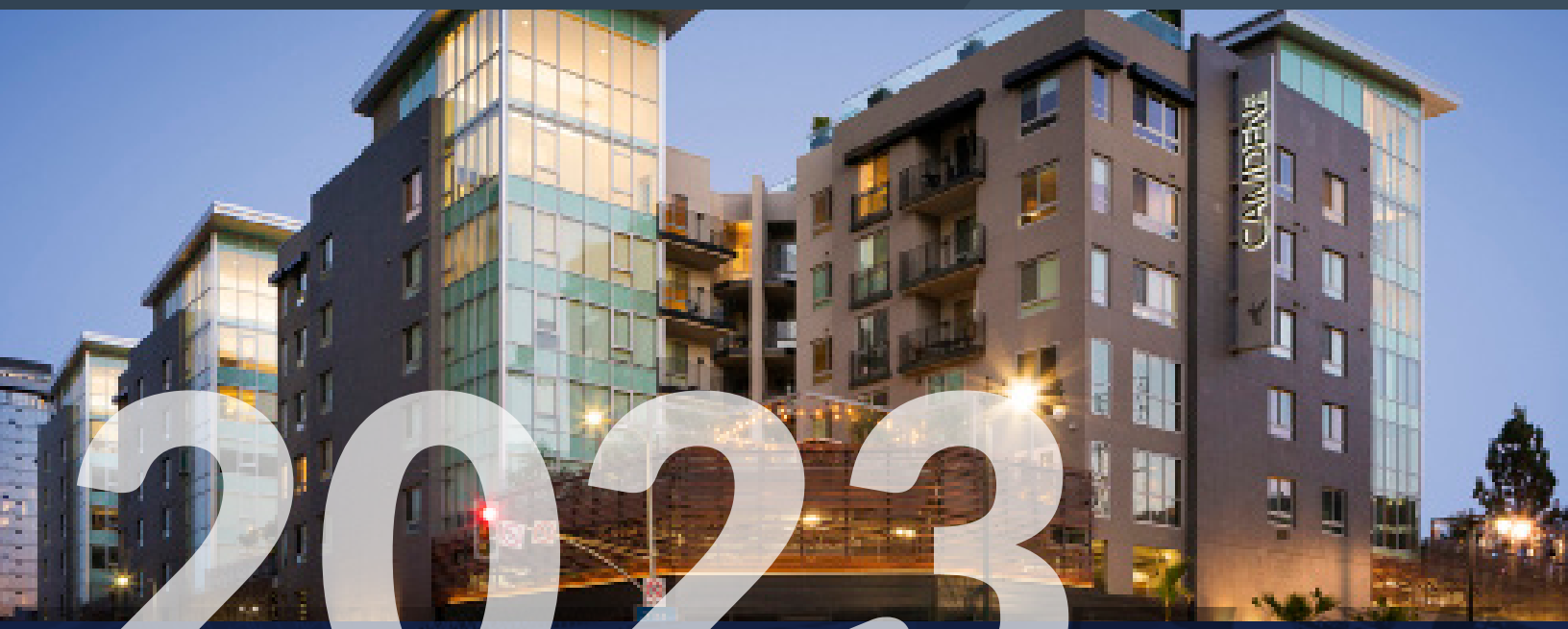
BERNARDS



2023

Employee Benefit Booklet

Contents

Live Well. Be Well.

At Bernards, we believe that you, our employees, are our most important asset. Helping you and your families achieve and maintain good health—physical, emotional and financial—is the reason Bernards offers you this benefits program.

We are providing you with this booklet to help you understand the benefits that are available to you and how to best use them. Please review it carefully and make sure to ask about any important issues that are not addressed here.

While we've made every effort to make sure that this booklet is comprehensive, it cannot provide a complete description of all benefit provisions. For more information, please visit http://benefits.filice.com/bernards. The information in this booklet is a general outline of the benefits offered under the Bernards benefits program.

Specific details and limitations are provided in the plan documents, such as the Summary of Benefits and Coverage (SBCs), Evidence of Coverage (EOC) and/or insurance policies. The plan documents contain the relevant plan provisions. If the information in this booklet differs from the plan documents, the plan documents will prevail.

The benefits in this booklet are effective: January 1, 2023 – December 31, 2023.

Who Can You Cover?

WHO IS ELIGIBLE?

Employees working 30 or more hours per week are eligible for the benefits.

You can enroll the following family members in our medical, dental and vision plans:

- Your spouse (the person who you are legally married to under state law, including a same-sex spouse).
- Your domestic partner. Please contact Human Resources if you would like to add a domestic partner. Any premiums for your domestic partner paid for by Bernards are taxable income and will be included on your W-2. Any premiums you pay for your domestic partner will be deducted on an after-tax basis.
- Your children (including those of your domestic partner) under the age of 26 are eligible to enroll in medical coverage. They do not have to live with you or be enrolled in school. They can be married and/or living and working on their own.
  - Over age 26 ONLY if they are incapacitated due to a disability and primarily dependent on you for support.
  - Named in a Qualified Medical Child Support Order (QMCSO) as defined by federal law.

Please note: If you elect healthcare coverage for your dependent(s), you must enroll them in the same healthcare plan(s) as you.

Please refer to the Summary Plan Description for complete details on how benefits eligibility is determined.

WHO IS NOT ELIGIBLE?

Family members who are not eligible for coverage include (but are not limited to):

- Parents, grandparents, and siblings
- Divorced spouses
- Spouse of married children
- Grandchildren (unless legal guardianship)
- Employees who work less than 30 hours per week, temporary employees, contract employees, or employees residing outside the United States

WHEN CAN I ENROLL?

