BERNAU CAPITAL PARTNERS

Arona Corporation
Aterra Real Estate
Endurance Sports Marketing
First Iowa Title
Globe Acceptance
Ivy Lane Corporation dba Valvoline
Hickory Park

2023 Benefit Summary
Semi-Monthly Deductions

CHIP NOTICE

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 on the following page, 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, dial **1-877-KIDS NOW**, or visit **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 a state listed below, you may be eligible for assistance paying your employer health plan premiums. The list of states is current as of July 31, 2022. Contact your State for further information on eligibility.

To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, ext. 61565

State	Website/E-mail	Phone
Alabama (Medicaid)	**http://www.myalhipp.com/**	1-855-692-5447
Alaska (Medicaid)	*Premium Payment Program:* **http://myakhipp.com/** *Medicaid Eligibility:* **https://health.alaska.gov/dpa/Pages/default.aspx** ***E-mail:*** **CustomerService@MyAKHIPP.com**	*1-866-251-4861*
Arkansas (Medicaid)	**http://myarhipp.com/**	1-855-692-7447
California (Medicaid)	**http://dhcs.ca.gov/hipp** **hipp@dhcs.ca.gov**	916-445-8322 916-440-5676 (fax)
Colorado (Medicaid and CHIP)	*Medicaid:* **https://www.healthfirstcolorado.com/** *CHIP:* **https://www.colorado.gov/pacific/hcpf/child-health-plan-plus** *HIBI:* **https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program**	1-800-221-3943 1-800-359-1991 1-855-692-6442 State relay 711

State	Website/E-mail	Phone
Florida (Medicaid)	**https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html**	1-877-357-3268
Georgia (Medicaid)	*HIPP:* **https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp** *CHIPRA:* **https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra**	678-564-1162, press 1 678-564-1162, press 2
Indiana (Medicaid)	***Healthy Indiana Plan for low-income adults 19-64:*** **http://www.in.gov/fssa/hip/** ***All other Medicaid:*** **https://www.in.gov/medicaid**	1-877-438-4479 1-800-457-4584
Iowa (Medicaid and CHIP)	*Medicaid:* **https://dhs.iowa.gov/ime/members** *CHIP:* **http://dhs.iowa.gov/Hawki** ***HIPP:*** **https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp**	1-800-338-8366 1-800-257-8563 1-888-346-9562
Kansas (Medicaid)	**https://www.kancare.ks.gov/**	1-800-792-4884
Kentucky (Medicaid and CHIP)	*Medicaid:* **https://chfs.ky.gov** ***KI-HIPP:*** **https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.apsx** ***KI-HIPP E-mail:*** **KIHIPP.PROGRAM@ky.gov** ***KCHIP:*** **https://kidshealth.ky.gov/Pages/index.aspx**	1-855-459-6328 1-877-524-4718
Louisiana (Medicaid)	**www.medicaid.la.gov** **www.ldh.la.gov/lahipp**	1-888-342-6207 1-855-618-5488
Maine (Medicaid)	**https://www.maine.gov/dhhs/ofi/applications-forms**	*Enroll:* 1-800-442-6003 *Private HIP:* 1-800-977-6740 TTY: Maine relay 711
Massachusetts (Medicaid and CHIP)	**https://www.mass.gov/masshealth/pa**	1-800-862-4840 TTY: 617-886-8102
Minnesota (Medicaid)	**https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp**	1-800-657-3739
Missouri (Medicaid)	**http://www.dss.mo.gov/mhd/participants/pages/hipp.htm**	573-751-2005
Montana (Medicaid)	**http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP** **HHSHIPPProgram@mt.gov**	1-800-694-3084
Nebraska (Medicaid)	**http://www.ACCESSNebraska.ne.gov**	1-855-632-7633 *Lincoln:* 402-473-7000 *Omaha:* 402-595-1178
Nevada (Medicaid)	**http://dhcfp.nv.gov/**	1-800-992-0900
New Hampshire (Medicaid)	**https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program**	603-271-5218 or 1-800-852-3345, ext. 5218
New Jersey (Medicaid and CHIP)	*Medicaid:* **http://www.state.nj.us/humanservices/dmahs/clients/medicaid/** *CHIP:* **http://www.njfamilycare.org/index.html**	*Medicaid:* 609-631-2392 *CHIP:* 1-800-701-0710
New York (Medicaid)	**https://www.health.ny.gov/health_care/medicaid/**	1-800-541-2831
North Carolina (Medicaid)	**https://medicaid.ncdhhs.gov/**	919-855-4100
North Dakota (Medicaid)	**http://www.nd.gov/dhs/services/medicalserv/medicaid/**	1-844-854-4825
Oklahoma (Medicaid and CHIP)	**http://www.insureoklahoma.org**	1-888-365-3742
Oregon (Medicaid)	**http://healthcare.oregon.gov/Pages/index.aspx** **http://www.oregonhealthcare.gov/index-es.html**	1-800-699-9075
Pennsylvania (Medicaid)	**https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx**	1-800-692-7462
Rhode Island (Medicaid and CHIP)	**http://www.eohhs.ri.gov/**	1-855-697-4347 or 401-462-0311 (Direct RIte)
South Carolina (Medicaid)	**https://www.scdhhs.gov**	1-888-549-0820
South Dakota (Medicaid)	**http://dss.sd.gov**	1-888-828-0059
Texas (Medicaid)	**http://gethipptexas.com/**	1-800-440-0493
Utah (Medicaid and CHIP)	*Medicaid:* **https://medicaid.utah.gov/** *CHIP:* **http://health.utah.gov/chip**	1-877-543-7669
Vermont (Medicaid)	**http://www.greenmountaincare.org/**	1-800-250-8427
Virginia (Medicaid and CHIP)	**https://www.coverva.org/en/famis-select** **https://www.coverva.org/en/hipp**	1-800-432-5924
Washington (Medicaid)	**https://www.hca.wa.gov/**	1-800-562-3022
West Virginia (Medicaid)	**https://dhhr.wv.gov/bms/** **http://mywvhipp.com/**	*Medicaid:* 304-558-1700 *CHIP:* 1-855-699-8447
Wisconsin (Medicaid and CHIP)	**https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm**	1-800-362-3002
Wyoming (Medicaid)	**https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/**	1-800-251-1269

