2025

EMPLOYEE BENEFITS

Bi-Weekly 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 Bernau Capital Partners 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 one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility.

To see if any other states have added a premium assistance program since July 31, 2024 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** *Email:* **hipp@dhcs.ca.gov**	916-445-8322 916-440-5676 (fax)
Colorado (Medicaid and CHIP)	*Medicaid:* **https://www.healthfirstcolorado.com/** *CHIP:* **https://hcpf.colorado.gov/child-health-plan-plus** *HIBI:* **https://www.mycohibi.com/**	1-800-221-3943 1-800-359-1991 1-855-692-6442 State relay 711
Florida (Medicaid)	**https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html**	1-877-357-3268

State	Website/E-mail	Phone
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/dfr/** *All other Medicaid:* **https://www.in.gov/medicaid**	1-800-403-0864 1-800-457-4584
Iowa (Medicaid and CHIP)	*Medicaid:* **https://hhs.iowa.gov/programs/welcome-iowa-medicaid** *CHIP:* **http://dhs.iowa.gov/Hawki** *HIPP:* **https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp**	1-800-338-8366 1-800-257-8563 1-888-346-9562
Kansas (Medicaid)	**https://www.kancare.ks.gov/**	1-800-792-4884 HIPP: 1-800-967-4660
Kentucky (Medicaid and CHIP)	*Medicaid:* **https://chfs.ky.gov/agencies/dms** *KI-HIPP:* **https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.apsx** *KI-HIPP E-mail:* **KIHIPP.PROGRAM@ky.gov** *KCHIP:* **https://kynect.ky.gov**	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.mymaineconnection.gov/benefits/s/?language=e n_US** **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** **Email: masspremassistance@accenture.com**	1-800-862-4840 TTY: 711
Minnesota (Medicaid)	https://mn.gov/dhs/health-care-coverage/	1-800-657-3672
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** *Email:*DHHS.ThirdPartyLiabi@dhhs.nh.gov	603-271-5218 or 1-800-852-3345, ext. 15218
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 (TTY: 711)
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)	**https://www.hhs.nd.gov/healthcare**	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**	1-800-699-9075
Pennsylvania (Medicaid and CHIP)	Medicaid: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html *CHIP:* ***https://www.pa.gov/en/agencies/dhs/resources/chip.html***	*Medicaid:* 1-800-692-7462 *CHIP:* 1-800-986-KIDS (5437)
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)	**https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program**	1-800-440-0493
Utah (Medicaid and CHIP)	*Medicaid:* **https://medicaid.utah.gov/** *CHIP:* https://chip.utah.gov/ *Adult Expansion Website*: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/	1-888-222-2542
Vermont (Medicaid)	**https://dvha.vermont.gov/members/medicaid/hipp-program**	1-800-250-8427
Virginia (Medicaid and CHIP)	**https://coverva.dmas.virginia.gov/learn/premiumassistance/famis-select**	1-800-432-5924

	https://coverva.dmas.virginia.gov/learn/premiumassistance/health-insurance-premium-payment-hipp-programs	
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

TABLE OF CONTENTS

This benefit summary describes the benefit plans available to you as an employee of Bernau Capital Partners. The details of these plans are contained in the official plan documents that have been provided to you by your employer, including some insurance contacts. This summary is meant only to cover the highlights of each plan. It does not contain all the details that are included in your summary plan description as described by the Employee Retirement Income Security Act (ERISA).

If there is ever a question about one of these plans, or if there is a conflict between the information in this summary and the formal language of the plan documents, the formal wording in the plan documents will govern. Please note that the benefits described in the summary may be changed at any time and do not represent a contractual obligation on the part of Bernau Capital Partners.

IMPORTANT CONTACTS

Coverage	Contact	Phone	Website
Medical	Wellmark	800-524-9242	www.wellmark.com
Telehealth	Doctor on Demand	800-997-6196	www.DoctorOnDemand.com
Health Savings Account	HealthEquity	866-346-5800	www.healthequity.com
Flexible Spending Accounts	HealthEquity	866-346-5800	www.healthequity.com
Dental	MetLife	800-942-0854	www.metlife.com
Vision	Avesis	800-828-9341	www.Avesis.com
Life and AD&D	MetLife	800-858-6506	www.metlife.com
Disability	MetLife	800-858-6506	www.metlife.com
Employee Assistance Program	ENI	800-327-2255	www.nexgeneap.com
Human Resources	Rachel West	515-225-9029	hr@bernaucapital.com

WELCOME!

We are committed to providing competitive benefit programs that are flexible enough to meet your individual needs. Our comprehensive benefits are carefully designed to give you the tools you need to keep you and your family healthy, provide financial protection in the event of unforeseen circumstances and help you build long-term security for retirement.

Getting the most from your benefits is up to you. You know your family, your goals and your lifestyle best. This benefits guide was designed to answer some of the basic questions you may have about your benefits. Please take the time to review this guide to make sure you understand the benefits that are available to you and your family and be sure to act before the enrollment deadline.

OPEN ENROLLMENT: OCTOBER 28 – NOVEMBER 11 TAKE ACTION!

This Open Enrollment is an active enrollment, meaning , if you do not take action to enroll, most of your benefits will be carried over from the prior year beginning January 1, 2025.

FSA and HSA contributions require an **active election** every year, so be sure to make that election if applicable.

You will not be able to enroll or make changes to your elections until the next Open Enrollment, unless you experience a Qualifying Life Event (QLE).

