BOTT RADIO NETWORK
Getting the Word of God into the People of God

Employee Benefits Enrollment Guide

WELCOME TO OPEN ENROLLMENT

PLAN YEAR | **2024**

Employee Benefits Guide

This guide is a summary of the benefits available to you. Please read it carefully along with any supplemental materials you receive. If for any reason there is a discrepancy between the actual plan documents and this guide, the plan documents will always govern. Benefit plans are subject to change at any time at the discretion of the company.

Open Enrollment for your 2024 Benefits

Medical and Dental benefit elections you make during open enrollment will become effective January 1, 2024.

Bott Radio Network strives to offer you and your eligible family members a comprehensive and valuable benefits program. We encourage you to take the time to educate yourself about your options and choose the best coverage for you and your family.

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Eligibility and Enrollment

Who is Eligible?

Active full-time employees working 35 hours or more per week are eligible for Medical, Dental, Life, Disability and Voluntary Insurance plans. If you are enrolled in the Medical, Dental or Vision plan you may also enroll your spouse and/or dependent children. Employees reasonably expected to work an average of 30 hours per week are eligible for **Medical coverage** only.

Important reminder: Dependent children can be covered until age 26 for Medical insurance.

How to Enroll?

For the 2024 Open Enrollment, **you will be required to enroll telephonically with the Hilb Group Employee Engagement team**. In order to schedule your call, please go to the new Bott Radio Benefit Website at the following link: www.Benefits.site/Bottradio Once at the website, please click the blue "Schedule HERE" button and select the time that works best for you. The Engagement Team will then call you at your desired time and walk you through all the new offering for 2024!

When to Enroll

The open enrollment period runs from **December 4, 2023 through December 8, 2023.** The benefits you elect during open enrollment will be effective from January 1, 2024 through December 31, 2024.

Qualifying Events

Unless you have a qualified change in status, you cannot make changes to the benefits you elect until the next open enrollment period. Qualified changes in status include: marriage, divorce, legal separation, birth or adoption of a child, change in child's dependent status, death of spouse, child or other qualified dependent, change in residence due to an employment transfer for you or your spouse, commencement or termination of adoption proceedings, or change in spouse's benefits or employment status.

For More Information

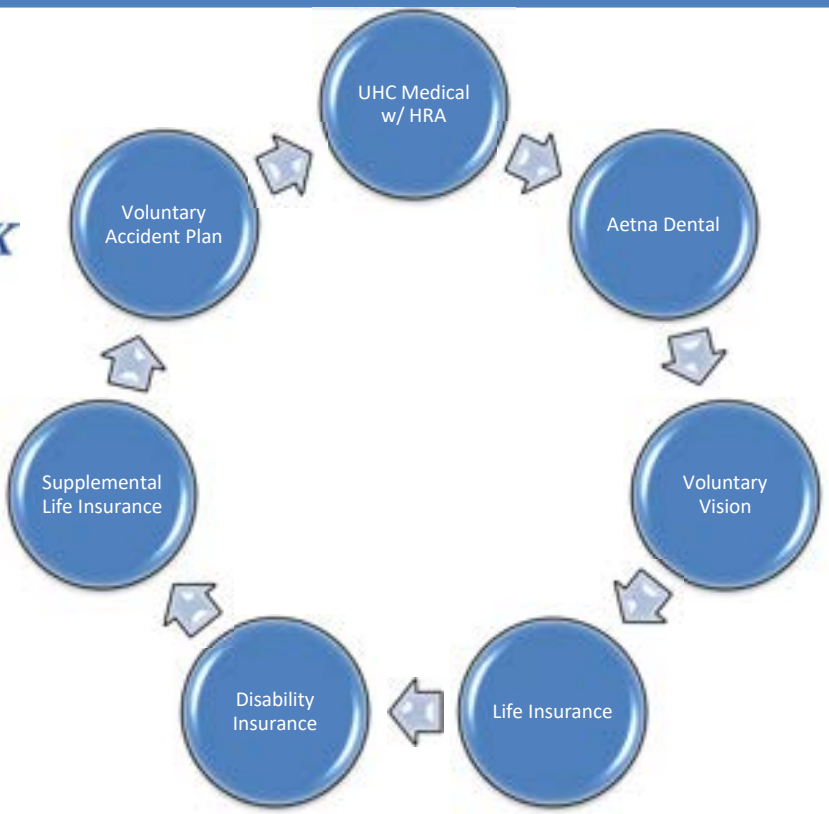
If you have questions about your benefit plans you can contact:

