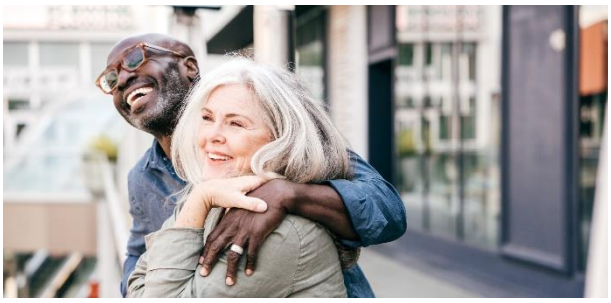
The choice is yours.

2021



Benefits decision guide

BriskHeat®

Briskheat is pleased to offer a wide selection of benefits that offer you flexibility, choice, and the ability to take charge of your benefits spending. Please see below for information on new plan offerings, eligibility, changes, enrollment and what is inside the benefit decision guide.

Who is Eligible…

Employees: Full-time employees of Briskheat working 30 or more hours per week that have satisfied the waiting period (**60 full days of service**) are eligible to enroll in the benefits described in this guide. Please note, the waiting period is waived if you were a temporary employee that has transitioned to a BriskHeat employee.
Legal spouse: Your legal spouse is eligible to enroll in medical, dental, vision, and employee paid life insurance.
Dependent Children: Dependent children to age 26 are eligible for medical, dental, vision, critical illness, accident and hospital indemnity benefits. Dependent children up to age 19 (age 26 if full-time student) are eligible to enroll in employee paid life insurance.

When to make changes…

Unless you have a qualified change in status, you cannot make changes to the benefits you elect that are pre-taxed until the next open enrollment period. Your pre-taxed benefits are Medical, Dental and Vision. All other benefits may be changed at any time with proper notification to HR. Qualified changes in status include: marriage, divorce, legal separation, birth or adoption of a child, change in child's dependent status, death of a legal spouse, child or other qualified dependent, change in residence due to an employment transfer for you, your legal spouse, commencement or termination of adoption proceedings, or change in legal spouse's benefits or employment status. **Please contact Human Resources within 30 days of the change in status to make benefit changes.**

When to enroll…

The benefits you elect during annual open enrollment will be effective January 1, 2021.
For annual open enrollment, the annual open enrollment period occurs within three (3) months prior to the January 1 effective date.

For new hire enrollments, the enrollment period will be communicated based on the employee's hire date.
Elections MUST be completed **NO LATER THAN** the assigned deadline.

What is inside your Group Benefits Decision Guide:

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the Creditable Prescription Drug Coverage and Medicare Notice in the Legal Notices at the back of this booklet for more details.

Contacts

BENEFIT	ADMINISTRATOR	PHONE NUMBER	WEBSITE MOBILE APP
Medical	UMR	800-826-9781	www.umr.com
Prescription Drug	Maxor	800-687-0707	www.maxorplus.com
Healthcare Reimbursement Account	UMR	800-826-9781	www.UMR.com
FSA	Discovery Benefits	866-451-3399	www.discoverybenefits.com
Dental	Delta Dental of TN	800-223-3104	www.DeltaDentalTN.com
Vision	VSP	800-877-7195	www.vsp.com
Term Life Insurance/ Accidental Death & Dismemberment	Mutual of Omaha	800-775-6000	www.mutualofomaha.com
Disability	Mutual of Omaha	800-775-6000	www.mutualofomaha.com
COBRA	Discovery Benefits	866-451-3399	www.discoverybenefits.com

Medical and Prescription Drug Coverage

Medical coverage offers valuable benefits to help you stay healthy and pay for care if you or your covered family members become sick or injured. The medical plans available to you include a range of coverage levels and costs, giving you the flexibility to select the plan that is right for you. You will find a summary of each of the plans in this guide.

It's the law!

As part of the Affordable Care Act, most Americans must have medical insurance. Be sure you are covered, either through your employer-sponsored plan or through another option available to you, such as your spouse's employer benefits or a government program such as Medicare or Medicaid.

Affordable Care Act (ACA)

The medical plans offered meet the Affordable Care Act (ACA) Minimum Value and Affordability standards.

Medical Plan Key Words to Know:

Below are general examples of key words to know and is not a guarantee of coverage. Check your Plan Documents and Benefit Summaries to confirm covered benefits.

Copay: An amount you pay for a covered service each time you use that service. It does not apply toward the deductible.

Deductible: The amount you pay before the plan begins to pay.

Out-of-Pocket Costs: Expenses you pay yourself, such as deductibles, copays, coinsurance and non-covered services.

Out-of-Pocket Maximum: The maximum amount you pay for covered services in a year (you may need to pay additional amounts if coverage is received from an out-of-network provider).

Coinsurance: Percentage of the charge that your plan will pay, typically after you have met the deductible.

