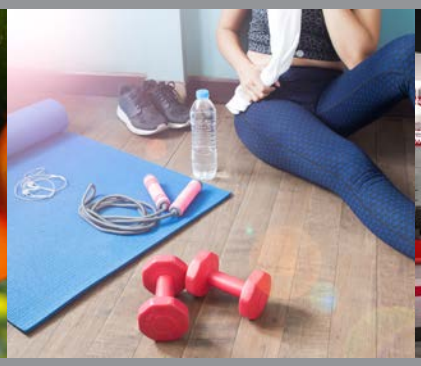
Complete Guide to Your

EMPLOYEE BENEFITS

PSP Holdings is pleased to provide you with a comprehensive employee benefits program.

Plan Year 2018

PSP Holdings

Welcome to your 2018 Employee Benefits!

Your benefits are an important part of your overall compensation. We are pleased to offer an array of comprehensive benefits to protect your health, your family and your way of life. 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 questions or concerns, please do not hesitate to call PSP Holdings' Benefit Resource Center at 1-877-250-2480 (option 1) or e-mail customerservice@crawfordadvisors.com.

Carrier	Web / E-mail	Phone / Email
Medical		
UnitedHealthcare	www.myuhc.com	1-866-633-2446
Flexible Spending Accounts		
Crawford Advisors	http://fsa.crawfordadvisors.com	1-800-657-6265 410-771-9487 (fax)
Dental		
MetLife	www.mybenefits.metlife.com	1-800-638-5433
Vision		
Vision Service Plan	www.vsp.com	1-800-877-7195
Life Insurance		
Lincoln Financial	www.lincoln4benefits.com	1-800-423-2765
Crawford Advisors Benefits Helpline	customerservice@crawfordadvisors.com	1-877-250-2480 (option 1)

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.

Follow these steps if you require assistance:

- **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 carriers site to download an ID card.
- For claims assistance, you can contact Crawford Advisors or call the insurance carrier. You will need your ID number or Social Security number along with date of service and provider name.
- If you require further assistance, contact Crawford Advisors. We have partnered with Crawford Advisors as our Third Party Administrator for expert assistance with benefit related questions, plan procedures, life events and claim issues.

Please have the same information available when you call Crawford Advisors for assistance.

PLEASE NOTE: This booklet provides a summary of the benefits available, but is not your Summary Plan Description (SPD). PSP Holdings 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.

Eligibility

PSP Holdings shares in the costs by paying for a portion of the employee and dependent health insurance costs. Employee's dependents are eligible to participate in the health & welfare plan. Completed enrollment serves as a request for coverage and authorizes any payroll deductions necessary to pay for that coverage.

Any elections made will remain in effect and cannot be changed or revoked until the next annual Open Enrollment period, unless the change is due to and consistent with a family/life status change.

Eligibility Requirements

Full-time and part-time team members with a normal schedule of 30 hours per week are eligible for the benefits described in this guide, unless otherwise stated.

Newly Hired/Eligible Team Members

Newly hired or newly eligible team members must complete enrollment even if they choose to waive coverage. Benefits become effective on the first day of the month after 60 days of employment*, provided you enroll within 30 days from your date of hire.

**Your eligibility is measured during rolling 90 day periods. In order to become and remain eligible, you must continuously work a minimum of 30 hours per week during each 90 day measurement period, as determined by the plan administrator.*

Eligible Dependents

Your eligible dependents include*:

- A spouse to whom you are legally married.
- A dependent child un der age 26. Coverage will terminate at the end of the month of the dependent's 26th birthday. Coverage may be extended past the age of 26 for disabled dependents. Dependent childred can include natural and adopted children, stepchildren, and grandchildren.

Coverage for eligible dependents generally begins on the same day your coverage is effective.

**Additional carrier conditions may apply.*

Pre-Tax Benefits: Section 125

PSP Holdings' 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 Changes

The benefit elections you make during Open 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 Qualifying Life Event (status change) occurs. For purposes of health, dental, vision and Flexible Spending Accounts, you will be deemed to have a Status Change if:

- your marital status changes through marriage, the death of your spouse, divorce, legal separation, or annulment;
- The start or end of a domestic partnership;
- your number of dependents changes through birth, adoption, placement for adoption, or death of a dependent;
- you, your spouse, domestic partner or dependents terminate or begin employment;
- your dependent is no longer eligible due to attainment of age;
- you, your spouse, domestic partner 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/domestic partner's employer;
- a change in residence for you, your spouse, domestic partner or your dependent resulting in a gain or loss of eligibility.

