2017-2018 Benefits Enrollment Guide

Helping You Become A Better You.

The purpose of this booklet is to describe the highlights of your benefit program. Your specific rights to benefits under the Plans are governed solely, and in every respect, by the official Plan documents and insurance contracts, and not by this booklet. If there is any discrepancy between the description of the Plans as described in this material and official Plan documents, the language of the documents shall govern.

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Contact Information

Breads of the World, LLC (BOTW) in partnership with the following carriers, strives to meet your benefit needs. If you have any questions regarding your benefits, please contact the corresponding carrier listed below or the Breads of the World Benefits Team.

Contacts		
		
Medical: *United Healthcare* Group Number: 903021	800.241.4675	myuhc.com
Voluntary Dental: *Sun Life* Group Number: 5481478	800.443.2995	assurantemployeebenefits.com
Voluntary Vision: *EyeMed* Group Number: 1007538	866.939.3633	eymedvisioncare.com
Basic Life & AD&D: *Reliance Standard* Group Number: GL-148916	800.351.7500	reliancestandard.com
Voluntary Life: *Reliance Standard* Group Number: GL-148916	800.351.7500	reliancestandard.com
Short-Term Disability: *Reliance Standard* Group Number: STD160603	800.351.7500	reliancestandard.com
Long-Term Disability: *Reliance Standard* Group Number: LTD119914	800.351.7500	reliancestandard.com
Employee Assistance Program (EAP): ***Reliance Standard/ACI Specialty Benefits***	855.775.4357	rsli.acieap.com
Worksite Benefits: *Allstate Benefits** Accident and Critical Illness Group Number: G0341	800.521.3535	allstatebenefits.com/mybenefits
Benefits Team	**Phone**	**Email**
CBIZ Benefits Team	(844)-3-Bens-4-U (323-6748)	myBOTWBenefits@cbiz.com

Reasons to Call:

Claim Questions—Contact Carrier
I.D. Cards / Numbers—Contact Carrier
Provider Search—Carrier Websites
Payroll Issues / Status Changes/ Miscellaneous Issues - BOTW Benefit Team

How to Use This Claims Resolutions:

1. First contact Member Services
2. If issue still unresolved, contact BOTW Benefits Team.

*Allstate Benefits (AB) is the marketing name used by American Heritage Life Insurance Company (Home Office, Jacksonville, FL), a subsidiary of The Allstate Corporation.

Medical Insurance

Eligibility

JOINING THE PLAN:

If you are a new BOTW employee, you are eligible for coverage on the 90th day of full-time employment based on BOTW's new Benefit Eligibility Policy that conforms with ACA requirements. The full policy is posted on our **IntraBread** website. You may submit your enrollment forms/applications and complete your enrollment anytime before this date, but you must complete the enrollment process within 30 days of the effective date. If you do not submit your enrollment information within 30 days after your effective date, you will need to wait until the next annual open enrollment to make your benefit elections. **Enrollment instructions can be found on Page 3**.

WHO CAN YOU ADD TO YOUR PLAN:

Eligible:

- Legal Spouse (if not offered by employer)
- Natural and Adopted Children up to age 26
- Your Stepchildren
- Children placed in your custody for adoption
- Children under your legal guardianship
- Children under a qualified medical child support order
- Disabled children 26 years of age or older

Ineligible:

- Divorced or legally separated spouse
- Common law spouse
- Same or Opposite Sex Domestic Partners
- Foster children
- Sisters, brothers, parents, or in-laws, grandchildren, etc.

Frequently Asked Questions

ARE CHANGES TO MY PLAN ALLOWED DURING THE YEAR?

Generally, you may only enroll in the plan, or make changes to your benefits, during the open enrollment period or when you are first hired. However, you can make changes/enroll during the plan year if you experience a qualifying event. As with a new enrollee, you must have your paperwork turned in within 30 days of the qualifying event or you will have to wait until the next annual open enrollment period. Premiums and enrollment eligibility may change; contact the CBIZ Benefits Team for details.

EXAMPLES OF QUALIFYING EVENTS:

- Your dependents or you lose health coverage because of loss of eligibility or loss of employer contributions
- You get married, divorced, or legally separated (with court order)
- You have a baby or adopt a child
- You or your spouse take an unpaid leave of absence
- You or your spouse dies
- You become eligible for or lose Medicaid coverage
- You become eligible for Medicare

Pre-tax Premium Contributions

It is important to remember that all contributions for medical, dental, and vision premiums are paid on a pre-tax basis according to Section 125 of the IRS code. This results in a tax savings for you and allows you to maximize your take home pay!

