BrightView

BENEFITS GUIDE 2024

pick the best benefits for you and your family

BrightView, LLC strives to provide you and your family with a comprehensive and valuable benefits package. We want to make sure you're getting the most out of our benefits—that's why we've put together this Open Enrollment Guide.

Open enrollment is a short period each year when you can make changes to your benefits. This guide will outline all of the different benefits BrightView, LLC offers, so you can identify which offerings are best for you and your family.

Elections you make during open enrollment will become effective on January 1, 2024. If you have questions about any of the benefits mentioned in this guide, please don't hesitate to reach out to the benefits department.

INFO ON THE GO!

Scan with your Smartphone to access your 2024 Benefits Guide and enrollment materials online *any time*.

Provided by

BENEFITS GUIDE 2024

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Medical Insurance

BrightView, LLC offers comprehensive medical options to help you and your family protect your health. A traditional PPO plan with copays (**Value Based PPO**), and an HSA-qualified High Deductible Health Plan (**Simple Savings $5000 HSA**) through BPA. This provides team members the flexibility to choose a medical plan that best fits your family needs.

The following chart outlines our medical benefits that will take effect **January 1, 2024**.

MEDICAL NETWORK:

RX NETWORK:

	Value-Based $2,500 PPO	Simple Savings $5,000 HSA
SERVICES	IN-NETWORK	IN-NETWORK
Network	Cigna PPO	Cigna PPO
Deductible (Individual/Family)	$2,500/$5,000	$5,000/$10,000
NEW! *Eligible Garner HRA Reimbursement*	*$2,000/$4,000*	*$2,000/$4,000*
Deductible after Garner Reimbursement	**$500/$1,000**	**$3,000/$6,000**
Member Coinsurance	20%	20%
Out-of-pocket Maximum (Individual/Family)	$6,000 $12,000	$6,000 $12,000
Preventive Care NEW! *Now includes 3D Mammograms & Colonoscopies (regardless of outcome)*	Covered at 100%	Covered at 100%
Physician Visit	PCP: $25 Copay Specialist: $40 Copay	20% after Deductible
Emergency Room	$350 Copay	20% after Deductible
NEW! Teladoc for General & Mental Health	Covered at 100%	Covered at 100%
Urgent Care	$40 Copay	20% after Deductible
Hospitalization	20% after Deductible	20% after Deductible
Prescription Drugs		
- Retail	$10/$40/$70	20% coinsurance
- Specialty	25% up to $350	20% coinsurance
- Mail Order	$20/$50/$80	30% coinsurance

garner™

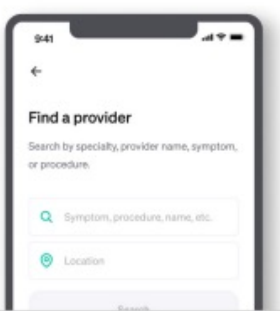
NEW!

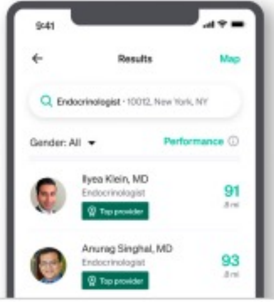
Health Reimbursement Account

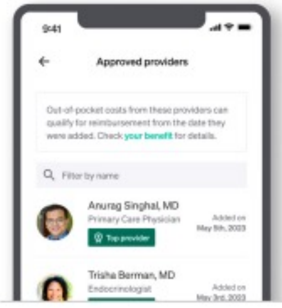
How to use Garner

We've made the very best care more affordable!

Create your account. Then find the best doctors and get reimbursed for out-of-pocket medical costs.







Find doctors.

Costs from doctors with a Top Provider badge qualify for reimbursement as long as the service is in-network and covered by your health insurance plan.

Add doctors to your list of approved providers.

Top Providers are automatically added to your list as soon as they are visible on your screen.

Check your list.

Ensure your doctor is added to this list **before** you see them. Out-of-pocket medical costs from your approved providers will qualify for reimbursement after they are added to your list.

Get reimbursed.

When you receive care from an approved provider, pay your upfront costs as usual. After your health insurance company processes the claim, Garner will reimburse your qualifying costs. You should receive a reimbursement check about 6-8 weeks after you receive the care.

Garner gives you access to the **most accurate provider performance data** in the industry. We've identified the **top 20% of all doctors** so you'll know you're receiving the best care. And when you visit these **Top Providers**, your out-of-pocket medical costs qualify for reimbursement.*

***Your out-of-pocket medical costs will qualify for reimbursement if:**

- You have created a Garner account and added the provider to your list of approved providers prior to the date of service.
- Your provider is in-network and the cost was covered by your health insurance plan. (Check your health insurance plan.)
- The type of cost qualifies for reimbursement under your Garner plan. Depending on your Garner plan, costs for things like prescription drugs or emergency services may or may not qualify for reimbursement. (Check the "Your benefit" page in the Garner Health app to learn more.)
- If your health insurance plan is paired with an HSA, you will need to incur costs greater than the minimum deductible. (Check the "Your benefit" page in the Garner Health app to see if this requirement applies.)

Questions?
Message the Concierge through the Garner Health mobile app, online at getgarner.com or email **concierge@getgarner.com.**

Create account

Go to garner.guide/create

Expert help when you need it.

Our dedicated Concierge is here for you. For assistance, you can message the Concierge through the Garner Health mobile app, getgarner.com or concierge@getgarner.com Mon. – Fri., 8 a.m. to 8 p.m. ET. Se habla español.

