The choice is yours.

2021

Benefits decision guide

BACKER SPRINGFIELD

OMNI Control Technology, Inc.

BACKER HOTWATT

HEATRON

BACKER MARATHON

Backer North America 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 eligibility, changes, enrollment and what is inside the benefit decision guide.

Who is Eligible…

Employees: Full-time employees of Backer North America working 30 or more hours per week that have satisfied the waiting period (first of the month following one (1) month of service) are eligible to enroll in the benefits described in this guide.

Legal spouse: Your legal spouse is eligible to enroll in medical, dental, vision, critical illness, accident, hospital indemnity 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 and Prescription	Cigna	800-244-6224	myCigna.com myCigna app
Health Savings Account	Discovery Benefits	866-451-3399	www.discoverybenefits.com
Supplemental Medical: Accident Critical Illness	UNUM	800-635-5597	www.unum.com/employees
Telahealth	Cigna Telehealth	MDLIVE: 888-726-3171	www.MDLIVEforCigna.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	UNUM	866-679-3054	www.unum.com/employees
Disability	UNUM	866-679-3054	www.unum.com/employees
Short Term Disability Claim and/or Leave Request	UNUM	866-779-1054	
Employee Assistance Program	UNUM	800-854-1446	www.unum.com/lifebalance

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.

Affordable Care Act (ACA)

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

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.

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.Cigna.com**, click on FIND A DOCTOR at the top of the screen.
Step 2: Select the blue box that reads "Employer or School" (If you already have a Cigna plan, log in to **myCigna**.)
Step 3: Enter the geographic location you want to search.
Step 4: Choose what you are looking for: Doctors by type, Doctor by Name or Locations.
Step 5: Log In, Register or Continue as Guest
Step 6: Review Results

Cigna One Guide 24/7 customer assistance: Click, call or chat. Your personal guide is ready and waiting to help at **myCigna.com, myCigna app and/or 800.Cigna24**.

Cigna One Guide is an extension of the 24 hours a day, seven days a week customer service. You can reach your Cigna One Guide representative to help understand your plan, get care, save and earn. Allow Cigna to help you get answers to your health, claims and benefit questions, order ID cards, update and check claim status. Ask for a Spanish-speaking service representative or someone who can translate one of 200 languages.

Medical and Prescription Drug Coverage

Cigna

MEDICAL PLAN SUMMARY

	Option 1: $2,500 HDHP Non-Embedded		Option 2: $4,000 HDHP Embedded	
	In Network Open Access Plus (OAP)	Out of Network	In Network Open Access Plus (OAP)	Out of Network
HSA Eligible	Yes		Yes	
In-Network				
Preventive Doctor's Visit	Covered at 100%, deductible waived	You pay 40% after deductible	Covered at 100%, deductible waived	You pay 40% after deductible
Individual/Family Deductible	$2,500 / $5,000	$6,000 / $12,000	$4,000 / $8,000	$9,000 / $18,000
Member Coinsurance	20%	40%	20%	40%
*Individual/Family Out-of-Pocket Max	$4,900 / $7,350	$10,000 / $20,000	$6,000 / $12,000	$12,000 / $24,000
Office Visit (Primary Care/Specialist)	You pay 20% after deducible	You pay 40% after deductible	You pay 20% after deducible	You pay 40% after deductible
Retail Prescriptions	Retail / Cigna90 Now		Retail / Cigna90 Now	
Preventive Medications	No cost share for certain preventive medications		No cost share for certain preventive medications	
Tier 1 Generic	$15 copay** / $30 copay**	You pay 40% after deductible	$15 copay** / $30 copay**	You pay 40% after deductible
Tier 2 Preferred Brand	$30 copay** / $60 copay**	You pay 40% after deductible	$30 copay** / $60 copay**	You pay 40% after deductible
Tier 3 Non-Preferred Brand	$60 copay** / $120 copay**	You pay 40% after deductible	$60 copay** / $120 copay**	You pay 40% after deductible
Tier 4 *** Specialty	$100 copay** / not included	You pay 40% after deductible	$100 copay** / not included	You pay 40% after deductible
Mail Order Prescriptions				
Tier 1 Generic	$30 copay**	Not applicable	$30 copay**	Not applicable
Tier 2 Preferred Brand	$60 copay**	Not applicable	$60 copay**	Not applicable
Tier 3 Non-Preferred Brand	$120 copay**	Not applicable	$120 copay**	Not applicable
Tier 4 *** Specialty	$100 copay**	Not applicable	$100 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.

