ARENA
SKILLED TRADE SOLUTIONS

BENEFIT GUIDE

2022-23

Improving Your Quality of Life

TAC Benefits Group
Challenge the status quo.

What's Inside

Have a question about benefits?

The Loomis Company 866-410-7248

If you have questions about your benefits? The Loomis Company is available to help you. We are open Monday through Friday, 8:00 a.m. to 8:00 p.m. (Eastern Time). All calls are confidential.

Enrollment Center -The Loomis Company 866-410-7248

Welcome To Your Benefits!

Arena Skilled Trade Solutions is committed to providing you with valuable benefits and opportunities. To reward you for your hard work and dedication, we continually look for ways to enhance your overall compensation package. We are pleased to offer generous benefits and valuable health and wellness resources at competitive rates.

We invite you to take a close look at the information provided in this guide to learn more about the benefit programs offered to you. Taking the time to research your options now will help you choose the plans that best meet your family's needs now and in the future.

Plan Eligibility and Waiving Coverage

All part-time and full-time employees are eligible for MEC benefits on the first day of the payroll period following 60 days from the date of hire. If you are **newly hired** you will be automatically enrolled in individual coverage for Minimum Essential Coverage (MEC).

You may call the Loomis Enrollment Call Center at 866-410-7248 to waive coverage within 60 days of your hire date without payroll deductions from your paycheck.

Once 60 days have passed, your payroll deductions will begin. You still have the opportunity to waive coverage, but no more than 90 days from the date of hire.

Due to the Affordable Care Act (ACA), you must take action if you are waiving healthcare coverage. If you do not wish to have the benefits, you must waive coverage by calling The Loomis Enrollment Center within 90 days of your date of hire.