United Healthcare - Plan Designs

Features	Base Plan		Buy-Up Plan	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible (Individual / Family)	$3,000 / $6,000	$9,000 / $18,000	$2,000 / $4,000	$4,000 / $8,000
Coinsurance	80%	50%	80%	50%
Out-of-Pocket Maximum Incl. Co-pays, Coinsurance & Deductibles) (Individual / Family)	$6,350 / $12,700	$12,500 / $25,000	$6,350 / $12,700	$13,700 / $27,400
Office Visit Co-Pays (Primary Care physician / Specialist/ Virtual Visits)	$30 / $60 co-pay for first 4 visits* in a calendar year; 80% after deductible for any subsequent vis-its in that calendar year; $30 co-pay for Virtual Visits**	50% after deductible	$20 / $40 co-pay; $20 co-pay for Virtual Visit	50% after deductible
Wellcare Benefits	100%	50% after deductible	100%	50% after deductible
Diagnostics Lab & X-Ray: Imaging: (CT, PET, MRI, MRA…)	 80% after deductible 80% after deductible	 50% after deductible 50% after deductible	 80% after deductible 80% after deductible	 50% after deductible 50% after deductible
Emergency Room	80% after In-Network deductible		$150 Co-pay	
Urgent Care	$75 co-pay for first 4 visits in a calendar year; 80% after deductible for any subsequent visits in that year	50% after deductible	$100 Co-pay	50% after deductible
Hospital - Inpatient Stay	80% after deductible	50% after deductible	80% after deductible	50% after deductible
Surgery Outpatient	80% after deductible	50% after deductible	80% after deductible	50% after deductible
Prescription Drug Retail Mail Order (90-Day Supply)	*at Participating Pharmacies* $10 / $35 / $70 Co-Pay $25 / $87.50 / $175 Co-Pay		*at Participating Pharmacies* $10 / $35 / $70 Co-Pay $25 / $87.50 / $175 Co-Pay	

***Wellness visits do not count toward your 4 plan office visit maximum per year.**
****Virtual Visits do not count toward your 4 office visit maximum per calendar year. You have unlimited availability to Virtual Visits.**

Below are the semi-monthly costs associated with each of the two medical plan options being offered for 2017-2018. Please note there has been ***no change*** to your per paycheck cost for the new plan year! If you participate in the BOTW Wellness program, you are eligible for the reduced semi-monthly premium.

Base Plan Semi- Monthly

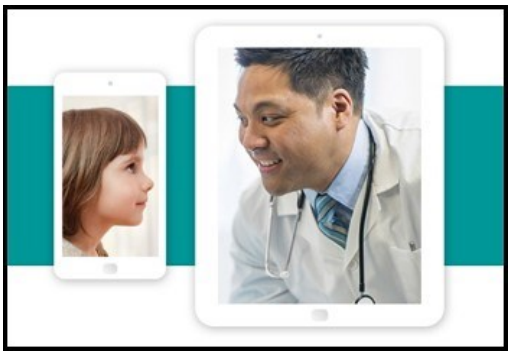
Type of Coverage	Cost With Wellness	Cost Without Wellness
Employee	$79.00	$124.90
Employee & Spouse	$204.48	$265.82
Employee & Child(ren)	$184.78	$240.21
Employee & Family	$282.23	$366.89

Buy-Up Plan Semi-Monthly

Type of Coverage	Cost With Wellness	Cost Without Wellness
Employee	$138.98	$180.68
Employee & Spouse	$292.34	$380.05
Employee & Child(ren)	$264.65	$344.05
Employee & Family	$403.64	$524.73

Virtual Visits

A virtual visit lets you see and talk to a doctor from your mobile device or computer without an appointment. Most visits take about 10-15 minutes and doctors can write a prescription, if needed, that you can pick up at your local pharmacy.



CONDITIONS COMMONLY TREATED THROUGH A VIRTUAL VISIT

- Diarrhea
- Bronchitis
- Cold/Flu
- Bladder infection/Urinary Tract Infection
- Fever
- Migraine/Headaches
- Pink Eye
- Rash
- Sinus Problems
- Sore Throat

ACCESS TO VIRTUAL VISITS

Log in to myuhc.com and choose from provider sites where you can register for a virtual visit. After registering and requesting a visit, you will pay the primary care visit co-pay for the United Healthcare PPO Base and Buy-Up Plans.

Rally

Rally is a user-friendly digital experience on myuhc.com that will engage you in a new way by using technology, gaming and social media to help you understand, learn and support you on your health journey. With the online Rally Health Survey, personalized missions, rewards and connections to wearables like Fitbit, Jawbone and more, it is easier for you to get motivated to be healthier.

How to Enroll

What you need to do...

Login to workforcenow.adp.com for employee self-service. First time user will use registration code: breads-adp and follow registration prompts.

Enroll online in benefits, add dependents, and select benefit plans (enroll or decline). Section 125 (pre-tax premium) is the only option for benefits this year, and this means you cannot cancel benefits until next Open Enrollment or unless you experience a qualified Life Event.

