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YOUR 2020-2021 BENEFITS GUIDE

ENROLLING FOR BENEFITS

Open Enrollment for 2021 Benefits

Open enrollment: July 20th to July 27th

There are changes to your benefits for 2020-2021. Please see detials below.

- You have until **July 27th, 2020** to make your ellections or waive benefits**.**
- You will be enrolling for benefits online using www.employeenavigator.com
- Everyone will need to get to www.employeenavigator.com and elect benefits or waive.
- Benefit elections you make during open enrollment are effective September 1st, 2020
- Your new Medical Insurance carrier changed to **Meritain-Aetna**
- Your Dental, Vision, Life-AD&D, Short Term Disability , Long Term Disability, and Other Benefits are changing to a new insurance carrier: **Guardian.**

BENEFITS OFFERED

Table Of Contents

This guide provides only a summary of your benefits. All services described within are subject to the definitions, limitations, and exclusions set forth in each insurance carrier or provider's contract.

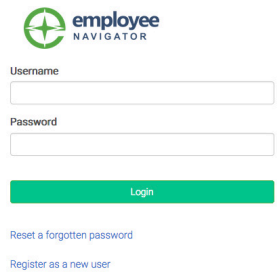
How to Enroll in Benefit

1

Log In

Go to www.employeenavigator.com and click **Login**

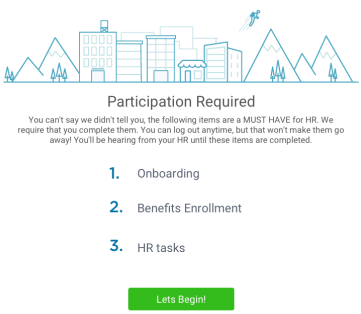
• Returning users: Log in with the username and password you selected. Click **Reset a forgotten password**.
• First time users: Click on your Registration Link in the email sent to you by your admin or **Register as a new user**.



2

Welcome!

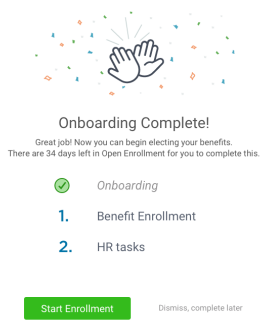
After you login click **Let's Begin** to complete your required tasks.



3

Onboarding (For first time users, if applicable)

Complete any assigned onboarding tasks before enrolling in your benefits. Once you've completed your tasks, click **Sart Enrollment** to begin your enrollments.

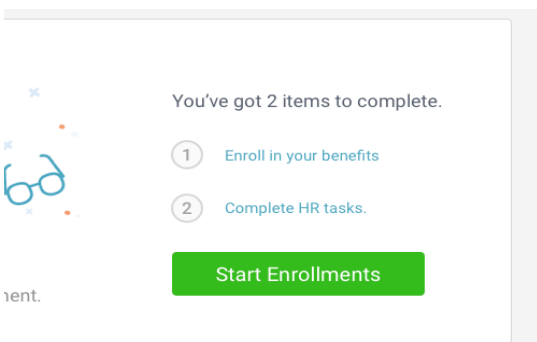


TIP if you hit "**Dismiss, complete later**" you'll be taken to your Home Page. You'll still be able to start enrollments again by clicking "**Start Enrollments**"

4

Start Enrollments

After clicking **Start Enrollment,** you'll need to complete some personal & dependent information before moving to your benefit elections.



TIP Have dependent details handy. To enroll a dependent in coverage you will need their date of birth and Social Security number.

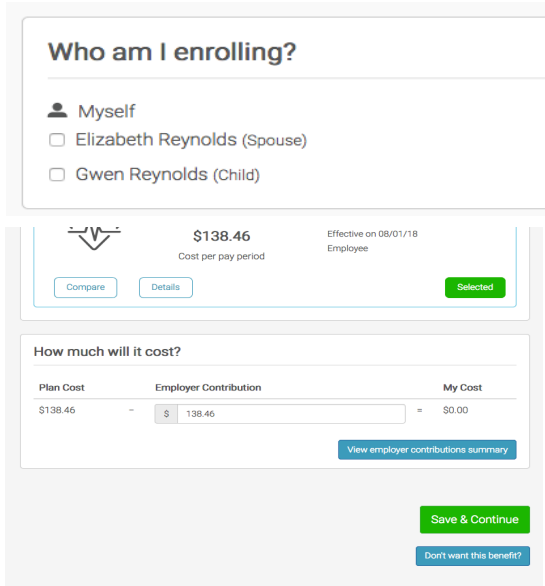
5 Benefit Elections

To enroll dependents in a benefit, click the checkbox next to the dependent's name under W**ho am I enrolling?**

Below your dependents you can view your available plans and the cost per pay. To elect a benefit, click **Select Plan** underneath the plan cost.

Click **Save & Continue** at the bottom of each screen to save your elections.

If you do not want a benefit, click **Don't want this benefit?** at the bottom of the screen and select a reason from the drop-down menu.