QUALIFYING LIFE EVENT

Your benefit elections made during Open Enrollment will be effective January 1, 2025. You may not make mid-year changes to your elections unless you experience a qualifying life event, including change in legal marital status (marriage, divorce, death of spouse), change in dependents (birth, adoption), change in employment status (termination, part-time), or your spouse's Open Enrollment.

IMPORTANT

If you need to make a change before the next Open Enrollment period due to a change in status, you must submit the required documentation WITHIN 60 DAYS of the qualifying life change event.

Log into ADP or contact Human Resources to process a Qualifying Life Event.

ELIGIBILITY

BENEFIT ELIGIBILITY

You and your eligible family members may participate in the employee benefits program if you're a regular, full-time employee working a minimum of 30 hours per week.

NEW-HIRE ELIGIBILITY

New hires can join the plan the first of the month following 30 days of employment. Spouses and dependent children of the employee are also eligible to participate in our benefit plans.

DEPENDENT ELIGIBILITY

You can enroll the following dependents in our group benefit plans:

- Your legal spouse or domestic partner. Employees will pay a $100 monthly surcharge to cover a spouse on the medical plan if they have access to insurance elsewhere.
- Children up to age 26*
- A child under the age of 26 who is your natural child, stepchild, legally adopted child, or child for whom you have obtained legal guardianship
- Unmarried children of any age if totally disabled and claimed as a dependent on your federal income tax return (documentation of handicapped status must be provided)

**Enrolled children lose coverage when they turn 26 and will be mailed COBRA enrollment information.*

EMPLOYEE BI-WEEKLY CONTRIBUTIONS

Medical	Wellmark $5,000 HDHP	Wellmark $5,000 PPO	Wellmark $2,000 PPO	Wellmark $5,000 HMO Iowa Only	Wellmark $2,000 HMO Iowa Only
Employee	$51.40	$34.10	$158.96	$31.21	$126.79
Employee & Spouse	$296.63	$309.33	$415.85	$267.71	$349.96
Employee & Children	$258.44	$280.29	$366.03	$228.00	$305.12
Family	$409.70	$434.39	$664.06	$387.80	$565.32

There will be a $100 per month surcharge applied to the medical premiums if you are covering a spouse who has coverage available through his/her employer sponsored plan and still chooses to be on the Bernau Capital Plan.

Dental	
Employee	$15.61
Employee & Spouse	$32.64
Employee & Children	$36.69
Family	$57.65

Vision	
Employee	$4.87
Employee & Spouse	$9.55
Employee & Children	$9.84
Family	$13.89

Accident	Low Plan	High Plan
Employee	$5.86	$11.21
Employee & Spouse	$9.09	$17.37
Employee & Children	$10.61	$20.28
Family	$14.14	$26.97

Bernau Capital pays the full cost of the Basic Life/AD&D & Long-Term Disability. The Voluntary Life, Voluntary Short-Term Disability, and Critical Illness rates are based upon your age and benefit. Please see rate charts in the benefit guide or log into ADP to calculate your premium.

REGISTER ONLINE

Your connection to great healthcare is only a click away. Register for an online account at www.mywellmark.com so you can access time- saving tools, tips for healthy living, choose a doctor, manage your EOBs, and more!

DOWNLOAD THE MOBILE APP

With the MyWellmark mobile app, you've got the tools you need to manage your healthcare all from your smartphone. The mobile app is available in the Apple and Google Play store.

CHOOSE YOUR MEDICAL PLAN

Your medical plans will be offered through Wellmark. Please review your Summary of Benefits and Coverage (SBC) for additional coverage information and full plan details.

You have five plan options to choose from. All plans 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.

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 (HDHP)

The High Deductible Health Plan is also a nationwide PPO network. You have coverage for both in- and out-of-network providers. The HDHP has higher deductibles and no office visit copayments. Once you've met your deductible, you no longer have to pay anything for covered services. This also applies to prescription drugs. The HDHP is compatible with a Health Savings Account.

Health Maintenance Organization (HMO)

The two HMO plan options are only available to employees who reside and seek medical care in the state of Iowa. This plan only offers in-network coverage. You will only have coverage for out-of-network claims in the case of a life or limb threatening emergency. This plan also 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, your network (PPO or HMO) and enter specific provider criteria to find an in-network provider that meets your needs.

MEDICAL PLANS

Wellmark BCBS – PPO Plans

	$2,000 PPO	$5,000 PPO	$5,000 HDHP
BENEFITS IN-NETWORK			
ANNUAL DEDUCTIBLE – Calendar Year			
Individual	$2,000	$5,000	$5,000
Family	$4,000	$10,000	$10,000
OUT-OF-POCKET (OOP) MAXIMUM – Calendar Year			
Individual	$6,000	$5,000	$5,000
Family	$12,000	$10,000	$10,000
BENEFIT DETAILS			
Virtual Visits	$25 Copayment	$25 Copayment	Deductible
Preventive Care	Covered at 100%	Covered at 100%	Covered at 100%
Primary Care Physician (PCP)	$25 Copayment	$25 Copayment	Deductible
Specialist	$50 Copayment	$50 Copayment	Deductible
Urgent Care	$25 Copayment	$25 Copayment	Deductible
Emergency Room	$300 Copayment	$300 Copayment	Deductible
Inpatient Hospital	Deductible, 20%	Deductible	Deductible
Outpatient Hospital	Deductible, 20%	Deductible	Deductible
Outpatient Surgery	Deductible, 20%	Deductible	Deductible
Children's Eye Exam	1 routine exam per year then $50 Copayment	1 routine exam per year then $50 Copayment	1 routine exam per year then Deductible
Adult Eye Exam	1 routine exam per year	1 routine exam per year	1 routine exam per year
Lab/X-Ray (Outpatient)	Deductible, 20%	Deductible	Deductible
BENEFITS OUT-OF-NETWORK			
Deductible – Individual / Family	$2,500 / $5,000	$6,000 / $12,000	$5,000 / $10,000
Coinsurance	30%	30%	30%
Out-of-Pocket Maximum– Individual / Family	$6,000 / $12,000	$10,000 / $20,000	$10,000 / $20,000

