



2024 EMPLOYEE BENEFITS



If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 41 for details.

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WISENBAKER BUILDER SERVICES, INC.

Welcome Letter

Welcome to your 2024 Employee Benefits Program! As a valued employee of WISENBAKER, you have access to a full menu of insurance benefits. The 2024 plan year starts April 1, 2024 (effective date) and runs through March 31, 2025.

As a company, we strive to provide our employees with the type of work environment and benefits that will offer you the incentive to remain an integral part of our team. The benefits available are designed to recognize your various needs by giving you the opportunity to select benefits that meet your lifestyle. The benefit programs include:

- Medical Insurance
- Dental Insurance
- Vision Insurance
- Employee Assistance Program
- Employer-paid Life and AD&D Insurance
- Telemedicine
- Voluntary Life and AD&D Insurance
- Voluntary Short Term Disability Insurance
- Voluntary Long Term Disability Insurance
- Accident Insurance
- Critical Illness Insurance
- Hospital Indemnity Insurance
- Whole Life with LTC Rider

WISENBAKER offers a comprehensive benefit program and pays a significant portion of the cost of many of these valuable programs. Descriptions of the WISENBAKER employee benefit products, both voluntary and those provided by the company at no cost to you, are described in this booklet.

Throughout the plan year, you may have questions about your employee benefits, and calling the right person is very important. There are times when your HR Department can help you and times when you must contact the insurance carrier directly. In most cases, your employee benefits broker team can assist you, or provide you with important knowledge, support and guidance. Important contacts are provided on page seven for your reference.



Download the HRVu App Now!



EVERYTHING YOU NEED IN ONE PLACE!

The HRVu app is designed to help you navigate through our benefit offerings and is personalized based on your enrollment. It also includes important company information.

Discover all the beneficial information you need, when you need it, all in one place.

Step 1: From the camera on your smartphone scan the above QR code.

Step 2: Follow the steps to complete the registration process.

Step 3: You will be prompted to download the app where you will enter your username and password that you just created.

Step 4: You are now in the app.

IF YOU HAVE ANY QUESTIONS, PLEASE EMAIL:
APP-SUPPORT@INGAGED.ME



How to Enroll

USE THE APP

Download HRVū App from the Apple App Store or Google Play

- Click on the "Open Enrollment" Tab
- Click "Enroll Now"

Verify Your Personal Information

- Review & verify your family information
- Be Prepared: Have names, birthdays, & Social Security Numbers on hand

Make Benefit Elections

- Enroll in or waive each benefit option
- Download or print the confirmation statement

OR ENROLL THROUGH PAYLOCITY

Go to www.paylocity.com

- Log in to your self-service portal
- Access your Enterprise Web Benefits from the gray HR and Payroll tab located at the top left hand corner of your self-service portal

Verify Your Personal Information

- Review & verify your family information
- Be Prepared: Have names, birthdays, & Social Security Numbers on hand

Make Benefit Elections

- Enroll in or waive each benefit option
- Download or print the confirmation statement

Important Contacts

Throughout the plan year, you may have questions regarding your employee benefits. If you need personal assistance or have any questions, please reach out to one of the contacts below.

Provider/Contact	Phone	Website/Email
Human Resources	Deborah Villareal [281] 220-3965	deborahv@WBS.com
Marsh & McLennan Agency	Maya Brooks Executive Team Lead [713] 780-6630	Maya.Brooks@MarshMMA.com
Enrollment	HRVŪ App or Paylocity Self-Service Portal	www.paylocity.com
Medical	BlueCross BlueShield [800] 521-2227	www.bcbstx.com
Health Savings Account	Clarity [888] 423-6359	www.ClarityBenefitSolutions.com CustomerService@ClarityBenefitSolutions.com
Dental	Guardian [888] 600-1600	www.GuardianAnytime.com
Vision		
Disability		
Life/AD&D		
Supplemental	AFLAC [800] 433-3036 [832] 604-7144	www.AflacGroupInsurance.com crystal_mulville@us.aflac.com
Whole Life with LTC Rider	TransAmerica [888] 763-7474 [832] 604-7144	crystal_mulville@us.aflac.com
Health Advocacy / Bill Saver	Health Advocate [855] 423-8585	www.HealthAdvocate.com/Members
Telemedicine	MDLive [888] 680-8646	www.mdlive.com/bcbstx
401k & Financial Wellness	Principal [800] 547-7754	www.principal.com/Welcome

Download the HRVŪ app to access these important contacts at your convenience!



Employee Eligibility

EMPLOYEES

All full-time employees working a minimum of 30 hours per week are eligible for benefits, which become effective on the 1st of the month following 60 days of employment. Please refer to the Eligibility Chart on page 9 to determine individual eligibility for each plan.

NOTE: Eligible dependents include your legal spouse and your dependent child(ren). Domestic Partners are not eligible for coverage.

DEPENDENT CHILD(REN)

Regardless of marital status, children are eligible for medical coverage from birth up to age 26. If a child becomes mentally or physically disabled while covered under the benefit plans, the child's coverage may be continued as long as the child remains disabled and depends on you for support. Eligible Dependent Child(ren) include:

- Natural children
- Legally adopted children or children placed for adoption for whom legal adoption proceedings have been started
- Stepchildren
- Children for whom benefits must be provided through a qualified Medical Child Support Order
- Any other child for whom you have obtained legal guardianship

MAKING COVERAGE CHANGES DURING THE YEAR

Once you make your benefit elections, these choices remain in effect until the next annual Open Enrollment unless you have a qualified life event or you or your eligible dependents become eligible for coverage through special enrollment rules. If you experience a qualifying life event, you must notify the HR Department in writing within 30 days of the event and provide appropriate documentation.

QUALIFYING LIFE EVENTS

Qualifying life events include, but are not limited to:

- Change in number of eligible dependents due to birth, adoption, placement for adoption or death
- Gain or loss of dependent status (i.e., your child reaches the age limit for eligibility)
- Change in legal marital status, including marriage, divorce, or death of a spouse
- Change in residence or workplace that changes your or your dependent's eligibility for coverage
- Change in employment status, such as starting or ending employment, for you, your spouse or your children
- Death of a dependent
- Change or loss of other health care coverage

Refer to the Summary Plan Description for a complete list of qualifying life events and special enrollment rules.

PRE-TAX PAYROLL DEDUCTIONS

Your Medical, Dental, Vision, Accident, Hospital Indemnity and HSA Contributions are offered on a pretax basis through the IRS Section 125. By making your contributions on a pretax basis, the premium is withheld from your pay before federal, state (in most cases), and FICA taxes are calculated. This can reduce the amount of taxes withheld from your paycheck.

ELIGIBILITY CHART

Plan	Eligibility
Medical Insurance	
Dental Insurance	
Vision Insurance	All full-time employees, actively at work, working a minimum of 30 hours per week are eligible for benefits which become effective on the 1 st of the month following 60 days of employment.
Voluntary Life/AD&D Insurance	
Employer-Paid Life/AD&D Insurance	All full-time employees, actively at work, working a minimum of 30 hours per week and enrolled in the Medical Plan are eligible for benefits which become effective on the 1 st of the month following 60 days of employment.
Voluntary Short-Term Disability Insurance	All full-time employees, actively at work, working a minimum of 30 hours per week with less than 5 years of employment are eligible for benefits which become effective on the 1 st of the month following 60 days of employment.
Voluntary Long-Term Disability Insurance	
Employer-Paid Short-Term Disability Insurance	All full-time employees, actively at work, working a minimum of 30 hours per week with 5 or more years of employment are eligible for benefits which become effective on the 1 st of the month following 60 days of employment.
Employer-Paid Long-Term Disability Insurance	
Supplemental Insurance	All full-time employees, actively at work, working a minimum of 30 hours per week are eligible for benefits which become effective on the 1 st of the month following 60 days of employment.
Whole Life with LTC Rider	All full-time employees, actively at work, working a minimum of 30 hours per week are eligible for benefits which become effective on the 1 st of the month following 60 days of employment.
Health Advocacy	Health Advocate is available only to those enrolled in the Medical Plan, upon activation of medical insurance.
Telemedicine	MDLive is available only to those enrolled in the Medical Plan, upon activation of medical insurance.

Medical Insurance

Blue Cross Blue Shield Group ID: HSA—165181 | PPO—165180

There are two medical plans offered, an HSA Eligible medical plan (High Deductible Health Plan) and a PPO (Preferred Provider Organization) medical plan, both administered through Blue Cross Blue Shield (BCBS).

The HSA Eligible medical plan offers you quality care, the ability to utilize the BlueChoice Network, and puts the financial decisions in the hands of the consumer! Out-of-Network benefits are available, however, you will incur twice the financial exposure as opposed to using the in network benefits. There are no copays with the HSA Eligible medical plan, and you are responsible for meeting the deductible for all services rendered before the insurance kicks in.

The PPO medical plan is an option for employees to “Buy Up” to a more robust health insurance offering. This plan costs more initially, but offers a richer benefit plan, and provides copays for everyday medical needs. You will have the ability to utilize the BlueChoice Network, and Out-of-Network benefits are available, however, the benefits are much less robust.

Network Providers may change throughout the year. To find out if your doctor participates in the BlueChoice Network, go to www.bcbstx.com and select “Find a Doctor or Hospital” or call 800.521.2227

2024 Employee Contribution to Medical Premium				
	HSA		PPO	
	Weekly	Bi-Weekly	Weekly	Bi-Weekly
Employee Only	\$22.50	\$45.00	\$122.50	\$245.00
Employee + Spouse	\$115.00	\$230.00	\$272.50	\$545.00
Employee + Child(ren)	\$105.00	\$210.00	\$250.00	\$500.00
Employee + Family	\$192.50	\$385.00	\$417.50	\$835.00

BLUECROSS BLUESHIELD MEMBER PORTAL

Our medical benefits are administered through BlueCross BlueShield of Texas. We encourage all members to register as a Blue Access Member by logging onto www.bcbstx.com/member. Once registered, you'll be able to log in directly to your Blue Access Member portal through the HRVŪ app! This online resource offers you tools and resources to help you manage your health benefits, such as finding a doctor, hospital and pharmacy in the BlueChoice network, view claim status, download an Explanation of Benefits (EOB), request ID cards and much more.