Open enrollment is the one time each year that employees can make changes to their benefit elections without a qualifying life event.

These life events include (but are not limited to):

- Birth or adoption of a baby or child
- Loss of other healthcare coverage
- Eligibility for new healthcare coverage
- Marriage
- Divorce

Make sure to notify Human Resources right away if you do have a qualifying life event and need to make a change (add or drop) to your coverage election.

You have 31 days to make your change after the qualifying life event and to complete all the necessary change forms. An employee may be held responsible for substantial charges if services are provided for a person who is found to be ineligible.

Qualifying Life Events

You will not be allowed to change your plan selections or add dependents until the next benefit year (starting January 1, 2024) unless you have a Qualifying Life Event. Qualifying Life Events can include marriage, divorce, birth or adoption. Changes must be submitted to Human Resources within 31 days of the life event. Effective date will be determined by the Qualifying Life Event date that allows for no break in service.

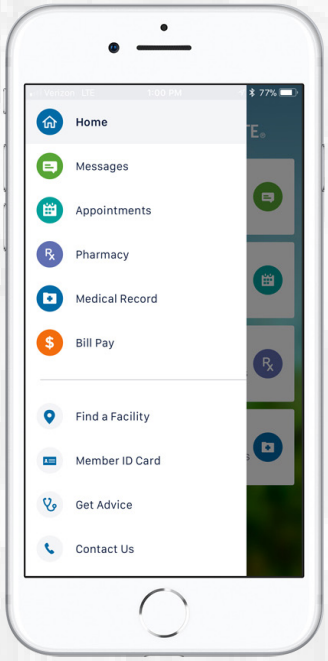
The following are considered Qualifying Life Events:

- Change in legal marital status, including marriage, divorce, legal separation, annulment, or death of a spouse
- Change in number of dependents, including birth, adoption, placement for adoption, or death of a dependent child
- Change in employment status, including the start or termination of employment by you, your spouse, or your dependent child
- Change in work schedule, including an increase or decrease in hours of employment by you, your spouse, or your dependent child, including a switch between part-time and full-time employment that affects eligibility for benefits
- Change in a child's dependent status, either newly satisfying the requirements for dependent child status or ceasing to satisfy them
- Change in place of residence or worksite, including a change that affects the accessibility of network providers
- Reduction in hours, when an employee's hours of service are reduced so that he/she is expected to average less than 30 hours of service per week, but the reduction does not affect his/her eligibility for coverage under the employer's group health plan
- To purchase marketplace coverage, when an employee seeks to cease coverage under the employer's group health plan and purchases coverage through the Marketplace, without having to incur a period of either duplicate coverage or no coverage
- Change in your health coverage or your spouse's coverage attributable to your spouse's employment
- Change in an individual's eligibility for Medicare or Medicaid
- A court order resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order) requiring coverage for your child or dependent foster child
- A special event under HIPAA (the Health Insurance Portability and Accountability Act), including acquisition of a new dependent or spouse or loss of coverage under another health insurance policy or plan if the coverage is terminated because of:
  - Voluntary or involuntary termination of employment or reduction in hours of employment or death, divorce, or legal separation
  - Termination of employer contributions toward the other coverage, or
  - If the other coverage was COBRA Continuation Coverage, exhaustion of the coverage

Care That Fits Your Life

As a Kaiser Permenente member, you have access to a robust suite of resources and tools that serve as your online gateway to great health. When you register, you can securely access many time-saving tools for managing the care you get at Kaiser facilities. Key features include:

- View most lab results
- Refill most presciptions
- Email your doctor's office with non urgent questions
- Schedule, change and cancel routine appointments
- Print vaccination records for school, sports and camp
- Video visits



Download the Kaiser App

Once you've registered, go to your smart phone and download the Kaiser mobile app. Use your *kp.org* user ID and password to activate the app and you'll be ready to use the secure features anytime, anywhere! Learn more at *kp.org/mobile.*

CARE WHILE TRAVELING

If you get hurt or sick while traveling, you are covered for emergency and urgent care anywhere in the world.

- Get urgent care at MinuteClinic in select CVS and Target tores when you are traveling outside a Kaiser area.
- Before leaving town you can check to see if you need a vaccination, need to refill an eligible prescription and more. Just call 24/7 Away from Home Travel Line at 951-268-3900 or go online to *kp.org/travel.*

Kaiser Permanente HMO | CA Residents Only

	In-Network
Calendar Year Deductible	$0 individual; $0 family
Annual Out-of-Pocket Max	$1,500 individual; $3,000 family
Office Visit	
Primary Provider	$10 copay
Specialist	$10 copay
Preventive Services	$0
Chiropractic Care *(up to 30 visits per year)*	$15 copay
Physician's Office Lab and X-ray	Plan pays 100%
Inpatient Hospitalization	Plan pays 100%
Physician/Surgeon	Plan pays 100%
Outpatient Surgery	$10 copay
Urgent Care	$10 copay
Emergency Room (copay waived if admitted)	$100 copay
Prescription Drug Deductible	None
RX Annual Out-of-Pocket Limit	Combined with medical
Retail Pharmacy (30 day supply)	
Generic	$10 copay
Brand Name	$20 copay
Specialty	20% up to $250
Mail Order Pharmacy (100 day supply)	
Generic	$20 copay
Brand Name	$40 copay
Specialty	Not Covered

Making the Most of Your Benefits Program

Helping you and your family members stay healthy and making sure you use your benefits program to its best advantage is our goal in offering this program. Here are a few things to keep in mind.