Please note: If you go to an out-of-network provider, your cost may be higher and your provider may ask you to pay the actual charge for your care at the time of your visit.

All of the medical plans have an embedded deductibles. If you are enrolled in a family plan, each family member has an individual deductible in addition to the overall family deductible. This means that if an individual in the family reaches his or her single deductible before the family deductible is reached, his or her services will be paid by the insurance company.

MEDICAL PLANS

Wellmark BCBS – HMO Plans

These plans are only offered to employees who are located in Iowa. Providers outside of Iowa not covered by the HMO network.

	$2,000 HMO – Iowa Only	$5,000 HMO – Iowa Only
BENEFITS IN-NETWORK		
ANNUAL DEDUCTIBLE – Calendar Year		
Individual	$2,000	$5,000
Family	$4,000	$10,000
OUT-OF-POCKET (OOP) MAXIMUM – Calendar Year		
Individual	$6,000	$5,000
Family	$12,000	$10,000
BENEFIT DETAILS		
Virtual Visits	$25 Copayment	$25 Copayment
Preventive Care	Covered at 100%	Covered at 100%
Primary Care Physician (PCP) Office Visit	Designated PCP - $20 Copayment Other PCP - $25 Copayment	Designated PCP - $20 Copayment Other PCP - $25 Copayment
Non-PCP Office Visit	$25 Copayment	$25 Copayment
Specialist	$50 Copayment	$50 Copayment
Urgent Care	$25 Copayment	$25 Copayment
Emergency Room	$300 Copayment	$300 Copayment
Inpatient Hospital	$300 Copayment	Deductible
Outpatient Hospital	Deductible, 20%	Deductible
Outpatient Surgery	Deductible, 20%	Deductible
Children's Eye Exam	1 routine exam per year then $50 Copayment	1 routine exam per year then $50 Copayment
Adult Eye Exam	1 routine exam per year	1 routine exam per year
Lab/X-Ray (Outpatient)	$50 Copayment per Provider 20% Facility Coinsurance	$50 Copayment per Provider 0% Facility Coinsurance
BENEFITS OUT-OF-NETWORK		
Deductible	No Benefits Available	No Benefits Available
Coinsurance	No Benefits Available	No Benefits Available
Out-of-Pocket Maximum (OOP)	No Benefits Available	No Benefits Available

Please note: These plans require that you designate a Primary Care Physician. There is no coverage for out-of-network benefits!

All of the medical plans have an embedded deductibles. If you are enrolled in a family plan, each family member has an individual deductible in addition to the overall family deductible. This means that if an individual in the family reaches his or her single deductible before the family deductible is reached, his or her services will be paid by the insurance company.

PHARMACY

CVS

		$2,000 PPO, $5,000 PPO, $2,000 HMO, $5,000 HMO	$5,000 HDHP
Rx Deductible		**$100 Single / $300 Family (waived for tier 1)**	**Same as Medical**
Retail 30-day supply	**Tier 1**	**$10 Copayment**	**Deductible**
	Tier 2	**$30 Copayment**	
	Tier 3	**$50 Copayment**	
	Specialty	**Preferred - $100 Copayment / Non-Preferred – 50% Coinsurance**	
Mail Order 90-day supply	**Tier 1**	**$30 Copayment**	**Deductible**
	Tier 2	**$90 Copayment**	
	Tier 3	**$150 Copayment**	

Send Medications Right to Your Home

Home delivery is a convenient, cost-effective and safe option for medications you take regularly. Make sure you have your ID card ready.

1. Call 866-611-5961 to enroll with FastStart.
2. Visit www.caremark.com and select **Register Now.**
3. Create a new, unique User ID.
4. Select **Start Mail Service** under the **Prescriptions Tab** in your portal
5. Send in your new 90-day prescription. Select **Request New Prescription** and complete the required information so CVS can reach out to your doctor.
6. You can also call customer service for assistance.

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.

Following the letter from BCBS, PrudentRx will be reaching out to coordinate your specialty prescription. PrudentRx offers a third-party (manufacturer) copay assistance program that may help save you money on your specialty medications.

If you do not enroll in the program, you will be required to pay 30% coinsurance and it will not count towards your out-of-pocket maximum.