Medical Benefit Notice

If you are eligible for Medical Benefits and wish to enroll YOUR SPOUSE, you must complete the Spousal Waiver. Complete these two steps ONLY if you and your spouse (if applicable) are eligible and enrolling in Medical Benefits with the wellness discounted rate.

1. Visit wellness https://wellness.hhhealthassociates.com to register. Online Registration: New User, Company Code = BOTW. Choose Option 2 - Off Site/Walk-In Clinic. You must choose a clinic to receive the form that you'll take to the lab.

2. If your blood draw is not completed by the enrollment deadline, you will automatically be enrolled in the elected equivalent Non-Wellness Medical Plan.

Advocate4ME

Advocate4Me is a consumer engagement program that provides United Healthcare's members with a single point of contact to address your various health needs. By calling a single toll-free number, or using your preferred communication channel, members are connected with an Advocate who provides them with end-to-end support, "owning" their request until it's resolved. This service is offered at no charge to United Healthcare members.

Health Care Coverage Options: COBRA and Its Alternatives

Selecting the right health care coverage option is important when facing an employment transition. We know how complex healthcare coverage can be, especially with the recent introduction of the Affordable Care Act.

The Affordable Care Act did not eliminate COBRA or change the COBRA rules. COBRA beneficiaries generally are eligible for group coverage during a maximum of 18 months for qualifying events due to employment termination or reduction of hours of work.

The question then becomes whether or not taking COBRA is a better choice than purchasing a new policy through an insurance exchange and applying for a federal subsidy if eligible.

- **COBRA coverage may be more expensive than a new individual policy through the health insurance exchanges.**

  This is because if a COBRA policy is continued, the employee has to pay both their share of the premium and the employer's contribution. If the policy is rich with benefits and the employer has been paying a significant portion of the premium, chances are the full premium will be higher than other health insurance coverage options through the health exchanges.

- **Rather than take COBRA, the Affordable Care Act provisions allow low-income individuals to get coverage at a lower cost because of their potential eligibility for federal subsidies.**

  These subsidies are designed for people who earn between 100 percent and 400 percent of the Federal Poverty Line, or about $23,850–$95,400 for a family of four or $11,670–$46,680 for an individual. If an employee's income is under these limits, it will probably be more cost effective to purchase a new policy and receive the subsidies to help pay the premium.

Why is CBIZ SelectQuote Being Offered?

SelectQuote Benefit Solutions, through its partner CBIZ, will help you understand your choices and guide you through the options related to healthcare coverage to help you find a plan that best suits your needs. This service available to anyone seeking additional health care options and there is no additional cost associated with this service.

Keeping Your Health Care Affordable

As the healthcare marketplace evolves, we are committed to providing you access to affordable, high quality healthcare options. Get started today to make the most of this benefit for you and your family.

Getting Started

Review your options at cbiz.sqbenefits.com or call at 1.855.801.5742.

When to Use Primary Care, Convenience Care, Urgent Care, Lab Services or Emergency Care

PRIMARY CARE

For routine, primary/preventive care, or non-urgent treatment, we recommend going to your doctor's office for medical care. Your doctor knows you and your health history, and has access to your medical records. You may also pay the least amount out-of-pocket when you receive care in your doctor's office.

CONVENIENCE CARE

Sometimes, you may not be able to get to your doctor's office, and your condition is not urgent or an emergency. In these situations, you may want to consider a Convenience Care Center that can be an alternative to seeing your doctor.

Convenience Care Centers are conveniently located often in malls or some retail stores, and offer services without the need to schedule an appointment. Services at a Convenience Care Center may be provided at a lower out-of-pocket cost than an urgent care center visit and are subject to primary care physician office visit copays and/or deductible/ coinsurance.

Services at a Convenience Care Center are generally available to patients 18 months of age or older. Services that are available may vary per center. We do, however, recommend that you seek routine medical care from your primary care physician whenever possible.

To find an in-network Convenience Care Center near you, visit United Healthcare's website at myuhc.com.

Typical conditions that may be treated at a Convenience Care Center include:

- Common infections (e.g.: bronchitis, bladder infections, ear infections, pink eye, strep throat)
- Minor skin conditions (e.g.: athlete's foot, cold sores; minor sunburn, poison ivy)
- Flu shots
- Pregnancy tests

This is a sample list and not all-inclusive. For a full listing of services please visit each center's Website.

URGENT CARE

Sometimes you may need medical care fast, but a trip to the emergency room may not be necessary. Of course during office hours, you may be able to go to your doctor for any urgently needed service; however, if you require urgent care outside your doctor's regular office hours or you are unable to be seen by your doctor immediately, you may consider going to an urgent care center. At an urgent care center, you can generally be treated for many minor medical problems faster than at an emergency room. We do however, recommend that you seek routine medical care from your primary care physician whenever possible.