Get access to the top 20% of doctors

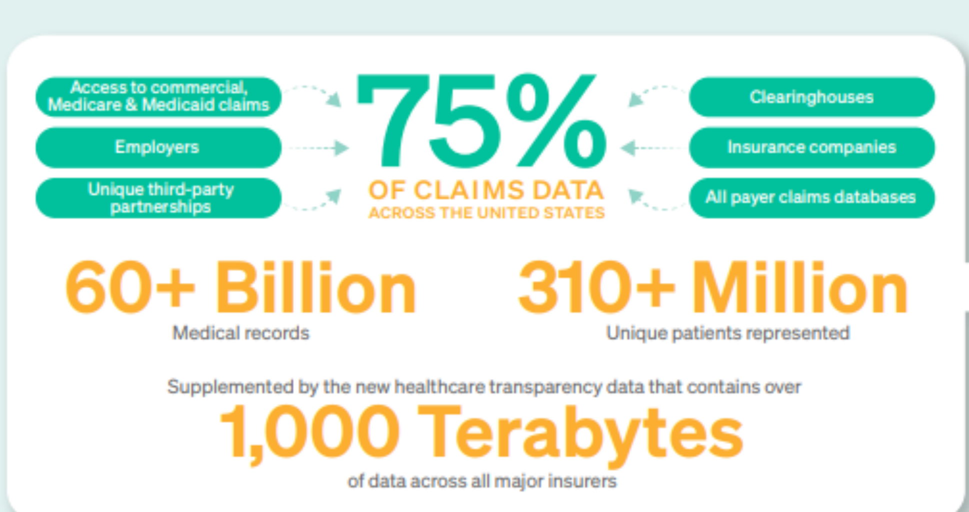
You'll get reimbursed for your out-of-pocket medical costs when you see them.

Create a Garner account. Then, use the Garner Health app or website to search for the very best doctors in your area. These Top Providers are automatically added to your list of approved providers as soon as they are visible on your screen. Once Top Providers are on your list of approved providers, you can get reimbursed for qualifying* out-of-pocket costs.

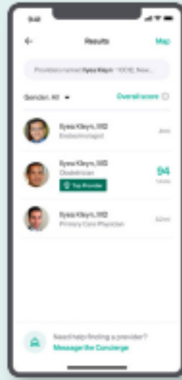
Top Providers have shown to:

- Practice based on the latest medical research
- Get the highest patient satisfaction ratings
- Successfully diagnose problems
- Produce the best patient outcomes

Garner analyzes the largest medical claims dataset in the U.S. to objectively evaluate doctor performance.



The Garner Health app gives you information on high-quality doctors in your network, with appointment availability.



Prescription Drug Benefits

We know prescription drug coverage is important to you and your family, so when you elect medical coverage, you are automatically covered under the prescription drug plan. You may fill your prescriptions at participating retail pharmacies. Under the prescription drug coverage, the mail order option allows you to buy qualified prescriptions in larger 90-day quantities for a slightly higher copay amount as a 30-day supply at the retail pharmacy.   Mail order saves you time in trips to the pharmacy because prescriptions are delivered right to your door.

- **Tier 1** – Lower-cost Medications that provide the highest overall value. Mostly generic drugs. Some brand-name drugs may also be included.
- **Tier 2** – Mid-range cost Medications that provide good overall value. Mainly preferred brand-name drugs.
- **Tier 3** – Highest-cost Medications that provide the lowest overall value.
- **Tier 4** – Specialty Medications that treat complex conditions and may require special storage and handling

To view a list of the most commonly prescribed medications, visit the benefits website at www.brightviewbenefits.net and review a copy of your Prescription Drug List (PDL) posted under the Resources tab.

Ways to Save

Start with generics, which are usually the lowest-cost options and have the same active ingredients as brand-name versions. And remember, if the generic price is lower than the co-pay, you receive the better price. If you currently take a Tier 3 drug, ask your provider if a Tier 1 or Tier 2 option could work for you

If your medication is intended for short-term use, such as antibiotic therapies for an illness, go to one of more than 68,000 network pharmacies to get it filled. Find a network pharmacy at www.brightviewbenefits.net

If you take a maintenance medication (a drug you take until further notice) you can get 90-day supplies by setting up home delivery under your member account at www.brightviewbenefits.net

NEW!