Bekah Eisman, Human Resources – Bott Radio Network
beisman@bottradionetwork.com 913-693-5709

Colin Fay, Dedicated Account Manager – The Hilb Group
cfay@hilbgroup.com 800-357-1840 x 106

Paul Lambert, Lead Consultant – The Hilb Group
plambert@hilbgroup.com 800-357-1840 x 102

2024 Employee Benefits Package



The 2024 Bott Radio Network Employee Benefit Package Includes

Benefits Snapshot	
NEW: UHC: Medical Insurance with HRA	Coverage will now be provided through UHC; Bott Radio will continue to cover 100% of the cost for employee only coverage. **An HRA will now over 50% of your deductible**
Aetna: Dental Insurance	Coverage will continue with Aetna; Bott Radio will continue to cover 100% of the cost for employee only coverage.
NEW: Mutual Of Omaha: Voluntary Vision	Bott Radio will now offer employees access to a 100% Employee Paid Vision plan provided through Mutual of Omaha
Mutual Of Omaha: Life Insurance	New carrier but no changes to the current plan; Bott Radio will continue to cover 100% of the cost for fulltime employees.
NEW: Mutual of Omaha: Employer Paid Disability Insurance	**Bott Radio will now cover 100% of the cost for Short & Long Term Disability plan** provided through Mutual of Omaha
NEW: Mutual of Omaha: Supplemental Life Insurance	Bott Radio will now offer employees access to a 100% Employee Paid Life Insurance plan provided through Mutual of Omaha
NEW: Mutual of Omaha: Voluntary Accident Insurance	Bott Radio will now offer employees access to a 100% Employee Paid Accident plan provided through Mutual of Omaha

Medical & Prescription Drug Benefits

Bott Radio Network will be moving to the UHC National Network for January 1, 2024. The UHC medical plan offers members access to the UHC national network of providers. **Bott Radio Network will now cover the last 50% of your deductible via a Health Reimbursement Account (HRA).** Below is a brief summary of benefits effective January 1st, 2024. Please review the UHC plan summary for a more detailed summary of benefits.

UHC Choice Plus HSA Plan		
	In-Network	**Out-of-Network**
Calendar Year Deductible (Individual/Family)	$3,200 / $6,400 **Employee pays first $1,600/$3,200** **HRA pays last $1,600/$3,200**	$5,000 / $10,000
Annual Out-of-Pocket Maximum (Individual/Family)	$4,000 / $8,000	$10,000 / $20,000
Health Savings Account	**Employer Monthly HSA Contribution:** Individual Policy: $175.00 Family Policy: $175.00	
Routine Preventive Care	No Charge	70% after deductible
Physician Visit	100% after Deductible	70% after deductible
Hospitalization	100% after Deductible	70% after deductible
Emergency Room	100% after Deductible	70% after deductible
Prescription Drugs **- Generic** **- Preferred** **- Non-Preferred** **- Specialty** **- Mail Order**	**Co-pay After Deductible** $15 $45 $85 $200 $45/$135/$255/$600	

Below are the semi-monthly contribution rates for the medical plan effective January 1, 2024:

Class of Coverage	Medical
Employee Only	No Cost
Employee & Spouse	$436.00
Employee & Child(ren)	$196.50
Family	$636.00

NEW Health Reimbursement Account (HRA)

How Your HRA Works

Bott Radio Network will now offer an HRA to help cover your medical and prescription deductibles. It will be administered by HRCTS.

This plan is designed so that the Employee must incur the cost of their medical deductible expenses. BEFORE the Employer will begin paying the next portion of the deductible, up to the plan year maximum.

Individual Coverage: The Employee pays the first $1,600 of deductible expenses, the Employer then pays the next $1,600 of deductible expenses.

Family Coverage: The Employee pays the first $3,200 of deductible expenses, the Employer then pays the next $3,200 of deductible expenses.

Any unused funds will not carry over to the new plan year.

Do I Pay for expenses at the time of service?

You may be required to pay Prescription Deductible expenses at the point of service but Medical Deductible expenses are typically billed after the service has been incurred unless you're Out of Network.

How do I know if a claim was received and how it was processed by HRCTS?

1. You will receive a payment notification through your email (if one was provided).
2. Log onto your HRCTS Participant Portal account or mobile app to view the details of your claim/payment.
3. You can contact HRCTS Customer Service at (603) 647-1147, option 1

What if I receive a bill from my provider/hospital?