IMPORTANT CONTACTS

Benefit	Carrier	Phone Number	Website/E-mail
Medical and Prescription	Wellmark BCBS	(800) 524-9242	www.wellmark.com
Dental	MetLife	(800) 942-0854	www.metlife.com
Vision	Avesis	(800) 828-9341	www.avesis.com
Life & Disability	MetLife	(800) 858-6506	www.metlife.com
Critical Illness & Accident	MetLife	(855) 564-6638	www.metlife.com
Identity Theft	LifeLock	(866) 917-2555	https://members.excelsiorenroll.com/arona/
Holmes Murphy	Contacts: Alesha Wilhite Mattie Raygor	(515) 518-2360 (515) 381-7441	awilhite@holmesmurphy.com mraygor@holmesmurphy.com

This guide highlights the main features of many of the benefit plans sponsored by The Company. Full details of these plans are contained in the legal documents governing the plans. If there is any discrepancy between the plan documents and the information described here, the plan documents will govern. In all cases, the plan documents are the exclusive source for determining rights and benefits under the plans. Participation in the plans does not constitute an employment contract. The Company reserves the right to modify, amend or terminate any benefit plan or practice described in this guide. Nothing in this guide guarantees that any new plan provisions will continue in effect for any period of time. This guide serves as a summary of material modifications as required by the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

WHO IS ELIGIBLE

You are eligible to enroll in The Company's benefit plans if you are a regular, full-time employee scheduled to work at least 30 hours per week. As a regular, full-time employee, you are eligible for benefits on the first day of the month following 60 days of continuous service.

Dependent Eligibility

You may also cover your eligible dependents, including:

- Your legal spouse.
- Your eligible children up to age 26 for medical coverage; your unmarried, eligible children up to age 25 for dental and vision coverage.
- "Children" are defined as your natural children, stepchildren, legally-adopted children, and children for whom you are the court-appointed legal guardian.
- Physically or mentally disabled children of any age who are incapable of self-support. Proof of disability may be requested.

WHEN COVERAGE BEGINS

Initial Enrollment

When you first join The Company, you have 60 days to enroll yourself and your dependents for benefits. Coverage begins the first of the month following 60 days of employment.

If you fail to enroll in benefits when you are first eligible, you will automatically be enrolled in the Company Sponsored benefits. You will not be able to enroll in any other benefits until the next Annual Enrollment Period.

Annual Open Enrollment

During annual Open Enrollment, coverage takes effect on January 1 of the following year.

You will need to enroll in coverage on the Oasis portal. This is the same website you will use to access your pay stubs and W2 information. If you have misplaced your username or password, call (800) 336-1931 and select option 3.

Website:
https://portal.oasisassistant.com

MAKING CHANGES TO COVERAGE

Once you make your benefit elections, these choices remain in effect until the next annual Open Enrollment unless you have a qualified status change or you or your eligible dependents become eligible for coverage through special enrollment rules.

If you have a qualified status change or you have another allowable event, you can make certain changes during the plan year. However, you must make your enrollment change within 31 days of the event by completing a Benefit Changes/Enrollment form and returning it to Human Resources. If you do not return your form within 31 days, you will have to wait until the next Open Enrollment to make new elections.

2023 SEMI-MONTHLY PREMIUMS

Coverage	Semi-Monthly Deduction
Wellmark $2,000 PPO	
Single	$145.43
Employee/Spouse	$382.79
Employee/Child(ren)	$336.22
Family	$634.53
Wellmark $2,000 HMO – Iowa Only	
Single	$111.73
Employee/Spouse	$313.76
Employee/Child(ren)	$272.42
Family	$531.09
Wellmark $5,000 PPO with Copays	
Single	$29.82
Employee/Spouse	$297.48
Employee/Child(ren)	$256.04
Family	$420.42
Wellmark $5,000 HMO with Copays – Iowa Only	
Single	$13.33
Employee/Spouse	$238.11
Employee/Child(ren)	$201.17
Family	$343.95
Wellmark $5,000 HDHP PPO	
Single	$32.64
Employee/Spouse	$248.34
Employee/Child(ren)	$214.22
Family	$338.11
Dental	
Single	$14.86
Employee/Spouse	$31.09
Employee/Child(ren)	$34.95
Family	$54.90
Vision	
Single	$3.44
Employee/Spouse	$6.64
Employee/Child(ren)	$6.64
Family	$9.72
Voluntary Life & STD	100%
Basic Life & LTD	Company Paid
Flexible Spending Account & Health Savings Account	100%
Other Voluntary Benefits	100%

MEDICAL PLAN – WELLMARK BCBS

All plan options provide coverage for the same types of expenses, such as doctor's office visits, preventive care, prescription drugs, and hospitalization. You choose the option that makes the most sense for you and your family based on your needs and what you want to pay for coverage.

Choosing a Medical Option

When it comes to medical coverage The Company offers, you have these choices:

- $2,000 PPO Plan
- $2,000 HMO Plan ***(Iowa Employees Only)***
- $5,000 PPO Plan
- $5,000 HMO Plan ***(Iowa Employees Only)***
- $5,000 High Deductible Health Plan (HDHP)

Preferred Provider Organizations (PPO)

The PPO plans offer in-network and out-of-network benefits. When you need care, you decide whether to go to an in-network or an out-of-network provider. If you receive care from in-network doctors and facilities, your out-of-pocket costs will be lower than if you use out-of-network providers and facilities because network providers discount their fees. And, with in-network providers, you generally do not have to file claims.

If you choose to receive care from an out-of-network provider, the medical plan pays a lower benefit and you must file a claim to receive reimbursement for covered expenses.

High Deductible Health Plan

The High Deductible Health Plan (HDHP) works much like the PPO plan in that you can choose to receive care from in-network or out-of-network providers when you need medical care — and it covers the same types of services — but you pay less out of your paycheck for coverage. However, the HDHP has higher deductibles and no office visit copays. Once you've met the in-network or out-of-network deductible, you and the plan begin sharing expenses. Your portion of the expense is the coinsurance. **This also applies to prescription drugs, which are subject to the plan's deductibles. Once the deductible is met, you pay the applicable prescription drug cost or copay amount.**

In addition, the HDHP offers a tax-savings feature called the Health Savings Account (HSA). With this account, you can pay for certain out-of-pocket medical expenses throughout the year.

Health Maintenance Organization (HMO)

The $2,000 HMO $5,000 HMO plans are only available to employees who reside and seek medical care in the state of Iowa. There are no in-network providers outside of the states of Iowa & South Dakota. If you seek care from an out-of-network provider, you will not have coverage for those services. Life & limb threatening emergencies can be billed as in-network claims and would be paid the same as an in-network Emergency Room visit. This plan requires that you designate a Primary Care Physician.