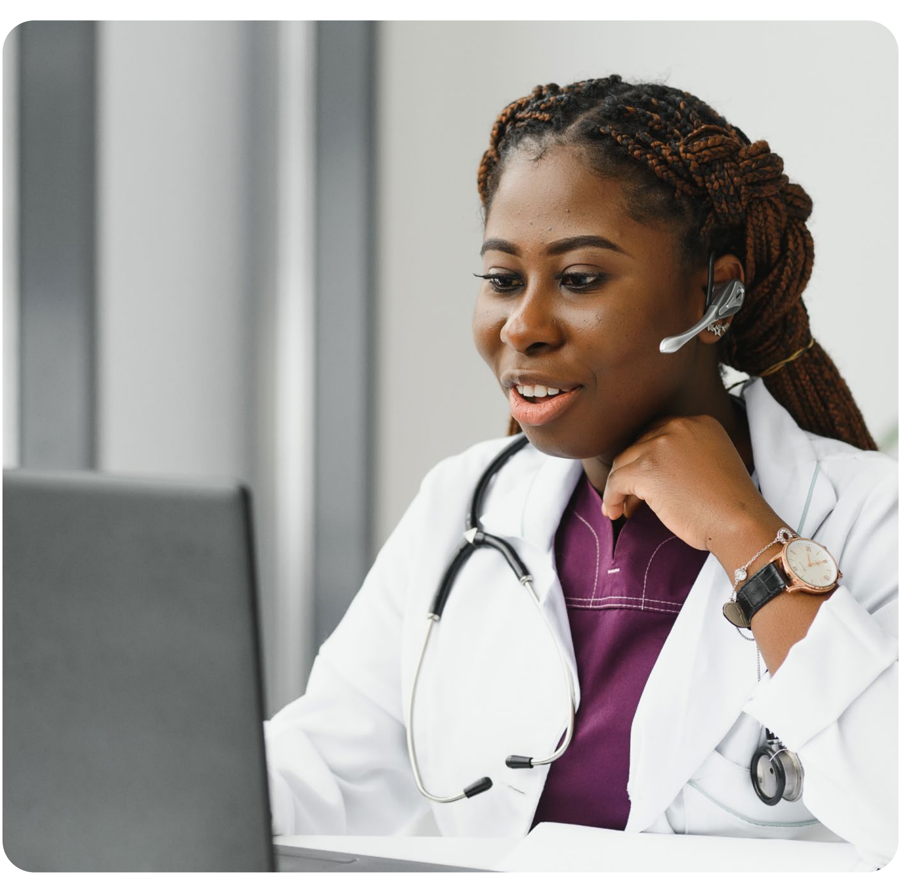
Telemedicine

A Teladoc doctor is always just a call or click away at *no* cost to you!

Meet the Doctors

Teladoc is simply a new way to access qualified doctors. All Teladoc doctors:

- Are practicing PCPs, pediatricians, and family medicine physicians
- Average 20 years' experience
- Are U.S. board-certified and licensed in your state
- Are credentialed every three years, meeting NCQA standards



Get the Care You Need

Teladoc doctors can treat many medical conditions, including:

- Cold and flu symptoms
- Allergies
- Sinus problems
- Urinary tract infection
- Skin problems
- And more!

TALK TO A DOCTOR ANY TIME FOR FREE!*

- www.Teladoc.com
- 1-800-TELADOC

**When enrolled in BrightView medical coverage.*

Why Teladoc?

It is a convenient and affordable option for quality care.

- When you need care now
- If you're considering the ER or urgent care for a non-emergency issue
- On vacation, on a business trip, or away from home
- For short-term prescription refills

Spousal Coverage

Special Notice Regarding Spousal Coverage (i.e., Spousal Carve Out)

BrightView, LLC values our members and strives to offer you excellent benefits at the lowest cost possible. With that goal in mind, BrightView, LLC is taking steps to ensure low premiums for your group health plan.

In order to keep your premiums low, BrightView, LLC's health plan will not cover a member's spouse if the spouse is offered coverage through his or her employer. Limiting spousal coverage to those who do not have other opportunities to obtain group coverage helps ensure that we can continue to offer you a quality health plan with small premiums.

An affidavit will be required to attest your spouse's eligibility if spousal coverage is elected.

If you have any questions about this policy or your benefits, please contact the benefits department.

**Affidavits are required on an annual basis. You are required to submit an affidavit in order to continue spousal coverage into 2024.*

Your Cost in 2024

BrightView pays a portion of your health care premiums; however, we do require teammates to contribute toward their health care costs as well. Members pay a dollar amount based on the level of coverage they select. The following payroll deductions will be effective for this plan year and will be reflected on your first paycheck after your effective date.

Employee Bi-Weekly Payroll Deductions				
	EMPLOYEE ONLY	EMPLOYEE & SPOUSE	EMPLOYEE & CHILD(REN)	EMPLOYEE & FAMILY
Value Based $2,500 PPO	$101.25	$267.46	$230.77	$451.15

Employee Bi-Weekly Payroll Deductions				
	EMPLOYEE ONLY	EMPLOYEE & SPOUSE	EMPLOYEE & CHILD(REN)	EMPLOYEE & FAMILY
Simple Savings $5,000 HSA	$42.69	$195.29	$147.69	$284.14

How to Maximum Your Medical Benefits

BrightView's goal is to ensure that our team members are well informed on their medical plan options. In addition to this, we also want to ensure that our members are educated consumers and understand how to maximize your benefits to obtain lower out-of-pocket costs, while still receiving quality care. Below is a list of options that employees can take to help minimize their out-of-pocket costs. If you have any questions, please contact the benefits department.

- Utilization of In-Network providers limits your out-of-pocket expenses due to the contracts that these providers and facilities have with the Cigna Network. You will also receive the highest level of coverage under your In-Network benefits. Search for In-Network providers and facilities by visiting www.cigna.com, click on "Find a Doctor, Dentist or Facility" and select "PPO, Choice Fund PPO" as your network
- Utilization of Teladoc visits are not only convenient for you and your family, but they cost less than a visit to your provider's office. Teladoc visits can be utilized for common illnesses and conditions such as the flu, sinus infections, skin irritations/rashes, earaches, and bronchitis. Please note that telehealth visits should not be utilized for emergency and life-threatening conditions. If you or a family member experience an emergency or life-threatening condition you should visit the nearest ER.
- Using a freestanding imaging center for an MRI, CT scan, or X-Ray is less expensive than seeking these services in a hospital setting. The average national cost of hospital-based imaging services is almost three times the cost of receiving the same services at freestanding imaging centers or a physician's office. You receive the same service at a lower cost!
- Utilization of mail order pharmacy is not only convenient but can save you money versus filling your prescription at a retail pharmacy. Your prescriptions will be delivered safely to your home and cost less! Call the **CVS Caremark** service number on the back of your ID card for assistance regarding how to begin or transfer a current prescription to mail order
- Utilization of generic medications instead of name-brand medications will cost less under your plan. If your doctor prescribes you a name-brand medication inquire if a generic is available.

Manage your medical plan coverage online by registering your member account at www.bpaco.com

- View your plan benefits and summaries
- Print or request an ID card
- Find a network healthcare provider
- Access your claims and explanation of benefits
- View current deductible and out of pocket balances

Health Savings Accounts

What are the Advantages of an HSA?