Lost or forgotten ID card? No problem!
Find a digital copy on the HRVŪ app!



IN-NETWORK PLAN HIGHLIGHTS

BlueCross and BlueShield of Texas (BCBSTX) Group ID: HSA—165181 | PPO—165180

The table below highlights some of the key components of the medical insurance options available to you. There are out-of-network benefits (not shown) for all services received outside of the BCBS BlueChoice network. For full plan details, please refer to your Summary Plan Document.

	HSA – 165181	PPO – 165180
Plan Provision	In-Network	In-Network
Network	BlueChoice	BlueChoice
Annual Deductible (Calendar Year January – December)	\$3,200 Individual \$6,400 Family	\$1,500 Individual \$3,000 Family
Annual Out-of-Pocket Maximum (includes deductible) (Calendar Year January – December)	\$5,200 Individual \$10,400 Family	\$3,000 Individual \$6,000 Family
Preventive Care <i>Adult physical examinations & routine pediatric care, including diagnostic tests, immunizations, mammograms, etc.</i>	100% Covered; Deductible Waived	100% Covered; Deductible Waived
Outpatient Care	You pay 20%; After Deductible	You pay 20%; After Deductible
Primary Care Physician Office Visit	You pay 20%; After Deductible	\$30 Copay
Specialist Office Visit	You pay 20%; After Deductible	\$40 Copay
Outpatient Mental Health Visit	You pay 20%; After Deductible	\$30 Copay
Virtual Visit [MDLive]	Up to \$48 Fee	\$30 Copay
Behavioral Health Virtual Visit [MDLive]	Up to \$90 - \$150 fee	\$30 Copay
Outpatient Surgery	You pay 20%; After Deductible	You pay 20%; After Deductible
Major Diagnostics and Imaging	You pay 20%; After Deductible	You pay 20%; After Deductible
Hospital & Emergency	You pay 20%; After Deductible	You pay 20%; After Deductible
Urgent Care	You pay 20%; After Deductible	\$75 Copay
Emergency Room	You pay 20%; After Deductible	\$250 Copay; Then you pay 20%; After Deductible
Inpatient Hospital	You pay 20%; After Deductible	You pay 20%; After Deductible
Surgical Services	You pay 20%; After Deductible	You pay 20%; After Deductible
Pharmacy – Balanced Formulary		
Out-of-Pocket Maximum	Integrated with Medical	\$2,000 Individual \$4,000 Family
Retail Prescriptions <i>Generic / Preferred Brand / Non-preferred Brand / Specialty</i>	You pay 20%; After Deductible	\$10 / \$25 / \$50 / 20% up to \$300
Mail Order Prescriptions (90 Day Supply)	You pay 20%; After Deductible	3x Copay

BLUECROSS BLUESHIELD PRESCRIPTION DRUG COVERAGE

Prescription Drug Lists

A drug list is a list of drugs available to Blue Cross and Blue Shield of Texas (BCBSTX) members. How much you pay out-of-pocket for prescription drugs is determined by whether your medication is on the list. These prescription drug lists have different levels of coverage, which are called "tiers." Generally, how much you pay out of pocket for a prescription drug will be less if you choose a drug that is a lower tier. Your doctor should consult the **BALANCED FORMULARY DRUG LIST** when prescribing drugs for you. This may help lower your out-of-pocket costs. Note: Based on your benefits, if you use a drug manufacturer's coupon or copay card to pay for a covered prescription drug, this amount may not apply to your plan deductible or out-of-pocket maximum.

Login to your Blue Access for Members portal to check your drug list and learn more about your prescription drug benefits. If you have any questions about your prescription drug benefits, call the number on your member ID card.

Mail Order Program

The mail order program through Express Scripts offers a convenient way to fill prescriptions for medications that you take on a regular basis (maintenance medications). At Express Scripts, licensed pharmacists process the orders and all medicines are shipped in tamper-evident containers and plain packaging. Home delivery can save you time — and possibly money.

24/7 SUPPORT

Visit www.esrx.com/BCBSTX or call 833.715.0942 to talk with a member of their pharmacy team.

Copay Coupon Accumulator Adjustment Program

Manufacturer copay assistance programs (aka coupons) promote the use of higher-cost drugs even when appropriate, less-expensive medications are available. In addition, coupons artificially accelerate members' accumulator balances by counting the coupon amount toward their out of pocket (OOP) maximum, leading to plans and employers paying more. With the copay accumulator adjustment program, only the amount paid out-of-pocket for a covered drug may apply to members' coinsurance, deductible (if part of the plan) and yearly out-of-pocket maximum. The amount paid for, or offset, by a copay assistance coupon will not apply.

Example:

Retail Cost of Drug	Member Copay	Coupon Amount	Member Cost at Point of Sale	What applies to the Deductible/OOP Max?	What doesn't apply to the Deductible/OOP Max?
\$1,000	\$100	\$90	\$100 - \$90 = \$10	\$10 member paid out of pocket at Point of Sale	\$90 coupon amount that drug manufacturer paid

Extended Supply Network

What is the Extended Supply Network?

This network works with participating pharmacies to provide eligible members the ability to fill a 90 day prescription at retail for most commonly prescribed maintenance medications including those for hypertension, diabetes, and arthritis. Work with your doctor to determine if the medications you are prescribed are eligible for this program. If so, login to myprime.com either directly or through Blue Access for Members (BAM). Then, select the Pharmacies tab to search for a participating pharmacy, type in your zip code and filter by clicking 90-day supply.

What are a few examples of prescription drugs that fall under this program?

A list of commonly prescribed maintenance medications can be found here bcbstx.com/pdf/rx/maintenance_drug_list.pdf. The list includes medications such as Intuniv, ipratropium, Aricept, Abilify, Glucotrol, Loestrin, Nuvaring, Restasis, Dutoprol, Caduet and more.

Oral Oncology Split Fill Program

What is the Oral Oncology Split Fill Program?

In an effort to provide greater patient support and avoid medication waste, BlueCross BlueShield is introducing the Split Fill program. This allows members who are starting chemotherapy to try expensive medications that have serious side effects for a shorter period (14-15 day supply), confirming effectiveness and tolerance before members pay for a full 30-day supply.

Multi Category Split Fill Program

What is the Multi Category Split Fill Program?

Similar to the Oral Oncology Split Fill Program, members are able to receive a partial fill on new prescriptions for up to 3 months to determine effectiveness prior to paying for a full 30-day supply. This program includes Multiple Sclerosis and Pulmonary Arterial Hypertension medications.

Specialty Medications and Prior Authorization (PA) Program

What is prior authorization (PA)?

The PA program encourages safe and cost-effective drug use. The program applies to certain high-cost drugs and those that can be misused. Before medications included in the PA program can be covered under your pharmacy benefit plan, your doctor will need to get approval through BCBS of TX.

What should I do if I take a drug that is part of the Prior Authorization (PA) Program?

If you are taking or prescribed a drug that is part of the PA program, your doctor will need to submit a PA request for coverage to keep receiving coverage for that drug.

- If the prior authorization request is approved: You will pay your share for the medication based on your pharmacy benefit plan.
- If the prior authorization request is not approved: The medication will not be covered. You can still fill your prescription, but you may have to pay for the full amount charged, based on your benefit plan.

Your doctor can find a PA request form on the provider portal at bcbstx.com. Doctors may visit the website or call 800.289.1525 for more information.

Proton Pump Inhibitors (PPIs)

PPIs are a class of drugs used to treat conditions linked to acid reflux disease or ulcers. There are over the counter (OTC) options that can be purchased without a prescription. Below are some examples:

- Omeprazole (Prilosec OTC)
- Lansoprazole (Prevacid 24 HR)
- Esomeprazole (Nexium 24 HR)
- Omeprazole-sodium bicarbonate (Zegerid OTC)

Compound Drugs

Compound drugs are two or more drugs that a licensed pharmacist combines, mixes or alters the ingredients of a drug to create a medication tailored to the needs of an individual patient. Compound drugs are not approved by the U.S. Food and Drug Administration (FDA) and have not been tested for safety, efficacy or side effects by the FDA. If you are taking a compound drug, ask your doctor if an alternative drug is right for you.

NOTE: The plan will allow for compound medications for children under the age of 13.

HEALTH SAVINGS ACCOUNT (HSA)

The HSA Eligible Plan allows you to contribute to a health savings account (HSA), which allows you to set aside pre-tax dollars from your paycheck and put them into a special savings account that can be used for expenses now, or can be set aside to grow, and be used in retirement. The HSA is administered by Clarity Benefit Solutions. You must be enrolled in the BlueCross BlueShield HSA Eligible Plan in order to participate in the Health Savings Account (HSA).

HSA CONTRIBUTIONS

WISENBAKER Builder Services supports employees participating as active consumers in their medical spending and also believes in saving properly for retirement. Therefore, when employees contribute to their HSA, WISENBAKER Builder Services will contribute monthly to employee HSA's. WISENBAKER Builder Services will match up to **\$650** annually in each employee's HSA. Employees may make additional voluntary contributions to their HSA account up to the total maximum limit allowed by the IRS for that plan year.

IRS Contribution Limits		
	Individual	Family
Employee Eligible Contribution	\$3,500	\$7,650
WISENBAKER Match	\$650	\$650
IRS Total Contribution Limit	\$4,150	\$8,300

NOTE: Employees over age 55 can contribute an additional \$1,000 annually

FAQS

Who is eligible to open an HSA and make contributions?

- You must be enrolled in the WISENBAKER HDHP/HSA Medical Plan through BlueCross BlueShield.
- You must not be covered by another medical plan, unless the other medical plan is an IRS-qualified HDHP.
- You must not be enrolled in Medicare or Tricare.
- You must not be receiving Social Security benefits.
- You cannot be claimed as a dependent on someone else's tax return.

Are there fees associated with Clarity Benefits Solutions HSA?

Yes. Please review information regarding their fees online at www.claritybenefitsolutions.com.

What expenses can I pay with my HSA?

Refer to IRS Publication 502 Medical and Dental Expenses at www.irs.gov for a complete description of eligible medical, dental, and vision expenses.

Is there a penalty for paying for non-qualified medical expenses from my HSA?

Yes, you will be subject to your regular income tax rate and a 20% penalty, unless you are over age 65. If you are over age 65, withdrawal is treated as retirement income and only subject to your regular income tax rate.