In-Network vs. Out-of-Network:

Your plan offers in- and out-of-network benefits that allow you the option to see any provider you choose. However, you will save money when receiving care from an in-network provider.

Find your Network Provider:

Step 1: Go to www.UMR.com , click on FIND A PROVIDER in the middle of the screen.

Step 2: Enter your provider network name: **UnitedHealthcare Choice Plus**

Step 3: Enter the provider you want to search, or search by people, places, conditions, and treatments catagory .

Step 4: Review Results

Telephonic 24/7 customer assistance: A phone call away. You can reach UMR 24 hours a day, seven days a week to get answers to your health, claims and benefit questions, order ID cards, update and check claim status.

Teladoc

This service provides members access to a national network of U.S. board-certified doctor who are available 24/7/365 to resolve many of your non-urgent medical issues. Teladoc three (3) different ways:

- Online: www.teladoc.com
- Phone: 1-800-Teladoc (835-2362)
- Mobile App: www.teladoc.com/mobile
  Please note: You must register online prior to using the mobile app

Medical and Prescription Drug Coverage

UMR

MEDICAL PLAN SUMMARY

	HRA Medical Plan	
	In Network Open Access Plus (OAP)	Out of Network
In-Network		
Preventive Doctor's Visit	Covered at 100%, deductible waived	You pay 40% after deductible
Individual/Family Deductible	$3,000 / $6,000	$6,000 / $12,000
Briskheat HRA Contribution	$1,500 per individual / $3,000 per family	Not applicable
Member Coinsurance	20%	40%
*Individual/Family Out-of-Pocket Max	$6,350 / $12,700	$15,000 /30,000
Office Visit (Primary Care/Specialist)	You pay 20% after deducible	You pay 40% after deductible
Preventive Doctor's Visit	Covered at 100%, deductible waived	You pay 40% after deductible
Urgent Care	$150 copay	Not applicable
Retail and Speciality Prescriptions (30 days / 90 days)	**MaxorPlus**	
Deductible	$100 individual / $300 family	
Tier 1 Generic	$10 copay** / $25 copay**	Not Covered
Tier 2 Preferred Brand	$35 copay** / $87.50 copay**	Not Covered
Tier 3 Non-Preferred Brand	$70 copay** / $175 copay**	Not Covered
Specialty Drugs:	Must be filled at designated Maxor Specialty Pharmacy and are limited to 30 day supply	
Preventive Medications	No cost share for some maintenance medications	
Mail Order Prescriptions		
Tier 1 Generic	$25 copay	Not applicable
Tier 2 Preferred Brand	$87.50 copay	Not applicable
Tier 3 Non-Preferred Brand	$175 copay	Not applicable

*Includes deductible, coinsurance, copays.

** Copays apply after deductible is satisfied. Please note, if the member or the physician requests brand when generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.

Note: In-Network facilities may have Out-of-Network providers, so balance billing may apply

Helpful information about Deductibles and Out-of-Pocket Maximums

For this HRA Medical Plan, if you cover any family member(s) in addition to yourself:

Once one family member meets the Individual Deductible, benefits begin to be paid for that individual.

Once one family member meets the Individual Out-of-Pocket Maximum, the plan pays covered benefits in full for that individual.

UMRHealth Reimbursement Account (HRA)

An HRA is an account provided by BriskHeat that can help pay for a portion of your individual or family deductible.

How it works

PLAN
- Medical plan with UMR
- Deductible, Coinsurance and Copayments
- Provides Insurance Protection

+

HEALTH REIMBURSEMENT ACCOUNT (HRA)

Account to help with your deductible responsibility if you need it

	Individual Plan	Family Plan
Deductible administered by UMR	**$3,000 per individual**	**$6,000 per family**
BriskHeat Deductible Funding	$1,500	$3,000
Benefit % after deductible paid by UMR	20% in most cases	20% in most cases

Medical and Prescription Drug Coverage

Prescription Drug Coverage Overview:

Medications are grouped into three (3) tiers, and the tier that your medication falls into determines your portion of the drug cost. See below for medication tier description:

Tier	You Pay	What's Covered
1	Lowest Cost Sharing	**Most Generic Prescription Drugs:** Generic prescription drugs use the same active ingredients as brand-name prescription drugs and work the same way. Generic drugs are equivalent to a brand product in dosage form, strength, quality, and intended use.
2	Second Lowest Cost Sharing	**Preferred Brand Name Drugs:** Drugs sold under a specific trade name that are favorably priced by the pharmacy plan.
3	Highest Cost Sharing	**Non-Preferred Brand Name Drugs:** Drugs sold under a specific trade name that have a reasonable, more cost-effective alternative on Tier 1 or Tier 2.

