Berkowitz Pollack Brant Advisors +CPAs

PROVENANCE WEALTH ADVISORS

BayBridge Capital Advisors

BayBridge REAL ESTATE CAPITAL

2024 BENEFITS GUIDE

Welcome to your 2024 Employee Benefits

Berkowitz Pollack Brant Advisors + CPAs strives to offer you and your family a comprehensive and valuable benefits package to help provide you with security and peace of mind. This guide serves as an overview of the health coverage options and offers various tools and resources to help you focus on key areas of wellness.

Table of Contents

At Berkowitz Pollack Brant Advisors + CPAs, we care about you and want to provide you with the plan and care options you and your family need to help you be and stay healthy. This guide summarizes everything you need to know as you choose the benefits that best meet your needs. It provides an overview of your benefit choices for 2024. The choices you make will be effective through December 31, 2024.

Please note that for new hires, you must complete your enrollment in ADP **within 31 days of your eligibility date.**

Once enrolled, you can only make changes if you have a qualifying life event (refer to "Eligibility and Enrollment" section). If you have any questions, contact HR at 305.960.8857 or submit an inquiry to Gabe Bevilacqua at hrpayrollbenefits@bpbcpa.com.

Eligibility and Enrollment

Benefit Eligibility

If you're a full-time employee, you're eligible to enroll in the benefits outlined in this guide. Full-time employees who work 30 hours or more per week are eligible for medical.

Eligible Dependents

- Your legal spouse, including same-sex spouses
- Your domestic partner, assuming:
    - You are both at least 18 years old
    - You reside in the same principal residence and have done so for at least six months
    - You are mutually responsible for basic living expenses and debts
    - Neither of you is legally married to anyone else
    - You are not blood relatives
- A child under the age of 26 who is your or your spouse/domestic partner's natural child, stepchild, or legally adopted child; or a child for whom you or your spouse/domestic partner are legal guardian; or disabled dependent over age 26.

If you enroll a spouse, domestic partner, or child on a company health plan, you will need to attest in the Benefits Enrollment System that each dependent meets company eligibility rules. Before enrolling dependents, please ensure they meet the eligibility requirements above. If they don't qualify, coverage will be canceled, and you may be liable for the cost of any ineligible claims and premiums paid.

Eligibility and Enrollment

Qualifying Life Events

Generally, you may only change your benefit elections during the annual open enrollment period. However, you may change your benefit elections during the year if you experience a qualifying life event, including:

- Marriage or domestic partnership
- Divorce, legal separation or end of domestic partnership
- Birth of your child or your domestic partner's child (within 60 days)
- Death of your spouse, domestic partner or dependent child
- Adoption of or placement for adoption of your child or your domestic partner's child (within 60 days)
- Change in employment status of employee, spouse/domestic partner or dependent child
- Qualification by the Plan Administrator of a child support order for medical coverage
- Loss of or Eligibility for Medicaid or CHIP coverage (within 60 days)
- For more details, see Section 125 - Qualifying Events

You must notify the Human Resources Department within 30 days of the qualifying life event.*

(60 days for loss of or eligibility for Medicaid or CHIP coverage)

**You must submit the proper documentation supporting the life event when reporting the event itself. If you do not notify the Human Resources Department within the required timeframe, you will have to wait until the next open enrollment period to make changes (unless you experience another qualifying life event).*

Eligibility and Enrollment

New Hire Effective Dates

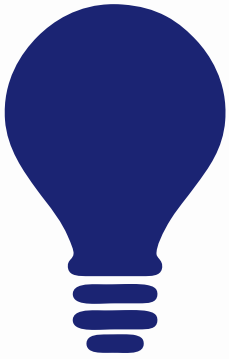
New hire elections will be effective, on the first of the month following 30 days after your hire date.

Annual Open Enrollment Dates

Current employees are eligible to make changes or enroll in new benefits during our annual open enrollment period.