Typical conditions that may be treated at a Urgent Care Center include:

- Sprains
- Strains
- Mild asthma attacks
- Minor infections
- Vaccinations
- Small cuts
- Sore throats
- Rashes
- Preventive Screenings
- Back Pain or Strains

This is a sample list and not all-inclusive. For a full listing of services please visit each center's Website.

Services that are available for Urgent Care may vary per center. If you choose to use an urgent care center, please make sure it is in-network by calling the toll-free number on the back of your medical ID card or visiting the United Healthcare website at myuhc.com.

LAB SERVICES

If you require lab work, consider having these services performed at **LabCorp.** If you choose to use Quest, services associated with the cost of your lab work will apply to the out-of-network deductible and coinsurance.

EMERGENCY ROOM

If you think you or your loved one may be experiencing an emergency medical condition, you should go to the nearest emergency room or call 911. Emergency services are always considered at the in-network benefit level.

An emergency medical condition is any condition (including severe pain) which you believe that without immediate medical care may result in:

- Serious jeopardy to your or your loved one's health, including the health of a pregnant woman or her unborn child
- Serious impairment to your or your loved one's bodily functions
- Serious dysfunction of any of you ror your loved one's bodily organ or part

If you obtain care at an emergency room, you will likely pay more out-of-pocket than if you were treated at your doctor's office, a Convenience Care Center or urgent care facility.

Some examples of emergency conditions may include the following:

- Heavy bleeding
- Chest pain
- Major burns
- Severe head injuries
- Sudden weakness or trouble walking
- Large open wounds
- Sudden change in vision
- Spinal injuries
- Difficulty breathing

This list only provides examples and is not intended as an exclusive list. If you believe you or your loved one is experiencing an emergency medical condition, you should go to the nearest emergency room or call 911, even if your symptoms are not described here.

PRESCRIPTION BENEFITS

Most prescriptions are filled right away when you take them to the pharmacy. However, some drugs need to be reviewed by United Healthcare and approved before they're covered. This process, called ***prior authorization***, helps ensure drugs are used as recommended by the FDA. Prior authorization focuses mainly on drugs that may have:

- Risk of serious side effects or dangerous drug interactions
- High potential for incorrect use or abuse
- **Better alternatives that may cost you less**
- Restrictions for use with very specific conditions

Prior authorization may require you to take an additional step when you are prescribed certain medications, but the long-term gain is lower out-of-pocket prescription costs for you and reduced claims expense for BOTW and potentially lower future renewal increases. Some prescription drugs are covered only if the physician obtains prior authorization from United Healthcare. In addition, coverage for some drugs is provided in limited quantities and duration.

This is only a brief summary of benefits. The Certificate, issued when coverage is approved for the group, contains program details, and will, in all cases, have control over any information in this summary. The certificate is available upon request.

PREVENTIVE CARE

Certain preventive services will be covered without charging a deductible, copayment, or coinsurance when these services are provided by a **network provider**. The types of preventive services covered are defined by federal law and can vary based on your age, gender, and health status. There may be services you had in the past that will now be covered as preventive at no cost to you. The preventive services included in this provision are described at healthcare.gov.

WOMEN'S PREVENTIVE CARE COVERAGE

Your health plan will provide first dollar coverage for certain women's preventive coverage without any cost sharing requirements (copayment, coinsurance or deductible), when delivered by in-network providers. This includes 100% coverage for FDA-approved tier 1 contraceptive methods for women when filled at an in-network pharmacy.

Voluntary Dental Insurance

Sun Life is the dental carrier for 2017-2018. The dental plan offers coverage in a PPO network, and out-of-network. It is to your advantage to utilize a network dentist to take advantage of contracted fees. If you go out-of-network, you will be responsible for any amount exceeding Sun Life's negotiated fees plus any deductible and coinsurance associated with your procedure.

The following is a brief summary of your Sun Life benefits:

Sun Life - Plan Design

Features		PPO In-Network	Out-of-Network
Calendar Year Deductible	■ Applied to basic and major services	$50 individual $150 family	$75 individual $225 family
Annual Maximum	■ Applied to preventive, basic and major services	$1,000	$1,000
Class I - Preventive Services	■ Oral examinations ■ Bitewing & intraoral/panoramic x-rays ■ Dental prophylaxis ■ Topical fluoride treatments ■ Dental sealants ■ Space maintainers	100%	100%
Class II - Basic Services	■ Fillings ■ Root canals ■ Periodontal ■ Extractions ■ Biopsy	80%	50%
Class III - Major Services	■ Inlays, onlays and crowns ■ Dentures ■ Fixed bridges ■ Implants	50%	40%
Orthodontia	■ Child Only	50%; lifetime benefit of $1,000	50%; lifetime benefit of $1,000

In-Network Providers: agree to be reimbursed from a fee schedule and no balance billing.