Pharmacy Resources:

For a more detailed list of covered and exluded medications, as well as drugs that require pre-authorization, please ask your HR Specialist for a copy of Briskheat's Summary of Drug Coverage. You can also call MaxorPlus anytime at **800-687-0707.**

Pharmacy Networks:

- Prescriptions must be filled at a MaxorPlus SELECT Network Pharmacy. Prescriptions filled at non-participating pharmacies, except in cases of Medical Emergency, are not covered.
- Specialty medications are restricted to be filled at Maxor Specialty Pharmacy.
- To find a Network Pharmacy, please contact Maxor Speciality Pharmacy at **866-629-6779**

Mail Order Pharmacy (90 day supply)

1. Go to members.maxorplus.com. Click 'Create Account'.
2. On the first page, enter your general information (First Name, Last Name, Email).
3. On the second page, enter the information on your member ID card to tie your prescription benefit information to your account (RX Group # or GRP Number, Member ID, DOB).
4. Click 'Link to Patient'.

Multiple ways to order prescriptions

Go online and activate your mail order account at www.maxorplus.com.

Fill out the MAIL ORDER FORM that is available on the website, and mail it to the pharmacy, along with your prescription and payment. You may also contact Member Services to have a MAIL ORDER FORM mailed to your address of choice.

Call Maxor toll-free at 800-687-8629 and speak to a Member Advocate who will help you activate your mail order account.

Access MaxorPlus:

- Find in-network doctors and medical services
- View ID card information
- Review your coverage
- Manage and track claims
- Compare prescription drug prices
- Compare cost and quality information for doctors and hospitals
- Access a variety of health and wellness tools and resources
- Sign up to receive alerts when new plan documents are available

Mobile App: You can also access your plan information on the go by downloading the MaxorPlus app.

Flexible Spending

A Health Care Flexible Spending Account (FSA) is an employer-sponsored benefit that enables employees to set aside pre-tax dollars out of their paycheck to pay for eligible health care expenses. Monies put into the plan avoid both Federal Income Tax and FICA. **Briskheat will partnerwith Discovery Benefits to administer your FSA.**

	Health Care FSA	Dependent Care FSA
Eligible for company contributions	No	No
Change your contribution amount any time	No	No
Access your entire annual contribution amount from the beginning of the plan year	Yes	No
Access only funds that have been deposited	No	Yes
"Use-it-or-lose-it" at year-end	Yes	Yes
Money is always yours to keep	No	No

Health Care FSA: Allows IRS-approved medical, Rx, dental or vision expenses not covered by the insurance plan with pre-tax.**Contribute up to $2,750**

Discovery Benefits Debit Card

Swipe your benefits debit card to instantly pay for eligible expenses with funds from your benefits accounts. Where you swipe the card will determine whether any steps are needed after that. In addition to using your benefits debit card to pay for services at your healthcare provider's office, you can also use it at the following types of merchants:

- IIAS: Many merchants provide IRS-required information for documentation right at the point of sale through an Inventory Information Approval System (IIAS). An IIAS merchant auto-substantiates the claim, so you will not need to provide additional documentation on qualifying expenses.
- 90% Merchants: Your debit card also works at pharmacies or drug stores that meet the IRS' 90 percent rule. At least 90 percent of the gross sales at these merchants come from eligible medical expenses. For a full list of IIAS and 90 percent rule merchants, visit www.DiscoveryBenefits.com.

Please note, if Discovery requests substantiation of your claims and you do not provide the required information timely, your debit card will be frozen until proper documentation is sent to Discovery Benefits. Please refer to Discovery's website for details.

Submitting Documentation for Debit Card Transactions. Occasionally, documentation will be needed to verify the eligibility of an expense paid for on your debit card. Even places like doctors and dentists' offices may require you to submit documentation because some expenses available at these facilities may not be IRS-eligible (e.g. cosmetic procedures, teeth whitening).

- **What to Submit:** When submitting documentation for a debit card transaction, an Explanation of Benefits (EOB) from your insurance company is your best option, as it contains all the information you need to substantiate a claim. But, when in doubt, the IRS has identified the criteria for what needs to be included when submitting documentation for eligible expenses: Name of the provider/merchant, Date(s) of service, Type(s) of service, Amount (after insurance, if applicable), Name of person who received the services (if the account covers dependents)
- **How to submit.** You can submit documentation in three (3) ways: Discovery Benefits mobile app, Online consumer portal, or Fax or mail. Claims process in two (2) business days. (**Discovery Benefits Benefit Debit Card Employee Handout Flyer (8/2/17)*)

Online Consumer Portal:
https://www.discoverybenefits.com/
Employee Resource Center:
https://www.discoverybenefits.com/employees/resource-center

Discovery Quick links:
Expense Eligibility List:
https://www.discoverybenefits.com/employees/eligible-expenses

Tax Savings Calculator:
https://www.discoverybenefits.com/employees/savings-calculators/fsa-tax-savings-calculator

Dependent Care FSA: Pay for eligible dependent care expenses, such as day care for a child or adult dependent care, so you and/or your spouse can work, look for work, or attend school full time.

