BRUCE O·A·K·L·E·Y, Inc

2024 EMPLOYEE

BENEFITS GUIDE

Welcome To Your Employee Benefits

Bruce Oakley is partnering with PEC to provide a world-class benefits experience for all employees. PEC's Benefit Counselors will review your benefits with you on an individual, confidential basis, and will provide a detailed explanation of our entire benefits program.
Each year, we strive to offer comprehensive and competitive benefit plans to our employees. In the following pages, you will find a summary of our benefit plans for the **January 1, 2024 - December 31, 2024** plan year. Please read this guidebook carefully as you prepare to make your elections for the upcoming Plan Year.

About this Benefits Guide

This benefits guidebook describes the highlights of Bruce Oakley' benefits program in non-technical language. Your specific rights to benefits under the plan are governed solely, and in every respect, by the official plan documents, and not the information in this guidebook. If there is any discrepancy between the description of the program elements as contained in this benefits guidebook and the official plan documents, the language in the official plan documents shall prevail as accurate. Please refer to the plan-specific documents published by each of the respective carriers for detailed plan information. You should be aware that any and all elements of Bruce Oakley' benefits program may be modified in the future, at any time, to meet Internal Revenue Service rules, or otherwise as decided by Bruce Oakley.

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Avoid making quick decisions - enroll early!

Contact one of our Benefits Counselors at the Benefits Service Center to learn more about your benefits and complete your enrollment process by either electing, changing, or waiving benefits.

Before you speak with a Benefit Counselor, please have the following information ready: *dependents' names, birth dates, social security numbers, addresses, and phone numbers.*

Benefits Service Center:
855-441-6135

Monday - Friday:
8:00 AM - 7:00 PM (CST)
Saturday:
9:00 AM - 3:00 PM *(CST)*

^ See pg.4 for more information regarding your enrollment options.

Professional Enrollment Concepts

Scan QR code to view your employee benefit guide and your claim forms online.

Bruce Oakley encourages the health and financial well-being of its employees by providing access to quality and affordable healthcare. Eligible Full-Time employees have access to Bruce Oakley' comprehensive Benefit Program. Please note that any time during the plan year, Bruce Oakley may conduct audit requesting supporting documentation on all eligible dependents.

At-A-Glance:

- **New!** - Virtual Behavior Health
- Changes in Medical Plan
- **New!** - Dental Rates

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Eligibility & Enrollment

Eligibility

You. If you are a full-time Bruce Oakley employee regularly scheduled to work at least 30 hours per week, you are eligible to enroll in the Bruce Oakley Benefits Program.

Your Dependents. You may also enroll your dependent for coverage. Eligible dependents include your:

- Legal spouses
- Children up to age 26 (includes birth children, stepchildren, legally-adopted children, children placed for adoption, foster children, and children for whom legal guardianship has been awarded to you or your spouse or domestic partner).
- Dependent children, regardless of age, provided he or she is incapable of self-support due to a mental or physical disability, is fully dependent on you for support as indicated on your federal tax return, and is approved by your medical plan to continue coverage past age 26.

Benefits Effective Date

Generally, you cannot make any changes to your benefits during the year, unless you experience a Qualifying Life Event (QLE). Examples of QLEs include:

- **New Hires.** Your coverage begins the first of the month following 60 days following your date of hire.
- **Current Employees.** Any changes you make during the annual open enrollment period will become effective on January 1st, 2024.

The benefits plan year is January 1, 2024 - December 31, 2024.

Making Changes During the Year

Generally, you cannot make any changes to your benefits during the year, unless you experience a Qualifying Life Event (QLE).

Examples of QLEs include:

- Change in your legal marital status (marriage, divorce or legal separation)
- Change in the number of your dependents (e.g., through birth or adoption, or if a child is no longer an eligible dependent)
- Change in your spouse or domestic partner's employment status (resulting in a loss or gain of coverage)
- Change in your employment status from full time to part time, or part time to full time, resulting in a gain or loss of eligibility
- Become Medicare or Medicaid eligible

Your change in coverage must be consistent with your change in status and must be made within 30 days of the QLE. Contact Human Resources for more information or if you have a QLE.

Call Center Enrollment

Before you speak with a Benefit Counselor, please have the following information ready: *dependents' names, birth dates, social security numbers, addresses, and phone numbers.*

Benefits Service Center:

855-441-6135

Monday - Friday: *8:00 AM - 7:00 PM (CST)*
Saturday: 9:00 AM - 3:00 PM *(CST)*

Professional Enrollment Concepts

Important Contacts

For any questions or concerns you may have regarding your 2024 Employee Benefits, you can contact the following;

Benefits Service Center:
855-441-6135
Monday - Friday: *8:00 AM - 7:00 PM (CST)*
Saturday: 9:00 AM - 3:00 PM *(CST)*

Benefit/Carrier	Phone Number	Funding	Website/Email
Medical Blue Cross Blue Shield of Arkansas	888-872-2531	Bruce Oakley contributes per month depending on plan and tier elected by staff.	*blueadvantagearkansas.com*
Virtual Health Behavior Blue Cross Blue Shield of Arkansas	888-872-2531	Employee Paid	*myvirtualhealth.com*
Dental Delta Dental	800-462-5410	Employee Paid	*deltadentalar.com*
Vision MetLife	800-638-5433	Employee Paid	*metlife.com*
Basic Life and AD&D **Voluntary Term Life and AD&D** Mutual of Omaha	800-775-6000	Company Paid Employee Paid	*mutualofomaha.com*
Short Term Disability Mutual of Omaha	800-775-6000	Employee Paid	*mutualofomaha.com*
Long Term Disability Mutual of Omaha	800-775-6000	Employee Paid	*mutualofomaha.com*
Accident **Critical Illness** **Hospital Indemnity** MetLife	866-626-3705	Employee Paid	*metlife.com*
Employee Assistance Southwest EAP	800-777-1797	Employer Paid	*sweapconnections.com*
Human Resources Lisa Hicks Leslie Jenkins	501-320-8449 662-759-6841	N/A	*lhicks@bruceoakley.com* *leslie@JanTran.com*

Medical

We are committed to providing you with comprehensive medical benefits to meet your needs. This section will provide a brief summary of each medical plan option. With any plan you can visit the physician of your choice, however, if you visit an out-of-network physician, you may be balance billed. Costs for coverage are paid through pre-tax payroll deductions. By paying on a pre-tax basis, your cost is lower because the earnings you use to pay premiums are not subject to federal tax withholding or Social Security (FICA) taxes. For greater detail on each of the plans listed, please refer to the summary plan descriptions.

Medical Plan Summary	BlueCross BlueShield PPO	
	In-Network	Out-of-Network
Annual Deductible Individual Family	 $1,500 $3,000	 $3,000 $6,000
Coinsurance	20%	40%
Annual Out-of-Pocket Maximum Individual Family	 $7,500 $15,000	 $15,000 $30,000
Office Visits Preventative Services Primary Care Specialist	 $0 copay $20 copay $20 copay	 40% after deductible $50 copay $20 copay
Virtual Health General Medical Behavorial Health	 $0 cost for members $20 cost for members	 N/A N/A
Urgent Care	$50 copay	$50 copay
Emergency Room With Emergency Diagnosis Without Emergency Diagnosis	 No copay $200 copay then 20% after deductible	 20% after deductible $200 copay then 40% after deductible
Outpatient Surgery	20% coinsurance	40% coinsurance
Inpatient Surgery	20% coinsurance	40% coinsurance

Medical: Weekly Contributions	Blue Cross Blue Shield
Employee Only	$0.00
Employee + Spouse	$79.36
Employee + Child(ren)	$49.09
Family	$128.69

Definitions

Deductible

The amount of money you must pay each year to cover eligible medical expenses before your insurance policy starts paying.

Coinsurance

The amount you pay to share the cost of covered services after your deductible has been paid. The coinsurance rate is usually a percentage.

Out of Pocket Max

The most money you will pay during a year for coverage (including deductibles, copays, and coinsurance).

^ For more definitions go to pg.36

Prescription

If you enroll in the BCBS of Arkansas PPO medical plan, you will automatically receive prescription drug coverage through BCBS. When you need prescriptions, you can purchase them through a local retail pharmacy or, for maintenance medications, through the mail order program.

We encourage you to speak to your physician about the drug that's best for you and to request less expensive prescription drugs (generic drugs). Your pharmacy technician will be able to recommend alternatives that create the same desired effect but may be more cost efficient than a name brand drug.

Retail Prescription Program

The retail prescription program uses a network of participating pharmacies. To receive the highest level of benefits, you must use a participating pharmacy. For more information about a particular pharmacy or pharmacy claim, visit the BCBS website at ***www.blueadvanatgearkansas.com/myblueprint*** or call them at **888.872.2531**

Mail Order Program

The mail order program offers a convenient and cost-effective way to fill prescriptions for medications you take on a regular basis (maintenance medications). Your medications are mailed directly to your home. To order prescriptions through the mail order program, please visit the BCBS website at ***www.blueadvanatgearkansas.com/myblueprint*** or call them at **888.872.2531**

SHARx Program for Specialty Medication

Coverage for specialty drugs is only applicable through the pharmacy program if the SHARx program fails to provide a solution. SHARx solutions assist members in obtaining specialty medication through a variety of sources, including manufacturer assistance programs, copay cards, grants, and mail order pharmacies. To obtain further information please contact SHARx customer service at **341.451.3555.**