Need Benefits Info?
Call The Loomis Company 866-410-7248

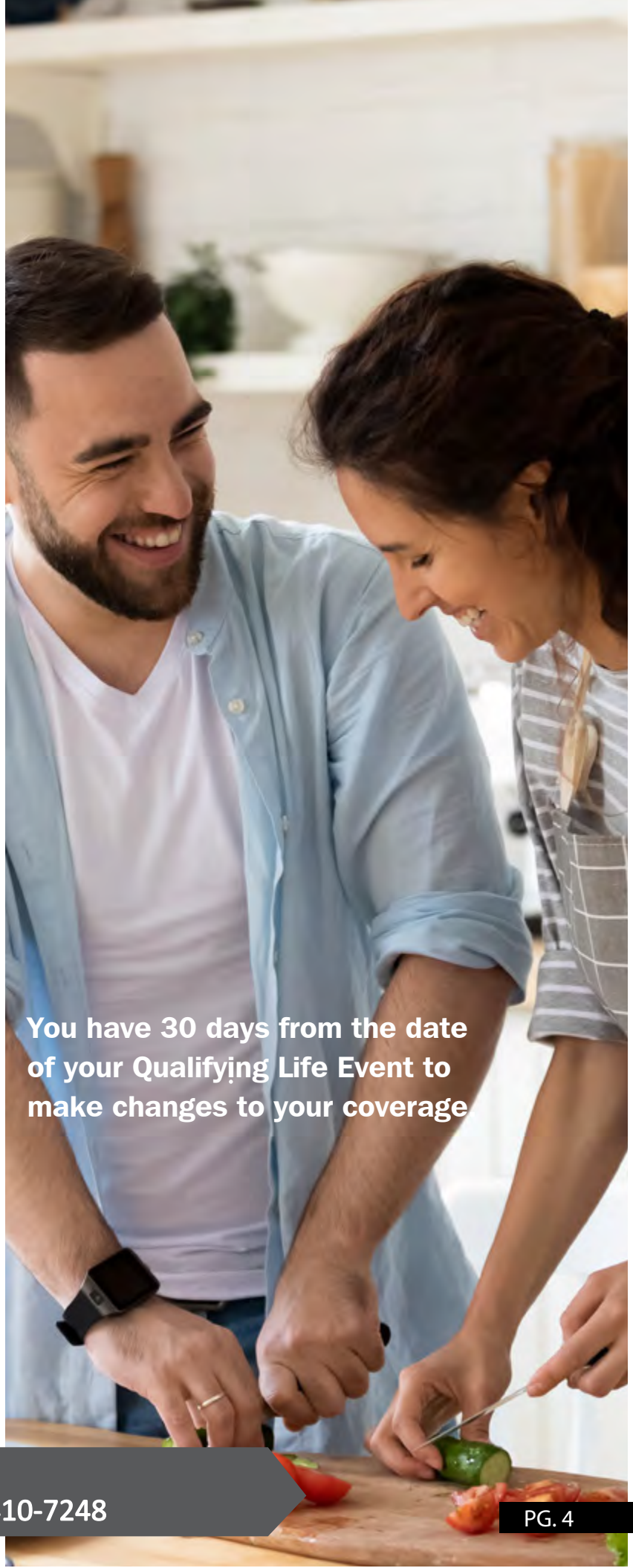
Making Changes

You will have a total of 90 days from the date of hire to waive, add dependents, or purchase additional coverage. After 90 days from your hire date, you will no longer be able to drop the plan or make changes, and you will be enrolled for the plan year, unless you experience a qualifying life event, as defined by the IRS below.

Qualified Life Events

The choices you make when you are first eligible are in effect until ***August 31, 2023*** . Once you enroll in coverage, you must wait until the next Open Enrollment to change your benefits or add or remove coverage for dependents, unless you experience a Qualified Life Event as defined the IRS.

- Marriage, divorce, or legal separation
- Birth or adoption of an eligible child
- Death of a spouse or dependent
- Change in your spouse or domestic partner's work status that affects their benefits
- Change in your work status that affects your benefits
- Change in residence or worksite that affects your eligibility for coverage
- Change in your child's eligibility for benefits or receiving a qualified medical child support order



Keep in mind: Any change you make to your coverage must be consistent with the change in status. If you fail to notify The Loomis Company or Arena Skilled Trade Solutions of a Qualifying Life Event within 30 days, you will not be allowed to make changes until the next Open Enrollment period in August 2023.

Need Benefits Info?
Call The Loomis Company 866-410-7248

Minimum Essential Coverage (MEC)

We are committed to helping your family maintain good health. To that end, we are offering Minimum Essential Coverage (MEC) to eligible employees. The MEC Plan will cover 100% of the 64 Preventive services mandated by the Center for Medicare & Medicaid Services. **The plan covers preventive services only.**

Covered Benefits	MEC
Deductible (single/family)	$0/$0
Coinsurance	100%
Out-of-Pocket Maximum (single/family)	$0/$0
ACA Required Preventative Care/ Screening/Immunization Benefits (MEC)	100% Covered
MEC Weekly Rates	
Employee Only	$12.69
Employee + Spouse	$15.00
Employee + Child(ren)	$17.31
Employee + Family	$21.92

This plan satisfies the Individual Mandate for maintaining health insurance coverage in the following states:

New Jersey

Rhode Island

Washington DC

Vermont

Massachusetts

If you reside in one of these states, you are required to have health insurance or pay a state fine at tax time. This plan is less expensive than the fine, which is approximated to be between $695 and $3012 for a traditional taxpayer. Penalties vary by state.

Need Benefits Info?
Call The Loomis Company 866-410-7248

Preventive Care

The Affordable Care Act requires all plans to cover certain preventive care services.