Out-of-Network Providers: benefit payments are made up to the 90th percentile of Reasonable and Customary; and balance billing is possible.

Dental Plan Semi-Monthly Cost

Type of Coverage	Employee
Employee	$12.87
Employee & Spouse	$24.94
Employee & Child(ren)	$30.14
Employee & Family	$42.23

FIND A DENTIST

To find a Sun Life provider in your area, visit the website at assurantemployeebenefits.com

- **Click on "Find a Dentist".**
- **Under "PPO Plan?", select the "Assurant Dental Network" in the drop down menu.**
- **Click "Go".**
- **You may enter just your Zip Code and click "Search" to find a dentist in your area or refine your search even more.**

A comprehensive directory of dentists will appear.

Voluntary Vision Insurance

EyeMed is the vision carrier for 2017-2087. The vision plan offers coverage both in-network and out-of-network. It is to your advantage to utilize a network provider to take advantage of the established contract rates and benefits. If you go out-of-network, your benefit is based on a reimbursement schedule. Also, if you are considering Lasik Surgery, there is a discount available with particular providers. To find a participating provider, go to eymedvisioncare.com.

EyeMed - Plan Design

Features	In-Network	Out-of-Network
Examination Co-pay	$10 Co-pay	$40 reimbursement
Frequency of Service: Exams Lenses Frames Contacts	Every 12 months Every 12 months Every 24 months Every 12 months	
Lenses Single Bifocal Trifocal Lenticular	 100% 100% 100% 100%	Reimbursement $30 $50 $70 $70
Frames	$120 allowance; 20% off remaining balance	$84
Contacts Necessary Elective	$120 allowance; 15% off remaining balance	Reimbursement $210 $120
Laser Vision Correction	Discount Available	N/A

Out-of-Network Services: You can choose to receive care outside of the EyeMed Vision network. You simply get an allowance toward services and you pay the rest. (In-Network benefits and discounts will not apply.) Just pay in full at the time of service and then file a claim for reimbursement.

Vision Plan Semi-Monthly Cost

Type of Coverage	Employee
Employee	$2.77
Employee & Spouse	$5.26
Employee & Child(ren)	$5.54
Employee & Family	$8.14

Please note there has been ***no change*** to your per paycheck cost for the new plan year!

FIND A PROVIDER

To find a EyeMed vision provider in your area, visit the website at eymedvisioncare.com.

- **Click "Find a Provider" at the top right of the webpage**
- **Enter your zip code and hit the "Get Results" button**
- **The search will generate a report of the Search Results, listing the providers closest to your zip code first**
- **Your refine your search even more under the "Filter Search Results" on the left side of the webpage.**
- **OR, you can call 866.939.3633 to speak with a Customer Service representative**

You can also use this website for practical tools and personalized information for your vision care.

- **Learn about vision wellness to manage your vision health and wellbeing**
- **Check your in-network and out-of-network vision benefits and how to use them.**

Basic Life and AD&D

BOTW provides employees with a Basic Life and Accidental Death & Dismemberment benefit. Coverage is provided by BOTW at no cost to you and is administered through Reliance Standard. This benefit provides a 1X salary up $150,000 maximum death benefit. It also carries an equal benefit of accidental death and dismemberment coverage. Benefit reductions apply upon attaining certain age levels.

Voluntary Life and AD&D

This benefit provides additional protection for you and your family in the event of accidental death or certain accidental injuries. This may be in addition to Life and AD&D benefits provided for active employees. Your Voluntary Life/AD&D is administered through Reliance Standard, and you must purchase voluntary life/AD&D on yourself in order to purchase coverage for your spouse and dependent children. Benefit reductions apply upon attaining certain age levels.

Employees can purchase up to $500,000 of coverage, with a minimum of $10,000 in $10,000 increments. This benefit amount also carries an equal benefit of accidental death and dismemberment coverage. The Guarantee Issue amount for newly eligible employees is $130,000.

Spousal coverage is available up to $250,000, not to exceed 50% of the employee amount in $5,000 increments. The Guarantee Issue amount for newly eligible spouses is $25,000. Coverage is available for children age 14 days up to 25 years or 26 years for full-time students. Dependent children coverage can be purchased up to $10,000 in $1,000 increments with a Guaranteed Issue amount of $10,000.

Please note: You and your dependents have a onetime special enrollment opportunity, which allows you and your dependents to enroll or increase your elections up the guarantee issue amounts. If you do not enroll during this initial enrollment period in the Voluntary Life/AD&D plan you will be required to complete an Evidence of Insurability (EOI) form and be approved by Reliance Standard before you are able to obtain coverage in the future.

