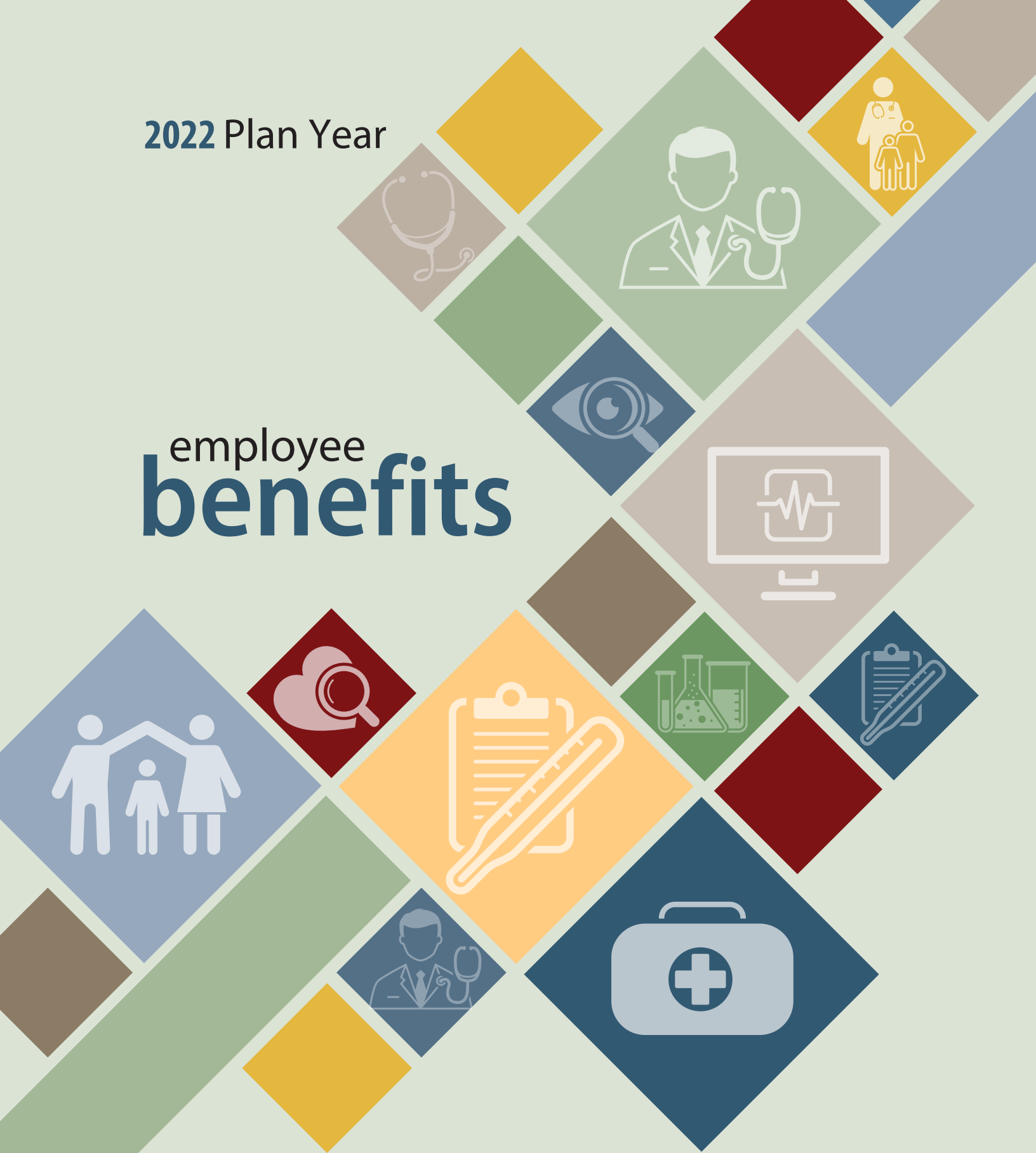


2022 Plan Year

employee
benefits





Questions, Problems or Concerns

Our goal is to make certain that you receive the correct coverage under the benefits plan. We are here to help with any issues that may arise. If you require assistance, have your ID number or Social Security Number available and follow these steps:

- **FOR CLAIMS ASSISTANCE** call the applicable insurance carrier. Have your ID number, date of service, and provider name available.
- **DO YOU NEED AN ID CARD?** If you do not have an ID card, please contact the insurance carrier to order your ID card or go online to the carrier's site to download an ID card.
- **IF YOU REQUIRE FURTHER ASSISTANCE** contact AssuredPartners. The Company has partnered with AssuredPartners as our benefits administrator for expert assistance with benefit related questions, plan procedures, life events and claim issues.

Important Contact Information

Carrier	Web	Phone / Email
Medical Blue Cross Blue Shield of Louisiana	www.MyHealthToolKitLA.com	locate a provider: 800-810-2583 customer service: 833-466-0181
Prescription Drugs CVS/Caremark	www.caremark.com	800-334-8134
Health Savings Account Wex Health	https://benefitslogin.wexhealth.com/	866-451-3399
Flexible Spending Accounts Wex Health	https://benefitslogin.wexhealth.com/	866-451-3399
Dental MetLife	www.mybenefits.metlife.com	800-942-0854
Vision VSP	www.vsp.com	800-877-7195
Life and Disability Lincoln Financial	www.mylincolnportal.com	Life/AD&D: 888-787-2129 Disability: 800-291-0112
Employee Assistance Program (EAP) Lincoln Financial	www.guidanceresources.com User name: LFGsupport Password: LFGsupport1	888-628-4824
Legal Services MetLaw	www.info.legalplans.com Access Code: GetLaw	800-821-6400
Critical Illness, Accident & Hospital Indemnity MetLife	www.mybenefits.metlife.com	866-626-3705
401(k) Retirement Plan Prudential	www.retirement.prudential.com	877-778-2100
MyHR Benefits Helpline Employee Enrollment Benefits Helpline 8:30am - 5:00pm ET	http://myhrbenefits.bswift.com	888-958-1447 myHRBenefits@AssuredPartners.com

Welcome to your 2022 Employee Benefits!

The Company is pleased to offer a wide range of benefits to its employees and their families. These company sponsored benefits are an important part of a total compensation package. They represent both a valuable asset to our employees and to their families, and demonstrate an investment by the Company in our employees. We are proud of our benefits program and are committed to continuously improving the plans that make up our benefits offerings.

This guide was created to answer some of the questions you may have about your benefits. Please read it carefully along with any supplemental materials you receive.

If you have any benefits related questions or concerns, please do not hesitate to call the MyHR Benefits Helpline.

What's New for 2022

No changes to the Plans for 2022 – Deductibles, Coinsurance and Payroll Contributions will remain unchanged for 2022

MyHR Benefits – Enrollment support services

Dedicated enrollers to assist in completing the enrollment process and answer questions about the benefits and cost

Wellness Incentive is back for 2022 – all Employees need to complete the Biometric Screening to receive the incentive for 2022

New Voluntary Benefits

Accident

Hospital Indemnity

Enhanced Critical Illness – updated policy providing more coverage and higher maximum benefit available

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PLEASE NOTE: This booklet provides a summary of the benefits available, but is not your Summary Plan Description (SPD). The Company reserves the right to modify, amend, suspend, or terminate any plan at any time, and for any reason without prior notification. The plans described in this book are governed by insurance contracts and plan documents, which are available for examination upon request. We have attempted to make the explanations of the plans in this booklet as accurate as possible. However, should there be a discrepancy between this booklet and the provisions of the insurance contracts or plan documents, the provisions of the insurance contracts or plan documents will govern. In addition, you should not rely on any oral descriptions of these plans, since the written descriptions in the insurance contracts or plan documents will always govern.