TELEHEALTH BENEFITS

Doctor on Demand

With telehealth, you can schedule a virtual appointment with board-certified doctors and pediatricians who can diagnose, treat and prescribe most medications for minor medical conditions, such as:

dr. on demand

- Acne
- Allergies
- Asthma
- Bronchitis
- Cold and flu
- Constipation
- Diarrhea
- Earaches
- Fever
- Headaches
- Joint aches
- Nausea
- Pink eye
- Rashes
- Respiratory infections
- Shingles
- Sinus infections
- Skin infections
- Sore throats
- Urinary tract infections
- Infections
- Insect Bites

We've all been there—it's the middle of the night and you have a sick child or maybe you are trying to get an appointment with your primary care provider but the first appointment isn't for two weeks. Good news… there's an easier way! Telehealth is a convenient option for scheduling virtual doctor visits from your own home. With telehealth, you don't have to drive to the doctor's office or sit in a waiting room when you're sick—you can see your doctor from the comfort of your own bed or sofa.

- See a board-certified, licensed, telehealth trained doctor on your schedule with on-demand virtual visits 24/7, including holidays.
- Get treated for more than 80 common conditions including colds, flu, allergies and more.
- Get a prescription or short-term refill of any existing prescription sent to a pharmacy nearby, in less time than your usual doctor visit.
- Avoid costly copays and deductibles of the ER and urgent care clinic.

Getting started is easy.

- Download the "Doctor On Demand" app or visit **DoctorOnDemand.com.**
- Have your Wellmark BCBS member ID card ready.
- Create an account or sign in.
- **Call 800-997-6196 with any questions 24/7.**

HEALTH SAVINGS ACCOUNT (HSA)

HealthEquity

WHAT IS A HEALTH SAVING ACCOUNT?

A Health Savings Account (HSA) is a way for you to save pre-tax dollars that can be used to pay for qualified healthcare expenses like deductibles, co-insurance, prescriptions, vision and dental expenses. High deductible health plans have lower premiums and may result in lower annual medical costs. These plans offer several advantages to reward you for taking an active role in your healthcare spending.

- **Lower paycheck costs** — allowing you to keep control over more of your money
- **Tax-advantaged savings account** — enrolling in and contributing to a Health Savings Account (HSA) helps you pay your deductible and out-of- pocket costs
- **Comparable benefits** — these plans use the same networks that other plans offer, and in-network preventive care is still 100% covered

WHO IS ELIGIBLE FOR AN HSA?

- Must be enrolled in a high deductible health plan
- Cannot be covered by any other medical plan that is not a qualified HDHP. This includes a spouse's medical coverage unless it's also a qualified HDHP.
- Cannot be enrolled in a traditional health care FSA in 2025
- Cannot be enrolled in Medicare, including Parts A or B, Medicaid or Tricare
- Cannot be claimed as a dependent on another person's tax return
- Cannot be a veteran who has received treatment, other than preventive care, through the Department of Veterans Affairs within the past three months

For a list of eligible expenses, see IRS Publication 502, available at www.irs.gov.

HOW MUCH CAN I CONTRIBUTE TO AN HSA?

- Employee only coverage: **$4,300**
- Employee plus dependents coverage: **$8,550**
- If you are 55 or older, you can make an additional annual catch-up contribution of **$1,000**

HSAs AND YOUR TAXES

All withdrawals from your HSA are tax-free, as long as you use the money to pay for eligible health care expenses. In addition, all the money in the account is yours and will never be forfeited. It rolls over from year to year, and you can take it with you if you leave the company or retire. After age 65, you can withdraw funds for any reason without a tax penalty — you pay ordinary income tax only if the withdrawal isn't for eligible health care expenses.

Note: You won't pay federal taxes on HSA contributions. However, you may pay state taxes depending on your residence. Consult your tax advisor to learn more.

FLEXIBLE SPENDING ACCOUNT (FSA)

HealthEquity

Tax-advantaged FSAs are a great way to save money. The money you contribute to these accounts comes out of your paycheck without being taxed, and you withdraw it tax-free when you pay for eligible health care and dependent care expenses.

HEALTH CARE FSA

- Pay for eligible health care expenses, such as plan deductibles, copays, and coinsurance.
- Contribute up to $3,300 in 2025.

Who can participate?

You do not have to be enrolled in any of the medical plans to be eligible to participate in the Flexible Spending Accounts. If you are enrolled, employees that are enrolled in the traditional PPO or HMO plans are eligible to participate in the Health Care FSA. Employees who enrolled in the $5,000 HDHP are eligible to participate in the Limited Purpose FSA.

What is a Limited Purpose FSA?

A Limited Purpose FSA can be paired with a Health Savings Account. If you are participating in the LPFSA, you are only eligible to reimburse your dental and vision expenses. Medical expenses may not be reimbursed.

If you are enrolled in the HDHP, you cannot enroll in the traditional HealthCare FSA. You must enroll in the Limited Purpose FSA.

What happens at the end of the year?

FSAs are “Use It or Lose It” meaning if you do not spend your funds by the expense deadline, your funds will be forfeited. Unused monies are forfeited at the time of termination of employment unless COBRA is elected.

The Company FSA plan allows a 2.5 month grace period after the plan year ends in which you can continue to incur eligible expenses and submit them for reimbursement.

DEPENDENT CARE FSA

Who can participate?

Any employee.

What are the contribution limits?

Employees can contribute up to $5,000 annually per family or $2,500 if filing separately.

What happens at the end of the year?

Dependent Care can only be reimbursed for expenses incurred in the plan year (1/1/2024 through 12/31/24). FSA funds expire at the end of each year. Unlike the healthcare FSA, your full election for the plan year is not available on the day your plan starts. For the dependent care FSA, you can only be reimbursed for qualified expenses up to the amount you have contributed to your FSA up to that point in time. As your contributions accrue, claims for reimbursement can be processed.