Call your provider to see if payment was received after the bill was sent out. You can log onto your HRCTS Participant Portal to check the status of your claim/payment.

Dental Benefits

Bott Radio Network will continue to offer dental insurance through Aetna. The plan has not changed. The dental PPO plan offers coverage both in and out of the Aetna Core PPO Advantage network.

Aetna DPPO Plan		
	In-Network	Out-of-Network
Deductible	$50 per Person $150 Family Maximum	$50 per Person $150 Family Maximum
Class I - Preventive Care Cleanings / Exams Fluoride Applications X-Rays Sealants Space Maintainers	100% - No Deductible	100% - No Deductible
Class II - Basic Services Fillings Extractions Emergency Treatment for Pain Oral Surgery Periodontics Endodontics – Root Canal Repairs – Bridges, Crowns, Inlays & Dentures	90% - After Deductible	80% - After Deductible
Class III - Major Services General Anesthesia Dentures/Bridges Crowns/Inlays/Onlays	60% - After Deductible	50% - After Deductible
Choice of Dentist	You may go to any dentist you like. If you go to a Aetna DPPO Advantage In-Network Dentist you will benefit from negotiated discounts of at least 20%	
Calendar Year Max	$1,500	

To locate an In Network dental provider prior to enrolling, go to the Aetna website at Find a Dentist | Aetna, click on "individual dental plan" and enter you zip code.

Below are the semi-monthly contribution rates for the dental plan effective January 1, 2024:

Class of Coverage	Dental
Employee Only	No Cost
Employee & Spouse	$13.85
Employee & Child(ren)	$22.55
Family	$36.40

NEW Voluntary Vision Plan

Bott Radio Network will now offer voluntary vision for the plan year beginning January 1, 2024. The plan offers both In and Out of Network coverage. It will be provided through Mutual of Omaha

The plan allows treatment from the vision provider of your choice however you will have a higher level of benefit should you utilize in network providers.

Service	Eligibility Period	Network Benefit	Non-Network Benefit
Routine Vision Exam	12 Months	100% after $10 Copayment	$37 Allowance
Prescription Glasses			
Eyeglass Frames	24 Months	$150 Allowance + 20% off balance over allowance	$66 Allowance
Eyeglass Lenses			
Single Vision	12 Months	100% after $25 Copayment	$20 Allowance
Bifocal Vision	12 Months	100% after $25 Copayment	$36 Allowance
Trifocal Vision	12 Months	100% after $25 Copayment	$64 Allowance
Lenticular Vision	12 Months	100% after $25 Copayment	$64 Allowance
Contact Lenses (in lieu of frames/lenses)			
Elective	12 Months	$150 Retail Allowance	$102 Allowance
Necessary	12 Months	No Charge, Covered in Full	$210 Allowance

Below are the semi-monthly contribution rates for the vision plan effective January 1, 2024:

	2024 Voluntary Vision Plan
Employee Only	$4.10
Employee + Spouse	$9.42
Employee + Child(ren)	$10.43
Family	$15.93

Company Paid Life and Disability Plans

Company Paid Life Insurance

Bott Radio Network will continue to provide protection for your family through life insurance through Mutual of Omaha.

Life Insurance / AD&D	
Benefit Amount	$30,000
Benefits Reduce	35% of the original amount at age 65, and an additional 15% of the original amount at age 70

NEW Company Paid Short and Long Term Disability Insurance

Bott Radio Network will now provide all eligible employees with company paid Short and Long-Term Disability benefits. Benefits will be provided by Mutual of Omaha, and Bott pays 100% of the cost of this coverage on your behalf. In the event you have a qualified disability, your disability plan(s) will provide you with a source of income. Below is an outline of the Short and Long-Term Disability coverages provided through Mutual of Omaha.