How To Enroll

Annual Enrollment

The Company's Annual Enrollment period will be held **November 1 through November 19, 2021.**

Log on to the enrollment site to review the benefits being offered, make any plan changes, or update dependent and/or beneficiary information.

Newly Hired / Eligible Employees

New hires and newly eligible employees have 30 days from their date of hire or date of eligibility to complete the online benefits enrollment. The enrollment **MUST** be completed, even if choosing to waive coverage, in order to provide beneficiary information for the company-provided benefits. Coverage, if elected, will be effective on the first day of the month following 30 days of employment or date of eligibility.



Have social security numbers and birth dates for all dependents and beneficiaries available prior to logging on.



To enroll in your benefits or for questions contact one of our Benefits Counselors at the MyHR Benefits Helpline to learn more about your benefits and complete your enrollment process.

Before you speak with a Benefits Counselor, please have the following information ready: dependents' names, birth dates, social security numbers, addresses, and phone numbers.

MyHR Benefits Helpline

855-441-6493

Monday - Friday: 8am – 7pm CST

Saturday: 9am – 3pm CST

Enrolling In Your Benefits

Please review this guide to gain a full understanding of the plans being offered. Be sure to go online to review your current benefits and make any changes for the upcoming plan year.

<http://myhrbenefits.bswift.com>

Username - first initial+last name+date of birth (mmddyyyy)

Password - date of birth (mmddyyyy)

Passwords are reset prior to Annual Enrollment every year and you will be prompted to change your password upon login.

The enrollment process will be broken down into 4 steps:

• Your Information

Employee - Verify accuracy of all information and add an email address.
Family - You may add new or edit existing dependent information as necessary. Please remember to include social security numbers for all dependents.

• **Your Benefits** - You will be automatically enrolled in benefits that are company-paid. These benefits will be checked off as completed. All benefits that indicate "Selection Required" must be completed. To make an election, click on the "View Plan Options" button next to each benefit plan type.

• **Enroll** - You will be asked to assign beneficiaries, confirm other coverage, do a final review of your elections and confirm.

• **Complete** - After you have made your benefit elections and verified them for accuracy, click "**COMPLETE ENROLLMENT.**" You will then have the option to e-mail and/or print a copy of the Confirmation Statement for your records.

You can make changes to your selections prior to the enrollment deadline by logging back into the system and clicking on "Change My Elections."

Minimum Browser Requirements:

- Internet Explorer 11.0
- Firefox 35.0
- Google Chrome 39.0.2171.99 m
- Safari 10.0
- You must have Cookies, Java-script, and Style Sheets enabled.
- The system will automatically log you out if left idle for more than 30 minutes.

Eligibility

Employees with a schedule of **30 or more hours per week** are eligible for the benefits described in this guide, unless otherwise stated.

Eligible Dependents

If you enroll in coverage, you can also cover your legal spouse and eligible children. Proof of eligibility will be required for all dependents who have not been previously verified. Supporting documents will need to be provided within 30 days of the effective date of coverage.

Your eligible dependents include*:

- A spouse to whom you are legally married;
- A dependent child under age 26. Coverage will terminate per the carrier eligibility guidelines. Coverage may be extended past the age of 26 for disabled dependents. Dependent children include natural, adopted children, and stepchildren.

Coverage for eligible dependents generally begins on the same day your coverage is effective. Completed enrollment serves as a request for coverage and authorizes any payroll deductions necessary to pay for that coverage.

**Additional carrier conditions may apply and may vary by state.*

Spouse Coverage

If you and your spouse are both benefits-eligible employees, you may each enroll as an employee, or one of you may enroll as an employee and the other as a dependent. If you both enroll as employees, only one of you may cover your eligible children.



Required proof of eligibility for dependent verification:

Spouse - marriage certificate and current year tax return

Child(ren) - birth certificate (hospital birth record for child up to the age of 6 months), paternity test result, adoption certificate naming you or your spouse as the child's legal guardian or any court order proving parent-child relationship.

Pre-Tax Benefits: Section 125

The Company's benefit plans utilize Section 125. This enables you to elect to pay premiums for health, dental, vision and flexible spending account coverage on a pre-tax basis. When you use pretax dollars, you will reduce your taxable income and have fewer taxes taken out of your paycheck. Under Section 125, you can actually have more spendable income than if the same deductions were taken on an after tax basis.

Pre-tax Note: When you pay for your dependent's benefits on a pre-tax basis you are certifying that the dependent meets the IRS' definition of a dependent. [IRC §§ 152, 21 (b)(1) and 105(b)]. Children/spouses that do not satisfy the IRS' definition will result in a tax liability to you, such as changing that dependent's election to a post-tax election, or receiving imputed income on your W-2 for the dependent's coverage that should not have been taken on a pre-tax basis.

Benefit Election Changes



You have 30 days from the date of a life event to make changes to your elections via the online benefits enrollment system.

The benefit elections you make during Annual Enrollment or as a new hire will remain in effect for the entire plan year. You will not be able to change or revoke your elections once they have been made unless a life event status change occurs.

For purposes of health, dental, and vision, you will be deemed to have a life event status change if:

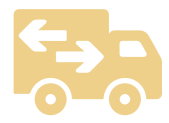
- your marital status changes through marriage, the death of your spouse, divorce, legal separation, or annulment;
- your number of dependents changes through birth, adoption, placement for adoption, or death of a dependent;
- you, your spouse or dependents terminate or begin employment;
- your dependent is no longer eligible due to attainment of age;
- you, your spouse or dependents experience an increase or reduction in hours of employment (including a switch between part-time and full-time employment; strike or lock-out; commencement of or return from an unpaid leave of absence);
- gain or loss of eligibility under a plan offered by your employer or your spouse's employer;
- a change in residence for you, your spouse or your dependent resulting in a gain or loss of eligibility.

In order to be permitted to make a change of election relating to your health, dental or vision coverage due to a life event status change, the change must result in you, your spouse or dependent gaining or losing eligibility for health, dental or vision coverage under this plan or a plan sponsored by another employer by whom you, your spouse or dependent are employed. The election change must correspond with that gain or loss of eligibility.

You may also be permitted to change your elections for health coverage under the following circumstances:

- a court order requires that your child receive accident or health coverage under this plan or a former spouse's plan;
- you, your spouse or dependent become entitled to Medicare or Medicaid;
- you have a Special Enrollment Right;
- there is a significant change in the cost or coverage for you or your spouse attributable to your spouse's employment.

For purposes of all other benefits under the plan, you will be deemed to have a life event status change if the change is on account of and consistent with a change in status, as determined by the plan administrator, in its discretion, under applicable law and the plan provisions.