A Dependent Care Account is a simple way to save money on care for your dependents. It allows you to set aside pre-tax dollars to pay for day care expenses. **The annual IRS limit for this type of account is $5,000. If you are married and file separate returns, you can each elect $2,500 for the calendar year**. To be eligible for this type of account, both you and your spouse (if applicable) must work, be looking for work or be full-time students. You may receive reimbursement up to the current balance in your account at the time the request is made. Please note: your medical FSA debit card cannot be used for Dependent Care transactions.

	Dependent Care FSA
Eligible Dependents	• Children under age 13 who are claimed as a dependent for tax purposes • Disabled spouse or disabled dependent of any age
Ineligible Expenses	• Costs claimed as a dependent care tax credit on your tax return • Services provided by one of your dependents • Expenses for nighttime babysitting • Expenses paid for school (Kindergarten and above)

Use-it-or-Lose-it

Keep in mind, **FSAs are "use-it-or-lose-it" accounts**. You will forfeit money in the account at the end of the 2 ½ month carryover provision ending on March 15, 2022. It is important that you estimate your needs conservatively. There is a use-it-or-lose-it rule in place that prohibits you from carrying over unused funds beyond the carry over period. Your FSA plan year begins January 1, 2021 and ends on December 31, 2021, carryover provision ends March 15, 2022.

Dental

Delta Dental of TN

Dual Network: PPO & Premier Network

Your smile says a lot about your overall health. Healthy teeth and gums are an essential part of your general health and well-being. Research shows there may be a connection between poor dental health and serious health conditions. Dental exams can detect some health conditions, which is why it is important to have regular dental check-ups and maintain good oral hygiene.

Delta Dental Mobile App

- Mobile ID card
- Claims and coverage information
- Dentist network search tool
- Dental care cost estimator tool

Provider Network

Delta Dental offers two (2) provider networks. The Delta Dental PPO Network provides a smaller network with richer discounts, while the Delta Dental Premier Network provides a larger network with standard discounts. You can also visit an out-of-network dentist; however, there are no discounts, you may be balance billed and need to file your own claims.

Find a Provider

Find network providers online at www.DeltaDentalTN.com, click on "FIND A DENTIST," and then choose your network; PPO or Premier or call toll-free 800-223-3104.

COVID-19 Resources for Delta Dental of TN Members

Visit the link below to find out what to expect at dental appointments and keep up your oral hygeiene at home.

https://tennessee.deltadental.com/en/covid-19-member-update.html

DENTAL PLAN SUMMARY

	Option 1: Base Plan			Option 2: Buy-Up Plan		
Network	**PPO**	**Premier**	**Out-of-Network**	**PPO**	**Premier**	**Out-of-Network**
Calendar Year Annual Maximum Benefit	$2,000 per person *Preventive Advantage Plan – Each year member receives a preventive service, the members' annual maximum will increase by $100 the following year, not to exceed a $500 increase*			$2,000 per person *Preventive Advantage Plan – Each year member receives a preventive service, the members' annual maximum will increase by $100 the following year, not to exceed a $500 increase*		
Individual/Family Deductible	$50/$150			$50/$150		
Preventive Services	Plan pays 100%*	Plan pays 100%*	Plan pays 100%*	Plan pays 100%*	Plan pays 100%*	Plan pays 100%*
	Diagnostic & Preventive Services, Sealants, Brush Biopsy, Radiographs, Periodontal Maintenance					
Basic Services	Plan pays 80%	Plan pays 80%	Plan pays 80%	Plan pays 80%	Plan pays 80%	Plan pays 80%
	Emergency Palliative Treatment, Minor Restorative Services, Simple Extractions, Relines & Repairs			Emergency Palliative Treatment, Minor Restorative Services, **Endodontics, Periodontics,** Oral Surgery, Relines & Repairs		
Major Services	Plan pays 50%	Plan pays 50%	Plan pays 50%	Plan pays 50%	Plan pays 50%	Plan pays 50%
	Endodontics, Periodontics, Oral Surgery, Major Restorative Services, TMD Treatment, Prosthodontics			Major Restorative Services, TMD Treatment, Prosthodontics		
Orthodontia Services	Not covered			Plan pays 50%	Plan pays 50%	Plan pays 50%
Orthodontia Maximum Lifetime	Not covered			$1,500**		

** Deductible does not apply.*

*** Orthodontia coverage available for eligible children and adults.*

Key Words to Know: Below are general examples of key words to know and are not a guarantee of coverage. Check your Plan Documents and Benefit Summaries to confirm covered benefits.

Annual Maximum Benefit: The maximum total amount the plan will pay during the plan year.

Deductible: The amount you pay before the plan begins to pay.

Preventive Services: Services designed to prevent or diagnose dental conditions including oral evaluations, routine cleanings, X-rays, fluoride treatments and sealants.

Basic & Major Services: Services such endodontics and periodontics and vary based on plan option.

Orthodontia: Services such as straightening or moving misaligned teeth and/or jaws with braces and/or surgery.

