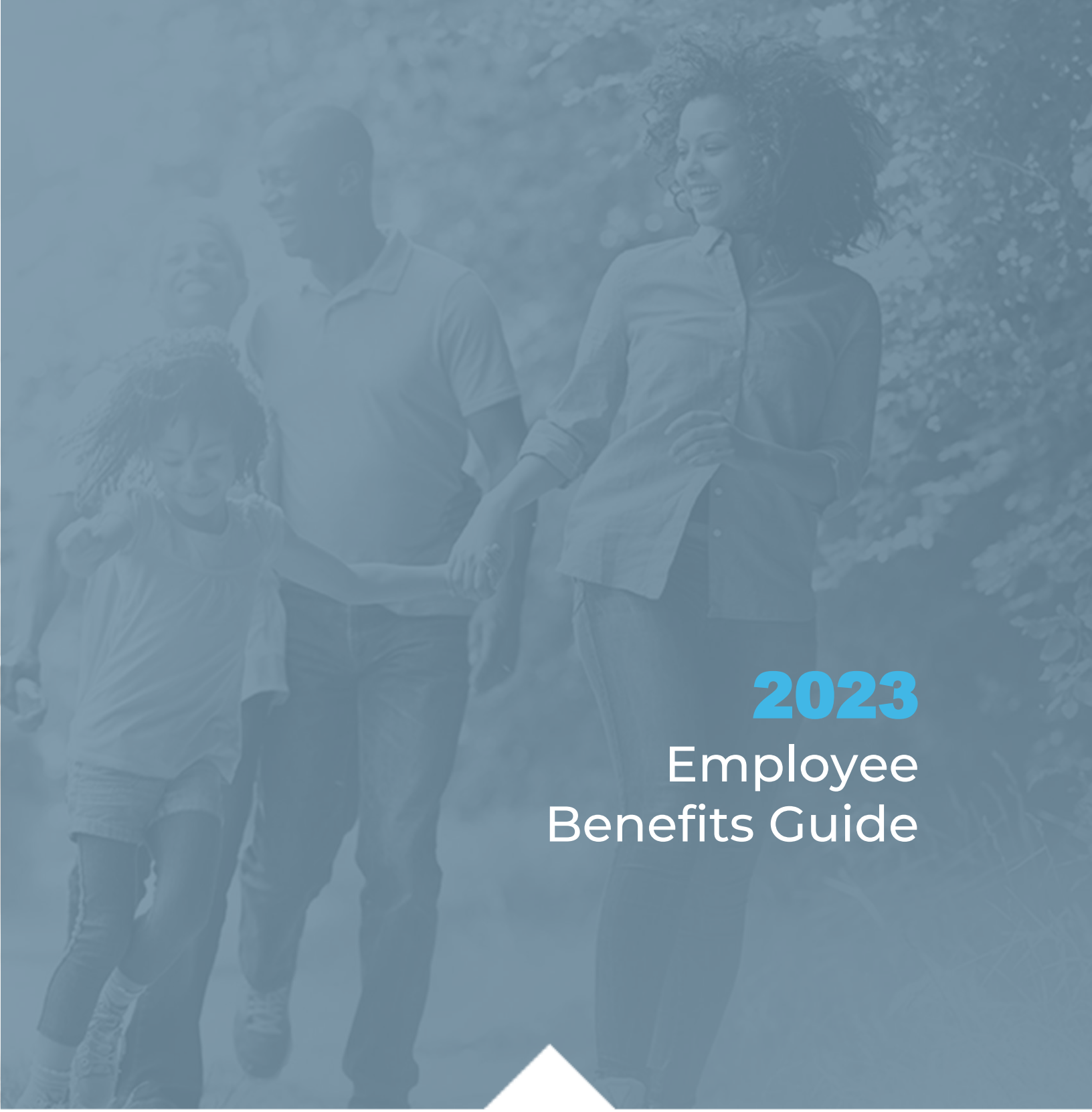


2023
Employee Benefits Guide

BOWEN CENTER

BOWEN CENTER

Welcome to your Benefits

Welcome to the 2023 Bowen Center Employee Benefits Guide. This guide offers you and your family members a look into your comprehensive benefits program. We encourage you to take the time to educate yourself about your options and choose the best coverage options for you and your family. We have included brief descriptions of our benefit offerings and the cost. If you have any questions, please contact your HR coordinator.

Contents

Enrollment

Open Enrollment

This benefit guide provides an overview of the benefits that Bowen Center offers.

Each year, Bowen Center conducts a benefits open enrollment, which allows employees to make changes to their benefit plan elections. Benefits elected during open enrollment are effective from January 1st through December 31st .

Who is eligible?

To be eligible for benefits, you must be a full-time employee of Bowen Center. Your spouse is eligible for coverage under applicable benefit plans unless they work full-time and are eligible for health coverage through their own employer. If your spouse works full-time and is eligible for health coverage through their own employer, they will need to gain coverage under their own employer. Dependent Children are also eligible for coverage under applicable benefit plans.

When does coverage become effective?

New employees will become eligible for benefits effective on the first day of the month following 30 days of employment, provided you have completed the enrollment process and all required information and documents.