To find a provider, visit www.wellmark.com and click "Find a Provider". You can enter your location, network, and search criteria to find a provider that is in-network.

**To find a provider, visit www.wellmark.com or log into your myWellmark account.
Click on find a provider and enter your location, network, and search criteria.**

MEDICAL PLAN COMPARISON

	$2,000 PPO	$2,000 HMO Iowa Only	$5,000 PPO	$5,000 HMO Iowa Only	$5,000 HDHP
In-Network					
Deductible[1,2]	Embedded	Embedded	Embedded	Embedded	Embedded
Individual	$2,000	$2,000	$5,000	$5,000	$5,000
Family	$4,000	$4,000	$10,000	$10,000	$10,000
Out-of-Pocket Maximum[1]					
Individual	$6,000	$6,000	$5,000	$5,000	$5,000
Family	$12,000	$12,000	$10,000	$10,000	$10,000
You Pay					
Coinsurance	20%	20%	0%	0%	0%
Preventive Care	No Charge	No Charge	No Charge	No Charge	No Charge
Doctor on Demand	$25 Copay	$25 Copay	$25 Copay	$25 Copay	$59 Charge
Primary Care	$25 Copay	$25 Copay	$25 Copay	$25 Copay	Deductible
Specialist	$50 Copay	$50 Copay	$50 Copay	$50 Copay	Deductible
Urgent Care	$25 Copay	$25 Copay	$25 Copay	$25 Copay	Deductible
Emergency Room	$300 Copay	$300 Copay	$300 Copay	$300 Copay	Deductible
Inpatient Hospital	Deductible, 20%	Deductible, 20%	Deductible	Deductible	Deductible
Outpatient Surgery	Deductible, 20%	Deductible, 20%	Deductible	Deductible	Deductible
Out-of-Network					
Deductible[1,2]					
Individual	$2,500	Not Covered	$6,000	Not Covered	$5,000
Family	$5,000	Not Covered	$12,000	Not Covered	$10,000
Out-of-Pocket Maximum[1]					
Individual	$6,000	Not Covered	$10,000	Not Covered	$10,000
Family	$12,000	Not Covered	$20,000	Not Covered	$20,000
Coinsurance	30%	Not Covered	30%	Not Covered	30%

(1) In and out-of-network deductibles and out-of-pocket maximums do not apply to each other.
(2) Member has benefits when single deductible is met regardless of coverage tier.

PRESCRIPTION DRUG COVERAGE - CVS

If you enroll in one of the Company medical plans, you will automatically receive prescription drug coverage. When you need prescriptions, you can purchase them through a local retail pharmacy or, for medications you take on an ongoing basis, through the mail order program.

Your formulary is the Wellmark Blue Rx Value Plus formulary.

Retail Prescription Program

The retail prescription program uses a network of participating pharmacies. To receive the highest level of benefits, you must use a participating pharmacy. Prescriptions you fill at non-participating pharmacies are generally not covered.

Mail Order Program

The mail order program offers a convenient and cost-effective way to fill prescriptions for medications you take on a regular basis (maintenance medications). When you use the mail order program, you receive a 3-month supply of medication. Your medications are mailed directly to your home. To order prescriptions through the mail order program, you must fill out a mail order form and return it with a 90-day prescription from your doctor and your payment. Mail order forms are available through CVS.

Specialty Prescription Program

If you have a chronic condition and take specialty medications, you must purchase these through a designated specialty pharmacy that provides the best available pricing and additional support. If you have a prescription that meets this requirement, BCBS will contact you and provide you with the necessary information to fill your prescription.

Prescription Drug Plan Highlights

	$2,000 PPO	$2,000 HMO	$5,000 PPO	$5,000 HMO	$5,000 HDHP
Retail Prescription Copays (up to 31-day supply)					
Rx Deductible	$100 Single / $300 Family				None
Tier 1 (deductible waived)	$10 Copay				Deductible
Tier 2	$30 Copay				Deductible
Tier 3	$50 Copay				Deductible
Specialty Preferred	$100 Copay				Deductible
Specialty Non-Preferred	50% Coinsurance				Deductible

HEALTH SAVINGS ACCOUNT - PAYCHEX

What's a Health Savings Account?

A Health Savings Account (HSA) is a tax-free account that earns interest. You can set up an HSA and make contributions to your account from your paychecks throughout the year. Then, you can use the HSA to pay for eligible health care expenses, such as deductibles, coinsurance, and other out-of-pocket dental, vision, and prescription drug expenses not covered by a health plan. Your account balance can carry over from year to year, and you can take it with you if you leave the company.

The IRS sets maximum limits for Health Savings Accounts. Below are the maximum limits for 2022.

Coverage Level	Total HSA Contribution Allowed Per Year
Employee Only	$3,850
Employee + Family	$7,750
Catch-Up for Age 55+	$1,000 annually

Who Is Eligible for the HSA?

You can participate in the HSA only if you enroll in the HDHP. You are not eligible to contribute if:

- You are enrolled in Medicare.
- You are covered by another medical plan (such as your spouse's plan) that does not qualify as a high deductible health plan.
- You or your spouse participates in a Health Care Flexible Spending Account (FSA) (through your employer or at your spouse's employer.)

How to Use the HSA to Pay for Care

Once you've set up your HSA, you will receive a debit card specifically for your account. Then, when you have an eligible expense, you have several choices for how to pay:

1. **Pay with your HSA debit card** if you have funds available in your account.
2. **Write a check from your HSA.** You must order checks when you enroll in the HSA to have this option. And, as with any other type of check, you must have funds available or the check will be returned — and you will be charged an insufficient funds fee.
3. **Pay for expenses out of your own pocket**, and then reimburse yourself from your HSA.

What are the Advantages of an HSA?

- Monies go in tax-free
- Monies grow tax-free if you choose to invest your HSA dollars
- Monies come out tax-free as long as they are used to pay for qualified medical expenses (including things like dental and vision expenses)
- Unspent monies roll over year to year
- The account owner (you!) decides whether to use the HSA dollars for current expenses, or to save them for future expenses
- You take the account with you

DENTAL PLAN - METLIFE

The Dental Plan provides you and your family with coverage for typical dental expenses, such as cleanings, X-rays, fillings, and orthodontia for children.

