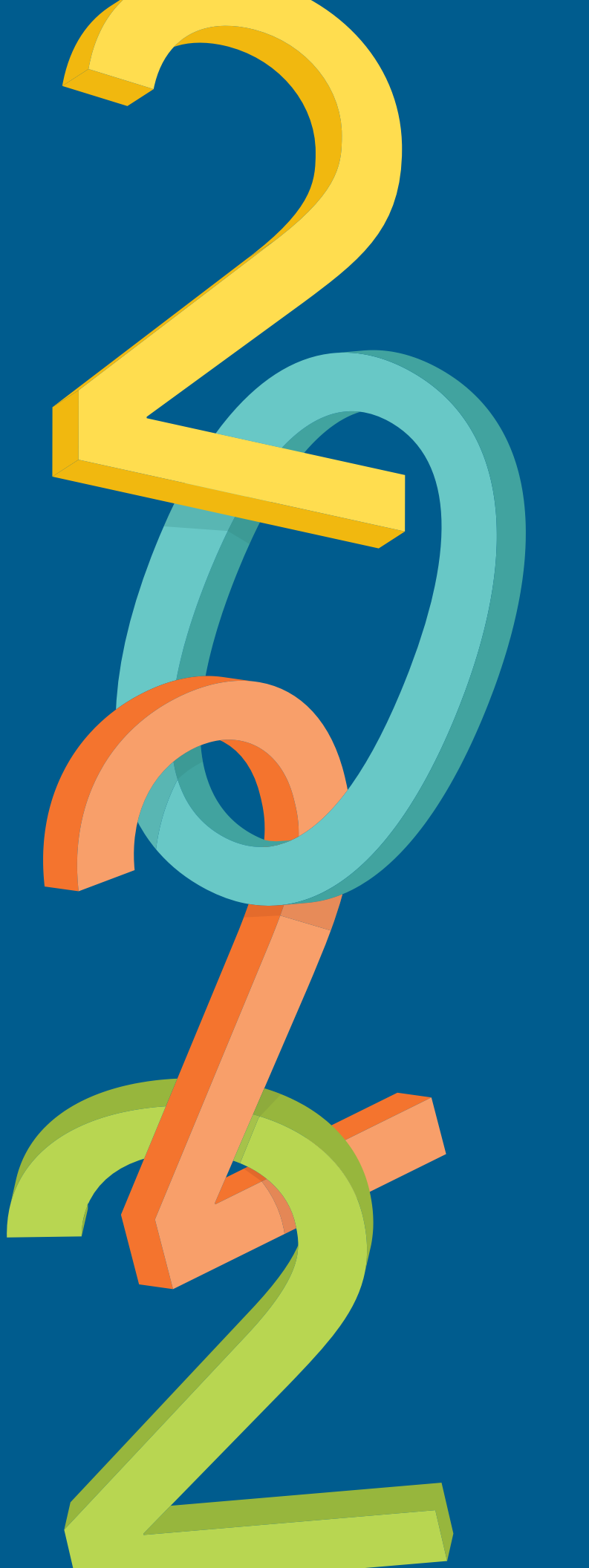
Globe Life

2022 Employee Benefits Guide



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See page 29 for important information concerning Medicare Part D coverage.

In this Guide, we use the term Company to refer to Globe Life. This Guide is intended to describe the eligibility requirements, enrollment procedures and coverage effective dates for the benefits offered by the Company. It is not a legal plan document and does not imply a guarantee of employment or a continuation of benefits. While this Guide is a tool to answer most of your questions, full details of the plans are contained in the Summary Plan Descriptions (SPDs), which govern each plan's operation. Whenever an interpretation of a plan benefit is necessary, the actual plan documents will be used.

Eligibility & Enrollment

At Globe Life, we are committed to your health and well-being. We are proud to provide you and your family with valuable and significant benefits. This Guide is an overview of the benefits available to you and their impact on your compensation as a whole. Please read it carefully in order to make the best choices for you and your family in the 2022 Plan Year.

You and your family have unique needs, which is why Globe Life offers a variety of benefit plans from which you may choose. Consider your spouse's benefits through his or her place of employment and your dependents' eligibility when weighing each option.

Who is Eligible to Enroll?

If you are a full-time employee or a part-time employee of Globe Life who averaged 30+ hours per week between the time period of October 1, 2020 to September 30, 2021, you are eligible to participate in the Medical, Dental and Vision plans, along with the Flexible Spending Accounts (FSAs) and additional benefits. Eligible part-time employees will be notified by HR of their eligibility.

When Does Coverage Begin?

The elections you make during the annual open enrollment period will be effective January 1, 2022. Due to IRS regulations, once you have made your choices for the 2022 Plan Year, you won't be able change your benefits until the next enrollment period unless you experience a Qualifying Life Event.

Eligible Dependents

Dependents eligible for coverage in the Globe Life benefit plans include:

- Your legal spouse. For specific restrictions on eligibility requirements for employed spouses, please refer to the summary plan descriptions.
- Children up to age 26 on the Medical, Dental and Vision plans (includes birth children, stepchildren, legally adopted children, children placed for adoption, foster children, and children for whom legal guardianship has been awarded to you or your spouse).
- Dependent children, regardless of age, provided he or she is incapable of self-support due to a mental or physical disability, is fully dependent on you for support as indicated on your federal tax return, and is approved by your Medical Plan to continue coverage past age 26.

Verification of dependent eligibility will be required upon enrollment and is subject to audit at any time.

Working Spouse Surcharge

Working spouses of Globe Life employees are encouraged to first look to their employers' offerings when making benefit elections. If your working spouse has access to medical coverage through his/her employer and you enroll your spouse in one of the Globe Life medical plans, a spousal surcharge of $75 bi-weekly ($37.50 weekly) per paycheck will apply.

If your spouse does not work, works only part time, is not eligible for coverage or has lost coverage as an active employee, but has been offered COBRA, the spousal surcharge will not apply.

If your spouse is covered by Medicare, the surcharge does not apply. If your spouse experiences a Qualifying Life Event (loss of job, etc.) during the year, he or she can be added to your Globe Life coverage within 31 days of the Qualifying Life Event.

Note: The Company reserves the right to verify whether or not your spouse is provided coverage elsewhere. We expect this information to be consistent with the information you reported during Annual Enrollment. Misrepresenting whether your spouse has access to Medical coverage outside of Globe Life may result in disciplinary action up to and including termination.

Tobacco Surcharge

Your health plan is committed to helping you achieve your best health. The Globe Life plan includes a Tobacco/Nicotine Surcharge if you use tobacco and/or nicotine products (including e-cigarettes). A $75 bi-weekly ($37.50 weekly) per pay period surcharge applies to each employee who does not meet the tobacco free requirement and is in addition to the regular bi-weekly or weekly medical premium. You may be eligible to avoid the surcharge by different means. Please contact your HR representative at benefits@globe.life to submit confirmation of completing the designated tobacco cessation program or confirmation of being under a physicians care for tobacco or nicotine use by March 31, 2022.

