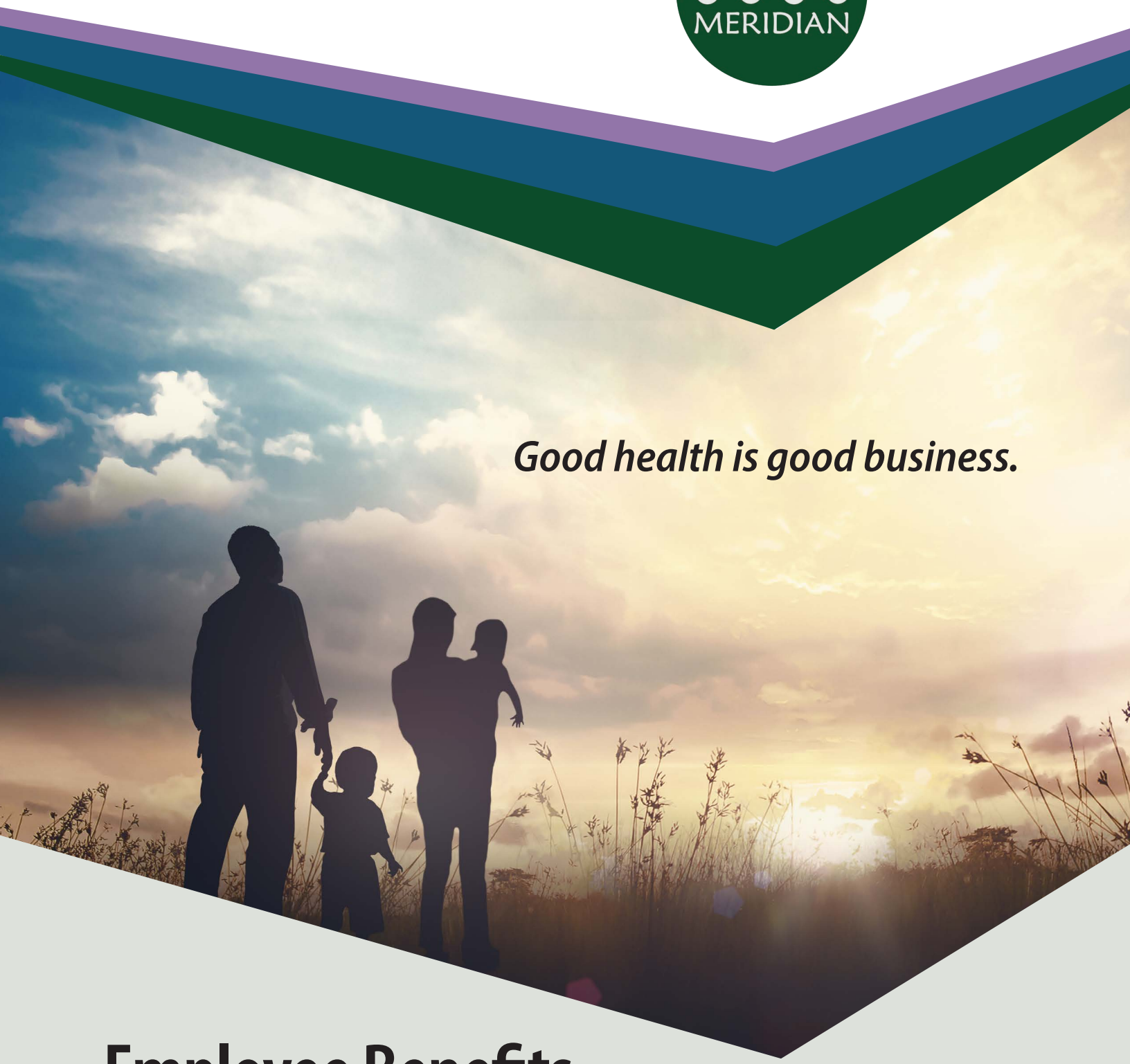


Employee Benefits

2022-2023 Plan Year

Questions, Problems or Concerns

Our goal is to make certain that you receive the correct coverage under the benefits plan. We are here to help with any issues that may arise. If you require assistance, have your ID number or Social Security Number available and follow these steps:

- **FOR CLAIMS ASSISTANCE** call the applicable insurance carrier. Have your ID number, date of service, and provider name available.
- **DO YOU NEED AN ID CARD?** If you do not have an ID card, please contact the insurance carrier to order your ID card or go online to the carrier's site to download an ID card.

Important Contact Information

Carrier	Web/Email	Phone
Medical United Healthcare	www.myuhc.com	888-842-4571
Dental Sun Life	www.sunlife.com/account	800-733-7879 / 247-6875
HSA Optum Bank	www.optumbank.com	866-234-8913
Vision United Healthcare	www.myuhcvision.com	800-638-3120
Life and LTD Prudential	http://www.prudential.com/mybenefits	888-598-5671
Group STD, Accident, Critical Illness, Cancer, Hospital AFLAC- Clete Alford	www.AFLAC.com	352-817-2487
Employee Assistance Program GuidanceResources	www.guidanceresources.com	800-311-4327
Pet Insurance Nationwide	www.PetsNationwide.com	877-738-7874
LegalShield/IDShield Steve Baker	www.legalshield.com	310-663-4735
Human Resources Manuel Peruga	manuel_peruga@mbhci.org	352-374-5600 x8327

Welcome to your 2022-2023 Employee Benefits!

Meridian Behavioral Healthcare, Inc. is pleased to offer a wide range of benefits to its employees and their families. These company sponsored benefits are an important part of a total compensation package. They represent both a valuable asset to our employees and to their families, and demonstrate an investment by Meridian Behavioral Healthcare, Inc. in our employees. We are proud of our benefits program and are committed to continuously improving the plans that make up our benefits offerings.

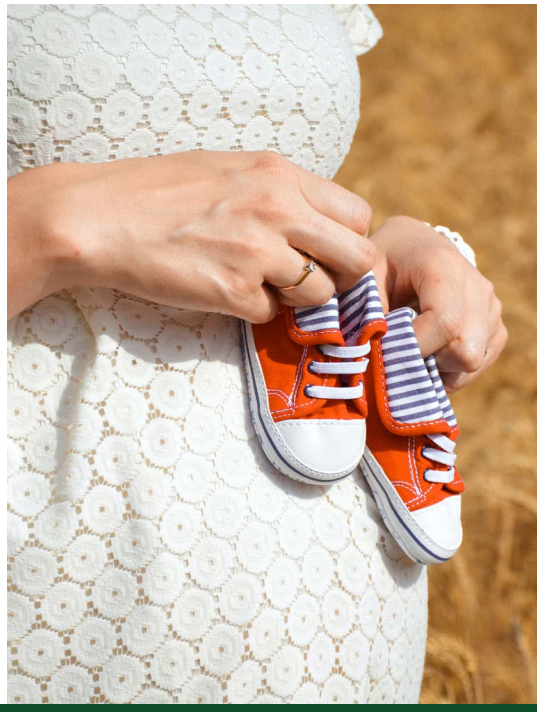
This guide was created to answer some of the questions you may have about your benefits. Please read it carefully along with any supplemental materials you receive.

Our plan year is July 1, 2022 through June 30, 2023.

