GIBBS & REGISTER

2023-2024 Employee Benefits Guide

Plan Year: January 1, 2023 – December 31, 2023

Information Provided by:

This Employee Benefits Guide is designed to provide select information about the benefit plans and programs offered by Gibbs & Register, Inc. from January 1, 2023 – December 31, 2023. It does not detail all of the provisions, restrictions and exclusions of the various benefit programs described herein. This booklet does not constitute a Summary Plan Description (SPD) or Plan Document as defined by the Employee Retirement Income Security Act (ERISA). If there is a conflict between this document and the SPD, the SPD shall prevail. The SPD is available from your Human Resource representative.

If you are electing dental, vision, short term disability, long term disability, and voluntary life coverage for the first time, you are required to be 'Actively at Work' on a full time basis on the day that the coverage begins. 'Actively at Work' is defined as, you are working for your employer for earnings that are paid regularly and that you are performing the material and substantial duties of your regular occupation.

Gibbs & Register, Inc. strives to provide you with a comprehensive employee benefits program as part of your overall compensation package.

We put together this guide to help you understand your benefits and to help you get the most out of them. We encourage you to review it thoroughly so you can identify which offerings are best for you and your family.

If you have questions about your benefits, reach out to Human Resources or use the contact information included in this guide to get the answers you need.

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CONTACT INFORMATION

Carrier / Vendor	Phone / Email	Website
LassiterWare	800-845-8437 Ext 605 Customer Service Specialist EAHelp@LassiterWare.com	www.lassiterware.com
Meritain Health	Meritan Health Customer Service: 800-925-2272 Aetna Provider Line: 800-343-3140	www.meritain.com
SmithRx	SmithRx Member Support: 844-454-5201 SmithRx Connect Member Support: 844-385-7612 connect@smithrx.com	www.smithrx.com
KISx Card	KISx Card Nurse Line: 877-GET-KISX KISx@bdsadmin.com	
MetLife	Basic & Voluntary Life: 866-492-6983 Dental: 800-942-0854 Vision: 855-638-3931	www.metlife.com www.metlife.com/claims
Benefit Solutions, Inc.	STD: 407-843-0058	

Contact **LassiterWare** if you have questions about the plans prior to enrolling or if you have issues with claims once enrolled.

MAKING YOUR SELECTION

There are limited opportunities to enroll and/or make changes to your benefit elections. Make your selections carefully! The choices you make now will be effective through the end of the plan year, as long as you remain eligible.

When you're first hired

The medical, dental, and vision benefits you elect begin on the first day of the month following 60 days of employment. This includes the company provided basic life insurance and voluntary life. Your short-term disability coverage begins first of the month following 90 days.

Your Benefit Election Form should be completed and returned to Human Resources by the due date specified (**even if you do not want to enroll**).

At Open Enrollment

Open Enrollment is your annual opportunity to make changes to your elections. Medical benefits selected during Open Enrollment are effective January 1, 2023, unless Evidence of Insurability (EOI) is required.

All benefits eligible employees are required to complete and return their Benefit Election Form to Human Resources by the due date specified – **even if you do not want to enroll**.

If you have a life event

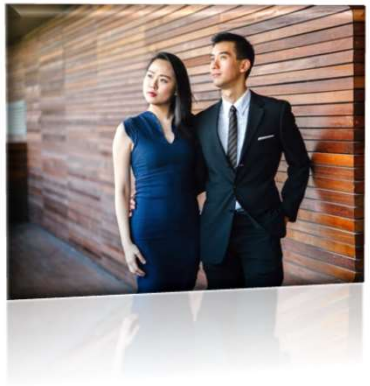
Some life events allow you to change your coverage during the year. If you experience a life event, you have 30 days from the date of the event to request changes and provide any required documentation. Some common life events are:

- Birth or adoption
- Marriage or Divorce
- Change in employment status or change in coverage under another employer-sponsored plan
- Loss or gain of eligibility under Medicare or Medicaid

Contact Human Resources to request a Benefit Election Form to submit a change request following a life event. These requests are subject to verification and approval.