Annual open enrollment is the only time you can change current benefit selections unless you qualify for a special enrollment period.

Notify your Human Resources Department within 30 days of a qualifying life event to request a special enrollment. See federal laws and disclosures for more details on qualifying life events.



Make sure your ID card is easily accessible and available before you visit a provider.

After the plan goes into effect, be sure you provide your new ID card to your provider during an office visit.

Medical - UHC

For more information
Please refer to your plan documents.

*=Gap reimbursable up to $5000 in-patient/$5000 out-patient

Plan name	CRWA-M (NHP HMO OA) Rx: NH42 (Florida Only)
Provider	UnitedHealthcare
Referral required	No
Network provider/Lab	NHP HMO/POS Access /Quest Diagnostics and LabCorp
Benefit	**In-Network**
CALENDAR YEAR DEDUCTIBLE	
Individual	$5,000
Family	$10,000
Coinsurance	$0
OUT-OF-POCKET MAX	
Individual	$8,150
Family	$16,300
PHYSICIAN SERVICES	
Preventative	100%
Physician visit	$0
Specialist visit	*$75 (Non-DDP: Ded+$75)
HOSPITAL MEDICAL SERVICES	
X-Ray and Lab *	Lab: $25 / $75
Complex Imaging (MRI & CT Scan *	Ded+$250 (Non-DDP Ded+$500)
Inpatient Hospital *	Ded+$500
Outpatient Surgery *	ASC: Ded+$250 Hosp: Ded+$500
Urgent Care *	$50
Emergency *	Ded+$500
RETAIL PRESCRIPTION	
Rx Tiers	$10/75/175/350; Adv PDL Natl

This guide is subject to periodic review and modification. Each plan is governed by an official Summary Plan Description (SPD) document. If there is any conflict between this benefits guide and the SPD official document, the plan SPD document is the final authority. As an enrollee, your actual SPD will be provided under separate cover by your health carrier or your employer.
*Designated / Non-Designated

Berkowitz HMO_CRWA MOD Summary Plan Description

Berkowitz UHC Carrier pages

Medical - UHC

For more information
Please refer to your plan documents.

*=Gap reimbursable up to $5000 in-patient/$5000 out-patient

Plan name	DB8X-M (UHC Choice Plus) Rx: D00 (old CRZV)		DB6G-M (UHC Choice Plus-HSA) Rx: 570-HSA-M (old AQUQ)		BWMD (UHC Choice Plus) Rx: 560	
Provider	UnitedHealthcare		UnitedHealthcare		UnitedHealthcare	
Referral required	No		No		No	
Network provider/Lab	Choice Plus / Quest Diagnostics and LabCorp		Choice Plus / Quest Diagnostics and LabCorp		Choice Plus / Quest Diagnostics and LabCorp	
Benefit	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
CALENDAR YEAR DEDUCTIBLE						
Individual	$5,000	$10,000	$4,000	$5,000	$5,000	$10,000
Family	$10,000	$20,000	$8,000	$10,000	$10,000	$30,000
Coinsurance	$0	50%	$0	50%	30%	50%
OUT-OF-POCKET MAX						
Individual	$7,500	$20,000	$6,400	$10,000	$6,350	$20,000
Family	$15,000	$40,000	$12,800	$20,000	$12,700	$40,000
PHYSICIAN SERVICES						
Preventative	100%	Ded+50%	100%	Ded+50%	100%	Ded+50%
Physician visit	0	Ded+50%	Ded	Ded+50%	$30	Ded+50%
Specialist visit	*$75 (Non-DDP: Ded+$75)	Ded+50%	Ded	Ded+50%	$55	Ded+50%
HOSPITAL MEDICAL SERVICES						
X-Ray and Lab	*Lab: $25 (Non-DDP $100) / X-Ray: $75 *	Ded+50%	*Lab: Ded (Non-DDP Ded+50%) / X-Ray: Ded	Ded+50%	*Lab: Ded+70% (Non-DDP * Ded+50%) / X-Ray: Ded+70%	Ded+50%
Complex Imaging (MRI & CT Scan)	*Ded+$250 (Non-DDP Ded+$500) *	Ded+50%	*Ded (Non-DDP Ded+50%)	Ded+50%	*Ded+70% (Non-DDP Ded+50%) *	Ded+50%
Inpatient Hospital	Ded+$500 *	Ded+50%	Ded	Ded+50%	Ded+70% *	Ded+50%
Outpatient Surgery	ASC: Ded+$250 * Hosp: Ded+$500	Ded+50%	Ded	Ded+50%	Ded+70% *	Ded+50%
Urgent Care	$50 *	Ded+50%	Ded	Ded+50%	$60 *	Ded+50%
Emergency	Ded+$500 *	Ded+$500	Ded	Ded+50%	$350 *	$350
RETAIL PRESCRIPTION						
Rx Tiers	$10/75/175/350; (Adv PDL) Natl	$10/75/175/350; (Adv PDL) Natl	Med Ded; $10/35/70; (Adv PDL; Core+ Prev $0 Cost Share) Natl	Med Ded; $10/35/70; (Adv PDL	$10/60/100; (Adv PDL) Natl	$10/60/100; (Adv PDL) Natl