What's Inside

PLEASE NOTE: This booklet provides a summary of the benefits available, but is not your Summary Plan Description (SPD). The Company reserves the right to modify, amend, suspend, or terminate any plan at any time, and for any reason without prior notification. The plans described in this book are governed by insurance contracts and plan documents, which are available for examination upon request. We have attempted to make the explanations of the plans in this booklet as accurate as possible. However, should there be a discrepancy between this booklet and the provisions of the insurance contracts or plan documents, the provisions of the insurance contracts or plan documents will govern. In addition, you should not rely on any oral descriptions of these plans, since the written descriptions in the insurance contracts or plan documents will always govern.

Benefit Election Changes



You must notify Human Resources within 31 days of the life event in order to make a change in your benefit selections.

The benefit elections you make during open enrollment or as a new hire will remain in effect for the entire plan year. You will not be able to change or revoke your elections once they have been made unless a life event status change occurs.

For purposes of health, dental, and vision, you will be deemed to have a life event status change if:

- your marital status changes through marriage, the death of your spouse, divorce, legal separation, or annulment;
- your number of dependents changes through birth, adoption, placement for adoption, or death of a dependent;
- you, your spouse or dependents terminate or begin employment;
- your dependent is no longer eligible due to attainment of age;
- you, your spouse or dependents experience an increase or reduction in hours of employment (including a switch between part-time and full-time employment; strike or lock-out; commencement of or return from an unpaid leave of absence);
- gain or loss of eligibility under a plan offered by your employer or your spouse's employer;
- a change in residence for you, your spouse or your dependent resulting in significant network disruption.

In order to be permitted to make a change of election relating to your health, dental, and vision coverage due to a life event status change, the change must result in you, your spouse or dependent gaining or losing eligibility for health, dental or vision coverage under this plan or a plan sponsored by another employer by whom you, your spouse or dependent are employed. The election change must correspond with that gain or loss of eligibility.

You may also be permitted to change your elections for health coverage under the following circumstances:

- a court order requires that your child receive accident or health coverage under this plan or a former spouse's plan;
- you, your spouse or dependent become entitled to Medicare or Medicaid;
- you have a Special Enrollment Right;
- there is a significant change in the cost or coverage for you or your spouse attributable to your spouse's employment.

For purposes of all other benefits under the plan, you will be deemed to have a life event status change if the change is on account of and consistent with a change in status, as determined by the plan administrator, in its discretion, under applicable law and the plan provisions.

Medical Coverage

Meridian Behavioral Healthcare, Inc. offers three medical plans contracted with United Healthcare. Choose the plan that meets your needs and those of your family. Each plan includes comprehensive health care benefits, including free preventive care services and coverage for prescription drugs. Each plan's cost is shared by Meridian Behavioral Healthcare, Inc. and the employee.

United Healthcare	HSA PLAN 70S		TRADITIONAL PLAN 2FZ		FLEX PLAN BWL4 RX C96
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Only
Annual Deductible					
Individual	$2,000	$4,000	$1,500	$3,000	$4,000
Family	$4,000	$8,000	$3,000	$6,000	$12,000
Coinsurance	**20%**	**40%**	**20%**	**40%**	**30%**
Out-Of-Pocket Maximum					
Individual	$4,000	$9,000	$6,350	$12,700	$7,150
Family	$6,850	$18,000	$12,700	$25,400	$14,300
Preventive Care - provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. If a diagnosis is made, any services provided as part of that diagnosis may require a copay, coinsurance or deductible.					
Routine Adult /Well Woman Exam	Covered 100%	40%	Covered 100%	40%	Covered 100%
Routine Mammograms	Covered 100%		Covered 100%		Covered 100%
Routine Well Child Exams	Covered 100%	40%	Covered 100%	40%	Covered 100%
Independent Clinical Lab	Covered 100%	40%	Covered 100%	40%	Covered 100%
Office Visits					
Physician	Deductible + Coinsurance		$30 copay	40%	**No copay per visit for the first 3 visits in a year; then 30% after deductible
Specialist	Deductible + Coinsurance		$60 copay	40%	***No copay per visit for the first 3 visits in a year; then 30% after deductible
Emergency Care					
Emergency Room	Deductible + Coinsurance		$500 copay		$250 per occurrence, then 30% after Deductible
Urgent Care	Deductible + Coinsurance		$75 copay		Deductible + Coinsurance
Hospital Services					
Hospitalization	Deductible + Coinsurance		Deductible + Coinsurance		$250 per occurrence, then 30% after Deductible
Prescription Drugs - *Mail Order: up to 90-day supply*					
Retail	Deductible then $10 / $35 / $60	40%	$10 / $35 / $60	40%	$10 / $45 / $80 / $125
Mail Order	Deductible then 2.5 times copay	40%	2.5 times copay	40%	2.5 times copay

***Flex plan - The number of visits for which a copay will apply are combined with any Specialist office visits.*
****Flex plan – The number of visits which a copay will apply are combined with any Primary Care Physician office visits.*

This Summary is for informational purposes only. For specific benefit information, please refer to the applicable Insurance Contract.

Employee Cost - Without Wellness Credit

Bi-weekly payroll (24) deductions will be as shown	HSA Plan 70S	Traditional Plan 2FZ	Flex Plan
Employee Only	$25.00	$132.18	$25.00
Employee + Spouse	$283.21	$483.64	$250.93
Employee + Child(ren)	$220.90	$398.82	$190.38
Family	$479.12	$750.28	$441.32

**Twice a year when three payrolls fall in the same month, the third payroll will not include premium deductions.*

Vitality Wellness Program (program renewal 7/1/2022)

The Vitality program helps you improve or maintain your health by giving you the knowledge and tools to establish and meet your health goals. When you participate in healthy activities, you'll feel great and you'll also earn Vitality Points® that will help you increase your Vitality Status®!

How to register (if you have not previously):

- Navigate to **www.powerofvitality.com** OR download the Vitality Today App and click on "First time logging in? Register now."
- Complete all the required (*) fields: first name, last name, date of birth (MM/DD/YYYY), and employee ID
- Once we validate the data you provide, we will ask you to create a secure username and password

You are registered and ready to go. Now what?

There are 3 activities that need to be completed by September 30th to earn the base $50 wellness discount:

- Vitality Health Review (VHR)
- Vitality Check / Biometric Screening
- Get to Silver Status*

**You will continue with your current premium credit status for the first 90 days of the program year (i.e., from July 1, 2022 through September 30, 2022). Keep the momentum going and achieve Gold status to earn an even greater reward (see page 5 for details).*

Spouse Participation

Spouses may participate in the wellness program. Call HR at extension 8277 to sign up your spouse. Any points the spouse earns will be applied to the employee's account. Only the employee can redeem the Vitality Bucks for rewards.

As shown below, when the employee participates in the wellness program with the spouse, more points are required to reach each Vitality Status because two individuals are earning points.

Vitality Points Kick-Start Bonus

- As you complete activities in the program, you will earn points.
- Your points DO reset each year. But you will receive a 10% Kick-Start Bonus to give you a head start!

Vitality Status

- Earning points in the program will help you to advance status.
- Your points status DOES reset each year.
- Your rewards status DOES NOT reset each year.

Vitality Bucks

- As you earn points in the program, you earn Vitality Bucks.
- Your bucks DO NOT reset each year. You only lose bucks when you spend them!
- What can you redeem with your bucks? Amazon.com Gift Card, Fandango e-Gift Card, iTunes Code, Nike e-Gift Card, Whole Foods Market e-Gift Card, and many popular fitness devices.