	Short-Term Disability
Benefits Begin	On the 15th consecutive day due to an Accidental Injury On the 15th consecutive day due to a Sickness
Maximum Benefit Duration	Up to 24 Weeks
Coverage amount	60% of salary to a maximum of $1,000

	Long-Term Disability
Benefits Begin	On the 181st day of absence due to illness or injury
Maximum Benefit Duration	To Social Security Normal Retirement Age
Percentage of Income Replaced	60% of your Monthly Covered Earnings
Own Occupation Period	Once you have been disabled for 24 months, you must be prevented from performing one or more of the essential duties of any occupation and as a result, your monthly earnings are 60% or less of your pre-disability earnings.
Maximum Benefit	$7,500 Per Month

NEW Supplemental Life Insurance

Bott Radio Network will now be offering the ability for employees to purchase additional life insurance on top of the company paid coverage through Mutual of Omaha. When you enroll yourself or your spouse during this enrollment, you can elect up to the Guarantee Amount **without answering medical questions**. Please note, if you do not enroll during the initial eligibility period and decide to enroll in future enrollments, you will be required to answer medical questions. Please see below for a highlight of the coverage.

Supplemental Term Life	
Employee Benefit Amount	5X annual earnings to $500,000 max, in increments of $10,000
Spousal Benefit Amount	100% of employee benefit, up to $250,000 in increments of $5,000
Employee Guarantee Issue	$100,000 max. in increments of $10,000
Spousal Guarantee Issue	100% employee benefit, up to $30,000 in increments of $5,000
Age Reductions	35% at age 65, 50% at age 70
Accelerated Death Benefit	Included
Premium Waiver	Yes
Conversion	Yes
Rate Guarantee	2 Years

What is Guarantee Issue?
The amount of insurance applied for without answering any health questions (or which does not require evidence of insurability). Coverage amounts over the Guarantee Issue Amount will require evidence of insurability.

What is Evidence of insurability?
Evidence of Insurability or proof of good health - may be required if you are a late entrant and/or you request any additional coverage above your guarantee issue amount.

Can I take this insurance with me if I change jobs/am no longer a member of this group?
In the event this insurance ends due to a change in your employment/membership status with the group, or for certain other reasons, you or your insured spouse may have the right to continue this insurance under the Portability or Conversion provision, subject to certain conditions.

Supplemental Life Insurance Premium Calculations

Please note that the premium amounts presented below may vary slightly from the amounts provided on your enrollment form, due to rounding. To select your benefit amount and calculate your premium, do the following:

1) Locate the benefit amount you want from the top row of the employee premium table. Your benefit amount must be in an increment of $10,000. Refer to the Coverage Guidelines section for minimums and maximums, if needed.
2) Find your age bracket in the far-left column.
3) Your premium amount is found in the box where the row (your age) and the column (benefit amount) intersect.
4) Enter the benefit and premium amounts into their respective areas in the Voluntary Life and AD&D section of your enrollment form.

If the benefit amount you want to select is greater than any amount in the table below, select the benefit amount from the top row that when multiplied by another number results in the benefit amount you want. For example, if you want $150,000 in coverage, you obtain your premium amount by m multiplying the rate for $50,000 times 3.

PREMIUM TABLE (24 PAYROLL DEDUCTIONS PER YEAR)										
Age	**$10,000**	**$20,000**	**$30,000**	**$40,000**	**$50,000**	**$60,000**	**$70,000**	**$80,000**	**$90,000**	**$100,000**
0 - 29	$0.65	$1.30	$1.95	$2.60	$3.25	$3.90	$4.55	$5.20	$5.85	$6.50
30 - 34	$0.70	$1.40	$2.10	$2.80	$3.50	$4.20	$4.90	$5.60	$6.30	$7.00
35 - 39	$0.80	$1.60	$2.40	$3.20	$4.00	$4.80	$5.60	$6.40	$7.20	$8.00
40 -44	$1.15	$2.30	$3.45	$4.60	$5.75	$6.90	$8.05	$9.20	$10.35	$ I 1.50
45 -49	$1.85	$3.70	$5.55	$7.40	$9.25	$11.10	$12.95	$14.80	$16.65	$18.50
50 - 54	$2.90	$5.80	$8.70	$ I 1.60	$14.50	$17.40	$20.30	$23.20	$26.10	$29.00
55 - 59	$4.40	$8.80	$13.20	$17.60	$22.00	$26.40	$30.80	$35.20	$39.60	$44.00
60 - 64	$6.75	$13.50	$20.25	$27.00	$33.75	$40.50	$47.25	$54.00	$60.75	$67.50
65 - 69	$12.00	$24.00	$36.00	$48.00	$60.00	$72.00	$84.00	$96.00	$108.00	$120.00
70 - 74	$21.30	$42.60	$63.90	$85.20	$106.50	$127.80	$149.10	$170.40	$191.70	$213.00
75 - 79	$35.00	$70.00	$105.00	$140.00	$175.00	$210.00	$245.00	$280.00	$315.00	$350.00
80+	$70.65	$141.30	$211.95	$282.60	$353.25	$423.90	$494.55	$565.20	$635.85	$706.50