WHAT IS AN ELIGIBLE EXPENSE?

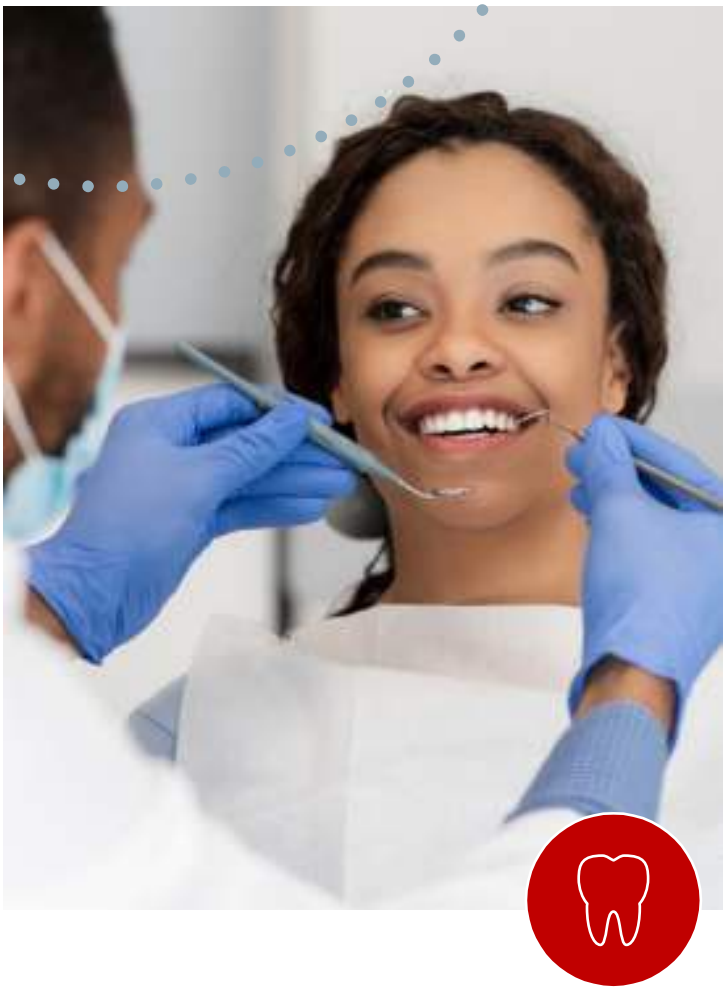
Health Care FSA – Plan deductibles, copays, coinsurance, and other health care expenses. To learn more, see IRS Publication 502 at www.irs.gov.

Dependent Care FSA – Child day care, babysitters, home care for dependent elders, and related expenses. To learn more, see IRS Publication 503 at www.irs.gov.

HSA & FSA COMPARISON

This chart shows the features of the healthcare FSAs and the Health Savings Account (HSA)

	HSA	Health Care FSA
Available if you select these plans	High-deductible Health Plan	Traditional PPO or HMO Plans You do not have to be enrolled in any medical plan to elect the Health Care FSA
How much you may contribute	**Employee only coverage:** $4,300 **Employee plus dependents coverage**: $8,550 Catch-up contributions of up to $1,000 for 2025 year for age 55+	Up to **$3,300** for plan year
Expenses you may pay from your account	Out-of-pocket expenses incurred any time after the HSA was established	Out of pocket expenses incurred during the current calendar year (including the grace period):
	Medical Prescription drug Dental Vision Long-Term Care premiums	Medical Prescription drugs Dental Vision
Account balance available to reimburse expenses	Current account balance	Entire contribution amount elected for the plan year
Time limits for using your account balance	No limit	Must use 2024 account balance for expenses incurred through 3/15/2025; Claims must be filed by 5/1/2025
If you don't use all your account balance each year	Any account balance carries over from year-to-year	You must submit claims by 5/1/2025 for all expenses incurred through 3/15/2025 Any remaining funds will be forfeited
How it saves you money	Your contributions are tax free, which reduces your taxable income Any investment or interest earnings on your account balance is tax free Distributions are tax free if used for qualified healthcare expenses	Your contributions are tax-free, which reduces your taxable income and increases your take-home pay You pay for healthcare expenses with pre-tax dollars



DENTAL PLAN

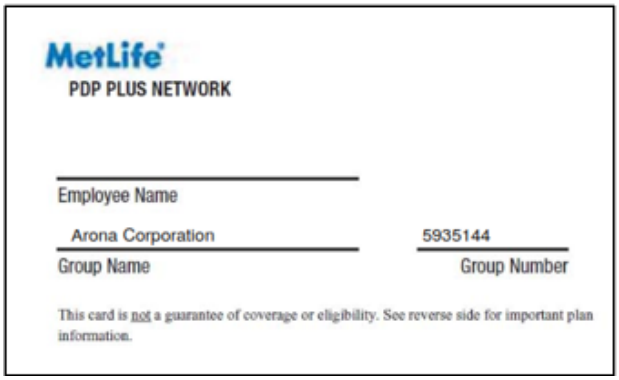
Metlife

In addition to protecting your smile, dental insurance helps pay for dental care and includes regular checkups, cleanings and x-rays. Receiving regular dental care can protect you and your family from the high cost of dental disease and surgery.

