months of employment (need not be consecutive, but employment prior to a continuous break in service of seven or more years may not be counted).
- You have worked at least 1,250 hours during the 12-month period immediately preceding the commencement of the requested leave.
- You are employed at a work site where 50 or more employees are employed by the Company within 75 miles of that work site ("eligible employees").

To the extent permitted by law, leave taken pursuant to FMLA will run concurrently with Workers' Compensation, Short Term Disability, and all other Company leave policies.

The *"break in service cap"* doesn't apply if it:

- is attributable to fulfillment of National Guard or Reserve military service obligations; or
- is addressed in a written agreement, including a collective bargaining agreement, that expresses the employer's intent to rehire the employee after the break in service, such as a break to pursue education or raise children.

Procedure for Applying for FMLA Leave

If you desire and require an FMLA leave of absence under this policy, you must notify your manager and your Human Resources Department and call your FMLA Administrator at least 30 calendar days in advance of the start of the leave when the need for such leave is reasonably foreseeable (as in the case of a birth, the placement for adoption of a son or daughter, or a planned medical treatment for a serious health condition).

However, if the date of the birth, placement, or planned medical treatment requires leave to begin in less than 30 calendar days, you must provide such notice to the aforementioned parties as soon as it is both possible and practicable. Failure to provide timely notice may result in a delay or denial of FMLA leave.

IRS CODE SECTION 125

Premiums for medical, dental, vision insurance, and/or certain supplemental plans and contributions to FSA accounts (Health Care and Dependent Care FSAs) are deducted through a Cafeteria Plan established under Section 125 of the Internal Revenue Code (IRC) and are pre-tax to the extent permitted. Under Section 125, changes to an employee's pre-tax benefits can be made ONLY during the Open Enrollment period unless the employee or qualified dependents experience a qualifying event and the request to make a change is made within 30 days of the qualifying event.

Under certain circumstances, employees may be allowed to make changes to benefit elections during the plan year, if the event affects the employee, spouse, or dependent's coverage eligibility. An "eligible" qualifying event is determined by the Internal Revenue Service (IRS) Code, Section 125. Any requested changes must be consistent with and on account of the qualifying event.

Examples Of Qualifying Events:

- Legal marital status (for example, marriage, divorce, legal separation, annulment);
- Number of eligible dependents (for example, birth, death, adoption, placement for adoption);
- Employment status (for example, strike or lockout, termination, commencement, leave of absence, including those protected under the FMLA);
- Work schedule (for example, full-time, part-time);
- Death of a spouse or child;
- Change in your child's eligibility for benefits (reaching the age limit);
- Change in your address or location that may affect the coverage for which you are eligible;
- Significant change in coverage or cost in your, your spouse's or child's benefit plans;
- A covered dependent's status (that is, a family member becomes eligible or ineligible for benefits under the Plan);
- Becoming eligible for Medicare or Medicaid; or
- Your coverage or the coverage of your Spouse or other eligible dependent under a Medicaid plan or state Children's Health Insurance Program ("CHIP") is terminated as a result of loss of eligibility and you request coverage under this Plan no later than 60 days after the date the Medicaid or CHIP coverage terminates; or
- You, your spouse or other eligible dependent become eligible for a premium assistance subsidy in this Plan under a Medicaid plan or state CHIP (including any waiver or demonstration project) and you request coverage under this Plan no later than 60 days after the date you are determined to be eligible for such assistance.

Qualifying Events, which ARE NOT available for a Health Care FSA program, if applicable:

- Coverage by your spouse or other covered dependent permitted under the spouse's or covered dependent's employer's benefit plan due to a Change Event;
- The availability of benefit options or coverage under any of the Benefit Programs under the Plan (for example, an HMO is added to or deleted from the Medical Program);
- An election made by your spouse or other covered dependent during an open enrollment period under your spouse's or other covered dependent's employer's benefit plan that relates to a period that is different from the Plan Year for this Plan (for example, your spouse's open enrollment period is in July and your spouse changes coverage); or
- The cost of coverage during the Plan Year, but only if it is a significant increase or decrease.