ELIGIBILITY

- **Employees**
  - You are eligible to participate in the employee benefits program if you normally work a minimum of 30 hours each week.
- **Spouse**
  - If you enroll, you may also enroll your current legal spouse in the same plans you select for yourself.
- **Children**
  - If you enroll, you may also enroll your qualified dependent children in the same plans you select for yourself. This includes your natural, adopted, foster, step-children, or children for whom legal guardianship has been court appointed. There are additional qualifications that vary by plan as follows:
    - Medical plan: Coverage may continue until the end of the month in which the child turns age 26.
    - Dental and Vision plans: Coverage may continue until the end of the month in which the child reaches age 26, provided they are unmarried and are a full-time student, or if they are unmarried and living in the employee's household and dependent upon the employee for support.
    - Voluntary Life plan: Coverage for unmarried dependent children may continue under the voluntary life plan until the child reaches the age of 26.



MEDICAL INSURANCE

You may choose from Two medical plans through Meritain Health. When selecting your medical plan consider:

- The premium you'll pay (your payroll deduction)
- What you'll pay when accessing care (copays, deductible, coinsurance)
- What medications are covered
- Which providers are In-Network

SOME INSURANCE TERMS

Copay – a fixed amount you pay when seeking care for certain services.

Deductible – the amount you pay for certain health care services in a plan year before the plan begins paying any portion of those services.

Coinsurance – the percentage you pay for certain services after meeting your deductible and before you meet your Out of Pocket Maximum.

Out of Pocket Maximum – the most you will pay in a plan year for covered services. This includes copays, deductibles, coinsurance, and prescriptions. Once the Out of Pocket Maximum has been met, the plan will pay 100% of covered services for the remainder of that plan year.

Balance Billing – the amount you are billed by out-of-network providers to make up the difference between the amount they charge and what the insurance reimburses. This amount is in addition to and does not count toward your Out of Pocket Maximum.

	Meritain Health – POS 2000	**Meritain Health – POS 250**
What Provider Network do I use?	Aetna Choice POS II (Open Access)	Aetna Choice POS II (Open Access)
Do I need to choose a Primary Care Physician (PCP)?	No	No
Do I need a referral to see a Specialist?	No	No
Can I go Out-of-Network?	Yes. However, you will pay a higher cost share when using a provider that is not in the network.	Yes. However, you will pay a higher cost share when using a provider that is not in the network.

MEDICAL INSURANCE

	Meritain Health – POS 2000	Meritain Health – POS 250
In-Network Coverage		
Deductible	$2,000 Individual | $4,000 Family	$250 Individual | $750 Family
Coinsurance	40% after Deductible	0% after Deductible
Out of Pocket Maximum	$6,350 Individual | $12,700 Family	$3,000 Individual | $6,000 Family
Preventive Care	No Charge	No Charge
Office Visit	Primary Physician: $35 Copay Specialist: $50 Copay	Primary Physician: $20 Copay Specialist: $45 Copay
Diagnostic Testing at an Independent Facility	Bloodwork: No Charge X-ray: Deductible + 40% MRI / CT / PET: $200 Copay	Bloodwork: No Charge X-ray: $50 Copay MRI / CT / PET: $200 Copay
Urgent Care Center	Teladoc: $0 Copay CVS Minute Clinic: $0 Copay All Other: $100 Copay	Teladoc: $0 Copay CVS Minute Clinic: $0 Copay All Other: $50 Copay
Emergency Room	Facility: Deductible + 40%	Facility: $200 Copay
Inpatient Hospitalization	Facility Services: $1,500 Copay per Admission	Facility Services: $700 Copay per Admission
Outpatient Hospital Services	Facility Services: $300 Copay per visit	Facility Services: $300 Copay per visit
Pharmacy Coverage **Retail: 30-day supply** **Mail Order: 90-day supply** **Tier 1 / Tier 2 / Tier 3 / Tier 4**	Tier 1 Retail: $15 Copay Tier 2 Retail: $35 Copay Tier 3 Retail: $50 Copay Specialty: 20% coinsurance; $250 maximum Mail Order: 2x retail copays (excludes Specialty)	Tier 1 Retail: $15 Copay Tier 2 Retail: $35 Copay Tier 3 Retail: $50 Copay Specialty: 20% coinsurance; $250 maximum Mail Order: 2x retail copays (excludes Specialty)
Out-of-Network Coverage	**Note: You also pay the balance over the allowed amount when using an Out-of-Network Provider**	
Deductible	$6,000 Individual| $6,000 Family	$1,000 Individual| $3,000 Family
Coinsurance	50% after Deductible	50% after Deductible
Out of Pocket Maximum	$20,000 Individual | $20,000 Family	$6,000 Individual | $12,000 Family

