Welcome to
Open Enrollment

Plan Year: 2023

COMPASS CHRISTIAN CHURCH

CBR
Creative Business Resources

If you have Medicare or will become eligible for Medicare in the next 12 months, a new Federal law gives you more choices about your prescription drug coverage, which started in 2006. Please see page 24 for more details.

Pick the best benefits for you and your family.

Compass Christian Church 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 Benefit 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 benefit 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, 2023, to May 31, 2024. If you have questions about any of the benefits mentioned in this guide, please don't hesitate to reach out to HR.

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Eligibility and QE's

Who Is Eligible?

You are eligible for benefits once you meet the eligibility criteria. In addition, the following family members are eligible for medical, dental and vision coverage:

- Legal Spouse
- Domestic Partner
- Children up to the age of 26

How to Enroll

Are you ready to enroll? The first step is to review your current benefits. Did you move recently or get married? Verify all of your personal information and make any necessary changes.

Once all your information is up to date, it's time to make your benefit elections. The decisions you make during open enrollment can have a significant impact on your life and finances, so it is important to weigh your options carefully.

How to Make Changes

Unless you experience a life-changing qualifying event, you cannot make changes to your benefits until the next open enrollment period. Qualifying events include things like:

- Marriage, divorce, or legal separation
- Birth or adoption of a child
- Change in child's dependent status
- Death of a spouse, child, or other qualified dependent
- Change in residence
- Change in employment status or a change in coverage under another employer-sponsored plan

You have 31 days, and in some special cases 60 days, to notify your HR team of a qualified event. If you do not advise the HR team and provide the necessary documentation, you may need to wait until the next open enrollment period in order to make changes to your pre-tax benefits.

Health Terms to Know

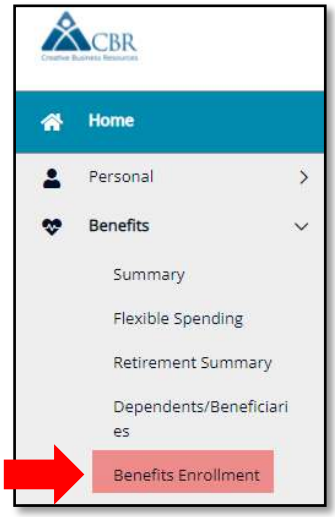
Do you know the ABCs of health insurance? With a good understanding of what some healthcare buzzwords mean, it will be easier to find an insurance plan that meets your needs—and fits within your budget.

- ✓ Allowable Costs - Charges for health care services and supplies for which benefits are available under your health insurance plan. An allowable cost may also be referred to as an allowable charge, an approved charge, or an allowed amount. Actual charges are different and refer to the amount billed by the provider for the specific service. The allowed amount is the amount your insurance carrier is willing to pay for the rendered service.
- ✓ Coinsurance - The percentage you pay for the cost of covered health care services, after you meet your deductible. It's important to understand that coinsurance and copayments are not the same thing and are two separate parts of your health insurance plan. Read on to learn about copayments.
- ✓ Copayment - A flat fee you pay upfront for doctor visits, prescriptions, and other health care services. Copayments, or copays, do not count toward your deductible. You are typically required to pay your copay when you receive the service. When shopping for a plan, look closely to see when you'll have a copay and how much it will cost for different services.
- ✓ Deductible - The amount you pay out-of-pocket before your health insurance starts to cover costs. Tip: Consider keeping your deductible to no more than 5% of your gross annual income.
- ✓ Flexible Spending Account (FSA) - An account set up through an employer to set aside pre-tax money for common medical costs and dependent care. An FSA is often part of an employer's benefits package and allows you to pay for copays, deductibles, medications, and other medical expenses with pre-tax dollars. The common rule with funds in an FSA is to "use it or lose it" each year. See page 11 for additional information.
- ✓ In-Network - A group of doctors, labs, hospitals, and other healthcare providers that your plan contracts with at a set payment rate. Health insurance companies would prefer you to receive services from their in-network providers because it costs them less. If you are considering changing plans, do a bit of homework to make sure desired providers are in your network.
- ✓ Out-of-Network - A provider who doesn't have a contract with your health insurance plan.
- ✓ Out-of-Pocket Maximum - The highest amount you'll pay for in-network healthcare services. Remember that only covered services from in-network providers will count toward reaching this cap. Once you hit the maximum, you won't have to worry if you suddenly get seriously sick, become critically injured or need specialized care.
- ✓ Premium - The amount charged by your health insurance company. Your premiums are paid via payroll deductions each payday. You must pay your premium to keep coverage active, regardless of whether you use it or not. The premium is usually the first cost you see and consider, but it's important to also factor in details such as copays, deductibles, coinsurance, and out-of-pocket maximums.

How to Enroll in Benefits

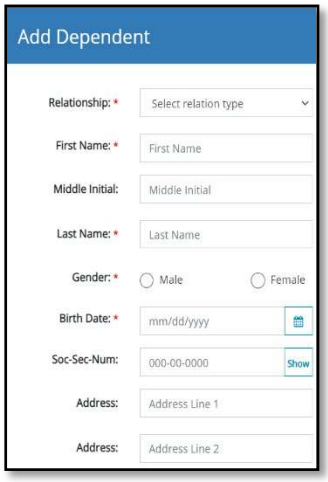
Please follow the instructions below to enroll or waive in your employee benefits.