Vision Insurance

VSP

VSP Choice Plan

Having an annual eye exam is one of the best ways to make sure you are keeping your eyes healthy. Eye exams can help prevent and treat easily correctable vision problems, which can cause permanent vision impairment. You can enroll in vision coverage to save money on eligible vision care expenses, such as eye exam, glasses and contact lenses.

Find a Provider

Find network providers online at www.vsp.com, click on "Find an In-Network Doctor", and then select your network location, office or doctor. VSP customer service is also available at 800-877-7195 to help you locate a local provider.

ID Cards

Elecronic ID cards are available by logging in as a member at www.vsp.com. However, ID cards are not required to obtain benefits. At time of service, please provide your doctor with your name, social and VSP as your provider. Your doctor will be able to locate your benefits electronically.

VISION PLAN SUMMARY

	IN-NETWORK	OUT-OF-NETWORK
Routine Eye Exam	$20 copay	$45 Reimbursement
	Once every rolling 12 months	
Eyeglass Lenses **(single vision, bifocal and trifocal)**	Single vision, bifocal and trifocal :$20 copay Standard progressive:$20 copay	Single: $30 Reimbursement Bifocal: $50 Reimbursement Trifocal: $65 Reimbursement Progressive: $50 Reimbursement
Contact Lenses **(in lieu of Frames & Lenses)**		
Conventional	$130 Allowance; Additional 20% off balance over allowance	$105 Reimbursement
Disposable	$130 Allowance	$105 Reimbursement
Medically Necessary	$20 Copay	$210 Reimbursement
	Once every 12 rolling months to purchase either 1 pair or eyeglass lenses or 1 order of contact lenses	
Frames	$130 Allowance; Additional 20% off balance over allowance	$70 Reimbursement
	Once every rolling 24 months	

Key Words to Know:

Below are general examples of key words to know and are not a guarantee of coverage. Check your Plan Documents and Benefit Summaries to confirm covered benefits.

Copay: An amount you pay for a covered service each time you use that service.

Retail Allowance: Maximum allowance paid toward the cost of vision materials. You are required to pay any amounts in excess of the retail allowance.

Exclusive Member Extras

We put our members first by providing Exclusive Member Extras from VSP and leading industry brands, totaling more than $2,500 in savings. Check out a sample below.

Contacts	Exclusive mail-in savings on eligible contacts Savings on EyePromise EZ Tears dry eye and contact lens comfort formula
Glasses	Up to 50% savings on UNITY® digital lenses Up to 40% savings on sunsyncTM light-reactive lenses Average savings of $325 on Nike-authorized prescription sunglasses Extra $20 to spend on featured frame brands like bebe®, Calvin Klein, Cole Haan, Flexon®, Lacoste, Nike, Nine West, and more
LASIK	Up to $500 savings on LASIK
More Offers	Free shipping, shop-at-home convenience, and savings on contacts and sunglasses at eyeconic.com Access to special financing for vision and health care expenses with the CareCredit credit card
Hearing Aids	Savings of up to 60% on a pair of digital hearing aids and savings on batteries for you and your extended family members through TruHearing®

Above offers are updated frequently. Learn more about these and other offers at vsp.com/specialoffer.

Life Insurance

MUTUAL OF OMAHA – Term Life and Accidental Death & Dismemberment

Life insurance provides important financial protection for you and your family. You can choose from different levels of life insurance coverage to meet your needs.

Employer-Paid Life and Accidental Death and Dismemberment (AD&D) – Your employer provides you with a base level of employee term life and accidental death and dismemberment (AD&D) insurance **at no cost to you**. This coverage provides a benefit of **1.5 to 2 times your salary, rounded to the next highest $1,000, up to $200,000.**

Employee-Paid Term Life – To supplement the coverage provided by your employer, you can purchase additional term life insurance for yourself. This coverage is tied to your employment and typically ends if you leave your employer. However, you may be able to retain this coverage on your own with the same insurance carrier if you leave your employer. **You must purchase this coverage if you wish to purchase spouse and/or child term life.**

Important Information

Select a beneficiary
It's important to choose a beneficiary or beneficiaries to receive the policy's benefit payment in the event of the insured person's death. For Spouse and Child Term Life policies, you (the employee) are automatically listed as the beneficiary.

Statement of Health
Life insurance coverage over a certain amount may require an approval from the insurance company. After electing coverage, you will receive more information.

Spouse Term Life – You can purchase term life insurance for your spouse. This coverage is tied to your employment, and typically ends if you leave your employer. However, you may be able to retain this coverage for your spouse on your own with the same insurance carrier if you leave your employer.

Child Term Life – You can purchase term life insurance for your dependent children up to age 26. This coverage is tied to your employment, and typically ends if you leave your employer. However, you may be able to retain this coverage for your children on your own with the same insurance carrier if you leave your employer.