MEDICAL INSURANCE

A Note about Meritain Health's Provider Network

Verify that your provider is In-Network BEFORE your visit. **Aetna Choice POS II (Open Access)** includes coverage for providers both in and out of network but you will pay significantly more for care received from a provider that is not in the **Aetna Choice POS II (Open Access)**.

- **To find an In-Network Provider**
- Go to www.meritain.com
- Under the "Resources" tab, select "For members"
  - Scroll to the middle of the page to find "Provider Network Finder"
  - Click the "ABC" filter and select Aetna
  - Enter your location and desired travel distance
  - On the next page, select Aetna Choice POS II (Open Access) under "Broad Medical Networks" – click continue
  - Enter the physician or type of care you are looking for or search by category

MEDICAL INSURANCE

Your personalized member website

Once enrolled as a Meritain Health member, you will have access to the **Meritain Health member portal**. When you log in, you'll find everything you need to know about your benefits—from eligibility, to enrollment, to what's covered. It's another way we're working with you to help you get the most from your benefits—so you can live a life that's balanced and informed.

Registration for the member website is easy

If you're already registered to access your online account, simply enter **www.meritain.com** into your browser and login from the homepage.

If you're not yet registered, it's OK. Registration is an easy three-step process.

1 Go to **www.meritain.com**. Then, in the top right corner, click *Register*.

2 Next, select *Member* under *I am a* and enter your group ID. You can find your group ID on the front of your member ID card. (If you are new to the plan, you will soon receive your member ID card in the mail.) Then, click *Continue*.

Please note: *You may set up a login for yourself, as well as any children under age 18 who are covered by your plan. For privacy purposes, your spouse and dependents over the age of 18, covered by the plan, must each establish logins to access their individual information.*

3 You will need to fill in your:

- Group ID (located on your member ID card).
- Member ID (located on your member ID card).
- Date of birth.
- Name.
- ZIP code.
- Email address.

You can then create a username and password. After that, you will be asked to confirm your email address—then you're done! The next time you log in, just use the same username and password.

24X7 NURSE LINE

MERITAIN HEALTH
An Aetna Company

24x7 Nurse Line

Call anytime, day or night 866-726-6529

What do you do when you're not sure what to do?:

- When you don't know where to go for care (is it really an emergency?).
- When it's 4:00 a.m. and your child can't stop coughing?
- When you've taken a tumble and your ankle is swelling?

Now you can call the **24x7 Nurse Line** to talk to a registered nurse who will listen and give you professional, seasoned advice, making sure you get care in the right place at the right time.

When you call, you can also tap into our health information library, a collection of more than 1,100 health topics, many available in Spanish or English. One more great support feature for plan participants: Our nurse counselors can connect you to community resources, like support groups, classes and seminars.

TELADOC

On-demand medical advice from qualified physicians

Your Teladoc® program

With Teladoc, you can contact board-certified, licensed doctors by phone or email, 24 hours a day!

Sometimes you need to speak with a doctor when it's not possible to attend an office visit. That's why the Teladoc program is available to you and your family, and can be used in a variety of ways:

- During weekends, holidays or after business hours, when general practitioners don't typically schedule appointments.
- When you can't attend a medical appointment, such as when traveling or at work.
- If you need a prescription medication or refill for a common condition.

Contact a Teladoc physician at 1.800.835.2362, or send an email by logging in at www.meritain.com for advice on commonly treated conditions.

Some of these services include:

- Headaches/migraines
- Stomach ache/diarrhea
- Respiratory infections
- Urinary tract infections
- Prescription refills*
- Many other conditions

There is no consult fee or copay to the member when using Teladoc services.

