RedeemersGroup

Benefit Guide

MyRedeemersGroupBenefits.com

2023

BENEFITS
& ENROLLMENT

March 1, 2023 - February 28, 2024

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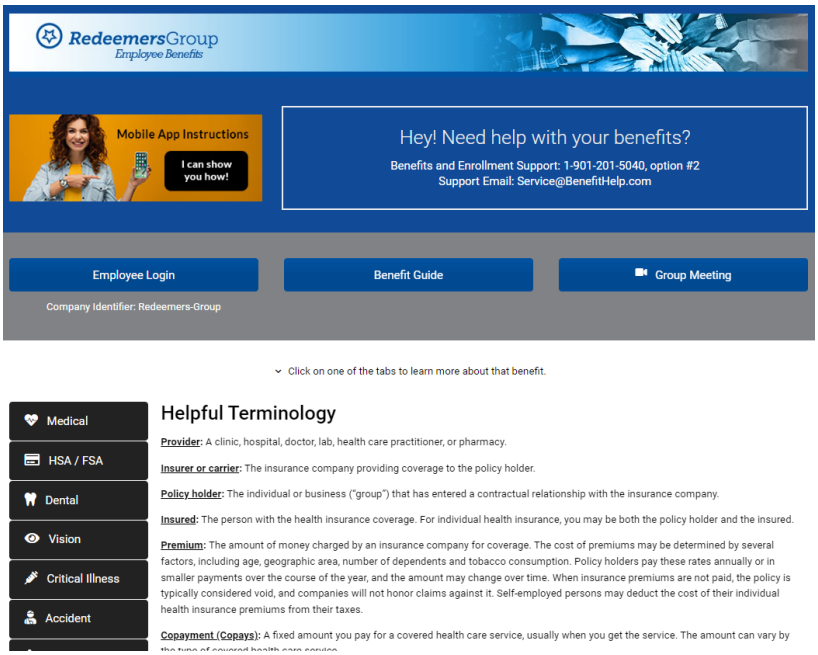
Where can I get more information about my benefits?

MyRedeemersGroupBenefits.com



Have you ever had trouble locating information about your benefits?
What about trying to remember how to find a participating doctor or dentist?

Not to worry, with MyRedeemersGroupBenefits.com
you are just an internet connection away from...

- Important Phone Numbers
- Support & Enrollment
- Provider & Facility Searches
- Employee Benefit News
- Important Documents
- Videos about Specific Benefits

Overview of Benefits Programs

CHANGES AND QUALIFYING EVENTS

When Coverage Begins and Ends

› Your coverage begins on the 1st day of the month following 30 days of employment.

› Your coverage under the benefits plans will end if you no longer meet the eligibility requirements, your contributions are discontinued, or the Group Insurance Policy is terminated.

Qualifying Events

› Eligible employees may enroll or make changes to their benefits elections during the annual open enrollment period. As with most benefits, once you elect an option you are bound to that choice for the entire plan year unless you experience a "Qualifying Event". These may include, but are not limited to:

- Changes in employment status
- Changes in legal marital status
- Changes in number of dependents
- Taking an unpaid leave of absence
- Dependent satisfies or ceases to satisfy eligibility requirement
- Family Medical Leave Act (FMLA) leave.
- A COBRA-qualifying event
- Entitlement to Medicare or Medicaid
- A change in the place of residence of the employee, resulting in the current carrier not being available

Value of Pre-Tax Benefits

SECTION 125 PLAN

Redeemers Group operates a Premium Only Section 125 Plan, which allows you to reduce your total taxable income by your portion of group insurance premiums. In effect, this is just like getting a raise - your withholding taxes are reduced, and your take-home pay increases!

Example: Employee earning $30,000 annually, paying $200/month for benefits

	Without Pre-Tax Benefits	With Pre-Tax Benefits
Gross Pay	$30,000	$30,000
Insurance Deductions/Payments	$0	$2,400
Taxable Income	**$30,000**	**$27,600**
Taxes at 25%	$7,500	$6,900
After-Tax Income	**$22,500**	**$20,700**
After-Tax Payment for Benefits	$2,400	$0
Take-home Pay	**$20,100**	**$20,700**
INCREASE IN TAKE-HOME PAY		**+$600**

Medical/Rx

EXCEL HEALTH PLANS

SUMMARY OF COVERAGE

Plan Features	Option 1 HDHP	Option 2 Copay Plan
IN NETWORK	**PHCS**	**PHCS**
Deductibles (Indiv / Family)	$5,000 / $12,700	$5,000 / $12,700
Preventive Care	no charge	no charge
Primary Care Visit	70% after deductible	$10 copay
Specialist Visit	70% after deductible	$80 copay
Complex Images	70% after deductible **	70% after deductible *
Xray / Lab	70% after deductible **	70% after deductible *
Outpatient Procedure	70% after deductible	70% after deductible
Inpatient Visit	70% after deductible	70% after deductible
Emergency Room	70% after deductible	70% after deductible
Urgent Care	70% after deductible	$100 copay
Pharmacy / Rx (30 Day Supply)	70% after deductible	$1 / $35 / $75 / $200
Out-of-Pocket Max (Indiv / Family)	$6,000 / $12,700	$6,000 / $12,700

* May qualify for a $0 disappearing deductible program. For Option 2, qualification is automatic without any deductible having to be met.
** May qualify for a $0 disappearing deductible program. For Option 1, HDHP may qualify after the IRS allowable minimum of $1,500 employee / $3,000 family. See subsequent pages.

