Account Key: 48609
Effective Date: 01/01/2023
Representative: Acripoint LLC dba Fischer Rounds and Associates
Group Number: 082766-0000

RIVERFRONT BROADCASTING LLC

Notice of Renewal Rates

Health Benefits 1 Current *

Benefit Code:	**MCM006U5/RCM00117 - Primary PPO SD**		
Deductible:	$5000/$15000		
Coinsurance:	30% IN 50% OUT		01/01/2022
OPM:	$8550/$17100	Employee:	$778.77
Preventive:	Yes	Employee/Spouse:	$1,562.22
OV Copay:	$45/$90	Employee/Child(ren):	$1,446.35
ER Copay:	$500	Emp/Spouse/Child(ren):	$2,325.49
RX Description:	$30/$65/$100/$240 w $190 BioSim/$275 specialty/$325 np specialty		

Health Benefits 1 Renewal

Benefit Code:	**PM000181/RM000237 - Primary PPO SD**		
Deductible:	$5000/$15000		01/01/2023
Coinsurance:	30% IN 50% OUT		
OPM:	$8550/$17100	Employee:	$884.20
Preventive:	Yes	Employee/Spouse:	$1,778.14
OV Copay:	$45/$90	Employee/Child(ren):	$1,645.92
ER Copay:	$500	Emp/Spouse/Child(ren):	$2,649.05
RX Description:	$30/$65/$100/$240 w $275 specialty/$325 np specialty	% of Change:	13.65%

* This group's current benefit is no longer available. A benefit has been chosen as this group's renewal benefit and is shown above. If the group does not want to renew with this benefit, please ask about alternate options available to this group.

HealthEquity®

Enrollment Form - 2023 Flexible Spending Accounts

Employee Name: ____________________

Mailing Address: ____________________

City: ____________ State: ________ Zip: ________

E-mail Address: ____________________

Social Security Number: ____________ Date of Birth (MM/DD/YYYY): ____________

Date of Hire (MM/DD/YYYY): ____________________

Enter your Annual Election amount:

☐ **Health Care FSA** __________ (Maximum is $3050)

☐ **Dependent Care FSA** __________ (Maximum is $5000)

Effective date of coverage: 1/1/2023 The first payroll deduction will be on 1/15, 2023

My pay schedule is: ☐ weekly ☐ bi-weekly ☒ semi-monthly ☐ monthly

AUTHORIZATION & ACKNOWLEDGEMENT:

I understand that I cannot revoke or change this election during the Plan Year unless there is a qualifying "Change in Status" event that affects my or my dependents' eligibility under this Plan or another employer plan. The rules regarding election changes are described in more detail in the Summary Plan Description. I also understand that if I or my spouse participates in a Health Savings Account (HSA), eligible medical expenses under the Health Care Reimbursement Account may be limited.

I understand that I must submit a claim and appropriate documentation (e.g. explanation of benefits, itemized bill) for out-of-pocket, Medical, Dental, Vision and/or Dependent Care expenses before I can be reimbursed. I certify that I will only submit claims for reimbursement under the Flexible Spending Accounts for eligible expenses incurred by myself or my eligible dependents, in accordance with the terms of the respective Flexible Spending Account Plan. I certify that I will not submit claims for reimbursement under the Flexible Spending Accounts for amounts that have already been reimbursed by another source nor will I seek reimbursement for such amounts from any other source.

____________________ Employee Signature ____________ Date

HealthEquity is the administrator of your Plan.
Please return this form to your Employer.