*** limited to a 30-day supply

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

Helpful information about Deductibles and Out-of-Pocket Maximums

Under the $2,500 HDHP, if you cover any family member(s) in addition to yourself:
The entire Family Deductible must be met before benefits begin to pay out for *any* family member.
The entire Family Out-of-Pocket Maximum must be met before the plan pays in full for *any* family member.

For the $4,000 HDHP 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.

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.

Cigna 90 Now:

Cigna 90 Now combines the savings of a 90-day fill benefit with the flexibility and convenience of being able to choose where to fill prescriptions – at one of approximately 29,000 retail pharmacy locations in the Cigna 90 Now network or through Cigna Home Delivery Pharmacy. Cigna 90 Now offers you a pharmacy benefit that's designed to strike the right balance between access, cost and customer satisfaction. Participating pharmacy includes CVS, Walmart, Target, Kroger, Access Health, Elevate Provider Network and Cardinal Health.

Pharmacy Resources:

Prescription Drug Lists and Coverage Link: https://www.cigna.com/individuals-families/member-resources/prescription/
Please note: Once above link is launched, you will need to select *Cigna Value Prescription Drug* lists under *pharmacy resources for plans offered by employers*. This drug list is specific to your employer plan.

Prescription **Home Delivery** through Express Scripts. Three easy ways to place a new order

1. Electronically: For fastest service, ask your doctor's office to send your prescription electronically to Express Scripts Home Delivery, NCPDP 2623735.
2. By fax: Have your doctor's office call 888.327.9791 to get a Fax Order Form.
3. By mail: Send your prescription to Express Scripts, P.O. Box 66301, St. Louis MO, 63166-6301.

Visit Link for more details:
https://www.cigna.com/static/www-cigna-com/docs/individuals-families/express-scripts-pharmacy.pdf

Access Cigna:

Website: Nothing is more important than your good health. That's why there's www.myCigna.com – your online home for assessment tools, plan management, medical updates and much more. On myCigna you can:[5]

- 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 myCigna app.
Cigna Medical Plan Mobile Apps: https://www.cigna.com/about-us/cigna-mobile/

Need more coverage?
*Consider combining medical insurance with **supplemental health insurance**, like an accident or critical illness insurance plan. These options are supplement your medical plan's coverage. The combined coverage could offer effective protection against out-of-pocket expenses.*

Medical and Prescription Drug Coverage

Maximize your benefits: Medical Plan Programs & Perks

If you decide to participate in the medical plan, Cigna offers several programs and perks to maximize your medical plan.

Cigna Telehealth Connection:

On-demand 24/7/365 access to cost-effective, quality non-urgent care through a national network of licensed, board-certified U.S.-based doctors. **Copay will be collected at time of service*.**

Visit Link for more information on your Telehealth connection:
https://www.cigna.com/individuals-families/member-resources/telehealth-connection-program

When to use Telehealth

- For minor, nonemergency medical issues (especially as an alternative to the high cost of an emergency room or urgent care center)
- Your doctor or pediatrician is not available on your schedule
- You are traveling and need medical care
- You need a prescription or refill (provisions apply)
- When it's not convenient to leave your home or office
- Anytime, including nights, weekends and holidays

How to Use

- Set up and create an account with MDLIVE
- Complete a medical history using their "virtual clipboard"
- Download vendor apps to your smartphone/ mobile device.*** Visit the website or call to register
- Register today so you'll be ready to use a telehealth service when and where you need it.
- Request your consultation

Telehealth and COVID-19: Virtual care is a good way to get the medical attention you may need without leaving home. While a diagnosis of COVID-19 cannot be confirmed through virtual medical care, you may be directed to self-care or to follow-up with your PCP or a local hospital for additional evaluation and care.

Check with your doctor to see if they are offering virtual care visits. There are some restrictions to what a virtual care provider from MDLIVE can do relative to COVID-19.

Telehealth Services will be provided by MDLIVE.

MDLIVE
888.726.3171
URL: www.MDLIVEforCigna.com

**Copay is subject to change.*

Telehealth Specialty: Cigna Behavioral Health:

Behavioral health contracted providers are available, for Telehealth video consultations during the providers' regular business hours. Behavior health specialty providers are not part of Cigna's MDLive vendor. If you are seeking a behavioral health provider to assist with mental health care, substance use disorder care, and/or EAP clinical care. Cost for service varies depending on provided service.

