August 2024 – July 2025

BENEFIT GUIDE

It's Your Health.Get Involved.

Your health is a work in progress that needs your consistent attention and support. Each choice you make for yourself, and your family is part of an ever-changing picture. Taking steps to improve your health such as going for annual physicals and living a healthy lifestyle can make a positive impact on your well-being.

It's up to you to take responsibility and get involved, and we are pleased to offer programs that will support your efforts and help you reach goals.

Preventive HealthCare Services

Preventive care includes services like checkups, screenings and immunizations that can help you stay healthy and may help you avoid or delay health problems. Many serious conditions such as heart disease, cancer, and diabetes are preventable and treatable if caught early. It's important for everyone to get the preventive care they need. Some examples of preventive care services are:

- Blood pressure, diabetes, and cholesterol tests
- Certain cancer screenings, such as mammograms, colonoscopies
- Counseling, screenings, and vaccines to help ensure healthy pregnancies
- Regular well-baby and well-child visits

Immunizations

Some immunizations and vaccinations are also considered preventive care services. Standard immunizations recommended by the Centers for Disease Control (CDC) Include: hepatitis A and B, diphtheria, polio, pneumonia, measles, mumps, rubella, tetanus, and influenza although these may be subject to age and/or frequency restrictions.

Understanding What's Covered

If a service is considered preventive care, it will be covered at 100%. If it's not,it may still be covered subject to a copay, deductible, or coinsurance. The Affordable Care Act (ACA) requires that services considered preventive care be covered by your health plan at 100% in- network, without a copay, deductible, or coinsurance. To get specifics about your plan's preventivecare coverage, call the customer service number on your member ID card. You may want to ask your doctor if the services you're receiving at a preventive care visit (such as an annual checkup) are all considered standard preventive care.

If any service performed at an annual checkup is as a result of a prior diagnosed condition, the office visit may not be processed as preventive, and you may be responsible for a copay, coinsurance or deductible. To learn more about the ACA or preventive care and coverage, visit www.healthcare.gov.

ELIGIBILITY & ENROLLING

Who is Eligible to Join the Benefit Plan?

You and your dependents are eligible to join the health and Company's ancillary benefit plans if you are a full-time employee regularly scheduled to work 35 hours per week. You must be enrolled in the plan to add dependent coverage.

Who is an Eligible Dependent?

- Your spouse to whom you are legally married
- Your dependent child under the maximum age specified in the Carriers' plan documents including:
  - Natural child
  - Adopted child
  - Stepchild
  - Child for whom you have been appointed as the legal guardian

The Dependent Maximum Age Limits is up to age 26. The dependent does not need to be a full-time student; does not need to be an eligible dependent on parent's tax return; is not required to live with you; and may be unmarried or married.

Once the dependent reaches age 26, coverage will terminateon the last day of the birth month.

A totally disabled child who is physically or mentally disabled prior to age 26 may remain on the if the child is primarily dependent on the enrolled member for support and maintenance.

When Do Benefits Become Effective?

Your benefits become effective on the first day of employment.

Annual Open Enrollment?

Each year during the annual Open Enrollment Period, you are given the opportunity to make changes to your current benefit elections. To find out when the annual Open Enrollment Period occurs, contact HR

Qualifying Event Changes

You are allowed to make changes to your current benefit elections during the plan year if you experience an IRS- approved qualifying change in life status. The change to your benefit elections must be consistent with and on account of the change in life status.

IRS-approved qualifying life status changes include:

- Marriage, divorce or legal separation
- Birth or adoption of a child or placement of a childfor adoption
- Death of a dependent
- Change in employment status, including loss or gainof employment, for your spouse or a dependent
- Change in work schedule, including switching between full-time and part-time status, by you, your spouse or a dependent
- Change in residence or work site for you, your spouse, or adependent that results in a change of eligibility
- If you or your dependents lose eligibility for Medicaid orthe Children's Health Insurance Program (CHIP) coverage
- If you or your dependents become eligible for a state'spremium assistance subsidy under Medicaid or CHIP

If you have a life status change, you must notify the company within 60 days for changes in life status due to a Medicare or CHIP event and within 31 days of the other events.

If you do not notify the company during that time, you and/oryour dependents must wait until the next annual open enrollment period to make a change in your benefit elections

Please note, loss of coverage due to non-payment or voluntary termination of other coverage outside a spouse's or parent's open enrollment is **not** an IRS-approved qualifying life event and you do not qualifyfor a special enrollment period.