STAY WELL!

Harder than it sounds, of course, but many health problems are avoidable. Take action—from eating well to getting enough exercise and sleep. Taking care of yourself takes care of a lot of potential problems.

ASK QUESTIONS AND STAY INFORMED

Know and understand your options before you decide on a course of treatment. Informed patients get better care. Ask for a second opinion if you're at all concerned.

GET A PRIMARY CARE PROVIDER

Having a relationship with a PCP gives you a trusted person who knows your unique situation when you're having a health issue. Visit your PCP or clinic for non-emergency healthcare.

GOING TO THE DOCTOR?

To get the most out of your doctor visit, being organized and having a plan helps. Bring the following with you:

- Your plan ID card
- A list of your current medications
- A list of what you want to talk about with your doctor

If you need a medication, you could save money by asking your doctor if there are generics or generic alternatives for your specific medication.

TELADOC ONLINE

Teladoc Online is an easy way to get care. Doctors can help with many different health issues, such as colds, flus, allergies and much more — right from your phone, tablet or computer. It's more convenient than urgent care, and doctors can also provide prescriptions, if needed.

Teladoc.com/BSC

Set Up Account | Choose a Doctor | Start a Session

USING THE EMERGENCY ROOM

Did you know most ER visits are unnecessary? Use them only in a true emergency—like any situation where life, limb, or vision are threatened.

Otherwise, call your doctor, your nurse line, or go to an Urgent Care clinic within your medical network. You'll save a lot of money and time.

BE MED WISE!

Always follow your doctor's and pharmacist's instructions when taking medications. You can worsen your condition(s) by not taking your medication or by skipping doses. If your medication is making you feel worse, contact your doctor.

AN APPLE A DAY...

Eating moderately and well really does help keep the doctor away. Stay away from fat-heavy, processed foods and instead focus on whole grains, vegetables, and lean meats to be the healthiest you can be.

Blue Shield Medical Access+ HMO | CA Residents Only

	In-Network
Calendar Year Deductible	$0 individual; $0 family
Annual Out-of-Pocket Max	$1,500 individual; $3,000 family
Office Visit	
Primary Provider	$10 copay
Specialist	$10 copay
Access+ Specialist	$20 copay
Teladoc	$0 copay
Preventive Services	$0
Chiropractic Care *(up to 30 visits per year)*	$10 copay
Physician's Office Lab and X-ray	Plan pays 100%
Inpatient Hospitalization	Plan pays 100%
Physician/Surgeon	Plan pays 100%
Outpatient Surgery	Plan pays 100%
Physician/Surgeon	Plan pays 100%
Urgent Care	$10 copay
Emergency Room (copay waived if admitted)	$100 copay
Prescription Drug Deductible	None
RX Annual Out-of-Pocket Limit	Combined with medical
Retail Pharmacy (30 day supply)	
Generic	$10 copay
Preferred Brand	$15 copay
Non-preferred Brand	$30 copay
Specialty	20% up to $250
Mail Order Pharmacy (90 day supply)	
Generic	$20 copay
Preferred Brand	$30 copay
Non-preferred Brand	$60 copay
Specialty	20% up to $500

Blue Shield Medical PPO HDHP + HSA

	In-Network	Out-Of-Network
Individual Calendar Year Deductible	$1,500 per individual member (All providers combined; applies to both medical and pharmacy)	
Individual Annual Out-of-Pocket Max	$3,000 per individual member	$5,000 per individual member
Family Calendar Year Deductible	$3,000 family member/$3,000 per family (All providers combined; applies to both medical and pharmacy)	
Family Annual Out-of-Pocket Max	$3,500 family member/$6,000 per family	$5,000 family member/$10,000 per family
Office Visit		
Primary Provider	You pay 10%*	You pay 30%*
Specialist	You pay 10%*	You pay 30%*
Teladoc	$0 copay*	Not covered
Preventive Services	Plan pays 100%	Not covered
Chiropractic Care *(up to 20 visits per year)*	You pay 10%*	You pay 30%*
Acupuncture Care *(up to 20 visits per year)*	You pay 10%*	You pay 30%*
Physician's Office Lab and X-ray	You pay 10%*	You pay 30%*
Inpatient Hospitalization	You pay 10%*	You pay 30%* (max benefit $600 per day)
Physician/Surgeon	You pay 10%*	You pay 30%*
Outpatient Surgery	You pay 15%*	You pay 30%* (max benefit $350 per day)
Physician/Surgeon	You pay 10%*	You pay 30%*
Emergency Room *(copay waived if admitted)*	You pay $150 per copay + 10%*	You pay $150 per copay + 10%*
Retail Pharmacy (30 day supply)		
Generic	$10 copay*	25% + $10 copay*
Preferred Brand	$25 copay*	25% + $25 copay*
Non-preferred Brand	$40 copay*	25% + $40 copay*
Specialty	30% up to $250*	30% up to $250 + 25%*
Mail Order Pharmacy (90 day supply)		
Generic	$20 copay*	Not covered
Preferred Brand	$50 copay*	Not covered
Non-preferred Brand	$80 copay*	Not covered
Specialty	30% up to $500*	Not covered

*after deductible

WealthCare Saver | Health Savings Account (HSA)

The HSA enables tax-free savings for the qualified medical expenses of "eligible individuals" and their dependents.