Benefit Election Changes continued

Event	Action Required	Results If Action Not Taken
New Hire or newly eligible:	Make elections within 30 days of hire date or date of eligibility. Documentation is required if adding dependents.	You and your dependents are not eligible until the next Annual Enrollment.
Marriage:	Your new spouse must be added to your elections within 30 days of the marriage date. A copy of the marriage certificate must be presented.	Your spouse is not eligible until the next Annual Enrollment period.
Divorce:	The former spouse must be removed within 30 days of the divorce. Proof of the divorce will be required. A copy of the divorce decree must be presented.	Benefits are not available for the divorced spouse and will be recouped if paid erroneously.
Birth or adoption of a child:	The new dependent must be added to your elections within 30 days of the birth and adoption, even if you already have family coverage. A copy of the birth certificate, footprints, or hospital discharge papers must be presented. Once you receive the child's Social Security Number, be sure to contact AssuredPartners to update your child's insurance information record.	The new dependent will not be covered on your health insurance until the next Annual Enrollment period.
Death of a spouse or dependent:	Remove the spouse or dependent from your elections within 30 days from the date of death. Death certificate must be presented.	You could pay a higher premium than required and you may be overpaying for coverage.
Spouse or dependent gains or loses other coverage:	Add or drop spouse and/or dependent from your elections within 30 days of the event date. A letter from the employer or insurance company must be presented.	You need to wait until the next Annual Enrollment period to make any change.
Employee gains or loses other coverage:	Change your elections within 30 days from the gain or loss of coverage. A letter from the employer must be provided.	You will be unable to enroll in the benefits until the next Annual Enrollment period.



If you Experience a Life Event Status Change

You must update your elections within 30 days of your life event status change or you will not be able to make changes until the next Annual Enrollment period. If adding or removing dependents, you are required to submit specific documents. Failure to submit the required documents timely may result in your election changes being voided and/or your dependents losing coverage. For assistance processing life event status changes, contact MyHR Benefits Helpline.

Medical Coverage

The Company is proud to offer you a choice of two medical plans from Blue Cross Blue Shield of Louisiana. Coverage under both plans include comprehensive medical care and prescription drug coverage. The plans also offer many resources and tools to help you maintain a healthy lifestyle. Below is a brief description of the types of plans.

Preferred Provider Organization (PPO)

The PPO Plan is designed to appeal to those who want to pay slightly more out of their paycheck for coverage but pay less out-of-pocket when they use the plan. You pay copays and coinsurance and the annual out-of-pocket maximum.

Consumer Driven Health Plan (CDHP)

The Consumer Driven Health Plan (CDHP) features lower payroll contributions in exchange for a higher deductible.

Under a CDHP, you pay for all medical and prescription drug expenses until you reach your annual deductible, so there is no first dollar coverage and no copays as part of this plan.

The CDHP allows you to put money into a Health Savings Account (HSA) to help cover medical and prescription expenses. The HSA is a tax-favored account that may be used in conjunction with CDHPs. The Company will contribute \$500 to your HSA account. See page 8 for more information on HSAs.

My Health Toolkit - *Stay connected while on the go*

My Health Toolkit is a one-stop shop for managing your health benefits — customized just for you!

- Check medical claims and medical history
- Replace your I.D. card
- Find a doctor or hospital
- Manage financial accounts
- Estimate costs ahead of time

1. Visit www.MyHealthToolkitLA.com and select **Register Now**
2. Enter the number on your ID card and your date of birth. If you don't have your membership card, enter the policyholder's Social Security number.
3. Choose a username and password.
4. Enter your email address and choose to go paperless.



Medical Plan Comparisons

BCBS of LA	PPO		CDHP	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (Individual / Family)	\$1,250 / \$3,125	\$7,500 / \$18,750	\$3,000 / \$7,500	\$7,500 / \$18,750
Out-Of-Pocket Maximum (Individual / Family) <i>Includes annual deductible, coinsurance and copays</i>	\$6,000 / \$12,000	Unlimited	\$6,000 / \$12,000	Unlimited
Preventive Services includes routine physical exams, well-child care, women's preventive health services and routine screening tests	Covered 100%	50% AD	Covered 100%	50% AD
Office Visits PCP or Specialist	20% AD	50% AD	20% AD	50% AD
Urgent Care Centers	20% AD	50% AD	20% AD	50% AD
Emergency Room	\$200 Copay + 20% AD	\$200 Copay + 50% AD	20% AD	50% AD
Inpatient Hospital*	20% AD	50% AD	20% AD	50% AD
Outpatient Hospital <i>certain outpatient services require preauthorization</i>	20% AD	50% AD	20% AD	50% AD
Diagnostic Test	20% AD	50% AD	20% AD	50% AD
Imaging	20% AD	50% AD	20% AD	50% AD
Mental Health Outpatient Services	20% AD	50% AD	20% AD	50% AD
Substance Use Disorder Outpatient	20% AD	50% AD	20% AD	50% AD
Skilled nursing care*	20% AD	50% AD	20% AD	50% AD
Hospice services*	20% AD	50% AD	20% AD	50% AD
Durable medical equipment*	20% AD	50% AD	20% AD	50% AD
Prescription Drugs - Retail: 34-day supply; Mail Order or CVS Pharmacy: 90-day supply				
Deductible	Separate \$200 per person for brand name Rx, then:		Rx deductible combined with medical deductible, then:	
Generic - Retail / Mail Order	\$15 / \$45		20% after deductible for all tiers	
Preferred - Retail / Mail Order	\$45 / \$135			
Non-Preferred - Retail / Mail Order	\$60 / \$180			

AD - After Deductible * Pre authorization is required.

This Summary is for informational purposes only. For specific benefit information, please refer to the applicable summary plan document.

Health Savings Account

The Health Savings Account (HSA) is an independently owned bank account that allows you to contribute money on a pre-tax basis to pay for out-of-pocket qualified health care expenses, as defined by the Internal Revenue Service. (For a complete list of qualified health care expenses, visit <https://www.wexinc.com/insights/benefits-toolkit/eligible-expenses/>.) If you use the money for other expenses, you will pay a tax and a penalty fee.

The company contributes \$500 to your HSA account*.

You are only eligible to enroll in this account if you are enrolled in the CDHP medical plan.

For more information, call **866-451-3399**.

HSA Advantages

- The money in your HSA always belongs to you. Any money you haven't spent at the end of the plan year will stay in your account—you do not have to "use it or lose it" during the plan year, as you do with a health care FSA.
- At age 65, monies can be used for non-eligible medical expenses with no penalty.
- You can use monies in your account to pay for eligible medical expenses for all family members – even if they are not on your plan!
- When you retire or leave the Company, you could use the money in your HSA to pay for COBRA coverage, Medicare premiums and out-of-pocket expenses, or long-term care insurance.

You can choose to contribute to your HSA on a before-tax basis, up to the IRS annual maximums. If you are or will be age 55 or over during the calendar year and not enrolled in Medicare, you may also make a "catch-up" HSA contribution of an additional \$1,000 each year.

* prorated for employees who elect the CDHP during the year.

Other Coverage Affects Your HSA Eligibility

If you are enrolled in Medicare Part A or Part B, a government health plan such as TRICARE, or another employer plan such as your spouse's, IRS regulations may make you ineligible to contribute to an HSA. **You can still enroll in the CDHP, but both you and the Company are prohibited from contributing to an HSA.**

	2022 IRS CONTRIBUTION LIMITS <i>(Total combined Employee and Employer contribution limit)</i>
Single	\$3,650
Family	\$7,300
Catch-Up	\$1,000

Note: As a taxpayer, it is your responsibility to ensure that your HSA contributions do not exceed the maximum possible for your specific tax situation.



Only Consumer Driven Health Plan (CDHP) participants are eligible.

Flexible Spending Accounts

Flexible Spending Accounts (FSAs) offer another way to save money on health care and dependent care expenses. You may submit expenses incurred by any of your dependents, whether or not they are covered by the insurance plans you have through your employer. (For a list of eligible medical expenses, visit <https://www.wexinc.com/insights/benefits-toolkit/eligible-expenses/>).

How it Works

If you enroll, you fund the accounts via a payroll deduction each pay period. Money that you contribute to your FSA is not subject to social security taxes, federal, and in most cases, state income taxes.

