2021

Employee Health Benefit Guide

RENSA FILTRATION

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YOUR BENEFITS PACKAGE

Please read this benefits guide to learn about the various options available to you, so you can make informed decisions about your health care. When you make smart, well-informed decisions, you reduce your out-of-pocket health care costs, and you also help control the rising cost of health care premiums.

ELIGIBILITY

If you are scheduled to work 30 or more hours per week, you are eligible for Rensa Filtration benefits on the first of the month following 60 days after your first day of employment.

You may enroll your eligible dependents in the same plans you choose for yourself.

WHEN TO ENROLL

You must enroll for coverage within 30 days of your eligibility date or during the annual open enrollment period.

If you don't enroll for coverage within the allowed 30 days, you will not be able to enroll in any benefit coverage during the plan year, unless you experience a qualified change in family status (see Making Changes for details).

MAKING CHANGES

The choices you make when you are first eligible are in effect for the remainder of the plan year, which ends on December 31, 2021. Once you enroll for coverage, you must wait until the next open enrollment period to change your benefits or add or remove coverage for dependents, unless you experience a qualified change in family status as defined by the IRS.

Here are some examples:

- Marriage, divorce, legal separation, or annulment
- Birth or adoption of a child
- Change in your residence or workplace (if your benefit options change)
- Loss of other health coverage
- Change in your eligibility status because of marriage, age, etc.

You have 30 days to make changes to your coverage. **Keep this in mind:** Any change you make to your coverage must be consistent with the change in status.

RENSA FILTRATION

Bernie Portal will begin on November 23rd and will end on December 9th. It is mandatory to elect your benefits during this period

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If you are enrolling during the open enrollment period, any changes you make will begin on January 1, 2021

MEDICAL COVERAGE TO KEEP YOU HEALTHY

As a foundation for your good health, Rensa provides you with a selection of medical plans that offer quality, flexibility and value. Choose the plan that best meets your personal needs. Review the comparison chart below for coverage details. Please notice there are changes to our medical plans this year. Shown below in **"RED"** represents an increase in your responsibility for copays or co-insurance. **"BLUE"** represents a increase in benefit.

Plan Features		Blue Cross Blue Shield of Illinois High Deductible Health Plan MIEEE206 Blue Edge HSA		Blue Cross Blue Shield of Illinois PPO MIBPP209 Blue Print	
		In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible	Single	$2,800	$5,600	$2,000	$4,000
	Family	$5,600	$11,200	$6,000	$12,000
Annual Out-of-Pocket Maximum	Single	$5,600	$16,800	$4,000	$12,000
	Family	$11,200	$33,600	$12,000	$36,000
Annual Out-of-Pocket Maximum Includes	Copays	This plan does not offer copays for services		Yes	
	Deductibles	Yes		Yes	
Physician Office Visit		**30% after deductible**	40% after deductible	$30 copay	40% after deductible
Specialist Office Visit		**30% after deductible**	40% after deductible	$50 copay	40% after deductible
Preventative Care		Covered in full	40% after deductible	Covered in full	40% after deductible
Emergency Room		**30% after deductible**		**$350 per visit**	
Urgent Care		**30% after deductible**	40% after deductible	**$75 copay**	40% after deductible
Physical Therapy		**30% after deductible**	40% after deductible	CH $0 copay/ Anthem $45 copay	50% after deductible
Outpatient Hospital Services		**30% after deductible**	40% after deductible	**30% after deductible**	40% after deductible
Inpatient Hospital Services		**30% after deductible**	$300 per visit Plus 40% after deductible	**30% after deductible**	$300 per visit Plus 40% after deductible
Outpatient Mental Health		**30% after deductible**	40% after deductible	**$40 copay**	40% after deductible
Inpatient Mental Health		**30% after deductible**	40% after deductible	**30% after deductible**	$300 per visit Plus 40% after deductible

PERSCRIPTION DRUG COVERAGE

Plan Features	Blue Cross Blue Shield of Illinois High Deductible Health Plan MIEEE206 Blue Edge HSA		Blue Cross Blue Shield of Illinois PPO MIBPP209 Blue Print	
	In-Network Preferred / Non-Preferred Pharmacy	Out-of-Network	In-Network Preferred / Non-Preferred Pharmacy	Out-of-Network
Prescription Drugs: Retail	**Up to 30 days**		**Up to 30 days**	
Generic Preferred	10% or 20% after deductible *	Retail: 20% after deductible	$0 or $10 Copay *	$10 Copay
Generic Non-Preferred	10% or 20% after deductible *	Retail: 20% after deductible	**$15 or $25 Copay ***	$20 Copay
Brand Preferred	20% or 30% after deductible *	Retail: 20% after deductible	**$50 or $70 Copay ***	$55 Copay
Brand Non-Preferred	30% or 40% after deductible *	Retail: 20% after deductible	**$100 or $120 Copay***	$95 Copay
Specialty	40% for Preferred 50% for Non-Preferred	Retail: 20% after deductible	$150 for Preferred $250 for Non-Preferred	$150 for Preferred $250 for Non-Preferred
Prescription Drugs: Mail Order	**Up to 90 days**		**Up to 90 days**	
Generic	10% or 20% after deductible *	20% after deductible	$0 or $10*	Not Covered
Generic Non-Preferred	10% or 20% after deductible *	20% after deductible	**$30 or $40***	Not Covered
Brand Preferred	20% or 30% after deductible *	30% after deductible	**$100 or $120***	Not Covered
Brand Non-Preferred	30% or 40% after deductible *	40% after deductible	**$200 or $220***	Not Covered
Specialty	40% for Preferred 50% for Non-Preferred after deductible	40% for Preferred 50% for Non-Preferred after deductible	$150 Preferred $250 Non-Preferred	$150 Preferred $250 Non-Preferred

* Blue Cross Blue Shield of Illinois offers a network of select retail pharmacies where you pay the lower percentage shown. Utilizing these select pharmacies offers you savings. You are limited to a 30 day supply at retail pharmacies, however, 90-day supplies are available at the select retail pharmacies and through mail order. Payment of the difference between the cost of a brand name drug and a generic may also be required if a generic drug is available.

COST SAVING OPTIONS

Utilize In-Network Providers - Limit your out-of-pocket expenses by utilizing network providers. Visit the carrier website to find network providers for your medical, and dental care.

Avoid Non-Network Providers - If you utilize a provider which is not part of the network, your expenses increase. Non-Network deductibles and co-insurance levels are higher plus claims are paid on an allowance set by the carrier. You are not only responsible for the higher non-network deductible and co-insurance, you are also responsible for charges above the set allowance.

Preventive Care - Get your preventive check ups. These annual visits are covered 100% and can save on medical claims if a health condition is caught at an early state.

Urgent Care - Sometimes you need medical care that may be urgent, but does not need a trip to the emergency room. If you can't go to your doctor, you may want to visit an urgent care facility. Care will be less costly and treatment may be faster than an emergency room.

Lab Services - If your doctor wants you to get some medical testing, check your network for independent labs. Ask about the cost for their service. You may find lower charges causing lesser out-of-pocket expenses for you.

Prescription Drugs - When prescription drugs are needed, contact several pharmacies for the cost of your medication. The cost of medication can vary by provider. You may find significant savings by comparing pharmacy pricing. Savings can also be found when you are prescribed generic drugs. Ask your doctor or check with your pharmacist on how your prescription is written and if a generic drug is available.

Also a Prescription Drug option…

Good Rx - Significant savings can be found by utilizing Good Rx for your prescription. Good Rx compares pharmacy pricing and discounts to find the lowest cost and directs you to a local pharmacy. Good Rx will not process your prescription through your insurance coverage. Compare the cost of your prescription utilizing your insurance coverage and what Good Rx finds for you. Shopping is the key to savings. The website is www.goodrx.com. A mobile app is also available.

Find a Preferred Pharmacy:

•Go to https://www.bcbsil.com/find-a-doctor-or-hospital

•Click on Blue Choice Options

•Under "Other Types of Care" click on Pharmacy

•For Health Plan Type click on "Preferred"

GLOSSARY OF TERMS

Coinsurance - The shared cost of covered services between you and the insurance carrier. Your share is a percentage of the allowed amount. The percentage is applied after the deductible has been met and you pay this percentage until the out-of-pocket maximum is met. Coinsurance percentages will be different between in-network and out-of-network services and may be different if you have more than one plan.

Coordination of Benefits - If you are covered under a benefit plan plus another insurance coverage, (i.e. your spouses coverage), both plans will pay according to their benefit plan. This lessens your out-of-pocket expenses, however, at no time will the combined coverage allow more than 100% of the expenses to be paid.

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

Deductible - The amount of money you pay before services are covered. Services subject to the deductible will not be covered until the deductible has been fully met. It does not apply to any preventive services.

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

Explanation of Benefits (EOB) - Information you receive explaining how your claim was processed.