Enrollment Changes

As long as you remain eligible, your benefit elections will be in place until December 31st , 2023. However, you may make mid-year changes if you have a qualifying event. Examples of qualifying events that allow you to change your benefits elections during the year are:

- Marriage or divorce
- Birth, adoption or change in the custody of a child
- Death of your spouse or dependent child
- A change in the employment status of a spouse, impacting your benefit eligibility
- A change in your dependent's status (due to age or eligibility for medical coverage through his/her own employer)
- A significant reduction in the average number of hours worked

If you have a qualifying event, you must change your benefit elections within 30 days of the event. If you do not make a change within 30 days, you must wait until the next open enrollment period. Please contact human resources for more information.

Medical Plan

Medical Plan Details

Bowen Center offers eligible full-time employees a choice between two health insurance plan options.

Both the PPO and HSA-Qualified Health Insurance Plans

- Are administered by UMR and use the United Health Care Choice Plus PPO network
- Cover preventive care, such as your annual routine physical and related preventive tests at 100% with no deductible or copayment
- Cover the same types of medical expenses and have the same exclusions
- Have an unlimited lifetime maximum benefit
- Meet and exceed the minimum coverage requirement under the Affordable Care Act

UMR Online Services

- Visit www.umr.com
- Select “Members”
- Enter the member ID located on your ID card
- Click “Go to my online services”
- Submit your username and password. If you have not yet registered for online services, click “Need a Username?” and follow the prompts to complete your registration.
- There will be a link to log in to OptumRx to review your prescription claims.

UMR online services are fast, easy, and free with convenient access to tools and resources such as:

- Claim status (including copies of Explanations of Benefits - EOBs)
- Status of medical deductibles and out-of-pocket amounts
- Frequently used forms
- Ordering ID cards (duplicates or replacements)
- Health information
- Prescription benefits information
- Note: Once logged in to your account on umr.com, there is a link to log in to OptumRx where you can view your prescription claims.

If you have questions or problems, you can contact the UMR technical support team at 866-922-8266.

UHC Choice Plus Network

Our Health Plans utilize the United HealthCare (UHC) Choice Plus network. The UHC Choice Plus network is one of the broadest networks of physicians and hospitals available. The UHC Choice Plus PPO network includes most hospitals, as well as most physicians in our area. Additionally, the UHC Choice Plus PPO includes a broad national network of providers across the country. Please visit their website, www.umr.com, for a complete list of participating providers. It is very likely that your physician already participates in the UHC Choice Plus PPO, but it is recommended that you verify this with your doctor's office before each visit.

To find physicians within the PPO network:

- Please visit www.umr.com
- Click "Find a Provider"
- Click "Medical"
- Select "United Health Care Choice Plus PPO"
- Follow the prompts **OR**
- Call customer service for a PPO referral at 800-826-9781

Additional Information

Enhanced Preventive Benefits

Maintaining or improving your health is important. Remember the old saying that "an ounce of prevention is worth a pound of cure"? This can be especially true when it comes to preventive health care. Better health may lower your health care costs, both in the amount you pay out of your pocket for deductibles and copays, as well as in future premium contributions you may pay for your coverage.

As a reminder, our health plans cover routine and preventive care at 100% with no deductible or copayment. This includes your annual routine physical, routine and preventive mammograms, pap tests, PSA tests, immunizations, etc. Please note that claims must be coded by your doctor as "routine and preventive" rather than "diagnostic" in order to be covered at 100% under the Preventive Care benefit.

How Does the Mail Order Prescription Program Work?

The Mail Order program is a great way to help you save money on medications you take every day. Once you begin using the mail order plan, getting refills is easier than waiting in line at the store, and it can save you money. Get started in two easy steps:

Step 1: Obtain a prescription from your doctor for a 90-day supply, plus 3 refills.

Step 2: Call OptumRx at 877-559-2955 or visit www.optumrx.com. Have your prescription handy and the name and phone number of your doctor.

UMR Customer Service
800.826.9781
www.umr.com

Medical Plan

Health Plan In-Network Benefits Summary

This brief benefit summary includes in-network benefits only. UMR is a well-recognized health insurance carrier whose network includes most local physicians and hospitals. As always, please check with your health care provider to verify participation before receiving services. ***Please refer to pages 21-23 for additional benefits for staff who elect a medical plan.***

Employees participating in Bowen Center's Biometric Screening OR if employee obtains same required information from personal provider obtained between 01/01/2022 to 10/31/2022 are eligible for a $10 per pay discount on their premium.

	Traditional Plan	High Deductible Plan
Deductible: Individual/Family	$1,500 / $3,000	$3,000 / $6,000
Coinsurance (You Pay)	20%	20%
Out of Pocket Max: Individual/Family	$4,000 / $8,000	$5,000 / $10,000
Preventive Care	100% - No Deductible	100% - No Deductible
Primary Care Provider	$30 copay per visit	Deductible & Coinsurance
Specialist	$50 copay per visit	Deductible & Coinsurance
Urgent Care	$50 copay per visit	Deductible & Coinsurance
Emergency Room	$250 copay per visit, 20% coinsurance	Deductible & Coinsurance
Prescription Drugs		
Retail (30 day supply)		
Tier 1 **Tier 2** **Tier 3** **Tier 4**	$10 copay 30% (minimum of $30 / script) 30% (minimum of $60 / script) 30% (minimum of $60 / script)	Deductible & Coinsurance
Mail Order (90 day supply)		
Tier 1 **Tier 2** **Tier 3** **Tier 4**	$20 copay 30% (min $30 – max $250 / script) 30% (min $120 – max $500 / script) 30% (min $120 – max $500 / script)	Deductible & Coinsurance

Medical Plan

Understanding Health Insurance Terminology

What is a deductible?