How to Reach Silver Status by September 30th?

Below is example 1 of activities that you can complete to earn your 2,500 Vitality Points by September 30th:

Activity	Points
Vitality Health Review (VHR)**	500
VHR bonus: Complete in the first 90 days of renewal	250
All 4 Components of Vitality Check**	
Body Mass Index (BMI)	125
Blood Pressure	125
Cholesterol	125
Fasting Glucose / HB1C	125
Mental Well-Being Review (4 parts at 75 points each)	300
Physical Activity Review	250
Non-Tobacco User or RAS	725
Total	**2,525**

Wellness Program

Medical Plan Wellness Incentives

Employees have an opportunity to earn a monthly discount on their medical plan premiums by participating in the Vitality wellness program. You will earn a $50 monthly discount on your medical plan premiums when you complete a health review, submit your biometric screening and achieve Silver status.

In compliance with HIPAA, Vitality will never share your information with a third party. Everyone who earned the wellness credit last year will continue to receive the $50 monthly wellness premium credit for the first 90 days.

Once you reach Gold status, you have the option to choose from one of two additional wellness incentives:

Option One: Elect to receive a greater premium discount on your medical plan premiums. Note, the Gold status discount is tiered by Salary Band and is in addition to the Silver status discount as displayed below.

Option Two: Elect to receive an annual $900 company contribution into your Health Savings Account (HSA).

Note, this option is only available to employees who are enrolled in the HSA Plan 7OS only.

Salary Band	Silver Status Discount	Gold Status Discount	Total Discount Opportunity
$0 - $60,000	$50.00	$100.00	$150.00
$60,001 - $75,000	$50.00	$75.00	$125.00
$75,001 - $100,000	$50.00	$50.00	$100.00
$100,001 and Greater	$50.00	$25.00	$75.00

Health Savings Account (HSA)

The Health Savings Account benefit is only available to those enrolled in the HSA PLAN. HSA's are financial accounts that you can use to accumulate tax-free funds to pay for qualified health care expenses, as defined by the Internal Revenue Service.

The account acts like a regular savings account with a debit card and accrues interest. The money in the account is owned by you and is fully portable. Funds can accumulate over time and roll over each year. If you use the funds for qualified health care expenses, you will pay no taxes. If you use the money for other expenses, you will pay a tax and a penalty fee.

You will receive a debit card that will allow you to access your money to pay for services.

Please note: HSA account funds cannot be used to pay or reimburse expenses for Over the Counter (OTC) medicines or drugs unless a prescription is obtained. There is an exception to this rule for insulin, which can be purchased and reimbursed without a prescription.

How you save with an HSA

As an HSA user, you will save in several ways:

- HSA contributions are not taxed
- You earn tax-free interest on HSA balances
- HSA funds used for qualified medical expenses are not taxed

HSA funds remain yours to grow

With an HSA, you own the account and all contributions. Unlike flexible spending accounts (FSAs), the entire HSA balance rolls over each year and remains yours even if you change health plans, retire or leave the company.

Supplement your retirement

Once your HSA balance reaches a certain point, you may invest your funds for increased earning potential that is also tax-free. After age 65, you can use your HSA much like a 401(k) and withdraw funds for any purpose. Qualified medical expenditures remain tax-free even into retirement.

You can win with an HSA

Regardless of your personal medical situation, an HSA can empower you to maximize savings while building a reserve for the future.

Using your HSA for qualified medical expenses

HSA funds can be used for a variety of qualified medical, dental and vision expenses; for yourself, your spouse, and your qualified dependents. Eligible expenses include:

- Birth control
- Chiropractor
- Contact lenses
- Dental treatment
- Prescription eyeglasses
- Hearing aids
- Physical exams
- Prescriptions
- Stop-smoking programs
- Surgery (non-cosmetic)
- Therapy
- and more...

2022 HSA Annual Contribution Limit:

$3,650 for individual coverage

$7,300 for all other coverage tiers

You can choose to contribute to your HSA on a before-tax basis, up to the IRS annual maximums. If you are or will be age 55 or over during the calendar year, you may also make a "catch-up" HSA contribution of an additional $1,000 each year.

Note: As a taxpayer, it is your responsibility to ensure that your HSA contributions do not exceed the maximum possible for your specific tax situation. Please consult your attorney, CPA or tax adviser about your specific tax situation before deferring monies to your Health Savings Account. The benefits of an HSA, who is qualified to have an HSA, etc. can be found in IRS Publication 969, beginning on page 2. https://www.irs.gov/pub/irs-pdf/p969.pdf

Dental Coverage

You may purchase dental insurance through Sun Life. They offer two dental plans to choose from. The DHMO Plan offers benefits only through a network of plan dentists. When you enroll, treatments you receive from your selected plan dentist will be provided at reduced fees called copayments. There is no deductible, no waiting period and no annual maximum. It includes Orthodontic copayments. Refer to the DHMO copayment reference sheet, available from HR, for information on this plan. You can buy up to a PPO plan with in-network and out-of-network coverage. Outlined below are the benefits for the PPO plan.

PPO stands for Preferred Provider Organization. A PPO is a network of participating dentists who agree to provide services at a negotiated discount. With a PPO plan, you can see any dentist you choose, but you will receive a discount when you see a dentist within the PPO network.

DHMO stands for Dental Health Maintenance Organization. A DHMO or prepaid plan has a network of participating dentists who agree to accept a copayment for services covered by the plan. With a DHMO/prepaid dental plan, you know exactly what you are going to pay out of pocket when you go to the dentist, but you are required to select and be assigned to a dentist within the network. A DHMO/prepaid plan is not the same thing as a discount plan.

PPO plan offer:	DHMO/prepaid plan offer:
Deductibles, benefit maximums and waiting periods	No deductibles, maximums or waiting periods
Freedom to choose dentists both in and out of the network	You must select a dentist who is in the network
Coinsurance for covered services—this means you pay a percentage of the provider's fee	Copayment schedule for covered services—this means you know costs up-front and pay at time of service
Some exclusions for pre-existing conditions	Benefits are payable for pre-existing dental conditions within the copayment schedule

Sun Life Dental	PPO SUMMARY - YOUR COST
Annual Deductible - Applies to basic and major services only	
Individual / Family	$50 / $150
Yearly Maximum	**$1,250**
Preventive - Preventive services do not reduce the $1,250 annual maximum.	
Oral Exams	covered in full (out-of-network based on in-network fee schedule).
Routine Cleanings	
X-rays	
Basic	
Fillings	20% in-network; 40% out-of-network based on in-network fee schedule
Major	
Crowns	50% in-network; 60% out-of-network based on in-network fee schedule
Root Canals	
Oral Surgery	
Orthodontia	**Not Covered**

This Summary is for informational purposes only. For specific benefit information, please refer to the applicable Insurance Contract.

Bi-weekly payroll (24) deductions	DHMO	PPO
Employee Only	$5.57	$11.74
Employee + Spouse	$9.38	$25.50
Employee + Child(ren)	$12.62	$28.48
Family	$16.59	$42.71

To register online for claim and benefit information, go to **www.sunlife.com/oaregister**.