The Dental PPO allows you the freedom to visit any dentist, without referrals, for all of your dental care. If you receive care from an in-network dentist, you'll pay less for your care. If you choose a non-preferred dentist, your share of costs will generally be higher and you may need to file your own claims.

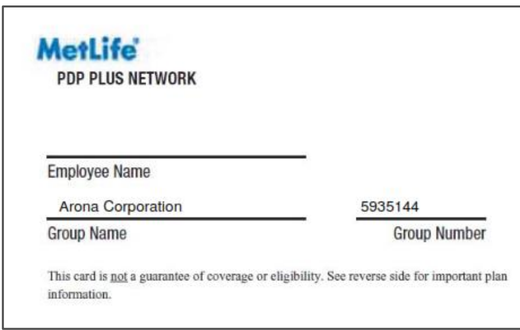
For a list of MetLife preferred dentists, go to **www.metlife.com**.

DENTAL PLAN HIGHLIGHTS

Plan Feature	Premium Plan – PPO
Annual Deductible Individual Family	 $50 $150
Annual Benefit Maximum	$2,000/person
Preventive Services (Exams, routine cleanings, fluoride treatments, space maintainers)	Deductible waived, covered at 100%
Basic Services (X-rays, fillings, sealants, denture repairs)	Deductible, 20% coinsurance
Major Services (Crowns, inlays, onlays, bridges, dentures)	Deductible, 50% coinsurance
Orthodontia – children up to age 19	50% coinsurance up to lifetime maximum of $1,000 per dependent child

Out-of-Network benefits are reimbursed based on Reasonable & Customary charge. Reasonable & Customary is based on the lowest the dentist's actual charge or charge of most dentists in the area for the same or similar services.

DENTAL ID CARD – METLIFE DOES NOT MAIL ID CARDS TO YOUR HOME



VISION PLAN - AVESIS

The Vision Plan promotes preventive care through regular eye exams and provides coverage for corrective materials, such as glasses and contact lenses.

If you enroll in vision coverage, you can go to any eye care provider you choose for care. However, if you choose providers who are part of the Avesis network, you will receive a discount on services. To find a network provider, go to www.avesis.com

The Vision Plan is designed to cover eye care needs that are visually necessary. You have to pay extra if you choose certain cosmetic or elective eyewear, so be sure to ask your eye doctor what items are covered by the plan before you purchase materials.

VISION PLAN HIGHLIGHTS

	In-Network	Out-of-Network
Plan Feature	**You Pay**	**Reimbursement**
Exam	$10 copayment	Reimbursed up to $45
Prescription Glasses Benefits		
Single Lenses	$10 copayment	Reimbursed up to $30
Bifocals – Lined	$10 copayment	Reimbursed up to $50
Trifocals – Lined	$10 copayment	Reimbursed up to $65
Frames	$50 Wholesale Allowance	Reimbursed up to $70
Contact Benefits		
Elective Contacts	Reimbursed up to $130	Reimbursed up to $105
Medically Necessary Contacts	$10 copayment	Reimbursed up to $210
Benefit Frequency		
Exam	Vision Exam every 12 months	
Frames	Frames every 24 months	
Lenses	Spectacle Lenses every 12 months	
Contacts	Contact Lenses every 12 months	

BASIC LIFE & AD&D INSURANCE - METLIFE

The Company offers life and accidental death and dismemberment insurance coverage to provide financial protection in the event you or your dependents pass away while you are still working.

The Company automatically provides Basic Life Insurance and Accidental Death and Dismemberment for all eligible employees at no cost. Basic Life Insurance is a flat benefit of $15,000 for all employees. The benefit is paid to your beneficiaries in the event of your death. AD&D is paid if you pass away or are dismembered due to an accident.

VOLUNTARY LIFE & AD&D COVERAGE - METLIFE

In addition to Basic Life/AD&D Insurance, you may also purchase Optional Life/AD&D Insurance for you and your eligible dependents. You pay for this coverage on a post-tax basis through payroll deductions. If you waive coverage when you are first eligible, future elections will be subject to Evidence of Insurability and must be approved by the carrier.

Rates can be found by logging into Oasis.

Beneficiary Designation

You must designate a beneficiary for Basic Life & Voluntary Life Insurance benefits when you enroll. Your “beneficiary” is the person(s) who will receive the benefits from your Life and AD&D coverage in the event of your death. You can change your beneficiaries at any time during the year.

If you do not name a beneficiary, or if your beneficiary dies before you, your Life and AD&D benefits will be paid to your estate.

You are automatically the beneficiary for policies purchased on your spouse or children.

Benefits Reduce at Age 65

When you reach age 65, Basic & Voluntary Life Insurance benefits are reduced to 65% of the original face value of the policy. Once you reach age 70, benefits are reduced to 50% of the original face value of the policy. For more information, refer to your Group Life Insurance booklet.

If you terminate employment, you have the option to port or convert your coverage if you apply with MetLife within 31 days of termination.

Optional Life Insurance Coverage

Coverage For	Coverage Available	Guarantee Issue Amounts[1]
Employee	Up to 5x salary; $10,000 increments up to a maximum of $500,000	$100,000
Spouse	$5,000 increments up to a maximum of $100,000	$25,000
Child(ren)	$1,000 increments up to a maximum of $10,000	All Amounts

Monthly Cost per $1,000 of Life/A&D	
Age <30	$0.092
30-34	$0.101
35-39	$0.112
40-44	$0.154
45-49	$0.227
50-54	$0.343
55-59	$0.520
60-64	$0.760
65-69	$1.273
70+	$2.380
Child	$0.288

(1) Employees and spouses are eligible for amounts up to the guaranteed issue amount if cove... e. If you waive coverage as a new hire, any amounts elected in the future will be subject to Evidence of Insurability and must be approved by the carrier.

DISABILITY COVERAGE - METLIFE

The Company offers you two disability plans that work together to keep all or part of your paycheck coming if you cannot work because of illness, injury, or pregnancy.

Short-Term and Long-Term Disability have a pre-existing condition waiting period of 3/12. This means if you have been treated for or diagnosed with a medical condition within 3 months of your effective date, benefits are not payable for that condition for a period of 12 months.

Voluntary Short-Term Disability

Voluntary Short-Term Disability (STD) benefits are paid for through payroll deduction and you pay 100% of the cost if you choose to enroll. Your STD benefits will replace 60% of your base pay, up to $1,000 per week. Your STD benefits begin on the 8th calendar day of your disability if you are unable to work. The maximum benefit available is 26 weeks per STD claim.