PHARMACY INFORMATION

- Effective January 1, 2023, SmithRx will replace your pharmacy network with over 75,000 pharmacies available for your prescription needs, including:

  - Costco
  - CVS
  - Kroger
  - Medicine Shoppe Pharmacy
  - Publix Supermarket
  - Target
  - Walgreens
  - Walmart
  - Winn Dixie

To determine if a pharmacy is currently in the SmithRx network, please contact SmithRx at 844-454-5201.

PHARMACY INFORMATION

SmithRx Connect
Connecting you to the lowest cost prescription solutions

SmithRx can help lower your drug costs

Did you know your local retail pharmacy may not always be the lowest cost option?
SmithRx Connect can help you navigate alternative sources and supports you throughout the process. We'll do the work so you can stay healthy and happy.

Patient Assistance Programs

Many high cost specialty medications can be accessed through Patient Assistance Programs. SmithRx will help you navigate through the process while you reduce out of pocket costs on the medications that work for you.

CoPay Coupon Maximization

Did you know it's possible to leverage additional savings on traditional branded medications? If Patient Assistance is not available, our team will work with preferred pharmacy partners to capture coupon savings through our Copay Max program.

International Sourcing

Our contracted network of international pharmacies helps members obtain medications at a lower cost. The international network dispenses select medications from first-tier countries to ensure product purity and safety. If you are using a medication that qualifies, our team can work with you on the potential to source your medication internationally.

PHARMACY INFORMATION

Mail-Order Service

If covered by your plan, most non-specialty (traditional) medication can be filled through **Serve You DirectRx**. To utilize the mail-order pharmacy, contact **Serve You DirectRx** at 800-759-3203.

•E-prescribe or Fax: Have your doctor electronically prescribe or fax your prescription to(866)494-0364. Faxed prescriptions may only be sent by a doctor's office and must include patient information and diagnosis for timely processing.

•Phone: Your doctor can call in the prescription to (800) 759-3203 with an IVR (interactive voice recognition) option.

•Please Note: For prompt delivery, please call Serve You at (800) 759-3203.

Specialty Medications

Prescribed specialty medications covered by your plan benefits can be secured through the following specialty pharmacies:

US BioServices – 888-518-7246

Senderra – 888-777-5547

To utilize the specialty pharmacy, simply call either of the pharmacies above to enroll. Many specialty medications require prior authorization, so please call SmithRx Member Support (844-454-5201) to check coverage and start any necessary authorization processes.

Online Member Portal

SmithRx's online Member Portal allows you to access important forms, review your pharmacy transactions, print ID cards, find Member Support contact information, and more.

To register for your account, go to www.mysmithrx.com/login and click on "Create An Account". Please have your SmithRx prescription benefits card available.

KISX CARD

SURGERY. SIMPLIFIED.
TO HELP YOU BE HEALTHY.

The KISx Card is a surgery and imaging program that your employer has made available to you for the most common surgical and imaging procedures. Some of the most common procedures through the KISx Card include:

- Orthopedic Surgery
- General Surgery
- Colonoscopies
- MRIs, CT and PET Scans

If you utilize the program, you will receive your procedure at no cost to you.

HOW IT WORKS?

Before seeking In-Network providers through your health plan, call a KISx Card Nurse at 877-GET-KISX regarding your elective procedure. You can also email them at KISx@bdsadmin.com. They will work to find a facility within 60 miles from your home for your care.

By choosing a KISx Card provider, you will always pay $0.

KISxCard
Keep It Simple Surgery

KISX CARD


Procedures
Ankle & Foot
Arthroscopy
Ear
Elbow
Gastroenterology
General Surgery
Hip
Knee
Neck & Throat
Shoulder
Spine
Urology
Wrist & Hand
And More!
01
You have been diagnosed and are in need of surgery or major imaging
02
You call a KISx Card Nurse using the number on the back of your KISx Card
03
The KISx Card Nurse will find a participating facility close to your home
04
Once a facility has been selected, The KISx Card will reach out to the facility to negotiate the procedure pricing
05
After the procedure price has been determined, we will help you schedule an initial consult with the facility & surgeon
SEP
16
06
Once the facility validates the need for surgical intervention, the facility will schedule your surgery with you
07
You will receive a voucher in replacement of your insurance card to present the day of the procedure
08
You receive the procedure at no cost!