Vision Coverage

Meridian Behavioral Healthcare, Inc. offers its employees the opportunity to purchase Vision coverage at their own expense. This plan is being offered through UHC Vision. If you utilize the services of a provider listed in the Preferred Provider Directory, your benefits include routine vision exams paid at 100% after a $10 co-pay, and preferred pricing on a large selection of frames, lenses, and lens options after a $25 co-pay. You may replace lenses every 12 months under this plan and frames every 24 months.

UHC Vision has updated their contact lens formulary to include some of the most popular disposable lenses available. The non-formulary allowance is $200.

Bi-weekly payroll (24) deductions	Vision
Employee Only	$3.85
Employee + Spouse	$7.31
Employee + Child(ren)	$7.66
Family	$11.78

Register online for claim and benefit information at **www.myuhcvision.com**

Employee Assistance Program

GuidanceResources is a company-sponsored service that is available to you and your dependents, at no cost, to provide confidential support, resources and information to get through life's challenges.

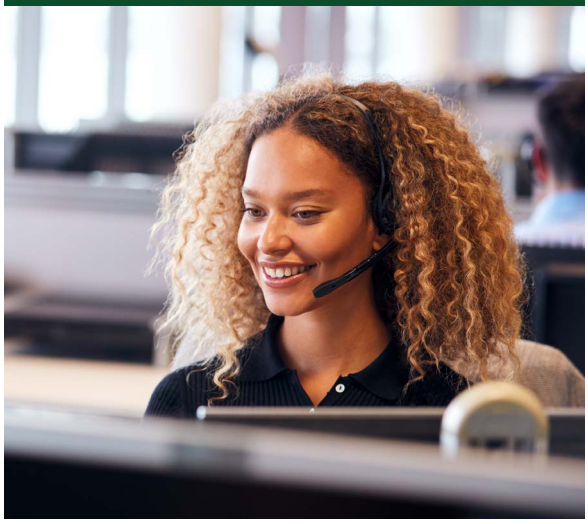
- **Confidential Counseling on Personal Issues** - staffed by experienced clinicians, allows unlimited telephonic support from a counselor who can provide immediate help with issues of concern and help connect you with support groups and resources in your community for ongoing help.
- **Legal Information, Resources and Consultation** - attorneys are available to provide confidential support with practical, understandable information and assistance. If you require representation, you can also be referred to a qualified attorney in your area for a free 30-minute consultation with a 25% reduction in customary legal fees thereafter.
- **Financial Information, Resources and Tools** - financial professionals are here to discuss your concerns and provide you with the tools and information you need to address your finances
- **Online Information, Tools and Services** - GuidanceResources® Online is your one stop for expert information to assist you with the issues that matter to you, from personal or family concerns to legal and financial concerns. Create your own account by going to **www.guidanceresources.com**. Each time you return to the site, you will find personalized, relevant information based on your individual life needs.

Call or visit online - 24 hours a day, seven days a week!

800-311-4327

www.GuidanceResources.com

Web ID: GEN311



Basic Life and AD&D Insurance

Meridian Behavioral Healthcare, Inc. provides employees with group life and accidental death and dismemberment (AD&D) insurance calculated at 1 times your annual salary. There is no cost to the employee for this coverage. To update your beneficiary information, log into the Datis system, click on ***MYe3*** on the top menu bar and then select ***Benefits***.

Plan Cost: 100% Employer Paid

Voluntary Life and AD&D Insurance

Employees who want to supplement their group life insurance benefits may purchase additional coverage through Prudential. When you enroll yourself and/or your dependents in this benefit, you pay the full cost through bi-weekly payroll deductions. You can purchase coverage on yourself and your spouse in $10,000 increments. Minimum coverages are $10,000 and maximum coverage is 5x your annual earnings or $500,000.

If you are enrolling in Voluntary Life for the first time during the 2022 Open Enrollment session, EOI is waived for any amounts elected up to the guarantee amount of $150,000. Evidence of Insurability (EOI) forms are required to be completed for amounts over $150,000. Visit **https://gi.prudential.com/POGH/Controller/standalone?VR=eFRVNlhyL2RtamtMdU00UzJyY3ZlZz09** to access the form.

Age reductions will apply. Rates are based on employee age.

Plan Cost: 100% Employee Paid

	Semi-Monthly Life Rate	
Age	**Employee Rate per $10,000 of coverage**	**Spouse Rate per $5,000 of coverage**
Under 35	$0.26	$0.15
35 - 39	$0.41	$0.23
40 - 44	$0.71	$0.38
45 - 49	$1.11	$0.58
50 - 54	$2.16	$1.13
55 - 59	$3.51	$1.78
60 - 64	$3.91	$1.98
65 - 69	$6.96	$3.50
70 - 74	$17.56	$8.80
70 - 100	$69.41	$34.73

Dependent Children	$10,000 of coverage
	$1.00 (covers all children)

Note: If you did not enroll when initially eligible or are requesting a coverage increase, you will be asked to complete an Evidence of Insurability form and be approved for the coverage.

Long-Term Disability

Meridian Behavioral Healthcare, Inc. provides employees with long-term disability income benefits, and pays the full cost of this coverage. In the event you become disabled from a non work-related injury or sickness, long term disability benefits are provided as a source of income.

- Benefits Begin - After 90 day elimination period
- Benefits Payable - ADEA I - with Social Security Normal Retirement Age
- Percentage of Income Replaced - 66 2/3% of gross monthly earnings
- Maximum Benefit - $6,000 monthly

Register online at **http://www.prudential.com/mybenefits** to check status of a claim or evidence of insurability. Customer support for claims is **800-524-0542** for Life and Disability is **800-842-1718**.

Plan Cost: 100% Employer Paid

Voluntary Short-Term Disability

Disability can be expensive - especially if you are unable to work. Having an income can help you cover bills, pay for your home and provide for your family. But if you got sick or injured and couldn't work, how long could you afford life without a paycheck? Would your finances become disabled if you lost your paycheck? Voluntary Short Term Disability coverage from AFLAC pays a monthly cash benefit to employees only for disabilities due to non-occupational sickness or injury. The monthly cash benefit can range from $700 to $5,000, subject to income requirements. Guaranteed Issue! Benefit period of up to 90 days; Waiting period selections of (Accident/Sickness): 0/7, 0/14, 7/14 days.

Plan Cost: 100% Employee Paid

Monthly Benefit Premium	Income Required	0/7 Days Waiting Bi-Weekly Premium		0/14 Days Waiting Bi-Weekly Premium		7/14 Days Waiting Bi-Weekly	
		18 - 49	50 – 64	18 - 49	50 – 64	18 - 49	50 – 64
$1,000	$20,000	$13.00	$16.25	$9.75	$12.35	$8.45	$11.05
$1,200	$24,000	$15.60	$19.50	$11.70	$14.82	$10.14	$13.26
$1,400	$28,000	$18.20	$22.75	$13.65	$17.29	$11.83	$15.47
$1,600	$32,000	$20.80	$26.00	$15.60	$19.76	$13.52	$17.68
$1,800	$36,000	$23.40	$29.25	$17.55	$22.23	$15.21	$19.89
$2,000	$40,000	$26.00	$32.50	$19.50	$24.70	$16.90	$22.10

Voluntary Accident Insurance

Voluntary Accident Insurance pays benefits for accidents on and off the job, plus some benefits that correspond with medical care. Because accident insurance is supplemental, it pays in addition to other coverage the insured may already have in place. This coverage pays a benefit up to a specified amount for covered injuries resulting from accidents 24/7. Benefits can also help with deductibles and copays. The chart below is a partial list of the benefits included. Accident coverage is guarantee issue!