As you incur health care or dependent care expenses, you can use your WEX FSA Debit Card to pay at the point of sale or submit a paper claim form to get reimbursed.

NOTE: You cannot use money from the Health Care FSA to cover expenses eligible under the Dependent Care FSA or vice versa.

Reimbursement Timing Differences: Health Care FSA vs. Dependent Care FSA

- For the Health Care FSA, eligible expenses may be reimbursed up to the full amount you've elected to contribute into the FSA even if year-to-date contributions are less than the reimbursement.
- For the Dependent Care FSA, expenses will be reimbursed only up to the year-to-date contribution amount.

Changing Your Contribution Amount

Federal regulations prohibit you from changing your enrollment or the amount of your election during the plan year. You are only eligible to change your elections during the year if you have a life event status change. Only benefit changes consistent with the change in status are permitted. Life event status changes that may warrant a change in benefit elections are described on pages 4 and 5 of this guide.

HCFA Annual
Contribution Limit:
\$2,750

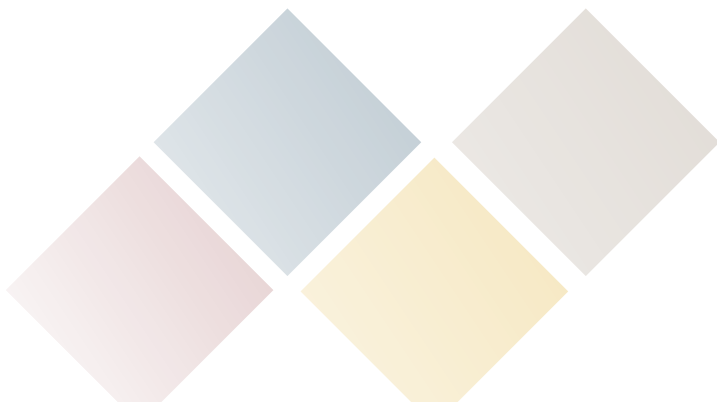
Health Care Flexible Spending Account (HCFA)

Federal regulations do not allow participation in a CDHP with HSA and this type of account. Eligible health care expenses include many of the out-of-pocket expenses you pay to maintain your health and well-being.

DCFA Annual
Contribution Limit:
\$5,000
(**\$2,500 if married
filing separately**)

Dependent Care Flexible Spending Account (DCFA)

You may use pre-tax dollars from your DCFA to pay expenses for care when the services enable you and your spouse to work outside of the home. These include expenses for the care of a dependent child, spouse or elderly parent inside your home. Only the portion of expenses which enable you to remain employed are eligible. Educational expenses are not eligible.



Dental Coverage

MetLife

The dental plan gives you the flexibility to visit any dental care provider you wish and access to one of the largest dental networks in the country. If you select one of MetLife's network providers, you will generally pay less out-of-pocket for services.



To find a participating provider, visit www.metlife.com/mybenefits

Benefit	In-Network	Out-of-Network*
Calendar Year Maximum Per Individual	\$1,500	\$1,500
Calendar Year Deductible Per Individual / Per Family	\$50 / \$150	\$50 / \$150
Type A: Preventive Services Oral Exams, Cleanings (every 6 months), X-Rays	Covered 100%, No Deductible	Covered 100%, No Deductible
Type B: Basic Services** Fillings, Extractions, Root Canal, Anesthesia	Covered 80%, After Deductible	Covered 80%, After Deductible
Type C: Major Services** Crowns, Bridges, Dentures	Covered 50%, After Deductible	Covered 50%, After Deductible
Type D: Orthodontia Lifetime maximum per individual	Covered 50%, No Deductible \$2,000	Covered 50%, No Deductible \$2,000

* **Out-of-Network Providers & Balance Billing** - Please note that providers that do not participate with your insurance plan can "balance bill" you for any difference between their charge and what the plan pays. Therefore, using non-participating providers may result in significant patient liability.

** Remember to have your dentist file a **pretreatment estimate** for any basic or major work. This will let you know how much of the bill you will be responsible for before the work is done.

This Summary is for informational purposes only. For specific benefit information, please refer to the applicable summary plan document.



ID Cards

You will **not** be issued a dental plan ID card. To receive services, the provider will need to know your member ID (which is your Social Security Number) and that you are enrolled in the MetLife Preferred Dentist Program. If you prefer to have an ID card, you can print one at www.metlife.com/mybenefits.

Vision Coverage

VSP

The vision plan is administered by VSP and allows you the freedom to choose any vision care provider you want, but when you use a VSP network provider, you will receive additional savings on your vision care, and you pay only a copay for most covered services. If you use a non-VSP provider, you pay the full retail cost and submit a claim.



To locate a participating provider, visit www.vsp.com

Benefit	In-Network	Out-of-Network
Exam - Once every calendar year	\$15 copay	Plan reimburses up to \$45
Eyewear Copay - lenses and frames	\$25 copay	N/A
Frames - Once every other calendar year Wide Selection: Retail Featured Frame: Retail	You pay any amount exceeding \$150 allowance You pay any amount exceeding \$170 allowance	Plan reimburses up to \$70
Lenses - Once every calendar year Single Vision Bifocal Trifocal Lenticular	Covered 100% after copay	Plan reimburses up to \$30 Plan reimburses up to \$50 Plan reimburses up to \$65 Plan reimburses up to \$100
Contact Lenses (instead of glasses) - Once every calendar year Elective* Medically Necessary	\$130 materials only Covered 100%	Plan reimburses up to \$105 Plan reimburses up to \$210
Additional Discounts and Savings		
Frames	You may receive a 20% discount on any balance remaining beyond what the plan covers.	N/A
Laser Vision Correction	Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities	N/A

This Summary is for informational purposes only. For specific benefit information, please refer to the applicable summary plan document.

2022 Employee Contributions

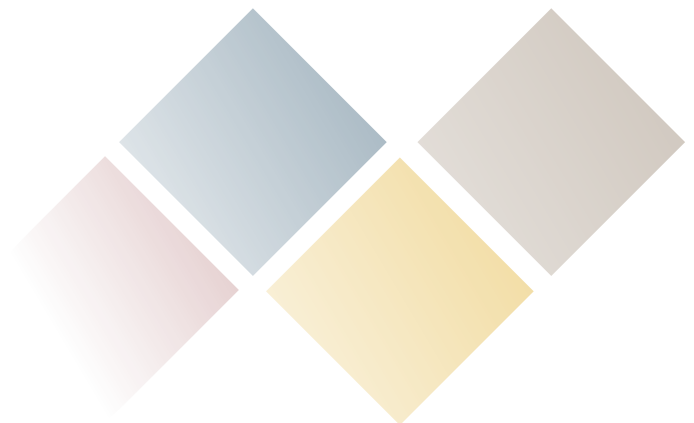
MEDICAL PLAN CONTRIBUTIONS <i>without</i> Wellness Incentive				
	PPO		CDHP	
	Monthly	Annual	Monthly	Annual
Employee Only	\$143.23	\$1,718.76	\$99.45	\$1,193.40
Employee + Spouse	\$316.19	\$3,794.28	\$227.28	\$2,727.36
Employee + Child(ren)	\$231.23	\$2,774.76	\$134.64	\$1,615.68
Employee + Family	\$420.83	\$5,049.96	\$279.49	\$3,353.88

Wellness Participation Incentive

The wellness participation incentive allows you to lower your medical plan contributions. You and your covered spouse (if applicable) are eligible to participate in the wellness program and employees will receive their own incentive independent of the spouse's participation; each will earn their own wellness participation incentive. The wellness participation incentive for 2022 is **\$50.00 per month** for employee; **\$50.00 per month** for spouse. **All employees and spouses who complete the Biometric Screening by 11/30/21 will receive the Wellness Incentive for the 2022 year. Employees hired after 10/2/21 will automatically receive the wellness incentive for 2022.**