Dental coverage is offered for basic and major services. The dental plan also includes 100% coverage for preventive care. You and your eligible dependents may enroll in dental coverage options administered by MetLife.

MetLife Dental ID Card

MetLife will not mail you an ID card – if you would like an ID card, please use the copy below.


MetLife
PDP PLUS NETWORK

Employee Name

Arona Corporation — Group Name

5935144 — Group Number

This card is not a guarantee of coverage or eligibility. See reverse side for important plan information.

Find a provider visit: www.metlife.com

PLAN FEATURES	PPO
Annual Deductible – Individual	$50
Annual Deductible – Family	$150
Annual Maximum – Per Person	$2,000
Preventive Care	$0 – deductible waived
Basic Services (Fillings, sealants, oral surgery)	20% after deductible
Major Services (Crowns, onlays, inlays, bridges, dentures)	50% after deductible
Orthodontia Services Lifetime Maximum	$1,000
Orthodontia Services – to age 19	50%

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.

VISION PLAN

Avesis

Driving to work, reading a news article and watching TV are all activities you likely perform every day. Your ability to do all of these activities, though, depends on your vision and eye health. Vision insurance can help you maintain your vision as well as detect various health problems.

Your vision insurance is provided by Avesis and entitles you to specific eye care benefits. Our policy covers routine eye exams and provides specified dollar amounts or discounts for the purchase of eyeglasses and contact lenses.

Find a provider visit: www.avesis.com

	In Network	Out Of Network
EXAM		
Routine Eye Exam	$10 Copayment	Up to $35
MATERIALS & FRAMES		
Single Vision Lenses	$10 Copayment	Up to $25
Standard Lined Bifocal Lenses	$10 Copayment	Up to $40
Standard Trifocal Lenses	$10 Copayment	Up to $50
Polycarbonate	$10 Copayment	Up to $10
Standard Scratch-Resistant Coating	$10 Copayment	Up to $5
UV Screening	$10 Copayment	Up to $6
Solid or Gradient Tint	$10 Copayment	Up to $4
Standard Anti-Reflective Coating	$10 Copayment	Up to $24
Level 1 / Level 2 Progressives	$10 Copayment	Up to $40 / $48
All Other Progressives	$140 Allowance + 20% discount	$Up to $48
Transitions	$70/$80 copayment	N/A
Polarized	$75 copayment	N/A
PGX/PBX	$40 copayment	N/A
Frames	$65 Wholesale Allowance	Up to $45
Contact Lens:		
Elective	Up to $130	Up to $110
Medically Necessary	$10 Copayment	Up to $250
FREQUENCY OF SERVICES		
Comprehensive Eye Exam	12 Months	
Lenses / Contact Lenses (in lieu of one another)	12 Months	
Frames	24 Months	

LIFE INSURANCE

MetLife

BASIC LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) PLAN

The Basic Life and AD&D plan provides a benefit in the event of your death, dismemberment or paralysis. This benefit is sponsored by Bernau Capital Partners, so you will automatically be enrolled at no cost to you.

Your coverage will be a flat **$15,000**. Benefits will be reduced to 65% at age 65, and 50% at age 70.

SUPPLEMENTAL LIFE INSURANCE

You may purchase additional life insurance at group rates:

- Chose from $10,000 up to $500,000 in $1,000 increments, or 5x your earnings. You can elect up to $100,000 at your new hire enrollment without having to go through medical underwriting
- You pay the full cost of this plan and the amount deducted depends on your age and the amount of coverage elected
- Benefits will be reduced to 65% at age 65 and 50% at age 70.
- Rates can be found by logging into ADP.
- If you terminate employment, you are eligible to port or convert your coverage if you apply to MetLife within 31 days.
- Please make sure your beneficiary is up-to-date. Your beneficiary should be updated within ADP and can be changed at any time. You do not need a qualifying life event to update your beneficiary.

SPOUSAL AND CHILD LIFE INSURANCE

You may purchase additional dependent life insurance at group rates:

- Spousal life is available in increments of $5,000 up to a max of $100,000, not to exceed 100% of employee coverage
- Can elect up to $25,000 without medical underwriting as a new hire
- Child life is available in flat amounts of $1,000, $2,000, $4,000, $5,000, or $10,000
  - Children are not subject to medical underwriting
  - The cost remains the same regardless of the number of children you have

GUARANTEED ISSUE AND EVIDENCE OF INSURABILITY

Employees and spouses who elect Voluntary Life and AD&D coverage when they are first eligible can elect up to the Guaranteed Issue (GI) amount without Evidence of Insurability (EOI). If the amount requested is more than GI, you will need to provide EOI before the amount over GI becomes effective.

IMPUTED INCOME

Under current tax laws, imputed income is the value of your Basic Life insurance that exceeds $50,000 and is subject to federal income, Social Security and state income taxes, if applicable. This imputed income amount will be included in your paycheck and shown on your W-2 statement.

DISABILITY COVERAGE

MetLife

At Bernau Capital Partners, we want to do everything we can to protect you and your family. That's why Bernau Capital Partners pays for the full cost of long-term disability insurance—meaning that you owe nothing out of pocket. You also have the opportunity to purchase voluntary short-term disability and pay the full cost through payroll deduction.

In the event that you become disabled from a non-work-related injury or sickness, disability income benefits will provide a partial replacement of lost income. Please note that you are not eligible to receive short-term disability benefits if you are receiving workers' compensation benefits.