Incident	Payable
ER and Physician Visits	$120
Hospital Admission Benefit	$1,000
Hospital Confinement	$250 per day
Broken Bones and Dislocation	$65 - $2,500
Physical Therapy	$35 per visit up to 10 per accident
Follow-up Visits	$35 per visit up to to 6 per accident
Ambulance	$200 ground; $1,500 air
Accidental Death	Up to $100,000 Employee; Up to$50,000 Spouse; Up to $25,000 Child
Dismemberment	Up to $200,000 Employee; Up to$100,000 Spouse; Up to $50,000 Child

Wellness Benefit: The AFLAC Accident Plan includes a Wellness Benefit that pays $60 per covered person per year.

Bi-weekly payroll (24) deductions	AFLAC Accident
Employee Only	$13.39
Employee + Spouse	$20.54
Employee + Child(ren)	$23.27
Family	$31.20

Voluntary Hospital Advantage

Pays $25 for Doctor Visit and $100 for Emergency Room visits. Pays $1000 upon admission to the hospital for any reason, plus $100 each day thereafter. Pays Invasive exam benefit, Diagnostic and Imaging benefit, In and Out-patient Surgery benefit, Ambulance and Intensive Care benefits.

	AFLAC Hospital Advantage			
	Individual 1,000 / EBR / HSR	One Parent Family 1,000 / EBR / HSR	Individual / Spouse 1,000 / EBR / HSR	Family 1,000 / EBR / HSR
18-49	$13.52 / $19.37 / $28.60	$17.16 / $28.80 / $41.54	$19.18 / $31.47 / $48.37	$20.35 / $35.24 / $52.40
50-59	$13.78 / $20.41 / $32.24	$17.42 / $29.32 / $43.82	$20.28 / $34.06 / $57.53	$20.54 / $35.69 / $59.94
60-75	$14.17 / $20.87 / $36.28	$17.75 / $29.91 / $48.96	$21.71 / $35.62 / $65.00	$21.97 / $37.77 / $69.17

Voluntary Critical Illness Insurance

If you suffer a critical illness like a heart attack, chances are you'll recover. However, your bank account might not spring back as quickly. It's true that your medical insurance can help cover the cost of care and treatment. But there are other expenses you may face beyond those resulting from a loss of income. These costs may include deductibles, copays or prescriptions; rehabilitation, alternative treatments; and/or transportation to health facilities, and family travel for visits.

Voluntary Critical Illness Insurance pays you a lump sum benefit at first diagnosis of a covered critical illness, and can be used however you choose. So you can focus on getting better – not on your bills!

Maximum Benefit by Category

Employee - $10,000 GI (up to 50,000 simplified)

Spouse - $5,000 GI (up to 25,000 simplified)

Dependent Child - $2,500 GI

Below is a partial list of the benefits included.

- Heart Attack
- Major Organ Transplant
- Stroke
- Coronary Artery Bypass*
- Cancer
- Carcinoma In-Situ*
- Renal (Kidney) Failure

** Paid at 25% Face Amount*

Plan Cost: 100% Employee Paid

Voluntary Personal Cancer Care Insurance

According to the American Cancer Association, one out of three Americans will be diagnosed with Cancer. Traditional health insurance covers only 34% of those expenses. Plan pays $4000 upon initial diagnosis of internal cancer (initial diagnosis benefit grows by $500 per year), $200 per day Hospital Confinement, radiation, Chemotherapy, Experimental treatments, Skin cancer benefit, Surgery, Lodging, Travel expenses, $75 Annual Wellness benefit, also a rider for benefits covering 32 additionally diseases and more.

Bi-weekly payroll (24) deductions	AFLAC Cancer Care
Individual	$22.02
One-Parent Family	$22.02
Two-Parent Family	$39.96

LegalShield

As one of the first companies in North America to provide legal expense plans to consumers, we now provide legal services to over 1.5 million families across the U.S. and Canada—representing approximately 4 million people. With over 650 employees dedicated to serving you, our promise remains the same: to provide outstanding legal services by quality law firms at an affordable price.

Even better, members do not have to worry about finding out which attorney to use—we will do that for you. Our experienced attorneys focus specifically on our members and provide 24/7 access for covered emergencies.

Why LegalShield

LegalShield gives you the ability to talk to a lawyer on any personal legal matter without worrying about high hourly costs. That is why, under the protection of LegalShield, you and your family can live your lives worry free.

- Advice on an unlimited number of legal topics
- Letters and phone calls on your behalf
- 24/7 emergency assistance
- Legal document review
- Toll-Free phone consultations
- Trial defense hours
- Forms service center
- Will preparation

Service Level Standards

LegalShield Provider Law Firms adhere to the following service standards for our members:

- Return call from attorney - 8 business hours
- Document review - 3 business days
- Letter or phone call - 3 business days
- Will preparation - 10 business days
- Referrals - 3 business days

Bi-weekly payroll (26) deductions	LegalShield
Family	$8.75

Covered Family Members include: Member, Member's spouse/domestic partner, Never-married dependent children under age 26 living at home, Dependent children under age18 for whom the member is legal guardian, Never married, dependent, children who are full-time college students up to age 26, Physically or mentally disabled children living at home.

IDShield

Identity theft has been the top consumer complaint filed with the FTC for 15 years straight. Victims are spending an exorbitant amount of time and money dealing with it. The criminals are getting smarter. And they're not going away. That's why you need a company that's more than a website. Worry less, live more!

Members have unlimited access to identity consultation services provided by Kroll's Licensed Private Investigators. The Investigator will advise members on best practices for identity management tailored to the member's specific situation. Services include:

- Consultation (Unlimited counseling, sex offender reports, identity alert and more...)
- Restoration ($5M service guarantee, medical & financial fraud, and more...)
- Privacy Monitoring (DOB/SSN, DL, and email monitoring, web surveillance, and more...)
- Security Monitoring (Score tracker, Bank account, credit, credit cards, and more...)

Monitor More of What Matters

We monitor your identity from every angle, not just your Social Security number, credit cards and bank accounts. We ensure everything connected to you is safe, even your social media accounts. If any change in your status occurs, you receive an email update immediately.

Counsel When You Need It

Our identity specialists are focused on protecting you. They are available to provide you with a complete picture of identity theft, walk you through all the steps you can take to protect yourself and answer any questions. Plus, they are available 24 hours a day, every day, in the event of an identity theft emergency. We're always here to help, no matter what.

Restore Your Identity Completely

IDShield is the only company with an exclusive partnership with Kroll, the worldwide leader in theft investigative services. If a compromise occurs, contact your licensed private investigator who will immediately begin restoring your identity to exactly the way it was.

Bi-weekly payroll (26) deductions	IDShield
Individual	$4.13
Family	$8.75

Covered Family Members include: employee, spouse/partner + Up to 8 dependent children up to age 26. (includes consultation/ restoration only, for dependent children age 18 to 26.)

