Burrito Concepts, LLC

Med-Pay, Inc.
(417) 886-6886 (800) 777-9087
www.med-pay.com

This memo is to inform all employees of the open enrollment period for the Medical and Flexible Spending Account plans. Coverage will become effective January 1, 2018.

1) **New enrollment, enrollment change or declining medical coverage:** Complete the enrollment form if:
   a. you are adding or terminating existing medical coverage for yourself or your dependents. If you are adding dependents to the plan, you must provide documentation (marriage license and birth certificates for the dependents) to prove eligibility.
   b. you are currently not covered and are continuing to decline coverage. You must complete and sign the enrollment form.

   You do not need to do anything if you are maintaining the same coverage for you and your covered dependents.

2) **Flexible Spending Account Plans:**
   a. You are **NOT** automatically re-enrolled in the FSA plan. You **must complete** a new enrollment form each year in order to participate. The following options are available for election:
      i. Unreimbursed Healthcare Expenses (medical, dental, vision, RX and over-the-counter) up to $2,650. You may elect auto-processing of medical and/or prescription out-of-pocket responsibility on the form. Up to $500 of unclaimed funds can roll-over into the 2018 plan year. These funds will be available for the entire 2018 plan year and is in addition to the election made for next year. Same for subsequent years' elections.
      ii. Dependent Care Assistance Plan (daycare) up to $5,000 (see enrollment form for details). Must incur expenses by 12/31.
   b. You may monitor your balances, add direct deposit information and file claims on the employee portal: https://hrbenefitsdirect.com/med-pay. Watch for our new portal available in February 2018. Website will be redirected automatically.

3) **Other Health Insurance form**: If you have a dependent spouse and/or child(ren) enrolled in this plan, you **must** complete the enclosed Other Health Insurance form annually. It may be returned directly to Med-Pay by mail or fax (417-890-0741).

4) **Annual Notices:** These are required notices related to your coverage under this Plan.

5) **Summary Schedule of Benefits:** The enclosed Summary provides coverage at a glance. This includes changes to the deductible, coinsurance, certain RX copays and total out-of-pocket effective January 1, 2018.

6) **Summary of Benefits and Coverage:** The enclosed document provides the PPACA-required summary of the benefits of this Plan.

7) Med-Pay provides **on-line access to your medical claims history** via www.Med-Pay.com. You must first contact Med-Pay's Customer Service to receive your log-in information. (417) 886-6886 or (800) 777-9087. Once you have this information, click on the "EOB log-in" tab. In addition to your claims history, you can request a new ID card and access forms to print/mail or complete and submit on-line. Helpful Hints, Claims Filing Instructions and Frequently Asked Questions are also available.

Sincerely,

Burrito Concepts Human Resource department and Med-Pay's Customer Service department

Tier of Coverage	Premium per Pay Period
Employee Only	$99
Employee + Spouse	$200
Employee + Child(ren)	$182
Family	$278

Burrito Concepts -- Annual Notices

Women's Health and Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights act of 1998, benefits under the Policy are provided for mastectomy, including reconstruction and surgery to achieve symmetry between the breast, prostheses, and complications resulting from a mastectomy (including lymphendema). If you are receiving benefits in connection with a mastectomy, benefits are also provided for the following covered health services, as you determine appropriate with your attending Physician: 1) All stages of reconstruction of the breast on which the mastectomy was performed ; 2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and 3) Prostheses and treatment of physical complications of the mastectomy, including lymphendema.

The amount you must pay for such covered health services (including copayments and any annual deductible) are the same as are required for any other covered health service. Limitations on benefits are the same as for any other covered health service.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

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

Continuation of Benefits (COBRA)

Upon termination of employment for reasons other than gross misconduct, continuation of an employee's medical, dental and vision coverage – and/or any insured dependent's coverage - is available for up to 18 months under COBRA (Consolidated Omnibus Budget Reconciliation Act), with the employee assuming all premium costs. If the employee is disabled, COBRA eligibility is increased to 29 months. The terminating employee will receive personalized information concerning COBRA continuation procedures. Continuation of coverage is also available for "qualified beneficiaries" up to 36 months when one of the following qualifying events occurs: Death of a covered employee; Divorce or legal separation; Employee becomes eligible for Medicare; or Dependent child reaches maximum age allowed under group plan

Please note: It is the responsibility of you, the employee, or qualified beneficiary to notify your HR Department of qualifying events, such as divorce, legal separation or dependent child reaching the maximum allowable age to remain on your benefit plans so that COBRA notification can be sent.

Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Policy

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") imposes upon this Plan and certain other entities various responsibilities to ensure that protected health information (PHI) pertaining to participants remains confidential, subject to limited exceptions in which PHI may be disclosed. This notice is available in the health care plan booklet or a full copy of the policy may be obtained by contacting the HIPAA Privacy Officer.

Medicaid and the Children's Health Insurance Program ("CHIP")

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums. If you or your dependents are already enrolled in Medicaid or CHIP, you can 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, you can 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, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan. Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, you and the qualified dependent are eligible for a Special Enrollment opportunity under this Plan as long as you request coverage within 60 days of being determined eligible for premium assistance. Proper documentation of qualifying for the subsidy must be provided along with the enrollment form if the application is to be accepted.

For more information about any of the above notices, contact Human Resources.

Burrito Concepts, LLC Medical Plan Summary Schedule of Benefits

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Deductible and Medical Copays, per Calendar Year		
Per Covered Person	$5,000	$10,000
Per Family Unit	$10,000	$20,000
Maximum Coinsurance, per Calendar Year	20% after deductible	40% after deductible
Per one Covered Person	$1,000	$4,000
Per Family Unit	$2,000	$8,000
Total Copay (Medical/RX) Out-of-Pocket, per Calendar Year		
Per Covered Person	$1,350	(Network allowance and maximum)
Per Family Unit	$2,700	
Total Out-of-Pocket, per Calendar Year		
Per Covered Person	$7,350	$15,350
Per Family Unit	$14,700	$30,700
The Plan will pay its percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year, unless stated otherwise.		
COPAYMENTS (Copay applies only to visit charge. All other services are regular benefits. Emergency room care is all inclusive for copay.)		
Primary Care Physician office visit charge	$25	N/A
Specialist office visit charge	$70	N/A
Urgent Care visit charge	$100	N/A
Emergency Room	$300	$300

COVERED CHARGES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Diagnostic Testing: (Labs, X-rays & Imaging at the following locations)		
Diagnostic testing related to:		
-Physician's Office	80% after deductible	60% after deductible
-Radiologists and Pathologists	80% after deductible	60% after deductible
-Outpatient/independent x-rays and labs, includes Pre-Admission Testing	80% after deductible	60% after deductible
-Outpatient nuclear medicine x-rays	80% after deductible	60% after deductible
-Inpatient x-rays and labs	80% after deductible	60% after deductible
Hospital Services - Inpatient and Outpatient	80% after deductible	60% after deductible
- Emergency Room Services	$300 copayment	$300 copayment
Precertification penalty of $500 applies of any portion of the inpatient stay is not precertified with Med-Pay/MPI Care (see ID card).		
Physician Services		
Physician office visit charge only	$25 or $70 copayment	60% after deductible
Urgent Care visit charge only	$100 copayment	60% after deductible
Physician visits while inpatient	80% after deductible	60% after deductible
Allergy shots and testing	$25 copayment	60% after deductible
All other services	80% after deductible	60% after deductible
Preventive Care		
Routine Well Adult Care	100%, deductible waived	60% after deductible
Routine Well Child Care	100% deductible waived	60% after deductible 100%, deductible waived for immunizations for children up to age 5.
Spinal Manipulation/Chiropractic	50% after deductible	50% after deductible

Prescription Benefits	NETWORK PHARMACIES
Oral Contraceptives	$0 copayment
Generic drugs	$15 copayment
Preferred Brand drugs	$45 copayment
Non-Preferred Brand drugs	$75 copayment
Specialty drugs (Only thru Specialty Pharmacy)	25% copayment up to $300

Generic Incentive: Covered Expenses will be limited to the cost of a Generic drug if a Generic drug is available. However, the brand name drug will be considered a covered expense if a Generic drug is not available, or if the Physician writes "DAW" (dispense as written) on the prescription. If not, then in addition to the copayment, the Covered Person must pay the difference between the cost of the Generic drug and the Brand Name drug.
Prior authorization is required for any prescription over specified dollar limits.