An "eligible individual" or HSA owner is someone covered under an HSA-compatible, High Deductible Health Plan (HDHP) and is not covered under a non-HDHP or claimed as a dependent on another individual's tax return.

Bernards will contribute an annual total of $1,500 for employee only coverage and $3,000 for employee plus dependents to each employee's HSA fund.

HSA Advantages:

- HSA contributions are tax-deductible.
- Interest on an HSA is tax-deferred.
- HSAs are portable and owned by the individual; contributions cannot be taken away.
- Unspent balances roll over to the following year and can accumulate over a lifetime to help pay for uncovered medical expenses.
- In the event of the holder's death, HSA balances pass on free of tax to their designated beneficiaries.

Frequently Asked Questions:

Q: What is the calendar year maximum amount that can be contributed to an HSA?

A: For 2023, if you have self-only HDHP coverage, you can contribute up to $3,850. If you have family HDHP coverage, you can contribute up to $7,750.
If you are 55 or older you can make additional "catch-up" contributions up to $1,000 per year.

Q: How does the HSA plan work?

A: Money in the HSA can be used to pay for covered qualified medical expenses and prescriptions not paid by the HDHP. If all of the dollars are not spent, the money remaining in the account will roll over to the following year.

For additional resources on HSA plans, visit www.naviabenefits.com

Q: What are Bernards Contributions?

A: Bernards on a weekly basis, contributes to your HSA. Each week for employee only coverage $28.85 and for two-party or family coverage $57.69 as long as you remain employed with the company. For those employed throughout the 2023 calendar, Bernards contributes the amount equal to the annual Blue Shield HDHP deductible. Although you are not required to make additional contributions, you may choose to save in your HSA each year by electing automatic

pre-tax contributions made from your weekly paycheck, or making direct contributions. Each year the IRS sets contributions limits, which are listed on the previous page. These limits are the total funds contributed to your HSA, including company contributions, your contributions, and any other contributions.

Q: What if I leave Bernards?

A: You own the HSA, so even if you leave your employer, the account stays with you. In fact, if you keep your HSA-qualified health plan (or get another HSA-qualified health plan) you can still contribute to the account.

For more information contact WealthCare Saver Help Center:

866.609.4655, *https://navia.force.com/helpcenter*

Cigna | Dental DHMO and PPO

Regular visits to your dentists can help protect more than just your smile, they can help protect your health as well. Recent studies have linked gum disease to damage elsewhere in the body and dentists are able to screen for oral symptoms of many other diseases including cancer, diabetes and heart disease.

Bernards provides employees with comprehensive dental coverage through Cigna.

CIGNA DENTAL CARE DHMO

You and your eligible dependents must select a primary dentist from the CIGNA DHMO list. You have the option of changing your dentist as often as once a month. Network providers may be accessed online through *www.CIGNA.com*. The CIGNA DHMO Plan contains copays for every American Dental Association (ADA) code. Please refer to the CIGNA DHMO plan summary for more information.

CIGNA DENTAL PPO

Under the CIGNA PPO plan, CIGNA pays a percentage of the allowed fees for covered diagnostic, preventive, basic and major services. CIGNA's PPO network dentist accepts reduced fees for covered services they provide you, so you'll usually pay the least when you visit a PPO network dentist. CIGNA has many network dentists to choose from, visit *www.CIGNA.com* to search CIGNA's dental directory by location or specialty.

	Dental Care DHMO	Dental PPO[1]		
	Copays	**Advantage In-Network**	**In-Network**	**Out-of-Network**
Calendar Year Deductible	None	$50 per person $150 per family	$100 per person $300 per family	$100 per person $300 per family
Annual Benefit Maximum	N/A	$2,000 per insured person	$2,000 per insured person	$2,000 per insured person
Preventive & Diagnostic Care				
Exams Routine Cleaning X-Rays Sealants	See contract for fee schedule[2]	Plan pays 100%	Plan Pays 100%	Plan Pays 100%
Basic Services				
Fillings Root Canal/Endodontics Periodontics Oral Surgery, Simple Extractions	See contract for fee schedule[2]	Plan pays 90% after deductible	Plan pays 80% after deductible	Plan pays 80% after deductible
Major Services				
Crowns/Inlays/Onlays Dentures Bridges Stainless Steel/Resin Crowns	See contract for fee schedule[2]	Plan pays 60% after deductible	Plan pays 50% after deductible	Plan pays 50% after deductible
Orthodontic Services	Children copay $1,608 Adult copay $1,800	Not covered	Not covered	Not covered
Orthodontic Lifetime Max	N/A	N/A	N/A	N/A

[1] All deductibles, plan maximums, and service specific maximums (dollar and occurrence) cross accumulate between in and out of network. For services provided by a Cigna Dental PPO network dentist, Cigna Dental will reimburse the dentist according to a Contracted Fee Schedule. For services provided by an out-of- network dentist, Cigna Dental will reimburse according to Reasonable and Customary Allowances but the dentist may balance bill up to their usual fees. You are responsible for any applicable deductibles, coinsurance, and amounts over plan maximums and charges for non-covered services.

[2] Fee schedule located on benefit website at http://benefits.filice.com/bernards

VSP through MetLife | Vision

Routine vision exams are important, not only for correcting vision, but because they can detect other serious health conditions. We offer you a vision plan through MetLife.

Choose from a large network of ophthalmologists, optometrists and opticians, from private practices to retailers like Costco® Optical and Vision works.

Take advantage of MetLife's service agreement with Walmart and Sam's Club—they check your eligibility and process claims even though they are out of network.