Medically Necessary - Health care services or supplies required to prevent, diagnose, or treat an illness, injury, condition, disease or its symptoms, which meet accepted medical standards.

Network Provider - A provider (physician, lab, or hospital) who has a contract with a health insurer to provide services at set fees. These contracted fees are usually lower than the provider's normal fees for services.

Out-of-Network (Non-Network) - Doctors, hospitals, labs, etc. that do not participate in an insurance carrier network. You will pay the non-network deductible and co-insurance plus any amount above the allowed amount. The allowed amount is usually based on a small percentage above Medicare allowed fees. You would have high out-of-pocket expenses going out of network.

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

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

Usual, Customary, and Reasonable (UCR) - Based on a geographic area, an insurance carrier uses the usual fee charged by providers for a specific service along with the customary and reasonable fee for the same service to calculate an average fee. This average is the base when determining the percentage paid on claims.

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

DENTAL COVERAGE TO ENHANCE YOUR SMILE

Strong teeth and gums are an important part of good health, which is why Rensa Filtration offers you and your eligible dependents dental coverage to help pay for many of the dental expenses you and your family incur. The plan helps you pay for most necessary dental services and supplies, including diagnostic and preventive care (such as exams, cleanings, and X-rays), and basic and major restorative services (such as fillings, crowns, and dentures).

The dental benefits are provided by United Concordia. Choose your dentist from the network and you will receive the benefit of negotiated discounts, which creates lower cost, resulting in lower out of pocket expenses.

Plan Features		United Concordia - Elite Plus Network	
		In-Network	Out-of-Network*
Annual Deductible (Does not apply to Diagnostic and Preventive Services)	Single	$50	
	Family	$150	
Annual Maximum		$1,800	
Diagnostic and Preventive Services (e.g. X-rays, cleanings, exams)		100%	
Basic and Restorative Services (e.g. fillings, extraction, root canals)		80%	
Major Services (e.g. dentures, crowns, bridges, Implants)		50%	
Orthodontia		Not Covered	

***Note:** If you visit an out-of-network provider, you are responsible for charges above usual, customary and reasonable (UCR) limits.

VISION COVERAGE TO HELP YOU SEE CLEARLY

See clearly and keep your life in focus with the vision plan, which includes benefits for eye exams, glasses, and contact lenses.

You are free to choose any provider, however, visiting a doctor within the network offers better benefits and greater savings. Benefits are provided through Sun Life Financial. Sun Life utilizes VSP for their network providers. To find a network provider go to www.vsp.com or call 1.800.877.7195

Plan Features	Sun Life - VSP Network	
	In-Network Member Cost:	Out-of-Network Plan Reimburses You Up To:
Exam (Once very 12 months)	$10 copay	Up to $45
Frames (Once every 24 months)	$130 allowance, then 20% off remaining balance	Up to $70
Lenses (Once every 12 months)		
Single Vision	$25 copay	Up to $30
Bifocal	$25 copay	Up to $50
Trifocal	$25 copay	Up to $60
Lenticular	$25 copay	Up to $100
Contact Lenses—in lieu of lenses and frames (Once every 12 months)		
Medically Necessary	Covered in full after $25 copay	Up to $210
Elective	$130 allowance	Up to $105

LIFE AND AD&D COVERAGE FOR PEACE OF MIND

BASIC LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE

Life and Accidental Death and Dismemberment (AD&D) insurance can provide economic security for your loved ones if you die, become disabled, or experience an injury or illness. Rensa provides you with this coverage at no cost to you. You automatically receive basic employee Life and AD&D coverage in the amount of $25,000 through Sun Life Financial. Be sure to choose a beneficiary to receive benefits in the event of your death - and don't forget to change your beneficiary when your life changes.

SUPPLEMENTAL LIFE & AD&D INSURANCE

Eligible employees have the opportunity to purchase additional Life and Accidental Death & Dismemberment (AD&D) insurance coverage at group rates. Elected benefits can include coverage for yourself, your spouse, and/or children. Coverage for a spouse and/or children can only be elected if you enroll in coverage for yourself.

The voluntary life benefit is offered by Sun Life Financial and is available, up to the guaranteed issue amount, only during your initial enrollment period. Evidence of Insurability is required for late entrants, coverage increases, and coverage in excess of the guaranteed issue amount.

Coverage is portable which allows you to take your coverage with you if you terminate employment.

As you elect coverage, consider costs such as funeral expenses, legal expenses, and general living expenses for your surviving family members when determining an appropriate amount of additional coverage.

Employee: You may choose increments of $10,000 up to the lesser of 5 times your annual earnings or $300,000. The guaranteed issue amount is lesser of any current group coverage you may have or $100,000. Coverage reduces to 50% at age 70.

Spouse: You may choose increments of $10,000 up to 50% of the coverage you elected for yourself up to a maximum of $50,000. Guaranteed issue is the lesser of any current coverage your spouse has or $25,000. Coverage terminates at age 70

Child(ren): You may choose amounts in $5,000 increments up to $10,000. Elected benefit cannot exceed 50% of coverage you elected for yourself. Eligible children are unmarried from 14 days to age 26.

Monthly Rates
Per $1,000 of Elected Coverage

Rates are used to calculate the monthly premium for the Voluntary Life and AD&D coverage. Rates are guaranteed until January 1, 2022.

The child rate applies to all eligible children in your family. If you have one child or 10 children, one benefit rate applies to all children.

Rate Per $1,000 of Coverage

Voluntary Life Insurance

Age	Employee	Spouse
Under 20	$.131	$.131
20 - 24	$.160	$.160
25 - 29	$.209	$.209
30 - 34	$.277	$.277
35 - 39	$.458	$.458
40 - 44	$.772	$.772
45 - 49	$1.119	$1.119
50 - 54	$1.606	$1.606
55 - 59	$2.848	$2.848
60 - 64	$6.301	$6.301
65 - 69	$6.301	$6.301
70 +	$6.301	Terminates
Child	Per $5,000	$.20

AD&D

Employee	$.02
Spouse	$.02
Child	$.02

HOW TO CALCULATE PER PAY PERIOD PREMIUMS

Elected Coverage												
$50,000	÷	1,000	=	50 Units	X	$.772 Rate*	=	$38.60 Monthly Cost	X	12 Months	÷	24 Pay Periods

$19.30 Your Cost Per Pay Period

DISABILITY COVERAGE FOR PEACE OF MIND

What if you become disabled and cannot work. How would you pay your bills? To help make a difficult time a little easier, Rensa provides employees with an employer paid benefit along with your option to purchase additional disability coverage. If you choose the buy-up option, you are responsible for the cost difference between the Rensa plan and the optional buy-up coverage. Benefits are provided through Sun Life.

Please remember that the maximum benefit shown is the maximum benefit allowed and may not be the amount you receive. The maximum benefit is based upon your current income.

Coverage Description	Short Term Disability	Long Term Disability
Coverage Amount	**50% of Pre-Disability Earnings** **Buy-Up Option:** **You can purchase an additional 10% of coverage, making the coverage amount** **60% of Pre-Disability Earnings** *This is earnings reported by your employer on the date immediately prior to the date you became disabled and does not include commissions, bonuses, overtime pay or any other compensation.*	**50% of Pre-Disability Earnings** **Buy-Up Option:** **You can purchase an additional 10% of coverage, making the coverage amount** **60% of Pre-Disability Earnings** *This is earnings reported by your employer on the date immediately prior to the date you became disabled and does not include commissions, bonuses, overtime pay or any other compensation.*
Maximum Benefit Amount	**Weekly Maximum of: $750** **Buy-Up Option:** **Based on your pre-disability earnings, the benefit amount increases up to a maximum of:** **$2,000 Weekly**	**Monthly Maximum of: $5,000** **Buy-Up Option:** **Based on your pre-disability earnings, the benefit amount increases up to a maximum of:** **$10,000 Monthly**
Maximum Benefit Period	**12 Weeks**	**Social Security Normal Retirement Age**
Accident Benefits Begin	**Day 8**	**Day 91**
Illness Benefits Begin	**Day 8**	**Day 91**
Definition of Disability	Loss of duties and loss of earnings	During the first 24 months you are unable to earn 80% of your own occupation's pre-disability earnings. After 24 months the inability to earn 50% of your pre-disability earnings in any occupation.
Are benefits reduced by other Income benefits	**Yes** *The disability amount from this plan can be reduced if you become eligible for Social Security or other income benefits*	**Yes** *The disability amount from this plan can be reduced if you become eligible for Social Security or other income benefits*
Are there benefit limitations	**Yes** Benefits are limited to nonoccupational coverage.	**Yes** Drug/Alcohol and Mental/Nervous conditions are limited to a 24-month benefit. Limitations may also apply to certain other conditions.
Pre-existing Condition Limitation	Benefits will not be paid for any pre-existing condition where you received treatment in the three month period prior to the beginning of coverage until you are covered continuously for 12 months	

NOTE: The above benefit summary is an attempt to give a brief description of the disability coverage. Specific rules may apply that are not mentioned in this summary. For a complete and accurate description, please refer to the certificate of coverage or contact from Sun Life. If there are any differences between this description and the Sun Life's benefit description, Sun Life's will prevail.