It is a set dollar amount determined by your plan that you will pay out of your pocket if you have claims. The deductible accumulates on a calendar year basis and is reset at $0 each January 1.

What is coinsurance?

After your deductible is met, you then pay a share of your eligible medical expenses. This is called coinsurance. For the traditional plan, you pay 20% of the charges after the deductible for each covered person on your plan up to the maximum of $4,000 ($8,000 for family coverage). For the high deductible, you pay 20% after the deductible for each covered family member up to the maximum of $5,000 ($10,000 for family coverage). This is your share of the coinsurance.

What is my out of pocket maximum?

This is the maximum amount (deductible and coinsurance combined) you are responsible to pay per calendar year. For the traditional plan, it is $4,000 per person ($8,000 family). For the high deductible, it is $5,000 per person ($10,000 per family).

Health Savings Account

Understanding A Health Savings Account

What is an HSA?

It is your personal tax-exempt account used to pay for out-of-pocket medical expenses.

Am I eligible to establish an HSA?

The High Deductible Health Plan is specially designed to meet the IRS requirements that allow you to establish and make contributions to an HSA, although you are not required to do so.

You cannot open an HSA or make contributions to an HSA if you are enrolled in a health plan that is not a qualified “High Deductible Health Plan” (“HDHP”) as defined by the IRS. A qualifying HDHP is one that does not reimburse covered medical expenses until a maximum annual deductible established by the IRS is met.

You are not eligible for an HSA if you are:

- Covered under another medical plan that is not an HDHP;
- Entitled to (eligible for AND enrolled in) Medicare benefits; or
- Eligible to be claimed on another person’s tax return.

Who holds my HSA funds?

The HSA is an individual bank account owned by you. Bowen Center has chosen The HSA Authority as our preferred administrator for all HSA accounts for our employees. After you open a Health Savings Account at The HSA Authority, any pre-tax payroll deductions and company matches will be deposited into the account by Bowen Center. If you are not approved by The HSA Authority for an account, please contact Human Resources.

How and when do I make contributions to my HSA?

You may have contributions direct deposited from your paycheck on a pre-tax basis. You may also make contributions directly into your HSA on an after-tax basis. You will receive a Form 1099 from The HSA Authority annually that will show your annual HSA contribution. You then report your HSA contribution by completing Form 8889 with your annual federal income tax return.

What can I spend my HSA funds on?

The IRS allows you to use your HSA funds to pay for your out-of-pocket costs for qualified medical, dental, and vision expenses that are incurred after your HSA is established. Qualified expenses are those as defined by IRC Section 213(d). Visit https://www.irs.gov/pub/irs-pdf/p502.pdf for a list of allowed expenses. Amounts distributed from your HSA for any other reason are subject to income tax and an additional 20% penalty tax.

How do I access my HSA funds?

The bank will provide you with a debit card and check book (if requested). Remember, in the event of an IRS audit, you are responsible for providing your receipts for services and other items purchased with money from your HSA.

What if I don’t have enough money in my HSA account to pay for my medical expenses during the year which apply toward my deductible and coinsurance out-of-pocket?

The good thing about an HSA is that it is flexible and allows you to add additional money (up to the maximum below) if your medical claims are more than you had anticipated. You can either request a change in the amount of your pre-tax payroll deduction during the year, or you can deposit after-tax money and generally take a deduction when you file your taxes. Talk to your tax advisor about this option.

For further information and a list of HSA qualified medical expenses, please visit https://www.irs.gov/pub/irs-pdf/p502.pdf

Health Savings Account

How much can I contribute to an HSA?

The annual HSA contribution limits for 2023 are:

- $3,850 for individual coverage and $7,750 for family coverage
- Individuals age 55 or older may be eligible to make a catch-up contribution of $1,000.

What if I enroll in an HSA in the middle of the year?

Your HSA contributions are generally determined on a monthly basis. However, if you enroll in an HSA mid-year, you are allowed to make a full year's contribution, provided you are eligible on Dec. 1 of that year and you remain eligible for HSA contributions for at least the 12-month period following that year.

Who is eligible to use my HSA funds?

You can use your HSA funds to reimburse Qualified Medical Expenses incurred by you, your spouse, and your tax dependents, as long as the expenses are incurred after the date that your HSA is established.

What happens to my HSA funds if I leave?

You take your HSA account and funds with you because it's your personal bank account. Remaining HSA funds may continue to be spent on qualified out-of-pocket medical, dental, and vision expenses.

Does Bowen Center contribute to my HSA?

Yes, Bowen Center will contribute to your HSA if you are in the High Deductible plan and you also contribute to your HSA. Bowen will match dollar for dollar up to the annual maximums listed below:

Coverage Tier	Max Annual Employer Match
Single	$600
Employee/Spouse	$900
Employee/Child	$900
Family	$1,200

Bowen will match $1 into your HSA for every $1 you contribute, up to the maximum annual match amount. Once you have contributed up to the maximum annual Bowen match, the Bowen matching will cease but you may continue contributing up to the IRS annual maximum. The Bowen employer match will be deposited every pay period rather than quarterly.