DENTAL PLAN CONTRIBUTIONS		
	MetLife	
	Monthly	Annual
Employee Only	\$6.43	\$77.16
Employee + Spouse	\$12.86	\$154.32
Employee + Child(ren)	\$14.56	\$174.72
Employee + Family	\$20.99	\$251.88

VISION PLAN CONTRIBUTIONS		
	VSP	
	Monthly	Annual
Employee Only	\$4.82	\$57.84
Employee + Family	\$13.30	\$159.60



AssuredExcellence

The AssuredExcellence program is designed to connect employees and their dependents¹ with high quality health care at minimal to no cost. The program includes benefits for a broad range of services such as:

- orthopedic procedures
- surgical cardiac and cancer procedures
- organ transplant
- bariatric surgery
- gallbladder surgery
- treatments for various
- bleeding and clotting disorders
- anorexia
- substance abuse treatment
- other treatments are also available

Employees can begin the process by completing an application that includes basic information. Applications are reviewed by the prospective provider of care and, if it is determined that the applicant is a candidate for services, the provider will gather and review medical records. Following this review the provider will contact applicants who remain eligible for services to schedule a consultation, surgery or services depending on the medical issue being addressed. A stipend is paid to the employee to assist with lodging and/or transportation expenses associated with traveling (if necessary) to the designated Center of Excellence.

Why is this program being offered?

The health and well being of our employees and their families is of paramount importance, and we feel strongly about helping you get care at the best facilities across the country.

How much does it cost?

For most health plans, all treatments at these providers will be at NO COST to you. Diagnostic procedures required prior to your treatment will go through your regular insurance.

Do I have to travel?

You may, but there are stipends built into the program that are generally enough to cover your travel and more.

If you are interested in learning more about the program, checking to see if it includes benefits for the services you need and/or receiving an application, please contact AssuredExcellence at **888-856-4317** or via e-mail at **assuredexcellence@assuredpartners.com**.

How do I get started?

Step 1: Contact the AssuredExcellence team to discuss your condition and possible procedure requirements.

Step 2: Complete an application with your pertinent information so the AssuredExcellence service team can determine the AssuredExcellence provider that is best suited for your treatment.

Step 3: The AssuredExcellence provider will gather the relevant medical records and following the review of the records will contact you to schedule services.

Step 4: You will automatically receive the travel reimbursement stipend after treatment.

Procedure Group	Travel Stipend
Bladder Cancer Surgery	up to \$2,800
Bone Marrow Transplant	up to \$5,300
Cancer Diagnosis Confirmation	up to \$500
Cancer Surgery	up to \$2,800
Cardiac/Heart Surgery	up to \$2,800
Colorectal Cancer Surgery	up to \$2,800
Gall Bladder Surgery	up to \$1,800
Heart Transplant	up to \$5,300
Hemophilia/Medications	up to \$2,000
Kidney Transplant	up to \$5,300
Liver Transplant	up to \$5,300
Lung Transplant	up to \$5,300
Lymph Node Surgery	up to \$1,800
Neck and Spine Surgery	up to \$1,800
Orthopedic Surgery	up to \$1,800
Pancreas Transplant	up to \$5,300
Pancreatic Cancer Surgery	up to \$2,800
Prostate Cancer Surgery	up to \$2,800
Stem Cell Transplant	up to \$5,300
Substance Abuse/Rehab	100% of cost
Thyroid Surgery	up to \$1,800
<i>Bariatric Surgery*</i>	<i>*If covered by plan, coverage limitations based on your plan apply.</i>

Travel stipend is determined by the necessary procedure and the AssuredExcellence provider you choose.

To find out what reimbursement you might be eligible to receive, please call AssuredExcellence.

¹ Patients must be over age 18 for certain services.

Employee Assistance Program (EAP)

We offer free and confidential counseling along with referrals to community resources for full-time employees experiencing personal problems. You and the members of your household are entitled to up to five counseling sessions per incident, per individual, per calendar year. Your sessions may be conducted via telephone or in an EAP counselor's private office. The use of EAP services is voluntary and available 24 hours per day. No personal information will be shared with your employer.

Your EAP can help you resolve a broad range of issues, including:

- Relationship/marriage/family problems
- Stress/emotional issues
- Alcohol & drug dependency
- Advice and support for your beneficiaries: Grief counseling, Guidance on financial and legal matters
- Legal, financial, family and career support: Online will preparation, Estate planning, Budgeting
- Working Advantage discount network: Health and fitness, Home and garden, Broadway shows
- Identity theft protection: Articles and quizzes to help protect yourself from identify theft



For assistance, call **888-628-4824** or visit www.GuidanceResources.com



Plan Cost: 100% Employer Paid



Life and AD&D Insurance

Lincoln Financial Group

The Company provides Life Insurance and Accidental Death and Dismemberment (AD&D) coverage as financial protection if you or your dependents die or become injured in an accident.

Employee Benefit Amount:

- 3 times your annual base earnings, up to a \$500,000 maximum benefit. AD&D insurance is equal to your life insurance amount.

Dependent Benefit Amount:

- \$2,000 for your legal spouse and \$2,000 for each of your children between the age of 14 days and age 26.

 **Plan Cost: 100% Employer Paid**

Optional Life

In addition to company provided life insurance and AD&D, you may purchase optional life insurance for yourself, your spouse, and your dependent children. However, you may only elect coverage for your dependents if you enroll for optional life coverage for yourself.

 **Plan Cost: 100% Employee Paid**

Short and Long Term Disability

Lincoln Financial Group

The Company provides eligible employees disability coverage. This coverage provides a source of income replacement to keep part of your paycheck coming if you cannot work because of illness or injury. We pay the full cost of this benefit for you.

 **Plan Cost: 100% Employer Paid**

Voluntary Benefits

The following Voluntary Benefits offered through MetLife, can complement existing medical coverage and help fill financial gaps caused by out-of-pocket expenses such as deductibles, co-payments, and non-covered medical services. Benefits are paid regardless of what is covered by medical insurance. Payments are made directly to you, to spend as you choose.

All three plans are portable (you can continue coverage if you leave the company) and **each plan includes a wellness benefit.**

Plans Cost: 100% Employee Paid

Accident Insurance

Accident Insurance is designed to help covered individuals meet the out-of-pocket expenses and extra bills that can follow an off-the-job accidental injury, whether minor or catastrophic. Lump sum benefits are paid directly to you based on the amount of coverage listed in the schedule of benefits. The coverage is guaranteed issue so no health questions are required.

You are offered the High Plan.

Below are some examples of covered accidents and the Benefit Amount that you will be paid:

Basic Accidental Death:	\$50,000
Loss of one finger or one toe:	\$1,000
Loss of one arm or one leg:	\$15,000
Loss of one hand or one foot:	\$15,000
Loss of sight in one eye:	\$15,000
Fractured Rib:	\$2,000
Dislocated Wrist:	\$2,000
Major Diagnostic:	\$200
Urgent Care:	\$100
Ground Ambulance:	\$400
Initial Hospitalization:	\$1,500
Health Screening Benefit:	\$100

Critical Illness Insurance

Critical Illness Insurance is designed to help you offset the financial effects of a catastrophic illness with a lump sum benefit if you are diagnosed with a covered critical illness. The benefit is based on the amount of coverage in effect on the date of diagnosis or the date treatment is received according to the terms and provisions of the policy.