This guide is subject to periodic review and modification. Each plan is governed by an official Summary Plan Description (SPD) document. If there is any conflict between this benefits guide and the SPD official document, the plan SPD document is the final authority. As an enrollee, your actual SPD will be provided under separate cover by your health carrier or your employer.
*Designated / Non-Designated

Berkowitz UHC Choice Plus Medical Plans - Summary Plan Description

Berkowitz UHC Carrier pages

Gap Insurance – Transamerica

Amwins Customer Service (800) 476-4491 * www.webtpa.com

Medical gap provides supplemental coverage for employees' deductibles and total out of pocket expenses.

How it works:	Example:	
You select a **medical plan with a**	$5,000 deductible	You need to spend the deductible amount (money out of your own pocket) before the plan kicks in. These plans generally have lower premiums (the amount you pay each month) and why they are favored by some.
You have a **gap plan** of	$5,000	During this period, the gap plan pays for outpatient hospital benefits, outpatient labs, and in-hospital benefits, up to the plan amounts.* This helps provide benefits up to your $5,000 deductible and decreases your out-of-pocket expenditure during this period.

5000-5000 Enhanced GAP With Lab Composite

$5000 Gap plan included on the following plans:

- CRWA-M NHP Florida Only
- DB8X-M National Plan
- BWMD National Plan

$2500 Gap plan included on the DB6G-M HSA Plan

$2500 Gap plan included on the following plan:

- DB6G-M HSA Plan

Dental

	LDCS500B	DPPO Low		DPPO High	
	Lincoln	Lincoln		Lincoln	
Benefit	**In-Network**	**In-Network**	**Out-Network**	**In-Network**	**Out-Network**
Annual Maximum Per Individual / Per Benefit Year	Unlimited	$2,500	-	$2,500	$2,500
Calendar Year Deductible (CYD) Per Individual / Per Family	No Ded $0 Office Visits	$50 / $150	$50/$150	$50/$150	$50/$150
Preventive/Basic*/Major Services**	Co-Pays Apply	100% / 90% / 60%	100% / 90% / 60%	100% / 90% / 60%	100% / 90% / 60%
Orthodontia (children to age 19)	Co-Pays Apply (Adult & Child)	50% $1,500	50%	50% (Child to age 19)	50% $1,500
Orthodontia Lifetime max. (per individual)	Unlimited	$1,500	$1,500	$1,500	$1,500

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

- * *Basic services cover* fillings, extractions,
- ** Major services cover crowns, bridgework, dentures periodontics, endodontics

[Berkowitz Dental DHMO LDCS500B Plan Summary]