If you do not contribute to your HSA, you will not receive the Bowen employer match. You must contribute to your HSA in order to receive the employer match. Please see the examples below:

Examples:	Max Annual Employer Match:	If you contribute annually:	Bowen will match annually:	Total combined contribution:
Single coverage	$600	$0	$0	$0
Single coverage	$600	$100	$100	$200
Single coverage	$600	$1,000	$600	$1,600
Family coverage	$1,200	$700	$700	$1,400
Family coverage	$1,200	$1,200	$1,200	$2,400
Family coverage	$1,200	$3,000	$1,200	$4,200

Flexible Spending Accounts

Health Care Flexible Spending Account FAQs

What is a Health Care Flexible Spending Account? It is a separate account administered by UMR and funded by you through payroll deductions. The money in your account can be used to pay for any out-of-pocket medical, dental and vision expenses for you and your family members. This plan is only available for those on the Traditional Plan.

How do I make contributions to my Health Care FSA? You choose an amount you would like to contribute to your Health Care FSA from your paycheck each week. Bowen Center will deduct that amount from your paycheck before any taxes are taken out, and it will be deposited into your Health Care Account.

How much money can I contribute? The maximum contribution you can make is $2,500, which would be $104.16 per bi-monthly payroll deduction. **Note: The total amount pledged at the beginning of the year will be fully available immediately even though the payroll deductions have not all been made.**

How do I decide how much money to contribute? Take into consideration any ongoing medical, dental and vision expenses you or family members may be experiencing, as well as the cost of maintenance drugs prescribed. If you and your family members are relatively healthy, you may want to reduce your contributions. It is entirely up to you how much up to the maximum you wish to contribute.

Can I keep the money in my Health Care FSA at the end of the calendar year? You can rollover up to $500 of unused funds for the following year.

What are some examples of expenses I can use my FSA money on?

- Out-of-pocket Medical and Prescription expenses
- Dental expenses not covered by dental insurance
- Vision expenses not covered by insurance
- Professional services not covered by insurance: extensive physical therapy or chiropractic services as well as acupuncture
- Prescription drugs and insulin
- Over-the-counter health care items: bandages, pregnancy test kits, blood pressure monitors, etc.

Dependent Care Flexible Spending Account FAQs

What is a Dependent Care Flexible Spending Account? It is a separate account administered by UMR and funded by you through payroll deductions. The money in your account can be used to pay for any dependent care eligible expense such as care for children under 13, before and after school care, summer camps, and care for a relative who is physically or mentally incapable of self-care and lives in your home..

How much money can I contribute? The maximum contribution you can make is $5,000, which would be $208.33 per bi-monthly payroll deduction. **Note: You will only be able to use what is deposited at each pay period. This money is use it or lose it and does not rollover to future years.**

Dental Insurance

UMR

This year you have two different options for your dental plan. Both plans offer a comprehensive dental insurance plan, administered by UMR. You do not need to be enrolled in the health insurance plan to enroll in dental insurance.

Type of Service	Basic Plan	Enhanced Plan
Calendar Year Deductible Single Family	 $50 $150	 $50 $150
Annual Dental Maximum per Person	$1,000	$1,500
Preventive Services Oral Exams & Cleanings, Bitewing X-rays & Fluoride Treatments, Sealants (children up to age 14)	100%	100%
Basic Services Fillings, Simple Extractions, X-rays, Periodontics	50%	80%
Major Services Major Restorative Services, Crowns, Bridges, Dentures	50%	50%
Orthodontia Coinsurance Lifetime Max per Individual	 N/A N/A	 50% $1,500

This is a partial listing of benefits and services only. All covered services are subject to the conditions, limitations, exclusions, terms and provisions of the Dental Certificate.

Vision Insurance

Vision Service Plan

You have the option to enroll in a vision insurance plan through Vision Service Plan (VSP). You may visit www.vsp.com to find participating providers in your area. No ID Card is necessary for your provider to file claims with VSP.

Benefits When Using a Participating VSP Provider		Copay
Well Vision Exam	• Focuses on your eyes and overall wellness • One every calendar year (two per year for dependent children*)	$10
Frame	• $130 allowance for a wide selection of frames • 20% off amount over your allowance • Every other calendar year	$25
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses • Every calendar year	Included in $25 Materials Copay
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average 35 – 40% off other lens enhancements	$0 $80 - $90 $120 - $160
Contacts (in lieu of glasses)	• $130 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation) • Every calendar year	Up to $60

Disability Insurance

Short Term Disability (STD) – Plan Features

Short-Term disability insurance provides you with weekly income if you become disabled due to injury or illness, including maternity.

- STD benefits begin on the 8th day of a disability, whether your disability is due to injury or sickness. PTO can be used during the first 7 days if you are eligible to use PTO.
- Your weekly benefit is equal to 60% of your salary to a maximum of $1,500. The benefit is reduced by other income you may receive, including Social Security.
- You are eligible to receive STD benefits for up to 12 weeks, provided you remain disabled.

Your ability to work and provide an income for yourself and your family is one of your most important assets. If you are unable to work due to an illness, or non-work-related injury, this benefit helps replace your lost income.

Long Term Disability (LTD) – Plan Features

Long Term Disability insurance helps protect you and your family's income in the event of a long-term illness or disability.

- LTD benefits begin on the 91st day of a disability due to an injury or illness.
- Your monthly benefit is equal to 60% of your salary to a maximum of $6,000.
- The monthly benefit is reduced by Social Security or other income you receive.
- LTD benefits continue to age 65, provided you remain disabled.
- Benefits are generally tax-free.

Bowen Center provides both STD and LTD benefits at no cost to you!

Life Insurance

Basic Life and AD&D Insurance

Bowen Center provides you with a $10,000 Basic Life and $20,000 AD&D benefit through Lincoln Financial. Bowen Center provides this benefit to you at no cost.