Follow the method above to select the benefit amount and calculate premiums for your spouse. **Your spouse's rate is based on your age.**

SPOUSE PREMIUM TABLE (24 PAYROLL DEDUCTIONS PER YEAR)										
Age	**$5,000**	**$10,000**	**$15,000**	**$20,000**	**$25,000**	**$30,000**	**$35,000**	**$40,000**	**$45,000**	**$50,000**
0 -29	$0.33	$0.65	$0.98	$1.30	$1.63	$1.95	$2.28	$2.60	$2.93	$3.25
30 - 34	$0.35	$0.70	$1.05	$1.40	$1.75	$2.10	$2.45	$2.80	$3.15	$3.50
35 - 39	$0.40	$0.80	$1.20	$1.60	$2.00	$2.40	$2.80	$3.20	$3.60	$4.00
40 -44	$0.58	$1.15	$1.73	$2.30	$2.88	$3.45	$4.03	$4.60	$5.18	$5.75
45 -49	$0.93	$1.85	$2.78	$3.70	$4.63	$5.55	$6.48	$7.40	$8.33	$9.25
50 - 54	$1.45	$2.90	$4.35	$5.80	$7.25	$8.70	$10.15	$11.60	$13.05	$14.50
55 - 59	$2.20	$4.40	$6.60	$8.80	$11.00	$13.20	$15.40	$17.60	$19.80	$22.00
60 - 64	$3.38	$6.75	$10.13	$13.50	$16.88	$20.25	$23.63	$27.00	$30.38	$33.75
65 - 69	$6.00	$12.00	$18.00	$24.00	$30.00	$36.00	$42.00	$48.00	$54.00	$60.00

NEW Group Accident Insurance

Help lessen the financial impact of out-of-pocket medical costs related to a covered accident that occurs on/off the job! This policy pays a lump-sum benefit based on type of injury sustained and treatment needed. It covers injuries including broken bones, cuts, burns, eye injuries, ruptured discs, coma, etc. **The benefit can be used however employees choose, whether you need to pay medical expenses or bills, the cash payout can be used how you see fit!** It is Portable to if you leave Bott Radio, and it is guaranteed issue so no medical questions! Below is a snapshot of a few of the benefits. There will be two plans offered, a low and high plan.

Low Plan Benefit Highlights:

Benefit Category	Benefit Amount
Ambulance	Up to $1,500
ER Care	$300
High-Cost Diagnostic	Up to $300
X-ray	Up to $300
Fractures (Surgical / Non-Surgical)	Up to $9,000 / $4,500
Dislocations (Surgical / Non-Surgical)	Up to $10,000 / $5,000
Lacerations	Up to $900
Burns	Up to $20,000
Hospital Admission	$1,500
Surgery	Up to $3,500
Hospital Confinement	$300 per day
Intensive Care Confinement	$600 per day

High Plan Benefit Highlights:

Benefit Category	Benefit Amount
Ambulance	Up to $2,000
ER Care	$400
High-Cost Diagnostic	Up to $400
X-ray	Up to $400
Fractures (Surgical / Non-Surgical)	Up to $12,000 / $6,000
Dislocations (Surgical / Non-Surgical)	Up to $12,000 / $6,000
Lacerations	Up to $1,500
Burns	Up to $25,000
Hospital Admission	$2,000
Surgery	Up to $5,000
Hospital Confinement	$400 per day
Intensive Care Confinement	$800 per day

NEW Group Accident Insurance

Voluntary Accident Premium Rates

Below are the semi-monthly contribution rates for the accident plan effective January 1, 2024:

Tier	Low Plan	High Plan
Employee Only	$6.15 ($0.40 per day)	$8.75 ($0.58 per day)
Employee + Spouse	$9.54 ($0.63 per day)	$13.00 ($0.85 per day)
Employee + Child(ren)	$11.44 ($0.75 per day)	$16.00 ($1.05 per day)
Family	$15.21 ($1.00 per day)	$22.00 ($1.45 per day)

Questions & Answers

Changes that can be made effective January 1, 2024:

- Enroll or change your current election (add/remove dependents) in the medical and/or dental plans through UHC / Aetna
- Enroll in the new Voluntary Vision, Life or Accident plans.
- Update your Beneficiary Designation

How to enroll:

- **You will be required to enroll telephonically with the Hilb Group Employee Engagement team**. In order to schedule your call, please go to new Bott Radio Benefit Website at the following link: www.Benefits.site/Bottradio Once at the website, please click the blue "Schedule HERE" button and select the time that works best for you. The Engagement Team will then call you at your desired time and walk you through all the new offering for 2024!
- **If you are declining coverage for 2024 you will still need to contact the Employee Engagement team to waive.**

When does enrollment end?