If I do not spend all of the money in my HSA, do I lose it?

No, you own the HSA. Any unused funds are yours and roll over each year.

If I leave WISENBAKER, do I lose the money in my HSA?

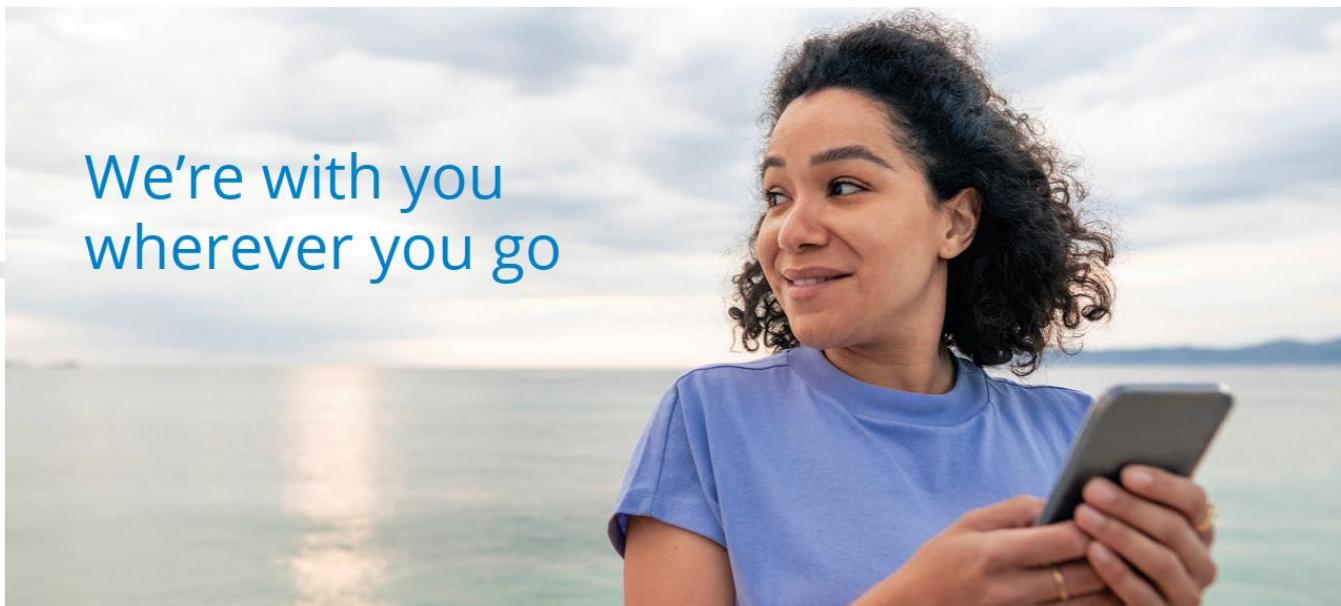
No, you own your HSA and the money is yours.

NOTE: The IRS requires you to remain enrolled in an HSA eligible plan for 12 months following the last month of the year in which you became eligible to open an HSA; otherwise, a prorated contribution amount will be included as income and subject to a 10% additional tax.

Visit www.claritybenefitsolutions.com to learn more about the contribution and withdrawal options available from Clarity Benefit Solutions. If you have questions regarding your HSA, please contact Clarity's Customer Service at 888.423.6359, or visit www.claritybenefitsolutions.com



BlueCross BlueShield of Texas



Download the Blue Cross and Blue Shield of Texas (BCBSTX) App to manage your health wherever you are.

- Find an in-network doctor, hospital or urgent care facility
- Access your claims, coverage and deductible information
- View or print your member ID card
- Log in securely with your fingerprint or face recognition*
- View your Explanation of Benefits

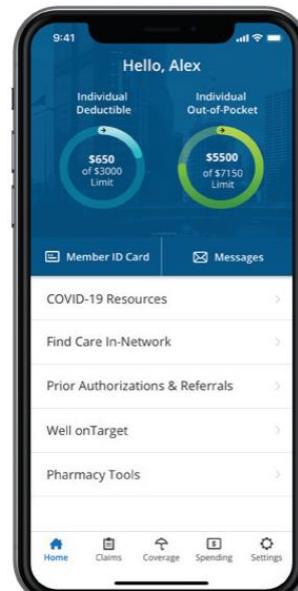
Then, Manage Your Preferences

In the BCBSTX App:

- Update your profile with your mobile number.
- Set your notification preferences to text.

Choose the messages and information you want to get:

- Claims, prior authorization or referral updates
- New documents to review
- Secure message notifications
- Find out about new benefits and services



Available in Spanish

Ready to get started? Text BCBSTXAPP to 33633 to get the app.**



* Availability varies by device.

** Message and data rates may apply. Terms and conditions and privacy policy at bcbstx.com/member/account-access/mobile/text-messaging.

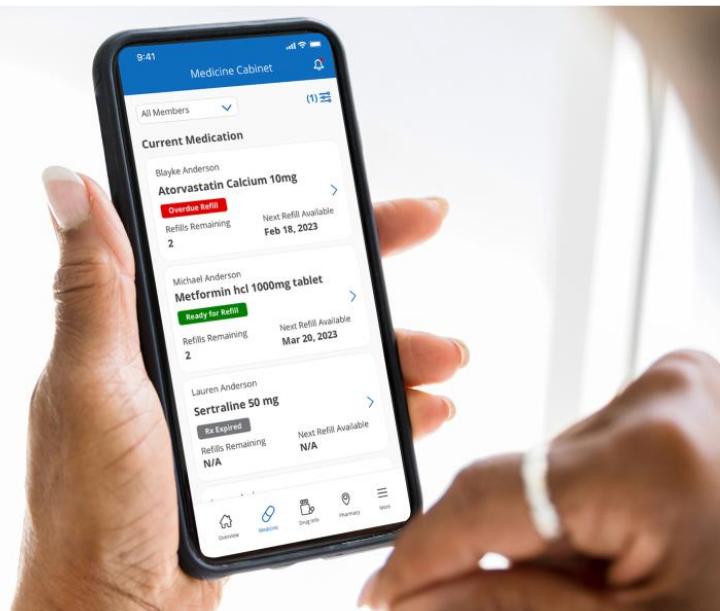
Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation,
a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

727545.0523



BlueCross BlueShield of Texas

Your Virtual Medicine Cabinet Is Here



Save On Prescriptions With Just A few Clicks

MyBlueRxTx is a personalized pharmacy app for Blue Cross and Blue Shield of Texas (BCBSTX) members. We're making it easy to understand and manage prescription drugs and out-of-pocket costs for yourself and your family.

How it works

This app puts your prescription drug information in your hands with features that allow you to:

- Compare drug costs at different pharmacies
- Find available lower-cost drug options
- Manage prescription drug care for your family* (Dependents who are 18 and older can download the app and create their own account)
- Access information about your prescription drugs, including medication details, claims history, coverage, pre-approvals and refills
- Get reminders when it's time to refill a prescription or renew a clinical review approval
- Search for and contact in-network pharmacies

Scan a QR code to download the free app.

Use your Blue Access for MembersSM login, or create an account to get started.



MyBlueRxTx (iOS)



MyBlueRxTx (Android)



* Who are listed as dependents on your BCBSTX plan.
Not all features are available for all plans.

Health Advocate—Group ID: HADV

It's not always easy to access the care your medical insurance provides. That's why your enrollment in WISENBAKER's BCBSTX medical insurance now includes Health Advocate, the nation's leading healthcare advocacy and assistance company. Included at no extra cost, it gives you 24/7 access to Personal Health Advocates who start helping you with your healthcare questions from the first call.

Available as soon as your medical insurance is active, Health Advocate's Personal Health Advocates will help give you peace of mind by being by your side when you need them.

When you call, your Personal Health Advocate can help with the following:

Find doctors, dentists, specialists, hospitals and other providers.

Schedule appointments with providers, including specialists, treatments and tests.

Resolve issues, from claim[s] problems and medical bills to coordinating benefits.

Get help with eldercare issues, including Medicare and related healthcare issues for your parents and parents-in-law.

Transfer medical records more easily with our help; we can also help transfer lab results and x-rays.

Your Advocate works with your insurance companies to get approvals and clarify coverage.

Get answers about your test results, treatments, prescriptions and more.

NEED HELP CUTTING COSTS?

Medical Bill Saver™ is available as soon as your employer sponsored medical coverage starts. It puts an expert negotiator in your corner who will try to help you reduce the medical or dental bills you incur for out-of-network providers or care not covered by your health insurance plan.

Saving on medical bills is easy. Just send in your bill.

- Send in your medical or dental bills of \$400 or more
- Your negotiator will contact the provider to negotiate a discount
- Once an agreement is made, the provider approves payment terms and conditions
- You get an easy-to-read personal Savings Result Statement, summarizing the outcome and payment terms
Call 855.423.8585 to get started today!



**MarshMcLennan
Agency**

Need Additional Help? Marsh & McLennan can help!
Maya Brooks – 713.780.6630

As a WISENBAKER employee, you now have access to medical and behavioral health virtual visits through MDLive, a national telehealth service, as part of your medical plan. Virtual visits are a convenient and affordable option for treating unexpected non-emergency injuries and illnesses. Avoid overcrowded waiting rooms and by-pass the scheduling headache of trying to get in to see your doctor – MDLive gives you access 24 hours, 7 days a week to a U.S. board-certified doctor or therapist through the convenience of phone, video or mobile app visits. Common conditions treatable through virtual visits include the cold or flu, pink eye and sinus infections.

Common conditions treatable through virtual visits include:

Medical:

- Allergies
- Asthma
- Cold/Flu
- Ear problems
- Fever

Behavioral:

- Depression
- Anxiety
- Trauma and PTSD
- ADHD
- Substance use disorders
- Autism Spectrum Disorder

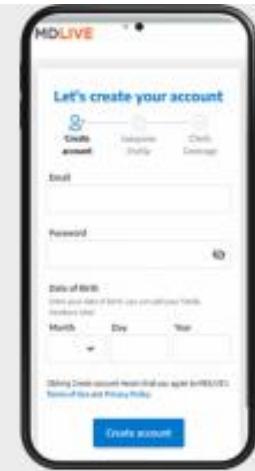
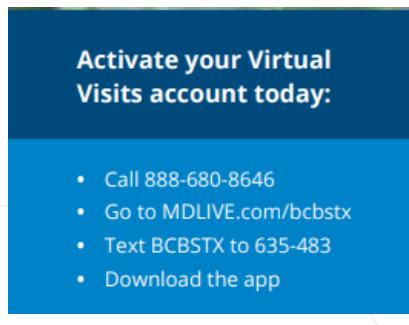
Medical Virtual Visits are covered with a \$30 copay on the PPO plan and are covered up to a \$48 fee on the HDHP. Behavioral Health Virtual Visits are covered with a \$30 copay on the PPO plan and with a \$90-\$150 copay on the HDHP.