Network providers may be accessed online at *www.metlife.com/mybenefits* or call 855- MET-EYE1 (855-638-3931). Out-of-Network claim form: *www.metlife.com/mybenefits*

MetLife Vision	In-Network Copayments	Out-Of-Network[1] Reimbursements
Examination		
Benefit	$5 copay	Plan reimburses up to $45
Frequency	Every 12 months	Every 12 months
Eyeglass Lenses *(Standard)*		
Single Vision Lens	$10 copay	Plan reimburses up to $30
Bifocal Lens	$10 copay	Plan reimburses up to $50
Trifocal Lens	$10 copay	Plan reimburses up to $65
Frames		
Frequency[2]	Every 24 months	Every 24 months
Benefit	Plan pays up to $150 allowance after $10 copay, then 20% off any remaining balance	Plan reimburses up to $70
Contacts[3] *(Elective)*		
Frequency	Every 12 months	Every 12 months
Benefit	Plan pays up to $150 allowance	Plan reimburses up to $105
In-Network Value Added Features:	*Savings on glasses and sunglasses:* Get 20% savings on additional pairs of prescription glasses and nonprescription 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.	
Dual Coverage Reminder:	If you or your family members are covered by more than one health care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and hospitals, and it may be impossible to comply with both plans at the same time. Before you enroll in this plan, read all of the rules very carefully and compare them with the rules of any other plan that covers you or your family.	

[1] If you choose to, you may receive covered benefits outside of the Blue View Vision network. Just pay in full at the time of service, obtain an itemized receipt, and file a claim for reimbursement of your out-of-network allowance. In-network benefits and discounts will not apply.
[2] You may select an eyeglass frame and receive an allowance toward the purchase price.
[3] In-lieu of frames

Navia | Flexible Spending Account (FSA)

A Flexible Spending Account lets you set aside money—before it's taxed—through payroll deductions. The money can be used for eligible healthcare and dependent day care expenses you and your family expect to have over the next year. The main benefit of using an FSA is that you reduce your taxable income, which means you have more money to spend. The catch is that you have to use the money in your account by December 31, 2023. You must re-enroll in this program each year. Navia administers this program.

IMPORTANT CONSIDERATIONS

- Expenses must be incurred between 1/1/2023 and 12/31/2023 and submitted for reimbursement no later than 3/31/2024. $610 of unused funds will carryover to the next plan year.
- Elections cannot be changed during the plan year, unless you have a qualified change in family status (and the election change must be consistent with the event).
- Dependent Care FSA: Unused amounts will be lost at the end of the plan year, so it is very important that you plan carefully before making your election.
- FSA funds can be used for you, your spouse, and your tax dependents only.
- You can obtain reimbursement for eligible expenses incurred by your spouse or tax dependent children, even if they are not covered on the Bernards health plan.
- You cannot obtain reimbursement for eligible expenses for a domestic partner or their children, unless they qualify as your tax dependents (Important: questions about the tax status of your dependents should be addressed with your tax advisor).
- Use Navia Debit Card to pay for eligible services and products. Payments are automatically withdrawn from your reimbursement account, so there are no out-of-pocket costs.
- Keep your receipts. In most cases, you'll need to provide proof that your expenses were considered eligible for IRS purposes.
- Track claims by visiting https://www.navia-benefits.com

HEALTHCARE FSA

This plan allows you to pay for eligible out-of-pocket healthcare expenses with pre-tax dollars. Eligible expenses include medical, dental, or vision costs including plan deductibles, copays, coinsurance amounts, and other non-covered healthcare costs for you and your tax dependents. You may access your entire annual election from the first day of the plan year and you can set aside up to $3,050 this year.

DEPENDENT CARE FSA

This plan allows you to pay for eligible out-of-pocket dependent care expenses with pre-tax dollars. Eligible expenses may include daycare centers, in-home child care, and before or after school care for your dependent children under age 13. Other individuals may qualify if they are considered your tax dependent and are incapable of self-care. It is important to note that you can access money only after it is placed into your dependent care FSA account.

All caregivers must have a tax ID or Social Security number. This information must be included on your federal tax return. If you use the dependent care reimbursement account, the IRS will not allow you to claim a dependent care credit for reimbursed expenses. Consult your tax advisor to determine whether you should enroll in this plan. You can set aside up to $5,000 per household for eligible dependent care expenses for the year.

Mutual of Omaha | Life Insurance

If you have loved ones who depend on your income for support, having life and accidental death insurance can help protect your family's financial security.

EMPLOYER PAID LIFE AND AD&D

Basic Life Insurance pays your beneficiary a lump sum if you die. AD&D provides another layer of benefits to either you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you die in an accident.

Eligible employees are automatically enrolled in coverage. The cost of coverage is paid in full by Bernards. Coverage is provided by Mutual of Omaha.

Basic Life Amount	$25,000
Basic AD&D Amount	$25,000

VOLUNTARY TERM LIFE

Voluntary Life Insurance allows you to purchase additional life insurance to protect your family's financial security. Coverage is provided by Mutual of Omaha.

COVERAGE GUIDELINES

	Employee	Spouse	Children
Min.	$10,000	$5,000	$10,000
Max.	$500,000, limited to 5X annual salary	$250,000;Limited to 50% of employee amount	$10,000
Guaranteed Issue Amount	Underage 70: $100,000, Age 70-74: $20,000; Limited to 3X annual salary	$20,000 No GI if spouse age 60 or over	100% of employee's benefit, up to $10,000

Note: "GI" Guarantee Issue means the amount of insurance applied for which does not require evidence of insurability. Guarantee Issue is available to New Hires Only. For Late Entrants, all coverage amounts will require a health application/evidence of insurability.