- **All enrollments must be called into to the Hilb Group Employee Engagement by Friday, December 8, 2023, however the sooner the better in order to have your ID cards in hand by January 1, 2024.**

Who do I contact with questions?

- Contact Bekah Eisman in Human Resources with any questions you may have.
- Contact Colin Fay or Paul Lambert at the Hilb Group
  800-357-1840 or via email to cfay@hilbgroup.com or plambert@hilbgroup.com.

Medicare Part D Creditable Coverage Notice

Important Notice from Bott Radio Network, Inc About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Bott Radio Network, Incand 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. Bott Radio Network, Inc has determined that the prescription drug coverage offered by your health plan 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 drug 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 current Bott Radio Network, Inc coverage may be affected.

If you do decide to join a Medicare drug plan and drop your current Bott Radio Network, Inc coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Bott Radio Network, Inc 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 be 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 the 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 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 Bott Radio Network, Inc changes. You may also request a copy of this notice at any time.

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 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 more information about this extra help, visit Social Security online at www.socialsecurity.gov or call them at 1-800-772—1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (penalty). You must give a copy of this notice to your Medicare-eligible dependents who are covered under the Bott Radio Network, Incplan.

Date: 10/17/2023

Name of Entity/Sender:Bott Radio Network,

Inc Contact: Bekah Eisman

Address: 10550 Barkley, #108

Overland Park, KS 66212

Phone Number:(913) 693-5709

2024 Health and Welfare Plan Participant Notices

Bott Radio Network, Inc

10550 Barkley, #108
Overland Park, KS 66212

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan' s copayments, coinsurance, and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out of network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count towards your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care – like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're <u>never</u> required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, your health plan must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you think you've been wrongly billed, you may contact your plan administrator for more information on your rights. The federal phone number for information and complaints is 1-800-985-3059.

Visit this website for more information about your rights under federal law:
https://www.cms.gov/nosurprises/consumers

State Balance Billing Laws & Protections

In addition to the federal balance billing protections, state protection laws may apply to you. Approximately 14 states have implemented broad surprise billing laws while many other states have laws that address certain issues related to surprise billing, such as a method for determining payment for emergency services. These state laws differ significantly in a variety of ways, including (1) the types of plans, items, services, and specialties to which the laws apply; (2) how the applicable out-of-network payment amount is determined; (3) the methodology used to resolve payment disputes; and (4) how they interact – and whether they are superseded by – federal law.

These state laws generally only apply to fully-insured plans, although self-insured plans may opt-in to state balance billing protections in some states. State balance billing laws have limited applicability to out-of-state providers. If providers or facilities are not covered under state law, disputes with those providers will be resolved under the federal No Surprises Act. Contact your state insurance department or your plan administrator for more information about whether and to what extent state balance billing laws and protections may apply.

Health Insurance Exchange Notice

Health Insurance Marketplace Notice Coverage Options and Your Health Coverage

Part A: General Information

To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and employment-based health coverage offered by your employer.

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.

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 our 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 9.5% (indexed annually) 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% 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 the cost of employer-sponsored 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 the coverage offered by your employer, please check your summary plan description or contact:

10550 Barkley, #108
Overland Park, KS 66212
(913) 693-5709 - beisman@bottradionetwork.com

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, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Part B: Information About Health Coverage Offered by Your Employer

Employer Name Bott Radio Network, Inc		Employer Identification Number (EIN) 48-1185140
Employer Address 10550 Barkley, #108		Employer Phone Number (913) 693-5709
City Overland Park	State KS	ZIP 66212
Who can we contact about employee health coverage at this job? Bekah Eisman		
Phone Number (913) 693-5709		Email Address beisman@bottradionetwork.com

NOTE: Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly-employed midyear, or if you have other income losses, you may still qualify for a premium discount.