EMPLOYEE-PAID LIFE/AD&D PLAN SUMMARY

	Minimum	Guarantee Issue Amount	Maximum
Employee	$10,000	$150,000	Incremental amounts of $10,000 up to the Lesser of five (5) x basic annual earnings or $500,000
Spouse	$5,000	$30,000	Increment amounts of $5,000 up to $250,000 not to exceed 100% of Employee's election
Child	$10,000	$10,000	$10,000, not to exceed 100% of Employee's election

Disability Insurance

MUTUAL OF OMAHA

A disability can be one of the biggest financial risks you face. Your work income will end, but your living expenses will continue. Make sure you protect your income by choosing the disability coverage you need.

SHORT-TERM DISABILITY

When you need to miss work for an extended period due to an illness or accident, short-term disability insurance can replace a percentage of your lost income up to a maximum weekly benefit for a certain number of weeks. This benefit is completely administered by your employer.

If you live in a state that requires your employer to offer short-term disability benefits, your disability will be coordinated between your employer and the state. This applies to employees in California, New York, New Jersey, Rhode Island, Hawaii, and Washington.

LONG-TERM DISABILITY

If you experience a disabling illness or injury that lasts longer than your short-term disability benefit, long-term disability insurance can replace a percentage of your lost income up to a maximum monthly benefit.

DISABILITY PLAN SUMMARY

	Short Term Disability	Long Term Disability
Benefit	60% of weekly base earnings	60% of monthly basic annual earnings up to plan maximums
Elimination Period	non-work related illness : 7 consecutive calendar days. The benefit payment will begin on the 8th day. Non-work related accident: no elimination period The benefit will begin on the first day of such disability, provided you have been absent more than 7 consecutive calendar days.	90 days
Duration Period	12 weeks (90 days) If you return to work and the same disability recurs within 90 days, you do not have to wait the 7 days; disability benefits will begin immediately, provided you have not reached the maximum payout.	If you become disabled prior to age 60, benefits are payable to age 65. At age 60 (and older), the benefit period will be based on a reduced duration schedule.
Pre-Existing condition Limitation	Briskheat will not pay benefits for any period of disability that starts before you are covered by this plan.	any Injury or Sickness for which You received medical treatment, advice or consultation, care or services, including diagnostic measures, or had drugs or medicines prescribed or taken in the **3 months prior** to the day You become insured under the Policy. You will not receive benefits for any Disability caused by, attributable to, or resulting from a Pre-existing Condition which begins in the **first 12 months** after You are continuously insured under the Policy

Additional Benefits & Resources

Your benefit offerings have included additional available benefits and resources. See below for a list

Benefits available to all benefit eligible employees:

Mutual of Omaha's Employee Assistance Program (EAP) has trained professionals to work with you and your family memebers to search for solutions to personal and workplace issues. EAP is paid for by your company and is available to help you deal with a variety of personal and professional issues. Staff members are highly trained, master's-level professionals with experience in family, personal, work-related and substance abuse issues. The program is voluntary and confidential; only your EAP professional will know you have called.

- EAP staff members are available 24 hours a day, 7 days a week, every day of the year by calling 1-800-316-2796.
- If you would benefit from speaking with a professional face to face, the EAP staff can help you find appropriate resources in your area.
- Help manange your work life balance and other issues including:
  - Stress, finances, family/relationships, substance abuse, grief, etc.

To access the above benefits, contact the Employee Assistance Program services at 800-316-2796 or www.mutualofomaha.com/eap.

Coronavirus (COVID-19) Resources

- *COVID-19 Resource Center:* Find educational and developmental online resources to assist during the Coronavirus Pandemic. This resource center link contains informative articles, special PDF documents, and links to additional support materials that will help you during this emergency.

- *COVID-19 Additional Resource Links:*

  - Mutual of Omaha COVID-19 Response & Resource Link: https://www.mutualofomaha.com/legal-services/coronavirus-information

  - Mutual of Omaha COVID-19 Response & Resource Link: https://www.mutualofomaha.com/legal-services/coronavirus-faqs

2021 ANNUAL NOTICES

Your Company reserves the right to change, amend or terminate any benefits plan at any time for any reason. Participation in a benefit plan is not a promise or guarantee of future employment. Receipt of benefits documents does not constitute eligibility.

The Benefits Decision Guide, combined with these legal notices, provides an overview of the benefits available to you and your family. In the event of a discrepancy between the information presented in the Benefits Decision Guide and official plan documents, the official plan documents will govern.

STATEMENT OF MATERIAL MODIFICATIONS

This enrollment guide constitutes a Summary of Material Modifications (SMM) or Summary of Material Reductions (SMR), as applicable, to the health and welfare plans. It is meant to supplement certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.

SUMMARY OF BENEFITS COVERAGE

A Summary of Benefits Coverage (SBC) for each of the employer-sponsored medical plans is available. You may request a paper copy by calling your Human Resources department.