GET STARTED - EMPLOYEE

Excel Health plans – What to know

- **Enhanced benefits plan** – Excel Health plans have enhanced benefits with high quality high value options – in addition to your network
- **Your disappearing deductible** – You may have the ability get any of the care listed below at $0 to you
- **Items eligible for disappearing deductible** – this means for surgical, labs, imaging, specialty medication, and injectable medications
- **Your plan may reach out to you** – to let you know that a disappearing deductible option is available
- **Medireview Team does outreach** – the concierge is called the Medireview team so please respond if they reach out.
- **Call Medireview for Questions benefits plan call 1–800–222–8734 Medireview** will assist you to make appointments, and seek prior authorizations for care that requires it!

TIPS TO GET THE MOST OUT OF YOUR PLAN...

- Check our list of in–network healthcare providers and pharmacies to make sure your preferred provider is covered by the Excel Health Plan
- Call the number on your ID card when you have questions about your benefits and/ or your existing health care providers as well as assistance with selecting a provider and scheduling appointments
- The CareNav team is available to assist you with existing care needs. Their number is on your ID card so feel free to call them when you have plan questions or need to find a specific provider
- Provide your new ID card to all of your existing health care providers and pharmacies
- The providers considered primary care for your health plan without prior authorization required – Primary Care, OBGYN, Pediactrics, Mental Health, Dermatology, Ear Nose and Throat

DISAPPEARING DEDUCTIBLES

VENDOR	PLAN ROLE
benefitSMART BUY HEALTHCARE BETTER	CANCER
ConnectDME	DURABLE MEDICAL EQUIPMENT
coral	MSK/ORTHOPEDIC
Diathrive HEALTH	DIABETES
Green Imaging	IMAGING
lyric	TELEHEALTH & VIRTUAL MENTAL HEALTH
OptiMed	J CODE
QuestSelect™ Formerly Lab Card®	LABS
scriptsourcing	1,200+ PRESCRIPTIONS
SPECIALTY Care Management	DIALYSIS/KIDNEY DISEASE

TO ACCESS YOUR DISAPPEARING DEDUCTIBLE PLEASE CALL: 1 800 222 8734

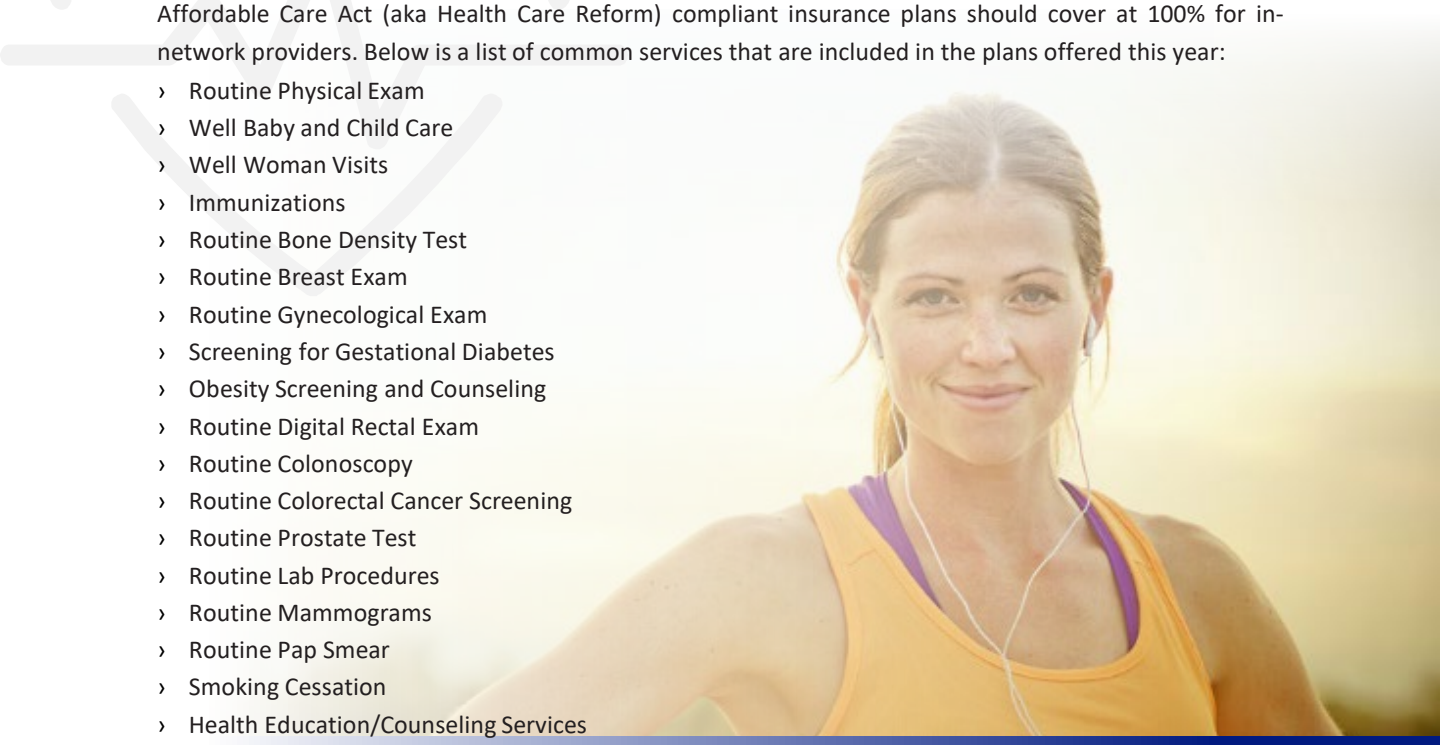
Medical

Understanding the full value of covered benefits allows you to take responsibility for maintaining good health and incorporating healthy habits into your lifestyle. Some examples include getting regular physical examinations, mammograms and immunizations. Through the plans offered by Redeemers Group, all covered individuals and family members are **eligible to receive routine wellness services like these, at no cost; all copays, coinsurance, and deductibles are waived.**

WHICH PREVENTIVE CARE SERVICES ARE COVERED?