Notice of Special Enrollment Rights

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

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.
If you or your dependent(s) lose coverage under a state Children's Health Insurance Program (CHIP) or Medicaid, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the loss of CHIP or Medicaid coverage.

If you or your dependent(s) become eligible to receive premium assistance under a state CHIP or Medicaid, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days of the determination of eligibility for premium assistance from state CHIP or Medicaid.
To request special enrollment or obtain more information, contact your plan administrator.

Notice of Privacy Practices

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), your health plan recognizes your right to privacy in matters related to the disclosure of health-related information. The Notice of Privacy Practices *(provided in the plan certificate booklet)* details the steps your plan has taken to assure your privacy is protected. The Notice also explains your rights under HIPAA. A copy of this notice is available to you at any time, free of charge, by request through your health plan.

Mental Health Parity and Addiction Equity Act (MHPAEA) Disclosure

The Mental Health Parity and Addiction Equity Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For information regarding the criteria for medical necessity determinations made with respect to mental health or substance use disorder benefits, please contact your plan administrator at Bott Radio Network, Inc.

Women's Health and Cancer Rights Act (WHCRA) 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 deductibles and coinsurance you will be subject to depends on the coverage provided by your health plan.

Michelle's Law Notice

Michelle's Law permits seriously ill or injured college students to continue coverage under a group health plan when they must leave school on a full-time basis due to their injury or illness and would otherwise lose coverage.

Newborns' and Mothers' Health Protection Act Notice

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother of the 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).

Genetic Information Nondiscrimination Act (GINA) Disclosure

Genetic Information Nondiscrimination Act of 2008

The Genetic Information Nondiscrimination Act of 2008 (GINA) protects employees against discrimination based on their genetic information. Unless otherwise permitted, your employer may not request or require any genetic information from you or your family members.

GINA prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to any request for medical information. “Genetic information,” as defined by GINA, includes an individual’s family medical history, the results of an individual’s or family member’s genetic tests, the fact that an individual or an individual’s family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual’s family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

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

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

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

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

GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization- act-2009-chipra Phone: 678-564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid- a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669

VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

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

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

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

U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services **www.cms.hhs.gov**
1-877-267-2323, Menu Option 4, Ext. 61

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, anddisplays 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, notwithstanding 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 1/31/2026)

USERRA Notice
Your Rights Under USERRA

A. The Uniformed Services Employment and Reemployment Rights Act

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

B. Reemployment Rights

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- You ensure that your employer receives advance written or verbal notice of your service;
- You have five years or less of cumulative service in the uniformed services while with that particular employer'
- You return to work or apply for reemployment in a timely manner after conclusion of service; and
- You have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

C. Right to be Free from Discrimination and Retaliation

If you:

- Are a past or present member of the uniformed service;
- Have applied for membership in the uniformed service; or
- Are obligated to serve in the uniformed service,

Then an employer may not deny you:

- Initial employment;
- Reemployment;
- Retention in employment;
- Promotion; or
- Any benefit of employment

Because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

A. Health Insurance Protection

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health coverage for you and your dependents for up to 24 months while in the military.

Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

B. Enforcement

The U.S. Department of Labor, Veterans' Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on UERRRA, contact VETS at 1-866-4-USA-DOL or visit its website at http://www.dol.gov/vets. An interactive online USERRA Advisor can be viewed at http://www.dol.gov/elaws/userra.htm.

If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.

You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS and may be viewed online at this address: http://www.dol.gov/vets/programs/userra/poster.htm. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees.

U.S. Department of Labor, Veterans' Employment and Training Service, 1-866-487-2365.

General Notice of COBRA 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 to:

Bekah Eisman
10550 Barkley, #108
Overland Park,KS 66212
beisman@bottradionetwork.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.

Second qualifying event extension of 18-month period of COBRA 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, Children's Health Insurance Program (CHIP), 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.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period* to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

* https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start

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

Bekah Eisman
10550 Barkley, #108
Overland Park, KS 66212
(913) 693-5709
beisman@bottradionetwork.com

General FMLA Notice

Employee Rights Under the Family and Medical Leave Act

The United States Department of Labor Wage and Hour Division

Leave Entitlements

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

Benefits & Protections

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

Eligibility Requirements

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

Requesting Leave

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

Employer Responsibilities

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

Enforcement

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:

1-866-4-USWAGE

1-866-487-9243 TTY: 1-877-889-5627

www.dol.gov/whd

U.S. Department of Labor – Wage and Hour Division