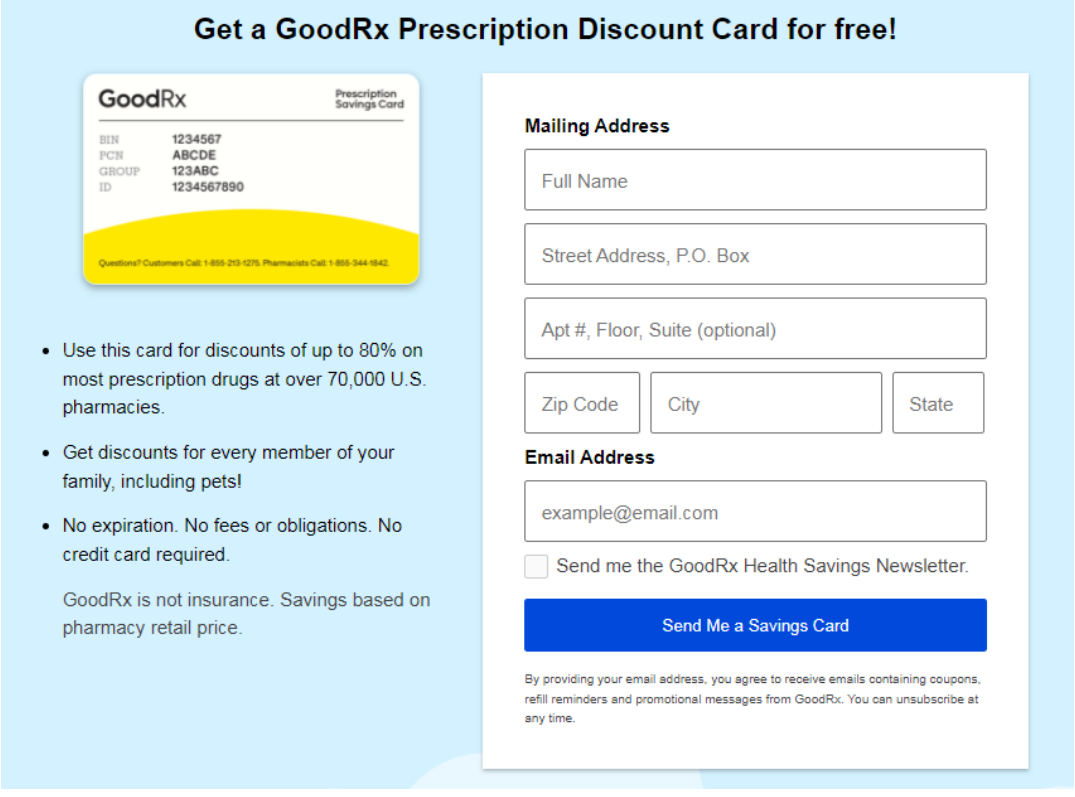
Prescription Drug Coverage	BlueCross BlueShield PPO	
	In-Network	Out-of-Network
Retail Pharmacy (31-day supply) Generic Formulary Non-Formulary Specialty	 $15 copay $30 copay $55 copay $100 copay	Not covered
Mail Order (90-day supply) Generic Formulary Non-Formulary	 $30 copay $60 copay $110 copay	Not covered

GoodRx

Additional Saving on Prescriptions through GoodRx

Bruce Oakley, Inc. understands that one of the largest expenses to our employees in regard to healthcare is prescription drugs. This is of particular concern when covered by High Deductible Health Plans. There are several ways to save money on prescription costs. In addition to comparing pharmacy pricing, GoodRx offers discounts of up to 80% on most prescription drugs at over 70,000 U.S. pharmacies.

You do not have to wait to get a card to begin saving! Log in to www.goodrx.com to request your GoodRX card. There is no expiration date, no fees or obligations and no credit card information is required. Once you are in the site you will click on “Discount Card” at the top of the page and it will bring you to the page below. Just complete the personal information and a card will be mailed to you within 4 weeks. You will also have the opportunity to print a temporary card right away. This card will work for every member of your family. The card is already activated and ready to use.



My Blueprint

Accessing your benefits

Our online member portal puts your health plan's power in the palm of your hand

What features of your health plan can you access and manage with the My Blueprint online member portal? Perhaps the better question is: "What can't you do with My Blueprint?"

You can log in on a smartphone, a tablet or a computer – wherever and whenever you want.

With My Blueprint, you can access and/or manage:

Claims & Policy Info

- View individual claim information and claims documents
- See who's covered
- See what's covered
- Check your copay (a fixed amount you must pay for a covered service)
- View your healthcare spending details (see where you are on your deductible levels and out-of-pocket expense limits)
- Choose your primary care physician (PCP)

Member ID cards

- Access to your digital ID card and email, fax or print it
- Request an ID card electronically
- Speak to a customer service rep about an ID card issue

Your Personal Health Record

- Medications you've been prescribed
- A history of your outpatient and inpatient visits (including dates, symptoms, diagnoses, treatment, etc.)
- Your lab and radiology history (with dates and tests/imaging performed)
- Your immunization history
- A Personal Health Record summary you can save, print or share

Find Care & Costs

- Procedures (with cost estimates)
- Conditions
- Doctors, hospitals or facilities
- Pharmacies
- Durable medical equipment (DME)

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Pharmacy

- Your claims history
- Drug costs
- Your pharmacy orders (medicines you have received, prescriptions ready for refills, etc.)
- Your cumulative out-of-pocket prescription costs

Blueprint Wellness

- Health risk assessment (HRA) or Wellbeing assessment
- Wellness progress tracking
- Access to a health library
- A nurse helpline
- Resources like action plans, challenges, decision tree for medical tests, search medical conditions and virtual coaching
- Health education
- Chronic condition management
- Case management

Virtual Health

- Medical help for nonemergencies, via smartphone, tablet or computer
- Available 24x7
- Accessible from home – or around the globe
- Board-certified, state-licensed physicians (including pediatricians)
- Short wait times (usually 10 minutes or less)

So the next time you're wondering ... how much a tonsillectomy will cost you ... or when you started that blood pressure medicine ... or whether you've met your deductible ... just sign in or register for My Blueprint and take a look. The answers you need are all there at your fingertips.

Registration is easy

Go to **blueadvantagearkansas.com**

Select the **Member portal** tab then select the **Register** button.

Follow the instructions. All you need is your:

- Member ID or the last four digits of your Social Security number
- Name
- Date of birth

If you're already a My Blueprint user, simply enter your username and password to sign in and access your account.

On the go?

Download the My Blueprint Mobile App to view, print or email your ID card while you are in your doctor's office. You can also access many more features through the app to manage your health plan.

Download on the App Store | GET IT ON Google Play

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Using your Pharmacy benefits

Whether you're healing from an illness or managing a chronic condition – prescription medications can play an important role in your wellness journey.

As a card-carrying Arkansas Blue Cross and Blue Shield member, you have access to a full suite of pharmacy benefits that connect you to the prescriptions you need as easily and cost effectively as possible.

Access to your medications starts with your member ID card, which is accepted at in-network pharmacies.

You can access our extensive pharmacy center by signing into My Blueprint and completing a one time sign up for a CVS Caremark account. You will have direct access to your pharmacy account information, find ways to save on your prescriptions, sign up for email or text alerts about your medications, request refills and more. From there, you'll be able to conveniently manage your prescriptions, as well as the prescriptions of everyone else on your health plan.

ID Card

You'll always have your ID card available, which you can view and/or print from My Blueprint, blueadvantagearkansas.com/myblueprint, or access directly from our mobile app.

Pharmacy Locator

Find network pharmacies near you by entering a ZIP Code, state, mileage preference or specific pharmacy you are trying to locate at My Blueprint, blueadvantagearkansas.com/myblueprint, or by using your current location with our mobile app. Select **Find Care** then **Pharmacies**.

Drug Cost and Coverage

Find out how much your medication will cost under your plan and whether there are opportunities to save money from your phone, tablet or our member portal.

Request a New Prescription

With this feature just enter the name and strength of your medication and your doctor's name.

Delivery by Mail & Text Reminders

You can have a 90-day supply of maintenance medications delivered by mail. They are filled by a licensed pharmacist, checked for quality and delivered in discreet, weather-proof, secure packages. Typically, a 90-day supply of a prescription will cost less than the same amount of medication split into three 30-day supplies. We'll also make sure you're ready for every refill by sending a reminder text 10 days before you're due for your next supply. Talk with your doctor about this option so your prescriptions can be written accordingly.

Easy Refills

Refill your mail order prescription without logging in. Just enter the prescription number from your pill bottle and your date of birth.

Go to My Blueprint, blueadvantagearkansas.com/myblueprint, to register or download the app. And if you already have an account, sign in to access your medications 24 hours a day, seven days a week.

Arkansas

Download on the App Store

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CVS caremark™

Where To Go

The cost for care and time you wait can vary greatly depending on where you go. Here is a simple guide to choosing the right place to go for health care. In addition to clinical settings, you have access to virtual visits as well.

	Conditions Treated*	Your Cost & Time
Emergency Room		
For the immediate treatment of critical injuries or illness. If a situation seems life-threatening, call 911 or go to the nearest emergency room. Open 24/7.	• Sudden numbness, weakness • Uncontrolled bleeding • Seizure or loss of consciousness • Shortness of breath • Chest pain • Head injury/major trauma • Blurry or loss of vision • Severe cuts or burns • Overdose	• Costs are highest • No appointment needed • Wait times may be long, averaging over 4 hours
Urgent Care Center		
For conditions that are not life threatening. Staffed by nurses and doctors and usually have extended hours.	• Minor cuts, sprains, burns, rashes • Fever and flu symptoms • Headaches • Chronic lower back pain • Joint pain • Minor respiratory symptoms • Urinary tract infections	• Costs are lower than an ER visit • No appointment needed • Wait times vary
Doctor's Office		
The best place to receive routine or preventive care, track medications, or get a referral to see a specialist.	• General health issues • Preventive services • Routine checkups • Immunizations and screenings	• May include coinsurance and/or deductible • Appointment usually needed • May have little wait time
Convenience Care Clinic		
Staffed by nurse practitioners and physician assistants. Treat minor medical concerns that are not life threatening. Located in retail stores and pharmacies, they're often open nights and weekends.	• Common cold/flu • Rashes or skin conditions • Sore throat, earache, sinus pain • Minor cuts or burns • Pregnancy testing • Vaccinations	• Costs are same or lower than office visit • No appointment needed • Wait times typically 15 minutes or less
Virtual Medicine		
Virtual visits with a doctor anytime 24/7/365 via computer with webcam capability or smartphone mobile app.	• Cold and flu symptoms such as a cough, fever and headaches • Allergies • Sinus infections • Family health questions	• Cost is the same as office visit • No appointment needed • Immediate, private, and secure visits

*List is not all inclusive. To find a specific health care facility or doctor, go to your medical carrier's website or call the number on your ID card. The listing of a health care professional or facility in the online directory does not guarantee that the services rendered by that professional or facility are covered under your specific medical plan. Check your official plan document for information about the services covered under your plan benefits. The information provided here is for informational purposes only. During a medical emergency, you should always visit the nearest hospital or call 911 for assistance.

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Virtual Health BEHAVIORAL

Wouldn't it be great if you had your own professional counselors who would be on call 24/7 to help you with emotional/mental health issues? Actually you do!

Help for your behavioral health needs is as close as your smartphone or computer. Virtual Health (powered by MDLIVE) is available for you 24/7.

Use it to talk through behavioral health nonemergencies like:

- **Family trouble**
- **Substance use problems**
- **Job stress**

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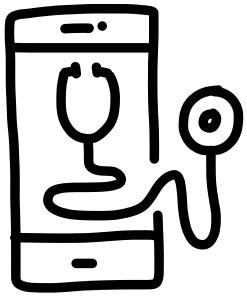
Register today, so when you need care, help is always available.

State-licensed, board-certified physicians are always ready and waiting **around the clock**.

Go to **myvirtualhealth.com** and follow the simple steps to sign up or log in.

For true emergencies (anytime your emotional condition might make you a danger to yourself or others) get inpatient care immediately.

But for nonemergencies, you can use virtual health to get the behavioral care you need without leaving home.