The US Preventive Services Task Force maintains a regular list of recommended services that all Affordable Care Act (aka Health Care Reform) compliant insurance plans should cover at 100% for in-network providers. Below is a list of common services that are included in the plans offered this year:

- Routine Physical Exam
- Well Baby and Child Care
- Well Woman Visits
- Immunizations
- Routine Bone Density Test
- Routine Breast Exam
- Routine Gynecological Exam
- Screening for Gestational Diabetes
- Obesity Screening and Counseling
- Routine Digital Rectal Exam
- Routine Colonoscopy
- Routine Colorectal Cancer Screening
- Routine Prostate Test
- Routine Lab Procedures
- Routine Mammograms
- Routine Pap Smear
- Smoking Cessation
- Health Education/Counseling Services
- Health Counseling for STDs and HIV
- Testing for HPV and HIV
- Screening and Counseling for Domestic Violence



"An ounce of prevention is worth a pound of cure"

Health Savings Account (HSA)

A Health Savings Account (HSA) is a tax-advantaged savings account you can use to pay for qualified medical expenses, including eligible dental and vision costs. An HSA puts you in control of your health care spending, letting you decide how much to save and allowing you to pay for qualified medical expenses with tax-advantaged dollars. If you choose to open an HSA, you will receive a debit card that you can use to access the money in your HSA. You can use your debit card to pay for qualified medical expenses directly or you can pay qualified expenses out of your own pocket and reimburse yourself from the HSA at a later date. That later date can be whenever you choose and can be withdrawn tax-free as long as you can prove you had eligible medical expenses to support the withdrawal.

Taking a Long-Term View of an HSA

You can also think of your HSA as a long-term investment. Since the funds roll over from year to year you can contribute up to the limit, even if you won't use that much each year. Every year you get the opportunity to contribute more, and your account will continue to grow tax-free, including interest and/or investment earnings, for future use. There is no limit to how much your account can accumulate.

Special Tax Rules for HSA Withdrawals

You can withdraw funds from your HSA account at any time; however, those withdrawals are taxable and subject to a penalty if the money is used for anything other than qualified medical expenses before you reach age 65. If you use the money for other expenses when you're older than 65 there is no penalty, but the money will be taxed upon withdrawal.

Note: You cannot participate in the HSA if you are covered by health insurance or other health plan coverage that is not a qualified high deductible health plan or if you are enrolled in Medicare. Once your Medicare coverage begins, you can no longer contribute to an HSA. However, you can still use your existing account balance to pay your health expenses tax-free, including Medicare premiums and other plan costs.

2023 HSA Contribution Limits =
$3,850 (individual)
$7,750 (family)

Advantages of an HSA

Triple tax savings:

- Contributions made through payroll deductions are made with pre-tax dollars, meaning they are not subject to federal income tax. Employer contributions from Redeemers Group are also excluded from gross income.
- Interest earned on your HSA balance is not subject to federal income tax.
- Withdrawals for qualified medical expenses are not subject to federal income tax.

There's no "use it or lose it" rule.
An HSA has no "use it or lose it" feature like the Health Care Flexible Spending Account, so your account balance rolls over each year. It's your choice to save for future health expenses or pay for current health care costs.

The money is yours to keep—forever.
The HSA is completely portable. Any unused funds in your account are yours to keep, even if you leave Redeemers Group or retire.

What is a Limited Purpose FSA

For employees enrolled in the High-Deductible Health Plan (HDHP) and Health Savings Account (HSA), a Limited Purpose FSA Healthcare has been established. Like a Healthcare FSA, this account allows employees to pre-tax up to $2,850 (per participant) of eligible expenses for 2023-2024 plan years. However, Limited Purpose FSA eligible expenses are **"limited" to reimburse dental and vision expenses**.

As in the case of Healthcare FSAs, another benefit of the Limited Purpose FSA is that all funds are available on day 1 of the plan year. This means employees do not have to wait for these funds to accumulate in their account to submit claims to the benefits administrators.

Health Savings Account (HSA)

FOR 2023 Redeemers Group IS OFFERING A HEALTH SAVINGS ACCOUNT (HSA). THIS IS HOW AN HSA WORKS:

A health savings account (HSA) is a health care account and savings account in one. The main purpose of this account is to offset the cost of a qualifying high deductible health plan (HDHP) and provide savings for your out-of-pocket eligible health care expenses – those you and your tax dependents may have now, in the future, and during your retirement.

This is a "portable" account. You own your HSA! It's included in your employee benefits package, but after you set up your account, it's yours to keep, even if you change jobs or retire.

Once your HSA is established, money is contributed to your account by you, Redeemers Group or friends and family, and you can then use your HSA dollars tax-free to pay for eligible health care expenses. You save money on expenses you're already paying for, like doctors' office visits, prescription drugs, and much more. Best of all, you decide how and when to use your HSA dollars.