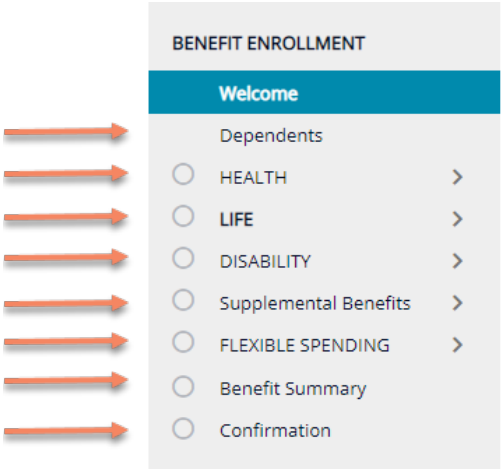
1. Please go to: https://cbr.prismhr.com/cbr/auth/#/login?lang=en or scan the QR code.
2. Log into MY PORTAL with your credentials.



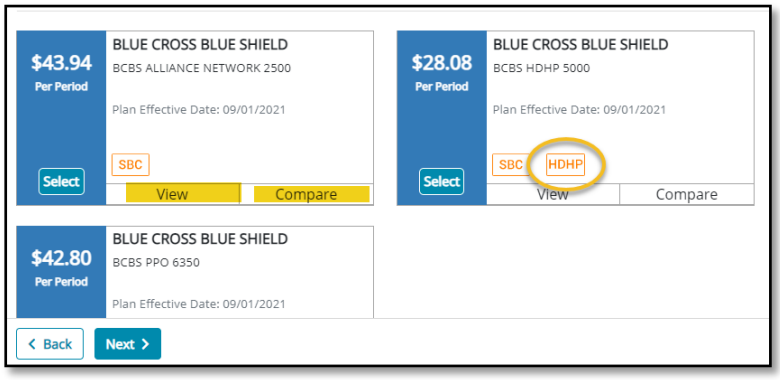
3. Select **Benefits Enrollment**

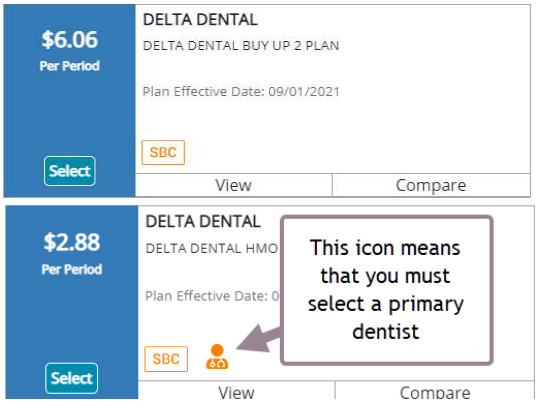
4. **Important: Enter your dependent information. It is best to enter all dependents whether or not you will choose to enroll them in any of your health insurance benefits. You MUST complete each section!!!**



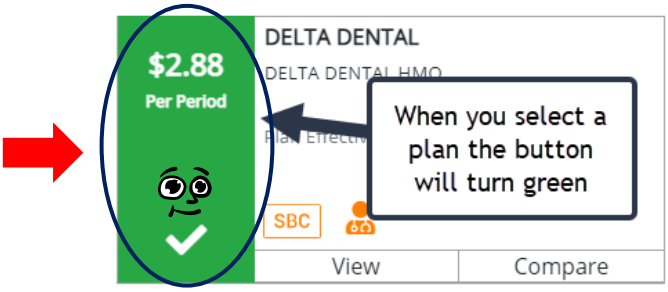


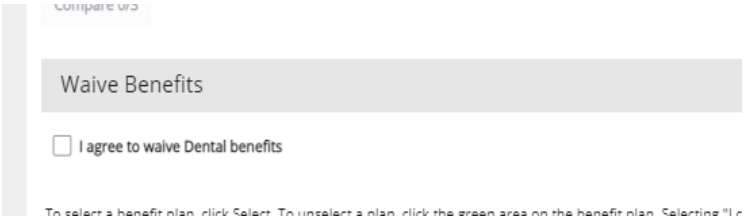
5. Continue to the Health Benefits and enroll in or waive each benefit, **the side bar will be blue until you complete the enrollment or waive the benefit.**





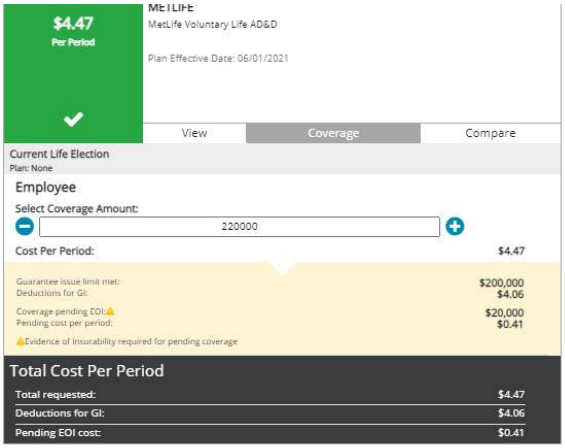
6. Once you enroll in or waive a benefit, the side bar will turn **green**, and you can proceed to the next benefit.