After open enrollment, you cannot change your benefit selections during the Plan Year unless you have a Qualifying Life Event, such as the birth or adoption of a child.

Things to Consider

Take the following situations into account before you enroll to make sure you have the right coverage.

- Does your spouse have benefits coverage available through another employer?
- Did you get married, divorced or have a baby recently? If so, do you need to add or remove any dependent(s) and/or update your beneficiary designation by contacting HR?
- Did any of your covered children reach their 26th birthday this year? If so, they are no longer eligible for benefits unless they meet specific criteria. Additional details can be found in the Eligible Dependents section of this Guide.

Qualifying Life Events

When one of the following events occurs, you have 31 days from the date of the event to notify Human Resources and/or request changes to your coverage.

- Change in your legal marital status (marriage, divorce or legal separation)
- Change in the number of your dependents (for example, through birth or adoption, or if a child is no longer an eligible dependent)
- Change in your spouse's employment status (resulting in a loss or gain of coverage)
- Change in your employment status from full-time to part-time, or part-time to full-time, resulting in a gain or loss of coverage
- Entitlement to Medicare or Medicaid
- Eligibility for coverage through the Marketplace
- Change in your address or location that may affect the coverage for which you are eligible

You may change your coverage tier but not your plan selection during the Plan Year. Your change in coverage must be consistent with your change in status. Please direct questions regarding specific life events and your ability to request changes to Human Resources.

Preparing to Enroll

Globe Life provides its employees the best coverage possible. As a committed partner in your health, Globe Life will be absorbing a significant amount of the costs. Your share of the contributions for Medical, Dental, Vision, HSA contributions and FSA benefits will be deducted on a pre-tax basis, which lessens your tax liability.

Please note that employee contributions for Medical, Dental and Vision coverage may vary depending on your salary and the level of coverage you select. In general, the more coverage you have, the higher your employee contribution will be.

Keep in mind that you may select any combination of Medical, Dental and/or Vision plan coverage categories. For example, you could select Medical coverage for you and your entire family, but select Dental and Vision coverage only for yourself. The only requirement is that you, as an eligible employee of Globe Life, must elect coverage for yourself in order to elect any coverage for eligible dependents.

Be sure to have the Social Security numbers and birthdates for any eligible dependent(s) that you plan to enroll. You cannot enroll your dependent(s) without this information.

The dates to enroll in or waive all 2022 benefits are: October 25 - November 5, 2021. All employees are required to enroll or waive benefits during the open enrollment period.

You CANNOT change your benefit selections during the plan year unless you have a qualifying life event, such as marriage and/or the birth or adoption of a child.

How to Enroll

You only have a small window of time to make selections that are effective for the entire plan year (unless you have a qualifying life event). Here are some things you should check off your to-do list before you make your selections for Open Enrollment.

1. Understand Your Choices

This Guide contains very useful reference material to help you prepare for Annual Enrollment. Keep it handy so you can refer to it throughout the year.

2. Review Your Options With Your Family

Make sure you include any other individuals who will be affected by your elections in the decision-making process.

3. Open Internet Explorer

Go to glemployeebenefits.com

Click on your company – double check that you are clicking on the correct company. If you are unsure, go to Infor Employee Self-Service/Job Profile to see which company you are employed by.

4. Sign into Infor (Lawson)

5. Click on the 'Profile' icon

6. Go to 2022 Employee Benefits Open Enrollment and follow the steps

7. Once you have finalized your elections, you should 'Print' your confirmation. You will also receive a confirmation email. Please retain these for your records.

If you have questions, please contact your local HR Department.

Medical Benefits

Our Medical coverage helps you maintain your well-being through preventive care and access to an extensive network of providers, as well as affordable prescription medication. Medical benefits are offered through Blue Cross and Blue Shield of Texas. It is up to you to choose the Plan that best matches your needs. Please keep in mind that the option you elect will be in place for all of the 2022 Plan Year, unless you have a Qualifying Life Event.

Medical Premiums

Premium contributions for Medical will be deducted from your paycheck on a pre-tax basis. Your level of coverage will determine your contributions. Refer to the contribution information sheet provided with your enrollment material.

How is my annualized benefit salary computed?

- For non-exempt/hourly employees, the benefit salary consists of all earnings such as personal/sick, vacation, incentive and holiday. The 2022 salary was derived from the last 12 months of earnings as of September 1, 2021.
- For non-exempt/hourly employees who have not earned 12 months of pay, the salary will be calculated by first averaging the per pay period earnings and then multiplied by the number of pays expected in the 12 month period of time. The result is the annualized benefit salary.
- For exempt/salaried and non-exempt/salaried employees, the benefit salary is the current annual salary as of September 1, 2021.

How to Find a Provider

To see a current list of BCBSTX network providers online, go to www.bcbstx.com. If you do not have internet access, please call BCBSTX Customer Care at 800-521-2227 for assistance.

Annual Physical Incentive

- When enrolled in a BCBSTX medical plan, your Annual Preventive Care Physical is covered 100%. As an incentive to you, when you go for your annual physical exam and the claim is processed by BCBSTX and subsequently reported to the Company, you will receive a one-time premium credit of $50 on your paycheck.

Who is eligible to receive the Annual Physical Incentive?

- Employees actively employed and enrolled in a BCBXTX medical plan at the time the incentive is paid.

When must I take my annual physical exam?

- Anytime between January 1, 2022 - December 31, 2022.

When will I receive my one-time $50 premium reduction?

- Approximately 60 days after your exam.

Medical Plan Summary

The chart below gives a summary of the 2022 Medical coverage provided by BCBSTX. All covered services are subject to Medical necessity as determined by the Plan. Please be aware that all out-of-network services are subject to Reasonable and Customary (R&C) limitations.