WHY IS IT A GOOD IDEA TO HAVE AN HSA?

HSAs benefit everyone who is eligible to have this account – single individuals, families, and soon-to-be retirees. You save money on taxes in three ways:

› Tax-free deposits – The money you contribute to your HSA isn't taxed (up to the IRS annual limit)	› Tax-free earnings – Your interest and any investment earnings grow tax-free.	› Tax-free withdrawals – The money used toward eligible health care expenses isn't taxed – now or in the future.

› Setting aside pre-tax dollars into your HSA means you pay fewer taxes and increase your take-home pay by your tax savings. You save money on eligible expenses that you are paying for out of your pocket. The amount you save depends on your tax bracket. For example, if you are in the 30 percent tax bracket, you can save $30 on every $100 spent on eligible health care expenses.

HSA funds roll over from year to year and accumulate in your account. There is no "use-it-or-lose-it" rule with HSAs, and you decide how and when to use your HSA funds, which can be used for eligible expenses you have now, in the future, or during retirement. And when you have a certain balance in your HSA, investment opportunities are available.

Refer to your HSA documentation for more information.

Flexible Spending Account (FSA)

Healthcare flexible spending accounts allow employees to set aside pretax dollars to use for eligible healthcare expenses, while reducing your FICA and federal unemployment tax liability. Employee contributions are made through paycheck deductions.

Both a Health Care FSA and a Dependent Care FSA are available as part of your benefits.

• Employees can enroll in an FSA even if they decline health coverage

• Employees can't change their election amount during the plan year unless they experience a qualifying life event

• You can choose to allow employees to roll over up to $500 from one plan year to the next (the $500 is not calculated into the IRS maximum contribution)

Dependent Care FSA

The Dependent Care FSA enables you to set aside pre-tax dollars to pay for qualified dependent care expenses. Funds can be used to pay for eligible day care, preschool, elder care or other dependent care.

The IRS requires that the dependent care is necessary for you and your spouse to work, look for work or attend school full-time, along with other requirements.

What you need to know about FSAs

- Pre-tax contributions **reduce taxable income**, making each dollar stretch up to 30% further
- Full election amount is **available first day of the plan year**, like a tax-free, interest-free loan
- Election **changes require a qualifying event**, like enrolling in a new health plan
- The IRS sets the annual contribution limit.

Eligible expenses*

- Medical services including copays and deductibles
- Dental services including copays and deductibles
- Prescription drugs
- Eye exams, eyeglasses, contact lenses and solution
- Orthodontia, dental cleanings, fillings, crowns and root canals
- Physical therapy, speech therapy,
- Chiropractor
- Hearing aids
- Laser surgery

** For further guidance refer to the IRS publications 969, 502 and code section 213(d). These publications are available at www.irs.gov.*

Flexible Spending Account FSA

Redeemers Group is offering a Flexible Spending Account (FSA) for 2023 - 2024. This is how an FSA works:

- You set aside money for your FSA from your paycheck before taxes are taken out.
- Then use your pre-tax FSA funds throughout the plan year to pay for eligible health care or dependent care expenses.
- You save money on expenses you're already paying for.

You may also be able to carry over up to $500 of unused health FSA funds to the following plan year. Refer to your FSA documentation for more details.

HEALTH FSA ELIGIBLE EXPENSES

- Medical expenses: co-pays, co-insurance, and deductibles
- Dental expenses: exams, cleanings, X-rays, and braces
- Vision expenses: exams, contact lenses and supplies, eyeglasses, and laser eye surgery
- Professional services: physical therapy, chiropractor, and acupuncture
- Prescription drugs and insulin
- Over-the-counter health care items: bandages, pregnancy test kits, blood pressure monitors, etc.

2023 Contribution Limit = $3,050

DEPENDENT CARE FSA ELIGIBLE EXPENSES

- Care for your child who is under age 13
- Before and after-school care
- Baby sitting and nanny expenses
- Day care, nursery school, and preschool
- Summer day camp
- Care for a relative who is physically or mentally incapable of self-care and lives in your home

2023 Contribution Limit = $5,000

Refer to your FSA documentation for more information.

Dental Coverage

GUARDIAN®

SUMMARY OF COVERAGE

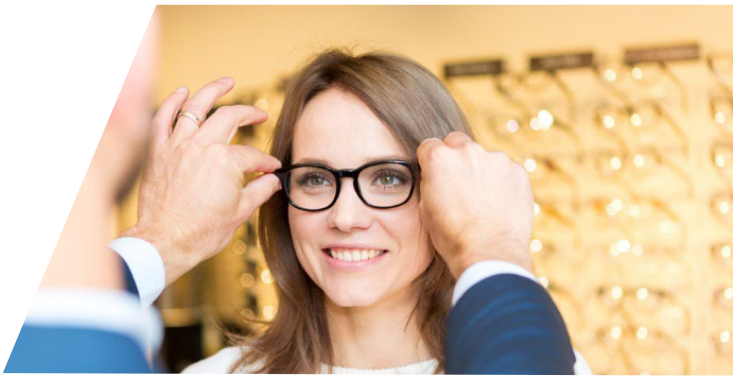
Plan Features	Voluntary Dental
IN NETWORK	
Annual Deductible (Individual / Family)	$0 / $0
Preventive Care	100%
Basic Procedures (Extractions, fillings, etc.)	80%
Major Procedures (Crowns, dentures, etc.)	50%
Child Orthodontia	50%
Lifetime Orthodontia Maximum	$1,000
Calendar Year Maximum Benefit	$1,500 Plus Maximum Rollover
OUT OF NETWORK	
Annual Deductible (Individual / Family)	$50 / $150
Preventive Care	100%
Basic Procedures (Extractions, fillings, etc.)	80%
Major Procedures (Crowns, dentures, etc.)	50%
Child Orthodontia	50%
Lifetime Orthodontia Maximum	$1,000
Calendar Year Maximum Benefit	$1,500 Plus Maximum Rollover
Maximum Rollover Benefit	
Rollover Threshold	$700
Rollover Amount	$350
Rollover In-network Amount	$500
Rollover Account Limit	$1,000