HEALTH SAVINGS ACCOUNT TO SAVE YOU MONEY

(Only offered with the Qualified High Deductible Health Plan)

Health Savings Account (HSA)

A HSA is an account that can be funded with your pre-tax dollars to help pay for current eligible expenses (deductible, co-pays, dental and vision expenses, prescription drugs, etc.) with the option to save for future health expenses. You may only open a health savings account if you are enrolled in the Qualified High Deductible Plan (QHDHP), with the $2,800 Deductible.

What are the Eligibility Rules?

To be HSA eligible, an individual must:
-Be covered under the QHDHP;
-Not be covered under another health plan that is not a QHDHP;
-Not be enrolled in Medicare or Tricare; and,
-Not be claimed as a dependent on another person's tax return.

What is the difference between an HSA and Flexible Spending Account (FSA)?

-An HSA can roll-over all unused funds from year to year.

-An FSA can roll-over up to $500 from year to year

-You may not have a medical FSA if you intend to make contributions to an HSA.

What if I currently participate in an FSA?

If you currently participate in an FSA, you will not be able to open a HSA until the end of the FSA plan year. If funds remain in your FSA account due to the $500 rollover, it will affect your ability to open an HSA.

When do I contribute to my HSA account, and how often can I?

You can contribute to your HSA account through payroll deduction or by making deposits to your account. You can contribute as often as you like, provided the annual contribution limits do not exceed; $3,600 for individual coverage or $7,200 for family coverage in 2021. Individuals that are age 55 or older may be eligible to make additional catch-up contribution of $1,000.

When can I start using my HSA dollars?

You can use your HSA dollars immediately following your HSA account activation. At any given time, you may only use funds that have already been deposited to your account. Your account will be held with **Bank of America**.
New contribution amount to your HSA will begin January 1

HEALTH SAVINGS ACCOUNT (CONTINUED)

(Only offered with the Qualified High Deductible Health Plan)

What if I have HSA dollars left in my account at year-end?

The money is yours to keep. If will continue to earn interest and will be available to you for future health care costs.

How do I pay my physician or network facility at time of service with my HSA dollars?

You may request that the network provider submit your claim to your health plan. Once the medical claim has been processed, out-of-pocket expenses will be billed. At this time you may choose to use your HSA debit card to pay for any out-of-pocket expenses, or you may choose to write a personal check, receiving reimbursements at a later date. You should always ask that your medical claim be submitted to the health plan before you seek reimbursement from your HSA. This procedure will ensure that provider discounts are applied. Also, remember to keep all medical receipts and Explanation of Benefits (EOBs).

How do I manage my HSA?

Since you are the account holder, you manage your HSA account. You may choose to use your HSA debit card, manage payments through Bank of America, or submit for reimbursement. Most commonly, the HSA account holder will pay their out-of-pocket expenses (i.e. deductible and coinsurance) associated with their high deductible health plan with their HSA dollars.

What expenses are eligible for reimbursement from my HSA?

Qualified medical expenses are expenses for medical care and are outlined within the IRS Section 213(d). In summary the IRS Section 213(d) states that “the expense has to be primarily for the prevention or alleviation of a physical or mental defect or illness.” Eligible expenses are consistent with those permitted under an FSA program. Money withdrawn from an HSA account to reimburse non-eligible medical expenses is taxable income to the account holder and is subject to a 20% tax penalty, unless over age 65, disabled, or upon death of the account holder.

Employee Assistance Program

Confidential Emotional Support

Our highly trained clinicians will listen to your concerns and help you or your family members with any issues, including:

- Anxiety, depression, stress
- Grief, loss and life adjustments
- Relationship/marital conflicts

Work-Life Solutions

Our specialists provide qualified referrals and resources for just about anything on your to-do list, such as:

- Finding child and elder care
- Hiring movers or home repair contractors
- Planning events, locating pet care

Legal Guidance

Talk to our attorneys for practical assistance with your most pressing legal issues, including:

- Divorce, adoption, family law, wills, trusts and more

Need representation? Get a free 30-minute consultation and a 25% reduction in fees.

Financial Resources

Our financial experts can assist with a wide range of issues.

- Retirement, taxes, mortgages, budgeting and more

For additional guidance, we can refer you to a local financial professional and arrange to reimburse you for the cost of an initial one-hour in-person consult.

Online Support

GuidanceResources® Online is your 24/7 link to vital information, tools and support. Log on for:

- Articles, podcasts, videos, slideshows
- On-demand trainings
- "Ask the Expert" personal responses to your questions

Help for New Parents

ParentGuidance℠ supports you through the process of becoming a biological or adoptive parent, including:

- Preparing for the baby emotionally and financially
- Finding child care
- Planning for back-to-work and other issues

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EstateGuidance® lets you quickly and easily create a will online.

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- Provide funeral and burial instructions
- Choose a guardian for your children

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BlueCross BlueShield of Illinois

Well onTarget®

Blue Points℠ — Rewards for Healthy Living

Well onTarget understands how hard it can be to maintain a healthy lifestyle. Sometimes, you may need a little motivation. That's why we offer the Blue Points[1] program. This program may help you get on track — and stay on track — to reach your wellness goals.

With the Blue Points program, you will be able to earn points for regularly participating in many different healthy activities. You can redeem these points in the online shopping mall, which provides a wide variety of merchandise.

Created with your needs in mind, the Blue Points program has many convenient, user-friendly, personalized and flexible features:

EARN POINTS INSTANTLY

The program gives you points immediately, so you can start using them right away.[2]

GET EXTRA POINTS

Don't have enough points yet for that reward you really want? No problem! You can apply the points you have and use a credit card to pay the remaining balance.

EASILY MANAGE YOUR POINTS

The interactive Well onTarget portal, available at wellontarget.com, uses the latest user-friendly technology. This makes it easy to find out how many points are available for you to earn. You can also track the total number of points you've earned year-to-date. All of your points information will appear on one screen.

CHOOSE FROM A LARGE SELECTION OF REWARDS

Redeem your points in our expanded online shopping mall. Reward categories include apparel, books, health and personal care, jewelry, electronics, music and sporting goods. And be sure to check out the "Rewards on Sale" section, where you'll find discounted electronics, games, luggage and other merchandise.[3]

PARTICIPATE IN ACTIVITIES THAT MATCH YOUR GOALS

Look how quickly your Blue Points can add up! Here are some sample activities you can complete to earn Blue Points:

ACTIVITIES	POTENTIAL BLUE POINTS AMOUNTS
Completing the Health Assessment every six months[4]	2,500 points every six months
Complete a Self-management Program	1,000 points per quarter
Tracking your progress toward your goals in the Well onTarget Member Wellness Portal	10 points, up to a maximum of 70 points per week
Enrolling in the Fitness Program	2,500 points
Adding weekly Fitness Program center visits to your routine	Up to 300 points each week
Completing any Self-management Program Milestone Assessment	Up to 250 points per month
Connecting a compatible fitness device or app to the portal	2,675 points
Tracking progress using a synced fitness device or app	55 points per day

[1] Blue Points Program Rules are subject to change without prior notice. See the Program Rules on the Well onTarget Member Wellness Portal for more information.

[2] This does not apply to points you earn for completing Fitness Program activities.

[3] Member agrees to comply with all applicable federal, state and local laws, including making all disclosures and paying all taxes with respect to their receipt of any reward.

[4] Well onTarget is a voluntary wellness program. Completion of the Health Assessment is not required for participation in the program.

The Fitness Program is provided by Tivity Health®, an independent contractor that administers the Prime Network of fitness centers. The Prime Network is made up of independently owned and operated fitness centers.