[Berkowitz Dental DPPO Low Plan Summary] [Berkowitz Dental DPPO High Plan Summary]

Vision

	LVC10 (RGY 2025)	
	Lincoln	
Benefit	**In-Network**	**Out-Network**
Eye Exams*	$20 copay	Up to $40
Lenses*	$20 Copay	Up to $40
Frames Allowance**	Up to $130 + 30% off balance	Up to $45
Contact Lenses (Allowance) -Elective -Medically Necessary	Up to $125	Up to $125

This Summary is for informational purposes only. For specific benefit information, please refer to the plan information.
**Once every 12 months*
***Once every 24 months*

[Berkowitz Vision Plan Summary]

Employee Assistance Program

The Employee Assistance Program (EAP) provides resources at no cost. It is available to you, your spouse, dependent children up to age 26, and all other household members (if applicable). The program provides access to many services, including:

Counseling – Professional counselors are available to you 24 hours a day. They can assist with navigating family, relationships, dealing with depression, stress or anxiety, helping with loss or grief, parenting, life changes, substance abuse, and much more.

Work-Life – Members have assistance with daycare/childcare services, elder care services, coping with change, real estate issues, estate and probate concerns, living wills, college, and co-worker relationships.

Legal – Professional legal services are provided unrelated to employment or medical concerns. Members are eligible for a free 30-minute legal consultation per each legal issue with an attorney. A 25% discount is applied if the attorney is retained after consultation.

Debt and Financial – Professional debt counseling is available. This includes financial counseling to assist with retirement, college planning, or other financial concerns.

Personal Assistant or Self-Help Resources – This service is available to help with consumer law rights, automotive purchases, weight loss, wellness coaches, scholarships or financial aid, summer camps, and much more.

For additional information and programs available with EAP, click the link below:

Berkowitz Pollack Brant Advisors + CPAs EAP

Or contact:
UHC: 1-888-887-4114
member.uhc.com

Supportlinc:
1-888-881-5462
Supportlinc.com
Group Code:
bpbsupport

Flexible Spending Account (FSA) - EBC

Flexible Spending Accounts (FSAs) are designed to save you money on your taxes. They work in a similar way to a savings account. Each pay period, funds are deducted from your pay on a pre-tax basis and credited to a Health Care and/or Dependent Care FSA. You then use your funds in the applicable account to pay for eligible health care or dependent care expenses.

Account Type	Eligible Expense*	Annual Contribution Limits	Pre-Tax Benefits
Health Care FSA**	Most medical, dental, and vision care expenses that are not covered by your health plan (such as copayments, coinsurance, deductibles, eyeglasses, and doctor-prescribed over-the- counter medications) for you and your dependents. .	Maximum contribution is $3050, (projected to be $3200 for 2024)	Saves on eligible expenses not covered by insurance
Dependent Care FSA	Dependent care expenses (such as daycare, after-school programs, or eldercare programs) so you and your spouse can work or attend school full-time. This account cannot be used for reimbursement of healthcare expenses for dependents.	Maximum contribution in 2024 is $5,000 per year ($2,500 if married and filing separate tax returns)	Reduces your taxable income

* You can obtain a complete list of eligible and ineligible expenses for FSAs at www.irs.gov. Search Forms and Publications (502 for health care plans and 503 for dependent care plans).

** Individuals enrolled in the Health Savings Accounts (HSA) Health Plan are not permitted to elect the Medical FSA.

🔗 The Bestflex Plan FSA Enrollment Guide

Important information about FSAs

Your FSA elections will be in effect from January 1 through December 31. Claims for reimbursement must be submitted by March 31st, 2024. Please plan your contributions carefully. Any money remaining in your account aside from allowed rollover of $610 (projected 2024 rollover of $640) will be forfeited. This is known as the "use it or lose it"* rule, and it is governed by Internal Revenue Service regulations. Note that FSA elections do not automatically continue from year to year. You must actively enroll each year.