Supplemental Term Life Insurance

Term Life insurance is an important part of your benefits. It's not easy to think about, but an unexpected death in the family could burden the surviving family members with large expenses on less income. Purchasing additional term life insurance could assist your loved ones with mortgage payments, funeral expenses, medical expenses, childcare expenses, etc.

Guaranteed issue amounts are available to you one time as a new hire at your initial benefits eligibility. If you are not a new hire electing benefits for the first time, you must complete a health questionnaire, and coverage is not guaranteed.

Term Life Benefit*	Employee	Spouse	Dependent Child
*Term Life: Benefit paid to designated beneficiary upon death of insured. Coverage is for a certain term and has no cash value.	Choice of $25,000 increments. Not to exceed 5 times your salary.	Choice of $25,000 increments. Employee must elect coverage for spouse to be eligible. Not to exceed 50% of employee elected amount.	Choice of $2,500 increments (6 Months to Age 26; Birth to 6 Months limited to $250). Employee must elect coverage for child(ren) to be eligible.
Minimum Amount	$25,000	$25,000	$2,500
Maximum Amount	$500,000	$250,000	$10,000
Guarantee Issue* *Available amounts shown are offered to any eligible applicant (employee and dependent(s)) without regard to health status if you enroll during the initial new employee waiting period. No medical questions are asked on the application unless the amount applied for exceeds the amounts shown.	$175,000 of coverage is available on a guaranteed acceptance basis within your new employee waiting period.	$25,000 of coverage is available on a guaranteed acceptance basis within your new employee waiting period.	No health questions required for eligible children.

Continued next page >

Life Insurance

AD&D Benefit*	Employee	Spouse	Dependent Child
Amount *AD&D (Accidental Death & Dismemberment): Double indemnity for accidental death or a percentage of the benefit payable per covered non-work-related accidental injury.	The benefit amount is equal to the life amount elected by you. Cost included in the schedule.	Employee must elect coverage for dependent to be eligible.	Employee must elect coverage for dependent to be eligible.

Additional Benefits	
Accelerated Death Benefit	Cash advance against the death benefit available if insured has a terminal illness.
Portability	You may continue your term insurance coverage when employment ends by paying the required premiums.
Conversion	You may apply to convert your term life insurance to a whole life policy at termination of employment.

Eligibility	Employee	Spouse & Dependents
	All full-time active employees working 30 or more hours per week in an eligible class are eligible for coverage on the policy effective date. A delayed effective date will apply if the employee is not actively at work.	Cannot be in a period of limited activity* on the day coverage takes effect. *Period during which a dependent is confined to a health care facility and/or unable to perform what would be considered regular.

Employee Assistance Program

New Avenues

Bowen Center pays the full cost of this coverage for you. You get **5** Face-to-Face EAP sessions per person, per issue, per contract year.

The Employee Assistance Program (EAP) is designed to help you with life challenges. The EAP gives you and your dependents access to a network of licensed and/or certified professionals who can provide confidential support for a variety of matters like:

- Family and relationships: Marriage and partners, divorce, parenting, childcare and elder care assistance, domestic violence
- Emotional well-being: Anger management, coping with stress and anxiety, coping with depression, working through grief, traumatic life events
- Financial wellness: Managing finances
- Substance Abuse and Addiction: Alcohol, drugs, gambling and other addictions, support for families
- Physical Health: Diet and nutrition, exercise and fitness, sleep, smoking cessation
- Work and Career: Relationships in the workplace, work stress and transitions, career development

Information gathered by the EAP is confidential – it is not shared with Bowen Center unless there is a risk of harm to you or others.

To learn more or get help, visit www.NewAvenuesOnLine.com WEB ID: EAP or call 800.731.6501.

Contributions

Employee Bi-Monthly Premium. See Sage System for Supplemental Life and AD&D Premium amounts.

Medical

2023 Bi-Monthly Medical Payroll Deductions	Traditional No Discount	High Deductible No Discount
Employee Only	$100.00	$70.00
Employee + Spouse	$230.00	$160.00
Employee + Children	$185.00	$125.00
Employee + Family	$335.00	$230.00
2023 Bi-Monthly Medical Payroll Deductions	**Traditional Discount for Screening**	**High Deductible Discount for Screening**
Employee Only	$90.00	$60.00
Employee + Spouse	$220.00	$150.00
Employee + Children	$175.00	$115.00
Employee + Family	$325.00	$220.00

Dental

2023 Bi-Monthly Dental Payroll Deductions	Dental Basic Plan	Dental Enhanced Plan
Employee Only	$6.50	$10.00
Employee + Spouse	$20.00	$30.00
Employee + Children	$15.00	$22.50
Employee + Family	$27.50	$37.50

Vision

2023 Bi-Monthly Vision Payroll Deductions	Vision Plan
Employee Only	$4.00
Employee + Spouse	$8.00
Employee + Children	$8.50
Employee + Family	$13.50

Supplemental Benefits

The following supplemental benefit plans are offered through Bowen Center

403(b)

- Tax deferred retirement plan determined by section 501(c)(3) of the Internal Revenue Code
- Bowen Center matches up to 4% of your contributions to the plan according to the matching formula below

Years of Service	Match
0-5 years	$0.50 match per $1.00 contributed up to 4% of pay
5+ years	$1.00 match per $1.00 contributed up to 4% of pay

- Vesting Schedule.
  - Staff hired prior to 01/01/2021 are 100% vested.
  - Staff hired on or after 01/01/2021 follow the vesting schedule.
  - You receive credit for 1 year of vesting for each calendar year that you worked 1,000 hours or more.
  - You do not get credit for a year of vesting for any calendar year that you worked under 1,000 hours.