	PREMIER PPO		HDHP W/HSA		BASIC PPO	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
CALENDAR YEAR DEDUCTIBLE						
INDIVIDUAL	$2,500	$5,500	$2,800	$6,000	$6,500	$15,000
FAMILY	$5,000	$16,500	$5,600	$18,000	$13,000	$30,000
COINSURANCE (PLAN PAYS)	80%*	50%*	80%*	50%*	80%*	50%*
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (MAXIMUM INCLUDES DEDUCTIBLE)						
INDIVIDUAL	$4,000	$10,500	$6,000	$12,000	$8,000	$18,000
FAMILY	$8,000	$31,500	$12,000	$36,000	$16,000	$36,000
LIFETIME MAXIMUM	Unlimited		Unlimited		Unlimited	
COPAYS/COINSURANCE						
PREVENTIVE CARE	100%, no deductible	Not covered	100%, no deductible	Not covered	100%, no deductible	Not covered
MDLIVE GENERAL MEDICINE VIRTUAL VISIT	$10 copay	Not covered	$44 visit	Not covered	$10 copay	Not covered
OFFICE VISIT, PCP/ SPECIALIST	$30/$45 copay	Plan pays 50%*	Plan pays 80%*	Plan pays 50%*	$55/$65 copay	Plan pays 50%*
AIRROSTI PROVIDERS	$30 copay	Plan pays 50%*	Plan pays 90%*	Plan pays 50%*	$55 copay	Plan pays 50%*
URGENT CARE	$45 copay	Plan pays 50%*	Plan pays 80%*	Plan pays 50%*	$65 copay	Plan pays 50%*
EMERGENCY ROOM EMERGENCY CARE	$750 copay, then plan pays 80%*		Plan pays 80%*		$1,000 copay, then plan pays 80%*	
HOSPITAL SERVICES	Plan pays 80%*	Plan pays 50%*	Plan pays 80%*	Plan pays 50%*	Plan pays 80%*	Plan pays 50%*
CHEMOTHERAPY	80%*	Excluded	80%*	Excluded	80%*	Excluded
DIALYSIS	80%*	Excluded	80%*	Excluded	80%*	Excluded
BDC AND BDC+ PROVIDERS	Plan pays 90%*	Not applicable	Plan pays 90%*	Not applicable	Plan pays 90%*	Not applicable

*After Deductible

The individual deductible amount must be satisfied by each member enrolled under your medical coverage. If you have several covered dependents, all charges used to apply toward a "per individual" deductible amount will be applied toward the "per family" deductible amount. When the family deductible amount is reached, no further individual deductibles will have to be satisfied for the remainder of that calendar year. No member may contribute more than the individual deductible amount to the "per family" deductible amount.

Member Rewards & Call Requirement

The Globe Life Member Rewards program now includes a call requirement when you seek any of the following services:

- MRI & CT scans
- Bariatric surgery
- Diagnostic radiology
- Joint replacement
- Musculoskeletal services

Simply call a BVA (Benefit Value Advisor) and inquire about the Member Rewards program to avoid a $100 penalty. You are not obligated to select a more cost effective provider after speaking with the BVA, but if you do, you will also receive a check mailed directly to your home within 4 - 6 weeks. See page 12 for more information.

Save money by seeing in-network physicians and take advantage of free preventive care services offered by your plan.

Health Care Cost Transparency

High Deductible Health Plans (also called Consumer-Driven Health Plans) and tools such as Health Savings Accounts have helped put the power of health care spending in consumers' hands. This means you have control over how your health care dollars are spent. But with the cost of services varying widely even within the same network and geographic area, how can you be sure you're getting the most bang for your health care buck? Enter Health Care Cost Transparency tools. These online tools, which are available through most major health insurance carriers, allow consumers to compare costs for everything from prescription drugs to major surgeries. For more information, call a Benefits Value Advisor at the number on the back of your ID card before your next procedure.

Urgent Care Centers vs. Emergency Rooms

Emergency Rooms and freestanding emergency rooms look a lot like the urgent care centers you are likely used to, but the costs and services can be drastically different. In general, consider an urgent care center as an extension of your primary care physician, while freestanding emergency rooms should be used for health conditions that require a high level of care. Research the options in your area and determine which ones are covered by your insurance plan's network; note that balance billing may apply. Choosing an urgent care center for everyday health concerns rather than an emergency room could save thousands of dollars.

Member Rewards

You have the opportunity to save money and even earn cash for using certain providers and shopping smarter for your health care. Our new Member Rewards program, administered by Sapphire Digital, offers cash rewards when a lower-cost, quality provider is selected from several possibilities. You can locate Member Rewards-eligible providers with the help of your Benefits Value Advisor by calling the number on the back of your ID card or by logging in to Blue Access for Members at bcbstx.com and clicking on the Doctors and Hospitals tab, then on Find a Doctor or Hospital and Shop for Procedures. Choose a Member Rewards-eligible location and you may earn a cash reward.

The Globe Life Member Rewards program now includes a call requirement. In order to avoid a $100 penalty, call your BVA (Benefit Value Advisor) when seeking any of the following services:

- MRI & CT scans
- Bariatric surgery
- Diagnostic radiology
- Joint replacement
- Musculoskeletal services

There are no pricing standards for healthcare so charges for medical services can vary greatly — even for the same procedure, in the same area, within the same network. Make sure to use healthcare cost transparency tools to ensure the most cost-effective choice.

BlueCross BlueShield of Texas

Powered by MDLIVE®

Care When and Where You Need It Just Got Easier

Virtual Visits

Convenient health care at your fingertips

Getting sick is never convenient, and finding time to get to the doctor can be hard. Blue Cross and Blue Shield of Texas (BCBSTX) provides you and your covered dependents access to care for non-emergency medical issues and behavioral health needs through MDLIVE.

Whether you're at home or traveling, access to a board-certified doctor is available 24 hours a day, seven days a week. You can speak to a doctor immediately or schedule an appointment based on your availability. Virtual visits can also be a better alternative than going to the emergency room or urgent care center.[1]

MDLIVE doctors or therapists can help treat the following conditions and more:

General Health
- Allergies
- Asthma
- Nausea
- Sinus infections

Pediatric Care
- Cold/flu
- Ear problems
- Pinkeye

Behavioral Health
- Anxiety/depression
- Child behavior/learning issues
- Marriage problems

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Connect[2]
Access where the BCBSTX App, online video or telephone service is available

Interact
Real-time consultation with a board-certified doctor or therapist

Diagnose
Prescriptions sent electronically to pharmacy of your choice (when appropriate)

Telephone:

- Call MDLIVE (888-680-8646)
- Speak with a health service specialist
- Speak with a doctor

Get connected today!
To register, you'll need to provide your first and last name, date of birth and BCBSTX member ID number.

[1] In the event of an emergency, this service should not take place of an emergency room or urgent care center. MDLIVE doctors do not take the place of your primary care doctor. Proper diagnosis should come from your doctor, and medical advice is always between you and your doctor.

[2] Internet/Wi-Fi connection is needed for computer access. Data charges may apply when using your tablet or smartphone. Check your phone carrier's plan for details. Video on-demand consultations for behavioral health are available by appointment. Service is limited to interactive-audio consultations (phone only), along with the ability to prescribe, when clinically appropriate, in Texas. Service is limited to interactive-audio/video (video only), along with the ability to prescribe, when clinically appropriate, in Idaho, Montana, New Mexico and Oklahoma. Virtual visits are currently not available in Arkansas. Service availability depends on member's location. Virtual visits may not be available on all plans.