7. When enrolling in voluntary life insurance, you can elect the amount you are interested in. As a new hire or newly eligible employee, you may enroll in voluntary life (up to 5x your annual earnings not to exceed $200,000), without completing an Evidence of Insurability (EOI) health questionnaire.

   Please select a beneficiary or beneficiaries. If your beneficiary is a dependent, you will have the option of adding them.



8. Once you have elected and/or waived all benefits, click **Submit** and you will receive a summary of all coverages and amounts.

HEALTH INSURANCE

We are happy to announce that we are partnering with BlueCross BlueShield of Arizona for your medical benefits. There are three medical plans to choose from that will provide you and your family with great access to care. Important to know is your deductible will reset at the beginning of each year.

The following chart is a brief overview of your medical benefits that will take effect January 1, 2023, to May 31, 2024.

PPO Statewide/National Network

Services	PPO $500 PPO Statewide/National		PPO $1,000 PPO Statewide/National	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible Single | Family	$500 | $1,500	$1,500 | $4,500	$1,000 | $2,000	$3,000 | $6,000
Coinsurance	80% | 20%	60% | 40%	80% | 20%	60% | 40%
Out-of-Pocket Max Single | Family	$3,000 | $9,000	$6,000 | $18,000	$4,000 | $8,000	$8,000 | $16,000
Preventive Care	Covered 100%	Ded, then 40% + balance bill	Covered 100%	Ded, then 40% + balance bill
Office Visits PCP/Specialist	$25/$50 Copay	Ded, then 40% + balance bill	$25/$50 Copay	Ded, then 40% + balance bill
Diagnostic Test (x-ray, blood work)	Office Copay	Ded, then 40% + balance bill	Office Copay	Ded, then 40% + balance bill
Imaging (CT/PET scans, MRIs)	Ded, then 20%	Ded, then 40% + balance bill	Ded, then 20%	Ded, then 40% + balance bill
Urgent Care	$75 Copay	Ded, then 40% + balance bill	$75 Copay	Ded, then 40% + balance bill
Emergency Room	$250 Copay		$250 Copay	
Prescription Drugs	(30-day retail or 90-day mail order at 2x retail copay.)		(30-day retail or 90-day mail order at 2x retail copay.)	
- Tier 1 - Tier 2 - Tier 3 - Tier 4 - Specialty	$10 Copay $35 Copay $60 Copay $120 Copay See SBC	$10 Copay $35 Copay $60 Copay $120 Copay N/A	$10 Copay $35 Copay $60 Copay $120 Copay See SBC	$10 Copay $35 Copay $60 Copay $120 Copay N/A

BlueCross BlueShield Arizona

PPO Statewide/National Network

Services	PPO $2,500 PPO Statewide/National	
	In-Network	Out-of-Network
Deductible Single | Family	$2,500 | $5,000	$5,000 | $15,000
Coinsurance	80% | 20%	50% | 50%
Out-of-Pocket Max Single | Family	$6,350 | $12,700	$15,000 | $45,000
Preventive Care	Covered 100%	Ded, then 50% + balance bill
Office Visits PCP/Specialist	$30/$60 Copay	Ded, then 50% + balance bill
Diagnostic Test (x-ray, blood work)	Office Copay	Ded, then 50% + balance bill
Imaging (CT/PET scans, MRIs)	Ded, then 20%	Ded, then 50% + balance bill
Urgent Care	$75 Copay	Ded, then 50% + balance bill
Emergency Room	$250 Copay	
Prescription Drugs	(30-day retail or 90-day mail order at 2x retail copay.)	
- Tier 1 - Tier 2 - Tier 3 - Tier 4 - Specialty	$10 Copay $35 Copay $60 Copay $120 Copay See SBC	$10 Copay $35 Copay $60 Copay $120 Copay N/A

BCBS of Arizona Resources

Important Information When Using In-Network Providers

The BlueCross BlueShield plans do not require you to see a pre-selected primary care physician or obtain a referral for specialty, hospital, laboratory services, or another provider's care. You choose your doctors, specialists, hospitals, and laboratories from the network whenever or wherever you need care. With this freedom comes an important responsibility; you must make sure you are receiving care from network providers for your expenses to be reimbursed at the in-network level. It is necessary to confirm with your provider and the network that the provider belongs to the network before services are rendered.

Finding an in-network provider is easy by following the steps below:

Statewide/National PPO Network

1. Visit www.azblue.com/find-a-doctor or select the QR Code
2. Select "I am NOT yet a member," then click on the box that reads "But might get a BCBSAZ health plan through my employer"
3. Select "Statewide/National PPO"
4. Enter your zip code.
5. Enter your search criteria and you will have access to 1,000s of providers.

Telemedicine

BlueCare Anywhere® is available 24/7/365 from anywhere in the US.

Whether you're at home or work, or even while you're traveling, get fast help for common health issues such as:

- Cold, flu, fever
- Cough, bronchitis
- Diarrhea, vomiting
- Headache
- Pinkeye
- Rashes
- Sinus infection
- Sore throat
- Sprains, strains
- Stomach bugs

If life's challenges start feeling too heavy, a certified counselor, psychologist or psychiatrist is just a click away for private and confidential help with:

- *Anxiety*
- *Depression*
- *Divorce*
- *Grief Counseling*

FLEXIBLE SPENDING ACCOUNT (FSA)

Paying for health expenses can be stressful but planning ahead and putting money in a health flexible spending account (FSA) will help you save on taxes while keeping a reserve of money available for health care costs.