Bi-weekly payroll (26) deductions	LegalShield & IDShield
Individual	$12.88
Family	$15.65

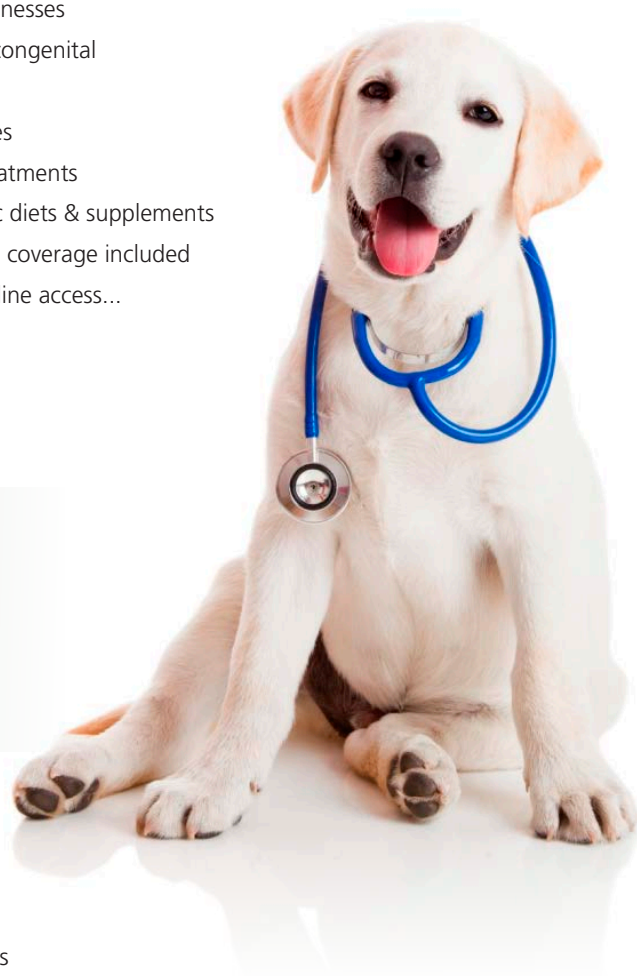
Pet Protection Plans

my pet protection **with wellness**

- $250 annual deductible
- Accidents & illnesses
- Hereditary & congenital
- Cancer
- Dental diseases
- Behavioral treatments
- Rx therapeutic diets & supplements
- Specialty & ER coverage included
- 24/7 Vet Helpline access
- Wellness exams
- Spay or neuter
- Flea & tick
- Preventive dental cleaning & more...

my pet protection

- $250 annual deductible
- Accidents & illnesses
- Hereditary & congenital
- Cancer
- Dental diseases
- Behavioral treatments
- Rx therapeutic diets & supplements
- Specialty & ER coverage included
- 24/7 Vet Helpline access...



90% cash back - use any vet and get 90% back
Open to all ages - one price regardless of pets age
More than just accident/illness - spay/neuter, Rx diet, dental and more
Exclusive to employees - not available to the general public
Easy enrollment - just two questions to get coverage
Employee preferred pricing - special discounts with employers

Plus additional coverage:

- Boarding/kennel fees if a family member hospitalized due to injury/illness
- Advertising/reward fees for pets that go missing during the policy term
- Pet replacement costs if a missing pet is not found within sixty (60) days
- Mortality coverage for euthanization due to illness/injury and cremation/burial fees

Key Points

Enroll anytime throughout the year. Enroll your pet when they're healthy, don't wait until they are sick or hurt!

- Sign up by the 15th of the month, effective date will 1st of the next month. Ex: enroll 2/14, effective date is 3/1.
- Sign up after the 15th of the month, effective date will be 1st of the next following month. Ex: enroll 2/17, effective date is 4/1.
- Each pet has an individual policy. Multiple pet discounts: 2 or 3 pets – 10% total discount. 4 or more pets – 15% total discount.

Easily enroll online at **PetsNationwide.com**. Type in your company name for preferred employee pricing or Call us at **877-738-7874** and speak with a trained representative – Please state your company name for preferred employee pricing.

Frequently Asked Questions and Answers

1. **When will the Open Enrollment presentation take place?** The presentation will be offered on June 1st at 3pm via webinar. If you are unable to attend one of the sessions you can watch a video recording posted on the Meridian Behavioral Healthcare, Inc. intranet. Go to the HR channel of MbhTube.

2. **How do I submit my open enrollment changes?** Log into Datis and click ***Open Enrollment*** on the right-hand side of the homepage. A new window will open with the enrollment wizard. Select or decline each plan and click ***Submit*** on the last page. The Submit button appears only when all pages of the wizard have been completed. If you don't see the Submit button, please read the Summary page of the wizard and complete all the pages.

3. **What changes can I make during open enrollment?** You can enroll, change or terminate individual and/or dependent coverage in the medical, dental, vision, voluntary life and AFLAC plans. All changes you submit will be processed for an effective date of July 1, 2022.

4. **If I have no changes to make, do I need to do anything?** If you are happy with what you are currently enrolled in, then no further action is required. Your enrollment will continue in the same plans you are enrolled in for 2022-2023. The benefits wizard will remain in your Datis landing page until the close of Open Enrollment.

5. **I made changes in Datis but when I go back to review my benefits, they are not showing up.** Datis knows that you are still in plan year 2021-2022. You will not see your 2022 changes until July 1, 2022 as those are future-dated benefits.

6. **When is the deadline to submit changes for 2022?** All changes must be made by June 2, 2022.

7. **Where can I find the enrollment forms?** Benefits open enrollment is done online through Datis. Enrollment forms are still used for Aflac and LegalShield; they are available through Datis also. On the landing page, click ***Forms*** on the right-hand side, download the form, print, complete, scan, and email to **manuel_peruga@mbhci.org**.

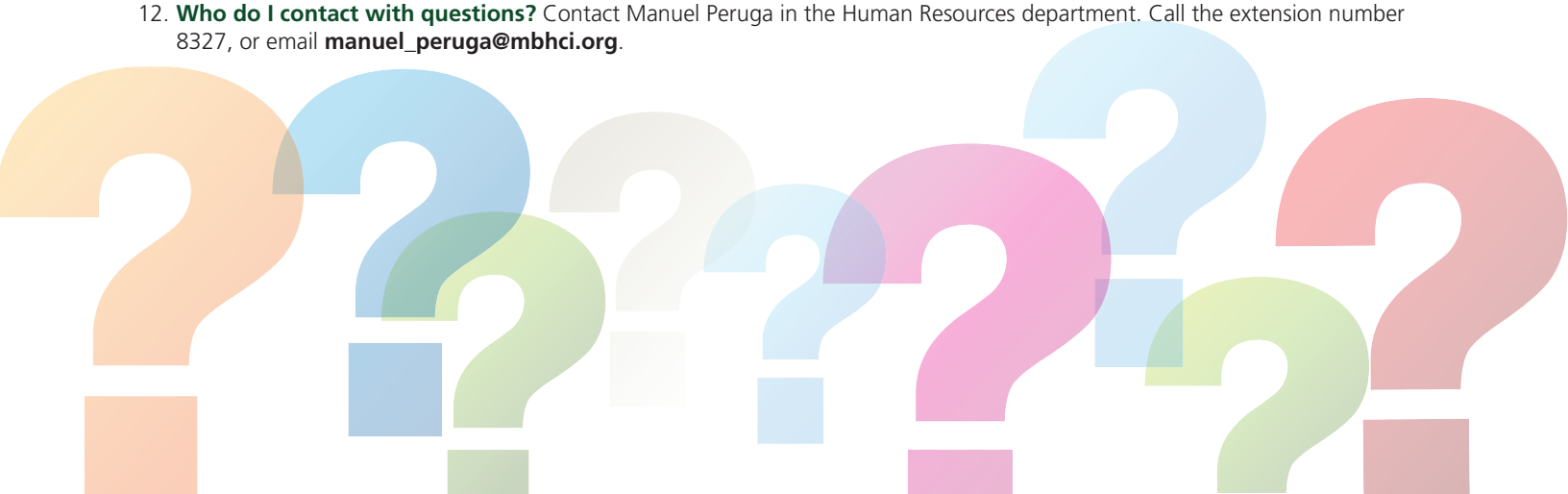
8. **When electing Voluntary Life Insurance, how do I complete the Personal Health Application?** You will receive the form in the next few weeks from HR.