MDLIVE is not an insurance product nor a prescription fulfillment warehouse. MDLIVE operates subject to state regulations and may not be available in certain states. MDLIVE does not guarantee that a prescription will be written. MDLIVE does not prescribe DEA-controlled substances, non-therapeutic drugs and certain other drugs that may be harmful because of their potential for abuse. MDLIVE physicians reserve the right to deny care for potential misuse of services.

BlueCross BlueShield of Texas

SAPPHIRE DIGITAL

Same Procedure, Different Cost and Potential Cash in Your Pocket!

Did you know that prices for the same quality medical services can differ by thousands of dollars within the same region and health plan network? Blue Cross and Blue Shield of Texas (BCBSTX) is excited to introduce **Member Rewards** – a new program, administered by Sapphire Digital, that offers cash rewards when a lower-cost, quality provider is selected from several options.

- Compare it to where you park your car – the $30 lot or the $15 one just a few blocks away.
- Member Rewards allows you to shop for your health care services in a similar way, and as the following examples show, you can save money depending on where you go for care.
- Best of all – shopping with Member Rewards could help lower your out-of-pocket costs and help get you a cash reward.

Medical Procedure	Cost Variance	Provider A Cost	Provider B Cost	Provider C Cost
MRI of the Brain	$682 to $3,849	$682	$2,723	$3,849
Knee Replacement	$17,003 to $61,980	$17,003	$47,617	$61,980

Most of us look for value when we're shopping – why not apply this practice to shopping for health care services? Member Rewards uses Provider Finder® to help you reduce costs and take more control of your health care financial decisions.

What Is the Member Rewards Program?

Member Rewards – combined with Provider Finder, our nationwide database of independently contracted health care providers – can help you:

- Compare costs and quality for numerous procedures.
- Estimate out-of-pocket costs.
- Earn cash while shopping for care.
- Save money and make the most efficient use of your health care benefits.
- Consider treatment decisions with your doctors.

How Does It Work?

1. When a doctor recommends treatment, log into Blue Access for Members℠ at **bcbstx.com**

2. Click **Doctors and Hospitals** tab – then on Find a Doctor or Hospital – and Shop for Procedures

3. Choose a Member Rewards eligible location, and you may earn a cash reward

4. Complete your procedure and, once verified, you will receive a check within 4 to 6 weeks

Questions? Call the number on the back of your member ID card.

Key Features

Ease of Shopping

- You can quickly find the information you need to help you choose a facility or service.
- Member Rewards is available via computer, smartphone and other mobile devices.

Cash Rewards

- It's easy to understand how much you could save with a reward option, based on location.
- After verification, Sapphire Digital will send you any earned reward check. Note that rewards are taxable.

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BLUE DISTINCTION BENEFIT DIFFERENTIAL PRODUCT

BlueCross BlueShield of Texas

Understanding and Using Your Benefits

With **Blue Distinction® Centers (BDC) and Blue Distinction® Centers+ (BDC+) Benefit Differential Product**, you have access to cost-efficient facilities that have met national measures for quality, efficiency and patient experience. You receive a higher level of benefits compared to other PPO providers, when you use a BDC or BDC+ facility for the following specialty care programs:

- Bariatric Surgery
- Cardiac Care
- Knee and Hip Replacement
- Maternity Care
- Spine Surgery
- Transplants

Blue Distinction® Centers
Hospitals recognized for their expertise in delivering specialty care

Blue Distinction® Centers+
Hospitals recognized for their expertise and efficiency in delivering specialty care

Choosing a BDC or BDC+ Facility

If you go to a BDC or BDC+ facility for your specialty care, you will receive the highest level of benefits and may have lower out-of-pocket costs. You will also have the reassurance that the facility has a record of providing effective care.

Compare Costs

The sample table below shows how out-of-pocket costs and savings can vary depending on the provider you choose.

	BDC/BDC+ Facility	PPO	Out of Network
Deductible (Your Responsibility)	$0	$2,000	$5,000
Coinsurance (Your Portion)	0%	20%	50%
Example Charges for a 2-Day Hospital Stay	$10,000	$10,000	$10,000
Total Out-of-Pocket Cost to You*	**$0**	**$3,600**	**$7,500**

** Actual savings may vary. Totals provided in table are examples of what you can save when BDC/BDC+ facilities are used.*

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BLUE DISTINCTION BENEFIT DIFFERENTIAL PRODUCT

Finding a Participating Provider is Easy

Provider Finder®

Provider Finder is the quick and easy way to find a designated BDC or BDC+ facility for specialty care. With Provider Finder you can search for Blue Distinction Centers or Blue Distinction Centers+ in your area.

Here's how:

- Go to **bcbstx.com** and click on the *'Find a Doctor or Hospital'* tab
- Click on the *'Find a Doctor with Provider Finder'* image
- Select the state in which you live
- Select your PPO plan
- Select the providers you need by specialty under *Search Criteria*
- Click on *Show Only Blue Distinction Centers/Blue Distinction Centers+* to find facilities in your area

Be sure to select one of the BDC or BDC+ facilities in your network to receive the highest level of benefits. You may still be covered at non-BDC facilities, but your out-of-pocket costs may be higher.

On the Phone

You can also call a Blue Cross and Blue Shield of Texas (BCBSTX) Customer Service Advocate at the toll-free telephone number listed on the back of your BCBSTX member ID card for help locating a participating facility.

Remember: Treatment decisions are always between you and your doctor.

AIRROSTI

FIX PAIN FAST!

NEW HEALTH PLAN BENEFIT

For all employees and dependents on the health plan offered by

Globe Life

Visits are an in-network benefit

Airrosti providers are experts at diagnosing and rapidly resolving the source of your injury.

Each patient receives one full hour of assessment, diagnosis, treatment, and education designed to eliminate the pain associated with many common conditions, allowing you to quickly and safely return to activity - usually within 3 visits (based on patient-reported outcomes).

Schedule Your Appointment Today!

3.2 visits average to complete injury resolution*

*Based on patient reported outcomes

9,000+ SURGERIES AVOIDED

40% THE AVERAGE COST OF OTHER CARE

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A Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
an Independent Licensee of the Blue Cross and Blue Shield Association

Call a Benefits Value Advisor

to help you compare cost on your next procedure.[1]

A Benefits Value Advisor can:

- Help compare costs at different providers near you[2]
- Help you schedule your appointment
- Help with pre-certification
- Tell you about online educational tools

Estimated cost comparison for maternity delivery services	
Provider A: $10,696*	Provider B: $13,677*
Estimated cost comparison for a knee MRI	
Provider A: $374*	Provider B: $2,779*
Estimated cost comparison for a hip replacement surgery	
Provider A: $32,293*	Provider B: $52,307*

Which provider will you choose? The same procedure performed in the same area by different providers can vary greatly in cost.