Use virtual health for:

- Addictions
- Anxiety
- Depression
- Bipolar disorders
- Eating disorders
- LGBTQ support
- Grief and loss
- Relationship issues
- Men's issues
- Panic disorders
- Stress management
- Trauma and PTSD
- Women's issues
- More

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MDLIVE is a separate company that provides telehealth services for members of BlueAdvantage Administrators of Arkansas.

Virtual Health currently is available to all fully insured health plans but not available to all health plans. Members with an active medical plan whose coverage includes Virtual Health should be able to successfully register via the link within My Blueprint. Your benefit summary will indicate if Virtual Health is available to you. Notably, it is not available to members who have limited duration plans, Medicare Prescription Drug and Medicare Supplement plans, or plans covering employees of FEP, Arkansas State and Public Schools, or Baptist Health.

Behavioral health benefits through Virtual Health are available for select members served by BlueAdvantage Administrators of Arkansas. For coverage verification, call the number on the back of your member ID card or contact your group administrator.

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Virtual Health

Set up access to online medical help

You need healthcare 24/7 — not just when it's convenient. Virtual health (powered by MDLIVE) gives you access to medical help for nonemergency conditions on your smartphone or computer.

Get started!

1. **Go to MyVirtualHealth.com**
2. **Go to Member sign in**
   - Sign in or register for your Blueprint Portal account.
3. **Activate your virtual health account**
   - In Blueprint Portal, select **Virtual Health** from the tHealth & Wellness tab, select **Visit MDLIVE** and follow the prompts to activate your account.

     (**Note**: You'll skip this step in the future and be sent directly to MDLIVE.)
   - Establish your account profile and those of your dependents if applicable. You will need member ID numbers to complete this step.
4. **Choose a doctor**
   - Choose from a large network of state-licensed, board-certified doctors (including pediatricians).

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5. Start your virtual health visit

You may be required to have your first call be a video call (like FaceTime or Skype).

- Choose to see the next available physician (usually within 10 minutes) or schedule an appointment at a specific time, with a specific physician.
- You will need to provide some details about your past history and medical problem(s):

Reason(s) for visit | **Medicines you currently take** | **Payment information**

What can be treated

- Allergies
- Common cold
- Constipation
- Cough
- Diarrhea
- Ear problems
- Fever
- Flu
- Headache
- Insect bites
- Nausea
- Pink eye
- Rash
- Respiratory problems
- Sore throat
- Urinary problems
- Vomiting
- More

We recommend setting up your account now. That way, when you need to speak with a doctor you can just sign in and get the help you need. The details of your call are confidential and secure. For emergencies (like broken bones, excessive bleeding, dangerously high fever, symptoms of heart attack or stroke, etc.) get to the nearest emergency room. But for many common conditions, Virtual Health is your healthcare solution. Anytime, anywhere.

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Dental

Good oral health is just as important as maintaining your physical health. Bruce Oakley offers you a dental plan through **Delta Dental**.

About the Dental Plan Option

Dental plans are designed to encourage preventive treatment so you can achieve oral health, while minimizing costs. Dental care may be obtained from any dental provider; however choosing dental services from a dentist participating in-network will provide you with substantial savings. If you choose to see a dentist who is out-of-network, your out-of-pocket costs will be higher and you will be subject to any charges beyond the reasonable and customary (R&C).

Sometimes dental insurance pays based on a less expensive alternative to treatment that may be available. If you anticipate receiving dental treatment in excess of $400 your dentist should submit your treatment plan to the dental carrier to obtain a pre-treatment estimate.

The deductible is waived for routine preventive services, such as regular dental checkups.

- Visit ***www.deltadental.com*** for a list of participating dentists online or call **800-521-2651** to have a list faxed or mailed to you.

Dental Plan Features	Delta Dental of Arkansas	
	In-Network	Out-of-Network
Annual Deductible Individual Family	 $50 $150	 $50 $150
Annual Maximum Benefit Per Person	$1,000	$1,000
Preventive Services Exams, routine cleanings, x-rays	100% deductible waived	100% deductible waived
Basic Services Fillings, simple extractions, oral surgery	80% after deductible	80% after deductible
Major Services Crowns, inlays, onlays, bridges, dentures	50% after deductible	50% after deductible
Orthodontia	50%	50%
Orthodontia Lifetime Maximum Benefit	$1,000 (children to age 19)	$1,000 (children to age 19)

Dental: Weekly Contributions	Delta Dental of Arkansas
Employee Only	$6.00
Employee + Spouse	$17.66
Employee + Child(ren)	$17.66
Family	$17.66

Vision

About the Vision Plan

With the **VSP Vision Plan,** you have access to in-network and out-of-network providers. When you see a network provider, you pay a copay for services or receive coverage up to a certain allowance. For out-of-network providers, you will receive a specific reimbursement amount depending on the service.

The Vision Plan offers you and your family a comprehensive vision program that reduces the cost of eye exams, eyeglasses and contact lenses. To receive the highest level of benefits use an in-network provider. The plan offers exams and lenses every 12 months; frames are available every 12 months. You may use your lens coverage once every 12 months to purchase two pairs of eyeglass lenses or one pair of eyeglasses and an allowance toward your contact lenses. If you decide to use an out-of-network doctor, you typically will pay more out-of-pocket.

- Visit ***www.vsp.com*** for a list of participating vision providers online or call **1-800-877-7195**.

Vision Plan Features	VSP Vision Plan	
	In-Network	Out-of-Network
Eye Exam	$10 copay	Up to $45 reimbursment
Lenses Single Vision Bifocal Trifocal	 $25 copay $25 copay $25 copay	 Up to $30 reimbursment Up to $50 reimbursment Up to $65 reimbursment
Frames	$150 allowance + 20% discount on remaining balance	Up to $70 reimbursment
Contact Lenses Fitting and Evaluation Elective Neccessary	 Covered in full with max copay of $60 $150 allowance Covered after eyewear copay	 N/A Up to $105 reimbursment Up to $210 reimbursment
Frequency	Eye Exam: Once every calendar year Frames: Once every 12 months Lenses & Contact Lenses: Once every 12 months	
Retail Frame Benefit	$85 allowance at Costco, Walmart & Sam's Club	

Vision: Weekly Contributions	VSP Vision Plan
Employee Only	$1.84
Employee + Spouse	$2.95
Employee + Child(ren)	$3.01
Family	$4.85

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In-network Value Added Features:

Additional lens enhancements: In addition to standard lens enhancements, enjoy an average 20-25% savings on all other lens enhancements.*

Savings on glasses and sunglasses: Get 20% savings on additional pairs of prescription glasses and non-prescription sunglasses, including lens enhancements. At times, other promotional offers may also be available.*

Laser vision correction:** Savings averaging 15% off the regular price or 5% off a promotional offer for laser surgery including PRK, LASIK and Custom LASIK. This offer is only available at MetLife participating locations.

** All lens enhancements are available at participating private practices. Maximum copays and pricing are subject to change without notice. Please check with your provider for details and copays applicable to your lens choice. Please contact your local Costco, Walmart and Sam's Club to confirm availability of lens enhancements and pricing prior to receiving services. Additional discounts may not be available in certain states.*

*** Custom LASIK coverage only available using wavefront technology with the microkeratome surgical device. Other LASIK procedures may be performed at an additional cost to the member. Additional savings on laser vision care is only available at participating locations.*

Learn more about your MetLife benefits

The MetLife Mobile App is available on the iTunes App Store and Google Play. Download the app and use it to find a participating provider.

MetLife benefits information right from your laptop

The MyBenefits website is a quick and easy way for you to get the information you need about your MetLife benefits — all in one place. Log in to **metlife.com/mybenefits** to see how we've taken personalization and integration to a new level.

Personalized homepage to all your MetLife benefits

Get more information on your MetLife benefits, where you can link to detailed coverage information and can perform tasks, such as:

Vision Plans — Easily find a vision provider or view your benefits and claims online. Plus, you will have access to our extensive Vision Health Library to research important vision topics.

Vision ID cards are available online for you to download and print at your convenience. Cards contain your name, MetLife's claims submission address, website and customer service telephone number.

Additional MyBenefits features include:

- Planning tools that you can use to help you make informed decisions regarding your retirement and benefits coverage as well as other useful information for a variety of everyday topics.
- Forms and documents that you may need are located in the "Tools & Resources" area at the bottom of the MyBenefits home page for you to download.
- In the "News & Updates" section you'll find information from MetLife and your employer such as enrollment dates and new product offerings.

metlife.com/mybenefits

Navigating life together

MetLife | VisionAccess Program

Set your sights on savings and convenience.

MetLife VisionAccess is a discount program that helps you save and stay on top of your care. You get great discounts that couldn't be easier to use — just visit one of the thousands of participating private practice ophthalmologists and optometrists.

What you get is clear:

- Savings on eye exams
- Discounts on glasses and frames
- Lower costs for laser vision correction
- A broad choice of quality providers
- Availability of the program to your entire family
- No enrollment or claim forms

Using your discount is simple. Just provide your program code, **MET2020**, when making an appointment or receiving services or materials. And remember, you'll need to visit a participating private practice to take advantage of the program. Save the attached cards for easy reference.

Pricing in regional areas should not exceed certain amounts

Refer to schedule of benefits on the back of this flyer

Region 1	AK, CA (Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Solano), CT, DC, HI, NJ, NY (Bronx, Kings, Nassau, New York, Queens, Richmond, Rockland, Suffolk, Westchester), and MA
Region 2	California (all except Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Solano), DE, FL, IL, MD, MI, NH, NV, PA, RI, and WA
Region 3	AZ, CO, GA, LA, MN, ME, NM, NY (all except Bronx, Kings, Nassau, New York, Queens, Richmond, Rockland, Suffolk, Westchester), OH, OR, TX, UT, VT, and VA
Region 4	AL, AR, IA, ID, IN, KS, KY, MO, MS, MT, NE, NC, ND, OK, SC, SD, TN, WV, WI, WY, and PR

Cut along dotted line

VisionAccess Program

See Well. Stay Healthy. Save More.

- 20% off eye exam
- 20% off lenses and lens options
- 25% off frames
- 20% off non-prescription sunglasses
- Discounts on laser vision correction

Program Code: MET2020

MetLife

Program provided through Vision Service Plan (VSP).

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Program Code: MET2020

MetLife

Program provided through Vision Service Plan (VSP).

Get a clearer view on life for less.