To determine your monthly premium, refer to the chart below. The maximum benefit amount cannot exceed 60% of your gross weekly earnings or $1,000, whichever is less (rounded down to the nearest $50).

Weekly Benefit	Employee's Age								
	<30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+
$100	$4.89	$4.89	$4.89	$4.89	$5.87	$7.47	$10.49	$12.53	$13.42
$150	$7.34	$7.34	$7.34	$7.34	$8.80	$11.20	$15.74	$18.80	$20.13
$200	$9.78	$9.78	$9.78	$9.78	$11.74	$14.94	$20.98	$25.06	$26.84
$250	$12.22	$12.22	$12.22	$12.22	$14.68	$18.68	$26.22	$31.32	$33.55
$300	$14.67	$14.67	$14.67	$14.67	$17.61	$22.41	$31.47	$37.59	$40.26
$350	$17.12	$17.12	$17.12	$17.12	$20.54	$26.14	$36.72	$43.86	$46.97
$400	$19.56	$19.56	$19.56	$19.56	$23.48	$29.88	$41.96	$50.12	$53.68
$450	$22.00	$22.00	$22.00	$22.00	$26.42	$33.62	$47.20	$56.38	$60.39
$500	$24.45	$24.45	$24.45	$24.45	$29.35	$37.35	$52.45	$62.65	$67.10
$550	$26.90	$26.90	$26.90	$26.90	$32.28	$41.08	$57.70	$68.92	$73.81
$600	$29.34	$29.34	$29.34	$29.34	$35.22	$44.82	$62.94	$75.18	$80.52
$650	$31.78	$31.78	$31.78	$31.78	$38.16	$48.56	$68.18	$81.44	$87.23
$700	$34.23	$34.23	$34.23	$34.23	$41.09	$52.29	$73.43	$87.71	$93.94
$750	$36.68	$36.68	$36.68	$36.68	$44.02	$56.02	$78.68	$93.98	$100.65
$800	$39.12	$39.12	$39.12	$39.12	$46.96	$59.76	$83.92	$100.24	$107.36
$850	$41.56	$41.56	$41.56	$41.56	$49.90	$63.50	$89.16	$106.50	$114.07
$900	$44.01	$44.01	$44.01	$44.01	$52.83	$67.23	$94.41	$112.77	$120.78
$950	$46.46	$46.46	$46.46	$46.46	$55.76	$70.96	$99.66	$119.04	$127.49
$1,000	$48.90	$48.90	$48.90	$48.90	$58.70	$74.70	$104.90	$125.30	$134.20

If you waive coverage when you are first eligible, you are limited to electing $100 in coverage at future enrollment periods. you may increase your election by $50 per enrollment period after that.

Long-Term Disability

If you remain totally disabled and unable to work for more than 26 weeks, you may be eligible for Long-Term Disability (LTD) benefits. The Company automatically provides you LTD benefits that replace up to 60% of your base pay, up to a maximum of $5,000 per month. Your monthly LTD benefit will be reduced by Social Security and any other disability income you are eligible to receive (such as Workers' Compensation).

You can continue to receive LTD benefits for up to a period of 24 months if you are unable to work in your own occupation. After 24 months, you may continue receiving LTD benefits if you are unable to work in any occupation.

FLEXIBLE SPENDING ACCOUNTS - PAYCHEX

The Company allows you to contribute to one or both Flexible Spending Accounts (FSAs), which allow you to save taxes on certain out-of-pocket health care and dependent care expenses.

How the FSAs Work

The Company offers two types of FSAs:

- Health Care FSA
- Dependent Care FSA

If you elect to contribute to one or both of the FSAs, you choose an annual amount to be taken from each of your paychecks and deposited into your account throughout the year. Your contributions are taken out of your paycheck before you pay taxes, so you save money. Then, when you have eligible health care or dependent care expenses, you can use the account to reimburse yourself, up to the amount you have elected to contribute to your account for the year.

With both accounts, the IRS requires you to use all of the money in your account by the end of the year or you lose it. This is called the "use it or lose it" rule.

The Company FSA plan allows a 2.5 month extension of time at the end of the 12 month plan year in which you may continue to incur eligible expenses and submit them for reimbursement. After 2.5 months, you will forfeit any money that remains in the account.

Annual Contribution Amount

You can contribute up to **$3,050 per year** to the Health Care FSA.

Health Care FSA

You can use the Health Care FSA to pay for eligible out-of-pocket expenses. Examples include, but are not limited to:

- Medical or dental deductibles
- Office visit copays
- Coinsurance amounts
- Amounts you pay for prescription drugs
- Amounts you pay for certain over-the-counter items
- Eyeglasses, contacts, and other vision-related expenses not covered by the vision plan
- Orthodontia expenses not covered by the dental plan

How the Debit Card Works

If you enroll in the Health Care FSA, you will receive a debit card.

You can use your debit card at certain places to pay for eligible expenses up-front, such as prescription drugs and office visit copays, without having to pay with cash and wait for a reimbursement. **You will need to submit your receipts as substantiation of your expense, so it's important to keep them.**

If you choose not to use your debit card, you can always pay for your eligible expense and file a claim for reimbursement.

If you enroll in the High Deductible Health Plan for medical coverage, which has a Health Savings Account (HSA), you cannot enroll in the Health Care FSA.

Dependent Care FSA

The Dependent Care FSA helps you afford day care for your children under age 13 or for a disabled dependent. There are some special rules for participating in this account:

- The day care expenses must be necessary so you can work.
- You can only be reimbursed for expenses incurred during the plan year.
- If you are married, your spouse must be employed, a full-time student at least five months during the plan year, or mentally or physically disabled and unable to provide care for himself or herself.
- For the Dependent Care FSA, you may only be reimbursed up to the amount in your account at the time you file a claim. If your eligible expenses are greater than the amount in your account, the unreimbursed amount will carry over and be reimbursed after your next deposit. (For the Health Care FSA, you can be reimbursed up to the full amount you have elected to contribute for the year — even if you have not yet contributed that much to your account.)
- If you use the Dependent Care FSA, you must provide your caregiver's Social Security number or tax ID when you file a claim for reimbursement.
- The Health Care FSA and the Dependent Care FSA are separate accounts. You cannot use funds from one account to pay for expenses of the other. You also cannot transfer funds between the two accounts.