Years of Service	% Employee is Vested
0-2 years	0%
2-3 years	20%
3-4 years	40%
4-5 years	60%
5-6 years	80%
Over 6 years	100%

Pet Insurance!

- Can purchase pet insurance for dogs and cats
- Billed directly at home
- Discount for being Bowen Center employee

Gradifi – Student Loan PayDown

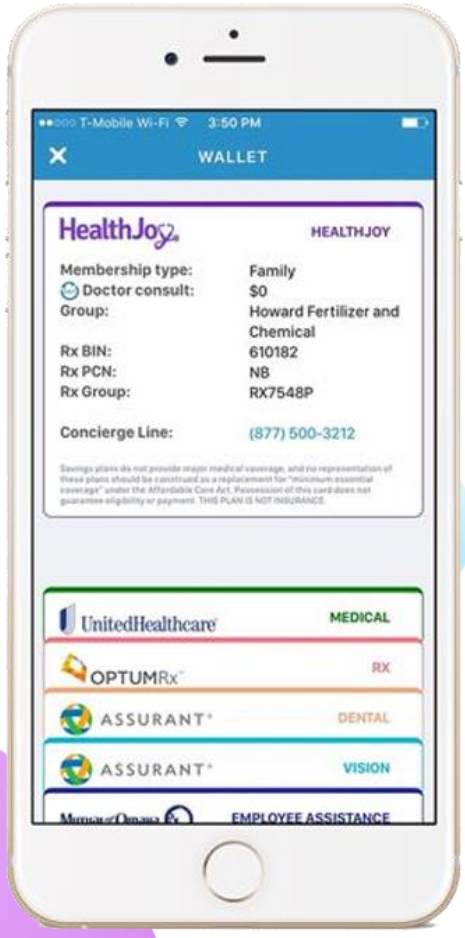
- Benefit offered to full time employees
- Bowen Center provides a monthly benefit for loan repayment
- $50 per month for Month 7 to Month 12 of employment and $100 per month at Month 13+

Additional Benefits

- Paid Time Off (PTO)
- Paid Holidays
- Funeral Leave
- Tuition Reimbursement
- YMCA – Corporate Discount with Payroll Deduction (at select YMCAs)
- Employee Referral Program
- Jellystone Park
- Oil Change Benefit
- Bowen TicketsAtWork Discount Program
- Bowen Wellness Initiative

HealthJoy

HealthJoy is your easy-to-use, chat-based app that gives you access to board-certified doctors, personal Healthcare concierges, and your company's Benefit Wallet.



One app for all your healthcare needs:

- *Consult with an online doctor – free to use!*
- Live healthcare concierges
- Locate providers & facilities
- Find lower-cost medications
- Check bills for errors
- Schedule appointments

On-demand benefit guide:

- Access & understand your benefits
- On-demand LIVE help
- Make smart decisions about your healthcare and save time & money
- Chat or phone 24/7/365

Download the mobile app at http://Downoad.HealthJoy.com

Through this app you will have access to a board-certified physician. As mentioned above, this is free to use!

Your Healthcare Concierge will assist you by clarifying your benefits, finding providers, Care Coordination and more!

You will have access to a benefits wallet on the app that will have your membership card for all your benefits virtually.

No Smartphone? No Worries! You can get the same services if you call HealthJoy at 877.500.3212 or email at groups@healthjoy.com.

Rx Help Centers

What is RX Help Centers (RXHC)?

Primarily targeted to more expensive brand name and specialty drugs, this concierge service can be a help to you if those ‘not so expensive’ drugs in total cost you $75 or more per month. There’s no guarantee that RXHC can help. But if they can you should be able to experience significantly lower costs for your prescriptions.

Who is eligible?

This program is available to members enrolled in the health plan. **Members are not required to use this service**, but there is potential cost savings if you’re spending more than $50 for any one prescription or $75 or more per month for multiple prescriptions.

What are the costs?

There are no costs to you. If you decide this service will benefit you and/or your family, Bowen Center will pay 100% of the cost of this service for you and your family as long as you are enrolled in Bowen Center's health plan. Prescriptions obtained through this service could often be **free** for you and your family. Sometimes a copay or out of pocket amount will be required but this out of pocket may be substantially less than what you are paying now.

You would still have the option and possibly need to obtain some drugs through your current health plan with the normal out of pocket for you and your family, but this service is aimed at helping you with the costlier specialty drugs making it more affordable.

What to expect

It is important to note that this is not an overnight solution and usually takes from two to four weeks on average to implement your cost savings, depending on outside circumstances of doctor cooperation, ease of communication, and understanding.

Please understand that this service is not insurance. RXHC is not an insurance company and they are not offering insurance. They are a prescription drug advocacy firm helping people like you lower the cost of their prescription and medications.

Compliance Notices

Notice of Special Enrollment Rights

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

If you are declining enrollment for yourself or your dependents (including your spouse) while coverage under Medicaid or a state Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' Medicaid or CHIP coverage ends. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or a CHIP program with respect to coverage under this plan, you may be able to enroll yourself and your dependents (including your spouse) in this plan. However, you must request enrollment within 60 days after you or your dependents become eligible for the premium assistance.