Set up your account online or through the MDLive app so that when treatment is needed, a doctor is just a call or click away!

GETTING STARTED

You can access MDLive directly through the HRVū app! After downloading the app or going to mdlive.com/bcbstx you'll set up an account and provide your medical history. **Please have your Health Plan ID Card available.** Your history will give doctors the information they need to provide you with quality medical care. You can add family members to your account to give them around-the-clock care as well.

When you need care, you'll have the option to speak with the first available MDLive doctor or schedule an appointment. Within minutes a doctor will call, ready to listen, diagnose and prescribe medication if necessary. After your consult you have the option to share your results with your primary care physician.



Use the HRVū App
Click-to-Call Feature!

BlueCross BlueShield Value Adds

24/7 NURSELINE

Life is full of ups and downs. You will have access to registered nurses to answer your health questions, 24 hours a day, seven days a week. Get trusted guidance on possible emergency care, urgent care, family care and more.

You can also call the 24/7 Nurseline whenever you or your covered family members need answers to health questions about:

- Asthma
- Back pain
- Diabetes
- Dizziness or severe headaches
- High fever
- A baby's nonstop crying
- Cuts or burns
- Sore throat
- And much more!

Call the 24/7 Nurseline with any health questions at 800.581.0393

Hours of Operation: Anytime

WELL ON TARGET / FITNESS PROGRAM

Wellness is more than healthy eating and working out. It involves making choices that enrich your mind, body and spirit. This program offers personalized tools and resources to help - no matter where you may be on the path to health and wellness. We encourage all members to download the HRVū App and access the Well on Target Wellness Portal (www.wellontarget.com) which is at the heart of this program. You will have access to the Health Assessment and Self-Management Programs on topics such as nutrition, fitness, stress management and tobacco cessation along with the Fitness Program.

Fitness Program

The Fitness Program is a flexible membership program that gives you unlimited access to a nationwide network of fitness centers. With more than 8,000 participating gyms on hand, you can work out at any place or at any time. Choose one gym close to home and another near your office.

There is no long-term contract: Membership is month-to-month. Monthly fees are \$25 per month per member, with a one-time enrollment fee of \$25 per member. Dependents can also be covered at a bundled price discount. You also have a pay as you go option for boutique-style studio classes with 30% off every 10th class. The Fitness Program also offers discounts through the Whole Health Living Choices Program, a nationwide network of health and wellbeing providers, such as acupuncturists, massage therapists and personal trainers. Register at whlchoices.com

To sign up log in to your Blue Access for Members Portal, through the HRVū App. Under "Quick Links," choose "Fitness Program." On this page, you can enroll, search for nearby fitness locations and learn more about the program. Click "Enroll Now." Then search and select the fitness location that is best for you. Remember, you can visit any participating fitness location after you sign up.

Prefer to sign up by phone or have questions about the Fitness Program? Just call 888.762.2583

Blue Points

The Blue Points Program allows you to earn points for wellness activities that can be redeemed in the online BCBS shopping mall for apparel, books, elections, sporting goods and more. You can earn points by completing challenges and tracking physical activity. Joining the fitness program gets you 2,500 points and additional points can be earned for weekly visits that can be tracked with popular fitness devices and mobile apps.

SPECIAL BEGINNINGS / MATERNITY PROGRAM

Expecting a baby? We understand how important having a healthy baby is to you, so BlueCross and BlueShield of Texas offers the confidential Special Beginnings maternity program.

Special Beginnings is designed to help you better understand and manage your pregnancy. You will receive the support you need through every stage of pregnancy, including:

- Pregnancy risk factor identification and ongoing communication/monitoring
- Education material covering pregnancy and infant care topics
- Personal telephone contact with program staff from early pregnancy until six weeks after delivery
- Access to an online resource with maternity tools, articles and information
- Assistance in managing high-risk conditions such as gestational diabetes and preeclampsia

Whether this is your first baby or you have other children, Special Beginnings is a wonderful source of information and support during your pregnancy.

Use the HRVÜ App's Click-to-Call feature, or call 888.421.7781 to enroll. The first step to having a healthy baby is getting prenatal care, so be sure to enroll in Special Beginnings as soon as you find out you are pregnant.

Dental Insurance

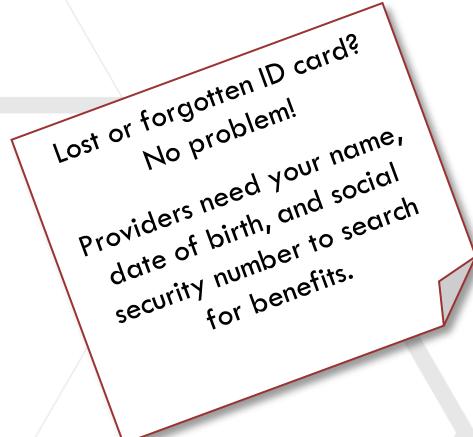
Guardian—Group ID: 00536986

WISENBAKER offers dental insurance, administered through Guardian, and provides you and your family with coverage for typical dental expenses, such as cleanings, x-rays and fillings. A visit to your dentist can help you keep a great smile and prevent many health issues. Dental care can be costly, but Guardian dental insurance will help you pay for it. With access to one of the largest network of dental providers in the country. With the Guardian dental plan, you have the ability to choose from 3 different options - a DHMO, which provides reduced copays for services received in network (Please refer to full plan documents for more information on copays). However, the DHMO provides no access to out-of-network benefits unlike the 2 dental PPO Plans, the PPO MAC plan and PPO Buy Up plan - which pay a portion of the claims for the services rendered.

To find a participating Guardian provider, visit www.guardiananytime.com, click on “Find A Dentist” or call 888.600.1600.

2024 Employee Contribution to Dental Premium						
	DHMO - 00536986		PPO (MAC) - 00536986		PPO (Buy Up Plan) - 00536986	
	Weekly	Bi-Weekly	Weekly	Bi-Weekly	Weekly	Bi-Weekly
Employee Only	\$2.25	\$4.50	\$4.61	\$9.22	\$7.97	\$15.95
Employee + Spouse	\$3.90	\$7.80	\$9.36	\$18.71	\$16.18	\$32.37
Employee + Child(ren)	\$5.87	\$11.74	\$13.01	\$26.01	\$20.11	\$40.22
Employee + Family	\$7.04	\$14.08	\$19.05	\$38.09	\$30.19	\$60.38

	DHMO	PPO MAC Plan	PPO Buy Up Plan
Network	Managed Dental Guard	Dental Guard Preferred	Dental Guard Preferred
Office Copay	\$5 Copay	N/A	N/A
Annual Deductible	N/A	\$50 Individual \$150 Family	\$50 Individual \$150 Family
Annual Benefit Maximum	N/A	\$1,000 per Member	\$2,500 per Member
Preventive Services	Copays Apply	100% Covered; Deductible Waived	100% Covered; Deductible Waived
Basic Services		You pay 20%	You pay 20%
Major Services		You pay 50%	You pay 50%
Orthodontia	\$2,500-2,800 Copay (Adults and Children under age 26)	You pay 50% up to \$1,000 Lifetime Maximum (Children under age 26)	You pay 50% up to \$1,000 Lifetime Maximum (Children under age 26)
Out-of-Network Reimbursement	No Coverage	Maximum Allowable Charge	90 th Percentile



Dental Max Rollover

Save Your Unused Claims Dollars for When You Need Them the Most

For employees enrolled in one of the Dental PPO (MAC and Buy Up) Plans - Guardian will roll over a portion of your unused annual maximum into your personal Maximum Rollover Account (MRA). If you reach your Plan Annual Maximum in future years, you can use money from your MRA. To qualify for an MRA, you must have a paid claim (not just a visit) and must not have exceeded the paid claims threshold during the benefit year. Your MRA may not exceed the MRA limit. You can view your annual MRA statement detailing your account and those of your dependents on www.guardiananytime.com.

	Plan Annual Maximum	Threshold	Maximum Annual Rollover	Maximum Rollover Account Limit
Description	Maximum claims reimbursement	Claims amount that determines rollover eligibility	Additional dollars added to Plan Annual Amount Maximum for future years	Overall maximum dollars added to Plan Annual Amount
PPO MAC Plan	\$1,000	\$500	\$250	\$1,000
PPO Buy-Up Plan	\$2,500	\$900	\$450	\$1,500

Here's how the benefits work:

- **YEAR ONE:** Jane starts with a \$2,500 Plan Annual Maximum on the PPO Buy-Up Plan. She submits \$600 in dental claims. Since she did not reach the \$900 threshold, she receives a \$450 rollover that will be applied to Year Two.
- **YEAR TWO:** Jane now has an increased Plan Annual Maximum of \$2,950. This year, she submits \$50 in claims and receives an additional \$450 rollover added to her Plan Annual Maximum.
- **YEAR THREE:** Jane now has an increased Plan Annual Maximum of \$3,400. This year, she submits \$2,000 in claims. All claims are paid due to the amount accumulated in her Maximum Rollover Account.
- **YEAR FOUR:** Jane's Plan Annual Maximum is \$3,900 (\$2,500 Plan Annual Maximum + \$1,400 remaining in her Maximum Rollover Account).

Vision Insurance

Guardian—Group ID: 00536986

WISENBAKER offers vision insurance administered by Guardian and provides access to preventive care, such as regular eye exams, and offers coverage for corrective vision materials, including glasses and contact lenses.

Eye care is a vital component of a healthy lifestyle. With vision insurance, having regular exams and purchasing contacts or glasses is simple and affordable. The coverage is inexpensive, yet the benefits can be significant! Guardian provides a rich, flexible plan that allows you to safeguard your health while saving you money. Review your plan options and see why vision insurance may be a great benefit for you. Significant out-of-pocket savings available with your Vision plan by visiting one of the Davis Vision network locations. To find a participating Davis Vision provider, visit www.guardiananytime.com, click on "Find A Provider" or call 888.600.1600.