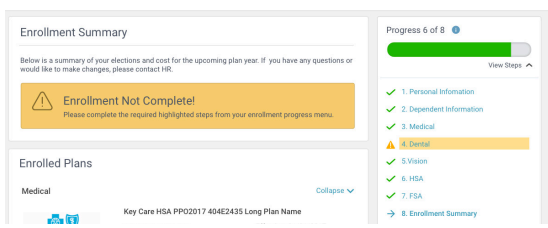


6 Forms

If you have elected benefits that require a beneficiary designation, Primary Care Physician, or completion of an Evidence of Insurability form, you will be prompted to add in those details.

7 Review & Confirm Elections

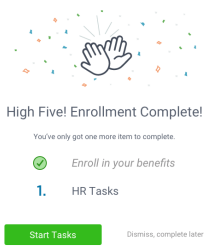
Review the benefits you selected on the enrollment summary page to make sure they are correct then click **Sign & Agree** to complete your enrollment. You can either print a summary of your elections for your records or login at any point during the year to view your summary online.



TIP If you miss a step you'll see **Enrollment Not Complete** in the progress bar with the incomplete steps highlighted. Click on any incomplete steps to complete them.

8 HR Tasks (if applicable)

To complete any required HR tasks, click **Start Tasks.** If your HR department has not assigned any tasks, you're finished!



You can login to review your benefits 24/7

The elections you make now will be effective September 1 - August 31, 2021

employeenavigator.com is your go-to place for everything benefits in one, convenient stop:

- Easy to access to benefit information
- Easy to use enrollment process

When to Enroll in Benefit

New Employees

A few weeks after your hire date, you'll receive information about how to enroll, including the deadline. Be sure to enroll by your deadline; otherwise, you'll need to wait until the next open enrollment.

The elections you make now are effective through August 31st, 2021. You may not make changes to your elections unless you have a qualifying life event.

Changing Your Benefit

Open enrollment for benefits happens each year in July. Open enrollment is the one time a year you can change, add, or cancel your benefit elections, unless you have a qualifying life event such as but not limited to marriage, divorce, child birth or adoption.

If you have a qualifying event, you must notify Human Resources. In most cases, make changes within 30 days of the event.
For details about ligfe qulifying events you may visit: https://www.irs.gov/credits-deductions/individuals/qualifying-life-events

When Benefits Start

For new employees your benefits coverage usually begins the first of the month following 60 days from the date you started working.

Who's Eligible?

Full-time employees who work at least 30 hours per week are eligible for benefits
Eligible dependents generally include your:

- Legal spouse
- Dependent children to age 26 (includes biological children, legally-adopted children and stepchildren)
- Disabled children over age 26 who are legally dependent upon the employee.
- In order to be eligible for Guardian benefits: Employees must be legally working **(a)** in the United States or **(b)** outside the United States, for a US based employer, in a country or region approved by Guardian.

USING YOUR MEDICAL COVERAGE

Choose Your Providers Wisely

You have the freedom to choose any doctor, but you get more from your benefits when you use network providers: you pay a lower deductible and the plan pays more of the cost of your services. To find a network doctor, provider, or facility, visit www.**meritain.com.**

Preventive Care is Free to You

Covered preventive care is paid in full by the plan – no deductible, no copay. Visit **www.healthcare.gov/prevention** for a list of covered preventive services and immunizations, along with age recommendations.

Your Out-of-Pocket Costs

In some ways, medical insurance is like car insurance:

• You pay a premium every month for your coverage (in this case, your premium is deducted from your paycheck before taxes).

• If you get into an accident and need to file a claim, you have to pay your deductible. It's the same with medical, you pay most medical expenses out of pocket until you meet your deductible and then the plan starts to pay. Like car insurance, generally the higher the deductible, the lower the premium.

• With car insurance, you typically have to meet your deductible each time you have a claim. With medical coverage, your deductible applies to the calendar year. Once you meet your deductible for the year, you're done. Then, it starts over again the next January 1.

• Once you meet your deductible for the year, you and the plan share the cost of your services. When you pay a percentage and the plan pays a percentage, that's called coinsurance. When you pay a fixed dollar amount, such as for a prescription, that's called a copay.

• Unlike car insurance, your medical coverage offers protection against very high expenses. If you reach what's called your **out-of-pocket maximum** in medical expenses in less than a calendar year, the plan will pay 100% for the remainder of that calendar year.

Family Deductibles and Out-of-Pocket Maximums

The deductible and out-of-pocket maximum for each person in the family is capped at the individual amount. In other words, once an individual has reached the individual deductible amount, the plan will start paying benefits for that person. And, once the combined expenses of all family members reaches the family amount, the deductible or out-of-pocket maximum will be considered met for all family members (even if they haven't met the individual amount).