VOLUNTARY LIFE/AD&D EMPLOYEE CONTRIBUTION (Rates are per month)	
Life Age Band	**Employee/Spouse Rate per $1,000***
Under 20	$0.06
20-24	$0.06
25-29	$0.06
30-34	$0.09
35-39	$0.13
40-44	$0.20
45-49	$0.34
50-54	$0.60
55-59	$0.99
60-64	$1.64
65-69	$2.50
70-74	$3.68
75-79	$6.71
80-84	$10.24
85-89	$18.73
90-94	$25.26
95-99	$55.10
Child Life	$0.19
AD&D	
Vol. AD&D	$0.04

***Spouse rates are based on the employee's age**

HOW TO CALCULATE VOLUNTARY PREMIUM

$\frac{\$50{,}000}{\text{Elected Coverage}} \div 1{,}000 = \frac{50}{\text{Units}} \times \frac{\$0.38^*}{\text{Rate}} = \frac{\$19.00}{\text{Monthly Cost}} \div 2 = \$9.50 \text{ Semi-Monthly Cost}$

*The premium calculation is based upon the Life **and** AD&D rate for a 45 year old employee.

Short-Term Disability Insurance

Your Reliance Standard short-term disability is intended to protect your income for a short duration in case you become ill or injured. BOTW provides this benefit to you at no cost.

Beginning on the 14th day of an illness or injury, you are eligible to receive 60% of your weekly income to a maximum of $2,000. The maximum benefit period is 11 weeks.

Long-Term Disability Insurance

Long-Term Disability (LTD) is intended to protect your income for a long duration. BOTW provides employees this benefit at no cost. The LTD premium is included on your W2 as imputed taxable income. This option allows the disability benefits that you receive to be income tax-free.

After the 90th day of an illness or injury, you may be eligible for LTD benefits through Reliance Standard. The disability benefit is a monthly benefit and covers 60% of your monthly salary to specific maximums per the plan document. This benefit may be paid to Social Security retirement age or until you no longer meet the definition of disability. You are considered disabled if you have a loss of duties in regards to your regular occupation due to an illness or injury. After a specific period of time per your plan document, benefits continue if you cannot perform any gainful occupation for which you would be reasonably fitted considering education, training, and experience. You must be under the care of a doctor.

Employee Assistance Program

Reliance Standard has partnered with ACI Specialty Benefits to offer employees with LTD insurance an Employee Assistance Program (EAP). From the stress of everyday life to relationship issues or even work-related concerns, the EAP and work-life benefits can help with any issue affecting overall health, well-being and life management. EAP offers confidential and professional assessment and referral services for employees and their family members.

Added Features

Unlimited telephonic sessions of professional assessment for employees and family members

3 face to face sessions

Getting Assistance

855.RSL.HELP
(855.775.4357)

rsli.acieap.com

Voluntary Worksite Benefits

Allstate Benefits* offers voluntary products that are used to compliment your medical benefits by helping you cover your expenses until your deductible and coinsurance are satisfied. You may take any of the below three plans with you should you leave BOTW.

Group Critical Illness

With Group critical illness and cancer plans, you'll receive a benefit after a serious illness or a condition such as a heart attack, stroke, coronary artery disease, or cancer is diagnosed. Group Critical illness coverage pays you a lump-sum cash benefit to help pay for treatment or bills. During your recovery, you and your loved ones can rest a little easier knowing you won't have to deplete your bank accounts or take on additional debt to cover day-to-day living expenses.

Group Critical Illness Semi-Monthly Employee Cost

$10,000	Non-Tobacco User		Tobacco User *	
Issue Age:	EE, EE & CH	EE & SP, Family	EE, EE & CH	EE & SP, Family
18-29	$2.67	$4.32	$3.91	$6.18
30-39	$4.68	$7.33	$7.25	$11.18
40-49	$8.54	$22.87	$15.06	$22.89
50-59	$15.04	$22.87	$25.34	$38.32
60-63	$24.36	$36.86	$41.69	$62.85
64+	$31.85	$48.08	$55.05	$82.89

*Allstate Benefits definition of tobacco usages is "Has anyone to be insured (employee and/or spouse) used tobacco products within the last 12 months."

Plan Benefits

$50 reimbursement for each covered person when you visit a doctor for your wellness visit.

Continuation of coverage can be portable and remain in effect for up to 3 years or until the employee reaches age 70, whichever occurs later.

Group Accident Insurance

This voluntary plan offered through Allstate Benefits* offers coverage for off the job accidents, injuries, ambulance services, and accidental death in addition to your primary medical insurance that are incurred off the job. Group Accident Insurance pays a lump sum benefit to the insured that can be used to help cover the costs not paid by the primary insurer. It's also available to your spouse and children.