Women's Health and Cancer Rights Act Notice

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact [the Plan Administrator].

Newborns' and Mothers' Health Protection Act Notice

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

Michelle's Law Notice

Michelle's Law was signed into law effective January 1, 2010. This law generally allows seriously ill or injured fulltime college students, who are covered under their parent's health insurance plan, to take up to one year of medically necessary leave of absence if the leave normally would cause the dependent child to lose eligibility for coverage under the plan due to loss of student status. For the Michelle's Law extension of eligibility to apply, a dependent child's treating physician must provide written certification of medical necessity (i.e., certification that the dependent child suffers from a serious illness or injury that necessitates the leave of absence or other enrollment change that would otherwise cause loss of eligibility).

*Under the Patient Protection and Affordable Care Act, group health plans are required to offer coverage to dependent children up to age 26, regardless of student status.

Compliance Notices

Important Notice from Bowen Center About Your Prescription Drug Coverage and Medicare (CREDITABLE)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Bowen Center 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. Bowen Center has determined that the prescription drug coverage offered by the Bowen Center 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.

Compliance Notices

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 Bowen Center coverage may be affected.

If you do decide to join a Medicare drug plan and drop your current Bowen Center 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. **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 Bowen Center changes. You also may request a copy of this notice at any time.

Compliance Notices

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).

Effective Date: January 1, 2023

Name of Entity/Sender: Bowen Center

Contact--Position/Office: Garrett Penn

Address: 2621 E Jefferson St; Warsaw, IN 46580

Phone Number: 574-267-7169

Compliance Notices

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 July 31, 2022. Contact your State for more information on eligibility.

ALABAMA-Medicaid	CALIFORNIA-Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Programhttp://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA-Medicaid	**COLORADO-Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment ProgramWebsite: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	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 711Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS-Medicaid	**FLORIDA-Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

Compliance Notices

GEORGIA-Medicaid	MAINE-Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone:678-564-1162 Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization- act-2009-chipra Phone: (678) 564-1162, Press 2	Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711
INDIANA-Medicaid	**MASSACHUSETTS-Medicaid and CHIP**
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: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
IOWA-Medicaid and CHIP (Hawki)	**MINNESOTA-Medicaid**
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 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and- services/other-insurance.jsp Phone: 1-800-657-3739
KANSAS-Medicaid	**MISSOURI-Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KENTUCKY-Medicaid	**MONTANA-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	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
LOUISIANA-Medicaid	**NEBRASKA-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)	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA-Medicaid	**SOUTH CAROLINA-Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

Compliance Notices

NEW HAMPSHIRE-Medicaid	SOUTH DAKOTA-Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345,ext 5218	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW JERSEY-Medicaid and CHIP	**TEXAS-Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.htmlCHIP Phone: 1-800-701-0710	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NEW YORK-Medicaid	**UTAH-Medicaid and CHIP**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH CAROLINA-Medicaid	**VERMONT-Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
NORTH DAKOTA-Medicaid	**VIRGINIA-Medicaid and CHIP**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OKLAHOMA-Medicaid and CHIP	**WASHINGTON-Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
OREGON-Medicaid	**WEST VIRGINIA-Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com Medicaid Phone 304-355-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8847
PENNSYLVANIA-Medicaid	**WISCONSIN-Medicaid and CHIP**
Website:https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website:https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
RHODE ISLAND-Medicaid and CHIP	**WYOMING-Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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

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

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

Compliance Notices

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

Compliance Notices

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the Employee Benefits Security Administration at askebsa.dol.gov or 1-866-444-3272.

Visit www.dol.gov/agencies/ebsa for more information about your rights under federal law.

Compliance Notices

Wellness Program – Notice of Reasonable Alternatives

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at 574-267-7169 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

Notice Regarding Wellness Program

Bowen Center Wellness Plan is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of $10 per pay off of your premium. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive an incentive of $10 per pay off of your premium.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information. We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Bowen Center may use aggregate information it collects to design a program based on identified health risks in the workplace, Bowen Center Wellness Plan will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) a registered nurse, a doctor, or a health coach in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Garrett Penn at 574-267-7169.

Compliance Notices

Genetic Information Nondiscrimination Act of 2008 (GINA)

The Genetic Information Nondiscrimination Act of 2008 ("GINA") prohibits the Plan from discriminating against individuals on the basis of genetic information in providing any the benefits under included benefit plans. GINA generally:

- Prohibits the Plan from adjusting premium or contribution amounts for a group on the basis of genetic information;
- Prohibits the Plan from requesting or mandating that an individual or family member of an individual undergo a genetic test, provided that such prohibition does not limit the authority of a health care professional to request an individual to undergo a genetic test, or preclude a group health plan from obtaining or using the results of a genetic test in making a determination regarding payment;
- Allows the Plan to request, but not mandate, that a participant or beneficiary undergo a genetic test for research purposes if the Plan does not use the information for underwriting purposes and meets certain disclosure requirements; and
- Prohibits the Plan from requesting, requiring, or purchasing genetic information for underwriting purposes, or with respect to any individual in advance of or in connection with such individual's enrollment.