For Children*

- Autism screening
- Blood pressure screening
- Congenital hypothyroidism screening
- Developmental screening
- Dyslipidemia screening
- Gonorrhea preventative medication
- Hearing screening
- Height, weight and Body Mass Index (BMI) measurements
- Hematocrit or hemaglobin screening
- Hemoglobinopathies or sickle cell screening
- Immunization vaccines
- Iron supplements
- Medical history throughout development
- Oral health risk assessment
- Phenylketonuria (PKU) screening
- Tuberculin
- Alcohol and drug assessments
- Behavioral assessments
- Blood pressure screening
- Cervical dysplasia screening
- Depression screening
- Fluoride chemoprevention supplements
- Height, Weight and Body Mass Index (BMI) measurements
- HIV screening
- Lead screening
- Medical history throughout development
- Obesity screening and counseling
- Sexually Transmitted Infection (STI) prevention counseling
- Tuberculin testing
- Vision screening

*This list includes ACA requirements in affect at the time your group renewal. Additional information can be found at https://www.healthcare.gov/coverage/preventive-care-benefits/

Preventive Care

For Women*

- BRCA counseling
- Breast cancer mammography screening
- Breast cancer chemoprevention counseling
- Breast feeding support and counseling
- Contraception and patient education counseling
- Gestational diabetes screening
- Gestatrional Diabetes: Screening asymptomatic pregnant person at 24 weeks or after
- Hepatitis B screening
- Human Papillomavirus (HPV) DNA testing
- Rh incompatibility screening
- Syphilis screening
- Anemia screening on a routine basis
- Bacteriuria (urinary tract or other urinary infection) screening
- Cervical cancer screening
- Chlamydia infection screening
- Domestic and interpersonal violence counseling
- Folic acid supplements
- Gonorrhea screening
- HIV screening and counseling
- Osteoporosis screening
- Sexually Transmitted Infection (STI) counseling
- Tobacco use screening and interventions
- Well-woman visits

For ALL Adults*

- Abdominal aortic aneurysm screening
- Colorectal cancer screening
- Immunization vaccines
- Alcohol misuse screening and counseling
- Aspirin use
- Cholesterol screening
- Lung cancer screening recommendation
- HIV Preexposure Prophylaxis
- Depression screening
- Type 2 diabetes screening
- Prediabetes & Type 2: asymptomatic adults 35-70 yrs who are overweight or obesity
- Diet counseling
- HIV screening
- Obesity screening and counseling
- Sexually Transmitted Infection (STI) prevention counseling
- Syphilis screening
- Tobacco use screening

*This list includes ACA requirements in affect at the time your group renewal. Additional information can be found at https://www.healthcare.gov/coverage/preventive-care-benefits/

MEC Enhanced

The Loomis Company - PHCS Network			
Medical	**Network Providers**	**Non-Network Providers**	**Lifetime Max: None**
Annual Deductibles Does not include Co-pays. In-network and Out-of-network are separate accumulations and do not cross apply	Individual: None Family: None	No Coverage	
Annual Co-pay and Co-Insurance Out of Pocket Maximums (Medical and Rx Co-pays apply to the annual out of pocket maximums)	Individual $2,500 Family $13,200	N/A	
Office Visits - Primary Care (exam or consultation)	$15 Co-pay, Plan pays 100%	No Coverage	Limited to Office Visit Charge
Office Visits - Specialist (exam or consultation)	$25 Co-pay, Plan pays 100%	No Coverage	
Diagnostic Services - Basic labs (related to office visit, LabCorp, etc.)	$50 Co-pay, Plan pays 100%	No Coverage	Limited to $500 per calendar year
Diagnostic Services - X-rays only	$50 Co-pay, Plan pays 100%	No Coverage	Limited to $500 per calendar year
Diagnostic Services. Major (MRI, CT, PET, Nuclear Medicine.etc.)	$400 Co-pay, Plan pays 100% of allowed amount	No Coverage	Limited to $1,000 per calendar year
Emergency Room Facilities	$400 Co-pay, Plan pays 100% of allowed amount		Limited to $4,000 per calendar year. Life threatening conditions Only
Emergency Room • All covered servlces other than facility charges			Physicians Benefits covered limited to $1500 per calendar year.
Urgent Care Center & 24 Hour Clinic	$100 Co-pay, Plan pays 100%	No coverage	Limited to $4,000 per calendar year.
Prescription	**In Network Only**		
Generic	$15 Co-pay		Max Benefit of $100 Per Script
Formulary	$25 Co-pay		Max Benefit of $300 Per Script
Non-Formulary	$75 Co-pay		Max Benefit of $500 Per Script
Specialty and Injectables	No Coverage		
Weekly Payroll Deduction			
Employee Only	$ 43.23		
Employee & Spouse	$ 77.65		
Employee & Children	$ 76.12		
Family	$111.18		

Specialty Rx and Compound drugs are excluded from coverage under the MEC Plus.