How to Use

- Search the Cigna behavioral provider directory.
- Select "Telehealth" from the specialty dropdown
- Or call the number on the back of your Cigna ID card and speak with a personal advocate

Medical and Prescription Drug Coverage

Cigna Lifestyle Management Programs:

If weight, tobacco use or stress is affecting your health or your ability to live an active life, it may be time to make some changes. A health coach can provide you with personalized support to:

- Learn to manage your weight using a non-diet approach that helps you build confidence, change habits, eat healthier and become more active.
- Develop a personal quit plan to become and remain tobacco-free.

Cigna Health & Wellness:

Health and wellness tips and resources to help you meet your health goals and care for your loved ones. Visit https://www.cigna.com/individuals-families/health-wellness/ for more information on autism, disaster resource center, eating well, family care, Substance Use Disorders, suicide awareness and prevention, exercise and fitness, healthy aging, mental health and much more.

Cigna Healthy Pregnancies, Healthy Babies Program:

This program offers additional support during and after your pregnancy.

- Understand any health issues that could affect your baby.
- Ask your own questions and get information to help you make informed choices about your pregnancy.
- Based on your situation and your doctor's care plan, a Cigna nurse will be there to support you throughout your pregnancy.
- You will also receive a kit with useful tips and tools to help you have a healthier nine months and a healthier baby.

Chronic Health Condition Support

If you are living with a chronic health condition such as diabetes, back pain, depression, arthritis, asthma or cardiac issues, programs are available where, in addition to seeing your physician, you will have the opportunity to work with a health coach who will work with you to establish and reach goals to improve your overall health and well-being.

With a one-on-one relationship you can get help managing your health condition and making more informed decisions, and create a plan to improve your health based on your personal goals. You can also focus on coping with stress, becoming tobacco-free, maintaining good eating habits and managing or losing weight.

The combination of knowledge and support can make a healthy difference. Programs that help manage a chronic condition can be an effective way to help you better manage your health and have more time and energy for life.

Discounts:

Cigna Healthy Rewards

Get discounts on the health products and programs you use every day for:

- Weight management and nutrition
- Fitness clubs and equipment
- Mind/body programs and equipment
- Vision and hearing care
- Alternative medicine
- Vitamins, and health and wellness products

Note if you want an Active&Fit Direct gym membership, call 800-870-3470 (press 3 to be transferred to a customer service agent).

For more information, Login to www.mycigna.com or call 800-870-3470.

Coronavirus (COVID-19) Resource Link

https://www.cigna.com/coronavirus/

Health Savings Account (HSA)

You can save money on your health care costs through the use of a tax-advantaged account that allows you to use before-tax dollars to pay for eligible expenses.

With the employer offered HSA-eligible medical plan(s), you are eligible to contribute money to a Health Savings Account (HSA). HSAs are tax-advantaged savings accounts you can use to help pay for eligible health care expenses as you incur them, or you can build up the money in your account and use it for future expenses, even during retirement. Your HSA is always yours to keep — if you leave your employer, your HSA goes with you.

What are eligible health care expenses?

For a complete list of eligible expenses, visit www.irs.gov and see Publication 502. Some examples include:

- Office visits
- Prescription drugs
- Hospital stays and lab work
- Speech/occupation/ physical therapy
- Dental and vision care

Reminder

It is your responsibility to keep documentation to support your use of the money in these accounts for tax purposes.

Key features

- **Company contribution.** Receive an annual contribution from your Employer for enrolling in a HSA, deposited on a per pay period basis. You must have an open account each year to receive your employer's contribution.
- **Works like a bank account**. Use account funds to pay for eligible health care expenses by using your debit card when you receive care, or submit a claim for reimbursement for payments you've made (up to the available balance in your account).
- **You can save**. You decide how much to contribute to your HSA and can change that amount at any time.
- **It's tax-advantaged.** You do not pay taxes on contributions made from your paycheck, and the money will never be taxed when used for eligible health care expenses.
- **It is your money**. Unused funds can be carried over each year and invested for the future — you can earn tax-free interest on your HSA balance. Once your account reaches a certain balance, you will have other investment choices for the money. You can even take the account with you if you leave your employer or save it to use during retirement.
- **You are not eligible to contribute to an HSA if you**:
  - Are enrolled in Medicare
  - Are covered by any health insurance (including Tricare) other than a qualified High Deductible Health Plan
  - Can be claimed as a dependent on another person's tax return
  - Have access to reimbursement under a Health Care Flexible Spending Account (FSA) established by another employer for you, your spouse, or other family member
- **It is an individually owned account.** Because this is your individual account, you are responsible for determining your eligibility and annual tax filings.