Qualified Medical Child Support Order Notice

A Qualified Medical Child Support Order (QMCSO) is a court order or an order issued by a state administrative agency in accordance with federal and state laws that requires an alternate beneficiary (for example, a child or stepchild) to be covered by a plan participant's group health plan. The Plan honors QMCSOs that meet the legal requirements for such orders. It is important to note that a QMCSO cannot require a plan to provide a type or form of benefit, or an option, that is not currently available from the plan to which the order is directed, unless receiving this benefit or option is necessary to meet the requirements of the Social Security Act, which relates to the enforcement of state child support laws and reimbursement of Medicaid. A QMCSO must be provided to the Plan Administrator to determine if it meets the legal requirements for a QMCSO. If it does, the alternate beneficiary is considered a beneficiary for the purposes of ERISA and is enrolled as a dependent of the employee participant. If the Plan Administrator receives a medical child support order that relates to you, you will be notified and then informed of the decision as to whether the order is qualified.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

Continuation and reinstatement rights may also be available if you are absent from employment due to service in the uniformed services pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). If you take leave under USERRA, to the extent required by USERRA, your Employer may continue to maintain your benefits on the same terms and conditions as if you were still an active employee.

Employees going into or returning from service in the uniformed services may have Plan rights mandated by USERRA. These rights apply only to employees and their dependents covered under the Plan before the employee left for military service. To be entitled to USERRA rights, the employee must give the employer advanced notice of the employee's absence from employment for uniformed service, unless precluded by military necessity or if it is otherwise impossible or unreasonable under all the circumstances. Additionally, subject to certain exceptions, the employee's absence from work may not exceed five years.

USERRA rights include up to 24 months of continued health care coverage. For periods of leave less than 31 days, the employee only needs to pay his or her normal portion of the premium. For periods of leave 31 days or more, coverage will only be extended upon payment of the entire cost of coverage plus a reasonable administrative fee.

If you comply with USERRA upon returning to active employment after military service, you may re-enroll yourself and your eligible dependents in health coverage immediately upon returning to active employment, even if you and your eligible dependents did not elect USERRA continuation coverage during your military service. Reinstatement will occur without any waiting periods or pre-existing condition exclusions, except for illnesses or injuries connected to the military service.

USERRA rights terminate if the employee's discharge from the uniformed service was a result of "dishonorable" or other undesirable conduct, the employee fails to report back to work or apply for reemployment within the time period required under USERRA, or if the employee fails to pay coverage premiums.

Compliance Notices

The time periods within which to elect and pay for USERRA continuation of coverage shall be the same time periods within which to elect and pay for COBRA coverage under the Plan. If both USERRA and COBRA apply, an election for continuation coverage will be an election to take concurrent COBRA/USERRA coverage. Note also that state law may provide continuation and/or conversion coverage.

Mental Health Parity Act Notice

The Mental Health Parity Act ("MHPA") requires that the annual or lifetime dollar limits on mental health benefits may not be lower than any such dollar limits for health and surgical benefits offered by a group health plan or health insurance issuer offering coverage in connection with a group health plan. The lifetime limit ceased to apply effective January 1, 2011 and the annual limit ceased to apply effective January 1, 2014. Beginning with the 2010 plan year, federal law also will require that plans providing both health/surgical and mental health benefits may not impose more restrictive financial requirements (such as deductibles and copayments) and treatment limitations (such as limits on days of coverage) on mental health benefits than are imposed on health/surgical benefits.

Family and Medical Leave Act (FMLA)

Leave Entitlements. Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within one year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse,child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness. An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

Benefits and Protections. While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave. Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions. An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

Eligibility Requirements. An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite. *Special "hours of service" requirements apply to airline flight crew employees.

Requesting Leave. Generally, employees must give 30-days' advance notice of the need for FMLA leave.

If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures. Employees do not have to share a medical diagnosis but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified. Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

Employer Responsibilities. Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility. Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

Enforcement. Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer. The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

HIPAA Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that we maintain the privacy of protected health information, give notice of our legal duties and privacy practices regarding health information about you and follow the terms of our notice currently in effect. Participants in insured group health plans may also receive a notice of privacy practices from those plans. You may request a copy of the current Privacy Practices, explaining how medical information about you may be used and disclosed and how you can get access to this information.

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law. You have the right to inspect and copy, right to an electronic copy of electronic medical records, right to get notice of a breach, right to amend, right to an accounting of disclosures, right to request restrictions, right to request confidential communications, right to a paper copy of this notice and the right to file a complaint if you believe your privacy rights have been violated.

Benefits Contact Information

Carrier	Policy	Website	Customer Service
UMR	7670-00-412299	www.umr.com	800.826-9781

Carrier	Website	Customer Service
HealthJoy	www.healthjoy.com	877.500.3212

Carrier	Policy	Website	Customer Service
HSA Authority	136671	www.thehsaauthority.com	888.472.8697

Carrier	Policy	Website	Customer Service
UMR – Dental	7670-02-412299	www.umr.com	800.826.9781

Carrier	Policy	Website	Customer Service
VSP – Vision	30011071	www.vsp.com	800.877.7195

Carrier	Policy	Website	Customer Service
Lincoln Financial – Life and Disability	09-LF0698	www.lfg.com	888.408.7300

Carrier	Policy	Website	Customer Service
New Avenues– EAP	WEB ID: EAP	www.NewAvenuesOnline.com	800.731.6501

Carrier	Policy	Website	Customer Service
Rx Help Centers	8290318	http://rxc8290318-bowencenter.rxhelpcenters.com/	866.478.9593

Carrier	Website	Customer Service
Gradifi	www.gradifi.com	844.GRADIFI

Carrier	Contact	Website	Customer Service
Retirement – West Point Financial Group	Mike Reed Client Relations	www.WestPointFinancialGroup.com	260.442.3627

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