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

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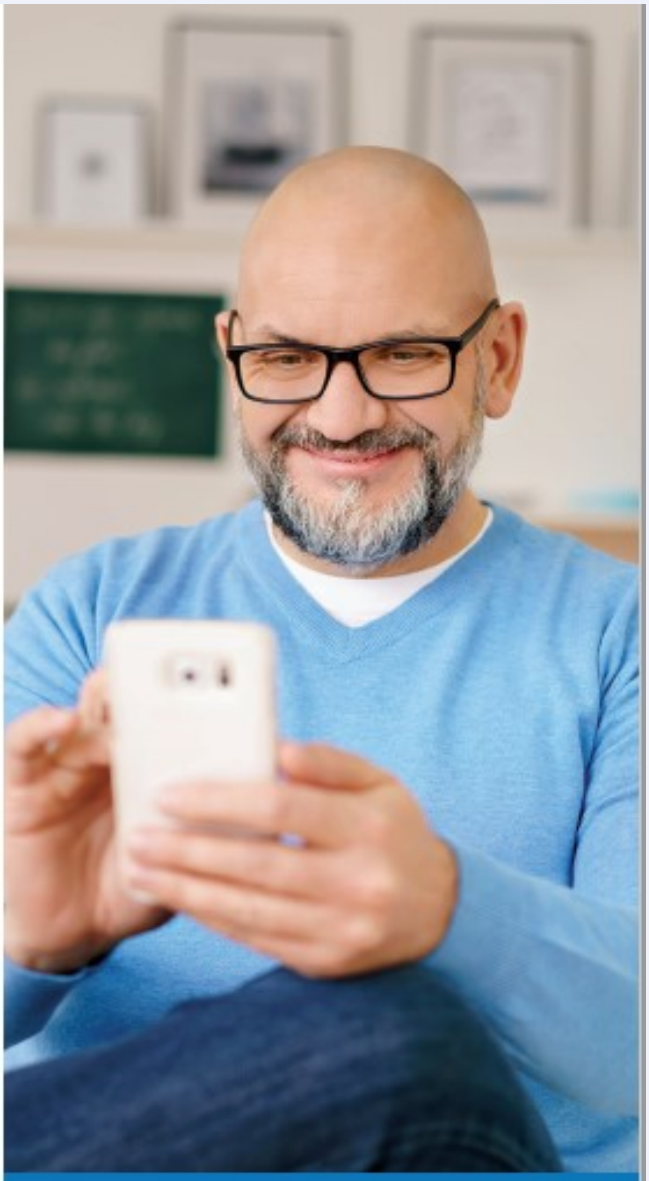


Log on to **wellontarget.com** today to find all the interactive tools and resources you need to start racking up Blue Points. Keep yourself motivated to earn more points by heading over to the online shopping mall and checking out all the rewards you can earn for adopting — and continuing — healthy habits.

BlueCross BlueShield of Illinois

Well onTarget®

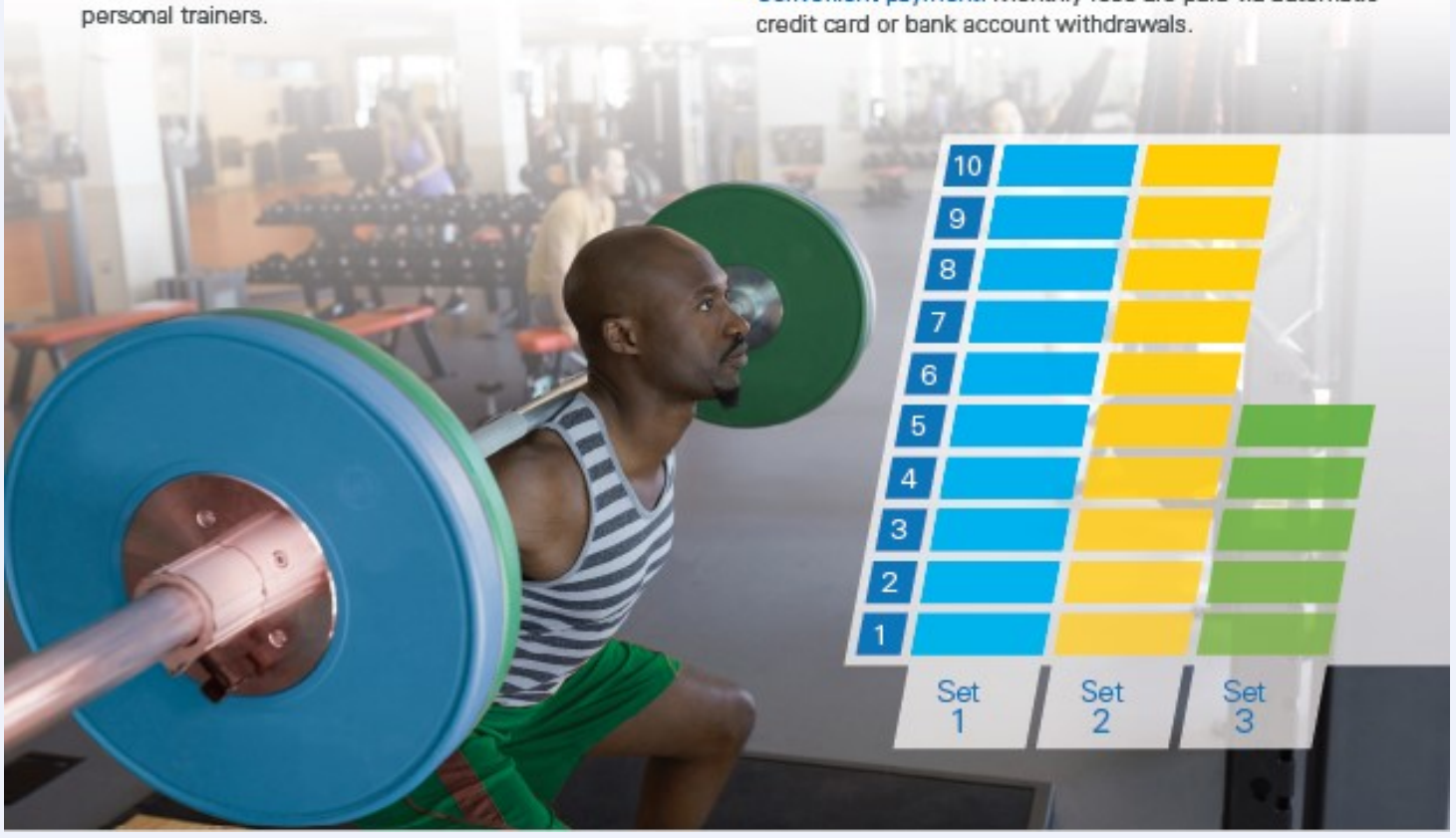
Make Your Fitness Program Membership Work for You!

Fitness can be easy, fun and affordable. Well onTarget makes it possible with the Fitness Program.

Since you are a Blue Cross and Blue Shield of Illinois member, the Fitness Program is available exclusively to you and your covered dependents (age 18 and older). The program gives you unlimited access to a nationwide network of more than 10,000 fitness locations. If you want, you can choose one location close to home and one near work. You can visit locations while you're on vacation or traveling for work.

Other program perks include:

- No long-term contract: Membership is month to month. Monthly fees are $25 per month per member, with a one-time enrollment fee of $25 per member.*
- Complementary and Alternative Medicine (CAM) discounts: Save money through a nationwide network of 40,000 health and well-being providers, such as acupuncturists, massage therapists and personal trainers.
- Blue Points℠: Get 2,500 points for joining the Fitness Program. Earn additional points for weekly visits. You can redeem points for apparel, books, electronics, health and personal care items, music and sporting goods.**
- Web resources: You can go online to find fitness locations and track your visits.
- Convenient payment: Monthly fees are paid via automatic credit card or bank account withdrawals.



ARE YOU READY FOR FITNESS?

It's easy to sign up:

1. Go to bcbsil.com and log in to Blue Access for Members℠.
2. Under "Quick Links," choose "Fitness Program." On this page, you can enroll, search for nearby fitness locations and learn more about the program.
3. Click "Enroll Now." Then search and select the fitness location that is best for you. Remember, you can visit any participating fitness location after you sign up.
4. Verify your personal information and method of payment. Print or download your Fitness Program membership ID card. You may also request to receive the ID card in the mail.
5. Visit a fitness location today!

Prefer to sign up by phone or have questions about the Fitness Program? Just call the toll-free number 888-762-BLUE (2583) Monday through Friday, between 7 a.m. and 7 p.m. CT (6 a.m. and 6 p.m. MT).

Find fitness buddies, take a class and try something new! Join the Fitness Program today to help you reach your health and wellness goals.

* Taxes may apply. Individuals must be at least 18 years old to purchase a membership.

** Member agrees to comply with all applicable federal, state and local laws, including making all disclosures and paying all taxes with respect to their receipt of any reward.

Blue Points Program Rules are subject to change without prior notice. See the Program Rules on the Well onTarget Member Wellness Portal for more information.

The Fitness Program is provided by Tivity Health™, an independent contractor that administers the Prime Network of fitness locations. The Prime Network is made up of independently owned and operated fitness locations.

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

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BlueCross BlueShield of Illinois

Well onTarget®

Experience a New Kind of Wellness — Log In to the Well onTarget Portal

Well onTarget is designed to give you the support you need to make healthy lifestyle choices — and reward you for your hard work.