Available for Dependent Care FSA Only, If applicable:

- Your dependent care provider or cost of dependent care (a significant increase or decrease).

Additional Change Events For Health Care Options:

In addition to the above Change Events, you may also change elections for the Medical, Dental, Vision and Health Care FSA Programs if:

- You, your spouse, or other covered dependent become eligible for continuation coverage under COBRA or USERRA;
- A judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order), is entered by a court of competent jurisdiction that requires accident or health coverage for your child;
- You, your spouse, or other covered dependent become enrolled under Part A, Part B, or Part D of Medicare or under Medicaid (other than coverage solely with respect to the distribution of pediatric vaccines); or
- You, your spouse, or other covered dependent become eligible for a Special Enrollment Period.

REQUIRED NOTICES

HEALTH COVERAGE REMINDER

The Patient Protection and Affordable Care Act (PPACA) requires most individuals to have minimum essential health coverage or pay a penalty. You may obtain coverage through your employer or through the Marketplace.

- Depending on your income and the coverage offered by your employer, you may be able to obtain lower cost private insurance in the Marketplace.
- If you buy insurance through the Marketplace, you may lose any employer contribution to your health benefits.

Visit **www.healthcare.gov** for Marketplace information.

WOMEN'S HEALTH & CANCER RIGHTS ACT (WHCRA)

In October 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act.

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

Health plans must determine the manner of coverage in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan.

SPECIAL ENROLLMENT NOTICE

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

Loss of Other Coverage or Becoming Eligible for Medicaid or a state Children's Health Insurance Program (CHIP)

If you are declining coverage for yourself or your dependents because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must enroll within 31 days after your or your dependents' other coverage ends (or after the employer that sponsors that coverage stops contributing toward the other coverage).

If you or your dependents lose eligibility under a Medicaid plan or CHIP, or if you or your dependents become eligible for a subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents in this plan. You must provide notification within 60 days after you or your dependent is terminated from, or determined to be eligible for such assistance.

Marriage, Birth or Adoption

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must enroll within 31 days after the marriage, birth, or placement for adoption.

For More Information or Assistance

To request special enrollment or obtain more information, contact Human Resource Department

MICHELLE'S LAW NOTICE

The health plan may extend medical coverage for dependent children if they lose eligibility for coverage because of a medically necessary leave of absence from school. Coverage may continue for up to a year, unless your child's eligibility would end earlier for another reason.

Extended coverage is available if a child's leave of absence from school — or change in school enrollment status (for example, switching from full-time to part-time status) — starts while the child has a serious illness or injury, is medically necessary, and otherwise causes eligibility for student coverage under the plan to end. Written certification from the child's physician stating that the child suffers from a serious illness or injury and the leave of absence is medically necessary may be required.

If your child will lose eligibility for coverage because of a medically necessary leave of absence from school and you want his or her coverage to be extended, contact your Human Resource Department as soon as the need for the leave is recognized. In addition, contact your child's health plan to see if any state laws requiring extended coverage may apply to his or her benefits.

THE GENETIC INFORMATION NON-DISCRIMINATION ACT (GINA)

Genetic Information Non-Discrimination Act (GINA) prohibits discrimination by health insurers and employers based on individuals' genetic information. Genetic information includes the results of genetic tests to determine whether someone is at increased risk of acquiring a condition in the future, as well as an individual's family medical history. GINA imposes the following restrictions: prohibits the use of genetic information in making employment decisions; restricts the acquisition of genetic information by employers and others; imposes strict confidentiality requirements; and prohibits retaliation against individuals who oppose actions made unlawful by GINA or who participate in proceedings to vindicate rights under the law or aid others in doing so.