The legal notices listed below are provided on following pages:

- ✓ Women's Health and Cancer Rights Act (WHCRA)
- ✓ Newborn's and Mother's Health Protection Act (NMHPA or Newborns Act)
- ✓ HIPAA Special Enrollment Notice
- ✓ Right to Special Enrollment in Another Plan
- ✓ USERRA
- ✓ Wellness Program Disclosure
- ✓ HIPAA Privacy Notice
- ✓ Public Exchange Notice
- ✓ Initial COBRA Notice
- ✓ Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)
- ✓ Creditable Prescription Drug Coverage and Medicare

2021 ANNUAL NOTICES

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA) 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.
- 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, call your medical carrier at the phone number listed on the back of your ID card.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT (NMHPA OR "NEWBORNS' 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). If you would like more information on maternity benefits, call your medical carrier at the phone number listed on the back of your ID card.

HIPAA SPECIAL ENROLLMENT NOTICE

Notice of special enrollment rights for health plan coverage

If you have declined enrollment in your employer's health plan for you or your dependents (including your spouse) because of other health insurance coverage, you or your dependents may be able to enroll in some coverages under this plan without waiting for the next open enrollment period, if you request enrollment within 30 days after your other coverage ends. 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 eligible dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Your employer will also allow a special enrollment opportunity if you or your eligible dependents either:

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or
- Become eligible for a state's premium assistance program under Medicaid or CHIP.

For these enrollment opportunities, you will have 60 days – instead of 30 – from the date of the Medicaid/CHIP eligibility change to request enrollment in your employer's group health plan. Note that this new 60-day extension does not apply to enrollment opportunities other than due to the Medicaid/CHIP eligibility change.

RIGHT TO SPECIAL ENROLLMENT IN ANOTHER PLAN

Under HIPAA, if you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. Therefore, once your coverage ends, if you are eligible for coverage in another plan (such as a spouse's plan), you should request special enrollment as soon as possible. (Additional special enrollment rights are triggered by marriage, birth, adoption, and placement for adoption.)

If you have questions about your HIPAA rights, you may contact your state insurance department or the U.S. Department of Labor, Employee Benefits Security Administration (EBSA), toll-free at 1-866-444-3272 (for free HIPAA publications ask for publications concerning changes in health care laws). You may also contact the CMS publication hotline at 1-800-633-4227 (ask for Protecting Your Health Insurance Coverage).

These publications and other useful information are also available on the Internet at:
http://www.dol.gov/ebsa,
the DOL's interactive web pages - Health Laws, or
www.cms.hhs.gov/healthinsreformforconsume/.

WELLNESS PROGRAM DISCLOSURE

If you have a health plan available to you, the 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 an opportunity to earn the same reward by different means. Contact your HR Department and we will work with you to find a wellness program with the same reward that is right for you in light of your health status.

USERRA

Your right to continued participation in the Plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA). Accordingly, if you are absent from work due to a period of active duty in the military for less than 31 days, your Plan participation will not be interrupted. If the absence is for more than 31 days and not more than 12 weeks, you may continue to maintain your coverage under the Plan by paying premiums.

If you do not elect to continue to participate in the Plan during an absence for military duty that is more than 31 days, or if you revoke a prior election to continue to participate for up to 12 weeks after your military leave began, you and your covered family members will have the opportunity to elect COBRA Continuation Coverage only under the medical insurance policy for the 24-month period (18-month period if you elected coverage prior to December 10, 2004) that begins on the first day of your leave of absence. You must pay the premiums for Continuation Coverage with after-tax funds, subject to the rules that are set out in that plan.

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SUMMARY NOTICE OF PRIVACY PRACTICES

This is a summary of your Group Health Plan's Notice of Privacy Practices, and is a reminder that a copy of the Privacy Notice can be obtained from the Human Resource Department. **Please review this summary carefully.**

In order to provide you with benefits, your employer's group health plan (hereafter referred to as the Plan) may receive personal health information from you, your physicians, hospitals, and others who provide you with health care services. We are required to keep this information confidential. This Summary Notice of Privacy Practices is intended to remind you of the ways we may use your information and the occasions on which we may disclose this information to others.

The following is a summary of the circumstances under which your health information may be used and disclosed:
To provide treatment
To obtain payment
To conduct health care operations

We use participants' health information to provide benefits. We may disclose participants' information to health care providers to assist them in providing you with treatment, or to help them receive payment. We may disclose information to insurance companies or other related businesses to receive payment. We may use the information within our organization to evaluate a request for coverage or a claim for benefits, to evaluate quality, and improve health care operations. We may make other uses and disclosures of participants' information as required by law or as permitted by our policies.

Your Rights with Respect to your Health Information
You have the following rights regarding your health information:
Right to request restrictions
Right to receive confidential communications
Right to inspect and copy your health information
Right to request an amendment to your health information
Right to an accounting of your health information
Right to a paper copy of the Notice of Privacy Practices

This is a reminder that you generally have a right to access and in certain instances to request an amendment to your Personal Health Information. This does not apply to information collected in connection with, or in anticipation of, a claim or legal proceeding.