In some cases, a federal child-tax credit may save you more money than the Dependent Care FSA. You may want to consult a tax advisor to find which option is better for you.

Eligible Dependent Care Expenses

Generally, you may use the money in your Dependent Care FSA for care for:

- Your children under age 13 whom you claim as a dependent for tax purposes.
- Other dependents of any age who are mentally or physically disabled and whom you claim as a dependent for tax purposes (spouses and dependents age 13 and older must spend at least eight hours a day in your home if you are reimbursing yourself for services provided outside the home).

Some typical expenses that are eligible for reimbursement under the plan are:

- Licensed nursery school and day care centers for children
- Licensed day care centers for disabled dependents
- Services from a care provider over the age of 19 (inside or outside the home)
- Day camps
- After-school care

Annual Contribution Amount

You can contribute up to **$5,000 per year** to the Dependent Care FSA. If you are married and you and your spouse file separate tax returns, the maximum you can contribute is $2,500.

OTHER VOLUNTARY BENEFITS – METLIFE & LIFELOCK

Critical Illness Coverage

The Company provides Critical Illness insurance that you can purchase through MetLife. The cost of this coverage is paid for through post-tax payroll deduction and is 100% paid by you.

Employee's can purchase a flat benefit amount of $15,000 or $30,000 which would be paid to you in a lump sum if you were to be diagnosed with a covered Critical Illness. Benefits can also be purchased for your spouse and children. More information can be found on the Plan Summary page that follows.

Accident Coverage

The company provides two Accident plans that you can purchase through MetLife. The cost of this coverage is paid for through post-tax payroll deduction and is 100% paid by you.

You have the option of purchasing the High Plan or the Low Plan. Both plans pay you based on a schedule of benefits when you are injured in an accident. The High Plan is more expensive, but pays a higher benefit when you are injured or receive treatment due to an accident. The Low Plan is the cheaper option, but pays a lesser benefit at the time of a claim. You can choose to cover yourself, your spouse, and your children.

LifeLock Identity Theft Protection

You also have the option to enroll in Identity Theft Protection through LifeLock. There are two options for you to enroll in – standard identity theft protection or LifeLock Ultimate, which is a comprehensive identity protection service. More information on the options available through LifeLock can be found late in the packet.

MetLife Critical Illness Insurance Plan Summary

COVERAGE OPTIONS

Critical Illness Insurance		
Eligible Individual	**Initial Benefit**	**Requirements**
Employee	**Initial Benefit Amount of $15,000 or $30,000**	Coverage is guaranteed provided you are actively at work.[3]
Spouse	**100% of the employee's Initial Benefit**	Coverage is guaranteed provided the employee is actively at work and the spouse/domestic partner is not subject to a medical restriction as set forth on the enrollment form and in the Certificate.[3]
Dependent Child(ren)[2*]	**100% of the employee's Initial Benefit**	Coverage is guaranteed provided the employee is actively at work and the dependent is not subject to a medical restriction as set forth on the enrollment form and in the Certificate.[3]

BENEFIT PAYMENT

Your **Initial Benefit** provides a lump-sum payment upon the first diagnosis of a Covered Condition. Your plan pays a Recurrence Benefit[4] equal to the Initial Benefit for the following Covered Conditions: Heart Attack, Stroke, Coronary Artery Bypass Graft, Full Benefit Cancer and Partial Benefit Cancer. A Recurrence Benefit is only available if an Initial Benefit has been paid for the Covered Condition. There is a Benefit Suspension Period between Recurrences.

The maximum amount that you can receive through your Critical Illness Insurance plan is called the **Total Benefit** and is [3] times the amount of your Initial Benefit.

Please refer to the table below for the percentage benefit amount for each Covered Condition.

Covered Conditions	Initial Benefit	Recurrence Benefit
Full Benefit Cancer[5]	100% of Initial Benefit	100% of Initial Benefit
Partial Benefit Cancer[5]	25% of Initial Benefit	25% of Initial Benefit
Heart Attack	100% of Initial Benefit	100% of Initial Benefit
Stroke[5]	100% of Initial Benefit	100% of Initial Benefit
Coronary Artery Bypass Graft[6]	100% of Initial Benefit	100% of Initial Benefit
Kidney Failure	100% of Initial Benefit	Not applicable
Alzheimer's Disease[7]	100% of Initial Benefit	Not applicable
Major Organ Transplant Benefit	100% of Initial Benefit	Not applicable
22 Listed Conditions[8]	25% of Initial Benefit	Not applicable

Example of Initial & Recurrence Benefit Payments
The example below illustrates an employee who elected an Initial Benefit of $15,000 and has a Total Benefit of 3 times the Initial Benefit Amount or $45,000.

Illness – Covered Condition	Payment	Total Benefit Remaining
Heart Attack – first diagnosis	Initial Benefit payment of $15,000 or 100%.	($30,000)
Heart Attack – second diagnosis, two years later	Recurrence Benefit payment of $15,000 or 100%	($15,000)
Kidney Failure – first diagnosis, three years later	Initial Benefit payment of $15,000 or 100%	($0)

SUPPLEMENTAL BENEFITS

MetLife provides coverage for the Supplemental Benefits listed below. This coverage would be in addition to the Total Benefit Amount payable for the previously mentioned Covered Conditions.

Health Screening Benefit[9]
After your coverage has been in effect for thirty days, MetLife will provide an annual benefit of $50 or $100* per calendar year for taking one of the eligible screening/prevention measures. MetLife will pay only one health screening benefit per covered person per calendar year. For a complete list of eligible screening/prevention measures, please refer to the Disclosure Statement/Outline of Coverage.

*The Health Screening Benefit amount depends upon the Initial Benefit Amount selected. Employees would receive a $50 benefit with the $15,000 initial benefit amount or a $100 benefit with the $30,000 Initial Benefit Amount.

QUESTIONS & ANSWERS

Who is eligible to enroll?
Regular active full-time employees who are actively at work along with their spouse and dependent children can enroll for MetLife Critical Illness Insurance coverage.[3]

How do I pay for coverage?
Coverage is paid through convenient payroll deduction.

If I Leave the Company, Can I Keep My Coverage? [10]
Under certain circumstances, you can take your coverage with you if you leave. You must make a request in writing within a specified period after you leave your employer. You must also continue to pay premiums to keep the coverage in force.

Who do I call for assistance?
Please call MetLife at 1-855-564-6638 and speak with a benefits consultant.