Life and Accidental Death & Dismemberment – Lincoln Financial

Basic Life

Berkowitz Pollack Brant Advisors + CPAs provides you with Basic Life and AD&D coverage for all eligible employees at no charge. The benefit level is equal to $10,000.

Voluntary Life Insurance

If you would like additional life insurance, you can purchase voluntary life and AD&D insurance for yourself, a spouse or domestic partner, and your eligible children through Lincoln Financial Group. Evidence of Insurability (EOI) is not required up to the guaranteed issue amount at initial enrollment. Your contribution for this additional benefit will be deducted post-tax from your paycheck. View the chart to the right for monthly voluntary life rates.

A single-child life policy covers all eligible children up to age 19 or 26 if full time student. Voluntary child life insurance is $2.000 monthly per $1,000 of coverage. Voluntary AD&D insurance is $0.020 (employee) and $0.020 (spouse).

MONTHLY VOLUNTARY LIFE CONTRIBUTIONS

Age Bands	**EMPLOYEE** Cost per $1,000 of coverage	**SPOUSE / DP** Cost per $1,000 of coverage
<24	$0.050	$0.050
25 - 29	$0.050	$0.050
30 - 34	$0.050	$0.050
35 - 39	$0.080	$0.080
40 - 44	$0.140	$0.140
45 - 49	$0.210	$0.210
50 - 54	$0.400	$0.400
55 - 59	$0.630	$0.630
60 - 64	$0.660	$0.660
65 - 69	$1.230	$1.230
70 - 74	$2.600	$2.600
75 - 79	$7.680	$7.680
80 +	$16.710	$16.71

Note: Spouse/domestic partner rate is dependent upon employee age as of December 31, 2023.

Berkowitz Pollack Brant Advisors + CPAs Vol Life AD&D Plan Summary

Plan	Coverage	Guaranteed Issue
Voluntary Employee Life and AD&D	Choice of 10,000 increments. Not to exceed 5 times your annual salary. Max amount $500,000	$150,000 at initial enrollment
Spouse/Domestic Partner Life and AD&D	Choice of $10,000 increments. Not to exceed $250,000.	$30,000 at initial enrollment
Child(ren) Life and AD&D	At least six months but under 19 years, or under 26 years if a fulltime student: A flat amount of $10,000. At least 14 days but under six months: $250	N/A

Note: Dependent life insurance cannot exceed 50% of employee voluntary life coverage. You must elect voluntary life insurance to be able to request it for your dependent. Also, if you choose coverage that is higher than the guaranteed amounts, it will be subject to evidence of insurability.

Disability – Lincoln Financial

If you ever become too sick or injured to work, you will receive a portion of your income while you're out so you can focus on getting well.

Voluntary - Short-term disability

Short-Term Disability (STD) coverage begins on the 14th day of an injury or illness and continues up to your recovery or 11 weeks, whichever comes first.

Coverage amount: 60 percent of your eligible earnings, up to a maximum benefit of $1,500 per week.

Your weekly benefit will be reduced by any amount of benefit you receive from other sources of income (i.e., state disability payments, workers' compensation, etc.).

🔗 Berkowitz Pollack Brant Advisors + CPAs Vol Short-Term Disability Plan Summary

Employer Paid - Long-term disability

ELIMINATION PERIOD: 90 calendar days of Disability caused by the same or a related Sickness or Injury, which must be accumulated within a 180-calendar day period. This benefit continues up to age 65 or Social Security normal retirement age, whichever comes first.

Class Descriptions

Class 1: Equity Partner

Class 2: Non-Equity Partners & FT Managers

Class 3: All Other FT Employees

Coverage amount

Class 1 & 2: 60 percent of your monthly salary, up to a maximum monthly benefit of $ $25,000

Class 3: 60 percent of your monthly salary, up to a maximum monthly benefit of $15,000

The Pre-Ex for this is 3/12

Critical Illness Insurance (Post-tax)

Critical Illness Insurance is designed to protect your income and personal assets when your out-of-pocket expenses increase as a result of an illness. Most of us don't plan on the unforeseen expenses associated with serious medical conditions. Critical Illness insurance pays you a lump sum benefit that can be used any way you choose, and benefits are paid in addition to any other coverage you may have.