Vision Coverage

GUARDIAN®

SUMMARY OF COVERAGE

Plan Features	Voluntary Vision
IN NETWORK	
Exam Copay	$10
Lenses	
Single	$25
Bifocal	$25
Trifocal	$25
Progressive	$25
Frames	80% of amount over $150
Elective Contact Lenses	85% of amount over $150
Medically Necessary Contact Lenses	$0 Covered (Copay Waived)
Frequency (Months)	
Exam	Every 12 Months
Lenses	Every 12 Months
Frames	Every 24 Months
Contacts	Every 12 Months
OUT OF NETWORK	
Vision Exam	$10 $50 max
Lenses	
Single	$25 up to $48 max
Bifocal	$25 up to $67 max
Trifocal	$25 up to $86 max
Progressive	$25 up to $126 max
Frames	$25 up to $48 max
Elective Contact Lenses	$25 up to $105 max (Copay waived)
Medically Necessary Contact Lenses	$25 up to $210 max (Copay waived)



Term Life Insurance

GUARDIAN®

SUMMARY OF COVERAGE

Employer Paid Life

Plan Features	
Employee Benefit Amount	$25,000
Maximum Benefit Amount	$25,000
AD&D Benefit	$25,000
The following shows how much benefits are reduced at certain ages:	
Age Band	**Benefit Reduction**
65	35%
70	60%
75	75%
80	85%

SAMPLE Bi-Weekly Rates

Issue Age	$25,000 Benefit	$50,000 Benefit	$75,000 Benefit
0-29	$ 1.62	$ 3.23	$ 4.85
30-34	$ 1.96	$ 3.92	$ 5.88
35-39	$ 2.65	$ 5 .31	$ 7.96
40-44	$ 4.04	$ 8.08	$ 12.12
45-49	$ 6.12	$ 12.23	$ 18.35

Voluntary Life

Plan Features	
Employee Benefit Amount	Employees can choose different amounts of coverage between the minimum and maximum benefit amount. See plan documentation for more details.
Minimum Benefit Amount	$25,000
Maximum Benefit Amount	$250,000
AD&D Benefit	Employee, Spouse & Child(ren) coverage. Maximum 1 times life amount.
Employee Guarantee Issue	Employee Less than age 65 $150,000, 65-69 $50,000, 70+ $10,000.
Spouse Benefit	$25,000 increments to a maximum of $250,000.
Spouse Guarantee Issue	Employee Less than age 65 $150,000, 65-69 $50,000, 70+ $10,000.
Dependent Benefit	$10,000
The following shows how much benefits are reduced at certain ages:	
Age Band	**Benefit Reduction**
65	35%
70	60%
75	75%
80	85%

Whole Life Insurance

SUMMARY OF COVERAGE

Guarantees you can count on.
Benefits that add up.

Whole life insurance offers valuable benefits you can use to help pay for retirement, finance education, or just make life easier.

Reasons to buy whole life insurance:
- Long-term protection (to age 121)
- Cash value you can use in retirement
- Premiums guaranteed not to increase

Includes:
- Accelerated Death Benefit
- Long Term Care Rider
- Guaranteed Issue
  - $50,000 Employee
  - $20,000 Working Spouse
  - $10,000 Non-working Spouse
  - $10,000 Child

SAMPLE Bi-Weekly Rates

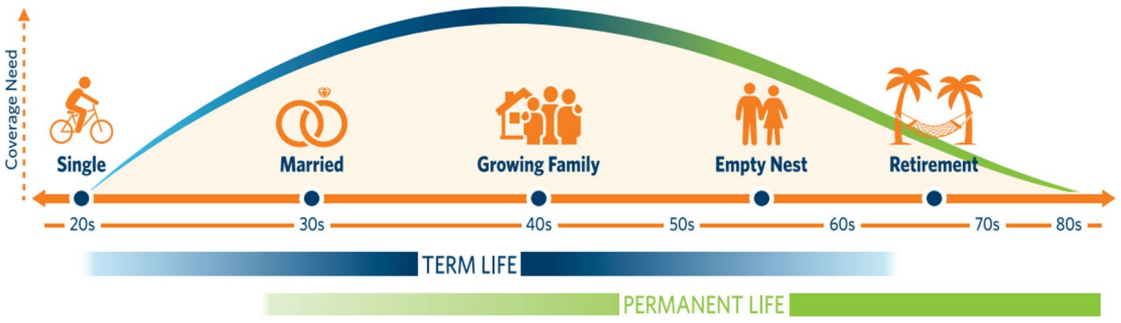
Issue Age	$10,000 Benefit	$20,000 Benefit	$50,000 Benefit
20	2.24	4.48	11.18
30	3.44	6.88	17.20
40	5.79	11.58	28.94
50	10.52	21.04	52.56
60	21.16	42.32	105.78

Rates illustrated are Non-Tobacco user

Allstate. BENEFITS

TERM LIFE OR WHOLE LIFE?