2024 Employee Contribution to Vision Premium		
Vision PPO - 00536986		
	Weekly	Bi-Weekly
Employee Only	\$1.26	\$2.52
Employee + Spouse	\$2.40	\$4.80
Employee + Child(ren)	\$2.52	\$5.04
Employee + Family	\$3.71	\$7.42

	In-Network	Out-of-Network (Plan Allowance)
Network	Davis Vision Network	N/A
Eye Exam [every calendar year]	\$10 Copay	Up to \$50
Materials	\$25 Copay	N/A
Standard Plastic Lenses [every calendar year]	\$0	Single Vision: Up to \$48 Bifocal: Up to \$67 Trifocal: Up to \$86
Frames [every two calendar years]	20% discount over \$130 allowance	Up to \$48
Contact Lenses [every calendar year] (in lieu of glasses & frames)	15% discount over \$130 allowance	Up to \$105

Lost or forgotten ID card?
No problem!

Providers need your name,
date of birth, and social
security number to search
for benefits.



Guardian Anytime

Guardian Anytime Registration



Register on Guardian Anytime today

Take advantage of self-service to access and manage your Guardian coverage

In response to the coronavirus, Guardian is working to minimize service disruption that could include longer wait times and delays. In addition, the explanation of benefits (EOB) on dental claims will now be delivered electronically using Guardian Anytime.

Now more than ever, our self-service options will save you time and keep you informed. We urge you to register on Guardian Anytime today.

Registering is easy

View this [how-to video](#) or follow these simple instructions.

- 1 Go to our [self-registration page](#) (guardianlife.com/login) and choose **Member** as your User Role.
 - Note, if you are registering as a dependent, you'll need the Member's Group ID Number(s) and Social Security Number.
- 2 Fill in your member information and Group ID Number(s) provided in this flyer. If you don't see a Group ID Number, contact your HR Department or Plan Administrator (you'll need it to register).
- 3 Create a username and password, click **Submit**, and you're done.

Already registered? [Log in](#) to your account anytime.

Your Guardian Group ID Number(s):

If more than one number is listed, enter all numbers when you register.

00536986

Services available to you on Guardian Anytime

- Submit claims and track status (except for Life products) including receiving email alerts when dental claims are paid
- View EOB for all of your dental services
- View your summary of benefits
- Find dental cost estimates and educational information
- Check status of evidence of insurability
- Print dental ID card and access forms and materials related to your coverage

The Guardian Life Insurance
Company of America
New York, NY

guardianlife.com

2020-98735 (04-21)

The Guardian Life Insurance Company of America (Guardian), New York, NY GUARDIAN® is a registered trademark of The Guardian Life Insurance Company of America®

Notes

Life Insurance

Guardian—Group ID: 00536986

WISENBAKER offers Life and Accidental Death and Dismemberment (AD&D) insurance coverage to provide financial protection in the event you or your dependents die while you are still working. This coverage is administered through Guardian.

GROUP LIFE INSURANCE + ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

WISENBAKER provides Group Life Insurance + AD&D for all active, full-time employees enrolled in the company sponsored medical insurance. The Group Life Insurance + AD&D benefit is in the amount of \$50,000, and is provided at no cost to eligible employees.

NOTE: Group Life Benefits reduce by 33% at age 65 and 55% at age 70.

VOLUNTARY LIFE INSURANCE + AD&D

WISENBAKER offers the option to purchase Voluntary Life Insurance for yourself, your spouse and your dependent children. However, you may only elect coverage for your dependents if you enroll for Voluntary Life coverage for yourself. You pay for the cost of Voluntary Life Insurance on an after-tax basis through payroll deductions.

Voluntary Life Insurance for yourself is available in \$10,000 increments, and cannot exceed \$500,000. You may elect up to \$150,000 without providing evidence of insurability (answering health related underwriting questions) during your initial enrollment. The AD&D benefit amount is equal to the life insurance benefit amount elected.

DEPENDENT VOLUNTARY LIFE INSURANCE + AD&D

If you select Voluntary Life Insurance for yourself, you may also elect coverage for your dependents. You may elect life insurance for your spouse in increments of \$5,000, up to 100% of your (the employee's) benefit amount or \$250,000 (whichever is less). The guaranteed issue is up to \$50,000 without providing evidence of insurability during your initial enrollment. The AD&D benefit amount is equal to the life insurance benefit amount elected.

Your child(ren), ages 14 days to 26 years may be covered for \$5,000 or \$10,000. Evidence of insurability is required for children only if enrolling outside of the initial eligibility period. The AD&D benefit amount is equal to the life insurance benefit amount elected.

NOTE: Voluntary Life Benefits reduce by 33% at age 65 and 55% at age 70. Spouse coverage terminates at age 70.

BENEFICIARY DESIGNATION

You must designate a beneficiary for all Life Insurance benefits when you enroll. Your "beneficiary" is the person(s) who will receive the benefits from your life + AD&D coverage in the event of your death. You are always the beneficiary of any dependent life + AD&D insurance you elect. You can change your beneficiaries at any time during the year. If you do not name a beneficiary, or if your beneficiary dies before you, your life + AD&D benefits will be paid to your estate.

VOLUNTARY LIFE INSURANCE RATES CHART

Monthly Premium Cost – Employee & Spouse* Life/ADD											
Benefit Amount	<20	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69
\$10,000	\$0.80	\$0.80	\$0.80	\$1.00	\$1.30	\$2.00	\$2.90	\$4.40	\$7.60	\$13.60	\$22.20
\$20,000	\$1.60	\$1.60	\$1.60	\$2.00	\$2.60	\$4.00	\$5.80	\$8.80	\$15.20	\$27.20	\$44.40
\$30,000	\$2.40	\$2.40	\$2.40	\$3.00	\$3.90	\$6.00	\$8.70	\$13.20	\$22.80	\$40.80	\$66.60
\$40,000	\$3.20	\$3.20	\$3.20	\$4.00	\$5.20	\$8.00	\$11.60	\$17.60	\$30.40	\$54.40	\$88.80
\$50,000	\$4.00	\$4.00	\$4.00	\$5.00	\$6.50	\$10.00	\$14.50	\$22.00	\$38.00	\$68.00	\$111.00
\$60,000	\$4.80	\$4.80	\$4.80	\$6.00	\$7.80	\$12.00	\$17.40	\$26.40	\$45.60	\$81.60	\$133.20
\$70,000	\$5.60	\$5.60	\$5.60	\$7.00	\$9.10	\$14.00	\$20.30	\$30.80	\$53.20	\$95.20	\$155.40
\$80,000	\$6.40	\$6.40	\$6.40	\$8.00	\$10.40	\$16.00	\$23.20	\$35.20	\$60.80	\$108.80	\$177.60
\$90,000	\$7.20	\$7.20	\$7.20	\$9.00	\$11.70	\$18.00	\$26.10	\$39.60	\$68.40	\$122.40	\$199.80
\$100,000	\$8.00	\$8.00	\$8.00	\$10.00	\$13.00	\$20.00	\$29.00	\$44.00	\$76.00	\$136.00	\$222.00
\$110,000	\$8.80	\$8.80	\$8.80	\$11.00	\$14.30	\$22.00	\$31.90	\$48.40	\$83.60	\$149.60	\$244.20
\$120,000	\$9.60	\$9.60	\$9.60	\$12.00	\$15.60	\$24.00	\$34.80	\$52.80	\$91.20	\$163.20	\$266.40
\$130,000	\$10.40	\$10.40	\$10.40	\$13.00	\$16.90	\$26.00	\$37.70	\$57.20	\$98.80	\$176.80	\$288.60
\$140,000	\$11.20	\$11.20	\$11.20	\$14.00	\$18.20	\$28.00	\$40.60	\$61.60	\$106.40	\$190.40	\$310.80
\$150,000	\$12.00	\$12.00	\$12.00	\$15.00	\$19.50	\$30.00	\$43.50	\$66.00	\$114.00	\$204.00	\$333.00
\$200,000	\$16.00	\$16.00	\$16.00	\$20.00	\$26.00	\$40.00	\$58.00	\$88.00	\$152.00	\$272.00	\$444.00
\$250,000	\$20.00	\$20.00	\$20.00	\$25.00	\$32.50	\$50.00	\$72.50	\$110.00	\$190.00	\$340.00	\$555.00
\$300,000	\$24.00	\$24.00	\$24.00	\$30.00	\$39.00	\$60.00	\$87.00	\$132.00	\$228.00	\$408.00	\$666.00
\$350,000	\$28.00	\$28.00	\$28.00	\$35.00	\$45.50	\$70.00	\$101.50	\$154.00	\$266.00	\$476.00	\$777.00
\$400,000	\$32.00	\$32.00	\$32.00	\$40.00	\$52.00	\$80.00	\$116.00	\$176.00	\$304.00	\$544.00	\$888.00
\$450,000	\$36.00	\$36.00	\$36.00	\$45.00	\$58.50	\$90.00	\$130.50	\$198.00	\$342.00	\$612.00	\$999.00
\$500,000	\$40.00	\$40.00	\$40.00	\$50.00	\$65.00	\$100.00	\$145.00	\$220.00	\$380.00	\$680.00	\$1,110.00

* Spouse premium based on employee's age.

Monthly Premium Cost – Child(ren) Life/ADD

\$5,000		\$1.06
\$10,000		\$2.12

Employee Assistance Program

Guardian offers an Employee Assistance Program (EAP) called UpriseHealth. Employees and their immediate family members may obtain completely confidential counseling for such matters as marital and family concerns, depression, substance abuse, grief and loss, financial difficulties and other matters causing personal stress.

UpriseHealth Employee Assistance Program offers services to help promote well-being and enhance the quality of life for you and your family.