NOTICE OF ELIGIBILITY FOR HEALTH PLANS RELATED TO MILITARY LEAVE

If you take a military leave, the Uniformed Services Employment and Reemployment Rights Act (USERRA) provides the following rights:

- If you take a leave from your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage at your cost for you and your dependents for up to 24 months during your military service; or
- If you don't elect to continue coverage during your military service, you have the right to be reinstated in the Plan when you are reemployed within the time period specified by USERRA, without any additional waiting period or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

The Plan Administrator can provide you with information about how to elect Continuation Coverage Under USERRA.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

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

MEDICARE PART D CREDITABLE COVERAGE NOTICE
Your Prescription Drug Coverage and Medicare

Important Notice from Askar Management Group 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 Askar Management Group 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. Askar Management Group has determined that the prescription drug coverage offered by the SB 1500 and SB 4000 plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan? You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th . However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan? If you decide to join a Medicare drug plan, your current Askar Management Group coverage will [or will not] be affected. [The entity providing the Disclosure Notice should insert an explanation of the prescription drug coverage plan provisions/options under the particular entity's plan that Medicare eligible individuals have available to them when they become eligible for Medicare Part D. You can keep this coverage if you elect part D and this plan will coordinate with Part D coverage; for those individuals who elect Part D coverage, coverage under the entity's plan will end for the individual and all covered dependents, etc. See pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current Askar Management Group coverage, be aware that you and your dependents will 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 Askar Management Group and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage contact the Human Resources Department.

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 Askar Management Group changes. You also may request a copy of this notice at any time.

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

For more information about Medicare prescription drug coverage:

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

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

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

CMS Form 10182-CC Updated April 1, 2011 According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

MEDICARE PART D NON-CREDITABLE COVERAGE NOTICE

Your Prescription Drug Coverage and Medicare

Important Notice from Your Employer 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 Askar Management Group 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. There are three 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. Askar Management Group has determined that the prescription drug coverage offered by the **Simply Blue HSA PPO Bronze 6900 plan** is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the Simply Blue HSA PPO Bronze 6900 plan. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.
3. You can keep your current coverage from Simply Blue HSA PPO Bronze 6900 plan. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you decide to drop your current coverage with Askar Management Group, since it is employer/union sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however you also may pay a higher premium (a penalty) because you did not have creditable coverage under **Simply Blue HSA PPO Bronze 6900 plan**

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

Since the coverage under **Simply Blue HSA PPO Bronze 6900 plan** is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, 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 (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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 Askar Management Group coverage may be affected. You can keep this coverage if you elect part D and this plan will coordinate with Part D coverage; for those individuals who elect Part D coverage, coverage under the entity's plan will end for the individual and all covered dependents, etc. See pages 9 - 11 of the CMS Disclosure of Creditable Coverage To Medicare Part D
Eligible Individuals Guidance (available at
http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.] If you do decide to join a Medicare drug plan and drop your current Askar Management Group coverage, be aware that you and your dependents will be able to get this coverage back.

For More Information About This Notice Or Your Current Prescription Drug Coverage contact the HR Department.

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 Askar Management Group 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).

CMS Form 10182-NC Updated April 1, 2011 According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

REMINDER: This is a courtesy copy of the Initial Rights notice provided to qualified beneficiaries.

COBRA COVERAGE

Federal law requires **your employer** to offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end.

To Qualify For COBRA Coverage:

Employees – As an employee of **your employer** covered by our health plans**,** you have the right to elect this continuation coverage if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

Spouses – As the spouse of an employee covered by our health plans**,** you have the right to choose continuation coverage for yourself if you lose group health coverage under **our health plans,** for any of the following reasons:

- The death of your spouse who was a **your employer e**mployee;
- A termination of your spouse's employment (for reasons other than gross misconduct);
- A reduction in your spouse's hours of employment;
- Divorce or legal separation from your spouse; or
- Your spouse becomes entitled to Medicare.