Vision care service	Member Savings[1]
Exams	20% off of Usual and Customary fee[2] with a maximum copay of: Region 1: $90 Region 2: $90 Region 3: $80 Region 4: $75
Exam — contact lens	15% off Usual and Customary fee[2] Discounts on contact lens materials are not available. Check with your participating private practice for available offers.
Standard corrective lenses — glass or plastic	
• Single vision	20% off of Usual and Customary fee[2] with a maximum copay of: Region 1: $50 Region 2: $45 Region 3: $45 Region 4: $40
• Lined bifocal	20% off of Usual and Customary fee[2] with a maximum copay of: Region 1: $70 Region 2: $65 Region 3: $65 Region 4: $60
• Lined trifocal	20% off of Usual and Customary fee[2] with a maximum copay of: Region 1: $90 Region 2: $85 Region 3: $85 Region 4: $75
Standard lens options	
• Ultraviolet coating	20% off of Usual and Customary fee[2] with a maximum copay of $15
• Tint — solid or gradient	20% off of Usual and Customary fee[2]
• Standard scratch-resistant coating (scratch A)	20% off of Usual and Customary fee[2] with a maximum copay of $15
• Standard polycarbonate	20% off of Usual and Customary fee[2] with a maximum copay of $40
• Standard progressive	20% off of Usual and Customary fee,[2] add on to bifocal, with a maximum copay of $55
• Basic anti-reflective coating	20% off of Usual and Customary fee[2] with a maximum copay of $45
• Blended invisible bifocal	20% off of Usual and Customary fee[2]
• Intermediate vision lenses	20% off of Usual and Customary fee[2]
• High index	20% off of Usual and Customary fee[2]
• Polarized	20% off of Usual and Customary fee[2]
• All other lens options/features	20% off of Usual and Customary fee[2]
Frames	25% off of Usual and Customary fee[2]
Laser vision correction[3]	Discounts averaging 15% off the regular price or 5% off a promotional offer for laser surgery including PRK, LASIK and Custom LASIK. Discounts are only available from MetLife participating facilities.
Non-prescription sunglasses	20% off of Usual and Customary fee[2]
Discounts are only available through participating private practices.	

For more information or to find a participating provider
visit our website at www.metlife.com/mybenefits or call 1-888-GET-MET8.

Discounts are available from any participating private practice. See your program schedule of benefits for more details.

Provide your program code, **MET2020**, when making an appointment or receiving services or materials.

To review benefits or find a participating provider, visit our website or call.

www.metlife.com/mybenefits
1-888-GET-MET8 (1-888-438-6388)

Say "Vision;" then select option 2 (MetLife VisionAccess Discount Program)

Discounts are available from any participating private practice. See your program schedule of benefits for more details.

Provide your program code, **MET2020**, when making an appointment or receiving services or materials.

To review benefits or find a participating provider, visit our website or call.

www.metlife.com/mybenefits
1-888-GET-MET8 (1-888-438-6388)

Say "Vision;" then select option 2 (MetLife VisionAccess Discount Program)

MetLife VisionAccess is a discount program and not an insured benefit. The program is available at no charge regardless of enrollment in other MetLife benefits. Participation in the vision discount program is not contingent on the purchase of a MetLife product. It is provided through Vision Service Plan (VSP), Rancho Cordova, CA. VSP is not affiliated with MetLife or its affiliates.

1. See listing of Regional Discount Areas on the front of this flyer.
2. Usual and Customary fee is the vision care provider's retail fee for services and materials.
3. Custom LASIK coverage only available using wavefront technology with the microkeratome surgical device. Other LASIK procedures may be performed at an additional cost to the member. Laser vision care discounts are only available from participating facilities.

Metropolitan Life Insurance Company | 200 Park Avenue | New York, NY 10166 1300000017 (0717) L0121010468[exp0122][All States]

MetLife

Life and AD&D

It's not always easy to talk with your family about how they'll be provided for if you weren't around, but it's an important conversation to have. Life and AD&D insurance can provide financial protection in the event of your death or a serious accident. The company provides a benefit, and you have the option to purchase additional coverage for yourself and your dependents through **Mutual of Omaha**. Below is a summary of coverage available.

Basic Life insurance and Accidental Death & Dismemberment (AD&D) coverage in the amount of $30,000. If you should pass away, the beneficiary you have designated will receive the amount of your life insurance. If you have AD&D coverage and suffer a covered injury, such as the loss of a limb or an eye, you would receive a portion of your AD&D benefits. The Basic Life and AD&D benefit will reduce when you turn age 65 to 65% of the original benefit amount. It will reduce again when you turn age 70 to 50% of the original benefit amount.

Life and AD&D Plan Features	Benefit
Basic Life and AD&D* *(Company-Paid)*	• Coverage Amount: $30,000 • Benefit payable if you die, lose a limb or suffer paralysis in an accident
Voluntary Life and AD&D *(Employee Paid)*	
For Yourself *Guaranteed Issue $200,000*	• Coverage Amount: $10,000 increments up to the lesser of 5x earnings or $500,000 • Evidence of Insurability (EOI): Required when electing more than $200,000 of coverage as a new hire. It is also required if you are enrolling late or if you would like to increase your current coverage during open enrollment by more than $10,000
For Your Spouse *Guaranteed Issue $50,000*	• Coverage Amount: $5,000 increments up to the lesser of $250,000 • Evidence of Insurability (EOI): Required when electing more than $50,000 of coverage as a new hire. It is also required if you are enrolling late or if you would like to increase your current coverage during open enrollment by more than $5,000
For Your Dependent Child(ren)	• Coverage Flat Amount: $10,000 • All dependent life coverage is 100% guaranteed issue; not EOI is required
Additional Feature: Accelerated Benefit	If you become terminally ill, you may be eligible to receive up to 75 percent of your combined Basic and Additional Life benefit to a maximum of $500,000.

* Age Reduction Formula (reduces by): Reduces by 35% at age 65, and to 50% of the original amount at age 70. The Spouse benefit will terminate when the employee reaches age 70.

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Beneficiary Designation

A beneficiary is the person you designate to receive your life insurance benefits in the event of your death.

When naming your beneficiary(ies), indicate their full name, address, Social Security number, relationship, date of birth and distribution percentage. If the beneficiary is not legally related, insert the words "Not Related" in the relationship field.

Note: In most states, benefit payments cannot be made to a minor younger than age 18. If you elect to designate a minor as beneficiary, all proceeds may be held under the beneficiary's name, and will earn interest until the minor reaches majority age of 18.

If you name more than one beneficiary with unequal shares, the total percentage share must equal 100%.

Disability Benefits

Bruce Oakley offers disability coverage to protect you against any debilitating illness or injury. This insurance protects a portion of your income until you can return to work, or until you reach retirement age, if you remain disabled.

Short Term Disability (STD) Insurance *(Employee-Paid)*

Short-term disability income benefits are available to you to provide income benefits if you become disabled from a non-work related injury or sickness. You pay full cost of this coverage.

Eligibility: All full time employees working a minimum of 30 hours per week.

STD Features	Benefit
Weekly Benefit Maximum	$1,150
Waiting Period	14 days injury/illness
Benefit Duration	24 weeks
Pre-Existing Condition	3/6

Long Term Disability (LTD) Insurance *(Employee-Paid)*

Long-term disability income benefits are provided to you in the event you become disabled from an injury or sickness, for 180 days or more. Disability income benefits are provided as a source of income.

- If you are approved for LTD benefits by the third party administrator, your benefits begin when salary continuation benefits end.
- Once you meet the plans definition of "disabled", and after you satisfy the elimination period the plan pays a percentage of your pay at the time of the disability. (see chart below).
- Your benefit amount may be reduced by disability income payments from other plans, such as Social Security.
- If you wish to add Long-term disability after your original hire date you will need to submit an Evidence of Insurability form and receive approval from Carrier.

LTD Features	Benefit
Maximum Monthly Benefit	$5,000
Minimum Monthly Benefit	Greater of 10% or $100
Elimination Period	180 days
Pre-Existing Condition	12/12
Duration of Benefits	To age 65 or Social Security Normal Retirement Age

Accident

The **MetLife** group accident plan can help you and your family manage the financial impact of an injury. The Group Accident Plan can help reduce the out-of-pocket expenses associated with an accident.

You may be eligible to receive payment for the initial treatment of a covered accidental injury.

Additionally, you may receive a benefit payment for:

- Follow-Up Visits
- Hospital Admission/Confinement
- Inpatient Surgical
- Dislocations
- Fractures

Wellness Benefit

This plan also offers a wellness benefit of $50 for each Empoyee, their spouse, and children, once per calendar year, payable when certain wellness tests are performed as the result of a preventive care visit.

Organized Sports Activity Injury Benefit Rider

If a covered person has an accident that is due to organized sports activity, we will pay an extra 25% of eligible benefits, subject to limitations described in the certificate, under the following benefit categories: Accidental Injury, Accident Medical Treatment and Services, Hospital benefits.

The Organized Sports Activity Injury Benefit Rider is pending regulatory approval in some states.

Accident Plan Summary	Base Plan
Accidental Death Benefit	Employee: $50,000 Spouse: $25,000 Child: $10,000
Accidental Death on Common Carrier	Employee: $150,000 Spouse: $75,000 Child: $30,000
Loss of hearing	up to $40,000
Loss of sight	up to $40,000
Loss of limbs	up to $40,000
Fractures	up to $10,000
Dislocations	up to $10,000
Burns	up to $15,000
Skin Grafts	50% of Burn Benefit
Concussion	$500
Coma	$10,000
Rupture Disc	$1,500
Knee Cartilage	$1,500
Laceration	up to $700
Prosthetic Device Benefit	One Device: $1,000 More than one Device: $2,000
Hospital Admission	$1,500
Intensive Care Admission	$1,500
Hospital Confinement	$300/day – up to 15 days
Intensive Care Confinement	$300/day – up to 15 days
Chiropractic Visit	$50 per visit up to 10 times
Prosthetic Devices or Artificial Limb	1: $1,000 2 or more: $2,000
Therapy Services Benefit (including physical therapy)	$50
Appliance (once per accident)	up to $1,000
Blood, Plasma, Platelets	$500
Ambulance Benefit Ground	$400
Lodging Benefit	$200

Accident: Weekly Contributions	
Employee Only	$2.96
Employee + Spouse	$5.82
Employee + Child(ren)	$6.97
Family	$8.24

*Any 65 to 69: Any benefit payable will be reduced by 25% of the amount listed for that benefit in the Schedule if the Covered Person's Attained Age is 65 to 69. For example, a $100 benefit, as listed in the Schedule, will be paid at $75 if the Covered Person's Attained Age is 67. Any 70 or older: Any benefit payable will be reduced by 50% of the amount listed for that benefit in the Schedule if the Covered Person's Attained Age is 70 or older. For example, a $100 benefit, as listed on the Schedule, will be paid at $50 if the Covered Person's Attained Age is 72.

Critical Illness

MetLife is pleased to offer you an opportunity to provide your employees with financial protection through our Group Critical Illness Insurance as part of our robust portfolio of voluntary products. Critical Illness Insurance provides features that could be valuable to your employees, including:

- Eligibility for portability through the Continued Insurance with Premium Payment provision may be subject to certain eligibility requirements and limitations. For more information, contact your MetLife representative.
- No coordination with other insurance benefits;
- Employees are paid a lump-sum benefit that they can use as they feel necessary.
- Employees and their families will have access to discounts or services that will provide them actionable tools and resources to help them navigate life's twists and turns.