🔗 Colonial Life Group Critical Illness Brochure

Cancer Insurance (Pre-tax)

How will you pay for what your health insurance won't? If diagnosed with cancer, would you have the money to cover:

● Out-of-network treatments ● Experimental treatments ● Rehabilitation ● Travel expenses to and from treatment centers ● Childcare expenses

Cancer Insurance from Colonial Life & Accident Insurance Company helps guard against financial hardship if you or a loved one is diagnosed with cancer.

Features:

- Helps pay some of the direct and indirect costs related to cancer diagnosis and treatment.
- Helps fill the gaps in your health insurance by helping to pay deductibles and coinsurance.
- Pays an annual benefit for specified cancer screening tests.

🔗 Cancer Level 3 Brochure

🔗 Cancer Level 4 Brochure

Accident Insurance (Pre-tax)

Accidents happen unexpectedly and can be costly if you are financially unprepared. Your medical coverage will help pay for expenses associated with an injury but won't cover all of the out-of-pocket expenses you may face. Accident Insurance, provided by Colonial Life, covers expenses associated with the cost for ER treatment, physician visits, hospitalization, physical therapy, and lodging. The plan covers a wide variety of injuries such as:

- Broken bones
- Eye injuries
- Burns
- Ruptured discs
- Torn ligaments
- Cuts repaired by stitches

🔗 Colonial Life Group Accident Brochure

Medical Bridge (Pre-tax) Hospital Confinement Indemnity Insurance

You may have health insurance… But are you really covered? Colonial Life's Group Medical Bridge Insurance helps fill in the gaps when you have unexpected health care expenses. These benefits are available for you, your spouse and eligible dependent children.

Features:

- Benefits are paid directly to you for hospital confinements, outpatient surgeries, and diagnostic procedures.
- Benefits are paid regardless of any other insurance you many have with other insurance companies.

🔗 Medical Bridge 1.0 Brochure - $1,000

🔗 Medical Bridge 1.0 Brochure - $2,000

Whole life Insurance (Post-tax)

You like to think that you'll be there for your family in the years to come but…

if something happened to you, would your family have the income it needs?

Whole life insurance can help provide protection for you and those who depend on you.

Features:

- Your premiums will never increase because of changes in your health or age
- Plan is Guaranteed Issue up to $18 per week to a maximum benefit of $75,000.

🔗 Whole life Insurance

Key Terms to Know

Brand-Name Drugs: Drugs that have trade names and are protected by patents. Brand-name drugs are generally the costliest choice.

Coinsurance: The percentage of a covered charge paid by the plan.

Copayment (Copay): A flat dollar amount you pay for medical or prescription drug services regardless of the actual amount charged by your doctor or healthcare provider.

Deductible: The annual amount you and your family must pay each year before the plan pays benefits.

Generic Drugs: Generic drugs are less expensive versions of brand-name drugs that have the same intended use, dosage, effects, risks, safety, and strength. The strength and purity of generic medications are strictly regulated by the Federal Food and Drug Administration.

High Deductible Health Plan: A health plan with a high deductible used in conjunction with a health reimbursement account (HRA) or a health savings account (HSA).

Health Reimbursement Account (HRA): A fund you can use to help pay for eligible medical costs that are not covered by your medical plan. Funds are contributed to the HRA by your employer.

Health Savings Account (HSA): A fund you can use to help pay for eligible medical costs that are not covered by your medical plan. Both employers and employees may contribute to this fund; employees do so through pre-tax payroll deductions.

In-Network: Use of a health care provider that participates in the plan's network. When you use providers in the network, you lower your out-of-pocket expenses because the plan pays a higher percentage of covered expenses.