DENTAL INSURANCE

Our dental plans through MetLife allows you to see any dentist. However, you will take advantage of discounted pricing and enjoy lower out-of-pocket expenses by visiting a dentist that participates in the network.

	Low Option		High Option	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible	$50 Individual | $150 Family Applies to Basic and Major Services		$50 Individual | $150 Family Applies to Basic and Major Services	
Preventive Services Including: Routine Oral Exams, Routine Cleanings, X-Rays, Space Maintainers, Fluoride	No Charge	Balance over the Reasonable & Customary charge	No Charge	Balance over the Reasonable & Customary charge
Basic Services Including: Fillings, Simple Extractions, X-Rays, Crown, Denture & Bridge Repair, Periodontics	Deductible + 50%	Deductible + 50% + balance over the Reasonable & Customary charge	Deductible +20%	Deductible + 20% + balance over the Reasonable & Customary charge
Major Services Including: Implants, Bridges & Dentures, Crowns/Inlays/Onlays, Endodontics, Oral Surgery, Periodontal Surgery, General Anesthesia	Deductible + 50%	Deductible + 50% + balance over the Reasonable & Customary charge	Deductible + 50%	Deductible + 50% + balance over the Reasonable & Customary charge
Orthodontia Braces & related services for children up to age 19	Not Covered	Not Covered	50% subject to a $1,000 Lifetime Maximum	50% + balance over the Reasonable & Customary charge; subject to a $1,000 Lifetime Maximum
Maximum Annual Benefit	$1,000 per person per calendar year	$1,000 per person per calendar year	$5,000 per person per calendar year	$1,000 per person per calendar year

Frequency and Age Limits apply to certain services.
For example, the plan includes coverage for one routine cleaning per 6 months and one set of bitewing x-rays per year. Coverage for fluoride treatments is included for dependent children up to age 19. Coverage for sealants is included for dependent children up to age 16. Additional restrictions are outlined in the Certificate of Coverage.

By registering via the mobile app or by visiting metlife.com you can easily find a participating dental or vision provider as well as keep track of your claims.

DENTAL INSURANCE

How to find an In-Network Dentist or Register as a Member

- Go to: www.metlife.com/insurance/dental-insurance/
- Click 'Find a Dentist'
- Select PDP Plus as the network
- Enter search criteria
- Click 'Find a Dentist'
- To register as a Member go to: www.metlife.com and select Register Now from the login screen

What Provider Network do I use?	MetLife PDP Plus Network
Do I need to choose a Dentist?	No, you may see any dentist. However, you will make the most of your plan by choosing an In-Network Dentist.
Do I need a referral to see a Specialist?	No
Can I go Out-of-Network?	Yes. However, Out-of-Network providers are paid based on Reasonable & Customary Charges, which may be less than your Out-Of-Network provider charges. You are responsible to pay the difference to the out-of-network provider.
Will I get an ID Card?	No, ID cards are not issued for Dental. After implementation, you can request ID cards once you register online at www.metlife.com. Providers can also locate your coverage by using your social security number.

Reasonable & Customary Charges – this refers to the base amount that is treated as the standard or most common charge for a particular dental service when rendered in any given geographic area. When accessing care Out-of-Network this is the amount on which the claim will be paid. You are responsible to pay the difference in the provider's actual charge and what the insurance reimburses.

Predetermination of Benefits – This optional service provides you with an estimate on the amount to be covered prior to having a dental procedure. When your treatment plan is expected to exceed $300, ask your dentist to request the Predetermination Review. Your dentist will submit your treatment plan and MetLife returns an estimate of what they expect to pay and what you can expect to pay.

Maximum Annual Benefit – This is the most that MetLife will pay for covered services in a calendar year. You are responsible for any additional charges during that calendar year once the benefit has been exhausted.

VISION INSURANCE

Our Vision plan through MetLife offers affordable coverage for your routine eye care needs.