If you're enrolled in the $5,000 High Deductible Health Plan (HDHP)—you're eligible to contribute on a pretax basis to a Health Savings Account (HSA). Other plan options are not eligible for the HSA.

If you've had a traditional co-payment plan, you may wonder how it is different from an HDHP with an HSA.

A Higher Deductible and a Lower Premium: Traditional co-payment plans typically have a lower deductible and higher premiums, so you pay more up front and less when you need care. HDHPs have the opposite—a higher deductible but lower premiums.

A Health Savings Account (HSA): You open an HSA which is a personal bank account that you own. BrightView, LLC uses Fifth Third Bank to manage HSAs. Here are some advantages of an HSA:

- **Get triple tax advantages:** (1) Contribute pre-tax dollars (2) Grow your account tax-free (3) Use your HSA to pay for eligible health care expenses tax-free.
- **Use it today or save for tomorrow.** Your HSA is an account in your name; you own it, and you decide how to get the most from it. Lose the worry of having to spend it all before the end of the year. With the HSA, the balance rolls over year after year so you can let it grow over time.
- **You own the money in the HSA.** There is no "use it or lose it" rule. If you choose to leave the company or switch health care plans, you keep the money.
- **It's convenient.** Contributions are automatically deducted from your paycheck. You can change or stop contributions at any time.

You can use your HSA to pay for a wide range of IRS-qualified medical expenses for yourself, your spouse, or tax dependents. An IRS-qualified medical expense is defined as an expense that pays for healthcare services, equipment, or medications. Funds used to pay for IRS-qualified medical expenses are always tax-free. HSA funds can be used to reimburse yourself for past medical expenses if the expense was incurred after your HSA was established. While you do not need to submit any receipts to Lively, you must save your bills and receipts for tax purposes.

EXAMPLES OF IRS-QUALIFIED MEDICAL EXPENSES

- Acupuncture
- Ambulance
- Annual physical examination
- Bandages
- Birth control pills, contraceptive devices
- Body scan
- Breast pumps and supplies
- Breast reconstruction surgery
- Chiropractor
- Contact lenses
- Crutches
- Dental treatment
- Diagnostic devices
- Disabled dependent care expenses
- Eye exam
- Eyeglasses
- Eye surgery
- Hearing aids
- Home care
- Hospital services
- Insurance premiums
- Laboratory fees
- Lactation expenses
- Learning disability
- Long-term care
- Medicines
- Nursing home
- Nursing services
- Optometrist
- Oxygen
- Physical examination

- Pregnancy test kit
- Prosthesis
- Psychiatric care
- Special education
- Sterilization
- Stop-smoking programs
- Surgery
- Transplants
- Vasectomy
- Vision correction surgery
- Weight-loss program
- Wheelchair
- Wig
- X-ray fees

INELIGIBLE MEDICAL EXPENSES MAY INCLUDE:

- Baby sitting, childcare, and nursing services for a normal, healthy baby
- Controlled substances
- Costmetic surgery
- Dancing lessons
- Diaper service
- Electrolysis or hair removal
- Flexible spending account
- Funeral expenses
- Future medical care
- Hair transplant
- Health club dues
- Health coverage tax credit
- Household help
- Illegal operations and treatments
- Maternity clothes
- Medicines and drugs from other countries
- Nonprescription drugs and medicines
- Nutritional supplements
- Personal use items
- Swimming lessons
- Teeth whitening
- Veterinary fees

*This list **is not** all-inclusive; additional expenses may qualify, and the items listed above are subject to change in accordance with IRS regulations. For more information or clarification on individual list items, refer to Publication 502 or consult a tax professional.*

HSA STATE TAXATION

There are currently three states that, unlike the federal government, subject your HSA contributions (Employee and employer) to state income taxes. The three states are New Jersey, California and Alabama. Similarly, these three states also subject earnings (interest and capital gains) on your HSA to state taxation. There are currently two other states, New Hampshire and Tennessee, that subject earnings on the account (but not the contributions) to state taxes. Tax laws are subject to change. Please contact your state tax authority or consult with a tax advisor to confirm the details for your state.

2024 MAXIMUMS

- $4,150 for individuals
- $8,300 for family
- $1,000 additional “catch-up” contributions for individuals who are 55 or older

Flexible Spending Accounts

An FSA allows you to place money in a tax-sheltered, short-term account for use in paying approved healthcare expenses. Enrollment occurs before the beginning of each plan year, or for new Employees, during your initial enrollment period. You must enroll each year to participate in the Healthcare and Dependent Care Reimbursement Accounts. The amount you designate is deducted from your paycheck in equal amounts throughout the plan year. Keep your receipts and Explanation of Benefits (EOBs) in the event Navia Benefit Solutions or the IRS requests additional information on your transactions.

General Purpose Health Care FSA

- Contribution Limit: **$3,200** (2024).
- General Purpose Health Care FSA is for those **NOT enrolled in the $5,000 HDHP plan**. You are eligible to contribute to an FSA and use the funds for out of pocket **medical**, **dental** and **vision** expenses.
- The General Purpose Health Care FSA contribution is deducted from your paycheck over the course of the year. Since you pay no taxes on the money placed in the FSA, you effectively adjust your annual taxable salary.
- **Contributions available first day of new plan year.**
- **Unused funds are rolled over up to the IRS max allowable amount.**

Dependent Care FSA

- Contribution Limit (2024):
  - **$5,000** if you are a single Employee or married filing jointly.
  - **$2,500** if you are married and filing separately.
  - **Money only available as contributed via your payroll deductions.**
  - **DCFSAs are NOT eligible for any rollover amount. All funds must be spent by the end of the plan year.**

Important: *Elections cannot be changed during the plan year unless you have a qualified change in family status like birth, death, marriage or divorce. Unused General Purpose Healthcare FSA amounts in excess of $610 will be forfeited, so plan carefully before making your elections.*

ROLLOVER PROVISION

- **For 2024 to 2025, the IRS maximum allowable rollover is $640 (HCFSA only)**
- Claims must be incurred between January 1, 2024 and December 31, 2024.
- These claims may be submitted for reimbursement between January 1, 2024 – March 31, 2025.