Dependent Children

Dependent children of **your employer** employees covered by our health plans, have the right to continuation coverage if group health coverage under our plans, is lost for any of the following reasons:

- The death of a parent who was a **your employer** employee;
- The termination of a parent's employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment with **your employer;**
- Parents' divorce or legal separation;
- A parent who is an employee of **your employer** becomes entitled to Medicare; or
- The dependent ceases to be a "dependent child" under the terms of the our health plans.

Please note that it is the employee's responsibility to notify the Human Resources/Benefits Department of any communication regarding loss of coverage and communication regarding such between the employee and the insurance carrier. Please note that employees must also provide notice of other events (e.g., divorce) to the Human Resources Department.

Continuation of Coverage Rights Under COBRA

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

You may have other options available to you when you lose group health coverage.

For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What Is COBRA Continuation Coverage?

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

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.
- If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:
- Your spouse dies
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.
- Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:
- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plans as a "dependent child."

When Is COBRA Continuation Coverage Available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

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

How Is COBRA Continuation Coverage Provided?

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

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

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

COBRA COVERAGE (cont.)

Disability Extension Of 18-month Period Of COBRA Continuation Coverage

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

Second Qualifying Event Extension Of 18-month Period Of Continuation Coverage

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

Are There Other Coverage Options Besides COBRA Continuation Coverage?

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

If you have questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www. dol.gov/ebsa. *(Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)*

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

*****Keep Your Plan Administrator Informed Of Address Changes*****

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

REQUIRED NOTICES
CHIP

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

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

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

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

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

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://flmedicaidtplrecovery.com/hipp/
Phone: 1-877-357-3268

GEORGIA – Medicaid

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

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

IOWA – Medicaid 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

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/default.htm
Phone: 1-800-792-4884

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)
Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov

KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718

Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) 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/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid

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

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

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

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 603-271-5218
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: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid

Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid

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

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

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
P: 866.444.EBSA (3272)

U.S. Department and Human Services Center for Medicare & Medicaid Services
www.cms.hhs.gov
P: 877.267.2323 Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement: According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)

GLOSSARY OF TERMS

Dependent Verification Services (DVS) – Service used to verify dependent proof of relationship when adding dependents to benefit plans.

Beneficiary – A person designated by you, the participant of a benefit plan, to receive the benefits of the plan in the event of the participant's death.

- **Primary Beneficiary –** A person who is designated to receive the benefits of a benefit plan in the event of the participant's death
- **Contingent Beneficiary** – A person who is designated to receive the benefits of a benefit plan in the event of the Primary Beneficiary's death

Charges – The term "charges" means the actual billed charges. It also means an amount negotiated by a provider, directly or indirectly, if that amount is different from the actual billed charges.

Coinsurance – The percentage of charges for covered expenses that an insured person is required to pay under the plan (separate from copayments)

Deductible – The amount of money you must pay each year to cover eligible expenses before your insurance policy starts paying.

Dependents – Dependents are your:

- Lawful spouse through a marriage that is lawfully recognized.
- Dependent child (married or unmarried) under the age of 26 including stepchildren and legally adopted children.

Proof of relationship documentation will be required in order to add dependents to your plan(s). Employees will receive request for documentation.

Emergency Services – Medical, psychiatric, surgical, hospital, and related health care services and testing, including ambulance service, that are required to treat a sudden, unexpected onset of a bodily injury or serious sickness that could reasonably be expected by a prudent layperson to result in serious medical complications, loss of life, or permanent impairment to bodily functions in the absence of immediate medical attention. Examples of emergency situations include uncontrolled bleeding, seizures or loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, burns, cuts, and broken bones.

The symptoms that led you to believe you needed emergency care, as coded by the provider and recorded by the hospital, or the final diagnosis – whichever reasonably indicated an emergency medical condition – will be the basis for the determination of coverage provided such symptoms reasonably indicate an emergency.