You have the choice of electing coverage of \$10,000, \$20,000 or \$50,000.

Both amounts are Guaranteed Issue coverage. Your Spouse and child(ren) will be offered 100% of your benefit amount.

Below are some examples of covered critical illnesses and the Benefit Amount (BA) that you will be paid:

Alzheimer's Disease:	Initial Benefit: 100% of BA Recurrence Benefit: None
Coronary Artery Bypass Graft:	Initial Benefit: 100% of BA Recurrence Benefit: 50% of BA
Full Benefit Cancer:	Initial Benefit: 100% of BA Recurrence Benefit: 50% of BA
Stroke:	Initial Benefit: 100% of BA Recurrence Benefit: 50% of BA
Heart Attack:	Initial Benefit: 100% of BA Recurrence Benefit: 50% of BA
Health Screening Benefit:	\$100

Hospital Indemnity

Hospital Indemnity insurance is designed to help provide financial protection by paying a benefit due to a hospitalization and, in some cases, for treatment received for an accident or sickness, even if that treatment occurs outside the hospital. You may use the benefit to meet the out-of-pocket expenses and extra bills that occur.

You are offered the High Plan.

Below are some examples of covered incidents and the Benefit Amount that you will be paid:

Admission Benefit:	(limited to four times per calendar year) \$1,000
ICU Supplemental Benefit:	(in addition to Admission) \$1,000
Confinement Benefit:	(limited to 15 days per calendar year) \$200
ICU Supplemental Benefit:	(in addition to Confinement) \$200
Health Screening Benefit:	\$50

Voluntary Benefits continued

ACCIDENT PLAN CONTRIBUTIONS

	High Plan
	Monthly
Employee Only	\$12.87
Employee + Spouse	\$25.27
Employee + Child(ren)	\$30.16
Employee + Family	\$35.70

HOSPITAL INDEMNITY PLAN CONTRIBUTIONS

	High Plan
	Monthly
Employee Only	\$15.73
Employee + Spouse	\$41.77
Employee + Child(ren)	\$26.97
Employee + Family	\$53.02

CRITICAL ILLNESS INSURANCE

Monthly Cost per \$1,000 of Coverage

Attained Age	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Employee Only	\$0.44	\$0.49	\$0.59	\$0.73	\$0.97	\$1.32	\$1.75	\$2.51	\$3.56	\$5.03	\$6.69	\$9.10
Employee + Spouse	\$0.88	\$1.00	\$1.20	\$1.48	\$1.97	\$2.65	\$3.38	\$4.70	\$6.56	\$9.12	\$12.25	\$17.04
Employee + Child(ren)	\$0.69	\$0.74	\$0.84	\$0.98	\$1.23	\$1.58	\$2.00	\$2.76	\$3.81	\$5.28	\$6.95	\$9.35
Employee + Family	\$1.13	\$1.25	\$1.45	\$1.73	\$2.22	\$2.90	\$3.64	\$4.95	\$6.81	\$9.37	\$12.50	\$17.29



Additional Benefits

MetLaw Legal Plan

This benefit was designed to give employees access to an affordable, comprehensive plan that provides both legal and related professional services on an ongoing basis. MetLaw is available to employees through payroll deduction and provides employees with telephone and office consultations for an unlimited number of matters with the attorney of your choice.

During the consultation, the attorney will review the law, discuss your rights and responsibilities, explore your options and recommend a course of action. The most utilized services include estate planning, family law, document review, civil lawsuits, financial matters, consumer protection matters, immigration matters, traffic offenses, juvenile matters, personal injury, probate and real estate.

To learn more, visit www.info.legalplans.com and enter access code 6090600 or GETLAW or call **800-821-6400** Monday – Friday 8:00 am – 8:00 pm (EST/EDT).

 **Plan Cost: 100% Employee Paid**

MetLife Home and Auto Insurance

Take advantage of special MetLife Auto & Home discounts and benefits that could save you hundreds.

- A group discount of up to 15%
- Automatic payment options
- Good driving rewards
- Multi-policy discounts
- Multi-vehicle savings
- 24/7 superior service

You may apply for group auto and home insurance at any time. Take advantage of these savings today by calling **1-800-GET-MET8** (1-800-438-6388) and mentioning the company you work for.

 **Plan Cost: 100% Employee Paid**

TravelConnect®

TravelConnect services from Lincoln Financial Group, provide a wealth of travel, medical, and safety-related services you can access while traveling over 100 miles from home, for business or pleasure, including:

- Medical emergency help and transportation
- Emergency travel arrangements
- Medical, dental and legal referrals
- ID recovery assistance
- Recovery of lost or stolen documents or luggage
- Language translation services

For a complete list of TravelConnect services, go to www.mysearchlightportal.com and enter your Group ID: **LFGTravel123**.

 **Plan Cost: 100% Employer Paid**

401(k) Retirement Plan

Prudential

One of the best financial tools for saving for retirement is a 401(k) savings plan. Contributing part of your salary to our company's 401(k) Retirement Plan through Prudential results in these key benefits:

- Immediate tax break since contributions come out of your paycheck before taxes are withheld
- Very generous employer contributions
- Tax-deferred investment growth, which means you don't pay taxes each year on capital gains, dividends and other distributions.

Enrollment and Eligibility

You are immediately eligible to participate in the 401(k) Plan, effective your hire date; however, it takes approximately two weeks for Prudential to set up a new employee 401(k) account. To enroll, please contact Prudential at **1-877-778-2100** or visit **www.retirement.prudential.com**. Employees who do not make an election will automatically be enrolled approximately 70 days after date of hire. If you don't want to participate in the plan, you must decline enrollment to avoid having deductions taken from your pay and contributed to your account.

Your Contributions

You can contribute up to 60% of your annual pay to the plan pre-tax. If you are at least 50 years old, you may make an additional pre-tax catch-up contribution. You can change your contribution amount any time.

Employer Contributions

We match fifty cents for every dollar you contribute. The company also contributes a minimum amount equal to 4 percent of annual eligible pay to all plan-eligible participants employed on December 31 of each year.

Vesting

Vesting refers to your ownership of funds in your account. You are always 100% vested in your own contributions and in all employer contributions.

Investment Choices

A diverse portfolio can help ensure success in meeting your future goals. To encourage investment diversification, a broad selection of funds is available to build your portfolio and reduce risk through spreading your money among different kinds of investments, such as stocks, bonds and short-term investments. In addition to balancing your overall portfolio, it is important to diversify within each investment asset class to further mitigate your risk. By choosing a mixture of investment options, you are less likely to be affected by the performance of one single investment.

If you enroll in the 401(k) plan but don't select an investment fund, your account will be invested in one of the Vanguard Target Retirement funds based on your birth date and assuming a retirement age of 65.



Glossary of Terms

This glossary has many commonly used terms, but it isn't a full list. These are not contract terms. Those can be found in your insurance policy or certificate.