Employee Assistance Program (EAP) Overview

CONSULTATIVE SERVICES

- Telephonic Counseling: unlimited, 24/7 consultations with master's and doctoral-level counselors
- Face-to-face counseling: up to 3 visits per employee/household member per year
- Bereavement: support available through telephonic or face-to-face sessions; online resources available on EAP website
- Tobacco Cessation Coaching: unlimited telephonic support and resources to assist with tobacco cessation; refers members directly to the American Lung Association's Quit program
- EAP Website Resources: comprehensive website that includes articles, videos, FAQs, etc.; additionally, individuals can chat online with an EAP consultant or email an EAP counselor through the website

WORK/LIFE ASSISTANCE & RESOURCES

- Work/Life Services: unlimited 24/7 access to Work/Life specialists (subject matter experts) in the areas of: family and care giving, health and wellness, emotional wellbeing, daily living, balancing work and life responsibilities.
- Child and Elder Care Referral: unlimited telephonic consultation with a Work/Life specialist (part of Work/Life services)
- Employee Discounts: access to discounts on a large number of products and services, from gym memberships to dental, vision and pharmacy items, entertainment, restaurants, computers, cars, and much more.
- Webinars, podcasts, articles and FAQs: Various topics available on the EAP website

LEGAL/FINANCIAL ASSISTANCE & RESOURCES

- Legal Consultation: unlimited telephonic support and free initial 30-minute face-to-face consultation with an attorney, with a 25% discount on attorney services thereafter; online legal forms; extensive online law library
- Financial Consultation: unlimited telephonic support for financial problems or planning needs; 30 days of financial coaching; extensive online financial library and calculators
- ID Theft: free consultation with a trained Fraud Resolution Specialist that will assist with ID theft resolution and education; ID theft educational materials available online
- Will Prep: online self-service documents available on EAP website; 30-minute consultation (part of Legal Consultation offering) can be used for estate planning/will preparation
- Legal Document Preparation: online self-service documents available on the EAP website
- Tax Consultation: tax questions only can be answered as part of the Financial Consultation offering
- Online self-service documents: examples include, but are not limited to: living trust, will, power of attorney, deeds

CONNECT TO A COUNSELOR FOR FREE SUPPORT SERVICES



**Use the HRVū App
Click-to-Call Feature!**

Phone: 800.386.7055 (available 24 hours a day, 7 days a week)
Web: worklife.uprisehealth.com | Access Code: worklife

Short-Term Disability (STD) Insurance

Guardian—Group ID: 00536986

WISEBAKER offers two voluntary disability plans. Guardian administers both the Voluntary Short-Term Disability (STD) plan as well as the Voluntary Long-Term Disability (LTD) plan, which can be found on the next page.

Employees that have worked for WISEBAKER for 5 or more consecutive years will receive the above mentioned Short-Term Disability plan at no cost. Please see HR for more information.

If you are disabled (Disabled means that, solely because of a covered injury or sickness, you are unable to perform the material duties of your regular occupation and you are unable to earn 80% or more of your covered earnings from working in your regular occupation) for 7 days from either accident or sickness, you may be eligible for STD benefits.

This plan pays a benefit up to a maximum of \$1,000 per week. Benefit cannot exceed 60% of your weekly covered earnings (Covered earnings means your wages or salary, not including bonuses, or other extra compensation other than commissions).

Once you qualify for benefits under this plan, you continue to receive them until the end of the 25-week benefit period, or until Long-Term Disability (LTD) begins, if purchased, whichever occurs first.

NOTE: Your benefit will be based on your salary as of April 1, 2024. If your salary changes after April 1, 2024 your short term disability benefit will not increase until our next renewal on April 1, 2025.

Monthly Premium Rate per \$10 – Short-Term Disability	
Age	Rate
<20	\$0.619
20-24	\$0.621
25-29	\$0.652
30-34	\$0.592
35-39	\$0.551
40-44	\$0.542
45-49	\$0.569
50-54	\$0.691
55-59	\$0.902
60+	\$1.121

NOTE: Pre-Existing Condition Limits apply. This policy will not cover any disabilities during the first 12 months after the effective date that is caused by a condition for which you sought treatment during the 3 months prior to the effective date of coverage.

Long-Term Disability (LTD) Insurance

Guardian—Group ID: 00536986

WISENBAKER offers two voluntary disability plans. Guardian administers both the Voluntary Short-Term Disability (STD) plan as well as the Voluntary Long-Term Disability (LTD) plan—which can be found below.

Employees that have worked for WISENBAKER for 5 or more consecutive years will receive the above mentioned Long-Term Disability plan at no cost. Please see HR for more information.

If you are disabled for 180 days, you may be eligible for LTD benefits.

This plan pays a benefit of up to 60% of your basic monthly earnings (Basic monthly earnings means your wages or salary, not including bonuses, and other extra compensation) to a maximum of \$7,000 per month.

Once you qualify for benefits under this plan, you continue to receive them until the end of the benefit period, or until you no longer qualify for benefits, whichever occurs first. Your benefit period begins on the first day after you complete your elimination period.

NOTE: Your benefit will be based on your salary as of April 1, 2024. If your salary changes after April 1, 2024 your long term disability benefit will not increase until our next renewal on April 1, 2025.

Monthly Premium Rate per \$100 – Long-Term Disability	
Age	Rate
<20	\$0.060
20-24	\$0.082
25-29	\$0.148
30-34	\$0.224
35-39	\$0.323
40-44	\$0.491
45-49	\$0.717
50-54	\$0.778
55-59	\$1.185
60+	\$0.852

NOTE: Pre-Existing Condition Limits apply. This policy will not cover any disabilities during the first 12 months after the effective date that is caused by a condition for which you sought treatment during the 3 months prior to the effective date of coverage.



Download the HRVU app today!

Supplemental Insurance

Aflac—Group ID: 22665

WISENBAKER offers three supplemental insurance plans administered by Aflac. Marketed through the workplace, Aflac provides innovative insurance solutions. Multiple products are offered so that you may pick and choose the policies that most effectively meet your unique insurance needs. In addition, all plans are offered on a voluntary basis so you can purchase only those products you feel will benefit you and your family.

You may choose to enroll in one of the offered plans or all of the offered plans.

These plans **PAY YOU** directly in the event you have an eligible claim.



Aflac Representative – Crystal Mulville | (832) 257-6201 | crystal_mulville@us.aflac.com

Group Accident
Insurance

Critical Illness
with Cancer

Group Hospital
Enhancement

PRODUCT FEATURES:

- Payroll Deduction: Premiums are paid through the convenience of payroll deduction.
- Pre-Tax: Most plans can be paid for pre-tax through a Section 125 plan.
- Pays in addition to other insurance: Benefits are paid in addition to any other insurance coverage you may have.
- Pays Policyholder: Benefits are paid directly to you unless assigned to a health care provider.
- Portable: These policies are individually owned and portable so you may convert your policy to a direct payment method with no increase in premium if your employment is terminated.
- Guaranteed Renewable: The plans are guaranteed renewable for the life of the policy as long as premium payments are maintained.

Aflac—Group ID: 22665

In the event of a covered accident, the plan pays cash benefits fast to help with the costs associated with out-of-pocket expenses and bills—expenses major medical may not take care of, including:

- Ambulance rides
- Emergency room visits
- Surgery and anesthesia
- Prescriptions
- Major Diagnostic Testing
- Burns
- Hospitalization

PLAN FEATURES:

- Benefits are paid to you unless otherwise assigned.
- Coverage is guaranteed-issue regardless of health.
- Benefits are paid regardless of any other medical insurance.
- Wellness benefit paid each year.

Accident Rates		
	Weekly	Bi-Weekly
Employee Only	\$4.53	\$9.07
Employee + Spouse	\$6.80	\$13.59
Employee + Child(ren)	\$7.95	\$15.90
Employee + Family	\$10.21	\$20.42

Benefits Summary ¹			
Medical Fee	\$125 for initial treatment visit to a Doctor or Urgent Care Center		
Hospital Admission	\$1,000 per year	Lacerations	
Hospital Confinement	\$200 per day	Under 2 inches long	\$50
Hospital Intensive Care Unit	\$400 per day	2 to 6 inches long	\$200
Family Member Lodging	\$100 per day	Over 6 inches long	\$400
Emergency Room	\$200	Lacerations not requiring stitches	\$25
Ambulance	\$200 Ground \$1,000 Air	Fractures	Up to \$4,000 based on a schedule
Emergency Room Observation	\$100 each 24-hour period	Dislocations	Up to \$3,000 based on a schedule
Major Diagnostic Testing	\$200	Transportation	\$300 Plane/Train \$150 Bus
Appliances (Cane, Ankle Brace, Walking Boot, Walker, Crutches, Leg Brace, Cervical Collar)	\$100	Accident Follow-Up Treatment	\$30 per day up to six visits
Physical Therapy	\$30 per day up to six visits	Wellness Rider	\$50
Paralysis		Accidental Death	\$50,000 Employee
Paraplegia	\$5,000		\$25,000 Spouse
Quadriplegia	\$10,000		\$5,000 Child

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Aflac—Group ID: 22665

Having group critical illness insurance from Aflac means that you may have added financial resources to help with medical costs or ongoing living expenses. Employees are eligible for coverage up to \$20,000 with approved underwriting.

PLAN FEATURES:

- Benefits are paid directly to you, unless you choose otherwise.
- Spouse is eligible to sign up for 50% of what the employee chooses.
- Coverage may be continued (with certain stipulations). That means you can take it with you if you change jobs or retire.
- Children under 26 are covered at 50% of the Employee's benefit at no additional cost.