MetLife Critical Illness Insurance can supplement existing medical coverage and help provide financial support to pay for out-of-pocket expenses such as mortgage payments, college tuition, hiring household help, or treatment not covered by your medical plan. Benefits are paid regardless of what is covered by medical insurance. Payments are made directly to covered employees to spend as they choose.

Critical Illness Summary	Benefit
Coverage Tier	
Employee	$10,000, $20,000 or $30,000
Spouse	50% of employee coverage amount
Child	50% of employee coverage amount
Covered Critical Illnesses	
Invasive Cancer Heart Attack Major Organ Transplant Kidney Failure Benign Brain Tumor Childhood Diseases Functional Loss Progressive Diseases Severe Burn Stroke	100%
Coronary Artery Bypass Graft (CABG) - where surgery involving either a median sternotomy or minimally invasive procedure is performed	50%
Bacterial Cerebrospinal Meningitis Diphtheria Encephalitis Legionnaire's Disease Malaria Necrotizing Fasciitis Osteomyelitis Rabies Tetanus	25%

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Wellness Benefit - For Critical Illness

This plan also offers a wellness benefit, once per calendar year, payable when certain wellness tests are performed as the result of a preventive care visit.

Employees, spouses and children get a $50 wellness benefit per calendar year simply for completing their annual wellness exam and blood work.

Critical Illness (cont.)

Employee Weekly Premium $10,000 Beneefit Amount				
Attained Age	Employee Only	Employee + Spouse	Empoyee + Child(ren)	Family
<25	$1.22	$2.01	$1.78	$2.58
25-29	$1.32	$2.22	$1.89	$2.77
30-34	$1.52	$2.52	$2.08	$3.07
35-39	$1.80	$2.95	$2.38	$3.51
40-44	$2.33	$3.74	$2.88	$4.29
45-49	$3.14	$4.94	$3.69	$5.49
50-54	$4.57	$6.88	$5.12	$7.43
55-59	$6.51	$9.46	$7.08	$10.02
60-64	$9.18	$13.06	$9.74	$13.62
65-69	$12.95	$18.09	$13.50	$18.65
70-74	$17.17	$24.09	$17.72	$24.65
75+	$22.96	$32.79	$23.52	$33.35

Employee Semi-Monthly Premium $10,000 Beneefit Amount				
Attained Age	Employee Only	Employee + Spouse	Empoyee + Child(ren)	Family
<25	$2.65	$4.35	$3.85	$5.60
25-29	$2.85	$4.80	$4.10	$6.00
30-34	$3.30	$5.45	$4.50	$6.65
35-39	$3.90	$6.40	$5.15	$7.60
40-44	$5.05	$8.10	$6.25	$9.30
45-49	$6.80	$10.70	$8.00	$11.90
50-54	$9.90	$14.90	$11.10	$16.10
55-59	$14.10	$20.50	$15.35	$21.70
60-64	$28.05	$28.30	$21.10	$29.50
65-69	$28.05	$39.20	$29.25	$40.40
70-74	$37.20	$52.20	$38.40	$53.40
75+	$49.75	$71.05	$50.95	$72.25

Employee Weekly Premium $20,000 Beneefit Amount				
Attained Age	Employee Only	Employee + Spouse	Empoyee + Child(ren)	Family
<25	$1.57	$2.58	$2.26	$3.28
25-29	$1.80	$2.95	$2.49	$3.65
30-34	$2.22	$3.55	$2.91	$4.29
35-39	$2.77	$4.43	$3.46	$5.17
40-44	$3.78	$6.00	$4.52	$6.69
45-49	$5.45	$8.40	$6.14	$9.09
50-54	$8.26	$12.28	$9.00	$12.97
55-59	$12.18	$17.49	$12.88	$18.18
60-64	$17.54	$24.65	$18.23	$25.34
65-69	$25.02	$34.71	$25.71	$35.40
70-74	$33.46	$46.71	$34.15	$47.45
75+	$45.05	$64.11	$45.78	$64.80

Employee Semi-Monthly Premium $20,000 Beneefit Amount				
Attained Age	Employee Only	Employee + Spouse	Empoyee + Child(ren)	Family
<25	$3.40	$5.60	$4.90	$7.10
25-29	$3.90	$6.40	$5.40	$7.90
30-34	$4.80	$7.70	$6.30	$9.30
35-39	$6.00	$9.60	$7.50	$11.20
40-44	$8.20	$13.00	$9.80	$14.50
45-49	$11.80	$18.20	$13.30	$19.70
50-54	$17.90	$26.60	$19.50	$28.10
55-59	$26.40	$37.90	$27.90	$39.40
60-64	$38.00	$53.40	$39.50	$54.90
65-69	$54.20	$75.20	$55.70	$76.70
70-74	$72.50	$101.20	$74.00	$102.80
75+	$97.60	$138.90	$99.20	$140.40

Employee Weekly Premium $30,000 Beneefit Amount				
Attained Age	Employee Only	Employee + Spouse	Empoyee + Child(ren)	Family
<25	$1.94	$3.12	$2.77	$4.02
25-29	$2.28	$3.67	$3.12	$4.57
30-34	$2.91	$4.64	$3.74	$5.47
35-39	$3.74	$5.95	$4.57	$6.78
40-44	$5.26	$8.31	$6.09	$9.14
45-49	$7.75	$11.91	$8.58	$12.74
50-54	$11.98	$17.72	$12.88	$18.55
55-59	$17.86	$25.48	$18.69	$26.31
60-64	$25.89	$36.28	$26.72	$37.11
65-69	$37.11	$51.37	$37.94	$52.20
70-74	$49.78	$69.37	$50.61	$70.20
75+	$67.15	$95.47	$68.05	$96.30

Employee Semi-Monthly Premium $30,000 Beneefit Amount				
Attained Age	Employee Only	Employee + Spouse	Empoyee + Child(ren)	Family
<25	$4.20	$6.75	$6.00	$8.70
25-29	$4.95	$7.95	$6.75	$9.90
30-34	$6.30	$10.05	$8.10	$11.85
35-39	$8.10	$12.90	$9.90	$14.70
40-44	$11.40	$18.00	$13.20	$19.80
45-49	$16.80	$25.80	$18.60	$27.60
50-54	$25.95	$38.40	$27.90	$40.20
55-59	$38.70	$55.20	$40.50	$57.00
60-64	$56.10	$78.60	$57.90	$80.40
65-69	$80.40	$111.30	$82.20	$113.10
70-74	$107.85	$150.30	$109.65	$152.10
75+	$145.50	$206.85	$147.45	$208.65

Hospital Indemnity

The **MetLife's** Hospital Indemnity plan can complement your health insurance to help you pay for the costs associated with a hospital stay. It can also provide funds that can be used to help pay the out-of-pocket expenses your medical plan may not cover, such as co-insurance, copays, and deductibles.

The MetLife's Hospital Indemnity plan pays $1,000 for each hospital admission per insured per calendar year.

This plan also allows you to continue coverage in the event that your employment ends or when the policy is terminated and not being replaced.

Hospital Indemnity Summary	Benefit
Hospital Admission	$1,000/admission up to 4 time(s) per calenday year
Hospital ICU Admission	$1,000/admission up to 4 time(s) per calenday year
Hospital Confinement	$200/day up to 15 days
Hospital ICU Confinement	$200/day up to 15 days
Confinement Benefit for Newborn Nursery Care	$50 for 2 day(s) per confinement

Hospital Indemnity: Weekly Contributions	
Employee Only	$3.59
Employee + Spouse	$10.81
Employee + Child(ren)	$6.51
Family	$13.73

Who can get coverage?	
You	If you're actively at work
Your Spouse	Ages 18+
Your Children	Dependent children until their 26th birthday, regardless of marital or student status.

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Benefit Reduction Due to Age

At age 65 - 69 Benefit amounts payable will be reduced by 25% of the amount listed. For example, a $100 benefit will be paid at $75 if the covered person's age is 67.

70 or older Benefit amounts payable will be reduced by 50% of the amount listed. For example, a $100 benefit will be paid at $50 if the covered persona's age is 72.

Whole Life Insurance Benefits

Whole Life Insurance may be a great supplement to any term life insurance you may already have because it protects your loved ones for your entire life, not just while you're working. Whole Life Insurance is permanent coverage you own; as long as the premiums are paid it can never be cancelled, even if your health changes.[1]

Available coverage is subject to certain minimums and maximums summarized in the Lifetime Coverage Limits table below.

Guaranteed Issue maximums are available in the employee's initial period of eligibility by answering "Yes" to the question ("Are you at work on a full-time basis, performing your usual duties?").] [After the initial enrollment period guaranteed issue maximums are subject to change.

Even if the employee does not apply for coverage, is available for spouse/domestic partner and children.

		Guaranteed Issue
Proposed Insured	**Ages**	**Defined Benefit Certificates (Min – Max)**
Employee	17-39	$10,000 - $100,000
	40-54	$10,000 - $100,000
	55-70	$10,000 - $100,000

[Spouses/[Domestic Partners] and children.[3]]

		Guaranteed Issue	Guaranteed Issue
Proposed Insured	**Ages**	**Defined Benefit Certificates (Min – Max)**	**Defined Benefit Riders (Min – Max)**
Spouse/ [Domestic Partner]	18-70	$5,000 – $25,000	$1,000 – $25,000
Children (15 days- 26 years old)	15 days - 26	$5,000 – $10,000	$1,000 – $10,000

*Guaranteed Issue available for children at $5,000-10,000 Face Amount Value only.

Additional features may help provide you with even more protection:

Accelerated Death Benefit for Terminal Illness Rider[4] Issue Ages 17-70 Employee Refer to minimum dependent eligibility age for Accelerated Death Benefit Option for Terminal Illness rider issue age for dependents. Standard on all plans. Standard up to 80% of the death benefit minus outstanding loans and loan interest if determined that death may occur in less than 12 months, may accelerate benefits. Premium will be discontinued indefinitely when rider is activated

Accelerated Death Benefit for Chronic Illness Rider[5] Issue Ages 17-70 Available to employee only 5% of the accelerated death benefit per month minus outstanding loans and loan interest with 20% of death benefit preserved; Triggered by inability to perform 2 of 6 Activities of Daily Living (ADLs) (without substantial assistance from another individual) or requires substantial supervision due to severe cognitive impairment that is permanent in nature. ADLs are

toileting, transferring, bathing, dressing, feeding and walking. Premium will be discontinued indefinitely when rider is activated.

Accidental Death Benefit[6] Issue ages 17-69 Employee. The amount of the rider is equal to the face amount of the certificate. Refer to Dependent age eligibility for minimum and maximum issue age. The amount of the rider is equal to the face amount of the certificate. No dismemberment available. Accidental Death can be added to certificates for employees, spouse, or child. (i.e. Covered Persons). If attached to Spouse certificate Spouse Education not available. If attached to Child certificate, Child Care Center, Child Education, and Spouse Education not available.