Evidence of Insurability (EOI) – Proof that you are insurable based on the requirements of the insurance carrier. *For example, the results of a blood test or a doctor's signature on a form may be required for you to be covered by/for Optional Life insurance.*

Explanation of Benefits — The health insurance company's written explanation of how a medical claim was paid. It contains detailed information about what the company paid and what portion of the costs are your responsibility.

Health Reimbursement Account (HRA) – The Health Reimbursement Account (HRA) is an employer-funded account that reimburses you for eligible out-of-pocket medical expenses. The HRA is only available to employees who are enrolled in the HRA Plan.

In-Network – The term "in-network" refers to health care services or items provided by your Primary Care Physician (PCP) or services/items provided by another participating provider and authorized by your PCP or the review organization. Authorization by your PCP or the review organization is not required in the case of mental health and substance abuse treatment other than hospital confinement solely for detoxification.

Emergency Care that meets the definition of "emergency services" and is authorized as such by either the PCP or the review organization is considered in-network.

Out-of-Network - The term "out-of-network" refers to care that does not qualify as in-network.

Maximum Out of Pocket — The most money you will pay during a year for coverage. It includes deductibles, copayments and coinsurance, but is in addition to your regular premiums. Beyond this amount, the insurance company will pay all expenses for the remainder of the year.

Medically Necessary/Medical Necessity – Required to diagnose or treat an illness, injury, disease, or its symptoms; in accordance with generally accepted standards of medical practice; clinically appropriate in terms of type, frequency, extent, site, and duration; not primarily for the convenience of the patient, physician, or other health care provider; and rendered in the least intensive setting that is appropriate for the delivery of the services and supplies.

Participating Provider – A hospital, physician, or any other health care practitioner or entity that has a direct or indirect contractual arrangement with Cigna to provide covered services with regard to a particular plan under which the participant is covered.

Post-Tax – An option to have the payment to your benefits deducted from your gross pay after your taxes have been withheld. Therefore, your tax contributions will be calculated based on a higher amount. Your statutory deductions (federal income tax, Social Security, Medicare) will be calculated based on a higher amount.

Pre-Tax – An option to have the payment to your benefits deducted from your gross pay before your taxes have been withheld. Therefore, your tax contributions will be calculated based on a lesser amount. Your statutory deductions (federal income tax, Social Security, Medicare) will be calculated based on a lesser amount.

Primary Care Dentist (PCD) – The term "Primary Care Dentist" means a dentist who (a) qualifies as a participating provider in general practice, referrals, or specialized care; and (b) has been selected by you, as authorized by the provider organization, to provide or arrange for dental care for you or any of your insured dependents.

Primary Care Physician (PCP) – The term "Primary Care Physician" means a physician who (a) qualifies as a participating provider in general practice, obstetrics/gynecology, internal medicine, family practice, or pediatrics; and (b) has been selected by you, as authorized by the provider organization, to provide or arrange for medical care for you or any of your insured dependents.

Proof of Relationship Documentation – Documents that show a dependent is lawfully your dependent. Documents can include marriage certificates, birth certificates, adoption agreements, previous years' tax returns, court orders, and/or divorce decrees showing your or your spouse's responsibility for the dependent.

IMPORTANT CONTACT INFORMATION

Have Questions?

Please see the chart below for provider customer service phone numbers and website addresses.

If you need any other assistance, contact HR.

PROVIDER	CONTACT INFORMATION
Blue Cross Blue Shield of Michigan Medical Plans	(877) 722-6030 www.bcbsm.com
MMA/MetLife Dental	(800) 275-4638 www.metlife.com
MMA/MetLife Vision	(800) 275-4638 www.metlife.com
Principal Life/AD&D & STD	(800) 986-3343 www.principal.com
Optional Life/AD&D	(866) 679-3054 www.unum.com

ASKAR BRANDS

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NFP

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