Inpatient: Services provided to an individual during an overnight hospital stay.

Mail-Order Pharmacy: Mail-order pharmacies generally provide a 90-day supply of a prescription medication for the same cost as a 60-day supply at a retail pharmacy, and they offer the convenience of shipping directly to your door.

Out-of-Network: Use of a healthcare provider that does not participate in the plan's network.

Out-of-Pocket Maximum: The maximum amount you and your family pay for eligible expenses each plan year. Once your expenses reach the out-of-pocket maximum, the plan pays 100% of eligible expenses for the remainder of the year.

Outpatient: Services provided to an individual at a hospital facility without an overnight hospital stay.

Primary Care Physician (PCP): A physician (generally a family practitioner, internist, or pediatrician) who provides ongoing medical care. A primary care physician treats a wide variety of health-related conditions and refers patients to specialists, as necessary.

Specialist: A physician who has specialized training in a particular branch of medicine (e.g., a surgeon, gastroenterologist, or neurologist).

Contacts

Below is a list of contacts for your benefits. If you can't find what you need or have questions, please contact HR at 305.960.8857 or submit an inquiry to Gabe Bevilacqua at hrpayrollbenefits@bpbcpa.com.

Plan / Program	Whom to call	Phone Number	Website	Group Number
Client Services	Mary Kreischer	305-948-8887 x 920	marykreischer@worldinsurance.com	
Account Executive	Lissette Calderon	305-964-2931 x 1250	lissettecalderon@worldinsurance.com	
Medical	United Healthcare	UHC 866-633-2446 NHP 844-651-3833	www.myuhc.com	**Grp#922616**
Dental DHMO	Lincoln/Solstice	888-877-7828	www.ldc.lfg.com	Provider Network-Solstice LDCS500B DHMO Grp#40D038755
Dental PPO Low/Dental PPO High	Lincoln Dental Connect	800-423-2765	www.lfg.com	Provider Network for PPO is Lincoln Dental Connect DPPO High Grp#1D038754 DPPO Low Grp# 1D038835
Vision	Lincoln/Spectera Vision	800-638-3120	www.lvc.lfg.com	Provider Network is Spectera Vision Grp#000400248946
Flexible Spending Account	Employee Benefits Corp (EBC)	800-346-2126	www.ebcflex.com	
Employee Assistance program	United Healthcare Supportlinc	UHC: 1-888-887-4114 Supportlinc: 1-888-881-5462	member.uhc.com Supportlinc.com	Group Code: bpbsupport
Life and AD&D	Lincoln Financial	800-423-2765	www.lincoln4benefits.com	Basic Life Grp#10237413 Vol Life Grp# 40237415
Disability STD/LTD	Lincoln Financial	800-423-2765	www.lincoln4benefits.com	STD Grp#10237416 LTD Grp#10237503
Gap Insurance	Transamerica/ Amwins for Customer Service	800-476-4491	www.webtpa.com	Berkowitz Grp#33503 Provenace Grp#34190 Baybridge Grp#34203
Supplemental Insurance	Colonial Life	800-325-4368	www.coloniallife.com	

DISCLOSURES

The following pages outline plan disclosure and additional information, including your rights.

Medicare Part-D

Important Notice 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 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. Prescription drug coverage offered by the **UnitedHealthcare plans** are, 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.

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

Section 125

Under certain circumstances, you may be allowed to make changes to your benefits elections during the plan year, such as additions, deletions and cancellations, depending on whether or not you experience an eligible qualifying event as determined by the Internal Revenue Service (IRS) Code, Section 125. You may change a benefit election upon the occurrence of a valid qualifying event only if the event affects your own, your spouse or your dependent's coverage (including domestic partners) eligibility.