Guardian®

Dental Insurance

Dental coverage is important to your overall health and wellness. You can enroll in dental benefits offered by Guardian for yourself and your family. The dental plan features a network of dentists and specialists who have agreed to provide services at a discounted price. If you choose to see a dentist out of the network, you may be balance billed for any charges over what is considered "reasonable and customary". This helps minimize any balance billing but remember that the best way to maximize the benefit is by visiting an in-network dentist.

Please note ID cards are *not* required for you to receive services. Providers can confirm coverage with your Social Security Number. Any dependents on your plan can also use your Social Security Number to get care.

The following chart shows the features of the Dental benefit option. A complete benefit summary is available on Paycom.

2024	Base Dental Plan	Premier Dental Plan
SERVICES	IN-NETWORK	IN-NETWORK
Preventive Services	Exams, cleanings, X-rays, Sealants **100%**	Exams, cleanings, X-rays, Sealants **100%**
Deductible	Applies to basic and major services only: **$50 Individual** **$150 Family**	Applies to basic and major services only: **$50 Individual** **$150 Family**
Basic Services	Fillings, Space Maintainers, Perio Maintenance **80%**	Fillings, Space Maintainers, Perio Maintenance, Extractions **80%**
Major Services	Crowns, Dentures, Bridges, Root Canals, Periodontics, General Anesthesia, Extractions **50%**	Crowns, Dentures, Bridges, Root Canals, Periodontics, General Anesthesia **50%**
Annual Maximum Per Individual	$1,000 plus Maximum Rollover	$2,500 plus Maximum Rollover
Orthodontia Applies to dependents up to age 19 only	N/A	50%
Orthodontia Lifetime Maximum (up to age 19)	N/A	$2,500
BI-WEEKLY PAYROLL DEDUCTIONS		
Employee Only	$8.99	$13.10
Employee + Spouse	$17.97	$26.20
Employee + Child(ren)	$22.91	$33.84
Family	$31.90	$46.98

Vision Insurance

Your vision health is an important part of complete wellness. Guardian is pleased to present your vision benefits which are designed to give you and your covered family members the care, value, and service to help maintain good vision and overall health.

Please note: ID cards are not required for you to receive services. Providers can confirm coverage with your Social Security Number. Any dependents on your plan can also use your SSN to get care.

The following chart shows the features of the Vision benefit option. A complete benefit summary is available on Paycom.

2024	Guardian Vision Plan	
TYPE OF SERVICE	IN-NETWORK VSP CHOICE NETWORK	OUT-OF-NETWORK REIMBURSEMENT
Annual Eye Exam	$10 Copay	Up to $39 Before Copay
Standard Lenses: Single Vision Bifocal Trifocal Lenticular	 Covered in full after $10 Copay Covered in full after $10 Copay Covered in full after $10 Copay Covered in full after $10 Copay	 Up to $23 Before Copay Up to $37 Before Copay Up to $49 Before Copay Up to $64 Before Copay
Standard Frames	$200 Allowance + 20% off balance over $200	Up to $100
Contact Lenses: Conventional Medically Necessary	 $200 Allowance (in lieu of frames), Copay waived Covered after $10 copay	 Up to $100 maximum Up to $210 maximum
Frequencies: Eye Exam Lenses Frames Contact Lenses	 Once every 12 months Once every 12 months Once every 12 months Once every 12 months	
Bi-Weekly Payroll Deductions	Employee Only— $5.33 Employee & Spouse—$10.64 Employee & Child—$10.10 Family—$15.89	

Disability Income Benefits

In the event you become disabled from a non-work-related injury or sickness, disability income benefits will provide a partial replacement of lost income. Please note, though, that you are not eligible to receive short-term disability benefits if you are receiving workers' compensation benefits.

If you aren't able to work after 7 consecutive days of disability due to an eligible injury or illness, **Short-Term Disability will replace 60% of your weekly pay up to a maximum benefit of $1,500 per week, for a maximum of 12 weeks**. Long-Term Disability benefits pay a portion of your income if you continue to be disabled and your Short-Term Disability benefits end. **Long-Term Disability benefits begin after 90 days of disability and provide you with 60% of your basic monthly earnings up to $5,000 per month maximum.**

> *This is your opportunity to enroll in STD and LTD without completing an EOI.*

2024	Short-Term Disability	Long-Term Disability
Benefits Begin	8th day for accident; 8th day for illness	91st day
Percentage of Income Replaced	60% of pre-disability income, up to $1,500 per week	60% of pre-disability income, up to $5,000 per month
Benefits Payable	12 weeks	Social Security Normal Retirement Age w/ Reducing Benefit Duration
Pre-Existing Condition Limitation	3 months prior/12 months insured	3 months prior/12 months insured

Premiums for disability are based on age and income. To view your monthly premium, please enter your election via Paycom.

HELPFUL TERMS

- **Elimination Period:** The period of time you have to wait before benefits begin, starting the day you become ill or injured.
- **Maximum Benefit:** This is the highest dollar amount a disabled employee can receive on a weekly basis under the STD plan.
- **Pre-Existing Limitations:** Anything that you have been diagnosed with or treated for within 3 months prior to the effective date will not be covered for the first 12 months.