9. **If I change my mind after Open Enrollment ends, when can I make changes to my benefits again?** Once elected, your benefit elections remain in place for the full benefit plan year which runs July 1, 2022 to June 30, 2023. Changes outside of Open Enrollment are only allowed for qualifying life events (e.g., birth of a child, marriage, divorce, etc.). If you experience a qualifying event, you must notify the Payroll Department within 30 days of that event in order to make changes to your benefits.

10. **Can I waive coverage if I have access to insurance elsewhere, such as through my spouse?** Yes, coverage is available on an a-la-carte basis. Employees have the option to elect or decline the coverage that is most suitable for their life situation.

11. **How much does our insurance plans cost?** When you logon into Datis, you will be able to see both the Employee (you) and the Employer (Meridian Behavioral Healthcare, Inc.) cost per month. For basic life, AD&D and long term disability, Meridian Behavioral Healthcare, Inc. pays 100% of the coverage.

12. **Who do I contact with questions?** Contact Manuel Peruga in the Human Resources department. Call the extension number 8327, or email **manuel_peruga@mbhci.org**.



Glossary of Terms

This glossary has many commonly used terms, but it isn't a full list. These are not contract terms. Those can be found in your insurance policy or certificate.

Allowed Amount: Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Appeal: A request for your health insurer or plan to review a decision or a grievance again.

Balance Billing: When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you.

Co-insurance: Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount. (Jane pays 20%, her plan pays 80%.)

Complications of Pregnancy: Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency cesarean section aren't complications of pregnancy.

Co-payment: A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible: The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services. (Jane pays 100%, her plan pays 0%.)

Durable Medical Equipment (DME): Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency Medical Condition: An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm. Emergency Medical Transportation Ambulance services for an emergency medical condition.

Emergency Room Care: Emergency services received in an emergency room.

Emergency Services: Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

Excluded Services: Health care services that your health insurance or plan doesn't pay for or cover.

Grievance: A complaint that you communicate to your health insurer or plan.

Habilitation Services: Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance: A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

Home Health Care: Health care services a person receives at home.

Hospice Services: Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization: Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care: Care in a hospital that usually doesn't require an overnight stay.

In-network Co-insurance: The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network co-insurance usually costs you less than out-of-network co-insurance.

In-network Co-payment: A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network co-payments usually are less than out-of-network co-payments.

Medically Necessary: Health care services or supplies needed to prevent, diagnose or treat an illness, injury, disease or its symptoms and that meet accepted standards of medicine.

Network: The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Non-Preferred Provider: A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.

Out-of-Network Co-insurance: The percent (for example, 40%) you pay of the allowed amount for covered health care services to providers who do not contract with your health insurance or plan. Out-of-network co-insurance usually costs you more than in-network co-insurance.

Out-of-Network Co-payment: A fixed amount (for example, $30) you pay for covered health care services from providers who do not contract with your health insurance or plan. Out-of-network co-payments usually are more than in-network copayments.

Out-of-Pocket Limit: The most you pay during policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit. (Jane pays 0%, her plan pays 100%.)

Physician Services: Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan: A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Preauthorization: A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Preferred Provider: A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium: The amount that must be paid for your health insurance or plan. You and or your employer usually pay it yearly.

Prescription Drug Coverage: Health insurance or plan that helps pay for prescription drugs and medications.

Prescription Drugs: Drugs and medications that by law require a prescription.

Primary Care Physician: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Provider: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

Reconstructive Surgery: Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Rehabilitation Services: Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care: Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist: A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

UCR (Usual, Customary and Reasonable): The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care: Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Health Insurance Marketplace

The Patient Protection Affordability Care Act ("PPACA") was signed into law on March 23, 2010. Under PPACA, individuals are required to have creditable health insurance coverage or pay a penalty to the Internal Revenue Service. This is known as the Individual Mandate. For more information on the details of PPACA please visit **https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-workers-and-families**.

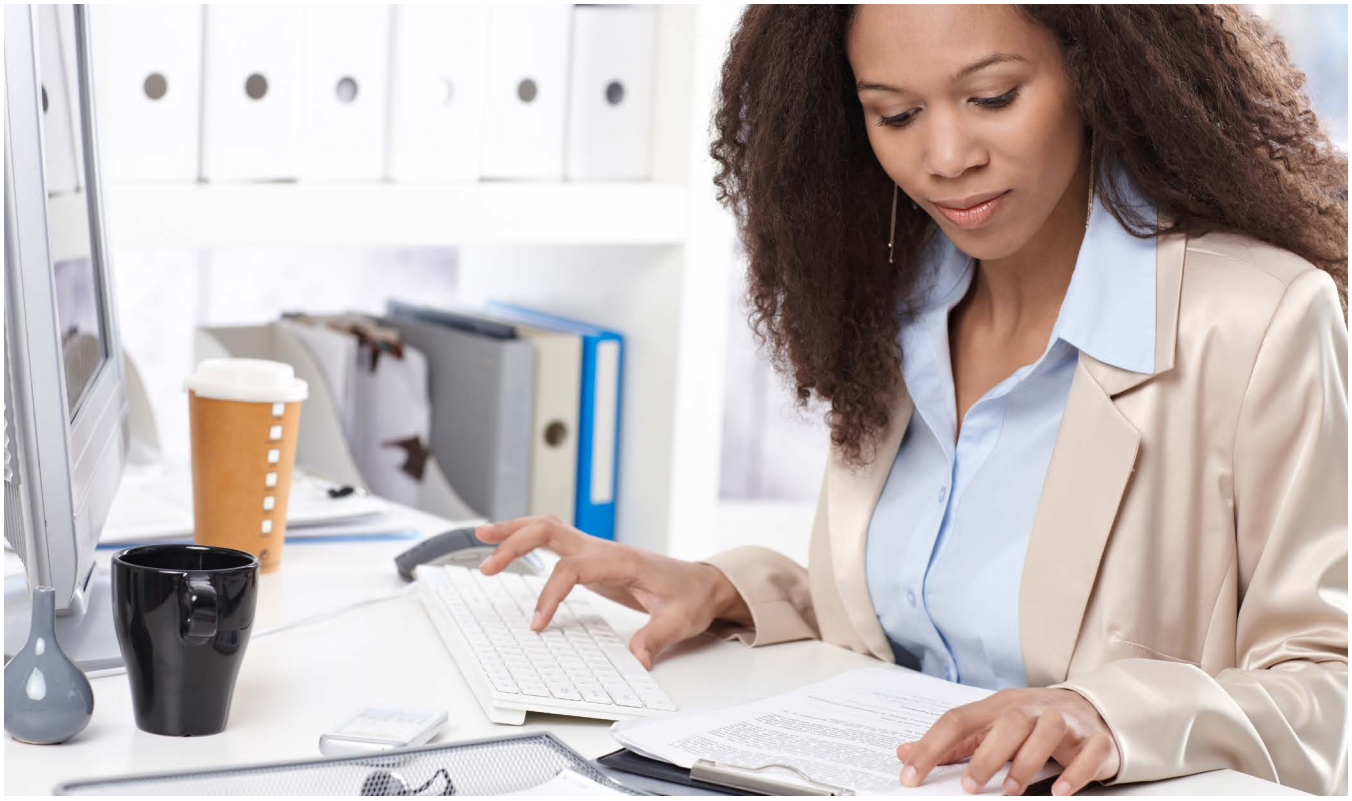
PPACA created a new way to buy health insurance which is called the Health Insurance Marketplace ("Marketplace"), also known as Exchanges. These Marketplaces are established by each individual state, the federal government or as a partnership between the state and the federal government. Through the Marketplaces, individuals can compare and purchase coverage (with a possible premium subsidy for those qualifying as low income; subsidies are made available as a federal tax credit through the Marketplace for individuals that are not eligible for coverage through their employer.