	Frequency Limits	In-Network Coverage	Out-of-Network Coverage
Eye Exam	Covered once every 12 months	No Charge	$45 allowance
Eyeglass Lenses	Covered once every 12 months	$10 Copay	Allowance up to: $30 Single Vision $50 Lined Bifocal $65 Lined Trifocal $100 Lenticular
Eyeglass Frames	Covered once every 24 months	$110 allowance ($130 allowance on featured frames). You will receive an additional 20% off any amount that you pay over your allowance. Costco, Walmart & Sams: $60 allowance; 20% discount does not apply	$55 allowance
Contact Lens Fitting	Covered once every 12 months instead of lenses and frames	Not to exceed $60 for standard or premium fit.	Applied to the $90 contact lens allowance
Contact Lenses	Covered once every 12 months instead of lenses and frames	Elective: $110 Contact Lens Allowance Medically Necessary: Covered in full after eyeware copay	Elective: $90 allowance Medically Necessary: $210 allowance

VISION INSURANCE

What Provider Network do I use?	MetLife Vision
Can I go Out-of-Network?	Yes. However, when using Out-Of-Network providers you will need to pay full price at the time of service and then submit a claim to MetLife Vision for reimbursement up to the plan allowances.
Will I get an ID card?	No, ID cards are not issued for Vision. After implementation, you can request ID cards once you register online at www.metlife.com. Providers can also locate your coverage by using your social security number.
How do the Frequency Limits work?	The frequency limits are based on your last date of visit. For example, if you had an eye exam and purchased a full set of glasses (lenses and frames) on 1/10/2022 under this plan, your benefits will reset for another exam and lenses on 01/10/2023 and frames on 01/10/2024 if you are still enrolled in the plan.
Can I add features to my lenses?	Yes. A variety of lens coatings and other upgrades are available. Some common enhancements, such as UV coating or standard polycarbonate for children up to age 18 are covered in full. Others, such as progressive lenses or tints, require an additional copay.

VOLUNTARY LIFE INSURANCE

You also have the option to purchase Voluntary Life Insurance through MetLife at affordable group rates. If you purchase Voluntary Life coverage for yourself, you may also purchase coverage for your spouse and/or dependent children.

NOTE: All current volumes will be grandfathered this year.

	Employee Coverage	Spouse Coverage	Dependent Child Coverage
Available Increments	$10,000	$5,000	$10,000
Coverage Maximum	5 times your annual salary up to $500,000	100% of the employee coverage amount up to $100,000	$10,000 Ages 6 months to 26 years
Guarantee Issue Amount	Newly eligible employees elect up to 5 times your annual salary up to $100,000 without Evidence of Insurability	Elect 50% of employee coverage up to $25,000 on your newly eligible Spouse without Evidence of Insurability	Elect up to $10,000 on your newly eligible dependent children without Evidence of Insurability
Future Increase Option	If currently enrolled, you may increase coverage by one incremental level ($10,000) during open enrollment. If this updated amount exceeds the guarantee issue amount, you will need to submit evidence of insurability (EOI). If you are newly electing coverage and had declined it when you were first eligible, you must submit evidence of insurability (EOI) regardless of the amount you are electing.	If currently enrolled, you may increase coverage by one incremental level ($5,000) during open enrollment. If this updated amount exceeds the guarantee issue amount, you will need to submit evidence of insurability (EOI). If you are newly electing coverage and had declined it when you were first eligible, you must submit evidence of insurability (EOI) regardless of the amount you are electing.	Not applicable
Additional Features	Accelerated Death Benefit: provides an option to withdraw a portion of your life insurance if diagnosed as terminally ill. Conversion: provides an option to convert this coverage to an individual policy after you terminate employment. Portability: provides an option to continue this coverage for a specified period after you terminate employment. You must apply and pay the required premium to Mutual of Omaha within 30 days of your termination to exercise the conversion or portability options.		

Note: If you and your spouse both work for Gibbs & Register, Inc. you cannot cover each other on spouse life insurance. Additionally, only one of you may elect dependent child life coverage.

Evidence of Insurability (EOI) - A Medical questionnaire referred to as an Evidence of Insurability (EOI) Form is required if you are a newly eligible employee or spouse electing an amount over the Guarantee Issue Limits, When EOI is required the insurance company will decide if your request will be approved. Amounts subject to EOI will not begin unless/until approved by the insurance company.

Benefit Reduction – There is no age reduction on either the employee or spouse coverage.