Life Insurance

Basic Life

Life insurance can help provide for your loved ones if something were to happen to you BrightView, LLC provides full-time employees with $25,000 in group life and accidental death and dismemberment (AD&D) insurance. BrightView, LLC pays for the full cost of this benefit—meaning you are not responsible for paying any monthly premiums.

FULL-TIME EMPLOYEES

$25,000

BENEFIT REDUCTION SCHEDULE

- 65% of benefit remains at age 65
- 50% of benefit remains at age 70

Voluntary Life Insurance

While BrightView, LLC offers basic life insurance, some members may want to purchase additional coverage. Think about your personal circumstances. Are you the sole provider for your household? What other expenses do you expect in the future (for example, college tuition for your child)? Depending on your needs, you may want to consider buying supplemental coverage.

With voluntary life insurance, you are responsible for paying the full cost of coverage through payroll deductions. You can also purchase coverage for your spouse and your children, but you must be enrolled in coverage yourself to elect coverage for your spouse or child.

EMPLOYEE

- Benefits must be elected in $10,000 increments to a maximum of $500,000
- **Guarantee Issue:** Newly eligible employees can elect up to $200,000 without the need to complete a medical questionnaire.
- At future annual enrollments Employees can elect up to $20,000 in additional coverage without an EOI as long as you do not exceed the guarantee issue amount

SPOUSE

- Benefits must be elected in $5,000 increments
- Maximum benefit is $100,000, not to exceed 50% of employee's benefit
- **Guarantee Issue:** Newly eligible spouses can elect up to $40,000 without the need to complete a medical questionnaire.
- Spouse cost is based on employee's age.
- At future annual enrollments Spouse coverage can be increased by up to $10,000 in additional coverage without an EOI as long as you do not exceed the guarantee issue amount

CHILD

- **Benefit election amounts:** <14 Days: $1,000; 14-26 years: $5,000 or $10,000, not to exceed 50% of employee's benefit

BENEFIT REDUCTION SCHEDULE:

- 65% of benefit remains at age 65
- 50% of benefit remains at age 70
- Reductions based on employee age

> *Premiums for Voluntary Life are based on age and income. To view your monthly premium, please enter your election via Paycom.*

Accident Coverage

Accidents can happen when you least expect them. And while you can't always prevent them, you can get help to make your recovery less expensive and stressful.

Accident insurance provides a financial cushion for life's unexpected events by helping you pay for costs that aren't covered by your medical plan. It provides you with a lump-sum payment—one convenient payment all at once—when you or your family need it most. The extra cash can help you focus on getting back on track, without worrying about finding the money to help cover the costs of treatment.

And best of all, the payment is made directly to you, and is in addition to any other insurance you may have. It's yours to spend however you like, including for your or your family's everyday living expenses. Below is a summary of common occurrences and their coverage. Please refer to the benefit summary for a full list of covered accidents and injuries.

Benefits Payable	
INJURY	BENEFIT
Burn	Up to $5,000
Coma	$15,000.00
Concussion	$500.00
Dental Injury	$500.00
Dislocation	Up to $3,750 non-surgical/$7,500 surgical
Fracture	Up to $5,000 non-surgical/$10,000 surgical
Wellness	$50.00
Actual benefit payment is dependent on type of occurrence. See benefit summary for details and additional coverage	
ACCIDENTAL DEATH & DISMEMBERMENT	
Employee	$25,000.00
Spouse	$12,500.00
Children	$6,250.00
% of AD&D benefit payout is dependent on type of occurrence. See benefit summary for details	
BI-WEEKLY PAYROLL DEDUCTIONS	
Employee Only	$6.26
Employee + Spouse	$8.83
Employee + Child(ren)	$10.30
Family	$14.28

NEW!

Critical Illness Coverage

If you're diagnosed with a serious illness, one of the last things you want to worry about is your finances. A critical illness policy can provide you a lump-sum cash benefit upon diagnosis of a critical illness. The benefit can be used to pay out-of-pocket expenses or to supplement your daily cost of living.

Offered by **Lincoln Financial Group**, a Critical Illness insurance policy helps provide protection from a variety of covered conditions, so you can focus on getting well.

- Pays a benefit to you if you are diagnosed with a major illness such as Cancer, Heart Attack, or Stroke
- Pays $50 each year for Health Screening
- There is no benefit waiting period
- You can choose a benefit amount that is right for you as the member
  - $5,000, $10,000, $15,000, $20,000 or $25,000
- You can also choose a benefit amount that is right for your Spouse and/or Child(ren). You must elect coverage on yourself in order to cover your spouse and dependents
  - $2,500 increments up to $12,500, not to exceed 50% of employee benefit

> *Premiums for Critical Illness are based on age and election. To view your monthly premium, please enter your election via Paycom.*

Mental Health & Wellness (Team Member Program)

Guardian® spring health

Mental health is more important than ever. That's why BrightView now offers Spring Health, in partnership with Guardian, to all BrightView Team Members. Spring Health makes getting started with mental health care easier—dedicated Care Navigators explain care options, give advice, find therapists, and set appointments.

Each year members have up to 3 therapy sessions with a Spring Health provider covered at no cost, and appointments available in as soon as two days. Members can also access on-demand mental wellness exercises, check-in assessments, Care Navigator support, and more.

At no cost, you can use Spring Health for:

- Care navigation
- One-to-one coaching
- In-app wellness exercises
- Therapy (including virtual options)
- Medication management
- Crisis support

To get started, activate your account:

- Go to www.guardianbenefits.springhealth.com
- Click "Create My Account"
- Provide your legal name, date of birth, and email address

CONTACT A CARE NAVIGATOR

- careteam@springhealth.com
- 1-855-629-0554

Lincoln Financial Group®

Employee Assistance Program (Members & Dependents)

EmployeeConnect℠ offers professional, confidential services to help you and your loved ones improve your quality of life.