What You Need to Know About HDHP Medical Coverage

High deductible health plans (HDHPs) are similar to traditional PPO medical plans in many ways: covered preventive care is paid in full by the plan, your benefits are higher when you use network providers, once you meet the deductible you and the plan share the cost of services, etc. **But there are some important differences**

• The HDHP deductible applies to **both medical and pharmacy costs.** This means you pay the full contracted cost of your prescriptions until you meet your annual deductible. The good news is that the amount you pay for prescriptions out of pocket (or with a health savings account) counts toward your combined medical/Rx deductible and out-of-pocket maximum – helping you reach it faster.

• If you enroll in an HDHP, you may be able to take advantage of a of a **health savings account (HSA).** An HSA allows you to set aside pre-tax money to pay for eligible expenses, like your deductible and copays. (See the "Health Savings Account (HSA)" section for more information.)

Medical Plan: Meritain - Aetna | Copay Plan $3,000

The Copay Plan $3,000 is administered by Meritain, and your network is Aetna. As a preferred provider organization (PPO) plan, you receive higher benefits if you use network providers. Prescription drug coverage is administered by Magellan (included when you enroll in medical). See the last page of this guide for who to contact with questions.

	In-Network		Out-of-Network
ANNUAL DEDUCTIBLE	$3,000 per individual, $6,000 per family		$6,000 per individual, $12,000 per family
ANNUAL OUT-OF-POCKET MAX	$6,000 per individual; $12,000 per family		$12,000 per individual, $24,000 per family
OFFICE VISIT	$40 copay per visit, $65 copay for specialists		60% of UR* after deductible
EMERGENCY ROOM	$350 copay per visit (copay waived if admitted) - Deductible - then 20%		
PREVENTIVE CARE (Exam including preventive lab, well baby, annual women's exam, immunizations	100%, deductible doesn't apply		60% of UR after deductible
INPATIENT HOSPITAL CARE	80% after deductible		60% of UR after deductible
MATERNITY CARE	80% after deductible		60% of UR after deductible
URGENT CARE	100% after $75 copay per visit		60% of UR after deductible
DIAGNOSTIC X-RAY AND LAB	80% after deductible		60% of UR after deductible
OUTPATIENT SURGERY	80% after deductible		60% of UR after deductible
PRESCRIPTION DRUGS (Deductible does not apply)	Pharmacy (up to 30 day supply)	Pharmacy or Mail-order (up to 90-day supply)	
Generic	100% after $10 copay	100% after $25 copay	Not covered
Preferred brand	100% after $40 copay	100% after $100 copay	Not covered
Non-preferred brand	100% after $70 copay	100% after $175 copay	Not covered
Speciality	You pay 25% (30-day fill at pharmacy allowed once: then you must use mail order)		Not covered

*UR means usual and reasonable charge — a charge which is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same area. If your non-network provider's charges exceed UR, you pay the excess in addition to any required coinsurance.

**The above information is intended as a benefit summary only. It does not include all of the benefit provisions, limitations and qualifications. If this information conflicts in any way with the contract, the contract will prevail.

Medical Plan: Meritain - Aetna | HDHP-HSA $4,000

The HDHP-HSA $4,000 Plan is administered by Meritain and your network is Aetna. As a preferred provider organization (PPO) plan, you receive higher benefits if you use network providers. Prescription drug coverage is administered by Magellan (included when you enroll in medical). See the last page of this guide for who to contact with questions.

	In-Network		Out-of-Network
ANNUAL DEDUCTIBLE	$4,000 per individual; $8,000 per family		$8,000 per individual, $16,000 per family
ANNUAL OUT-OF-POCKET MAX	$4,000 per individual; $8,000 per family		$16,000 per individual, $32,000 per family
OFFICE VISIT	100% after deductible		60% of UR* after deductible
EMERGENCY ROOM	100% after deductible		
PREVENTIVE CARE (Exam including preventive lab, well baby, annual women's exam, immunizations)	100%, deductible doesn't apply		60% of UR after deductible
INPATIENT HOSPITAL CARE	100% after deductible		60% of UR after deductible
MATERNITY CARE	100% after deductible		60% of UR after deductible
URGENT CARE	100% after deductible		60% of UR after deductible
DIAGNOSTIC X-RAY AND LAB	100% after deductible		60% of UR after deductible
OUTPATIENT SURGERY	100% after deductible		60% of UR after deductible
PRESCRIPTION DRUGS	Pharmacy (up to 30 day supply)	Mail-order (up to 90-day supply)	
Generic	100% after deductible	100% after deductible	Not covered
Preferred brand	100% after deductible	100% after deductible	Not covered
Non-preferred brand	100% after deductible	100% after deductible	Not covered
Speciality	100% after deductible		Not covered

*UR means usual and reasonable charge — a charge which is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same area. If your non-network provider's charges exceed UR, you pay the excess in addition to any required coinsurance.

**The above information is intended as a benefit summary only. It does not include all of the benefit provisions, limitations and qualifications. If this information conflicts in any way with the contract, the contract will prevail.

IMPORTANT NOTICE - HSA- Health Savings Account

By enrolling in this medical plan, you will be provided with a Health Savings Account. White Brothers Auto Supply will be your agent for the purpose of opening and administering/maintaining an Optum Bank, Inc. ("Bank") Health Savings Account ("HSA"). Please refer to the Optum Bank Notices at the end of this guide.
Please notify your HR department if you have any questions or concerns.