MEDICAL

BeVera Solutions offers comprehensive medical benefit plans through **Unitedhealthcare Allsavers.** The charts below provide an overview of the plan designs. In addition, as a plan member you have access (24 hours a day/7 day a week) to all plan information on the Employee Navigator Platform. All plans use the UHC Choice National Point of Service Network **(POS).**

	BeVera Solutions, LLC Plan Options - 8/1/24 to 7/31/25		
	UHC Allsavers	UHC Allsavers	UHC Allsavers
	P1000i10021	P2500i10021	P5000i10021
Plan	Allsavers	Allsavers	Allsavers
Deductible (Ind/Fam)	$1000/$2000	$2500/$5000	$5000/$10000
Coinsurance (In/Out of Network)	100%	100%	100%
Max Out of Pocket (Ind/Fam)	$3500/$7000	$5000/$10000	$8150/$16300
All Rx	$10/$35/$75/$250	$10/$35/$75/$250	$10/$35/$75/$250
Primary Care Visit	$25	$25	$25
Specialist Visit	$75	$75	$75
Emergency Room	$300 Ded+Coins	$300 Ded+Coins	$300 Ded+Coins
Urgent Care	$50	$50	$50

VOLUNTARY DENTAL

Staying healthy includes obtaining quality dental care for you and your family. BeVera Solutions offers a dental plan through **Companion Life.** All plan information is included on the Employee Navigator Platform.

Dental Plan Highlights	Orthodontic	Non-Orthodontic
Your Deductible	$50 individual / $150 Family	$50 individual / $150 Family
Calendar Year Maximum Applies to preventive, basic, and major services	$2000	$1,000
Preventive & Diagnostic Services Exams, Cleanings & Bitewing X-Rays, Fluoride, Sealants	100% (Deductible waived)	80% (Deductible waived)
Basic Services Filings, Periodontics, Endodontics	80% after deductible	80% after deductible
Major Services Crowns, Inlays, Onlays, Oral Surgery, Bridges, Dentures	50% after deductible	50% after deductible
Orthodontics (Children to age 19)		-
Lifetime Orthodontia Maximum		

VOLUNTARY VISION

BeVera Solutions offers a voluntary vision plan through **Companion Life**. All plan information is included on the Employee Navigator Platform.

VSP CHOICE NETWORK VISION PLAN

Services	In Network
Eye Exam:	
Routine Exam with Dilation	$10 Copay
Frames:	
Any available frame at provider location	$130 frame allowance 20% off balance over allowance
Contact Lenses: (Material Only)	
Elective	$120 allowance, 15% off balance over allowance up to $120
Frequency:	
Examination	12 months
Frames	24 months
Eyeglass Lenses	12 months
Contact Lenses	12 months

To find an eye care provider who is right for you:

visit

LIFE

Employer Paid Life Insurance

Life Insurance is a key element of proper financial planning and helps provide financial stability and protection for families in case of an untimely death. BeVera Solutions provides you with $25,000 of basic group term life through **Companion Life.**

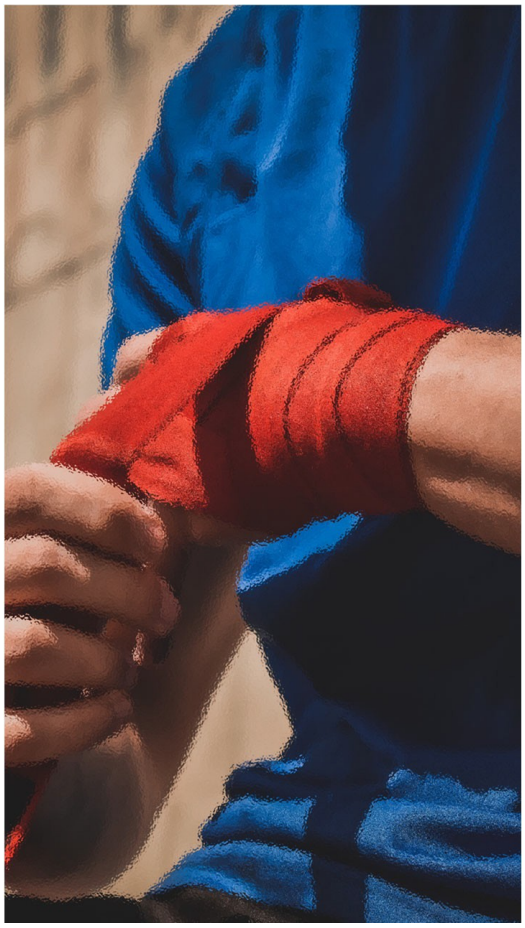
If you do not enroll in Voluntary employee or spouse life when you are first eligible (within 30 days of your eligibility), there is no guarantee issue amount and any amounts requested are subject to Evidence of Insurability (EOI).

Voluntary Life Insurance

Be Vera offers the opportunity for you to take voluntary life coverage for you and your dependents. The Guaranteed issue is $100,000 for you as the employee and $50,000 for your spouse. Dependent children may be covered up to $10,000. The cost for these coverages is age-banded and is provided on our enrollment website.

DISABILITY INSURANCE

Disability coverage provides the financial security of knowing that you will continue to receive income if yoiy ar unable to work due to injury or illness



Voluntary Short-Term Disability – Companion Life:

Employees are eligible for 60% of annual salary for illness or accident with elimination period of 8 days. Coverage is for 13 weeks. No dependents are covered. Full details are on the enrollment website.