In-Person Guidance

Some matters are best resolved by meeting with *EmployeeConnect*℠, you and your faily get:

- In-person help for short-term issues (up to five sessions with a counselor per person, per issue, per year)
- In-person consultations with network lawyers, including one free 30-minute in-person consultation per legal issue, and 25% off subsequent meetings

Unlimited 24/7 Assistance

You and your family can access the following services anytime--onloine, on the mobile app, or with a toll-free call:

- Information and referrals on famiy matters, such as child and elder care, pet care, vacation planning, moving, car buying, college planning, and more
- Legal information and referrals for family law, estate planning, consumer and civil law
- Financial guidance on household budgeting and short- and long-term planning

Online Resources

EmployeeConnect℠ offers a wide range of information and resources you can research and access on your own. Expert advice and support tools are just a click away when you visit GuidanceResources.com or download the GuidanceNow mobile app. You'll find:

- Articles and tutorials
- Videos
- Interactive tools, including financial calculators, budgeting worksheets, and more

TO FIND OUT MORE

- Visit GuidanceResources.com
  username: **LFGSupport**
  password: **LFGSupport1**
- Download the GuidanceNow℠ mobile app
- Call 888-628-4824

This program features 5 one-on-one counseling sessions for you and your immediate family members, per calendar year.

Pet Insurance

BrightView LLC is Offering Wishbone Pet Insurance to Employees

Nobody wants to imagine their pet getting sick or injured - but when it comes to your pet's health, it's best to expect the unexpected.

Enroll in pet health insurance from Wishbone and receive 90% reimbursement on your pet's veterinary care. With a low deductible of $250, protecting your pet's health and your finances has never been easier!

Wishbone Pet Insurance is accepted at any vet in the U.S., including emergency hospitals. Once you file a claim, expect fast reimbursement via mailed check. It's that easy!

Note: This coverage cannot be elected in Paycom.

Get a quote and enroll at www.wishboneinsurance.com/brightviewhealth

Wishbone Pet Insurance is a pet health insurance program administered by Odie Pet Insurance Marketing, Inc. and is underwritten by Clear Blue Insurance Group. Claims are processed by a third-party administrator, PrimeOne Insurance Co. Please visit https://www.wishboneinsurance.com/terms-and-conditions for more information.

POLICYHOLDERS ENJOY:

- Optional routine care plans
- Fast claims processing
- Easy-to-use member sccount
- Short waiting periods
- Lost pet recovery service from **ThePetTag**
- 24/7 Pet Telehealth from **AskVet**

Carrier Contacts

Health Insurance:	
BPA (Medical services)	Phone: (800) 236-7789 Website: www.bpaco.com
CVS/Caremark (Rx services)	Phone: 1-800-334-8134 Website: www.caremark.com
Deductible Reimbursement: Garner	Email: concierge@getgarner.com Website: www.getgarner.com
Medical & Behavioral Health Telemedicine: Teladoc	Phone: 1-800-Teladoc Website: www.teladoc.com
Dental Insurance: Guardian	Phone: (800) 627-4200 Website: www.guardianlife.com
Vision Insurance: Guardian	Phone: (866) 414-1959 Website: www.guardianlife.com
Life and Disability: Lincoln Financial Group	Phone: (877) 275-5462 Website: www.lfg.com
Critical Illness and Accident: Lincoln Financial Group	Phone: (800) 423-2765 Website: www.lfg.com
Employee Assistance Program: Lincoln Financial Group	Phone: (888) 628-4824 Website: www.guidanceresources.com
Mental Health & Wellness: Spring Health	Phone: 1-855-629-0554 Website: guardianbenefits.springhealth.com Email: careteam@springhealth.com

Your Human Resources Contact

- **Rachel Fitzgerald, Benefits Manager**
  859-588-1625
  r.fitzgerald@brightviewhealth.com
- **BrightView Benefits Department**
  benefits@brightviewhealth.com

Important Notices

Notice of Patient Protections & Prior Authorization Procedures

Your **Benefit Plan Administrators (BPA)** plans allows you to visit any doctor or hospital you choose. However, Prior Authorization is required for certain services. Make sure Your Provider obtains Prior Authorization before any planned hospital stays (except maternity admissions), skilled nursing and rehabilitative facility admissions, certain outpatient procedures, Advanced Radiological Imaging services, certain Specialty Drugs, and Durable Medical Equipment costing $500 or more. Contact Benefit Plan Administrators (BPA) Customer Service using the number on the back of your medical ID card or online at www.bpaco.com to find out which services require Prior Authorization. You can also call the customer service department to find out if your admission or other service has received Prior Authorization. For more information, please refer to your Evidence of Coverage document located online at www.bpaco.com.

Women's Health and Cancer Rights Act of 1998

Patients who undergo a mastectomy, and who elect breast reconstruction in connection with the mastectomy, are entitled to coverage for:

- Reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including Lymphedemas, in a manner determined in consultation with the attending physician and the patient.

The coverage may be subject to Coinsurance and Deductibles consistent with those established for other benefits. For more information, please refer to your Evidence of Coverage document located online at www.bpaco.com.

Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your Out-of-Pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

Notice of Special Enrollment Rights

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

request enrollment within 31 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact Human Resources.

Notice of Privacy Practices

Benefit Plan Administrators (BPA) is required to maintain the privacy of all medical information as required by applicable laws and regulations; provide a notice of privacy practices to all Members; inform Members of the Plan's legal obligations; and advise Members of additional rights concerning their medical information. For more information, please refer to your Evidence of Coverage document located online at www.bpaco.com.