If you are enrolled in the Company's medical plan, then PPACA may have little effect on you. The Company's medical plans meet or exceed the minimum coverage requirements set by PPACA. If you are eligible for our plans, you will not be eligible for federal tax credits. You still have the option to visit the Marketplace to see the coverage options available. If you purchase a health plan through the Marketplace instead of purchasing health coverage offered by the Company, you will lose any contribution your employer makes for your health coverage, and your payments for coverage through the Marketplace will be made on an after-tax basis. (See **https://www.healthcare.gov/have-job-based-coverage/**).

If you are not eligible to enroll in the Company's medical plan, you may have a few options to purchase medical coverage. These options, if applicable, may include but are not limited to: your spouse's medical plan, your parent's medical insurance plan (if you are under age 26), or from several insurance companies offered though the Marketplace. If you shop for coverage through the Marketplace, you may be eligible for a federal tax credit and/or subsidy if you qualify as low income. (See also: **healthcare.gov**).

How Can I Get More Information?

For more information about purchasing medical coverage through the Marketplace please visit **healthcare.gov** or call **800-318-2596**.



Annual Notices

Health Insurance Portability and Accountability Act (HIPAA)

For purposes of the health benefits offered under the Plan, the Plan uses and discloses health information about you and any covered dependents only as needed to administer the Plan. To protect the privacy of health information, access to your health information is limited to such purposes. The health plan options offered under the Plan will comply with the applicable health information privacy requirements of federal Regulations issued by the Department of Health and Human Services. The Plan's privacy policies are described in more detail in the Plan's Notice of Health Information Privacy Practices or Privacy Notice. Plan participants in the Company-sponsored health and welfare benefit plan are reminded that the Company's Notice of Privacy Practices may be obtained by submitting a written request to the Human Resources Department. For any insured health coverage, the insurance issuer is responsible for providing its own Privacy Notice, so you should contact the insurer if you need a copy of the insurer's Privacy Notice.

Newborns' and Mothers' Health Protection Act

Group health plans and health 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours if applicable).

Notice Regarding Special Enrollment

If you are waiving enrollment in the Medical plan for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in the Medical plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

States with Individual Mandate

Taxpayers in CA, DC, MA, NJ, RI, and VT (this list is neither complete nor exhaustive) are reminded that your state imposes an individual mandate penalty (tax) should you, your spouse, and children choose to not have (and keep) medical/rx coverage for each tax year. Please consult your tax advisor for how a non-election for health coverage may affect your tax situation.

Special Enrollment Rights CHIPRA – Children's Health Insurance Plan

You and your dependents who are eligible for coverage, but who have not enrolled, have the right to elect coverage during the plan year under two circumstances:

- You or your dependent's state Medicaid or CHIP (Children's Health Insurance Program) coverage terminated because you ceased to be eligible.
- You become eligible for a CHIP premium assistance subsidy under state Medicaid or CHIP (Children's Health Insurance Program).
- You must request special enrollment within 60 days of the loss of coverage and/or within 60 days of when eligibility is determined for the premium subsidy.

Genetic Nondiscrimination

The Genetic 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, the Company asks Employees not to provide any genetic information when providing or responding to a 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.

Qualified Medical Child Support Order

QMCSO is a medical child support order issued under State law that creates or recognizes the existence of an "alternate recipient's" right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An "alternate recipient" is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified, and to administer benefits in accordance with the applicable terms of each order that is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer on the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.

Annual Notices continued

Notice of Required Coverage Following Mastectomies

In compliance with the Women's Health and Cancer Rights Act of 1998, the plan provides the following benefits to all participants who elect breast reconstruction in connection with a mastectomy, to the extent that the benefits otherwise meet the requirements for coverage under the plan:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- coverage for prostheses and physical complications of all stages of the mastectomy, including lymphedemas. The benefits shall be provided in a manner determined in consultation with the attending physician and the patient. Plan terms such as deductibles or coinsurance apply to these benefits

Women's Preventive Health Benefits

The following women's health services are considered preventive. These services generally will be covered at no cost share, when provided in network:

- Well-woman visits (annually and now including prenatal visits)
- Screening for gestational diabetes
- Human papilloma virus (HPV) DNA testing
- Counseling for sexually transmitted infections
- Counseling and screening for human immunodeficiency virus (HIV)
- Screening and counseling for interpersonal and domestic violence
- Breast-feeding support, supplies and counseling
- Generic formulary contraceptives are covered without member cost-share (for example, no copayment). Certain religious organizations or religious employers may be exempt from offering contraceptive services.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

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 (including spouse) 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 for pre-existing conditions except for service-connected injuries or illnesses.

Medicare Part D

The prescription drug benefit is creditable coverage. Medicare-eligible participants need not enroll in a separate Medicare D drug plan.

Mental Health Parity and Addiction Equity Act of 2008

This act expands the mental health parity requirements in the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Services Act by imposing new mandates on group health plans that provide both medical and surgical benefits and mental health or substance abuse disorder benefits. Among the new requirements, such plans (or the health insurance coverage offered in connection with such plans) must ensure that: the financial requirements applicable to mental health or substance abuse disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance abuse disorder benefits.

COBRA

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, COBRA qualified beneficiaries (QBs) generally are eligible for group coverage during a maximum of 18 months for qualifying events 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.

COBRA coverage is not extended for those terminated for gross misconduct. Upon termination, or other COBRA qualifying event, the former employee and any other QBs will receive COBRA enrollment information.

Qualifying events for employees include voluntary/involuntary termination of employment, and the reduction in the number of hours of employment. Qualifying events for spouses or dependent children include those events above, plus, the covered employee becoming entitled to Medicare; divorce or legal separation of the covered employee; death of the covered employee; and the loss of dependent status under the plan rules.

If a QB chooses to continue group benefits under COBRA, they must complete an enrollment form and return it to the Plan Administrator with the appropriate premium due. Upon receipt of premium payment and enrollment form, the coverage will be reinstated. Thereafter, premiums are due on the 1st of the month. If premium payments are not received in a timely manner, Federal law stipulates that your coverage will be cancelled after a 30-day grace period. If you have any questions about COBRA or the Plan, please contact the Plan Administrator.

Please note, if the terms of the Plan and any response you receive from the Plan Administrator's representatives conflict, the Plan document will control.

This benefit guide is provided by