Maximum Annual Contributions

For 2021, you can make pre-tax contributions from your paycheck up to:

- Individual coverage = $3,600
- Family coverage = $7,200
- If you are age 55 or older, you can contribute an additional $1,000 per year.

Important! The maximum annual contributions include both employee ***AND*** employer's combined contribution.

Health Savings Account (HSA)

Discovery Benefits

Three (3) Key features from Discovery Benefits

Spending. Access your HSA funds in two (2) ways:

- Discovery Benefits debit card
- Discovery mobile app

Saving. Discovery offers a free savings calculator to help you decide how much to set aside.

Investing. Discovery offers a low HSA investment threshold of $1,000. Once your HSA reaches that amount, you are able to invest in interest-bearing accounts or mutual funds.

Discovery Benefits Debit Card*: The debit card makes it easy to access funds, reducing your out-of-pocket costs.

How it works. 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:

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

Savings Calculator:
https://www.discoverybenefits.com/employees/savings-calculators/hsa-goal-calculator

Investment Options:
https://hsainvestments.com/fundperformance/?p=HCBANK

- 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.

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)*

Supplemental Medical Insurance

UNUM

Supplemental health insurance can help protect you from significant expenses not covered by your medical plan. In fact, based on your situation, you may be able to save money by adding a supplemental plan to a lower cost medical plan. Be sure to consider your anticipated medical needs for the year along with the cost of the medical plans available to you. **If you do not elect supplemental medical insurance during initial offerings, you will be considered a late entrant and required to submit evidence of insurability (EOI) and be approved prior to active enrollment.**

Keep in mind

Supplemental health plans are intended to enhance your medical plan. On their own, they do not provide the minimum level of medical coverage needed to meet the Affordable Care Act requirement to have medical insurance.

ACCIDENT

You cannot always avoid accidents, but you can help protect yourself from accident related costs that can strain your budget. Accident insurance supplements your medical plan by providing cash benefits in cases of accidental injuries. You can use this money to help pay for non-covered medical expenses, such as your deductible or coinsurance, or for ongoing living expenses, such as your mortgage or rent. Benefits are paid in addition to your medical plan and are payable regardless of any other insurance plans you may have. You will be able to elect coverage for yourself and your dependents during your enrollment period regardless of prior health history.

Covered Services		Benefit Amount
Injuries	Fractures, Dislocations, Burns, Concussion, Coma, Ruptured Disc, Knee Cartilage, Laceration, Tendon/ligament and rotator cuff, emergency dental work, eye injury	Varied amounts from $20 up to $10,000 based on specific injury
Emergency and hospitalization benefits	Ambulance, Emergency Room Treatment, Emergency Treatment, Hospital Admission, Intensive care admission, Hospital Confinement, Medical imaging test, outpatient surgery facility service, pain management	Varied amounts from $100 up to $1,000 based on emergency and/or hospitalization
Treatment and Other Services	Surgery benefit, Hernia repair, physician follow-up visit from accident, Therapy services, Prosthetic device or artificial limb, appliance, blood/plasma/platelets	Varied amounts from $20 up to $1,000 based on treatment and/or service
Accidental death and other covered losses	Accidental death, Accidental dismemberment, Accidental loss	Varied amounts from $10,000 up to $50,000 based on accidental death or loss
Wellness Benefit	Be Well Benefit included for each covered family member	$50

CRITICAL ILLNESS

When a serious illness strikes, critical illness insurance can provide financial support to help you through a difficult time. It protects against the financial impact of certain illnesses, such as a heart attack or cancer. You receive a lump-sum benefit that you can use to cover out-of-pocket expenses for your treatment that are not covered by your medical plan. You can also use the money to take care of your everyday living expenses like housekeeping services, special transportation services, and day care. Benefits are paid in addition to your medical plan, and are payable regardless of any other insurance plans you may have. You will be able to elect coverage for yourself and your dependents, if you elect coverage for yourself, during your enrollment period regardless of prior health history.

Tier	Options	Guarantee Issue Amount (GIA)*
Employee	Option 1: $10,000 Option 2: $20,000	$20,000
Spouse:	50% of employee amount	$10,000
Child(ren): newborn to age 26	Automatically covered at 50% of employee election amount.	