Health Savings Account (HSA)

If you enroll in a high deductible health plan (HDHP) medical plan, you can also choose to set aside pre-tax money in a Health Savings Account (HSA) to use for eligible expenses. Your savings can build up year over year, earn interest, and can even be invested to grow your funds tax-free.

HSA Triple Tax Savings

Pre-tax payroll deductions lower your tax bill

Tax-free withdrawals for eligible health expenses

Tax-free growth from interest or investment returns

HSA Contribution Limits

For the 2021 calendar year, the IRS limits what you can contribute to an HSA to:

	2020	2021
Single coverage:	$3,550	$3,600
Family coverage:	$7,100	$7,200
Additional catch-up contribution (turning age 55+):	$1,000	$1,000

Enrollment in HDHP is necessary to participate in 2020-2021.

HSA Eligibility

You must be enrolled in a high deductible health plan (HDHP) to have an HSA.
To be eligible for an HSA, you cannot be:

- Claimed as a tax dependent
- Enrolled in Medicare (whether or not you were automatically enrolled due to age)
- Covered by your own or your spouse's fl xible spending account (FSA), health reimbursement arrangement (HRA), or non-high-deductible health plan. Exceptions: limited purpose FSA or post-deductible HRA.

Use the HSA for any IRS-Approved Healthcare Expenses

- For you, your spouse, and/or eligible tax dependents — whether they are on your medical plan or not.
- Now or in the future — even during retirement.
- Once you've enrolled in Medicare, you can't contribute to an HSA but you can still withdraw money tax-free to pay healthcare expenses.

You can start, stop, or change your contribution amount during the year — you don't have to wait for open enrollment.

Dental | Guardian

How it Works

The preferred dentist program administered by Guardian is designed to provide the dental coverage you need with the features you want — like the freedom to visit the dentist of your choice, in or out of network. Use network providers to receive higher benefits. See the last page of this guide for who to contact with questions.

Dental Value Plan: $1000 Your network is: Dental Guard Preferred	**In-Network** % of negotiated fee	**Out-of-Network** % of negotiated fee
ANNUAL DEDUCTIBLE	$50 per individual/3 family limit	
ANNUAL MAXIMUM BENEFIT	$1,000 per individual	
PREVENTIVE AND DIAGNOSTIC	100% (deductible does not apply)	100% (deductible does not apply)
BASIC RESTORATIVE	100% after deductible	100% after deductible
MAJOR RESTORATIVE	60% after deductible	60% of UR after deductible

Dental NAP Plan: $1000 Your network is: Dental Guard Preferred	**In-Network** % of negotiated fee	**Out-of-Network** % of UCR fee
ANNUAL DEDUCTIBLE	$50 per individual/3 family limit	
ANNUAL MAXIMUM BENEFIT	$1,000 per individual	
PREVENTIVE AND DIAGNOSTIC	100% (deductible does not apply)	100% (deductible does not apply)
BASIC RESTORATIVE	80% after deductible	80% after deductible
MAJOR RESTORATIVE	50% after deductible	50% of UR after deductible

* The Reasonable and Customary charge is based on the lowest of the: “Actual Charge” (the dentist’s actual charge); or “Usual Charge” (the dentist’s usual charge for the same or similar services); or UCR (Usual, Customary, and Reasonable) (the 90th percentile charge of most dentists in the same geographic area for the same or similar services as determined by Guardian).

****Always confirm with your provider how procedures will be covered prior to treatment.**

Guardian Choice – Additional Details IN THE NEXT PAGE

*The above information is intended as a benefit summary only. It does not include all of the benefit provisions, limitations and qualifications. If this information conflicts in any way with the carrier's contract, the carrier's contract will prevail.

Guardiananytime.com

Dental | Guardian

Guardian Choice – Additional Details

You have the flexibility to choose the plan that can best meet your needs.

Both plans can meet your needs; the difference is how out-of-network benefits are reimbursed. If you visit a dentist in the Guardian network, you will receive the most savings through the Value Plan. If there is a possibility of using an out-of-network dentist then the Network Access Plan offers the highest out-of-network reimbursement.

Here's how this benefit works:

- Premiums are the same for either plan
- Option to switch plans each year at annual enrollment time
- Save an average of 30% over what dentists usually charge by using network providers

	Value Plan	Network Access Plan
Plan Description:	You receive a higher co-insurance level with this plan than you would if you selected the NAP plan – which means less out-of-pocket costs. All benefits are paid based on a fee schedule. Therefore, when using out-of-network care, the dentist may charge the difference between the fee schedule and their regular fee.	You will receive the same reimbursement for in and out-of-network dentists. Co-insurance percentages for in-network care are not as high as with the Value Plan. In-network benefits are based on a negotiated PPO fee schedule, out-of-network charges are based on local UCR (usual, customary, reasonable) charges.
Out-of-network:	▪ Benefits are based on the discounted fee schedules agreed upon by our network dentists. ▪ Any amount that is charged over the fee schedule is the responsibility of the patient.	▪ Benefits are based on usual, customary and reasonable (UCR) charges that dentists in your area charge for each procedure.
Co-insurance:	▪ Preventive services are covered 100%. ▪ Co-insurance for other services is higher than the Network Access Plan.	▪ Preventive services are covered 100%. ▪ Co-insurance for other services is lower than the Value Plan.