Waiver of Premium Benefit[6] Issue ages 17-59. Available to employee only. Premiums waived under the certificate (including for riders attached to cert). If the covered person is under 60 years old and is still disabled, premium continues to be waived to attained age 70. 9 month waiting period. Definition of total disability is inability to perform the duties of the insured person's regular occupation and any occupation for which the insured is able to perform based on training, education and experience. If the Claim is approved, premiums paid during the waiting period will be refunded. Coverage must be in force for 9 months to qualify.

BENEFIT PAYMENT EXAMPLE

Sue Ellen was offered the ability to purchase a whole life policy through her employer. She liked the idea of purchasing permanent life insurance coverage to provide for her children even after she retired.

Sue Ellen, age 40, purchased a $50,000 policy that would provide her with paid up insurance at age 70.	**She dies during her working years at age 62 and her children are the beneficiaries of the whole life policy.**	**100% of the insurance proceeds, $50,000, is paid out to her children upon her death.**

Frequently Asked Questions

Who is eligible to apply for this coverage?
You, your spouse/domestic partner and children.[3]

How do I pay for my coverage?
Premiums will be conveniently paid through payroll deduction, so you don't have to worry about writing a check or paying a bill. If you should change jobs or retire before the policy becomes paid up, you simply pay the monthly premium directly to MetLife by automatic bank draft or monthly bill.

Will my Whole Life Insurance premium increase?
Designed to allow the insured to keep coverage into retirement even though the insured stops paying premium at age 70 or 100, (or in 20 years if purchased at age 51+). At that time, the policy becomes fully paid up with no further premiums due and the death benefit remains equal at 100% of the Face Amount.

Can I apply for this coverage without having to answer medical questions or take a medical exam?
Because this coverage is available through your employment, you can qualify for coverage if you are actively-at-work and answer a work status question.

[1]Coverage can never be cancelled, as long as the insured pays the level premiums when due.

[2] Coverage is subject to review and approval by MetLife based upon its underwriting rules. MetLife will review the information and evaluate any request for coverage based upon answers to the health questions.

[3] Employees do not need to have coverage to apply for an individual policy for their spouse/domestic partner and children. Coverage and eligibility for spouse/domestic partner may vary by state.

[4] The Accelerated Benefits Option is subject to state regulation and is intended to qualify for favorable federal income tax treatment, in which case the benefits will not be subject to federal income taxation. This information was written as a supplement to the marketing of life insurance products. Tax laws relating to accelerated benefits are complex and limitations may apply. You are advised to consult with and rely on an independent tax advisor about your own particular circumstances. Receipt of accelerated benefits may affect your eligibility, or that of your spouse or your family, for public assistance programs such as medical assistance (Medicaid), Temporary Assistance to Needy Families (TANF), Supplementary Social Security Income (SSI) and drug assistance programs. You are advised to consult with social service agencies concerning the effect that receipt of accelerated benefits will have on public assistance eligibility for you, your spouse or your family.

MetLife

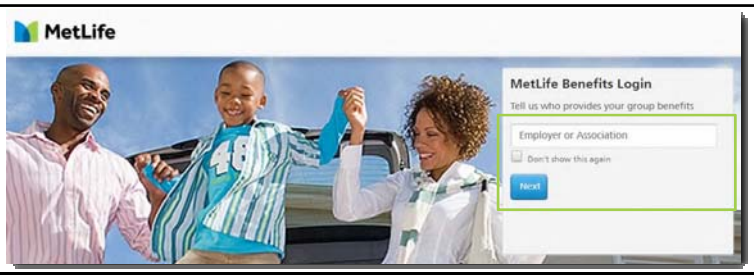
How To Register On MyBenefits

MyBenefits provides you with a personalized, integrated and secure view of your MetLife delivered benefits. You can take advantage of a number of self-service capabilities as well as easy to access information. As a first-time user, you will need to register on MyBenefits by following the steps outlined below:

Registration Process For MyBenefits:

STEP 1 – Provide A Group Name

Access MyBenefits at mybenefits.metlife.com. Enter your employer name, select it in the drop down and select 'Next'. Save this URL to access your MyBenefits account in the future.



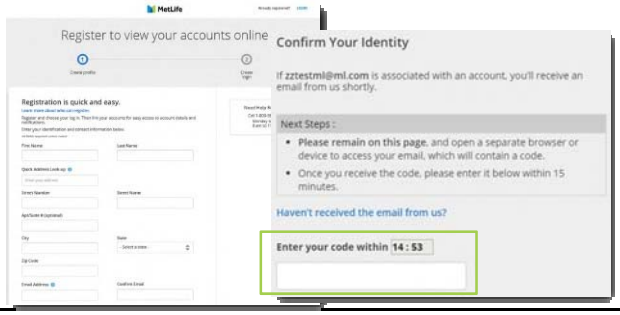
STEP 2 – Register

Once you have selected your employer, from the MyBenefits Home Page you will then select the 'Register' button.

Note – Current users will select 'Log In' and enter their username and password.

STEP 3 – Enter Authentication Information

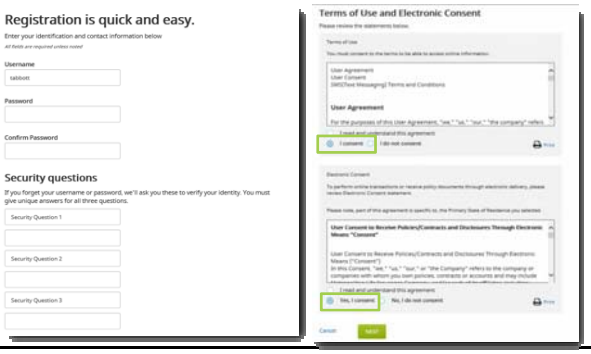
The next screen will begin by entering your name, address, phone number, e-mail (required) and unique security identifiers to confirm your identity. You will then receive a security code, via email or text, that you will need to enter to continue the registration process.



STEP 4 – Establish Account Credentials

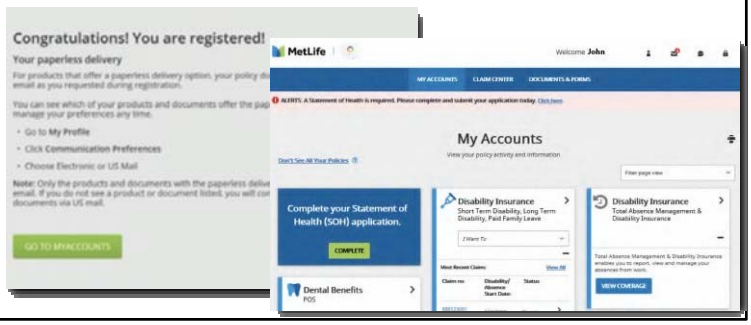
You will then be prompted to create a unique username and password for future access to MyBenefits, as well as choose and answer three identity verifications questions that will be used in the event you forget your password.

In addition to reading and agreeing to the Terms of Use, you will be asked to opt into electronic consent.



STEP 5 – Registration Is Complete

Once you have completed the process a 'congratulations' message window will display. You are now registered on MyBenefits! A registration confirmation email will be sent to the email address provided for your registration. You can immediately access your account information by selecting the 'Go To My Account' button within the congratulations window.



How do I get started?

Using the EAP is easy. Give us a call. Our trained staff will clarify your needs and suggest a possible plan of action. This is usually a face to face visit with an EAP counselor, it could also be a referral to a community resource or educational material depending on what you feel would be most helpful.

We are available 24 hours a day, 7 days a week.

Southwest EAP is always ready to help you and your family. Call the EAP NOW! Chances are we can help!

How else can I access EAP services?

Visit our website:
www.southwesteap.com

The website offers access to hundreds of articles, self assessments, online and video streaming programs, interactive tools, calculators and Federal and State documents and more.

for home...for work...for life.

Your employer provides an Employee Assistance Program (EAP) to protect it's most valuable investment - you. Southwest EAP provides you and your family with professional assistance for the challenges of everyday living.

Available 24 hours, seven days a week. Call us anytime.

501-663-1797
1-800-777-1797
www.southwesteap.com

Keeping People Productive

SOUTHWEST EAP

at home...at work...at life.

415 N. McKinley, Suite 520
Little Rock, Arkansas 72205
501-663-1797 1-800-777-1797
www.southwesteap.com

What is an Employee Assistance Program?

An Employee Assistance Program (EAP) is a **confidential** service designed to help employees and their families with personal or work related problems. **Southwest EAP** provides assessment, short-term counseling, referral if necessary and follow-up.

Sometimes life's problems are too big or complex for you and your family to handle alone. If you have a personal or work related problem of any kind, **Southwest EAP is a free, confidential, problem solving resource** provided by your employer to help in areas such as:

- Stress Management
- Emotional issues
- Depression and Anxiety
- Alcohol or Drug use
- Career concerns / job stress
- Family problems
- Child and Elder care resources
- Marriage/Relationship issues
- Legal troubles
- Grief or Loss issues
- Budgeting and Financial referrals
- Anything that is having a stressful impact on your life.

Will my job be affected?

Your job security or your chances of promotion will not be hurt by your use of the EAP. Your employer provides this program to help employees through stressful periods in their lives. Remember the EAP is **confidential** so nobody knows unless you decide to tell them. Actively addressing problems in your personal and professional life can actually improve your job performance and your chances for promotion.

Is the EAP confidential?

Your contact with the EAP is strictly **confidential**. The EAP will not release information to your employer or family without your written permission. The only exception, as required by law, are cases where clients express the intention of harming themselves or others, or the mandated reporting of child and elder abuse.

Who is eligible?

All full-time and regular part-time employees and their families are eligible for services.

Who does the counseling?

Your EAP counselor is a licensed Master or Doctoral level professional with a wide range of expertise.

What will it cost me?

Nothing! The EAP is provided by your employer. There is no cost for services. Assessments, short-term counseling, education, referrals and follow up are all **FREE** to you and your family.

Keeping People Productive
at home...at work...at life.

SOUTHWEST EAP

John Hancock

Your retirement plan: one great benefit, lots of advantages

Your retirement plan can be a great way to help you build your financial future. Be sure you're not missing out on the many ways you can benefit.

Tax savings now

When your contributions are taken out of your paycheck before federal income taxes, you may be able to lower your taxable income and find yourself in a lower tax bracket.

Tax savings later

Your retirement plan savings grow tax deferred, so your money and any earnings aren't taxed until withdrawal, ideally at retirement, when your tax rate may be lower.

Flexibility

You contribute as much as you want (subject to plan and IRS limits) to your plan. Plus, you have the flexibility to change your contribution rate at any time (subject to plan limits).

It's yours!

Even if you change jobs, your contributions and earnings belong to you. You'll typically have several distribution options to help you keep your savings invested and growing on a tax-deferred basis.[1]

1 Certain restrictions and conditions may apply. When withdrawing money from your plan, carefully consider the options available to you, including rolling your money over to another qualified account, to avoid potential tax penalties.