**GIA If you do not sign up during your initial offering and decide to apply later, you will be required to complete a medical questionnaire.*

Type	Conditions
Critical Illness	heart attack, stroke, major organ failure, end-stage kidney failure, coronary artery disease (major (50%), coronary artery bypass graft or valve replacement Minor (10%), balloon angioplasty or stent placement).
Cancer Conditions	Invasive, Non-invasive and Skin
Progressive Diseases	amyotrophic Lateral Sclerosis (ALS); dementia, including Alzheimer's disease; Multiple Sclerosis (MS), Parkinson's disease, functional loss
Supplemental Conditions	loss of sight, hearing or speech; benign brain tumor, coma, permanent paralysis, occupational HIV, hepatitis B, C or D; infectious Diseases (25%)
Wellness Benefit	$50 Be Well Benefit included for each covered family member

Please see your Human Resource Department for a full schedule of benefits description for Accident and/or Critical Illness.

Dental Insurance

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 hygiene 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

Electronic 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

UNUM – TERM LIFE, 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 **two (2) times your salary, rounded to the next highest $1,000, up to $300,000.**

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 19 (age 26 if full-time student). 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 Accidental Death and Dismemberment (AD&D) – You can purchase accidental death and dismemberment (AD&D) insurance for yourself. Get up to $500,000 of AD&D coverage for yourself in $10,000 increments to a maximum of five (5) times your earnings.

EMPLOYEE-PAID LIFE/AD&D PLAN SUMMARY

	Minimum	Guarantee Issue Amount	Maximum
Employee	$10,000	$200,000	Incremental amounts of $10,000 up to the Lesser of five (5) x basic annual earnings or $500,000
Spouse	$5,000	$50,000	Increment amounts of $5,000 up to $250,000 not to exceed 100% of Employee's election
Child	$2,000	$10,000	Increment amounts of $2,000 up to $10,000 *Maximum benefit for Children live birth to 6 months is $1,000

Disability Insurance

UNUM

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 paid 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	100% or 60% of earnings based on years of service	60% of monthly basic annual earnings up to plan maximums
Elimination Period	Off the job Injury: 8 days Illness: 8 days	90 days
Duration Period	12 weeks (90 days)	Social Security Normal retirement age with 2-year own occupation definition
Pre-Existing condition Limitation	None	Benefit limitations if claimant received medical treatment, consultation, care or services including diagnostic measures or took prescribed drugs or medicines in the **3 months** just prior to his/her effective date of coverage; and the disability begins in the first **12 months** after the employee's effective date of coverage.

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:

- *Employee Assistance Program (EAP):* The EAP program offers short-term counseling and support for a range of personal, family, financial, and work/life issues. This unique early intervention service takes a holistic approach to promoting total well-being. Product features include:
  - Clinical Support: up to three (3) confidential short-term counseling sessions
  - Work/Life Support: resources for childcare, eldercare, legal, financial and unlimited telephonic and web-based consultation.
  - Medical Bill Saver

- *Medical Bill Saver:* Get peace of mind with the medical bill saver that is included with your Employee Assistance Program. If you have a healthcare bill totaling over $400 in out of pocket costs, you have access to a skilled negotiating team to work with your providers to help reduce your out-of-pocket cost. They can also guide you on how to utilize your plan to keep future bills lower.

To access the above benefits, contact the Employee Assistance Program services at 800-854-1446 or www.unum.com/lifebalance.

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.

  How to access Covid 19 Resources:
  - Login to www.unum.com/lifebalance
  - Select ***access your EAP Benefits***
  - Click ***Learn More*** under Coronavirus (COVID-19) Resources

- *COVID-19 Additional Resource Links:*

  - UNUM COVID-19 Response & Resource Link: https://www.unum.com/covid-19

  - CIGNA COVID-19 Response & Resource Link: https://www.cigna.com/coronavirus/individuals-and-families

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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

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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.

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 doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% 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. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

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

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[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
OMB No. 1210-0149
(expires 6-30-2023)

2021 ANNUAL NOTICES

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

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)

IMPORTANT NOTICE FROM BACKER NORTH AMERICA
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 Backer North America 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: November 16, 2020 (Last Issue: September 1, 2020)

Name of Entity/Sender: Backer EHP Inc.

Human Resources

4700 John Bragg Highway, Murfreesboro, TN 37127


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