To find a dentist in your network, visit www.GuardianAnytime.com. You can also download our GuardianAnytime mobile app to use our Find-a-Provider tool.
For Overview of your Dental Benefits, please see About Your Benefit Section of this Enrollment Booklet.

Vision Plan | Guardian

Guardian administers the vision plan.

- Go to any licensed vision specialist and receive coverage (but you receive a better benefit if you stay in network: Guardian Vision).
- Choose from a large network of ophthalmologists, optometrists and opticians.
- Take advantage of our service agreements. It's easy to find network providers at **GuardianAnytime.com**

	In-Network	Out-of-Network
ROUTINE EYE EXAM	Once every 12 months (after $10 copay)	
	100%	Up to $59
LENSES	Once every 12 months (after $25 eyewear copay)	
Single vision	100%	Up to $30
Bifocal	100%	Up to $50
Trifocal	100%	Up to $65
Lenticular	100%	Up to $100
FRAMES	One pair every 24 months (after $25 copay)	
	100% (up to $130 + 20% balance)	Up to $70
	*See additional information about Retail Chain Provider below	Not Covered
CONTACT LENSES INSTEAD OF GLASSES	One pair every 12 months (after $25 copay)	
Fitting and evalutation	Member pays Standard: $50; Custom: $75	Included in the Contact Lens Allowance
Elective lenses	Up to $130	Up to $120
Necessary lenses	100%	Up to $210

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Significant out-of-pocket savings available with your Full Feature plan by visiting one of Guardian's Vision's network locations including retail centers such as Wal-Mart®, JCPenney®, Sears®, Target®, Sam's Club®, Costco®, Pearle®, America's Best®, For Eyes® and Visionworks®.

Voluntary Life and AD&D Insurance | Guardian

You may also purchase voluntary life for yourself, your spouse and/or your dependent. Our life and AD&D coverage is insured by Guardian. For premiums and more information about these benefits, visit Guardiananytime.com.

For You

The first time you are eligible to enroll (usually as a new employe), you can purchase voluntary life and AD&D insurance coverage of up to a maximum of $250,000. You cannot elect more than this. Evidence of Insurability (EOI)** is required for coverage amounts above $150,000. Accidental Death and Disburesemtn covers maximum for one time the life insurance election amount.

Portability and Conversion benefits are included - some restrictions may apply- refer to certificate of benefits (all availabel in your Online Portal).

For Your Spouse

You can purchase voluntary life and AD&D insurance for your spouse from $10,000 in multiples of $5,000 up to a maximum of 100% of your voluntary life election or $250,000 (whichever is less). Evidence of insurability (EOI) is required for coverage amounts above $25,000.

For Your Children

You can purchase $5,000, $10,000 of voluntary life and AD&D insurance for your children, not to exceed 100% of Employee's amount.

Extras

If you are enrolled in voluntary life and AD&D insurance, you have access to WillPrep Services.

WillPrep Services offer support and guidance to help you properly prepare the documents necessary to preserve your family's financial security. WillPrep has a range of services including online planning documents, a resource library and access to professionals* to help with issues related to: Advanced Health Care Directives, Estate Taxes, Executors & Probate, Financial Power of Attorney, Guardianship and Conservatorship, Healthcare Power of Attorney, Wills and Living Wills, Resource Library and Trusts.

• Will preparation provided by Integrated Behavioral Health, Inc. and its contractors.

www.ibhwillprep.com **Username: WillPrep Password: GLIC09 or call 877-433-6789**

** **Evidence of Insurability (EOI):** also known as proof of good health, EOI is an application process in which you provide information of your and your dependents' health. Download the EOI voluntary life form at Guardiananytime.com.

Select a beneficiary and make sure your loved ones are protected

Go to Guardiananytime.com to choose who you want to receive the basic and voluntary life insurance benefits in the event of your death.