>> Features:

LifeKeys

Online will & testament preparation service, identity theft resources and beneficiary assistance support for all employees and eligible dependents covered under the Group Term Life and/or AD&D policy.

Conversion

If you leave your job – for any reason – you may be able to change your group life coverage to an individual policy. You must apply for portability and pay the first month's premium for the individual policy within 31 days of the last day you were employed.

>> Important Reminders

Beneficiary: Make sure that you have named a beneficiary for your life insurance benefit. It's important to know that many states require that a spouse be named as the beneficiary, unless they sign a waiver.

Taxes: Due to IRS regulations, a life insurance benefit of $50,000 or more is considered a taxable benefit. You will see the value of the benefit included in your taxable income on your paycheck and W-2.

Accelerated Death Benefit: Benefit received may be treated as taxable income and may affect your eligibility for Medicaid or other government benefits or entitlements. You should consult your personal tax and/or legal advisor before you apply for an Accelerated Benefit.

Evidence of Insurability: Depending on the amount of voluntary life coverage you select, you may need to submit an Evidence of Insurability form, which involves providing the insurance company with additional information about your health.

Voluntary Life: If you purchase life insurance for a dependent and need to remove them from coverage due to a qualifying life event, you must notify Human Resources and complete a Change Request Form.

Need Assistance? Contact Mutual of Omaha: 800-769-7159

Mutual of Omaha | Disability Insurance

If you become disabled and cannot work, your financial security may be at risk. Protecting your income stream can provide you and your family with peace of mind.

VOLUNTARY SHORT-TERM DISABILITY INSURANCE

Short-Term Disability coverage pays you a benefit if you temporarily can't work because of an injury, illness, or maternity leave. Benefits may be reduced by income from other income sources such as paid time off. Your doctor and the insurance company will work together to determine how long benefits are payable, based on your condition. Coverage is provided by Mutual of Omaha.

BENEFIT SUMMARY FOR CALIFORNIA RESIDENTS

Weekly Benefit Amount	Plan pays 30% of covered weekly earnings
Maximum Weekly Benefit	$1,000
Benefits Begin After:	
Accident	14 days of disability
Sickness	14 days of disability
Maximum Payment Period[1]	11 weeks

BENEFIT SUMMARY FOR NON-CALIFORNIA RESIDENTS

Weekly Benefit Amount	Plan pays 60% of covered weekly earnings
Maximum Weekly Benefit[2]	$2,100
Benefits Begin After:	
Accident	14 days of disability
Sickness	14 days of disability
Maximum Payment Period[1]	11 weeks

EMPLOYER PAID LONG-TERM DISABILITY INSURANCE

Long-Term Disability coverage pays you a certain percentage of your income if you can't work because an injury or illness prevents you from performing any of your job functions over a long time. It's important to know that benefits are reduced by income from other benefits you might receive while disabled, like Workers' Compensation and Social Security. Coverage is provided by Mutual of Omaha.

Monthly Benefit Amount	Plan pays 60% of covered monthly earnings
Maximum Monthly Benefit	$15,000
Benefits Begin After:	
Accident	90 days of disability
Sickness	90 days of disability
Maximum Payment Period[3]	Later of Social Security normal retirement age or to age 65

[1] Maximum payment period is based on the first day you are disabled, not when benefits begin
[2] The benefits from this policy will be reduced by benefits you receive from state disability or temporary worker's compensation programs
[3] The age at which the disability begins may affect the duration of the benefits.
[4] Mutual of Omaha will prepare IRS form W-2 for each employee who receives benefits under this policy.

Aflac | Voluntary Benefits

Here are some other valuable programs that you are eligible to participate in:

ACCIDENT INSURANCE

If an accident occurs, you may be surprised at how the expenses can add up. Accident Insurance is designed to help you pay for unexpected costs that result from an accidental injury. It includes benefits for a wide range of common injuries such as fractures, dislocations, burns, Emergency Room or Urgent Care visits, and physical therapy.

If you or a covered family member suffers an accident, this plan will pay you a lump-sum, tax-free benefit. The amount of money you receive depends on the type and severity of your injury and can be used any way you choose. You may even be eligible for a benefit if you receive a covered Wellness Screening[1] such as blood tests, stress tests, or a chest x-ray.

Features:

- Coverage is guaranteed-issue; no health questions to answer.
- Benefits are paid directly to you unless you choose otherwise.
- Coverage is available to you and your dependents.
- Coverage is portable.
- Fast claims payments.

Video Link: *https://www.aflac.com/videos/accU/*

Customer Service: (800) 433-3036

File a claim: *http://aflacgroupinsurance.com/customer_service/file_claims.aspx*

CRITICAL ILLNESS INSURANCE[2]

Critical Illness Insurance can help fill a financial gap if you experience a serious illness such as cancer, heart attack or stroke. Upon diagnosis of a covered illness, a lump-sum, tax-free benefit is immediately paid to you.

Benefits can be used to help cover out-of-pocket medical costs like your plan deductible, copays, or related expenses like transportation to and from the hospital, child care, lost income from work or costs associated with adjusting to life following a covered critical illness.

You choose a benefit amount that fits your paycheck. You can cover yourself and your spouse if needed. This plan will also pay a $50 Health Screening benefit once per year and a $200 Mammography benefit for women (benefit frequency based on age at the time of the Mammogram).