SHORT-TERM DISABILITY (STD)

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. The maximum benefit available is 25 weeks per STD claim.

To determine your monthly premium, refer to the charts below. The maximum benefit amount cannot exceed 60% of your gross weekly earnings or $1,000, whichever is less.

Age	Rate per $10 of Covered Benefit
Less than 44	$0.497
45-49	$0.597
50-54	$0.759
55-59	$1.066
60-64	$1.273
65+	$1.364

Monthly Premium Calculation		EXAMPLE (42-year-old earning $40,000 per year)
List your annual earnings	$_____	$40,000
List your weekly earnings (annual earnings divided by 52)	$_____	$769.23
Calculate weekly benefit (weekly earnings X 60%)	$_____	$461.54
Value per $10 (divide weekly benefit by $10)	$_____	$46.15
Multiply by the premium factor for your age in chart	$_____	$0.497
Your Estimated Monthly Premium	$_____	$22.94

LONG-TERM DISABILITY (LTD)

If you are 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.

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.

Both 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.

ACCIDENT INSURANCE

MetLife

You have access to two accident plans that can be purchased through MetLife. Accident insurance pays out a lump sum if you become injured because of an accident — even if the injuries you incur do not keep you out of work. While health insurance companies pay your provider or facility, Accident insurance pays you directly.

How Does Accident Insurance Work?

- A set amount is payable based on the injury you suffer and the treatment you receive
- Benefits are payable directly to you (unless you specify otherwise) and can be used as you see fit
- Coverage is available for you, your spouse and eligible dependent children
- You do not need to answer medical questions or have a physical exam to get basic coverage
- Benefit payments are not reduced by any other insurance you may have with other companies
- If you terminate employment, you can convert your coverage and keep your in-force policy. Your coverage will only end if you stop paying your premium.

Covered expenses typically include:

- Emergency room visits
- Hospital stays
- Fractures and dislocations
- Medical exams
- Physical therapy
- Transportation and lodging
- See full list of benefits on the following page

Bi-Weekly Deduction	Low Plan	High Plan
Employee	$5.87	$11.22
Employee & Spouse	$9.11	$17.40
Employee & Children	$10.63	$20.28
Family	$14.16	$27.02

ACCIDENT INSURANCE

MetLife

	Low Plan	High Plan
Injuries		
Fractures	$50 - $3,000	$100 - $6,000
Dislocations	$50 - $3,000	$100 - $6,000
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 & Treatments		
Ambulance	$200 - $750	$300 - $1,000
Emergency Room Care	$25 - $50	$50 - $100
Non-Emergency Care	$25	$50
Physician Follow Up	$50	$75
Therapy Services	$15	$25
Medical Testing Benefit	$100	$200
Medical Appliances	$50 - $500	$100 - $1,000
Inpatient Surgery	$100 - $1,000	$200 - $2,000
Hospital Coverage (Accident)		
Admission	$500 - $1,000 per accident	$1,000 - $2,000 per accident
Confinement (ICU – 30 days / non-ICU – 365 days)	$100 / $200 per day	$200 / $400 per day
Inpatient Rehab (per accident)	$100 per day (up to 15 days)	$200 per day (up to 15 days)
Hospital Coverage (Sickness)		
Admission (1x per year) – non-ICU/ICU	$150 / $300	$150 / $300
Confinement (paid per sickness)	$100 / $200 per day (up to 30 days)	$100 / $200 per day (up to 30 days)
Accidental Death		
Employee (100% of amount shown) Spouse (50% of amount shown) Child (20% of amount shown)	$25,000 $75,000 for common carrier	$50,000 $150,000 for common carrier
Dismemberment/Loss/Paralysis		
Dismember, Loss, and Paralysis	$250 - $10,000 per injury	$500 - $50,000 per injury

CRITICAL ILLNESS INSURANCE

MetLife

CRITICAL ILLNESS INSURANCE

While Medical insurance is vital, it doesn't cover everything. If you suffer from a serious illness, such as cancer, stroke or a heart attack, Medical insurance may not provide the coverage you need. Critical Illness insurance will ease the financial strain and help you focus on your recovery.

How Will a Critical Illness Claim Get Paid?

After purchasing Critical Illness insurance, if you suffer from one of the serious illnesses covered by your policy, you'll be paid in a lump sum. The payment will go directly to you instead of to a medical provider. The payment you receive can be used for many things including:

- Childcare costs
- Medical and living expenses
- Travel expenses for you and your family
- Lost wages from missed time at work

Attained Age	EE Only	EE+SP	EE+CH	FA
<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

Health Screening Benefit

After your coverage has been active for 30 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 screenings, please refer to the Disclosure Statement/Outline of Coverage. The health screening amount depends on the initial benefit elected ($50 for $15,000 benefit and $100 for $30,000 benefit).

Eligible Individual	Initial Benefit	Requirements
Employee	$15,000 or $30,000	Coverage is guaranteed provided you are actively at work
Spouse	100% of Employee Benefit	Coverage is guaranteed provided the employee is actively at work and the spouse is not subject to medical restriction set forth in Certificate
Dependent Children	100% of Employee Benefit	Coverage is guaranteed provided the employee is actively at work and the dependent is not subject to medical restriction set forth in Certificate
Covered Condition	**Initial Benefit**	**Recurrence Benefit**
Full Benefit Cancer	100%	100%
Partial Benefit Cancer	25%	25%
Heart Attack	100%	100%
Stroke	100%	100%
Coronary Artery Bypass Graft	100%	100%
Kidney Failure	100%	Not Applicable
Alzheimer's Disease	100%	Not Applicable
Major Organ Transplant	100%	Not Applicable
22 Listed Conditions	25%	Not Applicable

NexGenEAP

YOUR TOTAL WELL-BEING & MENTAL HEALTH BENEFIT

You and your eligible family members can trust the **NexGen EAP** services to address your total well-being by providing barrier-free access to mental health and virtual life services.