An FSA is an employer-sponsored savings account for health care expenses. You are not taxed on the money put into the FSA, and you can then use the account to pay for qualified out-of-pocket health care costs, such as your deductible and copays, but not your premium. However, you cannot stockpile money in the account from year to year, and you will lose leftover money in excess of **$500** in the account at the end of the plan year.

Health FSAs can save you money on taxes while helping you regularly put aside money for health care expenses. If carefully planned, using an FSA for health care costs can be an asset to your family's budget.

For a full list of eligible items & CARES ACT expanded list go to: https://fsastore.com/

CBR FSA Rules for 2023

- Maximum election amount: $2,500
- Maximum rollover amount: $500 **(Keep in mind, any amount over $500 at the end of the year will be forfeited.)**
- If you enroll in an HDHP with a Health Savings Account, you cannot enroll in the FSA (flex) account.
- *CBR does not have a grace period. We only offer a run-off period from January 1 to the last day in February. This means you only have 60 days to submit receipts for expenses incurred during the prior plan year. Any carry over amount, $500 or less, will be made available the 6th day of March or thereafter.*

WHAT IS A DEPENDENT CARE FSA?

A dependent care flexible spending account (FSA), or dependent care assistance program, allows you to pay for certain expenses on a tax-free basis. If you care for a dependent, this may be for you!

Each pay period, money moves from your paycheck into your dependent care FSA. When you need to pay for dependent care expenses, like elder care or preschool, you can use the money from your account. And as long as you're paying for an eligible expense, the money is tax-free!

CBR Dependent Care FSA Rules for 2023

- Maximum election amount: $5,000 (or $2,500 if married and filing separately).
- There is NO rollover allowed for DCAP.
- There is a 60-day runout period to submit receipts for expenses incurred during the prior plan year. Any dollars left after March 1st will be forfeited. There are no exceptions to this rule.

DENTAL INSURANCE

In addition to protecting your smile, dental insurance helps pay for dental care and usually includes regular checkups, cleanings, and X-rays. Several studies suggest that oral diseases, such as periodontitis (gum disease), can affect other areas of your body—including your heart. Receiving regular dental care can protect you and your family from the high cost of dental disease and surgery.

The following chart outlines the dental benefits being offered.

Type of Service	PPO Base Plan		DHMO Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible Individual | Family	$50 | $150	$50 | $150	$0.00	N/A
Preventive Services	100%	100%	100%	N/A
Basic Services	80%	80%	Fee Schedule	N/A
Major Services	50%	50%	Fee Schedule	N/A
Annual Maximum	$1,500	$1,500	No Annual Maximum	N/A
Orthodontia	Child $1,000	Child $1,000	Fee Schedule for Child and Adult Orthodontia	N/A

Type of Service	PPO Buy Up 1 Plan	
	In-Network	Out-of-Network
Deductible Individual | Family	$50 | $150	$50 | $150
Preventive Services	100%	100%
Basic Services	80%	80%
Major Services	50%	50%
Annual Maximum	$1,500	$1,500
Orthodontia	Child $1,500	Child $1,500

VISION INSURANCE

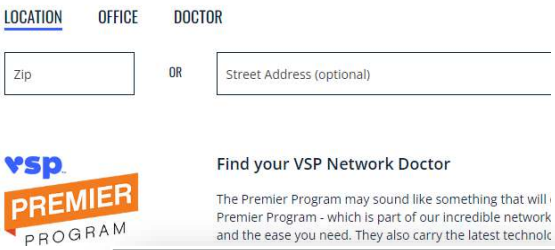
Driving to work, reading a news article, and watching TV are all activities you likely perform every day. Your ability to do all of these activities, though, depends on your vision and eye health. Vision insurance can help you maintain your vision as well as to detect various health problems.

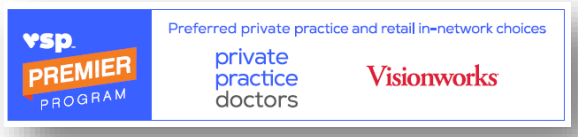
CBR's vision insurance entitles you to specific eye care benefits. Our policy covers routine eye exams and other procedures and provides specified dollar amounts or discounts for the purchase of eyeglasses and contact lenses. We're happy to say that CBR has renewed with ***EyeMed*** and added a ***NEW option, VSP***!