MEMBER WELLNESS PORTAL

The Well onTarget Wellness Portal uses the latest technology to give you the tools you need for better health. Your wellness journey begins with a suggested list of activities based on the information you provided in the Health Assessment.* Now you have a step-by-step plan to guide you on the way to living your best life. The suite of programs and tools include:

- Digital Self-management Programs: Learn about nutrition, fitness, weight loss, quitting smoking, managing stress and more!
- Health and Wellness Library: The health library has useful articles, podcasts and videos on health topics that are important to you.
- Blue Points℠ Program:** Earn points for wellness activities. Redeem your points for a wide variety of merchandise in the online shopping mall.
- Tools and Trackers: These interactive resources help keep you on track while making wellness fun.
- Health Assessment: Answer some questions to learn more about your health and receive a personal wellness report.
- Fitness Tracking: Get Blue Points for tracking activity with popular fitness devices and mobile apps.
- Nutrition Help: Members can choose a nutrition app to connect and monitor their food intake via the View Nutrition page. Enter calorie targets, carbs, fats, protein and more. Apps include Fitbit, MyFitnessPal and others.
- Personal Challenges: Join a personal challenge to help you reach your goals. There are over 30 challenges, so you can choose the best one to fit your wellness journey. Topics include stress, sleep, physical activity and more!

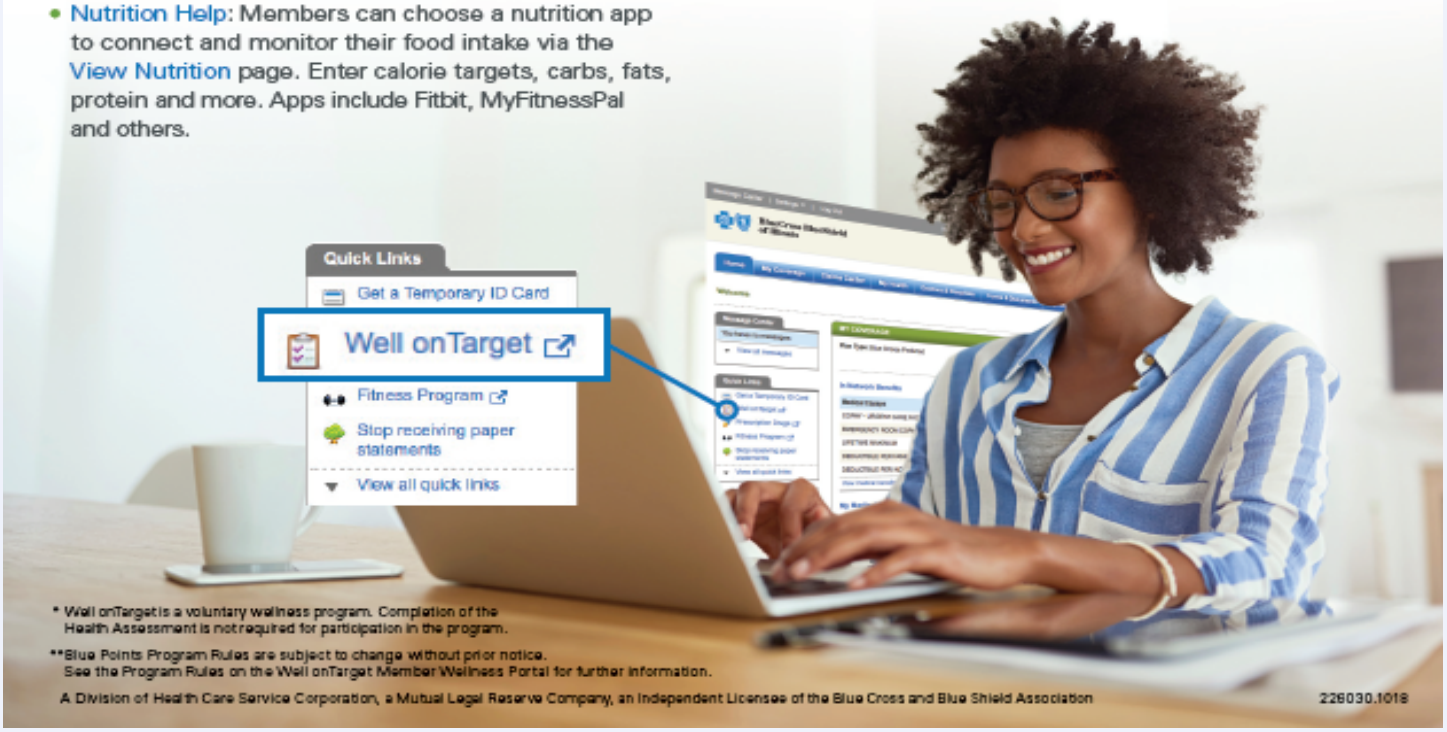
HOW TO ACCESS THE PORTAL

Use your Blue Access for Members℠ (BAM℠) account:

- Log in to BAM at bcbsil.com/members. If this is your first time logging in, you will need to register your account. Click Register Now on the login screen.
- Once you are in BAM, click on the Well onTarget link on the left side of the screen. You will be taken to the portal.

QUESTIONS?

If you have any questions about Well onTarget, call Customer Service at 877-806-9380.



* Well onTarget is a voluntary wellness program. Completion of the Health Assessment is not required for participation in the program.

**Blue Points Program Rules are subject to change without prior notice. See the Program Rules on the Well onTarget Member Wellness Portal for further information.

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

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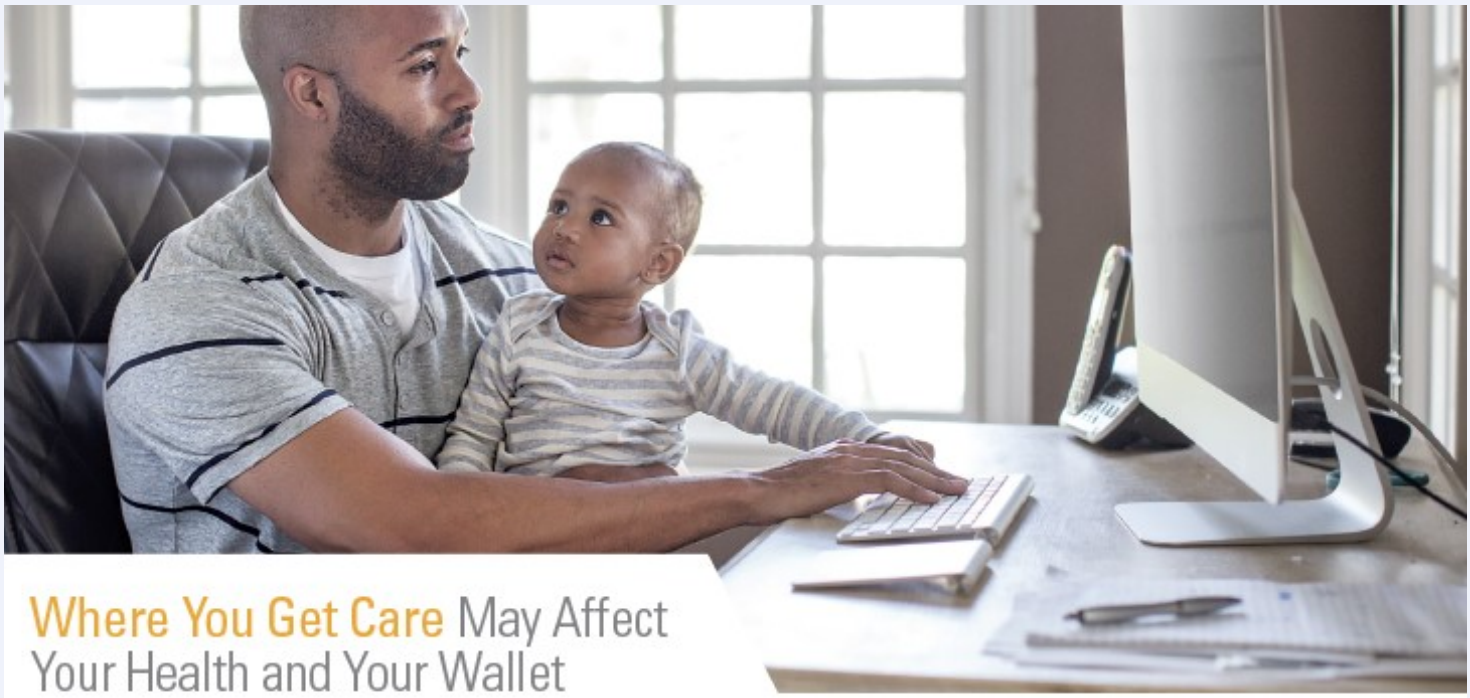

Where You Get Care May Affect Your Health and Your Wallet

Be a Smart Health Care Shopper with Help from Blue Cross and Blue Shield of Illinois (BCBSIL)

There's a lot to think about when deciding where to get health care. Just take a look at how much prices differ for the same procedure in the same area.

Procedure	Provider A	Provider B	Difference
MRI of the Brain	$682[1]	$3,849[1]	$3,167
Hysterectomy	$12,371[2]	$20,578[2]	$8,207
Hernia Repair	$4,142[2]	$11,692[2]	$7,550
Knee Replacement	$16,997[1]	$55,155[1]	$38,158

* Note that costs are examples and may not apply to every member's situation

Being informed does not have to be tricky and there are resources available for helping make the best decision for you.