- Allowed Amount:** Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)
- Appeal:** A request for your health insurer or plan to review a decision or a grievance again.
- Balance Billing:** When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is \$100 and the allowed amount is \$70, the provider may bill you for the remaining \$30. A preferred provider may not balance bill you.
- Co-insurance:** Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is \$100 and you've met your deductible, your co-insurance payment of 20% would be \$20. The health insurance or plan pays the rest of the allowed amount. (Jane pays 20%, her plan pays 80%.)
- Complications of Pregnancy:** Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency cesarean section aren't complications of pregnancy.
- Co-payment:** A fixed amount (for example, \$15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.
- Deductible:** The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is \$1000, your plan won't pay anything until you've met your \$1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services. (Jane pays 100%, her plan pays 0%.)
- Durable Medical Equipment (DME):** Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.
- Emergency Medical Condition:** An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm. Emergency Medical Transportation Ambulance services for an emergency medical condition.
- Emergency Room Care:** Emergency services received in an emergency room.
- Emergency Services:** Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.
- Excluded Services:** Health care services that your health insurance or plan doesn't pay for or cover.
- Grievance:** A complaint that you communicate to your health insurer or plan.
- Habilitation Services:** Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.
- Health Insurance:** A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.
- Home Health Care:** Health care services a person receives at home.
- Hospice Services:** Services to provide comfort and support for persons in the last stages of a terminal illness and their families.
- Hospitalization:** Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.
- Hospital Outpatient Care:** Care in a hospital that usually doesn't require an overnight stay.
- In-network Co-insurance:** The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network co-insurance usually costs you less than out-of-network co-insurance.
- In-network Co-payment:** A fixed amount (for example, \$15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network co-payments usually are less than out-of-network co-payments.
- Medically Necessary:** Health care services or supplies needed to prevent, diagnose or treat an illness, injury, disease or its symptoms and that meet accepted standards of medicine.
- Network:** The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.
- Non-Preferred Provider:** A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.
- Out-of-Network Co-insurance:** The percent (for example, 40%) you pay of the allowed amount for covered health care services to providers who do not contract with your health insurance or plan. Out-of-network co-insurance usually costs you more than in-network co-insurance.
- Out-of-Network Co-payment:** A fixed amount (for example, \$30) you pay for covered health care services from providers who do not contract with your health insurance or plan. Out-of-network co-payments usually are more than in-network copayments.
- Out-of-Pocket Limit:** The most you pay during policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit. (Jane pays 0%, her plan pays 100%.)
- Physician Services:** Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.
- Plan:** A benefit your employer, union or other group sponsor provides to you to pay for your health care services.
- Preauthorization:** A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.
- Preferred Provider:** A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.
- Premium:** The amount that must be paid for your health insurance or plan. You and or your employer usually pay it yearly.
- Prescription Drug Coverage:** Health insurance or plan that helps pay for prescription drugs and medications.
- Prescription Drugs:** Drugs and medications that by law require a prescription.
- Primary Care Physician:** A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.
- Primary Care Provider:** A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.
- Provider:** A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.
- Reconstructive Surgery:** Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.
- Rehabilitation Services:** Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.
- Skilled Nursing Care:** Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.
- Specialist:** A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.
- UCR (Usual, Customary and Reasonable):** The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.
- Urgent Care:** Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Health Insurance Marketplace

The Patient Protection Affordability Care Act (“PPACA”) was signed into law on March 23, 2010. Under PPACA, individuals are required to have creditable health insurance coverage or pay a penalty to the Internal Revenue Service. This is known as the Individual Mandate. For more information on the details of PPACA please visit <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-workers-and-families>.

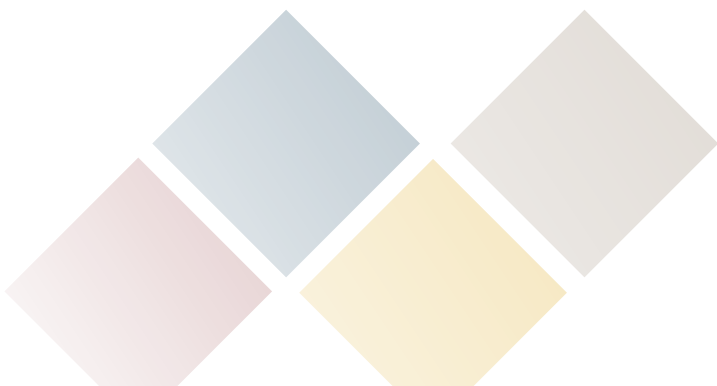
PPACA created a new way to buy health insurance which is called the Health Insurance Marketplace (“Marketplace”), also known as Exchanges. These Marketplaces are established by each individual state, the federal government or as a partnership between the state and the federal government. Through the Marketplaces, individuals can compare and purchase coverage (with a possible premium subsidy for those qualifying as low income; subsidies are made available as a federal tax credit through the Marketplace for individuals that are not eligible for coverage through their employer.

If you are enrolled in an the Company's medical plan, then PPACA may have little effect on you. The Company's medical plans meet or exceed the minimum coverage requirements set by PPACA. If you are eligible for our plans, you will not be eligible for federal tax credits. You still have the option to visit the Marketplace to see the coverage options available. If you purchase a health plan through the Marketplace instead of purchasing health coverage offered by the Company, you will lose any employer contribution makes for your health coverage, and your payments for coverage through the Marketplace will be made on an after-tax basis. (See <https://www.healthcare.gov/have-job-based-coverage/>).

If you are not eligible to enroll in the Company's medical plan, you may have a few options to purchase medical coverage. These options, if applicable, may include but are not limited to: your spouse's medical plan, your parent's medical insurance plan (if you are under age 26), or from several insurance companies offered though the Marketplace. If you shop for coverage through the Marketplace, you may be eligible for a federal tax credit and/or subsidy if you qualify as low income. (See also: www.healthcare.gov).

How Can I Get More Information?

For more information about purchasing medical coverage through the Marketplace please visit www.healthcare.gov or call **800-318-2596**.



Annual Notices

Health Insurance Portability and Accountability Act (HIPAA)

For purposes of the health benefits offered under the Plan, the Plan uses and discloses health information about you and any covered dependents only as needed to administer the Plan. To protect the privacy of health information, access to your health information is limited to such purposes. The health plan options offered under the Plan will comply with the applicable health information privacy requirements of federal Regulations issued by the Department of Health and Human Services. The Plan's privacy policies are described in more detail in the Plan's Notice of Health Information Privacy Practices or Privacy Notice. Plan participants in the Company-sponsored health and welfare benefit plan are reminded that the Company's Notice of Privacy Practices may be obtained by submitting a written request to the Human Resources Department. For any insured health coverage, the insurance issuer is responsible for providing its own Privacy Notice, so you should contact the insurer if you need a copy of the insurer's Privacy Notice.

Newborns' and Mothers' Health Protection Act

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

Notice Regarding Special Enrollment

If you are waiving enrollment in the Medical plan 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 dependents in the Medical 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.

Special Enrollment Rights CHIPRA – Children's Health Insurance Plan

You and your dependents who are eligible for coverage, but who have not enrolled, have the right to elect coverage during the plan year under two circumstances:

- You or your dependent's state Medicaid or CHIP (Children's Health Insurance Program) coverage terminated because you ceased to be eligible.
- You become eligible for a CHIP premium assistance subsidy under state Medicaid or CHIP (Children's Health Insurance Program).
- You must request special enrollment within 60 days of the loss of coverage and/or within 60 days of when eligibility is determined for the premium subsidy.

Genetic Nondiscrimination

The Genetic Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting, or requiring, genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, the Company asks Employees not to provide any genetic information when providing or responding to a request for medical information. Genetic information, as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Qualified Medical Child Support Order

QMCSO is a medical child support order issued under State law that creates or recognizes the existence of an "alternate recipient's" right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An "alternate recipient" is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified, and to administer benefits in accordance with the applicable terms of each order that is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer on the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.