Move a step closer to reaching your retirement dreams.

Join your retirement plan today and take advantage of all the benefits that can help you build your financial future!

Visit **myplan.johnhancock.com** to get started!

Power of compounding

Compounding is the growth on your original contributions and the earnings. With time on your side, compounding can go a long way toward giving your savings an opportunity to keep growing.

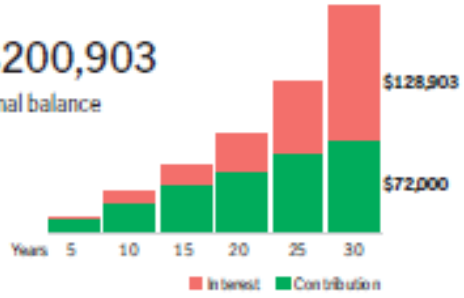
Start early and build your savings over time

When you save through your retirement plan, your deposits generate earnings. Those earnings are reinvested and generate their own earnings. The earlier you start saving, the more powerful the effect of compounding can be. Start small and incrementally increase your contributions to help meet your savings need. See below how putting away $200 each month in your retirement plan ($50 each week) can grow quickly and over time.

$72,000 + $128,903 → $200,903

Total deposits (Principal + contributions) | Total interest | Final balance

This chart is for illustration purposes only, and assumes a $0 starting balance, $200 per month in contributions, and a 6% annual rate of return.



There is no guarantee that the results shown will be achieved or maintained over any time period. This example assumes no withdrawals, does not take into account fees associated with investing which, if included, would reduce the account balance, and assumes reinvestment of earnings. Taxes are due at withdrawal.

Convenience

Your contributions are deducted from your paycheck automatically, so the money you're saving goes right from your paycheck to your plan account. And with regular contributions, your savings have a chance to add up.

Staying connected

Once you've joined your retirement plan, it's easy to stay connected by registering your account and adding your email address. Online account registration:

- Adds another layer of security to your account by providing timely transaction confirmations and activity updates
- Keeps you informed about new tools and resources that can help you build your retirement strategy and make progress toward meeting your goals

John Hancock

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Health Insurance Terms

In order to get the most out of your health care benefits, you need to understand the terms used by insurance companies, health plans, and health care providers.

- **Benefits -** The amount of money payable by an insurance company to a claimant under the insurance policy.
- **Claim -** A request by an individual (or his /her provider) for the insurance company to pay for services obtained.
- **Co-insurance -** The money that an individual is required to pay for services, after deductible has been paid. It is often a specified percentage of the charges. For example, the employee pays 20% of the charges while the health plan pays 80%.
- **Co-payment -** An arrangement where an individual pays a specified amount for various health care services and the health plan or insurance company pays the remainder. The individual must usually pay his or her share when services are rendered.
- **Deductible -** A set dollar amount that a person must pay before insurance coverage for medical expenses can begin. They are usually charged on an annual or contract year basis.
- **Exclusions and Limitations -** Specific conditions or circumstances for which an insurance policy or plan will not provide coverage (exclusions), or for which coverage is specifically limited (limitations).
- **Health Savings Account (HSA) -** An individual/person savings account where an insured can set aside pre-tax money to pay for qualified items (reference IRS Publication 502). You must be covered by a high deductible health plan (HDHP) in order to contribute to an HSA.
- **Flexible Spending Account (FSA) -** An individual/person savings account where an insured can set aside pre-tax money to pay for qualified items (reference IRS Publication 502). You must be covered by a high deductible health plan (HDHP) in order to contribute to an HSA.
- **High Deductible Health Plan (HDHP) -** A health plan that meets the requirements of being considered an HDHP. There are NO copayments on an HDHP. All medical and prescription drug expenses are applied towards the calendar year deductible first, then once a member has satisfied his/her deductible, the coinsurance will apply.
- **In-Network -** Typically refers to physicians, hospitals, or other health care providers who contract with the insurance plan to provide services to its members. Coverage for services received from in-network providers will typically be greater than for services received from out-of-network providers, depending on the plan.
- **Medically Necessary -** A term used to describe the supplies and services needed to diagnose and treat a medical condition in accordance with the standards of good medical practice. Many health plans will only pay for treatment deemed medically necessary. For example, most plans will not cover elective cosmetic surgery.
- **Out-of-Network -** Typically refers to physicians, hospitals, or other health care providers who do not contract with the insurance plan to provide services to its members. Depending upon the insurance plan, expenses incurred for services provided by out-of-network providers might not be covered, or coverage may be less than for in-network providers.
- **Maximum Out-of-Pocket Maximum -** The total amount paid each year by the deductible and coinsurance. After reaching the out-of-pocket maximum, the plan pays 100% of the allowable charges for covered services the rest of that calendar year.
- **Pre-Existing Condition -** Any medical condition that was diagnosed or treated within a specified period immediately before a health insurance policy became effective. These conditions may not be covered for a specified period of time under the new policy.
- **Preferred Provider Organizations (PPO) -** A type of managed care plan in which doctors and hospitals agree to provide discounted rates to plan members. Patients are typically reimbursed 80-100% for treatment received withing the network, versus 50-70% outside the network.
- **Primary Care Physician (PCP) -** A health care professional who is responsible for monitoring an individual's overall health care needs. Typically, a PCP services as a gatekeeper for an individual's care, referring him or her to specialists and admitting him or her to hospitals when needed.
- **Reasonable and Customary Charges -** The commonly charged or prevailing fees for health services within a geographic area. If charges are higher than what an insurance carrier considers reasonable and customary, the carrier will not pay the full amount and instead will pay what is deemed appropriate for the particular service. The remaining charges then are the responsibility of the patient.
- **Explanation of Benefits (EOB)-** A summary of claims processed which will be provided to you after a claim is processed for you or for a dependent. This statement outlines year-to-date deductible and out-of-pocket amounts met during the year. This statement will be mailed unless it is turned off on the website.

Frequently Asked Q&A About Your Health Benefits

General

If I am already enrolled and not making any changes, do I have to complete the Open Enrollment process?

No. However, you are encouraged to review your benefits each year to make sure what you are enrolled in is still what is best for you. It's also a good time to review your beneficiary information.

If I want to decline coverage, must I still complete the Open enrollment process?

Yes. It is important that Human Resources has a record of your decision. Please keep in mind that if you decline coverage, you won't be able to elect coverage during the year unless you have a special qualifying event such as a marriage, divorce, birth or adoption of a child, or loss of other coverage.

Can I enroll my spouse or dependent on one plan and myself on another?

No. All covered dependents, including spouse, must be on the same plan as the employee.

Can I drop or change plans during the plan year?

Changes can only be made if there has been a qualifying event or personal life change. Examples include marriage, divorce, birth of a child, or change in employment status.

What is the difference between a calendar year and a contract year?

A plan on a calendar year runs from January 1–December 31. Items like deductible, maximum out-of-pocket expense, etc. will reset every January 1. All Individual and Family plans are on a calendar year. A plan on a contract year (also called benefit year) runs for any 12-month period within the year. Items like deductible, maximum out-of-pocket expense, etc. will reset at the plan's renewal date. For example, ABC Company renews on July 1 every year. Your deductible would start July 1 and end on June 30. The deductible would reset every July 1 for Bruce Oakley Company members.

What happens if I sign up for insurance but find later on in the year that I cannot afford the premiums?

If the reason for your change in affordability is due to a life-changing event such as the loss of a job, death of a spouse, or birth of a child, you would be eligible for special enrollment within 30 days of the event. If you do not enroll during this period, you will not be assured a health plan will cover you either through the Health Insurance Marketplace or in the private market. If you do not pay your premium, you could lose coverage and will not be able to enroll again until the next open enrollment period.

Benefit payments

For benefits received in the Network, you are responsible only for your co-payment, deductible and coinsurance amounts. Your provider will file the claim.

Medical

Should I notify my pharmacy and physician of my benefits plan with BlueCross BlueShield of Arkansas?

Yes. On your next visit to the pharmacy or doctor, simply present your BCBS ID card. This will allow the provider to correctly bill BCBS for the services you have received. It's important to inform your physician of the requirement to utilize an BCBS facility as a medical plan participant.

Required Notices

This document outlines important annual, required legal notices for Bruce Oakley. If you have any questions about these notices, contact the Human Resources at **501-320-8449**.

Women's Health and Cancer Rights Act (WHCRA) of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act (WHCRA) of 1998. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you have questions about your benefits under HKS medical plans, please call the member services number on your medical plan ID card or contact Payroll & Benefits.

Newborns' and Mothers' Health Protection Act

Federal law (Newborns' and Mothers' Health Protection Act of 1996) prohibits the plan from limiting a mother's or newborn's length of hospital stay to less than 48 hours for a vaginal delivery or 96 hours for a Cesarean delivery or from requiring the provider to obtain pre-authorization for a stay of 48 or 96 hours, as appropriate. However, federal law generally does not prohibit the attending provider, after consultation with the mother, from discharging the mother or her newborn earlier than 48 hours for normal delivery or 96 hours as applicable.

Notice of Special Enrollment Rights

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

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- Coverage is lost under Medicaid or a State CHIP program; or
- You or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact person listed at the end of this summary.

Required Notices (cont.)

Important Notice from Bruce Oakley About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with [Carrier] 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. Bruce Oakley has determined that the prescription drug coverage offered by the [Carrier] 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 during Open Enrollment.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current Bruce Oakley coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Bruce Oakley coverage, be aware that you and your dependents will be able to get this coverage back (during open enrollment or in the case of a special enrollment opportunity).

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 Bruce Oakley 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.

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

Contact the person listed on the next page 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 Bruce Oakley 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.

Required Notices (cont.)

For more information about Medicare prescription drug coverage:

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

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

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

Date:	Jan 1, 2024
Name of Entity/Sender:	Bruce Oakley Corporation
Contract-Position/Office:	Human Resources
Address:	3400 Gribble St North Little Rock, AR 72114
Phone Number:	501-320-8449

Statement of ERISA Rights

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.
- Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if required to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

Continue Group Health Plan Coverage

If applicable, you may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants.

No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

Enforce your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $149 per day (up to a $1,496 cap per request), until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

If you have any questions about your Plan, this statement, or your rights under ERISA, you should contact the nearest office of the Employee Benefits and Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

Contact Information

Questions regarding any of this information can be directed to:

Bruce Oakley Corporation - HR
3400 Gribble St
North Little Rock, AR 72114
501-320-8449

Notice of Privacy Practices Regarding Your Medical Information

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.

We understand that your medical information is private, and we are committed to maintaining the privacy of your medical information.

This notice describes the ways in which the component plans that are considered group health plans under the Health Benefit Plan of Bruce Oakley (hereafter the "Plan") sponsored by Bruce Oakley (the "Company") may use and disclose medical information about you. This notice also describes your rights regarding the use and disclosure of your medical information.