WEEKLY RATES

Employee			Spouse								
Non-Tobacco		Tobacco	Non-Tobacco		Tobacco						
Issue Age	\$10,000	\$20,000	Issue Age	\$10,000	\$20,000	Issue Age	\$5,000	\$10,000	Issue Age	\$5,000	\$10,000
18-29	\$1.90	\$3.03	18-29	\$2.36	\$3.95	18-29	\$0.91	\$1.48	18-29	\$1.14	\$1.94
30-39	\$2.61	\$4.46	30-39	\$3.65	\$6.53	30-39	\$1.27	\$2.19	30-39	\$1.79	\$3.23
40-49	\$4.37	\$7.97	40-49	\$6.43	\$12.09	40-49	\$2.15	\$3.95	40-49	\$3.18	\$6.01
50-59	\$7.79	\$14.82	50-59	\$12.11	\$23.45	50-59	\$3.86	\$7.37	50-59	\$6.02	\$11.69
60+	\$14.23	\$27.69	60+	\$21.78	\$42.79	60+	\$7.08	\$13.81	60+	\$10.85	\$21.36

BI-WEEKLY RATES

Employee			Spouse								
Non-Tobacco		Tobacco	Non-Tobacco		Tobacco						
Issue Age	\$10,000	\$20,000	Issue Age	\$10,000	\$20,000	Issue Age	\$5,000	\$10,000	Issue Age	\$5,000	\$10,000
18-29	\$3.80	\$6.06	18-29	\$4.72	\$7.90	18-29	\$1.83	\$2.96	18-29	\$2.29	\$3.88
30-39	\$5.23	\$8.91	30-39	\$7.30	\$13.05	30-39	\$2.54	\$4.39	30-39	\$3.58	\$6.46
40-49	\$8.74	\$15.93	40-49	\$12.86	\$24.19	40-49	\$4.30	\$7.90	40-49	\$6.36	\$12.02
50-59	\$15.59	\$29.63	50-59	\$24.22	\$46.90	50-59	\$7.72	\$14.75	50-59	\$12.04	\$23.38
60+	\$28.46	\$55.39	60+	\$43.56	\$85.58	60+	\$14.16	\$27.62	60+	\$21.71	\$42.72

Benefit Summary²

100%	25%
Cancer, Heart Attack, Stroke, Major Organ Transplant, Kidney Failure, Bone Marrow Transplant, Sudden Cardiac Arrest, Severe Burn, Coma or Paralysis, Loss of Sight, Hearing, or Speech; Benign Brain Tumor, Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's Disease)	Non-Invasive Cancer, Coronary Artery Bypass Surgery, Advanced Alzheimer's or Parkinson's Disease, Sustained Multiple Sclerosis

Initial Diagnosis – Aflac will pay a lump sum benefit upon initial diagnosis of a covered critical illness when such diagnoses is caused by or solely attributed to an underlying disease. Cancer diagnoses are subject to the cancer diagnosis limitation.

Additional Diagnosis - Aflac will pay benefits for each different critical illness after the first when the two dates of diagnoses are separated by at least 6 consecutive months, and the new critical illness is not contributed to or caused by a critical illness for which benefits have been paid.

Reoccurrence - Aflac will pay benefits for the same critical illness after the first when the two dates of diagnoses are separated by at least 6 consecutive months, and the new critical illness is not contributed to or caused by a critical illness for which benefits have been paid.

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Aflac—Group ID: 22665

Your health insurance plan may pay only a portion of the total expenses of a hospital stay or medical treatment. That likely would leave the rest of the bill for you to pay, plus any deductible or other expenses that are not covered by the plan. As a result, you could incur significant out-of-pocket expenses if you or a family member were hospitalized. This plan can help cover those expenses.

PLAN FEATURES:

- Benefits are paid directly to you unless otherwise assigned.
- Coverage is guaranteed-issue regardless of health.
- Benefits are paid regardless of any other medical insurance.

Hospital Rates		
	Weekly	Bi-Weekly
Employee Only	\$8.15	\$16.29
Employee + Spouse	\$15.42	\$30.83
Employee + Child(ren)	\$12.26	\$24.52
Employee + Family	\$19.53	\$39.06

Benefit Summary ³	
Hospital Admission Once per covered sickness or accident per calendar year	\$2,000 per confinement
Hospital Confinement Maximum confinement period: 31 days per covered sickness or covered accident	\$200 per day
Hospital Intensive Care Maximum confinement period: 10 days per covered sickness or covered accident	\$200 per day
Intermediate Intensive Care Step-Down Maximum confinement period: 10 days per covered sickness or covered accident	\$100 per day

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TransAmerica—Group ID: ER00038180

While we all know that life insurance helps protect our loved ones for the long term, sometimes we don't consider that there are other benefits of a life insurance plan as well.

Priced to fit most budgets, Transamerica Universal Life insurance can give your family a financial cushion when they need it. In addition, unlike some kinds of life insurance, a universal life insurance plan won't be cancelled just because you reach a certain age.

What you may not realize is that in addition to offering valuable life insurance protection, Transamerica Universal Life insurance contains a Daily Living Benefit providing you direct income to help you with expenses associated with Long Term Care and Assisted Living. You don't have to use up your savings, 401k, or leave your medical care expenses in the hands of your children. You also now get the power to choose where you receive coverage even if it's at home with a family member taking care of you.

TransAmerica enrollment will be completed on paper forms; contact your HR representative for more information.

PLAN FEATURES:

- Guaranteed issue with no medical questions up to \$150,000
- No pre-existing condition limitations
- Spouse and Children coverage available
- Layoff premium protection
- Fully portable at the same rates

Benefit Summary ⁴		
	Coverage Amount	Example
Universal Life Face Amount	\$10,000 - \$300,000	\$100,000
Living Benefit Rider	4% of Face amount chosen paid out per month for 25 months	\$4,000 per month
Extension of Living Benefit Rider	Additional 25 months of Face Amount paid if needed	\$4,000 per month
Total Living Benefit Available	The total benefit is available as needed along with doctor's approval	\$200,000
Paid Up Life Insurance	If Extension of Benefits Rider is initiated for use, the face amount of the life insurance resets to 25%	\$25,000

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401(k) & Financial wellness

Principal—Plan ID: 345395

WISENBAKER offers a 401(k) plan administered by Principal that is available to eligible employees after completing 60 days of service. You may enroll starting the first of the month on or after meeting eligibility requirements.

Ready to take the next step? Enroll today by visiting www.principal.com/Welcome or text ENROLL to 78259

If you need assistance with enrollment, changing your elections, or any other general questions about your 401(k) account, you can speak with a licensed Principal Representative by calling 800-547-7754 Monday through Friday, 7 a.m. to 9 p.m. Central.

Principal Retire SecureSM

Need help deciding how much to save or how to invest for retirement? Principal offers one-on-one virtual meetings with a licensed financial representative to help you get on track to reach your retirement goals, and they can even assist with other financial topics beyond the 401(k) plan as well.

SERVICE FEATURES:

- Personalized, ongoing meetings with a retirement professional
- Easy to schedule at your own convenience
- No additional cost to you

Sign up for your retirement planning meeting today by visiting www.principal.com/virtual1on1

401(k) Plan Details

Please note that if you take no action, you will be automatically enrolled at pre-tax rate of 3% approximately 30-45 days after you become eligible. If you are automatically enrolled into the plan, your contribution rate will also automatically increase by 1% each year until you reach 10%.

If you would like to choose your own contribution rate, you may contribute up to 100% of your paycheck, not to exceed the annual IRS limits, which is \$23,000 for 2024. If you are at least age 50, you are eligible to make additional catch-up contributions up to \$7,500 (\$30,500 total) for 2024. You may elect to make your contributions on a Pre-Tax (tax-deferred) and/or Roth (post-tax) basis. WISENBAKER may also make a discretionary matching contribution into your retirement account on your behalf, in which you will be 100% vested after working 6 years of service.

Whether you get automatically enrolled or go through the enrollment process on your own, please be sure to complete the following steps to help keep your account secure:

1. Register your account online at <http://www.principal.com/Welcome>
2. Set up multifactor authentication
3. Regularly review your account activity at least quarterly
4. Consider changing your password at least annually

Want more info on the
401(k) plan? Check out
our Plan Resource
Center



For 401(k) assistance call Principal at 800-547-7754

You can also access your account on the go through Principal's mobile app!

Glossary of Health Coverage and Medical Terms

- This glossary has many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- **Bold blue** text indicates a term defined in this Glossary.
- See page 4 for an example showing how **deductibles**, **co-insurance** and **out-of-pocket limits** work together in a real life situation.

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

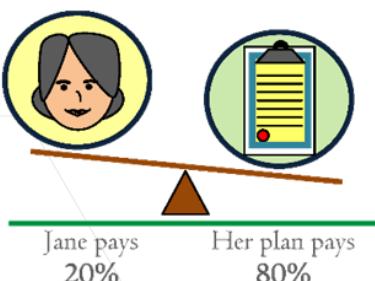
A request for your health insurer or **plan** to review a decision or a **grievance** again.

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 for covered services.

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** (See page 4 for a detailed example.) 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.

Complications of Pregnancy

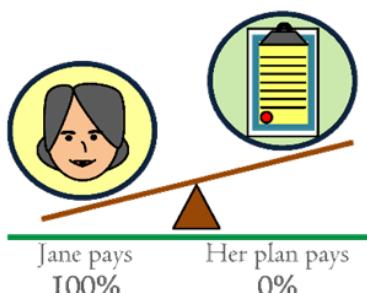
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

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.



(See page 4 for a detailed example.)

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 you get 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, condition, 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

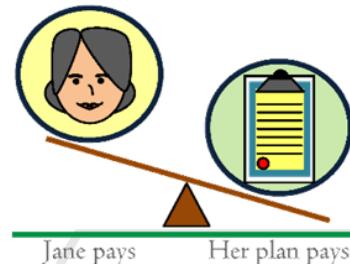
The percent (for example, 40%) you pay of the **allowed amount** for covered health care services to providers who do **not** contract with your **health insurance** or **plan**. Out-of-network co-insurance usually costs you more than **in-network co-insurance**.

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 co-payments**.

Out-of-Pocket Limit

The most you pay during a 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.



(See page 4 for a detailed example.)

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.

Preatuthorization

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. Preatuthorization 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 monthly, quarterly or 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**.

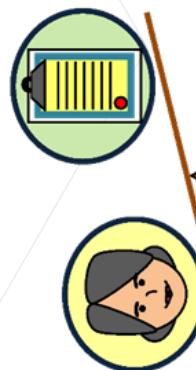
How You and Your Insurer Share Costs - Example

Jane's Plan Deductible: \$1,500 Out-of-Pocket Limit: \$5,000

Co-insurance: 20%

January 1st
Beginning of Coverage
Period

December 31st
End of Coverage Period



Jane pays
100%
Her plan pays
0%

48

Jane hasn't reached her \$1,500 deductible yet

Her plan doesn't pay any of the costs.
Office visit costs: \$125
Jane pays: \$125
Her plan pays: \$0

more
costs

Jane pays
100%
Her plan pays
0%

more
costs

Jane pays
20%
Her plan pays
80%

more
costs

Jane pays
0%
Her plan pays
100%

more
costs

Jane reaches her \$1,500 deductible, co-insurance begins

Jane has seen a doctor several times and paid \$1,500 in total. Her plan pays some of the costs for her next visit.