Disability Insurance | Guardian

A Disability insurance plan through Guardian provides:

- Income protection while you are unable to work
- Affordable group rates
- Fast claim payments paid directly to you that can help pay for expenses while you recover
- Extensive resources and support to help you get back to work and a productive life

About Your Benefits:

	Short-Term Disability	Long-Term Disability
Coverage amount	60% of salary to maximum$1000/week	60% of salary to maximum$5000/month
Maximum payment period: Maximum length of time you can receive disability benefits.	13 weeks	Social Security Normal Retirement Age
Accident benefits begin: The length of time you must be disabled before benefits begin.	Day 8	Day 91
Illness benefits begin: The length of time you must be disabled before benefits begin.	Day 8	Day 91
Evidence of Insurability: A health statement requiring you to answer a few medical history questions.	Health Statement may be required	Health Statement may be required
Guarantee Issue: The 'guarantee' means you are not required to answer health questions to qualify for coverage up to and including the specified amount, when applicant signs up for coverage during the initial enrollment period.	We Guarantee Issue $1000 in coverage	We Guarantee Issue $5000 in coverage
Minimum work hours/week: Minimum number of hours you must regularly work each week to be eligible for coverage.	Planholder Determines	Planholder Determines
Pre-existing conditions: A pre-existing condition includes any condition/symptom for which you, in the specified time period prior to coverage in this plan, consulted with a physician, received treatment, or took prescribed drugs.	3 months look back; 12 months after 2 week limitation	6 months look back; 24 months after exclusion
Premium waived if disabled: Premium will not need to be paid when you are receiving benefits.	Yes	Yes
Survivor benefit: Additional benefit payable to your family if you die while disabled.	No	3 months

UNDERSTANDING YOUR BENEFITS—DISABILITY (Some information may vary by state)

. Disability (long-term): For first two years of disability, you will receive benefit payments while you are unable to work in your own occupation. After two years, you will continue to receive benefits if you cannot work in any occupation based on training, experience and education.

. Earnings definition: Your covered salary excludes bonuses and commissions.

. Special limitations: Provides a 24-month benefit limit for specific conditions including mental health and substance abuse. Other conditions such as chronic fatigue are also included in this limitation. Refer to contract for details.

. Work incentive: Plan benefit will not be reduced for a specified amount of months so that you have part-time earnings while you remain disabled, unless the combined benefit and earnings exceed 100% of your previous earnings.

Guardiananytime.com

OTHER BENEFITS

Other benefits are offered by **Guardian**

Employee Assistance Program

WORKLIFE MATTERS

Your Confidential Employee Assistance Program – Helping find balance between work and home life.

WorkLifeMatters provides guidance for personal issues that you might be facing and information about other concerns that affect your life, whether it's a life event or on a day-to-day basis.

- Unlimited free telephonic consultation with an EAP counselor available 24/7 at 800-386-7055
- Referrals to local counselors — up to three sessions free of charge
- State-of-the-art website featuring over 3,400 helpful articles on topics like wellness, training courses, and a legal and financial center

WorkLifeMatters can offer help with:

Education
- Admissions testing & procedures
- Adult re-entry programs
- College Planning
- Financial aid resources
- Finding a pre-school

Dependent Care & Care Giving
- Adoption Assistance
- Before/after school programs
- Day Care/Elder Care
- Elder care
- In-home services

Legal and financial
- Basic tax planning
- Credit & collections
- Debt Counseling
- Home buying
- Immigration

Lifestyle & Fitness Management
- Anxiety & depression
- Divorce & separation
- Drugs & alcohol

Working Smarter
- Career development
- Effective managing
- Relocation

For more information about WorkLifeMatters, go to **www.ibhworklife.com**; User Name: **Matters**; Password: **wlm70101**

WorkLifeMatters Program services are provided by Integrated Behavioral Health, Inc., and its contractors. Guardian does not provide any part of WorkLifeMatters Program services. Guardian is not responsible or liable for care or advice given by any provider or resource under the program. This information is for illustrative purposes only. It is not a contract. Only the Administration Agreement can provide the actual terms, services, limitations and exclusions. Guardian and IBH reserve the right to discontinue the WorkLifeMatters Program at any time without notice. Legal services provided through WorkLifeMatters will not be provided in connection with or preparation for any action against Guardian, IBH, or your employer.

OTHER BENEFITS

Other benefits are offered by **Guardian**

Guardian Helpful Benefit Information Tools - Available 24/7

For Employees – Helpful Benefits Information Available 24/7

Members and dependents can access helpful, secure information about their Guardian benefits:

- Review benefits and update information1
- Check the status of a claim or Evidence of Insurability application
- View and print ID cards
- Submit a Short-Term Disability claim online
- Receive e-mails when a claim has been processed and a response is available online2
- Use the Find-A-Provider app to locate a provider anytime. Download the app to an Android or iPhone smart phone.
- Visit www.guardianananytime.com

CONTACT INFORMATION

Medical and Prescription Drugs

Medical

- Benefit
- Claims and pre-authorization

My Medical Benefits:
In-network doctors or hospitals
Meritain Health Customer Service 1.800.925.2272 |
www.meritain.com
Group Number: 17526

- Finding a network provider

The Aetna Choice® POS II provider network Aetna provider line

1.800.343.3140

www.aetna.com/docfind/custom/mymeritain

Prescription Drugs

- Benefit
- Claims

Magellan: **800-424-0472** or **www.magellanrx.com**

Dental, Vision, Voluntary Life/AD&D, STD & LTD you may contact:

Guardian Helpline **888-600-1600**, weekdays, 8:00 AM to 8:30 PM, EST. Refer to your member ID (social security number) and your plan number: **00576481**.