PREMIUMS

Monthly Premium for $1,000 of Coverage

Attained Age	Employee Only	Employee +Spouse	Employee +Children	Employee +Spouse/ Children
<25	$0.43	$0.87	$0.95	$1.39
25–29	$0.46	$0.92	$0.98	$1.44
30–34	$0.64	$1.24	$1.16	$1.76
35–39	$0.93	$1.76	$1.45	$2.28
40–44	$1.44	$2.67	$1.96	$3.19
45–49	$2.24	$4.08	$2.76	$4.60
50–54	$3.39	$6.03	$3.91	$6.55
55–59	$4.91	$8.56	$5.43	$9.08
60–64	$7.21	$12.42	$7.73	$12.94
65–69	$11.03	$18.75	$11.55	$19.27
70+	$16.40	$28.35	$16.92	$28.87

Example:
$15,000 in coverage for 34 yo employee only
$15,000 / $1,000 = 15
15 x $.64 = $9.60 per month

MetLife Accident Insurance Plan Summary

ACCIDENT INSURANCE BENEFITS

With MetLife, you'll have a choice of 2 comprehensive plans which provide payments in addition to any other insurance payments you may receive. Here are just some of the covered events/services.

Benefit Type[1]	Low Plan MetLife Accident Insurance Pays YOU	High Plan MetLife Accident Insurance Pays YOU
Injuries		
Fractures[2]	$50 – $3,000[2]	$100 – $6,000[2]
Dislocations[2]	$50 – $3,000[2]	$100 – $6,000[2]
Second and Third Degree Burns	$50 – $5,000	$100 – $10,000
Concussions	$200	$400
Cuts/Lacerations	$25 – $200	$50 – $400
Eye Injuries	$200	$300
Medical Services & Treatment[1]		
Ambulance	$200 – $750	$300 – $1,000
Emergency Care	$25 – $50	$50 – $100
Non-Emergency Care	$25	$50
Physician Follow-Up	$50	$75
Therapy Services (including physical therapy)	$15	$25
Medical Testing Benefit	$100	$200
Medical Appliances	$50 – $500	$100 – $1,000
Inpatient Surgery	$100 – $1,000	$200 – $2,000
Hospital[3] Coverage (Accident)		
Admission	$500 – $1,000 per accident	$1,000 – $2,000 per accident
Confinement (non-ICU confinement paid for up to 365 days. ICU confinement paid for 30 days)	$100 (non-ICU) – $200 (ICU) a day	$200 (non-ICU) – $400 (ICU) a day
Inpatient Rehab (paid per accident)	$100 a day, up to 15 days	$200 a day, up to 15 days
Hospital Coverage (Sickness)[4]		
Admission (payable 1 x per calendar year)	$150 (non-ICU) – $300 (ICU)	$150 (non-ICU) – $300 (ICU)
Confinement (paid per sickness)	$100 (non-ICU) – $200 (ICU) Payable up to 30 days per sickness	$100 (non-ICU) – $200 (ICU) Payable up to 30 days per sickness

Benefit Type[1]	Low Plan MetLife Accident Insurance Pays YOU	High Plan MetLife Accident Insurance Pays YOU
Accidental Death		
Employee receives 100% of amount shown, spouse receives 50% and children receive 20% of amount shown.	$25,000 $75,000 for common carrier[5]	$50,000 $150,000 for common carrier[5]
Dismemberment, Loss & Paralysis		
Dismemberment, Loss & Paralysis	$250 – $10,000 per injury	$500 - $50,000 per injury

BENEFIT PAYMENT EXAMPLE

Kathy's daughter, Molly, plays soccer on the varsity high school team. During a recent game, she collided with an opposing player, was knocked unconscious and taken to the local emergency room by ambulance for treatment. The ER doctor diagnosed a concussion and a broken tooth. He ordered a CT scan to check for facial fractures too, since Molly's face was very swollen. Molly was released to her primary care physician for follow-up treatment, and her dentist repaired her broken tooth with a crown. Depending on her health insurance, Kathy's out-of-pocket costs could run into hundreds of dollars to cover expenses like insurance co-payments and deductibles. MetLife Group Accident Insurance payments can be used to help cover these unexpected costs.

Covered Event[1]	Benefit Amount[8]
Ambulance (ground)	**$300**
Emergency Care	**$100**
Physician Follow-Up ($75 x 2)	**$150**
Medical Testing	**$200**
Concussion	**$400**
Broken Tooth (repaired by crown)	**$200**
Benefits paid by MetLife Group Accident Insurance	**$1,350**

QUESTIONS & ANSWERS

Who is eligible to enroll for this accident coverage?
You are eligible to enroll yourself and your eligible family members![9] You need to enroll during your Enrollment Period and be actively at work for your coverage to be effective.

How do I pay for my accident coverage?
Premiums will be conveniently paid through payroll deduction, so you don't have to worry about writing a check or missing a payment.

What happens if my employment status changes? Can I take my coverage with me?
Yes, you can take your coverage with you. You will need to continue to pay your premiums to keep your coverage in force. Your coverage will only end if you stop paying your premium or if your employer offers you similar coverage with a different insurance carrier.

Who do I call for assistance?
Please call MetLife at 1-855-564-6638 and speak with a benefits consultant.

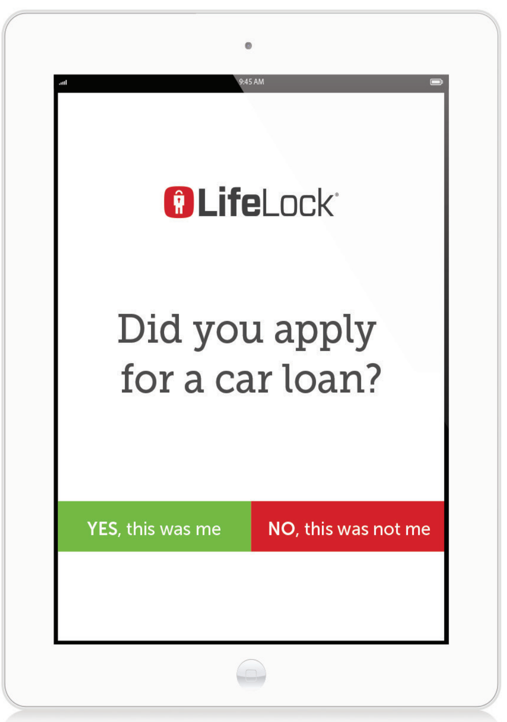
PREMIUMS

Low Plan	
Coverage Tier	Semi-Monthly Amount
Employee	$5.87
Employee+Spouse	$9.11
Employee+Child(ren)	$10.63
Family	$14.16

High Plan	
Coverage Tier	Semi-Monthly Amount
Employee	$11.22
Employee+Spouse	$17.40
Employee+Child(ren)	$20.28
Family	$27.02

Protecting Your Personal Information is Our Top Priority

LifeLock helps safeguard your finances, credit & good name.