CONFIDENTIAL ASSISTANCE

We ensure that your information and identity is kept completely confidential - even from your employer. Exceptions occur only when members are at risk of harming themselves or others or when the welfare of a child is in question.

Download THE APP

COMPANY ID: 10738

COMPANY ID IS NEEDED TO CREATE AN ONLINE ACCOUNT

Coaching & Counseling Services

NexGen EAP provides barrier-free access to mental health professionals and life coaches via phone, video, web, text, and chat. Either connect with one of our Life Service Navigators for assistance or effortlessly schedule an appointment on your own through the **NexGen EAP** web portal and mobile app. Get support for any wellness need from stress to anxiety, meditation, career development, relationships, and much more.

Legal and Financial Consultations

Half-hour legal consultations can be used for issues such as divorce, custody disputes, and wills. Discounted legal fees are also available if a longer consultation is required.

90-minute financial consultations can provide assistance with topics such as debt management, credit issues, and budgeting. ID Theft resources are also available.

Child/Elder Care Resources

NexGen EAP can assist you with finding a pediatrician, babysitter/day care, camps, sports lessons, music lessons, college applications, and financial aid.

Eldercare resources include help with housing options, assisted living facilities, Medicare, doctors, financial planning, and transportation.

Health Advocacy

Our Health Advocates are available to provide benefits information and assistance in navigating your health plan. They can also assist with healthcare claims and appeals management, billing assistance, prescription information and costs, and healthcare provider research.

Individualized Wellness Resources

Your comprehensive, personalized Wellness Program encompasses all areas of well-being from nutrition, dietary advice, and fitness to relaxation and restoration. Submit a wellness request, schedule a call with a Wellness Coach, or receive individualized wellness tools and resources.

Virtual Concierge

The Virtual Concierge Service features dedicated Personal Assistants available to provide you with research, referrals, or information on just about any topic including travel information, event planning, relocation, dining, entertainment, and more.

Mindfulness Training

*In partnership with **Self by Design***

To support you in building mental resilience, cognitive skills, and emotional management tools to navigate today's challenging world, our Mindfulness Training includes masterclasses on mental wellness/mindfulness and a video content library full of educational videos and exercises for the mind.

Self-Guided Mental Health Resources

Download the **NexGen EAP** app and select "Virtual Mental Health" from the menu. Using assessments and our proprietary Life Event Technology, our easy-to-use mobile app will connect you to thousands of wellness resources including podcasts, articles, assessments, videos, activities, and so much more.

The Virtual Mental Health benefit features custom-built Solutions Paths guided by AI-driven technology to provide you with mental health and personal development resources based on your individual needs and goals.

Barrier-Free Accessibility

Access your Total Well-being Program via the **NexGen EAP** app or the online web portal. Effortlessly schedule an appointment with a counselor or coach, and get connected to the full suite of your Virtual Life Services right from your computer or phone. You can also submit requests directly to your Personal Assistant, access exclusive entertainment discounts, live chat, and start a financial or legal request.

NexGen EAP

GET STARTED NOW:

WWW.NEXGENEAP.COM
1.800.327.2255
MOBILE APP: NEXGEN EAP

HOW DO I ENROLL?

1. LOG IN TO ADP

Review your current benefits selections.

Open enrollment will be passive this year. This means that if you do not make changes, your current elections will roll over, except for the Health Savings Account and Flexible Spending Account. The HSA and FSA require an active election, or you will not be enrolled or 2025.

2. CHOOSE YOUR PLAN

Verify your personal information and make any changes to your elections if necessary.

3. ENROLL

Based off of the best value plan for your needs, enroll in your benefits.

The deadline to enroll in benefits will be November 11, 2024. All benefit elections must be received within the Open Enrollment window. Benefit elections will not be accepted after November 11, 2024.

REMINDER

Benefits enrollment must be completed within 60 days of your event.

Make sure you hit 'submit' to save your elections before closing the window.

IMPORTANT NOTICE FROM BERNAU CAPITAL PARTNERS 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 the Wellmark Blue Cross Blue Shield 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.

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 Company coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drug. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits.

If you do decide to join a Medicare drug plan and drop your current Company coverage, be aware that you and your dependents may be able to get this coverage back, as long as you are an eligible active full time employee.

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 October 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:	January 1, 2025
Name of Entity/Sender:	Bernau Capital Partners/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

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

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 consultations with the attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles, copays and coinsurance applicable to other medical and surgical benefits provided under your medical plan. For more information on WHCRA benefits, contact Bernau Capital Partners or your medical plan administrator.

NEWBORNS' AND MOTHER'S HEALTH PROTECTION ACT

For maternity hospital stays, in accordance with federal law, the Plan does not 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 delivery.

However, federal law generally does not prevent the mother's or newborn's attending care provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). The plan cannot require a provider to prescribe a length of stay any shorter than 48 hours (or 96 hours following a Cesarean delivery).

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 or contact Human Resources.

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.