The Plan is required by law to maintain the privacy of medical information about you, provide you with certain rights with respect to your medical information, to provide you with this notice about the Plan's legal duties and privacy practices with respect to medical information about you, to maintain the privacy of medical information about you, and to abide by the terms of this notice as it is currently in effect.

Each time you submit a claim to the Plan for reimbursement, and each time you see a health care provider who is paid by the Plan, a record is created. The record may contain your medical information. In general, the Plan will only use or disclose your medical information without your authorization for the specific reasons detailed below. Except in limited circumstances, the amount of information used or disclosed will be limited to the minimum necessary to accomplish the intent of the use or disclosure. The Plan does not operate by itself but rather is operated and administered by the Company acting on the Plan's behalf. As a result, medical information used or disclosed by the Plan (as discussed below) necessarily means that the Company is using or disclosing the medical information on behalf of the Plan. As a result, references to the Plan in this Notice of Privacy Practices should also be construed as references to the Company to the extent necessary to carry out the actions of the Plan.

The health plans identified above may share your medical information with each other to carry out treatment, payment, and health care operations.

PERMITTED USES AND DISCLOSURES

The following categories describe different ways that the Plan may use or disclose your medical information. Not every use or disclosure in a category will be listed. However, all of the ways the Plan is permitted to use and disclose information will fall within one of the categories.

Primary Uses and Disclosures of Your Medical Information

Treatment. The Plan may use or disclose your medical information to facilitate medical treatment or services by providers. The Plan may disclose your medical information to providers, including doctors, nurses, technicians, pharmacists, medical students, or other hospital personnel who are involved in your care. For example, the Plan might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is contraindicative of prior prescriptions.

Payment. The Plan may use and disclose your medical information to determine 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, the Plan 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. The Plan may also share medical information with a utilization review or precertification service provider. Likewise, the Plan may share medical information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

Health Care Operations. The Plan may use and disclose your medical information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, the Plan may use medical information in connection with: conducting quality assessment and improvement activities; underwriting (with respect to medical information other than medical information which is genetic information), 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 and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities.

Family Members, Relatives, Close Personal Friends. The Plan may disclose your health information to your family members, relatives, or close personal friends if the information is directly relevant to the family or friend's involvement with your care or payment for your care and you have either agreed to the disclosure or have been given an opportunity to object and have not objected. The Plan may also disclose your health information if you are not able to agree or object or are not present if it has determined that the disclosure is in your best interests.

The Company. The Plan may disclose medical information about you to the Company for Plan administration purposes.

Business Associates. The Plan contracts with individuals and entities ("business associates") to perform various functions on behalf of the Plan or provide services to the Plan. These business associates may receive, create, maintain, use, or disclose your medical information, but only after they agree in writing to safeguard your medical information. For example, the Plan may disclose your medical information to a business associate to administer claims, perform utilization review management, or review the Plan's financial records.

Covered Entities. The Plan may use and disclose your medical information to assist health care providers with their treatment or payment activities, or to assist other health plans or health care clearing houses with payment activities and certain health care operations. For example, the Plan may disclose your medical information to a health care provider to conduct health care operations in the areas of quality assurance, accreditation, licensing, etc. This also means that the Plan may disclose your medical information to other health plans and/or insurance carriers to coordinate benefits, if you have coverage through another health plan or insurance carrier.

Other Possible Uses and Disclosures of Your Medical Information

Requirement by Law. The Plan will disclose your medical information when required to do so by federal, state, or local law. For example, the Plan may disclose medical information when required by a court order in a litigation proceeding such as a malpractice action.

Aversion of a Serious Threat to Health or Safety. Consistent with applicable federal and state laws, the Plan may use or disclose your medical 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, the Plan may disclose your medical information in a proceeding regarding the licensure of a physician.

Organ and Tissue Donation. If you are an organ donor, the Plan may release your medical 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, the Plan may release your medical information as required by military command authorities. The Plan may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. The Plan may release your medical information for workers' compensation or similar programs. These programs provide benefits for work related injuries or illness.

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

Health Oversight Activities. The Plan may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure proceedings. 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 dispute, the Plan may disclose your medical information in response to a court or administrative order. The Plan may also disclose your medical 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. The Plan may release your medical 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; if you are, or are suspected to be, the victim of a crime, under certain limited circumstances, and the Plan Administrator is unable to obtain your agreement; about a death the Plan Administrator believes may be the result of criminal conduct; about criminal conduct on the Company's premises; or 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.

Department of Health and Human Services. The Plan will disclose your medical information to the U.S. Department of Health and Human Services when requested for purposes of determining the Plan's compliance with applicable regulations.

Coroners, Medical Examiners, and Funeral Directors. The Plan may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. The Plan may also release medical information to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. The Plan may release your medical 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 under the custody of a law enforcement official, the Plan may release your medical information to the correctional institution or law enforcement official. This release would be 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.

Other Benefits. The Plan may contact you to provide information about treatment alternatives or other health related benefits and services that may be of interest to you. For example, if you are suffering from a complex illness, the Plan may contact you to discuss an alternate form of care or an alternate treatment facility.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

Right to Access and Copy. The Plan will make your medical information available to you for inspection and copying upon your written request. Please contact the individual listed below under the section titled "For More Information" to request the necessary paperwork. The Plan may charge a fee for the costs of copying, mailing or other supplies associated with your request. If the Plan maintains any of your medical information in an electronic health record, you can get a copy of that information in electronic format.

The Plan may deny your request to inspect and copy in certain limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed in certain circumstances.

Right to Request an Amendment. If you feel that medical information the Plan has about you is incorrect or incomplete, you may ask the Plan to amend the information. You must provide a reason that supports your request. You have the right to request an amendment for as long as the information is kept by or for the Plan. Any request to amend your medical information must be made in writing. Please contact the individual listed below under the section titled "For More Information" to request the necessary paperwork.

The Plan may deny your request for an amendment in certain circumstances, including your failure to request the amendment in writing or to include a reason to support the request, or, for example, if the information to be amended was not created by the Plan or is accurate and complete.

Right to an Accounting of Disclosures. If you wish to know to whom medical information about you has been disclosed, you may make a written request to the Plan. Please contact the individual listed below under the section titled "For More Information" to request the necessary paperwork.

Your request must state the time period for which you would like the accounting, and cannot include dates prior to the six-year period ending on the date of your request (in other words, if your request is dated January 1, 2012, you cannot request an accounting of disclosures for time periods prior to January 1, 2006). Your request should indicate in what form you want the accounting (for example, paper or electronic). The first accounting you request within a 12-month period will be free. For additional accountings, the Plan may charge you for the costs of providing the accounting. The Plan 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.

The accounting will not include disclosures for the purposes of treatment, payment, or health care operations (provided, that, to the extent required by law, if the Plan maintains an electronic health record, the accounting will include such disclosures made through an electronic health record). In addition, the accounting will not include disclosures, which you have authorized in writing or for certain other purposes.

Right to Request Restrictions. You may request that the Plan restrict or limit the medical information the Plan uses or discloses about you for treatment, payment, or health care operations. In addition, you may request that the Plan limit the medical information disclosed about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that the Plan not use or disclose information about a surgery you had.

To request a restriction or limitation, please contact the individual listed below under the section titled "For More Information." Your request must be in writing. In your request, you must specify (1) what information you want to limit; (2) whether you want to limit use, disclosure, or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Required Notices (cont.)

Please note that the Plan is not required to agree to your request, unless your request is to restrict disclosures to another health plan for payment or plan operations purposes and the health information pertains solely to a health care item or service for which you have already paid a health care provider out-of-pocket in full.

Right to Request Confidential Communications. If the disclosure of your medical information could endanger you, you may request that the Plan communicate with you about medical matters in a certain way or at a certain location. For example, you may request that the Plan only contact you at work or by mail. To request confidential communications, please contact the individual listed below under the section titled "For More Information." Your request must specify how or where you wish to be contacted. The Plan will only accommodate requests for confidential communications if the disclosure of the information would endanger you.

Right to Be Notified of a Breach. You have the right to be notified in the event the Plan (or a Business Associate) discovers a breach of your medical information.

Right to a Paper Copy of this Notice.. You may ask the Plan for a copy of this notice at any time by contacting the individual listed below under the section titled "For More Information." Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy.

CHANGES TO THIS NOTICE

The Plan reserves the right to modify this notice at any time. The Plan also reserves the right to make the revised or changed notice effective for medical information it already has about you, as well as any information received in the future.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Plan or with the Secretary of the Department of Health and Human Services. To register a complaint with the Plan, please contact the individual listed below under the section titled "For More Information." All complaints must be submitted in writing.

You will not be retaliated against for filing a complaint.

OTHER USES OF MEDICAL INFORMATION

Any uses and disclosures of medical information other than those listed above will be made only with your written authorization. If you provide the Plan authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, the Plan will no longer use or disclose medical information about you for the reasons covered by your written authorization. Please note that the Plan is unable to take back any disclosures it has already made with your authorization, and that the Plan is required to retain records of the care provided to you.

FOR MORE INFORMATION

If you have any questions about this notice, please contact:

Bruce Oakley Corporation - HR
3400 Gribble St
North Little Rock, AR 72114
501-320-8449

EFFECTIVE DATE: January 1, 2024

Required Notices (cont.)

Evaluating Your Health Insurance Options What You Need to Know

This letter has been created to help you understand your health insurance options. The health care reform law (called the Patient Protection & Affordable Care Act) requires most Americans to carry health insurance coverage or pay a penalty.

You can:

- Elect employer-provided health insurance (if offered).
- Purchase health insurance through the Marketplace.

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop" shopping to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

You may be able to save money on premiums if your employer does not offer coverage, or offers coverage that does not meet government standards. Your potential savings on health insurance premiums would be dependent on household size and income. If you are offered employer-provided health insurance that meets those government standards, you may not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. If the cost of your employer's plan to cover yourself only (and not other members of your family) is more than 9.5% of your annual household income, you may be eligible for a tax credit.

Open enrollment for health insurance coverage through the Marketplace generally begins in October each year for coverage starting as early as the following January. Visit ***www.healthcare.gov*** to learn more about your options, or to request assistance.

Want to Buy on the Marketplace? Start with This Information

STEP 1: Visit ***www.healthcare.gov*** and begin the application process

STEP 2: You will need the information below to apply (Numbers correspond directly to numbers on actual application.)

3	Employer Name:	Bruce Oakley Corporation
4	Employer Identification Number (EIN):	71-0483822
5	Employer Address:	3400 Gribble St
6	Employer Phone Number:	501-320-8449
7	Employer City:	North Little Rock
8	Employer State:	AR
9	Employer Zip Code:	72114
10	Who can we contact about employee health coverage at this job?	Lisa Hicks
11	Employer Contact Phone Number (if different from above):	501-320-8449
12	Employer Email:	lhicks@bruceoakley.com

Notes

BRUCE O·A·K·L·E·Y, Inc

2024

Employee Benefits Guide