If you experience a qualifying event, you must report the qualifying event to Human Resources Department within 30 days of the event. Beyond 30 days, additions and deletions will be denied and you may be responsible both legally and financially for any claims and/or expenses incurred as a result of any dependent(s) who continued to be enrolled who no longer meet the entity's eligibility requirements.

If approved, most election changes will be effective on the date of the qualifying event for additions; cancellations will be processed at the end of the month.

Payroll deductions for health, dental, vision, and certain supplemental accident insurance premiums, are deducted from your gross income before your income is taxed. The entity's plan is known as a Cafeteria Benefit Plan and is governed by IRS Code, Section 125. This pre-tax benefit means you pay less tax on a per-pay and annual basis.

See examples of Qualifying Life Events for allowable enrollment changes as determined by Section 125 of the IRS Code.

QUALIFYING EVENTS:

- Change is status (for example, employee's legal marital status, number of dependents, employment status, dependent eligibility change, change in residence, or adoption proceedings);
- Significant cost changes
- Significant curtailment of coverage
- Change in coverage under other employer's plan
- Addition or significant improvement of benefit package option
- FMLA leaves of absence
- Loss of group health coverage sponsored by a governmental or educational institution
- COBRA qualifying events
- HIPAA special enrollment events
- Judgement, decree, or court order, such as Qualified Medical Child Support Order (QMCSO)
- Medicare or Medicaid enrollment

HIPAA 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

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Example: You waived coverage because you were covered under a plan offered by your spouse's employer. Your spouse terminates his employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under our health plan.

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 request enrollment within 30 days after the marriage, birth or placement for adoption.

Example: When you were hired by us, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this group health plan. However, you must apply within 30 days from the date of your marriage.

MEDICAID OR CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired by us, your children received health coverage under CHIP, and you did not enroll them in our health plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this group health plan if you apply within 60 days of the date of their loss of CHIP coverage.

For More Information or Assistance

To request special enrollment or obtain more information, please contact your Human Resources department.

NMHPA / WHCRA

NEWBORNS' AND MOTHER'S HEALTH PROTECTION ACT

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT Enrollment Notice

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.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply:

UnitedHealthcare	CRWA-M (NHP HMO OA) Rx: NH42	DB8X-M (UHC Choice Plus) Rx: D00	DB6G-M (UHC Choice Plus-HSA) Rx: 570-HSA-M	BWMD (UHC Choice Plus) Rx: 560
Individual	$5,000	$5,000	$4,000	$5,000
Family	$10,000	$10,000	$8,000	$10,000
Co-insurance	100%	100%	100%	70%

If you would like more information on WHCRA benefits, call your plan administrator.

WOMEN'S HEALTH AND CANCER RIGHTS ACT Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator for more information.

Premium Assistance Under Medicaid/CHIP

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

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

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

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

If you live in one of the participating states, you may be eligible for assistance paying your employer health plan premiums. Follow the link below for a complete list of contact information by state.

Please visit https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/chipra/model-notice.pdf

COBRA Continuation Coverage Rights

INTRODUCTION

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you 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. You can learn more about many of these options at www.healthcare.gov.

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 below. 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.

Employee:	• Your hours of employment are reduced, or • Your employment ends for any reason other than your gross misconduct
Spouse* of Employee:	• 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 (or formally terminate your domestic partnership)
Dependent Child of Employee:	• The parent-employee dies; • The parent-employee's hours of employment are reduced; • The parent-employee's employment ends for any reason other than his or her gross misconduct; • The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both); • The parents become divorced or legally separated; or • The child stops being eligible for coverage under the Plan as a "dependent child."

* Spouse also refers to domestic partner. Divorce or legal separation does not apply.

When is COBRA coverage available?

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

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).
- If the plan has retirement coverage: Commencement of a proceeding in bankruptcy with respect to the employer

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. You must provide this notice to your human resources department.

Keep your plan informed of address changes.

COBRA Continuation Coverage Rights

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

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.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

The month after your employment ends; or the month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

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 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.

NOTES

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