VOLUNTARY LIFE INSURANCE

The cost for employee coverage is based on your age and the amount of coverage you elect. The cost for spouse coverage is based on your age and the amount of coverage you elect. The cost for child coverage is charged once per employee, not per child. Premiums increase on January 1st following the date you move into the next age bracket.

Voluntary Life Rate Table	
Age	**Monthly Cost per $1,000 of coverage**
<29	**$0.077**
30-34	**$0.086**
35-39	**$0.103**
40-44	**$0.146**
45-49	**$0.232**
50-54	**$0.377**
55-59	**$0.576**
60-64	**$0.908**
65-69	**$1.48**
70+	**$2.756**
Child Life	**$0.240**

How to calculate your supplemental life deduction

Example: An employee who is 47 years old wishes to elect $100,000 in coverage

$100,000 ÷ 1,000 = 100

100 x 0.232 (see rate chart) = $23.20 cost per month

$23.20 x 12 = $278.40 per year

$278.40 ÷ 52 = $5.35 per pay if paid weekly or

$278.40 ÷ 26 = $10.71 per pay if paid semi-monthly

Things to remember:

- **<u>Your spouse's rate is based upon your age</u>**
- You pay just one payroll deduction for child coverage, no matter how many children you are covering
- Employee coverage terminates at retirement
- Dependent spouse and child coverage is only available if the Employee has coverage under this plan

SHORT TERM DISABILITY INSURANCE

Short Term Disability Insurance is intended to provide you with temporary income replacement if you are unable to work due to an off-the-job accident or illness and are under the care of a doctor. Gibbs & Register, Inc. provides this coverage to benefits eligible employees at no cost to you.

Benefits Begin	On the 8th day you are disabled due to illness or injury
Benefit Amount	The plan pays you 70% of your weekly income, to a maximum of $2,000 per week
Payment Lasts	The plan will continue to pay you for up to 26 weeks if you remain disabled
Bi-Weekly Payroll Deductions	Provided to eligible employees at no cost to you.

Taxable Benefits - Since the premium for this coverage is paid for by your employer, the benefit is subject to income taxes.

Maternity Benefits - Benefits for a normal delivery are limited to a six week benefit period. Benefits for a normal C-Section delivery are limited to an eight-week benefit period.

IMPORTANT NOTICES

Changing your Benefit Choices

Your benefit choices will stay in effect for a full plan year (as long as you remain eligible). However, if you have a qualified change in family status, you may be able to change some of your benefit elections. Qualified family status changes include, but are not limited to:

- Marriage or divorce
- Birth, adoption or legal custody of an eligible dependent
- Death of your spouse or dependent
- Dependent covered by the plan becomes ineligible
- Change from full-time to part-time status, or vice versa, by you or your spouse
- Unpaid leave of absence by you or your spouse
- Significant change in your spouse's coverage attributable to employment
- Termination or commencement of spouse's employment

If you experience a qualified family status change during the plan year, it is possible that you may add or remove yourself and/or dependents to/from coverage. If you wish to make changes to your benefits as the result of a qualified family status change, you must notify Human Resources within 31 days of the change. *If you do not notify Human Resources within 31 days of the qualifying event, you must wait until the next annual enrollment period to make any desired changes*. Please keep in mind that documentation may be required and the requested change must be consistent with the Qualified Family Status Change.

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' 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 or your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. To request a special enrollment or obtain more information, contact your Human Resources Department.

Designation of Primary Care Providers and direct access to OB/GYN

The Affordable Care Act permits you to choose any available participating primary care provider as your doctor and to choose any available participating pediatrician as your child's primary care doctor. The Affordable Care Act also prohibits health plans from requiring a referral from a primary care provider before you can seek coverage for obstetrical or gynecological (OB-GYN) care from a participating OB-GYN specialist.

IMPORTANT NOTICES

HIPAA Privacy Notice

The Group Health Plan is a fully-insured group health plan sponsored by the Plan Sponsor. 'The Group Health Plan and the Plan Sponsor intend to comply with the requirements of 45 C.F. R. § 164.530 (k) so that the group health plan is not subject to most of HIPAA's privacy requirements.