*Allowable in-network cost data from Tarrant County. Costs are examples and may not be the same for every member's situation.

1. Benefits Value Advisors offer cost estimates for various providers, facilities and procedures. Lower pricing and cost savings are dependent on the provider or facility of your choosing.

2. Member communications and information from Benefits Value Advisors are not meant to replace the advice of health care professionals. Members are encouraged to seek the advice of their doctors to discuss their health care needs. Decisions regarding course and place of treatment remain with the member and his or her health care providers. Cost estimates are just an estimate. In addition to your usual deductibles, copayments and/or coinsurance, the actual cost of the services may vary based on a number of factors including the date of service, the actual procedure performed and what services were billed by the provider and your particular benefit plan. Coverage is subject to the limitations, exclusions and terms of your plan.

One call may result in big savings! Call the number on the back of your member ID card before your next procedure.

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Pharmacy Benefits

Prescription Drug Coverage for Medical Plans

Our Prescription Drug Program is coordinated through OptumRx.

You will have one ID card for Medical care and prescriptions. You may find information on your benefits coverage and search for network pharmacies by logging on to www.optumrx.com or by calling OptumRx customer service at 844-265-1719.

Your cost is determined by the tier assigned to the prescription drug product. All products on the list are assigned as Generic, Preferred or Non-Preferred.

	PREMIER PPO		HDHP W/HSA		BASIC PPO	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
RETAIL RX (30-DAY SUPPLY)						
GENERIC	$20 copay	50% of allowable amount minus copay	20%*	50% of allowable amount minus copay	$20 copay	50% of allowable amount minus copay
PREFERRED	$60 copay		20%*		$80 copay	
NON-PREFERRED	$90 copay		20%*		$120 copay	
MAIL ORDER RX (90-DAY SUPPLY)						
GENERIC	$40 copay	Not covered	20%*	Not covered	$40 copay	Not covered
PREFERRED	$120 copay		20%*		$160 copay	
NON-PREFERRED	$180 copay		20%*		$240 copay	

*After Deductible

Step Therapy

This program applies to certain high-cost drugs. In order for the drug to be covered, you will need to first try a proven, cost-effective medication before using a more costly treatment if needed.

Prior Authorization

This program applies to certain high-cost drugs that have the potential for misuse. The program will require your doctor to obtain approval through OptumRx. If your medication does not receive approval, you may still purchase the medication; however you will be responsible for the full cost.

Important Reminder: Pharmacy Benefit Enhancements

Flu shots received at an in-network pharmacy will be covered at a $0 copay.

Obesity medications; will be covered with Prior Authorization.

Sexual dysfunction medications will be covered up to 8 doses per month with Prior Authorization.

Important Note: CVS/Caremark pharmacies are considered out-of-network. You may use CVS/Caremark pharmacies to fill your retail prescriptions; however benefits will be paid at the out-of-network benefit level.

Q&A: Generic Drugs

What is a generic drug?

When a new, FDA-approved drug goes on the market, it may have patent or exclusivity protection that enables the manufacturer to sell the drug exclusively for a period of time. When those expire or no longer serve as a barrier to approval, other companies can make it in generic form.

Are generic drugs as effective as brand-name drugs?

Yes. A generic drug is the same as a brand-name drug in dosage, safety, strength, quality, the way it works, the way it is taken and the way it should be used. The FDA requires generic drugs have the same high quality, strength, purity and stability as brand-name drugs.

Are generic drugs as safe as brand-name drugs?

Yes. The FDA must approve the generic drug before it can be marketed.

Are generic drugs that much cheaper than brand-name medications?

Yes. On average, the cost of a generic drug is 80% to 85% lower than the brand-name equivalent.

Is there a generic equivalent for my brand-name drug?

To find out if there is a generic equivalent for your brand-name drug, visit www.fda.gov to view a catalog of FDA-approved drug products, as well as drug labeling information.

Dental Benefits

Routine preventive care such as regular Dental checkups can help lower your risk of stroke and heart disease. Globe Life's Dental coverage will provide you and your family affordable options for overall health. Coverage is available from MetLife.

Network Dentists

Your Plan's in-network dentists have agreed to charge lower fees, which helps keep money in your pocket. If you choose to use a dentist who doesn't participate in your Plan's network, your out-of-pocket costs will be higher, and you are subject to any charges beyond the Reasonable and Customary (R&C) limitations. To find a network dentist, visit MetLife at www.metlife.com/mybenefits.

Dental Premiums

Premium contributions for Dental will be deducted from your paycheck on a pre-tax basis. Your tier of coverage will determine your premium. Refer to the contribution information sheet provided with your enrollment material.

Dental Plan Summary

Dental Plan benefits are available to you on a voluntary basis. The chart below gives a summary of the 2022 Dental coverage provided by MetLife. All out-of-network services are subject to Reasonable and Customary (R&C) limitations.

	BASIC PLAN		FULL PLAN	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
CALENDAR YEAR DEDUCTIBLE				
INDIVIDUAL	$75		$50	
FAMILY	$225		N/A	
CALENDAR YEAR MAXIMUM				
PER PERSON	$1,000		$2,000	
COVERED SERVICES (AMOUNT PLAN PAYS)				
PREVENTIVE SERVICES	100%, no deductible	100%, no deductible, R&C limits apply	100%, no deductible	100%, no deductible, R&C limits apply
BASIC SERVICES	70%*	70%, R&C limits apply*	80%*	80%, R&C limits apply*
MAJOR SERVICES	40%*	40%, R&C limits apply*	50%*	50%, R&C limits apply*
ORTHODONTICS	Not covered		50%*	50%, R&C limits apply*
ORTHODONTIC LIFETIME MAXIMUM	N/A		$1,500	

*After Deductible

Flossing isn't fun, but it can go a long way toward preventing gum disease.

Vision Benefits

If you wear glasses or contacts, chances are you already have a steady appointment with an eye doctor. But even those with perfect eyesight should have their Vision checked on a regular basis. To ensure that you and your family have access to quality Vision care, Globe Life offers a comprehensive Vision benefit provided by MetLife accessing the Vision Service Plan (VSP) network of providers.

Vision Premiums

Premium contributions for Vision will be deducted from your paycheck on a pre-tax basis. Your tier of coverage will determine your premium. Refer to the contribution information sheet provided with your enrollment material.

Vision Plan Summary

Vision Plan benefits are available to you on a voluntary basis. The chart below gives a summary of the 2022 Vision coverage provided by MetLife. All out-of-network services are subject to Reasonable and Customary (R&C) limitations. In-network copayments are paid directly to the provider. Out-of-network services will be reimbursed up to the scheduled amounts below.