Go to www.GuardianAnytime.com to access secure information about your Guardian benefits.
Your on-line account will be set up within 30 days after your plan effective date.

Health Savings Account

Optum Bank

You may call 866-234-8913 or log in to www.optumbank.com

2020 -2021 YOUR ANNUAL NOTICES

*

SNELLINGS WALTERS

NOTICES

Optum Bank Notice

Appointment of Employer as Authorized Agent to Open an HSA

Appointment and Certification

By accepting, I appoint White Brothers Auto Supplu ("Employer") as my agent for the purpose of opening and administering/maintaining an Optum Bank, Inc. ("Bank") Health Savings Account ("HSA") on my behalf and authorize Employer to send and receive information to and from the Bank on my behalf (including account number) in order to accomplish this purpose. I authorize the Bank to make any inquiries that it considers appropriate to determine if it should open and maintain my HSA, and I acknowledge that I have received the Bank's USA PATRIOT Act Notice provided below:

IMPORTANT INFORMATION ABOUT PROCEDURES FOR OPENING A NEW ACCOUNT
To help the government fight the funding of terrorism and money laundering activities, federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account. What this means for you: When you open an account, we will ask for your name, address, date of birth, and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents.

I certify that I am eligible to contribute to an HSA under Internal Revenue Code Section 223. I authorize and direct the Bank to issue a Debit MasterCard® to me. I certify that I have received or viewed the Bank's statement of the hardware and software requirements for access to and retention of electronic records and that I have the ability to access the Bank's website where electronic statements and other documentation are stored. I instruct the Bank, unless otherwise notified and instructed by me, to provide the Custodial and Deposit Agreement and all other HSA notices, disclosures and information related to and governing my HSA to me online at www.optumbank.com. I understand that monthly account statements and other documentation and notices will be delivered or made available electronically. If I want HSA statements mailed to my home, I must notify the Bank directly.

I agree that Employer will remain my agent unless and until Employer and the Bank receive notice that the appointment of Employer as my agent has been terminated, that I am no longer employed by Employer, or that I am no longer an HSA eligible individual; or I receive a notice from the Bank that my application for an HSA has been declined.

_____ _____

Do not send to Optum Bank

NOTICES

IMPORTANT NOTICES FROM White Brothers Auto Supply Inc. REGARDING THE 2020 -2021 MEDICAL PLAN

The following notices provide important information about the group health plan provided by your employer. Please read the attached notices carefully and keep a copy for your records.

If you have any questions regarding any of these notices, please contact:

General Contact: Tyler Jones
Phone: 478 - 765-4448
Email: t.jones@whitebros.net
Mailing Address:356 Walnut St
Macon, GA - 31201

Plan Administrator: White Brothers Auto Supply Inc
Phone: 478 - 765-4448
Email: t.jones@whitebros.net
Mailing Address:356 Walnut St
Macon, GA - 31201

Please note this is not a legal document and should not be construed as legal advice.

NOTICES

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act of 1998 (WHCRA) provides protections for individuals who elect breast reconstruction after a mastectomy. Under WHCRA, group health plans offering mastectomy coverage must provide coverage for certain services relating to the mastectomy, in a manner determined in consultation with the attending physician and the patient.

The required coverage includes:

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

Under WHCRA, mastectomy benefits may be subject to annual deductibles and coinsurance consistent with those established for other benefits under the plan or coverage.

Group health plans, health insurance companies and HMOs covered by the law must provide written notification to individuals of the coverage required by WHCRA upon enrollment and annually thereafter.

Additional consumer information on WHCRA is available in the publication **Your Rights After A Mastectomy**.

Information for group health plans and employers on WHCRA and other health benefit law requirements is available in the publication **Compliance Assistance Guide – Health Benefits Coverage Under Federal Law**.

This fact sheet has been developed by the U.S. Department of Labor, Employee Benefits Security Administration, Washington, DC 20210. It will be made available in alternate formats upon request: Voice telephone: 202-693-8664; TTY: 202-501-3911. In addition, the information in this fact sheet constitutes a small entity compliance guide for purposes of the Small Business Regulatory Enforcement Fairness Act of 1996.

Important Notice from White Brothers Auto Supply, Inc. 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 White Brothers Auto Supply, Inc 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. **White Brothers Auto Supply, Inc has determined that the prescription drug coverage offered by the [Insert Name of Plan] is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current White Brothers Auto Supply, Inc coverage will be affected. Contact your plan administrator for an explanation of the prescription drug coverage plan provisions/options under the plan available to Medicare eligible individuals when you become eligible for Medicare Part D. If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents may or 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 [Insert Name of Entity] 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 refer to main contact in the front page of this notice.

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 [Insert Name of Entity] changes. You also may request a copy of this notice at any time.

CMS Form 10182-CC

Updated April 1, 2011

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).