The Loomis Company

LOOMIS
THE LOOMIS COMPANY

About the Loomis Company

- Founded in 1955
- SOC-1, SOC-2 with HIGHTRUST Mapping
- Licensed in all 50 states and Puerto Rico
- Offices in Pennsylvania, Maryland, Florida, New York, and Nevada

Member Experience

- Toll-free 800 number along with dedicated Loomis service team
- Skill-based call routing
- Call recording- inbound & outbound
- Call & document tracking

Claims Processing Overview: Best-in-Class Workflow Procedures

- All claims tracked and managed through our system digitally
- Claims pass through 300+ edits to assure data integrity
- Automated work distribution module equals real-time inventory management
- Ability to integrate self-funded and fully insured programs through our one-card technology solution

Dedicated Service Team

- Customer Service
- Claims Processing
- Billing
- Call Center
- Account Management
- Project Management
- Case Installations
- Enrollment

My Loomis Mobile App 24/7 Access

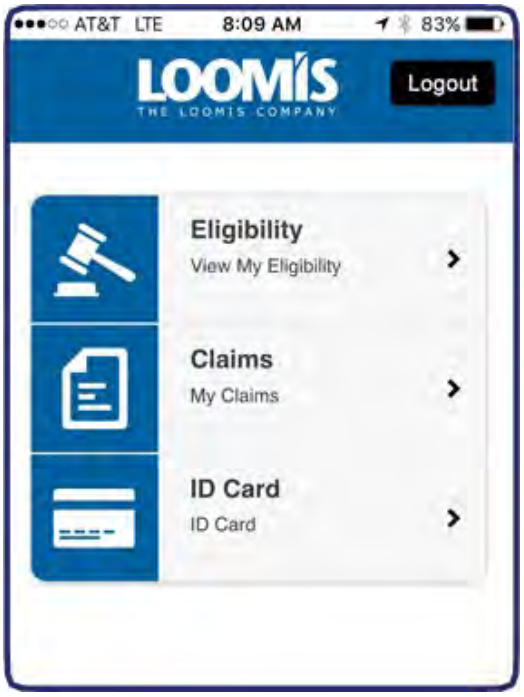
- View Eligibility & Claims
- View & Email ID Cards
- Update Access Rights
- View Accumulators
- Search for Providers
- Contact Customer Service
- Single Sign-on with Key Vendor Partners such as PBM

My Loomis Mobile App

The Loomis mobile benefit application is available to you and as a member, you can access your information 24/7!

The Loomis Mobile App is versatile and can help you keep track of important information:

- View Eligibility
- View Claims
- View and Email current ID Card
- Provider search engines
- Eligibility, coverage status of claims, and copies of EOBs
- Request ID cards
- Download claim forms
- Rx vendor Internet services
- Research health-related issues



Minimum Value Plan - BASIC PLAN

This plan asserts the MVP medical plan qualifies as having minimum essential coverage and meets the affordability provision per ACA regulations. As a foundation for good health, you have access to Innovative Health Plan (IHP) medical plan. IHP offers the PHCS/Multiplan network of providers. Find a network provider at www.multiplan.us.