I. **No Access to Protected Health Information (PHI) Except for Summary Health Information for Limited Purpose and Enrollment / Dis-enrollment information.**
Neither the Group Health Plan nor the Plan Sponsor (or any member of the Plan Sponsor's workforce) shall create or receive protected health information (PHI) as defined in 45 C. F. R § 160.103 except for (I) summary health information for purpose of (a) obtaining premium bids or (b) modifying, amending, or terminating the Group Health Plan, and (2) enrollment and dis-enrollment information.

II. **Insurer for Group Health Plan Will Provide Privacy Notice**
The insurer for the Group Health Plan will provide the Group Health Plan's Notice of Privacy Practices and will satisfy the other requirements under HIPAA related to the Group Health Plan's PHI. The Notice of Privacy Practices will notify participants of the potential disclosure of summary health information and enrollment/dis-enrollment information to the Group Health Plan and the Plan Sponsor.

III. **No Intimidating or Retaliatory Acts**
The Group Health Plan shall not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against individuals for exercising their rights, filing a complaint, participating in an investigation, or opposing any improper practice under HlPAA. If such an action should occur by one of the Plan Sponsor's employees, the action shall not be attributed to the Group Health Plan

IV. **No Waiver**
The Group Health Plan shall not require an individual to waive his or her privacy rights under HIPAA as a condition of treatment, payment, enrollment or eligibility. If such an action should occur by one of the Plan Sponsor's employees, the action shall not be attributed to the Group Health Plan.

Secondary Payer Mandatory Reporting Provisions

Effective January 1, 2009 group health plans are required by Federal government to comply with Section 111 of the Medicare, Medicaid, and SCHIP Extensions of 2007's new Medicare Secondary Payer regulations. The mandate is designed to assist in establishing financial liability of claims assignments. In other words, it will help establish who pays first. The mandate requires group health plans to collect additional information, more specifically Social Security Numbers for all enrollees, including dependents 6 months of age or older. Please be prepared to provide this information on your benefits enrollment form when enrolling into benefits.

IMPORTANT NOTICES

Uniformed Services Employment and Reemployment Rights Act

The Uniformed Services Employment and Reemployment Rights Act (USERRA) prohibits discrimination against anyone for serving in the armed forces or for taking military leave from a civilian job. This includes discrimination in hiring, promotion, reemployment, or any other benefit of employment. USERRA also prohibits retaliation against anyone who seeks to enforce their rights under USERRA or assists another in enforcing those rights.

Women's Health and Cancer Rights Act of '98

Under federal law, group plans providing benefits for a mastectomy must also provide, in connection with the mastectomy for which the participant or beneficiary is receiving benefits, coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

Prosthesis and physical complications of mastectomy, including lymph edemas, in a manner determined in consultation between the attending physician and the patient.

Newborns and Mothers' Health Protection Act of 1996 (NMHPA)

Under Federal law, you and your newborn child are covered for a hospital stay following childbirth. The law applies both to persons enrolled in group health plans and to persons who have individual health care coverage. In general, plans and health insurance issuers that are subject to NMHPA may NOT restrict benefits for a hospital stay in connection with childbirth to less than 48 hours following a normal delivery or 96 hours following a delivery by cesarean section.

Michelle's Law

This law requires employer health plans to continue coverage for employees' dependent children who are college students and need a medically necessary leave of absence. This law applies to medical plans that condition dependent eligibility upon student status. The dependent child's change in college enrollment must meet the following requirements:

- The dependent is suffering from a serious illness or injury.
- The leave is medically necessary.
- The dependent loses student status for purposes of coverage under the terms of the plan or coverage.

Coverage for the dependent child must remain in force until the earlier of:

- One year after the medically necessary leave of absence began.
- The date the coverage would otherwise terminate under the terms of the plan.

A written certification by the treating physician is required. The certification must state that the dependent child is suffering from a serious illness or injury and that the leave is medically necessary.

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Information Provided by:

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This Employee Benefits Guide is designed to provide select information about the benefit plans and programs offered by Gibbs & Register, Inc. from January 1, 2023 – December 31, 2023. It does not detail all of the provisions, restrictions and exclusions of the various benefit programs described herein. This booklet does not constitute a Summary Plan Description (SPD) or Plan Document as defined by the Employee Retirement Income Security Act (ERISA). If there is a conflict between this document and the SPD, the SPD shall prevail.