Group Accident Insurance Employee Semi-Monthly Cost

Type of Coverage	Employee
Employee	$6.26
Employee & Spouse	$9.71
Employee & Child(ren)	$14.61
Employee & Family	$18.29

Reimbursements:

- **$50 reimbursement for any office visit outside the hospital**
- **Includes wellness as well as a sick visit**
- **Employees are eligible for two reimbursements per calendar year**
- **Dependents are also eligible for two reimbursements up to a total of four per family**

Flu Shots

The flu affects millions of people each year and can result in severe illness — even death. A flu vaccine is the best defense to not only protect you, but also help protect the people around you. The Centers for Disease Control and Prevention (CDC) recommends annual flu vaccinations for everyone six months and older.

Choose a Convenient Provider

Annual flu shots are covered under most medical plans when you use a network provider. For quick and easy access to a flu vaccine, you can visit:

Your network doctor or other health care professional

A retail pharmacy

A Convenience Care Clinic

What you need to know:

- **Most UnitedHealthcare plans cover annual flu shots at 100 percent when you use a contracted network provider.**
- **Talk to your doctor about which vaccinations may be right for you.**
- **Show your health plan ID card before getting your shot.**
- **See other side for a list of national pharmacy chains and convenience care clinics that are contracted to provide flu shots to UnitedHealthcare members.**
- **To find network care visit www.myuhc.com or call the number on the back of your ID**

Albertsons	**CVS**	**Harris Teeter**	**H-E-B**	**Kmart**	**The Kroger Co.**	**Meijer**
New Albertsons	**Publix**	**Rite Aid**	**Safeway**	**Shopko**	**United Supermarkets**	**Walgreens**
Walmart	**Sam's Club**	**Minute Clinic**	**The Little Clinic**	**RedlClinic**	**Walgreens Clinic**	

Important Notices

Special Enrollment Notice

During the open enrollment period, eligible employees are given the opportunity to enroll themselves and dependents into our group health plans. If you elect to decline coverage because you are covered under an individual health plan or a group health plan through your parent's or spouse's employer, you may be able to enroll yourself and your dependents in this plan if you and/or your dependents lose eligibility for that other coverage. If coverage is lost, you must request enrollment within 30 days after the other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may enroll any new dependent within 30 days of the event. To request special enrollment or obtain more information, contact your Human Resource Department.

Notice of Material Change **(also Material Reduction in benefits)**

BOTW has modified their benefits plans. This benefit guide contains a summary of the modifications that were made. It should be read in conjunction with the Summary Plan Description or Certificate of Coverage, which is available to you once it has been updated by the carriers. If you need a copy, please submit your request to Human Resources.

Women's Health and Cancer Rights Act of 1998

As a requirement of the Women's Health and Cancer Rights Act of 1998, your plan 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. The benefits must be provided and are subject to the health plan's regular co-pays, deductibles, and co-insurance. You may contact our health carrier at the phone number on the back of your ID card for additional benefit information.

Newborns' and Mothers' Health Protection Act

Under Federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g. your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, call the member phone number on your health plan ID card.

Notice of Privacy Practices

BOTW is subject to the HIPAA privacy rules. In compliance with these rules, it maintains a Notice of Privacy Practices. You have the right to request a copy of the Notice of Privacy Practices by contacting the BOTW's Human Resources Department.

Marketplace Options

Health Insurance Marketplace Coverage Options and Your Health Coverage

General Information...When key parts of the health care law took effect in 2014, there was a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment-based health coverage offered by BOTW.

What is the Health Insurance Marketplace? The Marketplace is designed to help you find health insurance which meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit which lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October through February 15.

Can I Save Money on my Health Insurance Premiums in the Marketplace? You may qualify to save money and lower your monthly premium. Savings depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace? Yes. If you have an offer of health coverage from your employer which offers minimum essential coverage and meets affordability standards, you will not be eligible for a tax credit through the Marketplace. If you purchase health coverage through the Marketplace, you may lose any employer contribution offered for the employer-offered coverage. Employer and employee contributions for employer-offered coverage are often excluded from Federal income tax. Payment for Marketplace coverage is made on an after-tax basis.

More Information... New employees will receive a notice of Marketplace Coverage Options advising the standards of offered coverage. Please visit HealthCare.gov for more Marketplace information.

Important Information Regarding 1095 Forms

As an employer with 50 or more eligible employees we are required to provide 1095-C forms to all employees who were eligible for coverage under our group health plan in 2017. If you were eligible for coverage under our group plan you will receive a personalized 1095-C form before March 31, 2018. We are also required to send a copy of your 1095-C form to the IRS.

The information reported on Form 1095-C is used in determining whether an employer owes a payment under the employer shared responsibility provisions under section 4980H. Form 1095-C is also used by the IRS and the employee in determining the eligibility of the employee for the premium tax credit.