	MVP BASIC
NETWORK	PHCS / Multiplan and Referenced Based Pricing
Deductible (Indv/Fam)	$0 / $0
Maximum Out of Pockete (Indv/Fam)	$7,350 / $14,700
Preventative & Wellness (Non-Hospital Based)	Included
PCP Visits	$25 Copay (8 visits per plan year)
Specialist Visit	$50 Copay (8 visits per plan year)
Urgent Care Visits	$ 50 Copay (2 visits per plan year)
Telemedicine with Telehealth	$0 Copay (unlimited)
Laboratory & Radiology Services (Non-Hospital Based)	$50 Copay (3 visits per plan year)
CT / MRI / MRA / PET Scan (Non-Hospital Based (Prior Auth Req'd, Subject to Reference Based Pricing)	$350 Copay (1 per plan year)
Emergeny Room	$350 Copay (1 per plan year)
Inpatient Hospitalization (Prior Auth Req'd)	$350 Copay (5 days per plan year)
Inpatient Surgery (Prior Auth Req'd, 2nd option may be Req'd)	Included in IP Hospitalization Copay (2 surgeries per plan year)
Outpatient Hospital or Fee-Standing Facility Services & Surgery (Prior Auth Req'd)	$350 Copay (1 visit per plan year)
Anesthesthia	Included in IP, OP or FSF Services & Surgery (2 IP & 1 OP per plan year)
Ambulance (ground only)	$250 Copay (1 per plan year)
Pregnancy Professional Services	No coverage
Maternity / Childbirth / Delivery (Considered IP & subject to reference based pricing)	No coverage
Pharmacy	$0 Preventative Generic $10 Copay Generic Coverage Only
Discounted Pharmacy with Mail Order	Yes

The plan can charge you no more than 9.61% of your household income for the cost of Employee Only coverage of the Basic Plan. The plan utilizes the Federal Poverty Level Safe Harbor, as outlined by the IRS.

Your Cost for Health Coverage

Your per paycheck payroll deductions for medical.

Benefit Costs	Employee Only	Employee + Spouse/ Domestic Partner	Employee + Child(ren)	Employee + Family
MVP Plan Weekly	$ 88.86	$ 142.04	$ 125.47	$ 178.66

Required Notices

The Health Care Reform Law, officially known as the Patient Protection and Affordable Care Act (PPACA), was signed by President Obama in March 2010. The law is intended to expand access to affordable quality health care for Americans and will be implemented over a 10-year period. Several major provisions, or rules of the law, took effect in 2014. Some things may affect you and your family while others may not.

The Individual Mandate

The Individual Mandate was repealed on a federal level, but several states have enacted their own Individual Mandate. Citizens and legal residents of these states, with a few exceptions, are required to have "minimum essential coverage." Individuals who do not have minimum essential coverage will pay a tax. Coverage under your employer's medical plan will satisfy this requirement. Other types of coverage that meet the Individual Mandate include plans provided by another employer, Medicare, Medicaid or individual health insurance.

The Exchange Marketplace

You may have heard about the Health Insurance Marketplace or Exchange, as it is also sometimes called, that opened in Fall 2013. The Marketplace allows people to compare and purchase standard health insurance plans that comply with the new law. Federal subsidies are available to assist some qualified individuals in paying the premium for health insurance purchased through the new Health Insurance Marketplace.

Eligibility for a subsidy is based on income. However, individuals who are eligible for employer coverage that is "affordable" and provides "minimum value" are NOT eligible for the subsidy. If you purchase a health plan through the Marketplace instead of accepting coverage offered by your employer, then you will lose the employer contribution toward the cost of your premium. Also, an employer contribution – as well as your employee contribution to employer-sponsored coverage – is often excluded from income for Federal and State income tax purposes. Payment for coverage through the Marketplace is made on an after-tax basis.

COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employers who provide medical coverage to their employees to offer such coverage to employees and covered family members on a temporary basis when there has been a change in circumstances that would otherwise result in a loss of such coverage (26 USC §4980B). This benefit, known as "continuation coverage," applies in the event that, for example, a dependent child becomes independent, a spouse gets divorced, or an employee leaves the employer.

HIPAA

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

Special Enrollment Rights

If you have previously declined enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may, in the future, be able to enroll yourself or your dependent(s) in this plan, provided that you request enrollment within 30 days after your other coverage ends. 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, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption takes place.

Children's Health Insurance Program (CHIP)

If you are eligible for health coverage, but are unable to pay the premiums, some states offer premium assistance programs that can help pay for coverage. This legislation requires your employer to notify you that potential CHIP opportunities for premium assistance may exist in your resident state. To find out if your state offers CHIP premium assistance, please call 1-866-444-3272.