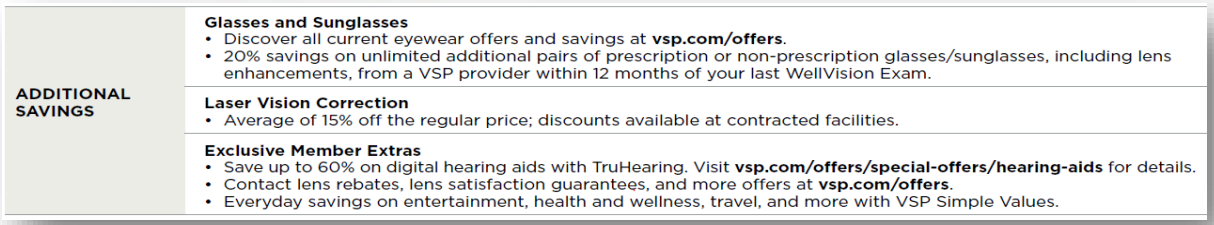
Type of Service	EyeMed Insight Network		VSP (Includes some wholesale locations)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Exam – Every 12 months	$10 copay	Up to $30	$10 copay	Up to $45
Frames – Every 12 months	$120 allowance, 20% off balance over $120	Up to $60	Featured brands - $200; $180 allowance, 20% off balance over $180; Walmart/Costco/Sam's Club - $100 allowance	Up to $70
Lenses – Every 12 months				
• Single Vision	$10 copay	Up to $25	$10 copay	Up to $30
• Bifocal	$10 copay	Up to $40	$10 copay	Up to $50
• Trifocal	$10 copay	Up to $55	$10 copay	Up to $65
Contact Lenses – Every 12 months (In lieu eye glass lenses)				
• Conventional	$80 allowance	Up to $64	Conventional & Disposable: $150 allowance, up to $60 for fitting and evaluation	Up to $105
• Disposable	$80 allowance, + balance over $80	Up to $64		Up to $105
• Medically Necessary	Covered in full	Up to $200	Covered in full	Up to $200

New VSP Resources

Using your VSP benefit is easy! Create an account on www.vsp.com or scan the QR code to view your in-network coverage, find the VSP network doctor who's right for you, and discover savings with Exclusive Member Extras. At your appointment, just tell them you have VSP. Or, enter your zip code to find a provider near you. Select "premier" or "premier retail" and find a provider that's right for you.







Delta Dental Resources

How To Get Your Delta Dental ID Card

Although we usually mail a Delta Dental ID card to new members, you do not need an ID card to visit the dentist. All dental offices need to check benefits is your name and date of birth!

Still want an ID card for peace of mind? No problem! There are 3 easy ways to get your Delta Dental ID card:

1. Go online — You can view or print your ID card from the Delta Dental website. Simply register or sign into the Member Connection at www.deltadentalaz.com/member. Your ID card is only a click away.
2. Use the mobile app — Download the Delta Dental Mobile App for on-the-go access to your ID card. When you're at your next dentist appointment, log in to the app and show your digital ID card to the office staff.
3. Ask for a new ID card — You can always request another copy of your ID card by contacting our customer service team at 800.352.6132.

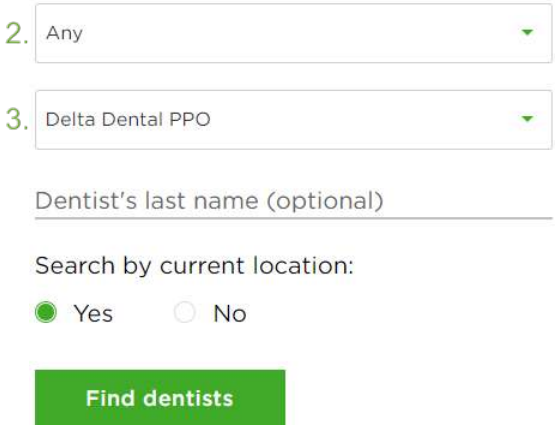
Keep in mind that Delta Dental ID cards only show the policyholder's name, as it is their benefit plan. If your spouse or child is on your dental plan, they will have the same member ID number as you. Alternatively, you can bring a generic ID card with you to your dental visit. Your dental office may be able to use it to verify your benefits.

Note: If your dental office asks for your member ID, or you need it to register for the Member Connection, our customer service team can help! Just call 800.352.6132 or email customerservice@deltadentalaz.com.

How to Find A Provider

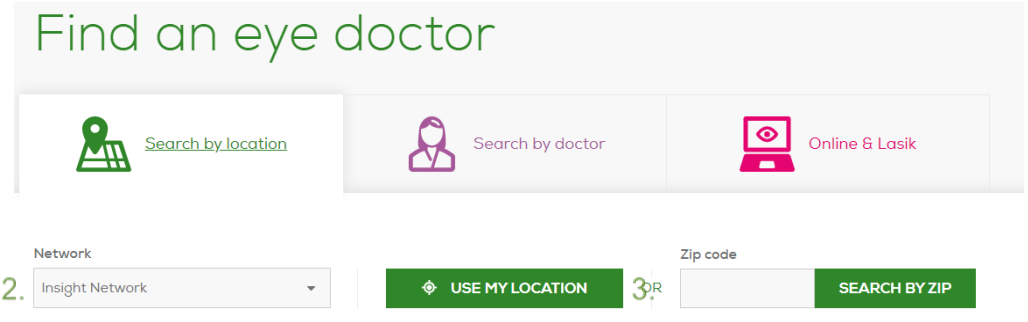
DENTAL

1. Go to below link or scan the QR Code https://www.deltadental.com/us/en/find-a-dentist.html
2. Select type of service
3. Select your plan
   a. **Delta Dental PPO**
   b. **DHMO (DeltaCare USA)**
4. Enter your zip code when prompted



VISION

1. Go to the link or scan the QR Code below: https://eyedoclocator.eyemedvisioncare.com/member/en?utm_content=leaf_button&utm_source=eyemed.com&utm_medium=multiple_pages&utm_campaign=cta&utm_term=find_an_eye_doctor
2. Select the **Insight** network
3. Enter your zip code



LIFE INSURANCE

Life insurance can help provide for your loved ones if something where to happen to you. Compass Christian Church provides full-time employees with $15,000 in group life and accidental death and dismemberment (AD&D) insurance.