	METLIFE (VSP)	
	IN-NETWORK	OUT-OF-NETWORK
COVERED MATERIALS		
LENSES		
SINGLE VISION LENSES	Covered in full*	$30 allowance
BIFOCAL LENSES	Covered in full*	$50 allowance
TRIFOCAL LENSES	Covered in full*	$65 allowance
FRAMES		
RETAIL FRAME EQUIVALENT	$150 allowance* (Costco $85 allowance*)	$70 allowance
CONTACT LENSES		
NECESSARY	Covered in full*	Covered in full
ELECTIVE	$150 allowance*	$105 allowance
COPAYS		
EXAMINATION	$20 copay	$45 allowance
MATERIALS	$20 copay	N/A
BENEFIT FREQUENCY		
EXAMINATION	1 x 12 months	
LENSES	1 x 12 months	
FRAMES	1 x 24 months	
CONTACTS (in lieu of Lenses and Frames)	1 x 12 months	

*After Copay

Eye doctors are often the first health care professionals to detect chronic systemic diseases such as high blood pressure and diabetes.

Health Savings Account

Your HSA can be used for qualified expenses, including those of your spouse and/or tax dependent(s), even if they are not covered by your Plan.

HSA Bank will issue you a debit card, giving you direct access to your account balance. When you have a qualified Medical expense, you can use your debit card to pay. You must have a balance to use your debit card. There are no receipts to submit for reimbursement.

Eligible expenses include doctors' visits, eye exams, prescription expenses, laser eye surgery, menstrual products, over-the-counter medications, and more. Visit IRS Publication 502 on www.irs.gov for a complete list.

Eligibility

You are eligible to open and fund an HSA if:

- You are enrolled in an HSA-eligible High Deductible Health Plan.
- You are not covered by your spouse's non-HDHP and your spouse does not have a Health Care Flexible Spending Account or Health Reimbursement Account.
- You are not eligible to be claimed as a dependent on someone else's tax return.
- You are not enrolled in Medicare or TRICARE.
- You have not received Department of Veterans Affairs medical benefits in the past 90 days for non-service-related care. (Service-related care will not be taken into consideration.)

Individually Owned Account

Your HSA is a personal bank account that you own and administer. You decide how much you contribute, when to use the money for medical services and when to reimburse yourself. You can save and roll over unused HSA funds to the next year. You can even let funds accumulate year over year to use for eligible expenses in retirement. HSA funds are also portable if you change jobs. There are no vesting requirements or forfeiture provisions.

Federal regulations related to HSA are indicated in the enrollment guide.

IMPORTANT NOTE:

Employees who have a health care FSA with remaining funds as of December 31, 2021 will be ineligible to contribute to a HSA until the first of the following month after the grace period is over (April 1, 2022).

How to Enroll

You must elect the HDHP w/HSA plan with Globe Life. You will need to complete all HSA enrollment materials and designate the amount to contribute through payroll deduction. Globe Life will establish an HSA account in your name with HSA Bank and send in your contribution once bank account information has been provided and verified.

Maximize Your Tax Savings

Contributions to an HSA are not subject to federal income tax. The money in this account (including interest and investment earnings) grows without being subject to federal income tax. When the funds are used for qualified medical expenses, they are spent tax free.

Per IRS regulations, if HSA funds are used for purposes other than qualified medical expenses and you are younger than age 65, you must pay federal income tax on the amount withdrawn, plus a 20% penalty tax.

HSA Funding and Limits

The IRS places an annual limit on the maximum amount that can be contributed to HSAs. For 2022, contributions (which include your contribution plus any Globe Life contribution detailed on the rate sheet) are limited to the following:

HSA FUNDING LIMITS	
EMPLOYEE	$3,650
FAMILY	$7,300
CATCH-UP CONTRIBUTION (AGES 55+)	$1,000

The Globe Life HSA for the HDHP w/HSA Plan will be established with HSA Bank. Visit hcsc.hsabank.com or call customer service at 855-731-5220.

HSA contributions over the IRS annual contribution limits are not tax deductible and are generally subject to a 6% excise tax.

If you contribute too much to your HSA, you have two options: (1) Remove the excess contributions and the net income attributable to the excess contribution before you file your federal income tax returns. You'll pay income taxes on the excess removed. (2) Leave the excess contributions in your HSA account and pay 6% excise tax on them.

Flexible Spending Accounts

Flexible Spending Accounts (FSAs) allow you to set aside pre-tax payroll deductions to pay for out-of-pocket health care expenses such as deductibles, copays and coinsurance, as well as dependent care expenses.

Health Care Flexible Spending Account

You can contribute up to $2,750 for qualified Medical expenses with pre-tax dollars, which will reduce the amount of your taxable income and increase your take-home pay. You can even pay for eligible expenses with an FSA debit card at the same time you receive them, allowing you to avoid waiting for reimbursement.

Limited Purpose Flexible Spending Account

Designed to complement a Health Savings Account, a Limited Purpose Flexible Spending Account (LPFSA) allows for reimbursement of eligible Dental and Vision expenses. You must decide how much to set aside for this account. You may contribute up to $2,750 in the LPFSA.

Dependent Care Flexible Spending Account

In addition to the Health Care FSA, you may opt to participate in the Dependent Care FSA as well—whether or not you elect any other benefits. The Dependent Care FSA allows you to set aside pre-tax funds to help pay for expenses associated with caring for elder or child dependents. Unlike the Health Care FSA, reimbursement from your Dependent Care FSA is limited to the total amount that is deposited in your account at that time.

- With the Dependent Care FSA, you are allowed to set aside up to $5,000 to pay for child or elder care expenses on a pre-tax basis.
- Eligible dependents include children under age 13 and a spouse or other individual who is physically or mentally incapable of self-care and has the same principal place of residence as the employee for more than half the year.
- Expenses are reimbursable as long as the provider is not anyone considered your dependent for income tax purposes.
- In order to be reimbursed, you must provide the tax identification number or Social Security number of the party providing care.

Eligible Dependent Care Flexible Spending Account Expenses

This account covers dependent day care expenses that are necessary for you and your spouse to work or attend school full time.

Examples of eligible dependent care expenses include:

- In-Home Baby-Sitting Services (not by an individual you claim as a dependent)
- Care of a preschool child by a licensed nursery or day care provider
- Before- and after-school care
- Day camp
- In-house dependent day care
- Due to federal regulations, expenses for your domestic partner and your domestic partner's children may not be reimbursed under the FSA programs

NOTE: Globe Life benefit plans do not include coverage for domestic partners or their dependent children.

How to Use the Account

You may use your FSA debit card at locations such as doctor and dentist offices, pharmacies, and Vision service providers. The card cannot be used at locations that do not offer services under the Plan, unless the provider has also complied with IRS regulations. Should you attempt to use the card at an ineligible location, the swipe transaction will be denied.