Most financial experts say a little of both is a good idea.
Term Insurance when your needs are greater with a growing family and Whole Life for the long term while locking in a lower rate earlier in life.



The examples above detail fictional thought processes and needs; your individual needs and reasons for coverage may vary.

Disability Insurance Short-Term

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SUMMARY OF COVERAGE

What Is Disability Insurance?

In general, disability insurance covers some of your income if something happens to you (like an illness or injury) and you can't work.

The younger and healthier you are, the easier it is to qualify for a policy. But as you age, premiums increase. And if your health goes south, you may find it hard to qualify for an affordable policy at all.

But disability insurance doesn't just cover freak accidents. Most claims are for things you may not realize are considered disabilities, like physical injuries, a heart attack, or cancer. These things could happen to anyone in *any* workplace.

Why You Need Disability Insurance

Think none of these will happen to you? Think again. The Social Security Administration (SSA) reports that one in four of today's 20-year-olds will become disabled for 90 days or more before they turn 67 years old—and that a massive 68% of non-government workers have no disability insurance.(1) *Yikes!*

Having a plan for the long term – beyond a 3-6 month emergency fund – is important not only to you, but also the people who rely on your income. How much better would it feel to know money is still coming in while you're recovering?

Plan Features

Employee Benefit Amount	60% of annual salary
Maximum Benefit Amount	$1,000/week
Elimination Period (Accident)	15 days
Elimination Period (Sickness)	15 days
Benefit Duration	26 weeks

Disability Insurance Long Term

GUARDIAN

SUMMARY OF COVERAGE

What is long-term disability insurance?

Long-term disability (LTD for short) protects you during lengthy periods of disability when you're unable to work. It's often described as income replacement insurance, because during the disability period when you're not getting a paycheck, your long-term disability insurance will pay you a monthly amount.

Long Term Disability Facts

Long-term disability isn't just for people with dangerous jobs. In fact, most long-term disability claims have nothing to do with the job. The average long-term disability claim is nearly three years. Plus, one in four of today's 20-year-old will become disabled before they retire, according to the Council for Disability Awareness.

Those disabilities are usually for non-work-related injuries and illnesses. Common reasons for disability claims are:

- Neck and back pain
- Muscle and tendon disorders
- Foot, ankle and hand disorders
- Cancer

A disability can strip you of your ability to make a living. While some people can tap into their savings to get by without working for a few months, few people can afford to stop working altogether for a longer period of time.

Plan Features

Employee Benefit Amount	60%
Maximum Benefit Amount	$6,000
Elimination Period	180 Days
Benefit Duration	65 ADEA

Critical Illness Coverage*

What Do Critical Illness Plans Cover?

When diagnosed with a serious illness, critical illness benefits can provide financial support during a very difficult time. Many people who experience a critical illness face serious financial difficulties as they recover. And while most medical plans provide coverage for hospital and medical expenses arising from these critical illnesses, many of the expenses are not covered.

	CRITICAL ILLNESS	
Benefit Amount(s)	Employee may choose a lump sum benefit up to $10,000. Please see your cost illustration for a full list of available benefit amounts.	
CONDITIONS		
Cancer	**1st OCCURRENCE**	**2nd OCCURRENCE**
Invasive Cancer	100%	50%
Carcinoma In Situ	30%	0%
Benign Brain Tumor	75%	0%
Skin Cancer	$250 per lifetime	Not Covered
Vascular		
Heart Attack	100%	50%
Stroke	100%	50%
Heart Failure	100%	50%
Coronary Arteriosclerosis	30%	0%
Other		
Organ Failure	100%	50%
Kidney Failure	100%	50%
Spouse Benefit	100% of employee's lump sum benefit	
Child Benefit- children age Birth to 26 years	25% of employee's lump sum benefit	

SAMPLE Bi-Weekly Rates			
Issue Age	$5,000 Benefit	$10,000 Benefit	$15,000 Benefit
0-29	$1.50	$3.00	$4.50
30-39	$ 2.33	$4.66	$6.99
40-49	$4.70	$9.42	$14.12

** Evidence of Insurability may be required for coverage.*

GUARDIAN®

Accident Coverage

Can help cover you in more than 40 ways…

No matter how hard you try to avoid them, accidents can still happen. In one year alone, over 80 million people in the U.S. seek medical treatment for injuries and 43 million people go directly to the emergency room. Whether it's a sports injury, a car accident, or a slip and fall, the financial implications for one of your employees could be overwhelming.

Common injuries such as:

- Burns,
- Dislocations,
- Fractures,
- Concussions
- Eye Injuries,
- Lacerations

Services during treatment and recovery, such as:

- Ambulance,
- Emergency Room Treatment,
- X-rays,
- Hospitalization,
- Surgery,
- Chiropractic Visits

More protection for child athletes

It’s important to encourage children to be active. With millions of children participating in organized sports such as baseball, soccer, lacrosse or football, they have a greater risk for accidents.

and more...

Visit MyRedeemersGroupBenefits.com and click on the Accident tab.

GUARDIAN®

Employee Assistance Program

WORKLIFEMATTERS

Help for what matters most.

WorkLifeMatters offers a variety of services to promote well-being and help enhance the quality of life for you and your family, at every stage of life.

From family support, legal assistance, fitness, mental health resources, and work-related help, the WorkLifeMatters Employee Assistance Program (EAP) provides access to solutions and support for the challenges of daily living.

For more information or counseling call: 1-800-386-7055

HELP WITH HEALTH

Resources for healthy living, stress management, fitness, and overall wellness.