Compass Christian Church pays for the full cost of this benefit—meaning you are not responsible for paying any monthly premiums. Contact HR if you would like to update your beneficiary information.

VOLUNTARY LIFE INSURANCE

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 purchase coverage for yourself or for your spouse in $10,000 increments. The minimum coverage level is $10,000 and the maximum is $500,000. The chart below outlines the monthly costs of purchasing additional coverage.

	Voluntary Life & AD&D
Eligibility	All employees working 20+ hours per week
Maximum Benefit - Employee - Spouse - Child(ren)	 5 x base annual earnings up to $500,000 Lesser of 100% of employee amount or $200,000 $10,000
Guarantee Issue - Employee - Spouse - Child(ren)	 5 x base annual earnings up to $100,000 (or up to $200,000 if you are newly eligible) $25,000 $10,000
Benefit Reduction	None
Waiver of Premium **Accelerated Benefit** **Portability** **Conversion**	Included 75% to $200,000 Included Included

DISABILITY INCOME BENEFITS

Compass Christian Church provides full-time employees with both short- and long-term disability income benefits. Without disability coverage, you and your family may struggle to get by if you miss work due to an injury or illness.

At Compass Christian Church, we want to do everything we can to protect you and your family. That's why Compass Christian Church will continue to pay for the full cost of both short- and long-term disability insurance—meaning that you owe nothing out of pocket.

In the event that 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.

Benefit Details	Short-Term Disability	Long-Term Disability
Benefits Begin to Pay	On the 15th day	On the 91st day or at the termination of short-term disability
Benefits Payable	Up to $1,000 Weekly	Up to $7,500 Monthly
Percentage of Income Replaced	60% of your pre-disability income	60% of your pre-disability income
Maximum Benefit Duration	Up to 9 weeks*	Normal Social Security Retirement Age

*Maternity leave benefits are paid for 4 or 6 weeks, dependent Upon type of delivery. STD may not be available in all states.
Note: Evidence of Insurability will be required if you waived coverage when initially eligible.

SHORT-TERM DISABILITY INSURANCE

Help replace a portion of your income when you are unable to work. If you are unable to work for a few weeks due to a covered injury, illness or even childbirth, Short-Term Disability insurance can provide an ongoing benefit to help keep your finances stable.

LONG-TERM DISABILITY INSURANCE

If you are out of work for a longer period of time due to a serious illness or accident, Long -Term Disability Insurance can help you maintain financial independence. The length of coverage depends on your plan.

ADDITIONAL BENEFIT OFFERINGS

AFLAC

- Accidental Policy - Helps cover out-of-pocket expenses in the event of a covered accident.
- Hospital - Helps pay for covered hospital-related expenses, including co-payments and deductibles.
- Critical Illness with Cancer - Helps with the high cost of cancer or critical illness screenings, diagnosis and treatment.

All benefits are post-tax deductions, offer flexibility, stability and all plans are portable. Please contact your HR specialist or AFLAC on how to enroll in these great benefits.

LEGALSHIELD AND IDSHIELD

- Unlimited Legal Consultation
- Standard Will Preparation
- Letters and Phone Call on Member's Behalf
- Legal Document Review
- 24/7 Emergency Assistance
- Credit Monitoring
- Identity Monitoring
- Full Identity Restoration
- Identity Theft Protection for Dependents

Enrollment Tier	Monthly Cost		
	LegalShield	IDShield	Combined
Individual	$18.95	$8.98	$25.90
Family	$18.95	$18.95	$33.90*

*Bundle Discount Applied

PET BENEFIT SOLUTIONS

Your pets are part of your family, and you'll do anything to keep them happy and healthy. But with the cost of pet care on the rise, it isn't always easy. That's why we're offering **Total Pet Plan**, which makes pet care more affordable. Enroll in Total Pet and get the same high-quality products and services your pets are used to, just at a lower price!

TOTAL PET PLAN

Enrollment Tier	Monthly Cost
Individual (1 pet)	$11.75
Family (2+ Pets)	$18.50

- **To search for a vet in your area go to https://www.petbenefits.com/search**
- **To enroll: Log in to your PRISM "My portal" or go to https://www.petbenefits.com/land/cbri**

SUPPORTLINC - EAP

- Allows 24/7 access for employees and dependents to master's level consultants to provide support on any range of personal issues ranging from minor as in stress at work, up to major as in drug addiction, and everything in between.
- 100% confidential.
- Three face-to-face visits per issue per year, unlimited telephonic/online per year, Skype appointments also available.

For additional information, go to https://cbr.mysupportportal.com pw: cbr

METLIFE ADVANTAGES EMPLOYEE ASSISTANCE PROGRAM

Receive confidential, professional guidance and counseling services for behavioral, health and life issues.

- Planning Services
- Will Preparation
- Grief Counseling
- Funeral Assistance
- Travel Assist

Log on to www.metlifeeap.lifeworks.com,
Username: metlifeeap
Password: eap
Or call toll free (888) 319-7819

ANNUAL COMPLIANCE NOTICES

Women's Health & Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed; Surgery and reconstruction of the other breast to produce a symmetrical appearance,
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: [insert deductibles and coinsurance applicable to these benefits]. If you would like more information on WHCRA benefits, call your plan administrator (602) 200-8500.