All Members will be notified of any changes by receiving a new notice of the Plan's privacy practices. You may request a copy of this notice of privacy practices at any time by contacting Benefit Plan Administrators (BPA).

Uniformed Services Employment and Reemployment Rights Act of 1994

A Subscriber may continue his or her Coverage and Coverage for his or her Dependents during military leave of absence in accordance with the Uniformed Services Employment and reemployment Rights Act of 1994. When the Subscriber returns to work from a military leave of absence, the Subscriber will be given credit for the time the Subscriber was covered under the Plan prior to the leave.

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 are 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 are not eligible for Medicaid or CHIP, you will not 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 are not 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 January 31, 2022. Contact your State for more information on eligibility.

ALABAMA - MEDICAID

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

ALASKA - MEDICAID

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

ARKANSAS - MEDICAID

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

CALIFORNIA - MEDICAID

- Website: Health Insurance Premium Payment (HIPP) Program 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+)

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

FLORIDA - MEDICAID

- Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery. com/hipp/index.html
- Phone: 1-877-357-3268

GEORGIA - MEDICAID

- A 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

INDIANA - MEDICAID

- 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)

- 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

KANSAS - MEDICAID

- Website: https://www.kancare.ks.gov/
- Phone: 1-800-792-4884

KENTUCKY - MEDICAID

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

LOUISIANA - MEDICAID

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

MAINE - MEDICAID

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

MASSACHUSETTS - MEDICAID AND CHIP

- Website: https://www.mass.gov/masshealth/pa
- Phone: 1-800-862-4840

MINNESOTA - MEDICAID

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

MISSOURI - MEDICAID

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

MONTANA - MEDICAID

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

NEBRASKA - MEDICAID

- Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633
- Lincoln: 402-473-7000
- Omaha: 402-595-1178

NEVADA - MEDICAID

- Medicaid Website: http://dhcfp.nv.gov
- Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE - MEDICAID

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

NEW JERSEY - MEDICAID AND CHIP

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

NEW YORK - MEDICAID

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

NORTH CAROLINA - MEDICAID

- Website: https://medicaid.ncdhhs.gov/
- Phone: 919-855-4100

NORTH DAKOTA - MEDICAID

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

OKLAHOMA - MEDICAID AND CHIP

- Website: http://www.insureoklahoma.org
- Phone: 1-888-365-3742

OREGON - MEDICAID

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

PENNSYLVANIA-MEDICAID

- Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP- Program.aspx
- Phone: 1-800-692-7462

RHODE ISLAND - MEDICAID AND CHIP

- Website: http://www.eohhs.ri.gov/
- Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA - MEDICAID

- Website: https://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA - MEDICAID

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

TEXAS - MEDICAID

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

UTAH - MEDICAID AND CHIP

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

VERMONT - MEDICAID

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

VIRGINIA - MEDICAID AND CHIP

- Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp
- Medicaid Phone: 1-800-432-5924
- CHIP Phone: 1-800-432-5924

WASHINGTON - MEDICAID

- Website: https://www.hca.wa.gov/
- Phone: 1-800-562-3022

WEST VIRGINIA - MEDICAID AND CHIP

- 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

- Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
- Phone: 1-800-362-3002

WYOMING - MEDICAID

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

To see if any other states have added a premium assistance program since January 31, 2022, 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 Employee Benefits Security Administration Centers for Medicare & Medicaid Services
- www.cms.hhs.gov
- 1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless OMB under the PRA approve it, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, 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.

Prescription Drug Coverage and Medicare Plans

Important Notice from BrightView, LLC About Your Prescription Drug Coverage and Medicare for Plans:

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with BrightView, LLC 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. Certain plans may also offer more coverage for a higher monthly premium.

2. BrightView, LLC has determined that the prescription drug coverage offered by the Simple Savings and Value Based plans are, 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.

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

Since the coverage under your plans are creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, 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 (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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 BrightView plan coverage will not be affected. You can keep this coverage if you elect part D, and this plan will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current BrightView, LLC coverage, be aware that you and your dependents will not be able to get this coverage back until next Annual Open Enrollment or a mid-year qualifying event.

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 will 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: 01/01/2024

Name of Entity/Sender: BrightView, LLC

Office Contact/Position: Rachel Fitzgerald, Benefits Manager

Phone: (513) 834-7063

Address: 4600 Montgomery Rd 4th Floor Norwood, OH 45212

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2024)

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 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 2013 for coverage starting as early as January 1, 2014.

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 does not meet certain standards. The savings on your premium that you are 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 **YOUR HUMAN RESOURCE DEPARTMENT**.

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.

1. Employer Name	2. Employer Identification Number (EIN)	
BrightView, LLC	**47-2519577**	
3. Employer Address	4. Employer Phone Number	
4600 Montgomery Rd 4th Floor	**1-833-510-4357**	
6. City	7. State	8. ZIP Code
Norwood	**OH**	**45212**

10. Who can we contact about employee health coverage at this job?	
Rachel Fitzgerald	
11. Phone number (if different from above)	12. Email Address
	r.fitzgerald@brightviewhealth.com

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

As your employer, we offer a health plan to:

☒ All employees. Eligible employees are:

Full-time Employees working 30+ hours per week

☐ Some employees. Eligible employees are:

As your employer, we offer a health plan to:

☒ We do offer coverage. Eligible dependents are:

1. Legal Spouses; includes same sex
2. Dependents up to age 26

☐ We do not offer coverage.

☒ **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 is the employer information you will 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)

☐ 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 (do not 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 did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $85

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☒ Monthly ☐ Quarterly ☐ Yearly

**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 (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)*

Phone: 833.510.HELP   **brightviewhealth.com**

The information in this Enrollment Guide is presented for illustrative purposes and the text contained herein was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Guide and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Guide, contact Human Resources.