HELP WITH FAMILY

Assistance with parenting support, child and elder care, learning programs, special needs help, and more.

HELP WITH LEGAL & FINANCIAL

Support for legal issues, will preparation, taxes, and debt, as well as financial planning tools and assistance.

For more information about WorkLifeMatters, go to www.ibhworklife.com.
Username: Matters
Password: wlm70101

Rates

Medical Plans	Who's Covered?	NON-MANAGEMENT Bi-Weekly Rates	NON-MANAGEMENT Monthly Rates
Option 1 HDHP	Employee	$91.42	$198.07
	Employee + Spouse	$226.66	$491.10
	Employee + Child(ren)	$186.54	$404.17
	Employee + Family	$321.78	$697.20
Option 2 Copay Plan	Employee	$98.66	$213.76
	Employee + Spouse	$246.16	$533.34
	Employee + Child(ren)	$202.40	$438.53
	Employee + Family	$349.90	$758.12

Medical Plans	Who's Covered?	MANAGEMENT Bi-Weekly Rates	MANAGEMENT Monthly Rates
Option 1 HDHP	Employee	$91.42	$198.07
	Employee + Spouse	$226.66	$491.10
	Employee + Child(ren)	$186.54	$404.17
	Employee + Family	$321.78	$697.20
Option 2 Copay Plan	Employee	$95.04	$205.92
	Employee + Spouse	$242.54	$525.50
	Employee + Child(ren)	$198.78	$430.69
	Employee + Family	$346.28	$750.28

Rates

Bi-Weekly Rates		
DENTAL	Employee	$10.50
	Employee + Spouse	$21.30
	Employee + Child(ren)	$25.57
	Employee + Family	$38.70
VISION	Employee	$3.40
	Employee + Spouse	$5.73
	Employee + Child(ren)	$5.84
	Employee + Family	$9.24
ACCIDENT	Employee	$3.84
	Employee + Spouse	$10.40
	Employee + Child(ren)	$11.29
	Employee + Family	$15.31

Monthly Rates		
DENTAL	Employee	$22.74
	Employee + Spouse	$46.16
	Employee + Child(ren)	$55.41
	Employee + Family	$83.85
VISION	Employee	$7.37
	Employee + Spouse	$12.41
	Employee + Child(ren)	$12.66
	Employee + Family	$20.02
ACCIDENT	Employee	$8.33
	Employee + Spouse	$22.54
	Employee + Child(ren)	$24.46
	Employee + Family	$33.18

Legal Notices

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that addresses the privacy and security of certain individually identifiable health information, called protected health information (or PHI). You have certain rights with respect to your PHI, including a right to see or get a copy of your health and claims records and other health information maintained by a health plan or carrier. For a copy of the Notice of Privacy Practices, describing how your PHI may be used and disclosed and how you get access to the information, contact Human Resources.

Women's Health and Cancer Rights Act Enrollment Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Woman'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:

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

These will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this benefits plan. Therefore, the plan deductibles and coinsurance apply. If you would like more information on WHCRA benefits, contact your plan administrator: Rosie Graves, COO/Human Resources | Phone: 901-458-3424 | Email: rosie@redeemersgroup.com

Newborns' and Mothers' Health Protection Act Disclosure

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).

Patient Protection Notice

Your carrier generally may require the designation of a primary care provider. You have the right to designate any primary care provider who participates in your network and who is available to accept you or your family members. Until you make this designation, your carrier may designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Humana at 1-800-448-6262.

For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from your carrier or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in your network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Humana at 1-800-448-6262.

Legal Notices

HIPAA Special Enrollment Notice

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

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy. To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact the plan administrator at Redeemers Group | Rosie Graves, COO/Human Resources | Phone: 901-458-3424 | Email: rosie@redeemersgroup.com

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 1,2022. Contact your State for more information on eligibility –

ALABAMA-Medicaid	CALIFORNIA-Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA-Medicaid	**COLORADO-Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS-Medicaid	**FLORIDA-Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA-Medicaid	**MASSACHUSETTS-Medicaid and CHIP**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
INDIANA-Medicaid	**MINNESOTA-Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
IOWA-Medicaid and CHIP (Hawki)	**MISSOURI-Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

KANSAS-Medicaid	MONTANA-Medicaid
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
KENTUCKY-Medicaid	**NEBRASKA-Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA-Medicaid	**NEVADA-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)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE-Medicaid	**NEW HAMPSHIRE-Medicaid**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
NEW JERSEY-Medicaid and CHIP	**SOUTH DAKOTA-Medicaid**
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	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK-Medicaid	**TEXAS-Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA-Medicaid	**UTAH-Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA-Medicaid	**VERMONT-Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA-Medicaid and CHIP	**VIRGINIA-Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924

OREGON-Medicaid	WASHINGTON-Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA-Medicaid	**WEST VIRGINIA-Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND-Medicaid and CHIP	**WISCONSIN-Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA-Medicaid	**WYOMING-Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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

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

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

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)

Legal Notices

Genetic Information Nondiscrimination Act (GINA) Disclosures
Genetic Information Nondiscrimination Act of 2008

The Genetic Information Nondiscrimination Act of 2008 ("GINA") protects employees against discrimination based on their genetic information. Unless otherwise permitted, your Employer may not request or require any genetic information from you or your family members.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

USERRA Notice

Your Rights Under USERRA

A. The Uniformed Services Employment and Reemployment Rights Act

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

B. Reemployment Rights

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- You ensure that your employer receives advance written or verbal notice of your service;
- You have five years or less of cumulative service in the uniformed services while with that particular employer;
- You return to work or apply for reemployment in a timely manner after conclusion of service; and
- You have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

C. Right to Be Free from Discrimination and Retaliation

If you:

- Are a past or present member of the uniformed service;
- Have applied for membership in the uniformed service; or
- Are obligated to serve in the uniformed service; then an employer may not deny you
  - Initial employment;
  - Reemployment;
  - Retention in employment;
  - Promotion; or
  - Any benefit of employment because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

D. Health Insurance Protection

- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

E. Enforcement

- The U.S. Department of Labor, Veterans' Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its Web site at *http://www.dol.gov/vets.* An interactive online USERRA Advisor can be viewed at *http://www.dol.gov/elaws/userra.htm*.