Model language provided in regulations with Medicaid and CHIP special enrollments added And Model Special Enrollment Notice

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 or your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within *See your HR consultant for specific waiting periods* after your 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 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 *See your HR consultant for specific waiting periods* after the marriage, birth, adoption, or placement for adoption.

Special enrollment rights also may exist in the following circumstances:

- If you or your dependents experience a loss of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP) coverage and you request enrollment within 60 days after that coverage ends; or
- If you or your dependents become eligible for a state premium assistance subsidy through Medicaid or a state CHIP with respect to coverage under this plan and you request enrollment within 60 days after the determination of eligibility for such assistance.

Note: The 60-day period for requesting enrollment applies only in these last two listed circumstances relating to Medicaid and state CHIP. As described above, *See your HR consultant for specific waiting periods* period applies to most special enrollments.

As stated earlier in this notice, a special enrollment opportunity may be available in the future if you or your dependents lose other coverage. This special enrollment opportunity will not be available when other coverage ends, however, unless you provide a written statement now explaining the reason that you are declining coverage for yourself or your dependent(s). Failing to accurately complete and return this form for each person for whom you are declining coverage may eliminate this special enrollment opportunity for the person(s) for whom a statement is not completed, even if other coverage is currently in effect and is later lost. In addition, unless you indicate in the statement that you are declining coverage because other coverage is in effect, you may not have this special enrollment opportunity for the person(s) covered by the statement. (See the paragraphs above, however, regarding enrollment in the event of marriage, birth, adoption, placement for adoption, loss of eligibility for Medicaid or a state CHIP, and gaining eligibility for a state premium assistance subsidy through Medicaid or a state CHIP. **You may have other options available to you when you lose group health coverage.** For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

To request special enrollment or obtain more information, contact Human Resources at (602) 200-8500.

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

Model General Notice of COBRA Continuation Coverage Rights

The Department of Labor has developed a model Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) continuation coverage general notice that plans may use to provide the general notice. To use this model general notice properly, the Plan Administrator must fill in the blanks with the appropriate plan information. The Department considers use of the model general notice, to be good faith compliance with the general notice content requirements of COBRA. The use of the model notices isn't required. The model notices are provided to help facilitate compliance with the applicable notice requirements.

For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator at (602) 200-8500.

Notice of CBR Management Services, Inc. Health Information Privacy Practices

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

The effective date of this Notice of **CBR Management Services, Inc.** Health Information Privacy Practices (the "Notice") is, revised as of January 1, 2023.

CBR Management Services, Inc. (the "Plan") provides health benefits to eligible employees of **CBR Management Services, Inc.** (the "Company") and their eligible dependents as described in the summary plan description(s) for the Plan. The Plan creates, receives, uses, maintains and discloses health information about participating employees and dependents in the course of providing these health benefits.

For ease of reference, in the remainder of this Notice, the words "you," "your," and "yours" refers to any individual with respect to whom the Plan receives, creates or maintains Protected Health Information, including employees and COBRA qualified beneficiaries, if any, and their respective dependents.

The Plan is required by law to take reasonable steps to protect your Protected Health Information from inappropriate use or disclosure.

Your "Protected Health Information" (PHI) is information about your past, present, or future physical or mental health condition, the provision of health care to you, or the past, present, or future payment for health care provided to you, but only if the information identifies you or there is a reasonable basis to believe that the information could be used to identify you. Protected health information includes in reasonable basis to believe that the information could be used formation of a person living or deceased (for a period of fifty years after the death.)

The Plan is required by law to provide notice to you of the Plan's duties and privacy practices with respect to your PHI, and is doing so through this Notice. This Notice describes the different ways in which the Plan uses and discloses PHI. It is not feasible in this Notice to describe in detail all of the specific uses and disclosures the Plan may make of PHI, so this Notice describes all of the categories of uses and disclosures of PHI that the Plan may make and, for most of those categories, gives examples of those uses and disclosures.

The Plan is required to abide by the terms of this Notice until it is replaced. The Plan may change its privacy practices at any time and, if any such change requires a change to the terms of this Notice, the Plan will revise and re-distribute this Notice according to the Plan's distribution process. Accordingly, the Plan can change the terms of this Notice at any time. The Plan has the right to make any such change effective for all of your PHI that the Plan creates, receives or maintains, even if the Plan received or created that PHI before the effective date of the change.

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

Mental Health Parity Act

The 2009 Wellstone Act added to the requirements of the 1996 Mental Health Parity Act (MHPA). The new act has extended parity requirements to substance use disorder benefits in addition to mental health benefits. It prohibits applying financial requirements (e.g., copayments and deductibles) or treatment limitations (i.e., annual limits on outpatient visits or hospital days) to mental health or substance use disorders unless those requirements and limitations are no more restrictive than those that apply to most medical and surgical benefits. The act also maintained the MHPA's ban on lower annual or lifetime dollar limits for mental health benefits.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2022. Contact your State for more information on eligibility –

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://myalhipp.com/ Phone: 1 (855) 692-5447	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: (916) 445-8322 Fax: (916) 440-5676 Email: hipp@dhcs.ca.gov
ALASKA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment ProgramWebsite: http://myakhipp.com/ Phone: 1 (866) 251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: Phone: 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
ARKANSAS – Medicaid	**FLORIDA – Medicaid**
Website: http://myarhipp.com/ Phone: 1 (855) MyARHIPP (855) 692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1 (877) 357-3268