Office visit costs: \$75
Jane pays: 20% of \$75 = \$15
Her plan pays: 80% of \$75 = \$60

Jane reaches her \$5,000 out-of-pocket limit

Jane has seen the doctor often and paid \$5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.

Office visit costs: \$200
Jane pays: \$0
Her plan pays: \$200

more
costs



Important Notices

MEDICARE PART D CREDITABLE COVERAGE NOTICE

**Important Notice from Wisenbaker
About Your Prescription Drug Coverage and Medicare
BCBSTX HSA—165181 & PPO—165180**

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Wisenbaker has determined that the prescription drug coverage offered by the BCBSTX HSA—165181 & PPO—165180 is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

If you decide to join a Medicare drug plan while enrolled in Wisenbaker coverage as an active employee, please note that your Wisenbaker coverage will be the primary payer for your prescription drug benefits and Medicare will pay secondary. As a result, the value of your Medicare prescription drug benefits will be significantly reduced. Medicare will usually pay primary for your prescription drug benefits if you participate in Wisenbaker coverage as a former employee.

You may also choose to drop your Wisenbaker coverage. If you do decide to join a Medicare drug plan and drop your current Wisenbaker coverage, be aware that you and your dependents may not be able to get this coverage back.

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

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

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

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

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Wisenbaker changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

Date: 04/01/2024

Name of Entity/Sender: WISENBAKER BUILDER SERVICES, INC.

Contact--Position/Office: DEBORAH VILLAREAL

Address: 1703 WESTFIELD LOOP, HOUSTON, TX 77073

Phone Number: 281-220-3965

HIPAA Special Enrollment Rights Notice

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

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

Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or a State health insurance ("CHIP") program, or when you and/or your dependents gain eligibility for state premium assistance. You have 60 days from the occurrence of one of these events to notify the company and enroll in the plan.

To request special enrollment or obtain more information, contact

DEBORAH VILLAREAL, WISENBAKER BUILDER SERVICES, INC. 1703 WESTFIELD LOOP, HOUSTON, TX 77073, 281-220-3965

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

WISENBAKER BUILDER SERVICES, INC. sponsors certain group health plan(s) (collectively, the "Plan" or "We") to provide benefits to our employees, their dependents and other participants. We provide this coverage through various relationships with third parties that establish networks of providers, coordinate your care, and process claims for reimbursement for the services that you receive. This Notice of Privacy Practices (the "Notice") describes the legal obligations of WISENBAKER BUILDER SERVICES, INC., the Plan and your legal rights regarding your protected health information held by the Plan under HIPAA. Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice to you pursuant to HIPAA. The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, which relates to:

your past, present or future physical or mental health or condition;

the provision of health care to you; or

the past, present or future payment for the provision of health care to you.

Note: If you are covered by one or more fully-insured group health plans offered by WISENBAKER BUILDER SERVICES, INC., you will receive a separate notice regarding the availability of a notice of privacy practices applicable to that coverage and how to obtain a copy of the notice directly from the insurance carrier.

Contact Information

If you have any questions about this Notice or about our privacy practices, please contact the WISENBAKER BUILDER SERVICES, INC.

HIPAA Privacy Officer:

Attention: HIPAA Privacy Officer

WISENBAKER BUILDER SERVICES, INC.

1703 WESTFIELD LOOP, HOUSTON, TX 77073, 281-220-3965

Effective Date

This Notice as revised is effective April 01, 2024

Our Responsibilities

We are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and

- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices. You may also obtain a copy of the latest revised Notice by contacting our Privacy Officer at the contact information provided above. Except as provided within this Notice, we may not disclose your protected health information without your prior authorization.

How We May Use and Disclose Your Protected Health Information

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose protected health information will fall within one of the categories.

For Treatment

We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is inappropriate or dangerous for you to use.

For Payment

We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations

We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. The Plan is prohibited from using or disclosing protected health information that is genetic information about an individual for underwriting purposes.

To Business Associates

We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with us.

As Required by Law

We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety

We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors

For the purpose of administering the Plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform Plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation

If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans

If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation

We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks

We may disclose your protected health information for public health actions. These actions generally include the following:
to prevent or control disease, injury, or disability;
to report births and deaths;
to report child abuse or neglect;
to report reactions to medications or problems with products;
to notify people of recalls of products they may be using;
to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence.
We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities

We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes

If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement

We may disclose your protected health information if asked to do so by a law enforcement official—
in response to a court order, subpoena, warrant, summons or similar process;
to identify or locate a suspect, fugitive, material witness, or missing person;
about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
about a death that we believe may be the result of criminal conduct;
about criminal conduct; and
in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors

We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities

We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates

If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research

We may disclose your protected health information to researchers when:
the individual identifiers have been removed; or
when an institutional review board or privacy board has (a) reviewed the research proposal; and (b) established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures

The following is a description of disclosures of your protected health information we are required to make.

Government Audits

We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You

When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Notification of a Breach.

We are required to notify you in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information, as defined by HIPAA.

Other Disclosures

Personal Representatives

We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

you have been, or may be, subjected to domestic violence, abuse or neglect by such person;
treating such person as your personal representative could endanger you; or
in the exercise or professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members

With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations

Other uses or disclosures of your protected health information not described above, including the use and disclosure of psychotherapy notes and the use or disclosure of protected health information for fundraising or marketing purposes, will not be made without your written authorization. You may revoke written authorization at any time, so long as your revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation. You may elect to opt out of receiving fundraising communications from us at any time.

Your Rights

You have the following rights with respect to your protected health information:

Right to Inspect and Copy

You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, submit your request in writing to the Privacy Officer at the address provided above under Contact Information. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may have a right to request that the denial be reviewed and you will be provided with details on how to do so.

Right to Amend

If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at the address provided above under Contact Information. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

is not part of the medical information kept by or for the Plan;
was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
is not part of the information that you would be permitted to inspect and copy; or
is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures

You have the right to request an “accounting” of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address provided above under Contact Information. Your request must state a time period of no longer than six years and may not include dates prior to your request. Your request should indicate in what form you want the list (for example, paper or electronic). We will attempt to provide the accounting in the format you requested or in another mutually agreeable format if the requested format is not reasonably feasible. The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions

You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had. We are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you. To request restrictions, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

Right to Request Confidential Communications

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, telephone or write the Privacy Officer as provided above under Contact Information.

For more information, please see [Your Rights Under HIPAA](#).

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20241, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

To file a complaint with the Plan, telephone write the Privacy Officer as provided above under Contact Information. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Rights or with us. You should keep a copy of any notices you send to the Plan Administrator or the Privacy Officer for your records.

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

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find

out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	CALIFORNIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp —Phone: 678-564-1162, Press 1———GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	LOUISIANA – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/laipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremessaging@accenture.com
MINNESOTA – Medicaid	MISSOURI – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPPP Phone: 1-800-694-3084 Email: HHSHPPIProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218

	Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/ dmabs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP- Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium- assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium- assistance/health-insurance-premium-payment-hipp-programs

	Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

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

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

Women's Health Cancer Rights Act (WHCRA) Notice

Do you know that your Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at 281-220-3965 for more information.

Newborns' and Mothers' Health Protection Act (NMHPA) Notice

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

EMPLOYEE RIGHTS UNDER THE FAMILY MEDICAL LEAVE ACT (FMLA)

The [Family and Medical Leave Act \(FMLA\)](#) provides certain employees with up to 12 weeks of unpaid, job-protected leave per year. It also requires that their group health benefits be maintained during the leave.

FMLA is designed to help employees balance their work and family responsibilities by allowing them to take reasonable unpaid leave for certain family and medical reasons. It also seeks to accommodate the legitimate interests of employers and promote equal employment opportunity for men and women.

Covered employers must provide an eligible employee with up to 12 weeks of unpaid leave each year for any of the following reasons:

- for the birth and care of the newborn child of an employee;
- for placement with the employee of a child for adoption or foster care;
- to care for an immediate family member (spouse, child, or parent) with a serious health condition; or
- to take medical leave when the employee is unable to work because of a serious health condition.

Employees are eligible for leave if they have worked for their employer at least 12 months, at least 1,250 hours over the past 12 months, and work at a location where the company employs 50 or more employees within 75 miles. Whether an employee has worked the minimum 1,250 hours of service is determined according to FLSA principles for determining compensable hours or work.

When an employee requests FMLA leave due to his or her own serious health condition or a covered family member's serious health condition, the employer may require certification in support of the leave from a health care provider. An employer may also require second or third medical opinions (at the employer's expense) and periodic recertification of a serious health condition.

Upon return from FMLA leave, an employee will be restored to his or her original job or to an equivalent job with equivalent pay, benefits, and other terms and conditions of employment. Group health insurance coverage for an employee on FMLA leave is maintained under the same terms and conditions as if the employee had not taken leave.

For additional information regarding your benefits under FMLA, please contact Human Resources at:

Contact--Position/Office: DEBORAH VILLAREAL

Address: 1703 WESTFIELD LOOP, HOUSTON, TX 77073

Phone Number: 281-220-3965

USERRA Continuation

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

If you do not elect to continue to participate in a group health plan during an absence for military duty that is more than 31 days, or if you revoke a prior election to continue to participate for up to 12 weeks after your military leave began, you and your covered family members will have the opportunity to elect COBRA continuation coverage under a group health plan for up to the 24-month period that begins on the first day of your leave of absence. You must pay the premiums for continuation coverage with after-tax funds, subject to the rules that are set out in the applicable Plan features.

USERRA continuation coverage is considered alternative coverage for purposes of COBRA. Therefore, if you elect USERRA continuation coverage, COBRA coverage will generally not be available

Genetic Information and Nondiscrimination Act (GINA)

Gina prohibits group health plans from discriminating on the basis of genetic information. Genetic information is:

1. Information about an individual's genetic tests;
2. Genetic tests of an individual's family members; and
3. The manifestation of a disease or disorder of an individual's family members.

The group health plan may collect genetic information after initial enrollment, it may not do so in connection with the annual renewal process. The group health plan may not adjust premiums or increase contributions based on genetic information, nor request or require genetic testing or use genetic information for underwriting purposes.