Women's Health and Cancer Rights Act of 1998 (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the 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 may apply. If you would like more information on WHCRA benefits, call your plan administrator.

Important Notice From Arena Skilled Trade Solutions About Your Minimal Essential Health Coverage (MEC and MEC Enhanced) 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 Arena Skilled Trade Solutions to 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three 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. Arena Skilled Trade Solutions has determined that the prescription drug coverage offered by the Arena Skilled Trade Solutions plan is, on average for all plan participants, **NOT** expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the [Insert Name of Plan]. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.

3. You can keep your current coverage from Arena Skilled Trade Solutions. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully
   - it explains your options.

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 through December 7th.

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

Since the coverage under Arena Skilled Trade Solutions plan is not 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 **Arena Skilled Trade Solutions** 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; for those individuals who elect Part D coverage.

If you do decide to join a Medicare drug plan and drop your **Arena Skilled Trade Solutions** plan coverage, be aware that you and your dependents will not be able to get this coverage back.

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 **Arena Skilled Trade Solutions** plan changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

Date:	**August 1, 2022**
Name of Entity/Sender:	**Arena Skilled Trade Solutions**
Contact:	**Human Resources**
Address:	**2910 Inland Empire Blvd, STE 100** **Ontario, CA 91764**
Phone Number:	**909-342-1244**

Important Notice from Arena Skilled Trade Solutions About Your Minimum Value Plan (MVP) 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 and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Arena Skilled Trade Solutions has determined that the prescription drug coverage offered by the Arena Skilled Trade Solutions is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

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

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current **Arena Skilled Trade Solutions** coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current **Arena Skilled Trade Solutions** coverage, be aware that you and your dependents will be able to get this coverage back at any open enrollment.

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 **Arena Skilled Trade Solutions** and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

CMS Form 10182-CC Updated April 1, 2011, According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850

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

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

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through **Arena Skilled Trade Solutions** changes. You also may request a copy of this notice at any
time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.
For more information about Medicare prescription drug coverage:
Visit www.medicare.gov

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

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

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

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

Date:	**August 1, 2022**
Name of Entity/Sender:	**Arena Skilled Trade Solutions**
Contact--Position/Office:	**Human Resources**
Address:	**2910 Inland Empire Blvd, STE 100**
	Ontario, CA 91764
Phone Number:	**909-342-1244**

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

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

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

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

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

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

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

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

For specific information about your state's balance billing laws or requirements, you can visit https://www.commonwealthfund.org/publications/maps-and-interactives/2021/feb/state-balance-billing-protections

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

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

- Your health plan generally must:

    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).

    - Cover emergency services by out-of-network providers.

    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.

    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the applicable contact information for entity responsible for enforcing the federal and/or state balance or surprise billing protection laws.

Contact List

Loomis	www.Loomisco.com	866-410-7248

The Loomis Company Call Center is available to you from 8 AM to 8 PM. Eastern Time. Agents are available to answer your benefits and enrollment questions. Encourage your employees to contact the enrollment call center with any questions. Spanish is available.

Loomis	www.Loomisco.com	866-873-6616

The Loomis Company processes MEC Claims, verifies eligibility, and provides administrative services for our MEC plan participants. Once enrolled, employees or providers can contact The Loomis Company for claims customer service, and to verify benefits and eligibility.

S&S Health	https://secure.healthx.com/ssh.aspx	866-862-6935

S&S Health processes medical claims, verifies eligibility, and provides administrative services for the Basic plan participants. Once enrolled, participants and their providers can call S&S Healthcare for customer service, and to verify benefits and eligibility.

America's Pharmacy Source Prescription Program	www.americaspharmacysource.com/rxhelp	800-376-7593

Prescriptions are processed through America's Pharmacy Source. Please see your Benefit ID Card for complete contact information. Please be sure to give your new ID Card to the pharmacist at your next visit.