Annual Notices continued

Notice of Required Coverage Following Mastectomies

In compliance with the Women's Health and Cancer Rights Act of 1998, the plan provides the following benefits to all participants who elect breast reconstruction in connection with a mastectomy, to the extent that the benefits otherwise meet the requirements for coverage under the plan:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- coverage for prostheses and physical complications of all stages of the mastectomy, including lymphedemas. The benefits shall be provided in a manner determined in consultation with the attending physician and the patient. Plan terms such as deductibles or coinsurance apply to these benefits

Women's Preventive Health Benefits

The following women's health services are considered preventive. These services generally will be covered at no cost share, when provided in network:

- Well-woman visits (annually and now including prenatal visits)
- Screening for gestational diabetes
- Human papilloma virus (HPV) DNA testing
- Counseling for sexually transmitted infections
- Counseling and screening for human immunodeficiency virus (HIV)
- Screening and counseling for interpersonal and domestic violence
- Breast-feeding support, supplies and counseling
- Generic formulary contraceptives are covered without member cost-share (for example, no copayment). Certain religious organizations or religious employers may be exempt from offering contraceptive services.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents (including spouse) for up to 24 months while in the military. Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions for pre-existing conditions except for service-connected injuries or illnesses.

States with Individual Mandate

Taxpayers in CA, DC, MA, NJ, RI, and VT (this list is neither complete nor exhaustive) are reminded that your state imposes an individual mandate penalty (tax) should you, your spouse, and children choose to not have (and keep) medical/rx coverage for each tax year. Please consult your tax advisor for how a non-election for health coverage may affect your tax situation.

Mental Health Parity and Addiction Equity Act of 2008

This act expands the mental health parity requirements in the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Services Act by imposing new mandates on group health plans that provide both medical and surgical benefits and mental health or substance abuse disorder benefits. Among the new requirements, such plans (or the health insurance coverage offered in connection with such plans) must ensure that: the financial requirements applicable to mental health or substance abuse disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance abuse disorder benefits.

COBRA

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, COBRA qualified beneficiaries (QBs) generally are eligible for group coverage during a maximum of 18 months for qualifying events due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

COBRA coverage is not extended for those terminated for gross misconduct. Upon termination, or other COBRA qualifying event, the former employee and any other QBs will receive COBRA enrollment information.

Qualifying events for employees include voluntary/involuntary termination of employment, and the reduction in the number of hours of employment. Qualifying events for spouses or dependent children include those events above, plus, the covered employee becoming entitled to Medicare; divorce or legal separation of the covered employee; death of the covered employee; and the loss of dependent status under the plan rules.

If a QB chooses to continue group benefits under COBRA, they must complete an enrollment form and return it to the Plan Administrator with the appropriate premium due. Upon receipt of premium payment and enrollment form, the coverage will be reinstated. Thereafter, premiums are due on the 1st of the month. If premium payments are not received in a timely manner, Federal law stipulates that your coverage will be cancelled after a 30-day grace period. If you have any questions about COBRA or the Plan, please contact the Plan Administrator.

Please note, if the terms of the Plan and any response you receive from the Plan Administrator's representatives conflict, the Plan document will control.

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

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS

NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2021. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: <http://myalhipp.com/>
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: <http://myakhipp.com/>
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: <http://dhss.alaska.gov/dpa/Pages/Medicaid/default.aspx>

ARKANSAS – Medicaid
Website: <http://myarhipp.com/>
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program <http://dhcs.ca.gov/hipp>
Phone: 916-445-8322
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: <https://www.healthfirstcolorado.com/>
Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711
CHP+: <https://www.colorado.gov/pacific/hcpf/child-health-plan-plus> CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI): <https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program>
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid
Website: <https://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html>
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website: <https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp>
Phone: 678-564-1162 ext 2131

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: <http://www.in.gov/fssa/hip/>
Phone: 1-877-438-4479
All other Medicaid
Website: <https://www.in.gov/medicaid/>
Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: <https://dhs.iowa.gov/ime/members>
Medicaid Phone: 1-800-338-8366
Hawki Website: <http://dhs.iowa.gov/Hawki>
Hawki Phone: 1-800-257-8563
HIPP Website: <https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp>
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid
Website: <https://www.kancare.ks.gov/>
Phone: 1-800-792-4884

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: <https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx>
Phone: 1-855-459-6328
Email: KIHIPPPROGRAM@ky.gov
KCHIP Website: <https://kidshealth.ky.gov/Pages/index.aspx>
Phone: 1-877-524-4718
Kentucky Medicaid Website: <https://chfs.ky.gov>

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid
Enrollment Website: <https://www.maine.gov/dhhs/ofi/applications-forms>
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage: <https://www.maine.gov/dhhs/ofi/applications-forms>
Phone: 1-800-977-6740.
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: <https://www.mass.gov/info-details/masshealth-premium-assistance-pa>
Phone: 1-800-862-4840

MINNESOTA – Medicaid
Website: <https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs-and-services/other-insurance.jsp>
Phone: 1-800-657-3739

MISSOURI – Medicaid
Website: <http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>
Phone: 573-751-2005

MONTANA – Medicaid
Website: <http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>
Phone: 1-800-694-3084

NEBRASKA – Medicaid
Website: <http://www.ACCESSNebraska.ne.gov>
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
Medicaid Website: <http://dhcnp.nv.gov>
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: <https://www.dhhs.nh.gov/oi/hipp.htm>
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website: <http://www.state.nj.us/humanservices/dmahs/clients/medicaid/>
Medicaid Phone: 609-631-2392
CHIP Website: <http://www.njfamilycare.org/index.html>
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: <https://medicaid.ncdhhs.gov/>
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: <http://www.nd.gov/dhs/services/medica/serv/medicaid/>
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: <http://www.insureoklahoma.org>
Phone: 1-888-365-3742

OREGON – Medicaid
Website: <http://healthcare.oregon.gov/Pages/index.aspx>
<http://www.oregonhealthcare.gov/index-es.html>
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website: <https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx>
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP
Website: <http://www.eohhs.ri.gov/>
Phone: 1-855-697-4347, or 401-462-0311 (Direct Rte Share Line)

SOUTH CAROLINA – Medicaid
Website: <https://www.scdhhs.gov>
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: <http://dss.sd.gov>
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: <http://gethipptexas.com/>
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: <https://medicaid.utah.gov/>
CHIP Website: <http://health.utah.gov/chip>
Phone: 1-877-543-7669

VERMONT - Medicaid
Website: <http://www.greenmountaincare.org/>
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website: <https://www.coverva.org/en/famis-select>
<https://www.coverva.org/en/hipp>
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid
Website: <https://www.hca.wa.gov/>
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid
Website: <http://mywvhipp.com/>
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website: <https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm>
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: <https://health.wyo.gov/healthcareinf/medicaid/programs-and-eligibility/>
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2021, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Company 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.

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.

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

For the 2022 BCBS PPO Plan

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

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 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 coverage may be affected. If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents may 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 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.

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).

For the 2022 BCBS CDHP Plan

1. The prescription drug coverage offered by this 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 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.**
2. You can keep your current coverage. 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 to December 7th. However, if you decide to drop your current coverage, since it is employer sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan. However, you also may pay a higher premium (a penalty) because you did not have creditable coverage under the BCBS CDHP Plan.

Your Prescription Drug Coverage and Medicare

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

Since the coverage under the BCBS CDHP 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 coverage may be affected. If you enroll for Medicare Part D coverage, you can keep or drop your medical and prescription drug coverage. If you do decide to join a Medicare drug plan and drop your current CDHP coverage, be aware that you and your dependents will not be able to get this coverage back.

Additional Information

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

Contact the Benefits Department at the phone number shown 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 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).

October 1, 2021
Benefits Department
1127 Hwy. 190, East Service Road
Covington, LA 70433
(844) 900-6947 (MyHR)



This benefit guide is provided by