General Contact: Tyler Jones
Phone: 478 - 765-4448
Email: t.jones@whitebros.net
Mailing Address:356 Walnut St
Macon, GA - 31201

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website:
https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website:
http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563

KANSAS – Medicaid

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

KENTUCKY – Medicaid

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

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

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

LOUISIANA – Medicaid

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

MAINE – Medicaid

Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-442-6003
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website:
http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-862-4840

MINNESOTA – Medicaid

Website:
https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp [Under ELIGIBILITY tab, see "what if I have other health insurance?"]
Phone: 1-800-657-3739

MISSOURI – Medicaid

Website:
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid

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

NEBRASKA – Medicaid

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

NEVADA – Medicaid

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

NEW HAMPSHIRE – Medicaid

Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP

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

NEW YORK – Medicaid

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

NORTH CAROLINA – Medicaid

Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website:
http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid

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

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2020. Contact your State for more information on eligibility –

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-800-541-5555	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864

PENNSYLVANIA – Medicaid	RHODE ISLAND – Medicaid and CHIP
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

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

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/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

Paperwork Reduction Act Statement

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

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

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

NOTICES

Newborns' and Mothers' Health Protection Act

The Newborns' and Mothers' Health Protection Act (the Newborns' Act) provides protections for mothers and their newborn children relating to the length of their hospital stays following childbirth.

Under the Newborns' Act, group health plans may not restrict benefits for mothers or newborns for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. The 48-hour (or 96-hour) period starts at the time of delivery, unless a woman delivers outside of the hospital. In that case, the period begins at the time of the hospital admission.

The attending provider may decide, after consulting with the mother, to discharge the mother and/or her newborn child earlier. The attending provider cannot receive incentives or disincentives to discharge the mother or her child earlier than 48 hours (or 96 hours).

Even if a plan offers benefits for hospital stays in connection with childbirth, the Newborns' Act only applies to certain coverage. Specifically, it depends on whether coverage is "insured" by an insurance company or HMO or "self-insured" by an employment-based plan. (Check the Summary Plan Description, the document that outlines benefits and rights under the plan, or contact the plan administrator to find out if coverage in connection with childbirth is "insured" or "self-insured.")

The Newborns' Act provisions always apply to coverage that is self-insured. If the plan provides benefits for hospital stays in connection with childbirth and is insured, whether the plan is subject to the Newborns' Act depends on state law. Many states have enacted their own version of the Newborns' Act for insured coverage. If your state has a law regulating coverage for newborns and mothers that meets specific criteria and coverage is provided by an insurance company or HMO, state law will apply.

All group health plans that provide maternity or newborn infant coverage must include in their Summary Plan Descriptions a statement describing the Federal or state law requirements applicable to the plan (or any health insurance coverage offered under the plan) relating to hospital length of stay in connection with childbirth for the mother or newborn child.

For more information, see the **Frequently Asked Questions** (FAQs) About the Newborns' and Mothers' Health Protection Act.

This fact sheet has been developed by the U.S. Department of Labor, Employee Benefits Security Administration, Washington, DC 20210. It will be made available in alternate formats upon request: Voice telephone: 202-693-8664; TTY: 202-501-3911. In addition, the information in this fact sheet constitutes a small entity compliance guide for purposes of the Small Business Regulatory Enforcement Fairness Act of 1996.

NOTICES

**** Continuation Coverage Rights Under COBRA ****

Introduction

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

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

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

What is COBRA continuation coverage?

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

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

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

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

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

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

When is COBRA continuation coverage available?

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

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

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

General Contact: Tyler Jones
Phone: 478 - 765-4448
Email: t.jones@whitebros.net
Mailing Address:356 Walnut St
Macon, GA - 31201

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would

have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

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

Are there other coverage options besides COBRA Continuation Coverage?

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

If you have questions

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

Keep your Plan informed of address changes

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

General Contact: Tyler Jones
Phone: 478 - 765-4448
Email: t.jones@whitebros.net
Mailing Address:356 Walnut St
Macon, GA - 31201

NOTICES

Your Information.
Your Rights.
Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of your health and claims records	• You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct health and claims records	• You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

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Your Rights *continued*

Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. • We are not required to agree to your request, and we may say "no" if it would affect your care.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

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Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in payment for your care • Share information in a disaster relief situation • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Help manage the health care treatment you receive	• We can use your health information and share it with professionals who are treating you.	***Example:*** *A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*
Run our organization	• We can use and disclose your information to run our organization and contact you when necessary. • **We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.** This does not apply to long term care plans.	***Example:*** *We use health information about you to develop better services for you.*
Pay for your health services	• We can use and disclose your health information as we pay for your health services.	***Example:*** *We share information about you with your dental plan to coordinate payment for your dental work.*
Administer your plan	• We may disclose your health information to your health plan sponsor for plan administration.	***Example:*** *Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

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How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests and work with a medical examiner or funeral director	• We can share health information about you with organ procurement organizations. • We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

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Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

*The above information is intended as a benefit summary only. It does not include all of the benefit provisions, limitations and qualifications. If this information conflicts in any way with the carrier's contract, the carrier's contract will prevail.

SNELLINGS WALTERS