Use Provider Finder® to help make more informed health care choices by:

Checking costs before your appointment: We're here to help you find quality independently contracted health care providers that may cost less and to help you understand what you may need to pay based on your plan's copay, coinsurance, deductible and other benefits.

Finding out how doctors in your area compare: Find a doctor in your network. Check if your facility has been recognized for providing quality care. Or read reviews and ratings from other members and share your own.

Go Online

Log in to Blue Access for Members℠ (BAM) at bcbsil.com, anytime, day or night.

Click **Doctors & Hospitals** to compare costs and find providers in your network.

Get the App

Text* BCBSIL to 33633 to download our app.

Go to the App Store or Google Play.

Use the app to find all kinds of useful information to help you choose a provider and save money.

VOLUNTARY ACCIDENT

LIFE and DISMEMBERMENT LOSSES *		LOW PLAN	HIGH PLAN
Accidental Death		$15,000	$25,000
Common Carrier Accidental Death		$30,000	$100,000
Catastrophic Loss: Both arms or both hands, both legs or both feet, one hand and one foot or one arm and one let, irrecoverable loss of sight of both eyes.	or	$7,500	$15,000
One hand, one foot, one let, one arm		$3,750	$7,500
Loss of sight of one eye or loss of one eye		$3,750	$7,500
Two or more fingers or toes		$750	$1,500
One finger or one toe		$375	$750
* Above benefits are payable for employee only. Spouse benefit is 100% of the employee benefit, dependent children's benefit is 50% of the employee benefit			
HOSPITAL			
Hospital Admission Benefit (once per benefit year)		$500	$1,000
Hospital Confinement (per day up to 365 days/covered accident)		$150	$250
Intensive Care Unit Admission (once per benefit year; payable Instead of Hospital Admission benefit if Confined immediately to ICU		$750	$1,500
Intensive Care Unit Confinement (per day up to 14 days, payable in addition to any Hospital Confinement benefit)		$300	$500
Ambulance (Ground)		$100	$200
Ambulance (Air)		$750	$1,500
Emergency Room Admission		$100	$150
Family Lodging (per day up to 30 days per benefit year)		$50	$100
Transportation (100 or more miles up to 3 times per covered accident		$250	$500
Rehabilitation Unit (per day up to 30 days per covered accident)		$50	$100
SURGERY			
Miscellaneous Surgery requiring general anesthesia (not covered by any other benefit)		$150	$300
Open Surgery		$625	$1,250
Exploratory Surgery or Debridement		$125	$250
Tendon/Ligament/Rotator Cuff Tear		$300	$625
Torn Knee Cartilage		$300	$625
Ruptured/Herniated Disc		$300	$625
FRACTURES			
Hip or thigh		$2,000 (Open) $1,000 (Closed)	$4,000 (Open) $2,000 (Closed)
Skull-depressed		$3,000 (Open) $1,500 (Closed)	$6,000 (Open) $3,000 (Closed)
Vertebrae, Sternum or Pelvis		$800 (Open) $400 (Closed)	$1,600 (Open) $800 (Closed)
Upper jaw or upper arm		$375 (Open) $190 (Closed)	$750 (Open) $375 (Closed)
Lower jaw, Collarbone, Shoulder, Forearm, Hand, Wrist, Foot, Ankle, Kneecap, Elbow, or Heel		$325 (Open) $170 (Closed)	$650 (Open) $325 (Closed)
Multiple ribs		$500 (Open) $250 (Closed)	$1,000 (Open) $500 (Closed)
WELLNESS			
Wellness Screening Benefit (once per benefit year)		$50	$50

The above benefits are only brief description of covered benefits. Please refer to the Sun Life benefit summary for full coverage details. Benefits offered are for 24 hours or you can elect coverage when you are not at work (Off Job).

Monthly Rates

PLAN	Employee (EE)	EE+Spouse	EE+Child(ren)	Family
Low/24 Hr.	$9.05	$15.34	$17.03	$23.32
High/24 Hr.	$14.33	$25.17	$28.64	$39.48
Low/Off Job	$7.23	$11.95	$13.21	$21.93
High/Off Job	$11.19	$19.32	$21.93	$30.06

VOLUNTARY CANCER INSURANCE

HOSPITAL AND RELATED BENEFITS	
Hospital Confinement (daily-limited to 90 days per period of hospital confinement)	$400
Private Duty Nursing Services (daily-limited to 30 days per benefit year)	$125
Extended Care Facility (daily-maximum 90 days per benefit year)	$200
Home Health Care (limited to 10 visits per hospital confinement-maximum of 30 days per benefit year)	$50
Hospice Care Center (daily– maximum of 100 days)	$100
RADIATION/CHEMOTHERAPY AND RELATED BENEFITS	
Radiation/Chemotherapy (weekly-benefit amount is based upon treatment)	$600 to $1,000
Blood, Plasma, and Platelets (each day insured receives blood and/or plasma)	$50
Medical Imaging (payable twice per benefit year)	$100
SURGERY AND RELATED BENEFITS	
Surgery	$150 to $5,500
Anesthesia	$50 to $1,815
Ambulatory Surgical Center (daily)	$250
Second Opinion	$200
Bone Marrow or Stem Cell Transplant	Bone Marrow - $10,000 (Donor - $1,500) Stem Cell - $2,500
ADDITIONAL BENEFITS	
Cancer Screening (once per benefit year)	$75
Skin Cancer (based on procedure performed)	$100 to $600
Physician's In-hospital Visits (daily)	$25
Ambulance (limited to 2 on-way trips per period of hospital confinement)	Ground-$250; Air-$2,000
Transportation (per round trip to hospital or clinic more than 100 miles from residence-limit 3)	$500
Outpatient Lodging (clinic must be more that 100 miles from residence, limit 1 per day up to 90 days)	$100
Alternative Care (per visit-limited to 20 visits per benefit year-lifetime maximum: 2 benefit years)	$50
Immunotherapy (monthly-Lifetime maximum of $3,500)	$450
Experimental Treatment (daily-maximum monthly benefit is $1,050)	$150
Prosthesis (lifetime maximum-2 times amount shown)	Implants-$3,000; Other Devices-$300
Anti-Nausea Benefit	$100
Reconstructive Surgery (Breast Symmetry, Breast & Facial Reconstruction, TRAM-based on procedure)	$350 to $2,500
Cancer Initial Diagnosis (one-time benefit)	$5,000

The above benefits are only a brief description of covered benefits. Please refer to the Sun Life benefit summary for full coverage details.

Monthly Rates

Age	Employee	Spouse	Child(ren)	Family
To 49	$32.52	$55.28	$35.77	$58.53
50 - 59	$40.10	$68.17	$43.35	$71.42
60 - 64	$63.95	$108.71	$67.20	$111.96
65+	$85.63	$145.56	$88.88	$148.81

VOLUNTARY CRITICAL ILLNESS

CRITICAL ILLNESS	Employee	Spouse	Child
Benefit Amount	Increments of $5,000	Increments of $2,500	Increments of $2,500
Maximum Benefit	$20,000	$10,000	$5,000
Guaranteed Issue	$20,000	$10,000	$5,000
Age Reduction	50% at age 70, rounded to the next higher $1,000	Benefit amount will be reduced if greater than 50% of employees reduced amount	Benefit amount will be reduced if greater than 50% of employees reduced amount

CORE CONDITIONS	INITIAL DIAGNOSIS	RECURRANCE
Heart Attack, Stroke, Major Organ Failure, End-Stage Kidney Disease, Occupational HIV, Hepatitis B, D, or D	100%	100%
Coronary artery bypass graft	25%	25%
Angioplasty	5%	5%
CANCER CONDITIONS		
Invasive cancer	100%	100%
Non-invasive cancer	25%	25%
Skin Cancer	5%	5%
SUPPLEMENTAL CONDITIONS-OPTION 1		
Complete Blindness, Loss of Speech, Complete Loss of Hearing	100%	N/A
SUPPLEMENTAL CONDITIONS-OPTION 2		
Benign Brain Tumor, Paralysis, Coma, Severe Burns	100%	N/A
SUPPLEMENTAL CONDITIONS-OPTION 3		
Advanced ALS or Lou Gehrig's Disease	100%	N/A
Advanced Alzheimer's or Parkinson's	25%	N/A
CHILDHOOD CONDITIONS-CHILD ONLY		
Down Syndrome, Cerebral Palsy, Cystic Fibrosis, Cleft Lip/Palate, Type 1 Diabetes Mellitus, Muscular Dystrophy, Complex Congenital Heart Disease, Spina Bifida	100%	N/A
WELLNESS BENEFIT		
Annual wellness screening benefit	Employee: $50 Spouse: $50 Child: $50	
ADDITIONAL PROVISIONS		
Additional occurrence waiting period	6 Months between diagnosis	
Maximum benefit	1 time per condition	
Recurrence waiting period	12 months	
Cancer recurrence waiting period	12 months	
Recurrence maximum	1 time per applicable condition	
Pre-existing conditions limitation	Any condition treated 12 prior to coverage will not be covered for 12 months	

Monthly Rates
Per $1,000 of Elected Coverage

Issue age rating applies - Premiums will not increase due to age increases.