Our Legal Duty
We are required by law to maintain the privacy and security of your health information and to provide you with a reminder that our complete Notice of Privacy Practices is available upon request. We reserve the right to implement new privacy and security provisions for health information that we maintain. If we change the Privacy Notice, we will provide you with a copy of the complete revised notice to you at that time. In addition, you have the right to express complaints to the contact person referenced below and to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to your employer should be made in writing to the contact person listed at the end of this notice.

Contact Person- For more information on the Plan's privacy policies or your rights under HIPAA, contact your Human Resources Department.

EXCHANGE NOTICE

PART A: General Information
When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that does not meet certain standards. The savings on your premium that you are eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.1

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

How Can I Get More Information?
For more information about your coverage offered by your employer, please check your summary plan description or contact your Human Resources department.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.
1 An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

Form Approved
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(Expires 5-31-2021)

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Summary of Rights and Obligations Regarding COBRA Continuation Coverage

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** 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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional 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 Human Resources Department.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as 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 are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens: Your hours of employment are reduced, or your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens: 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 any of the following qualifying events happens: 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."

> Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Human Resources Department has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Human Resources Department of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the 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 Human Resources Department within 30 days after the qualifying event occurs.

How is COBRA Coverage Provided?

Once the Human Resources Department 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. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Human Resources Department in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total 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 continuation coverage.

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

If your family experiences another qualifying event while receiving 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 notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

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 ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), 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 the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Human Resources Department informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Human Resources Department.

Plan Contact Information: Call your Human Resources department for more information.

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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, 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
IOWA – Medicaid and CHIP (Hawki)	**MONTANA – 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	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	**NEVADA – 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	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900

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LOUISIANA – Medicaid	NEW HAMPSHIRE – 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: 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
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	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
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – 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	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**UTAH – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	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)

2021 ANNUAL NOTICES

IMPORTANT NOTICE FROM BRISKHEAT
ABOUT CREDITABLE PRESCRIPTION DRUG COVERAGE AND MEDICARE

The purpose of this notice is to advise you that the prescription drug coverage listed below under the Briskheat medical plan is expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage. This is known as "creditable coverage."

Why this is important: if you or your covered dependent(s) are enrolled in any prescription drug coverage during the plan year listed in this notice and are or become covered by Medicare, you may decide to enroll in a Medicare prescription drug plan later and not be subject to a late enrollment penalty — as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment. You should keep this notice with your important records.

Notice of creditable coverage

You may have heard about Medicare's prescription drug coverage (called Part D), and wondered how it would affect you. Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans also offer more coverage for a higher monthly premium. Individuals can enroll in a Medicare prescription drug plan when they first become eligible, and each year from October 15 through December 7. Individuals leaving employer/union coverage may be eligible for a Medicare Special Enrollment Period. If you are covered by your employer's prescription drug plan, you will be interested to know that coverage is, on average, at least as good as standard Medicare prescription drug coverage for the plan year. This is called creditable coverage. Coverage under one of these plans will help you avoid a late Part D enrollment penalty if you are or become eligible for Medicare and later decide to enroll in a Medicare prescription drug plan.

If you decide to enroll in a Medicare prescription drug plan and you are an active employee or family member of an active employee, you may also continue your employer coverage. In this case, the employer plan will continue to pay primary or secondary, as it had before you enrolled in a Medicare prescription drug plan. If you waive or drop coverage, Medicare will be your only payer. You can re-enroll in the employer plan at annual enrollment or if you have a special enrollment event for the plan.

You should know that if you waive or leave coverage with your employer and you go 63 days or longer without creditable prescription drug coverage (once your applicable Medicare enrollment period ends), your monthly Part D premium will go up at least 1% per month for every month that you did not have creditable coverage. For example, if you go 19 months without coverage, your Medicare prescription drug plan premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll in Part D.

You may receive this notice at other times in the future — such as before the next period you can enroll in Medicare prescription drug coverage, if this coverage changes, or upon your request.

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. Medicare participants will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. Here's how to get more information about Medicare prescription drug plans: Visit www.medicare.gov for personalized help; Call your state Health Insurance Assistance Program (see a copy of the Medicare & You handbook for the telephone number); Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov or call 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in a Medicare prescription drug plan after your applicable Medicare enrollment period ends, you may need to provide a copy of this notice when you join a Part D plan to show that you are not required to pay a higher Part D premium amount.

For more information about this notice or your prescription drug coverage, contact:

Date: October 15, 2020

Name of Entity/Sender: Briskheat

Human Resources

4800 Hilton Corporate Dr.
Columbus, OH 43232
614-294-3376 Ext. 1124
Fax: 614-298-7724

BriskHeat®

2021 Annual Benefit Guide