You'll need a 1095 form to complete your annual Federal tax return.

Medicaid CHIP Notice

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 healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed on the DOL website provided 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 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 askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

Following is a link to the latest form and states where you may be eligible for assistance paying your employer health premiums: dol.gov/ebsa/pdf/chipmodelnotice.pdf

For more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
dol.gov/ebsa
1-866-444-3272
Menu Option 4, Ext 61565

U.S. Department of Health and Human Services
Centers for Medicare and Medicaid Services
cms.hhs.gov
1-877-267-2323

Medicare Part D Creditable Coverage

This notice has information about your current prescription drug coverage and about your options under Medicare's prescription drug coverage. If you are eligible for Medicare the following information can help you decide whether or not you want to join a Medicare drug plan. You should consider comparing your current coverage through our medical plan with the costs of plans offering Medicare prescription drug coverage in your area. Two important things you need to know about your current coverage and Medicare prescription drug coverage:

Medicare prescription drug coverage is available if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan. All Medicare drug plan provide at least a standard level of coverage set by Medicare. More coverage may be offered at a higher premium.

> United Healthcare has determined that the prescription drug coverage offered by BOTW is on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pay and is therefore considered Creditable Coverage. Because this coverage is Creditable Coverage, you can keep it and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

If you lose your current creditable prescription drug coverage through no fault of your own, you will be eligible for a two-month Special Enrollment Period to join a Medicare drug plan.

If you decide to join a Medicare drug plan, your current coverage will not be affected. This plan will coordinate with Part D coverage. If you drop your current coverage, be aware that you and your dependents will be able to get this coverage back.

If you drop or lose your current coverage and don't join a Medicare drug plan within 63 continuous days after your coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

This information is provided for the Medicare open enrollment period which begins on October 15. If you want more information about Medicare plans that offer prescription drug coverage, you will find it in the Medicare & You handbook or you can visit medicare.gov or call 1-800-MEDICARE (1-800-633-4227)

TTY users: 1-800-486-2048. If you have limited income and resources, visit Social Security on their website at socialsecurity.gov, or call them at 1-800-772-1213. TTY users: 1-800-325-0778.

Keep all Creditable Coverage notices. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of the notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Notice Regarding Wellness Program

Breads of the World's Wellness Program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for [be specific about the conditions for which blood will be tested.] You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive a reduced medical premium for completing a biometric screening. Although you are not required to participate in the biometric screening, only employees who do so will receive the reduced medical premium.

The results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and [name of employer] may use aggregate information it collects to design a program based on identified health risks in the workplace, [name of wellness program] will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) [indicate who will receive information such as "a registered nurse," "a doctor," or "a health coach"] in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. [Specify any other or additional confidentiality protections if applicable.] Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Human Resources.

GLOSSARY OF TERMS

Coinsurance – Your share of the cost of covered services which is calculated as a percentage of the allowed amount. This percentage is applied after the deductible has been met. The plan pays any remaining percentage of the cost until the out-of-pocket maximum is met. Coinsurance percentages will be different between in-network and non-network services.

Copays – A fixed amount you pay for a covered health care service. Copays can apply to office visits, urgent care, or emergency room services. Copays will not satisfy any part of the deductible. Copays should not apply to any preventive services.

Deductible – The amount of money you pay before service are covered. Services subject to the deductible will not be covered until it has been fully met. It does not apply to any preventive services as required under the Affordable Care Act.

Emergency Room – Services you receive from a hospital for any serious condition requiring immediate care.

Lifetime Benefit Maximum – All plans are required to have an unlimited lifetime maximum.

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

Network Provider - A provider who has a contract with your health insurer or plan to provide services at set fees. These contracted fees are usually lower than the provider's normal fees for services

Out-of-Pocket Maximum – This most you will pay during a set period of time before your health insurance begins to pay 100% of the allowed amount. The deductible, coinsurance, and co-pays are included in the out-of-pocket maximum.

Preauthorization – A process by your health insurer or plan to determine if any service, treatment plan, prescription drug, or durable medical equipment is medically necessary. This is sometimes called prior authorization, prior approval, or precertification.

Preferred Provider – A provider who has a contract with your health insurer or plan to provide services at set fees. These contracted fees are usually lower than the provider's normal fees for services.

Prescription Drugs – Each plan offers its own unique prescription drug program. Specific copays apply to each tier and a medical plan can have one to five separate tiers. The retail pharmacy benefit offers a 30-day supply. Mail Order prescriptions provide up to a 90-day supply. Sometimes the deductible must be satisfied before a copays are applied.

Preventive Services – All services coded as Preventive must be covered 100% without a deductible, coinsurance, or copayments.

UCR (Usual, Customary and Reasonable) – The amount paid for medical services in a geographic area based on what providers in the area usually charge for the same or similar service.

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