Features:

- Employee Benefit Amounts: in increments of $5,000, up to $50,000
- Spouse Benefit Amounts: in increments of $5,000, up to $25,000
- Guarantee Issue[3] is available to New Hires and to Current Insureds that would like to buy up an additional $5,000.
- Guarantee Issue[3] is available to Late Entrants. Benefit amount is $5,000 only, all other amounts will require a health application/evidence of insurability.
- Coverage is portable.

Video Link: *http://www.aflac.com/videos/ciW/*

Pre-existing Condition Limitation:

Pre-Existing Condition means a sickness or physical condition which, within the 6-month period prior to the Effective Date, resulted in the insured receiving medical advice or treatment. Aflac will not pay benefits for any critical illness starting within 12 months of the Effective Date which is caused by, contributed to, or resulting from a Pre-Existing Condition.

A claim for benefits for loss starting after 12 months from the Effective Date will not be reduced or denied on the grounds that it is caused by a Pre-Existing Condition. A critical illness will no longer be considered pre-existing at the end of 12 consecutive months starting and ending after the Effective Date.

Employee Assistance Program (EAP)

The Claremont Employee Assistance Program (EAP) helps you resolve personal issues before they become more serious and difficult to manage. You and your eligible family members can receive professional, confidential counseling at no cost. We also provide access to resources that can help you address virtually any personal concern or question.

Who provides the EAP? Claremont is a firm of select professionals who can help you with life's challenges. You will be referred to a conveniently located counselor or resource with expertise in your area of concern.

Who will know? The EAP is a confidential service. Claremont understands the importance of maintaining your privacy. Your involvement with Claremont is afforded the maximum confidentiality permitted under the law.

At what cost? A select number of EAP services is available to you and your covered dependents at no cost to you.

What's the first step? Call 800-834-3773 to discuss your question or issue with an experienced counselor who will refer you to the resources most appropriate for your needs.

1 After 12 months of paid premium and while coverage is in force, Aflac will pay this benefit for preventive testing once each 12-month period. Benefits include and are payable (for each covered person) for annual physical exams, mammograms, Pap smears, eye examinations, immunizations, flexible sigmoidoscopies, PSA tests, ultrasounds, and blood screenings.
2 You must be enrolled in either Bernards medical plans or a spouse's medical plan to be eligible for coverage.
3 May be subject to pre-existing condition limitations as outlined in the policy.

- Counseling visits
- Work/Life referrals
- Legal consultation
- Financial consultation

Call toll-free, 24 hours a day, seven days a week: 800-834-3773 or visit us at: *www.claremonteap.com*

Additional Benefits

401(k) PROFIT SHARING PLAN

Bernards 401(k) Profit Sharing Plan is available to employees on the first of the month following 30 days of employment. We offer a Core Mutual Fund Account or a Self-Directed Account. Both accounts are with Fidelity Investments. After achieving annual corporate profitability goals, Bernards typically matches 100% of the first 3% of employee deferrals. If it is determined that a company match will be made in that calendar year, the match will vest based upon the individual's years of services with the company.

Vesting Schedule:

End of Year	Vesting %
1	0%
2	20%
3	40%
4	60%
5	80%
6	100%

Employees will be automatically enrolled in the plan at a 3% weekly deferral rate on their eligible effective date to help them accelerate their planning for retirement. Newly hired employees may increase their deferral rate above 3%, reduce their deferral rate or "opt out" of the plan with no deferrals taken. If the employee does not specify how the funds will be invested, the funds will be placed in a Fidelity Freedom Fund based upon their projected retirement date. This does not apply to rehired or existing employees.

Eligible employees can view their account at *www.401k.com* or *www.fidelity.com*

TRAVEL ASSISTANCE PROGRAM

This type of program provides a wealth of travel, medical and safety related services you can access when traveling more than 100 miles from home for business or leisure travel. Staff and resources are available 24/7. This benefit is available to you at no additional cost through your employer-paid Mutual of Omaha plans.

Services include:

- Medical evacuation & transportation
- Dependent Child transportation
- Language translation services
- Medical or Dental referrals
- Treatment monitoring
- Repatriation services
- Identity Theft assistance

To Use Worldwide Travel Assistance:

For inquiries within the U.S. call toll free 800-856-9947 and outside the U.S. call collect 312-935-3658.

Teladoc

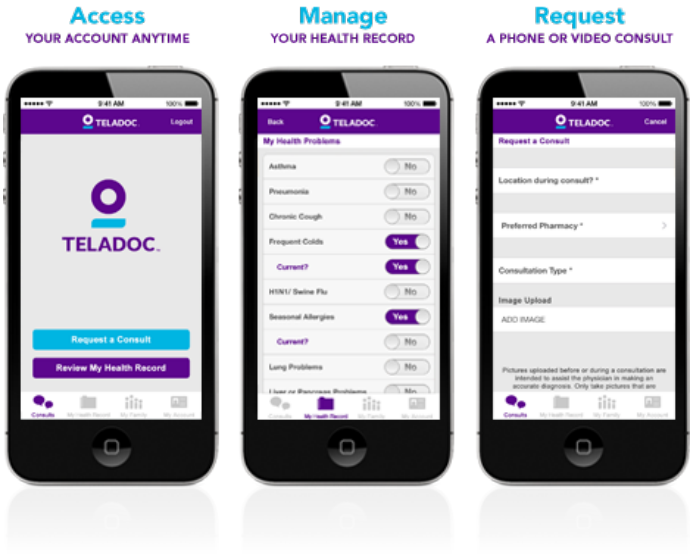
See a doctor 24/7 on your computer or mobile device

Set up Account ⇨ Choose a Doctor ⇨ Start a Session

Doctors can help with many different health issues, such as:

- Colds
- Flu
- Sore Throat
- Fever
- Allergies
- Sinus infections
- Bronchitis
- Diarrhea
- Pink eye and other eye infections
- Rashes
- Joint Pains

Doctors can also provide prescriptions, if needed.