Once you incur an eligible expense, submit a claim form along with the required documentation. If you have a question about a reimbursement, contact HSA Bank. Should you need to submit a receipt, you will receive an email or be mailed a receipt notification from HSA Bank. You should always retain a receipt for your records.

General Rules and Restrictions

In exchange for the tax advantages that FSAs offer, the IRS has imposed the following rules and restrictions for both Health Care and Dependent Care FSAs:

- Your expenses must be incurred during the 2022 Plan Year.
- Your dollars cannot be transferred from one FSA to another.
- You cannot participate in Dependent Care FSA and claim a dependent care tax deduction at the same time.
- You must "use it or lose it"—any unused funds will be forfeited.
- The Health Care FSA provides a grace period of up to 2.5 months after the end of the Plan Year. With the grace period, qualified expenses incurred during that period can be paid from the amount left in the account at the end of the previous year.
- For members terminating mid-year, you will have 30 days after last day 'Active' to file qualified expenses for reimbursement under your Health Care FSA and/or Dependent Care FSA.
- You cannot change your FSA election in the middle of the Plan Year unless you experience a Qualifying Life Event like marriage, divorce or birth of a child.

Those considered highly compensated employees (family gross earnings were $125,000 or more last year) may have different FSA contribution limits. Visit www.irs.gov for more information.

While FSA debit cards allow you to pay for services at point of sale, they do not remove the IRS regulations for substantiation. This means that you must always keep receipts and Explanation of Benefits (EOBs) for any debit card charges. Failure to provide proof that an expense was valid can result in your card being turned off and your expense being deemed taxable.

You cannot use FSA funds to pay for insurance premiums.

FSA VS. HSA: WHICH IS RIGHT FOR YOU?

Flexible Spending Accounts (FSAs) and Health Savings Accounts (HSAs) are two ways to save pre-tax money to pay for your eligible health care costs. But how do you know which one is right for you? The chart below explains the main differences between FSAs and HSAs to help you make the right choice for you and your family.

	FSA	HSA
OWNERSHIP	The FSA is owned by your employer. If you leave your employer, you lose access to the account unless you have a COBRA right.	The HSA is an account owned by you. It is a savings account in your name and you always have access to the funds, even if you leave your employer.
ELIGIBILITY & ENROLLMENT	The employer determines eligibility for an FSA. You cannot make changes to your contribution during the Plan Year without a Qualifying Life Event.	You must be enrolled in a Qualified High Deductible Health Plan to be eligible to contribute money to your HSA. You cannot be covered by a spouse's non-High Deductible plan or enrolled in Medicare or TRICARE. You can change your contribution at any time during the Plan Year.
TAXATION	Contributions are tax free via payroll deduction.	1. Contributions are not subject to federal income tax. 2. The account grows without being subject to federal income tax. 3. Funds are spent tax free (if used for qualified expenses).
CONTRIBUTIONS	Both you and your employer can contribute to the account according to IRS limits. The contribution limit for 2022 is $2,750. This amount does not have to include the employer contribution.	Both you and your employer can contribute to the account according to IRS limits. The contribution limit for 2022 is $3,650 for individuals and $7,300 for families. This amount includes the employer contribution. If you are 55 or older, you may make a "catch-up" contribution of $1,000 per year.
PAYMENT	Some plans include an FSA debit card to pay for eligible expenses. If not, you pay up front and get reimbursed from the account. You must submit your receipts for reimbursement.	Many HSAs include a debit card, ATM withdrawal or checkbook. You may use the debit card to pay for qualified expenses directly. You could also use online bill payment services from the HSA financial bank to pay for qualified expenses. You decide when and if you should use the money in your HSA to pay for qualified expenses, or if you want to use another account to pay for services and save the money in your HSA for future qualified expenses or retirement.
ROLL OVER OR GRACE PERIOD	You must use the money in the account by end of Plan Year; however some plans allow up to $500 to roll over to the next year. Other plans include a 2.5-month grace period after the end of the Plan Year for any extra expenses to be incurred and reimbursed. A plan can have either a rollover or a grace period, but not both. Any unclaimed funds at the end of the run out are lost and returned to your employer.	The money in the account rolls over from year to year. Funds are always yours and may be used for future qualified expenses.
QUALIFIED EXPENSES	Physician services, hospital services, prescriptions, menstrual products, over-the-counter medications, dental care, and vision care. A full list is available at www.irs.gov.	Physician services, hospital services, prescriptions, menstrual products, over-the-counter medications, dental care, vision care, Medicare Part D plans, COBRA premiums, and long-term care premiums. A full list is available at www.irs.gov.
OTHER TYPES	Other types of FSAs include: ‹ Dependent Care FSA – Allows you to set aside pre-tax dollars for elder or child dependent care and covers expenses such as baby-sitting, day care and before- and after-school care. ‹ Limited Purpose FSA – Some employers offer a Limited Use FSA that only covers eligible Dental and Vision expenses. Limited Purpose FSAs are typically offered in conjunction with an HSA as the IRS does not allow someone to have a Health FSA and an HSA.	There is only one type of HSA.

Voluntary Legal

Globe Life knows the value of well-rounded, balanced plans, which is why we offer additional benefits to help manage your life.

MetLife Legal Plan (formerly known as Hyatt Legal Plan)

This voluntary plan provides you and your family with legal assistance through an extensive network of legal professionals and services. You can receive assistance with the following:

- Court Appearances
- Document Review & Preparation
- Money Matters
- Estate Planning
- Family Law
- Real Estate Matters
- And more

For more information, visit info.legalplans.com and enter access code: GetLaw
Or call 800-821-6400, Monday - Friday 8:00 a.m. - 7:00 p.m. EST.

Once you've enrolled, visit www.metlife.com/mybenefits to find a legal professional in your area.

Glossary

Coinsurance – Your share of the cost of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service, typically after you meet your deductible. For instance, if your plan's allowed amount for an office visit is $100 and you've met your deductible (but haven't yet met your out-of-pocket maximum), your coinsurance payment of 20% would be $20. Your plan sponsor or employer would pay the rest of the allowed amount.

Copay – The fixed amount, as determined by your insurance plan, you pay for health care services received.

Deductible – The amount you owe for health care services before your health insurance or plan sponsor (employer) begins to pay its portion. For example, if your deductible is $1,000, your plan does not pay anything until you've met your $1,000 deductible for covered health care services. This deductible may not apply to all services, including preventive care.

Employee Contribution – The amount you pay for your insurance coverage.

Explanation of Benefits (EOB) – A statement sent by your insurance carrier that explains which procedures and services were provided, how much they cost, what portion of the claim was paid by the plan, and what portion is your liability, in addition to how you can appeal the insurer's decision. These statements are also posted on the carrier's website for your review.