Employee's age is used to determine Spouse rates.

Wellness benefit is an additional charge, if elected.

AGES	Non-Tobacco	Tobacco	AGES	Non-Tobacco	Tobacco
Under 25	$.44	$.47	55 - 59	$4.98	$9.56
25 - 29	$.54	$.59	60 - 64	$6.79	$13.64
30 - 34	$.75	$.89	65 - 69	$8.77	$18.13
35 - 39	$1.08	$1.41	70 - 74	$12.62	$24.89
40 - 44	$1.67	$2.47	75+	$17.48	$30.81
45 - 49	$2.49	$4.09			
50 - 54	$3.57	$6.39	Child	$.87	

Wellness Monthly Rate	
Employee	$1.39
Spouse	$1.39
Child	No Charge

NOTE: The above benefits are a summary of the full coverage. Please refer to the Sun Life Financial benefit information for full coverage details.

HOW TO ENROLL DURING OPEN ENROLLMENT
USE THESE INSTRUCTIONS IF YOU ARE A CURRENT EMPLOYEE

BERNIEPORTAL
A Bernard Health Production

How to Enroll in BerniePortal

How do I login?

1. **A BerniePortal account has been created for you!**
2. **You will login at www.bernieportal.com/en/login with the following credentials:**
   a. **Username:** Your email address. Your broker will let you know which address to use.
   b. **Password:** This will be the last 4 digits of your SSN and the two digits of your birth month.
      - E.g.: Last 4 digits of SSN is "1234" and birth month is June; password is "123406."

What do I do next?

1. **Verify your information on the Personal Information screen when you login.**
2. **Enroll in benefits.**
   a. List your spouse and dependents (if applicable).
   b. If you don't know one of their SSNs use "111-11-1111."
   c. Elect or waive each coverage: health, dental, & vision.
   d. Confirm your elections, sign with your mouse & select "I Agree."
3. **You're finished! You can login to your BerniePortal account anytime to view your elections.**

3 Tips for electing benefits

1. **Use the sidebar on the left to navigate among the benefit types.**
2. **Use the cart on the right to budget your elections.**
3. **Use the sidebar on the left if you need to review/adjust your elections.**

Forgot your password?

1. **Go to www.bernieportal.com**
2. **Click Login**
3. **Click Forgot Password**
4. **Type in email address**
5. **Submit**

www.BerniePortal.com

RENSA FILTRATION

January 1, 2021 - December 31, 2021 Annual Notices

RISK CONSULTING PARTNERS

***IMPORTANT NOTICE**: This document is provided to help employers understand the compliance obligations for Health & Welfare benefit plans, but it may not take into account all the circumstances relevant to a particular plan or situation. It is not exhaustive and is not a substitute for legal advice.*

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice and proof of legal documentation of qualified event to: Chip Meyer 4320 Winfield Rd., Suite 200, Warrenville, IL 60555, cmeyer@rensafiltration.com

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. **You must provide legal documentation from Social Security and notice to Chip Meyer (see above address or email address).**

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Rensa Air Filtration
Chip Meyer
4320 Winfield Rd., Suite 200
Warrenville, IL 60555
(917) 536-5987

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

Beginning in 2014, there is a new way to buy health insurance: the **Health Insurance Marketplace**. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace.

What is the Health Insurance 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.
The 2021 open enrollment period for health insurance coverage through the Marketplace ran from Nov. 1, 2020, through Jan. 31, 2021. Individuals must have enrolled or changed plans prior to Dec. 15, 2020, for coverage starting as early as Jan. 1, 2021. After Jan. 31, 2021 you can get coverage through the Marketplace for 2021 only if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP). Open enrollment for the 2022 plan year runs from Nov. 1, 2021, through Dec. 15, 2021.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards.

If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.83 percent (as adjusted each year after 2014) of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. (An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.)

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact **Chip Meyers, (917) 536-5987**

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.
If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2020. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/ Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA - Medicaid
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-916-440-5676

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid
Website: http://flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hppi/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162 ext. 2131

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: https://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid Website: http://www.in.gov/medicaid
Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website:https://dhs.iowa.gov/ime/members/
Phone: 1-800-388-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/default.htm
Phone: 1-800-792-4884

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)
Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid
Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711
Private Health Insurance Premium Webpage
https://www,naune.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740 TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/cohhs/gov/departments/masshealth/
Phone: 1-800-862-4840

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: (855) 632-7633 Lincoln: (402) 473-7000
Omaha: (402) 595-1178

NEVADA – Medicaid
Medicaid Website: https://dhcfp.nv.gov/
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE - Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 603-271-5218 Toll free number for HIPP program: 1-800-852-3345, ext. 5218

NEW JERSEY—Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://dma.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website:http://www.dhs.pa.gov/provider/Providers/Pages/Medical/HIPP-Program.aspx
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid
Website: http://www.eohhs.ri.gov/
Phone: 855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Medicaid Website: http://www.coverva.org/hipp
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid
Website: http://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since August 10, 2017, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, not withstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 12/31/2019)

IMPORTANT NOTICE FROM **RENSA AIR FILTRATION** ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

OMB 0938-0990

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Rensa Air Filtration 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. **Blue Cross Blue Shield of Illinois has determined that the prescription drug coverage offered by Rensa Air Filtration is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your **Blue Cross Blue Shield of Illinois** coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents will be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with **Blue Cross Blue Shield of Illinois** and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through **Blue Cross Blue Shield of Illinois** changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.
For more information about Medicare prescription drug coverage:

Visit www.medicare.gov

Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help

Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

Date: January 1, 2021
Name of Entity/Sender: Rensa Air Filtration
Contact—Position/Office: Chip Meyer
Address: 4320 Winfield Rd., Suite 200, Warrenville, IL 60555
Phone: (917) 536-5987

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).

CMS Form 10182-CC **Updated April 1, 2011**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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.

If you have creditable coverage from another plan, you may be entitled to a reduction or elimination of exclusionary periods (if applicable) of coverage for preexisting conditions under your group health plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to COBRA continuation of coverage, when COBRA continuation of coverage ceases, if you request before losing coverage or if you request it up to 24 months after losing coverage. Without evidence of prior creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in yourcoverage.

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 reviewed 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 $110 a day 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.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA)

Enrollment Notice

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 of 1998 (WHCRA). 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. Therefore, the following deductibles and coinsurance apply:

- **Deductible (In-Network/Out-of-Network): Blue Edge HSA 206: $2,800 / $5,600; Blue Print PPO 209: $2,000 / $4,000**
- **Coinsurance (BCBS pays In-Network/Out-of-Network): Blue Edge HSA 206: 70%/60%; Blue Print PPO 209: 70%/60%**

If you would like more information on WHCRA benefits, call your plan administrator, **Chip Meyer, (917) 536-5987**

Annual Notice

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

NEWBORN AND MOTHER'S HEALTH PROTECTION ACT (NMHPA)

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

MICHELLE'S LAW DISCLOSURE

Under the ACA, dependent children are covered by the group health plan until age 26. The group health plan extends dependent coverage beyond the ACA requirements, to age 26, so long as the child is covered as a student. If your child has extended coverage as a student but loses their student status because they take a medically necessary leave of absence from school your child may continue to be covered under the plan for up to one year from the beginning of the leave of absence. This is available if, immediately before the first day of the leave of absence, your child was (1) covered under the plan and (2) enrolled as a student at a post-secondary educational institution (includes colleges and universities).

HIPAA SPECIAL ENROLLMENT NOTICE

This notice is being provided to make certain that you understand your right to apply for group health coverage. You should read this notice even if you plan to waive health coverage at this time.

Loss of Other Coverage

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

Example: You waived coverage under this Plan because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this Plan.

Marriage, Birth or Adoption

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

Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this Plan. However, you must apply within 30 days from the date of your marriage.

Medicaid or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this Plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this Plan if you apply within 60 days of the date of their loss of CHIP coverage.

For More Information or Assistance

To request special enrollment or obtain more information, please contact:

Name: **Chip Meyer**
Address: **Rensa Air Filtration**
4320 Winfield Rd., Suite 200
Warrenville, IL 60555
Ph: **(917) 536-5987**
Email: **cmeyer@rensafiltration.com**

To request special enrollment, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272)

PRE-EXISTING CONDITION EXCLUSIONS

The Patient Protection and Affordable Care Act (PPACA) prohibits any pre-existing condition exclusion from being imposed by group health plans or group health insurance coverage and extends this protection to individual health insurance coverage. This prohibition is effective for new and grandfathered group plans beginning on or after January 1, 2014, but for enrollees who are under 19 years of age, this prohibition becomes effective for plan years beginning on or after September 23, 2010.