HMO Members $0 copay

HDHP/HSA Members $0 copay (after deductible)

How to Access

Register by calling **Teladoc** at 800-835-2362 or go online at *teladoc.com/bsc*

Blue Shield members will need to have their member ID number and the name, address and phone number of the covered member who needs medical assistance.

Employee Contributions per Weekly Pay Period

KAISER PERMANENTE & BLUE SHIELD MEDICAL

Kaiser HMO & Blue Shield Access+ HMO – California Residents Only	
Employee Only	$10.00
Employee + One	$35.00
Employee + Family	$40.00
Blue Shield PPO HDHP + HSA	
Employee Only	$62.00
Employee + One	$77.00
Employee + Family	$104.00

CIGNA DENTAL

DHMO	
Employee Only	$4.20
Employee + One	$7.67
Employee + Family	$11.33
PPO	
Employee Only	$16.37
Employee + One	$31.62
Employee + Family	$52.98

METLIFE VISION

Employee Only	$2.19
Employee + One	$4.11
Employee + Family	$5.85

Key Terms

MEDICAL/GENERAL TERMS

Allowable Charge - The most that an in-network provider can charge you for an office visit or service.

Balance Billing - Non-network providers are allowed to charge you more than the plan's allowable charge.

Coinsurance - The cost share between you and the insurance company. Coinsurance is always a percentage totaling 100%. For example, if the plan pays 70%, you are responsible for paying the remaining 30% of the cost.

Copay - The fee you pay to a provider at the time of service.

Deductible - The amount you have to pay out-of-pocket for expenses before the insurance company will cover any benefit costs for the year (except for preventive care and other services where the deductible is waived).

Explanation of Benefits (EOB) - The statement you receive from the insurance carrier that explains how much the provider billed, how much the plan paid (if any) and how much you owe (if any). In general, you should not pay a bill from your provider until you have received and reviewed your EOB (except for copays).

Family Deductible - The maximum dollar amount any one family will pay out in individual deductibles in a year.

Individual Deductible - The dollar amount a member must pay each year before the plan will pay benefits for covered services.

In-Network - Services received from providers (doctors, hospitals, etc.) who are a part of your health plan's network. In-network services generally cost you less than out-of-network services.

Out-of-Network - Services received from providers (doctors, hospitals, etc.) who are not a part of your health plan's network. Out-of-network services generally cost you more than in-network services. With some plans, such as HMOs and EPOs, out-of-network services are not covered.

Out-of-Pocket - Healthcare costs you pay using your own money, whether from your bank account, credit card, Health Reimbursement Account (HRA), Health Savings Account (HSA) or Flexible Spending Account (FSA).

Out-of-Pocket Maximum – The most you would pay out-of-pocket for covered services in a year. Once you reach your out-of-pocket maximum, the plan covers 100% of eligible expenses.

Preventive Care – A routine exam, usually yearly, that may include a physical exam, immunizations and tests for certain health conditions.

PRESCRIPTION DRUG TERMS

Brand Name Drug - A drug sold under its trademarked name. A generic version of the drug may be available.

Generic Drug – A drug that has the same active ingredients as a brand name drug, but is sold under a different name. Generics only become available after the patent expires on a brand name drug. For example, Tylenol is a brand name pain reliever commonly sold under its generic name, Acetaminophen.

Dispense as Written (DAW) - A prescription that does not allow for substitution of an equivalent generic or similar brand drug.

Maintenance Medications - Medications taken on a regular basis for an ongoing condition such as high cholesterol, high blood pressure, asthma, etc. Oral contraceptives are also considered a maintenance medication.

Non-Preferred Brand Drug - A brand name drug for which alternatives are available from either the plan's preferred brand drug or generic drug list. There is generally a higher copayment for a non-preferred brand drug.

Preferred Brand Drug - A brand name drug that the plan has selected for its preferred drug list. Preferred drugs are generally chosen based on a combination of clinical effectiveness and cost.

Specialty Pharmacy - Provides special drugs for complex conditions such as multiple sclerosis, cancer and HIV/AIDS.

Step Therapy - The practice of starting to treat a medical condition with the most cost effective and safest drug therapy and progressing to other more costly or risky therapy, only if necessary.

DENTAL TERMS

Basic Services - Generally include coverage for fillings and oral surgery.

Diagnostic and Preventive Services - Generally include routine cleanings, oral exams, x-rays, sealants and fluoride treatments. Most plans limit preventive exams and cleanings to two times a year.

Endodontics - Commonly known as root canal therapy.

Implants - An artificial tooth root that is surgically placed into your jaw to hold a replacement tooth or bridge. Many dental plans do not cover implants.

Major Services - Generally include restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Orthodontia - Some dental plans offer Orthodontia services for children (and sometimes adults too) to treat alignment of the teeth. Orthodontia services are typically limited to a life-time maximum.

Periodontics - Diagnosis and treatment of gum disease.

Pre-Treatment Estimate - An estimate of how much the plan will pay for treatment. A pre-treatment estimate is not a guarantee of payment.

Your Healthcare Broker

Contact the Bernards HR Team for more information: Benefits@bernards.com

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