Flexible Spending Accounts (FSAs) – An option that allows participants to set aside pre-tax dollars to pay for certain qualified expenses during a specific time period (usually a 12-month period). There are two types of FSAs: the Health Care FSA and the Dependent Care FSA.

- **Health Care FSA –** With the Health Care FSA, participants can use their accounts to cover eligible Medical expenses such as copays, eye exams, prescriptions and more. All expenses must be qualified as defined in Section 213(d) of the Internal Revenue Code. Please note that over-the-counter medications are not eligible for reimbursement without a doctor's prescription with the Health Care FSA.
- **Dependent Care FSA –** A Dependent Care FSA helps to reimburse participants for eligible expenses associated with caring for a qualified dependent, such as a dependent younger than age 13 or another dependent that may be incapable of self-care. For additional information on eligible expenses, refer to Publication 503 on the IRS website.

Both accounts are "use it or lose it," meaning that funds not used by the end of the plan year will be lost. Although, some Some plans allow for a Grace Period or a rollover into the next plan year.

Health Care Cost Transparency – Also known as Market Transparency or Medical Transparency. Health care provider costs can vary widely, even within the same geographic area. To make it easier for you to get the most cost-effective health care products and services, online cost transparency tools, which are typically available through health insurance carriers, allow you to search an extensive national database to compare costs for everything from prescription drugs and office visits to MRIs and major surgeries.

Health Savings Account (HSA) – A personal health care bank account funded by your or your employer's tax-free dollars to pay for qualified Medical expenses. You must be enrolled in a qualified HDHP to open an HSA. Funds contributed to an HSA roll over from year to year and the account is portable, meaning if you change jobs your account goes with you.

High Deductible Health Plan (HDHP) – Plan option that provides choice, flexibility and control when it comes to spending money on health care. Preventive care is covered at 100% with in-network providers, there are no copays, and all qualified employee-paid Medical expenses count toward your deductible and your out-of-pocket maximum.

In-Network – In-network providers are doctors, hospitals and other providers that contract with your insurance company to provide health care services at discounted rates.

Out-of-Network – Out-of-network providers are doctors, hospitals and other providers that are not contracted with your insurance company. If you choose an out-of-network doctor, services will not be provided at a discounted rate.

Out-of-Pocket Maximum – The most you pay during a policy period (usually a 12-month period) before your health insurance or plan begins to pay 100% of the allowed amount. This limit does not include your premium, charges beyond the Reasonable & Customary, or health care your plan doesn't cover. Check with your health insurance carrier to confirm what payments apply to the out-of-pocket maximum.

Over-the-Counter (OTC) Medications – Medications typically made available without a prescription.

Prescription Medications – Medications prescribed to you by a doctor. Cost of these medications is determined by their assigned tier: Generic, Preferred or Non-Preferred.

- **Generic Drugs –** Drugs approved by the U.S. Food and Drug Administration (FDA) to be chemically identical to corresponding Preferred or Non-Preferred versions. The color or flavor of a Generic medicine may be different, but the active ingredient is the same. Generic drugs are usually the most cost-effective version of any medication.
- **Preferred Drugs –** Brand-name drugs on your provider's list of approved drugs. You can check online with your provider to see this list.
- **Non-Preferred Drugs –** Brand-name drugs not on your provider's list of approved drugs. These drugs are typically newer and have higher copayments.

Reasonable and Customary Allowance (R&C) – Also known as an eligible expense or the Usual and Customary (U&C). The amount your insurance company will pay for a Medical service in a geographic region based on what providers in the area usually charge for the same or similar Medical service.

Step Therapy – The goal of a Step Therapy Program is to steer employees to less expensive, yet equally effective, medications while keeping member and physician disruption to a minimum. You must typically try a generic or preferred-brand medication before a non-preferred brand medication is eligible for coverage without prior authorization.

Summary of Benefits and Coverage (SBC) – Mandated by health care reform, your insurance carrier or plan sponsor will provide you with a clear and easy to follow summary of your benefits and plan coverage.

Required Notices

Important Notice from Globe Life Inc. About Your Prescription Drug Coverage and Medicare under the Blue Cross Blue Shield of Texas and Optum Rx Plan(s)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Globe Life Inc. 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. Globe Life Inc. has determined that the prescription drug coverage offered by the Blue Cross Blue Shield of Texas and Optum Rx plan(s) 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 during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. You may also enroll each year from October 15th through 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 Globe Life Inc. coverage will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed herein.

If you do decide to join a Medicare drug plan and drop your current Globe Life Inc. coverage, be aware that you and your dependents will not be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with Globe Life Inc. and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

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

Contact the person listed at the end of these notices 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 Globe Life 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 Medicare Part D 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:	January 1, 2022
Name of Entity/Sender:	Globe Life Inc.
Contact—Position/Office:	Human Resources
Address:	3700 S Stonebridge Dr. McKinney, TX 75070
Phone Number:	972-529-5085

Women's Health and Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. For deductibles and coinsurance information applicable to the plan in which you enroll, please refer to the summary plan description. If you would like more information on WHCRA benefits, please contact Human Resources at 972-529-5085.

HIPAA Privacy and Security

The Health Insurance Portability and Accountability Act of 1996 deals with how an employer can enforce eligibility and enrollment for health care benefits, as well as ensuring that protected health information which identifies you is kept private. You have the right to inspect and copy protected health information that is maintained by and for the plan for enrollment, payment, claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask your benefits administrator to amend the information. For a full copy of the Notice of Privacy Practices, describing how protected health information about you may be used and disclosed and how you can get access to the information, contact Human Resources at 972-529-5085.

HIPAA Special Enrollment Rights

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

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (i.e. legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment within 31 days after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or the CHIP, you may request enrollment under this plan within 60 days of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy towards this plan, you may request enrollment under this plan within 60 days after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact Human Resources at 972-529-5085.

Important Contacts

COVERAGE	PHONE NUMBER	ONLINE ACCESS
MEDICAL - BCBSTX	800-521-2227	www.bcbstx.com
OPTUMRX	844-265-1719	www.optumrx.com
DENTAL - METLIFE	800-438-6388	www.metlife.com/mybenefits
VISION - METLIFE (VSP)	855-638-3931	www.metlife.com/mybenefits
HEALTH SAVINGS ACCOUNT - HSA BANK	855-731-5220	hcsc.hsabank.com
FLEXIBLE SPENDING ACCOUNT - HSA BANK	855-731-5220	hcsc.hsabank.com
VOLUNTARY LEGAL - METLIFE LEGAL PLAN	800-821-6400	www.legalplans.com
BENEFITS CONTACT	**PHONE NUMBER**	**EMAIL**
GENERAL QUESTIONS		benefits@globe.life
MORGAN DEMBY	469-525-4874	benefits@globe.life
GABRIELLE GILDON	214-544-5355	benefits@globe.life


Globe
Life