- "Pre-existing condition exclusion" means a limitation or exclusion of benefits (including a denial of coverage):
  - ◊ Based on the fact that the condition was present before the effective date of coverage (or if coverage is denied, the date of the denial), whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day.
  - ◊ As a result of information relating to an individual's health status before the individual's effective date of coverage (or if coverage is denied, the date of the denial), such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period.
- Pre-existing condition exclusion prohibits not just an exclusion of coverage of specific benefits associated with a pre-existing condition in the case of an enrollee, but also a complete exclusion from such plan or coverage, if that exclusion is based on a pre-existing condition.
- The interim final regulations do not change the HIPAA rule that an exclusion of benefits for a condition under a plan or policy is not a pre-existing condition exclusion if the exclusion applies regardless of when the condition arose relative to the effective date of coverage.

NOTICE OF PRIVACY PRACTICES

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

As a participant in the company **Blue Cross Blue Shield of Illinois** plan (the "Plan"), you are eligible for certain health care benefits. In the course of providing these benefits to you, the Plan may receive and maintain some of your medical information. Federal law requires that the Plan protect the privacy of, generally, medical information that identifies you and relates to your past, present or future health or condition, the provision of health care to you, or the payment for health care received by you ("protected health information" or "PHI"). The Plan may hire other companies ("Business Associates") to help provide health care benefits to you. These Business Associates may also receive and maintain your medical information.

The Plan is required to abide by the terms of the Notice currently in effect.

The Plan may change its privacy practices and the terms of this Notice at any time. Changes will be effective for all of your medical information received or created by the Plan. If the Plan changes its policies regarding the protection of your medical information, the Plan will mail you a new notice of privacy practices that incorporates any changes within 60 days. The Plan will also will post a new notice on its internet website.

HOW THE PLAN MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION

The Plan may use and disclose your medical information without your written permission for the following purposes:

For treatment. While the Plan does not directly participate in decisions regarding your health treatment, the Plan may disclose medical information it has created or received for treatment purposes. For example, the Plan may disclose your medical information to your doctor, at the doctor's request, for his or her treatment of you.

For payment. The Plan or one of its Business Associates may use or disclose your medical information to pay claims for medical services provided to you or to provide eligibility information to your doctor when you receive medical treatment.

For health care operations. The Plan may provide your medical information to our accountants, attorneys, consultants, and others in order to make sure we are complying with federal law. Also, your medical information may be used or disclosed to assess the quality of health care that you receive or to assist the Plan in the management of its performance of administrative activities.

To you, your personal representative, or others involved in your healthcare. The Plan may provide your medical information to you and your legal representative. The Plan may also provide medical information to a person, including family members, other relatives, friends or others identified by you and acting on your behalf, so long as you do not object and the information is directly relevant to such person's involvement in your health care. For this purpose, a person acts on your behalf by being involved in the provision and/or payment of your health care.

As required by law. For example, the Plan may disclose your medical information to comply with workers' compensation laws or other similar laws.

To Business Associates. The Plan may disclose your medical information to its Business Associates so that they may perform the services that the Plan has asked them to perform. The Plan requires that these entities appropriately safeguard your medical information

For health-related benefits. The Plan or one of its Business Associates may contact you about treatment alternatives or other health benefits or services that may be of interest to you.

For other uses and disclosures permitted by law such as:

- To public health authorities for public health purposes (e.g. the reporting of communicable diseases);
- To state agencies handling cases of abuse, neglect, or domestic violence;
- To a government agency authorized to oversee the health care system or government programs (e.g. determining eligibility for public benefits);
- To law enforcement officials for limited law enforcement purposes (e.g. to locate a missing person or suspect);
- To a coroner, medical examiner, or funeral director about a deceased person (e.g. to identify a person);
- To an organ procurement organization under limited circumstances;
- For research purposes in limited circumstances (e.g. if identifying information is removed or a research board has approved the use of the Information);
- To avert a serious threat to your health or safety or the health or safety of others;
- To military authorities if you are a member of the armed forces or a veteran of the armed forces;
- To federal officials for lawful intelligence, counterintelligence, and other national security purposes;
- To an executor or administrator of your estate; and
- To any other persons and/or entities authorized under law to receive medical information.
- For any other use or disclosure of your medical information, the Plan must have your written authorization. You may cancel your written authorization for the use and disclosure of any or all of your medical information, unless the Plan has taken action in reliance on your permission.

Some uses and disclosures that require your authorization are those with respect to:

Psychotherapy notes, except:

- to carry out the following treatment, payment, or health care operations:
- use by the originator of the psychotherapy notes for treatment;
- use or disclosure by the provider for its own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling; or
- use or disclosure by the Plan to defend itself in a legal action or other proceeding brought by the individual; or with respect to a use or disclosure that is:
  - ◊ required by the Secretary to investigate or determine the Plan's compliance;
  - ◊ permitted to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law and in accordance with HIPAA;
  - ◊ to a health oversight agency for oversight activities authorized by law with respect to the oversight of the originator of the psychotherapy notes;
  - ◊ to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law; or
  - ◊ as necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
- Marketing except if the communication is in the form of:
  - ◊ a face-to-face communication made by a Plan to an individual; or
  - ◊ a promotional gift of nominal value provided by the Plan.
- If the marketing involves financial remuneration, to the Plan from a third party, the authorization must state that such remuneration is involved.
- Sale of PHI.

The Plan is prohibited from using or disclosing PHI that is genetic information of an individual for underwriting purposes.

The Plan is required by law to maintain the privacy of PHI, to provide individuals with notice of its legal duties and privacy practices with respect to PHI, and to notify affected individuals following a breach of unsecured PHI.

YOUR RIGHTS

You may make a written request to the Plan to do one or more of the following concerning your medical information received or created by the Plan and/or the Plan's Business Associates:

- The right to request restrictions on certain uses and disclosures of medical information; however, the Plan is not required to agree to such request unless:
  - ◊ the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and
  - ◊ the PHI pertains solely to a health care item or service for which the individual, or person other than the health plan on behalf of the individual, has paid the Plan in full.
- The right to receive confidential communications of medical information by alternative means or at alternative locations.
- The right to inspect and copy medical information.
- The right to amend medical information.
- The right to receive an accounting of disclosures of medical information.
- The right, even if you have agreed to receive this notice electronically, to obtain a paper copy of this from the Plan upon request.

Although the Plan will utilize its best efforts to comply with your request, the Plan may legally deny your request under certain circumstances. The Plan will notify you of the reason for the denial and you will get a chance to respond. The Plan may not deny a request to communicate with you in confidence by a different means or location if the current means or location used by the Plan endangers you. The Plan may, however, request payment for any additional expenses it incurs to comply with your request. Your request to communicate by a different means or location must be in writing, include a statement that disclosure of all or part of the medical information by the current means could endanger you, specifically state the different means or location by which you would like the Plan to communicate with you, and continue to allow the Plan to pay claims.

COMPLAINTS

If you feel as if your privacy rights have been violated, you may file a written complaint with your administrator.

You may also send a written or electronic complaint to the Secretary of the Department of Health and Human Services. The complaint must state the name of the entity that is the subject of the complaint and describe the act or omissions believed to be in violation of law. A complaint must be filed within 180 days of when you knew or should have known that the act or omission complained of occurred. The Plan may not retaliate against you if you file a complaint.

MORE INFORMATION

If you would like more information about this Notice, please contact **Chip Meyer (917) 536-5987**

This document is intended to convey general information and may not take into account all the circumstances relevant to a particular person's situation.

The information in this Federal Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Guide was taken from various sources and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible.

CONTACT INFORMATION

BENEFIT	CONTACT	TELEPHONE	WEBSITE
General Information	Human Resources	Contact your local HR Team Member	
Medical & Pharmacy	Blue Cross Blue Shield of Illinois	(800) 548-1687	www.bcbsil.com
Dental	United Concordia	(800) 332-0366	www.unitedconcordia.com
Vision	Sun Life	(800) 247-6875	www.sunlife.com
Basic Life and AD&D	Sun Life	(800) 247-6875	www.sunlife.com
Supplemental Life and AD&D	Sun Life	(800) 247-6875	www.sunlife.com
Short-Term Disability	Sun Life	(800) 247-6875	www.sunlife.com
Long-Term Disability	Sun LIfe	(800) 247-6875	www.sunlife.com
Employee Assistance Program (EAP)	Sun Life	(877) 595-5281	www.guidanceresources.com

This communication highlights some of your Rensa benefit plans. Your actual rights and benefits are governed by the official plan documents. If any discrepancy exists between this communication and the official plan documents, the plan documents will prevail. Rensa reserves the right to change any benefit plan without notice. Benefits are not a guarantee of employment.

NOTES