ENROLL IN PROACTIVE IDENTITY THEFT PROTECTION.

LifeLock Identity Theft Protection® detects your personal information in applications for credit and services within our extensive network.† We monitor over a trillion data points, including those for new credit cards, wireless services, retail credit, mortgages, auto and payday loans. You can respond immediately to confirm if the activity is fraudulent with our proprietary Not Me® verification technology. If identity fraud does occur, our Certified Resolution Specialists are available to personally manage your case from beginning to end.

†Network does not cover all transactions.
‡The benefits under the Service Guarantee are provided under a Master Insurance Policy underwritten by State National Insurance Company. As this is only a summary please see the actual policy for applicable terms and restrictions at LifeLock.com/legal

THE NECESSARY, VOLUNTARY BENEFIT

Choose the LifeLock Service That's Right for You

LifeLock Identity Theft Protection

LifeLock® identity theft protection helps proactively safeguard your personal information and alerts you of potential threats.†

LifeLock Ultimate

LifeLock Ultimate™ service is the most comprehensive identity theft protection service ever created and even includes monitoring of new and existing checking and savings accounts.†

How to enroll:

1. Learn more & enroll online at: http://arona.excelsiorenroll.com
2. Provide the name, Social Security number, date of birth, address, email and phone number for you and each dependent you wish to enroll.††
3. Select your level of coverage.*
4. Your LifeLock coverage will begin on the 1st of the month following the successful completion of your enrollment.
5. You will receive a welcome email from LifeLock with instructions on how to take full advantage of your LifeLock membership.

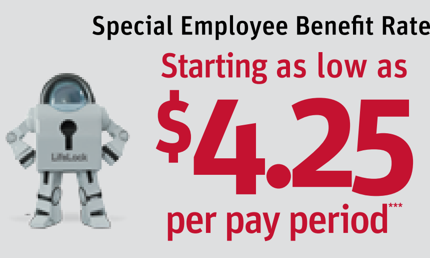
Enroll in LifeLock service during open enrollment and secure your personal information.

Special Employee Benefit Rate

Starting as low as

$4.25

per pay period***



LifeLock Service Payroll Deduction Pricing –

Plan Options		LifeLock Identity Theft Protection	LifeLock Ultimate
	Employee Only [18 and over]	$4.25	$10.63
	Employee + Spouse	$8.50	$21.25
	Employee + Children**	$7.44	$15.41
	Employee + Family**	$11.69	$26.03

**As LifeLock Identity Theft Protection and LifeLock Ultimate service are available for adults 18 years of age and older, children under the age of 18 will receive a product designed specifically for minors. Enrollment in LifeLock service is limited to employees and their eligible dependents.

Service Features	LifeLock Identity Theft Protection	LifeLock Ultimate
Proactive Protection	✓	✓
Credit Application Alerts†	✓	✓
Non-Credit Alerts†	✓	✓
Lost Wallet Protection	✓	✓
Address Change Verification	✓	✓
Black Market Website Surveillance	✓	✓
Reduced Pre-Approved Credit Card Offers	✓	✓
Award-Winning Member Service 24/7/365	✓	✓
$1 Million Total Service Guarantee‡	✓	✓
Alias Name and Address Monitoring		✓
Court Records Scanning		✓
File-Sharing Network Searches		✓
Unauthorized Payday Loan Notifications		✓
Sex Offender Registry Reports		✓
Checking and Savings Account Application Alerts†		✓
Bank Account Takeover Alerts†		✓
Enhanced Credit Application Alerts†		✓
Online Annual Credit Reports and Scores		✓
Monthly Credit Score Tracking		✓
Priority Award-Winning Member Service 24/7/365		✓

†Network does not cover all transactions and scope may vary.
††This information is required to receive LifeLock alerts.
*Must agree to the terms and conditions available at LifeLock.com/terms.
‡The benefits under the Service Guarantee are provided under a Master Insurance Policy underwritten by State National Insurance Company. As this is only a summary please see the actual policy for applicable terms and restrictions at LifeLock.com.

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IMPORTANT NOTICE FROM THE COMPANY 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 the Company 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. The Company has determined that the prescription drug coverage offered by all plans 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 the Company coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current the Company coverage, be aware that you and your dependents may not be able to get this coverage back.

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

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

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

For More Information About This Notice or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through The Company changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	1/1/2023
Name of Entity/Sender:	Arona Corporation
Contact--Position/Office:	Amy Linn, Director of Human Resources
Address:	1001 Grand Avenue, West Des Moines, IA 50265
Phone Number:	515-225-9029

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 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).

PATIENT PROTECTION NOTICE

Wellmark Blue Cross & Blue Shield requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Wellmark Customer Service at 800-524-9242.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Wellmark Blue Cross & Blue Shield or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Wellmark Customer Service

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 (including Medicaid and State Child Health Coverage)
If you are declining coverage for yourself or your dependents (including 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 you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). Some plans may allow longer than 30 days, so please refer to your plan documents for your specific plan details.

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

Marriage, Birth, or Adoption
If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, or placement for adoption. Some plans may allow longer than 30 days, so please refer to your plan documents for your specific plan details.

> Example: When you were hired, 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 State Child Health Coverage
If you or your dependents lose eligibility for coverage under Medicaid or State Child Health Coverage 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 or the determination of eligibility for a premium assistance subsidy.

> Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this 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.

WOMEN'S HEALTH & CANCER RIGHTS ACT OF 1998

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

As specified in the Women's Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction in connection with a mastectomy is also entitled to the following benefits:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis and treatment of physical complications at all stages of the mastectomy, including lymph edemas.

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 this plan.

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

Beginning in 2014, there is a new way to buy health insurance: the **Health Insurance Marketplace**. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

Each year, the open enrollment period for health insurance coverage through the Marketplace runs from Nov. 1 through Dec. 15 of the previous year. After Dec. 15, you can get coverage through the Marketplace only if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP).

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5 percent (as adjusted each year after 2014) of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. (An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.)

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.