Voluntary Long-Term Disability – Companion Life

Employees are eligible for 60% of annual salary for illness or accident with elimination period of 90 days. No dependents are covered. Full details are on the enrollment website.

Plan Highlights	Short-Term Disability
Waiting Period	8 days
Benefit Percentage	60%
Weekly Benefit Maximum	$1,250
Benefit Duration	13 weeks

Plan Highlights	Long-Term Disability
Waiting Period	90 days
Benefit Percentage	60%
Monthly Benefit Maximum	$3,000
Benefit Duration	Social Security Normal Retirement Age

ACCIDENT INSURANCE

You have the option to purchase Accident Insurance with **Allstate.** Benefits are paid directly to you based on a flat schedule when an accident occurs off the job.

Some examples of covered accidents include: fracture, dislocation, burn, concussion, coma, torn cartilage in knee, laceration, broken tooth, eye injury, ambulance, hospital admission, paralysis, dismemberment, etc.

Allstate pays a wellness rebate for any outpatient doctor or dental visit. Full details are on the Employee Navigator Platform.

CRITICAL ILLNESS INSURANCE

You have the option to purchase Critical Illness Insurance with Allstate. The Critical Illness policy provides a financial cushion if you are diagnosed with a critical illness or cancer. The cost is age banded. Full details are available on the enrollment website.

CONTRIBUTIONS

BeVera Solutions contributes 50% towards the cost of coverage for all eligible employees and dependents. Please refer to the chart below for your bi-weekly payroll deductions.

Bi-Weekly Payroll Deductions

UHC Medical Costs Per Pay Period

Pay Period Costs

Coverage Level	2024 - 2025 UHC LF Medical Option 1: $1,000 Deductible	2024 - 2025 UHC LF Medical Option 2: $2,500 Deductible	2024 - 2025 UHC LF Medical Option 3: $5,000 Deductible
Employee	$202.28	$177.15	$153.41
Employee + Spouse	$416.67	$363.90	$314.04
Employee + Child(ren)	$377.70	$329.94	$284.84
Employee + Family	$592.09	$516.68	$445.47

Allstate Group Accident Costs Per Pay Period

Costs

Coverage Level	Monthly Cost	Pay Period Cost
Employee	$14.30	$6.60
Employee + Spouse	$23.17	$10.69
Employee + Child(ren)	$32.39	$14.95
Employee + Family	$42.26	$19.50

Bi-Weekly Payroll Deductions Continued

Dental

Pay Period Costs

Coverage Level	2024 - 2025 Companion Dental - Low Plan	2024 -2025 Companion Dental - High Plan
Employee	$19.68	$25.18
Employee + Spouse	$37.76	$47.88
Employee + Child(ren)	$46.65	$62.58
Employee + Family	$62.21	$82.44

Vision

Costs

Coverage Level	Monthly Cost	Pay Period Cost
Employee	$7.63	$3.52
Employee + Spouse	$15.57	$7.19
Employee + Child(ren)	$15.76	$7.27
Employee + Family	$25.60	$11.82

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be 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 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. Open enrollment for health insurance coverage through the Marketplace begins in October 2021 for coverage starting as early as January 1, 2022.

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 9.5% 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.[1]

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 _____

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.

[1] 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.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name	4. Employer Identification Number (EIN)
5. Employer address	6. Employer phone number

7. City	8. State	9. ZIP
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above)	12. Email address	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - [x] All employees. Eligible employees are: Full-time employee regularly scheduled to work 35 hours per week
  - [ ] Some employees. Eligible employees are:
- With respect to dependents:
  - [x] We do offer coverage. Eligible dependents are: spouse and dependent child under the maximum age
  - [ ] We do not offer coverage.

[x] If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** 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 mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? (mm/dd/yyyy) (Continue)

☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

GENERAL NOTICE OF USERRA RIGHTS

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.

D. 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 plan 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.

E. 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 USERRA, contact VETS at 1-866-4-USA-DOL or visit its Web site 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 on the Internet 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.

Important Notice from BeVera Solutions About Your Prescription Drug Coverage and Medicare

This Notice Applies to You (or Dependent) ONLY if such person is (1) enrolled in a group medical plan offered by BeVera Solutions, LLC AND (2) eligible for 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 BeVera Solutions 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. **BeVera Solutions has determined that the prescription drug coverage offered by the United Healthcare 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 current 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 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 BeVera Solutions 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 at 908-982-1294. 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 BeVera Solutions 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).

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

Date:	10/05/2021
Name of Entity/Sender:	Erica Bitten
Contact--Position/Office:	Director, Human Resources
Address:	
Phone Number: 404.695.4917	

WELLNESS PROGRAM DISCLOSURE (GINA)

The Genetic Information Nondiscrimination Act of 2008 (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 this 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.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

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 the United Healthcare plan.

If you would like more information on WHCRA benefits, contact Erica Bitten, Director, Human Resources: 404.694.4917