GEORGIA – Medicaid	MINNESOTA - 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	Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp 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
INDIANA - Medicaid	**MISSOURI – 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	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: (573) 751-2005
IOWA – Medicaid and CHIP (Hawki)	**MONTANA – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/membersMedicaid Phone: 1 (800) 338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1 (800) 257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1 (888) 346-9562	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1 (800) 694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1 (800) 792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1 (855) 632-7633Lincoln: (402) 473-7000 / Omaha: (402) 595-1178
KENTUCKY – Medicaid	**NEVADA – 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	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1 (800) 992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – 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)	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
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
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: 1 (800) 977-6740. TTY: Maine relay 711	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
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1 (800) 862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1 (800) 541-2831

NORTH CAROLINA – Medicaid	TEXAS – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: (919) 855-4100	Website: http://gethipptexas.com/ Phone: 1 (800) 440-0493
NORTH DAKOTA – Medicaid	**UTAH – Medicaid and CHIP**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1 (844) 854-4825	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1 (877) 543-7669
OKLAHOMA – Medicaid and CHIP	**VERMONT– Medicaid**
Website: http://www.insureoklahoma.org Phone: 1 (888) 365-3742	Website: http://www.greenmountaincare.org/ Phone: 1 (800) 250-8427
OREGON – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1 (800) 699-9075	Websites: 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
PENNSYLVANIA – Medicaid	**WASHINGTON – Medicaid**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1 (800) 692-7462	Website: https://www.hca.wa.gov/ Phone: 1 (800) 562-3022
RHODE ISLAND – Medicaid and CHIP	**WEST VIRGINIA – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1 (855) 697-4347, or (401) 462-0311 (Direct RIte Share Line)	Website: http://mywvhipp.com/ Toll-free phone: 1 (855) MyWVHIPP [1 (855) 699-8447]
SOUTH CAROLINA – Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: https://www.scdhhs.gov Phone: 1 (888) 549-0820	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1 (800) 362-3002
SOUTH DAKOTA - Medicaid	**WYOMING – Medicaid**
Website: http://dss.sd.gov Phone: 1 (888) 828-0059	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1 (800) 251-1269

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

Paperwork Reduction Act Statement

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

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.

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 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?

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.

Important Notice from CBR Management Services, Inc.
About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with BlueCross BlueShield of Arizona (BCBSAZ) and about your options under Medicare's prescription drug coverage. This information can help you decide whether 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. CBR Management Services, Inc. has determined that the prescription drug coverage offered by the BCBSAZ Medical Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing 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 15 to December 7.

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 BCBSAZ coverage will not be affected.

BCBSAZ Prescription Drug Coverage

Retail-30-day supply	
Generic (2 tiers)	$10 Copay
Preferred Brand	$35 Copay
Non-Preferred Brand	$60 or $120 Copay

If you do decide to join a Medicare drug plan and drop your current BCBSAZ coverage, be aware that you and your dependents will be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with BCBSAZ 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) if you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through CBR Management Services, Inc. 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 you have maintained creditable coverage and, therefore, whether you are required to pay a higher premium (a penalty).

Date:	January 1, 2023
Name of Entity/Sender:	Creative Business Solutions
Contact--Position/Office:	Human Resource Specialist
Address:	1500 E Bethany Home Rd, Suite 200 Phoenix, AZ 85014
Phone Number:	(602) 200-8500

WHO TO CONTACT

It is highly encouraged that you call the carriers directly with personal health information, claims or network questions. They may be able to answer your question or assist with one call. Remember they have access to your plan, records and claims.

PLAN	WHO TO CALL	WEB ADDRESS/EMAIL	PHONE NUMBER
Medical	BlueCross BlueShield	https://www.azblue.com	(866) 422-2729
Telemedicine	BlueCare Anywhere	https://BlueCareAnywhereAZ.com	(866) 422-2729
Dental	Delta Dental	https://www.deltadentalaz.com/	(800) 352-3162
Dental	Delta DHMO	https://www1.deltadentalins.com/members.html	(800)422-4234
Vision	EyeMed	https://www.deltadentalaz.com/	(800) 352-3162
Vision	VSP	https://www.vsp.com/	(855) 492-9028
Flexible Spending Account	Discovery Benefits	customerservice@wexhealth.com	(866) 451-3399
Life, AD&D & Disability	MetLife	https://www.metlife.com/	(800) 438-6388
Worksite	AFLAC	Contact CBR	(602) 200-8500
Human Resource Team	General Number	hr@cbri.com	(602) 200-8500
Agency	Leticia Reynoso Kelly Raith	lreynoso@cbri.com kraith@cbri.com	(623) 688-3934 (602) 904-7580

This guide describes the benefit plans available to you as an employee of CBR MANAGEMENT SERVICES, INC. The details of these plans are contained in the official Plan Documents, including some insurance contracts. This guide is meant only to cover the major points of each plan. It does not contain all the details that are included in your Summary Plan Description (SPD) (as described by the Employee Retirement Income Security Act). If there is ever a question about one of these plans, or if there is a conflict between the information in this guide and the formal language of the Plan documents, the formal wording in the Plan Documents will govern. Please note that the benefits described in this guide may be changed at any time and do not represent a contractual obligation on the part of your employer.