- If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the Internet at this address: *http://www.dol.gov/vets/programs/userra/poster.htm.* Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees. U.S. Department of Labor, Veterans' Employment and Training Service, 1-866-487-2365.

Legal Notices

COBRA

Model General Notice of COBRA Continuation Coverage Rights

(For use by single-employer group health plans)

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

Introduction

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

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

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

What is COBRA continuation coverage?

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

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

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

Legal Notices

COBRA

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

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

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

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

When is COBRA continuation coverage available?

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

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

Legal Notices

COBRA

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

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information Contact: Rosie Graves, COO/Human Resources | Phone: 901-458-3424 | Email: rosie@redeemersgroup.com

Legal Notices

COBRA

Are there other coverage options besides COBRA Continuation Coverage?

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

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

Contact: Rosie Graves, COO/Human Resources | Phone: 901-458-3424 | Email: rosie@redeemersgroup.com

Legal Notices

Medicare Part D

Important Notice from Redeemers Group About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Redeemers Group and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **Redeemers Group has determined that the prescription drug coverage offered by the Redeemers Health Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current Redeemers Group coverage will not be affected. Medicare eligible individuals have available to them when they become eligible for Medicare Part D] (e.g., they can keep this coverage if they elect part D and this plan will coordinate with Part D coverage; *See* pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.]

If you do decide to join a Medicare drug plan and drop your current Redeemers Group coverage, be aware that you and your dependents will be able to get this coverage back.

Legal Notices

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Redeemers Group and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact: Rosie Graves, COO/Human Resources | Phone: 901-458-3424 | Email: rosie@redeemersgroup.com

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Redeemers Group changes. You also may request a copy of this notice at any time.

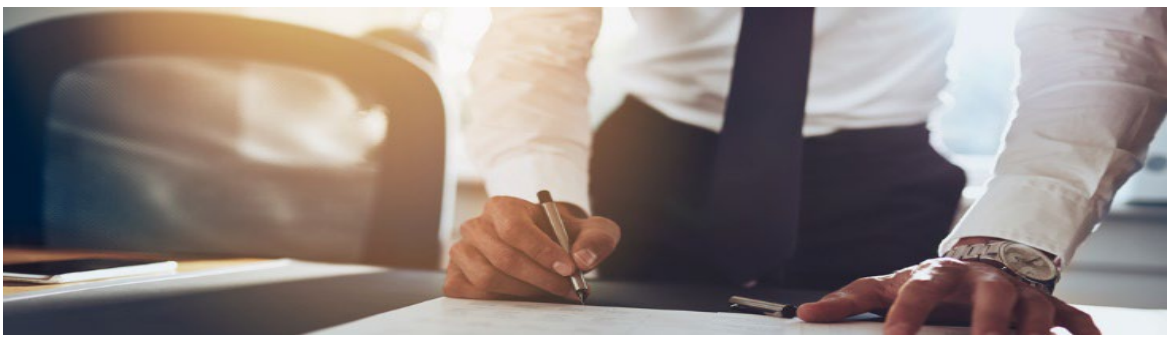
For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether you have maintained creditable coverage and, therefore, whether you are required to pay a higher premium (a penalty).



Legal Notices

New Health Insurance Marketplace Coverage Options and Your Health Coverage

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

PART A: General Information

When key parts of the healthcare 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 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.

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 visit **MyRedeemersGroupBenefits.com**

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.

Legal Notices

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer Name REDEEMERS GROUP	4. Employer Identification Number (EIN) 46-4911221	
5. Employer Address 3955 WHITEBROOK DRIVE	6. Employer Phone Number 901-458-3424	
7.City MEMPHIS	8. State TN	9. ZIP Code 38118
10. Who can we contact about employee health coverage at this job? ROSIE GRAVES		
11. Phone number (if different from above)	12. Email address rosie@redeemersgroup.com	

Here is some basic information about health coverage offered by this employer:

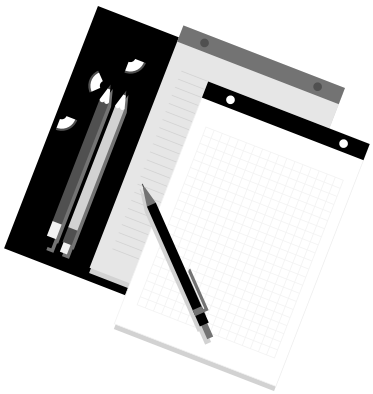
- As your employer, we offer a health plan to:
  - ☒ Eligible employees are: Full-time employees working over 30+ hours per week

- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are: employee's spouse or married or unmarried children (up to age 26).
  - ☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

^^ Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid–year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

Notes



RedeemersGroup

Booklet Developed in Partnership with

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