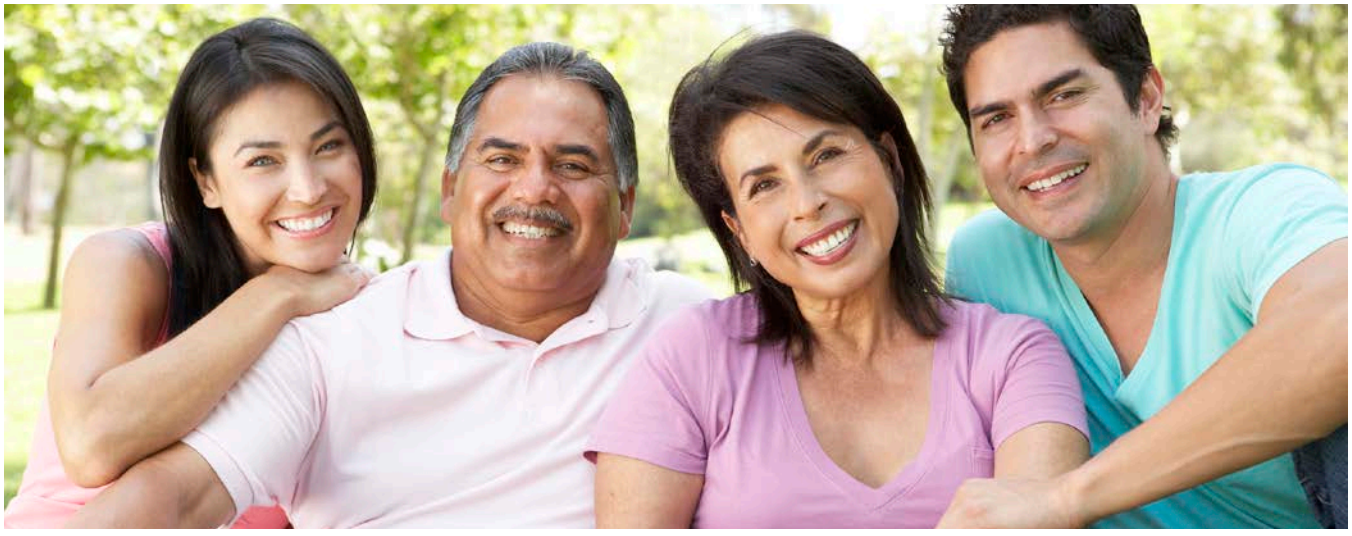
In order to be permitted to make a change of election relating to your health, dental or vision coverage due to a Qualifying Life Event, the Life Event Change must result in you, your spouse, domestic partner or dependent gaining or losing eligibility for health, dental or vision coverage under this Plan or a plan sponsored by another employer by whom you, your spouse/domestic partner, 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, domestic partner or dependent become entitled to Medicare or Medicaid;
- you have a Special Enrollment Right, excluding domestic partners;
- there is a significant change in the cost or coverage for you or your spouse/domestic partner attributable to your spouse/same-sex domestic partner's employment.

For purposes of all other benefits under the Plan, you will be deemed to have a 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.

You must notify Crawford Advisors at 1-877-250-2480 (option 1) within 30 days from the Status Change in order to make a change in your benefit selections.



Your Medical Plan Options

PSP Holdings is proud to offer you a choice between three different medical plans. The plans all offer many resources and tools to help you maintain a healthy lifestyle.

UnitedHealthcare Choice Plus Plans

The UHC Choice Plus Plans are Preferred Provider Organizations, or PPO's for short. All three plans options utilize UnitedHealthcare's Choice Plus network of physicians. With these plan, you will have the freedom to see any provider or other health care professional from the UHC network, including specialists, without a referral. You will receive the highest level of benefits when you seek care from an in-network physician, facility or other health care professional.

You may choose to seek care outside the UHC network without a referral, however you will pay a higher deductible and coinsurance for care received from an out-of-network physician, facility or other health care professional. In addition, UnitedHealthcare only pays a portion of those charges and it is your responsibility to pay the remainder if you choose to seek care outside the network. The amount you are required to pay, which could be significant, contributes to a separate out-of-network out-of-pocket maximum. It's recommended that you ask the out-of-network physician or health care professional about their billed charges before you receive care.

Who pays What and When

You Pay

For the **GOLD** and **SILVER** plans, you pay copays for many services and UHC pays the balance. For other services you will have to pay the full cost until you meet the deductible.

For the **BRONZE** plan, you will pay the full cost of most services until you meet the deducible.

Deductible Met

UHC Shares

For the **GOLD** and **SILVER** plans, once you meet your deductible you will continue to only be responsible for copays for certain services. For other services UHC will pay a percentage and you will pay a percentage (called coinsurance).

For the **BRONZE** plan, the plan pays a percentage and you pay a percentage.

Out-of-Pocket Maximum Met

UHC Pays

Once you meet your out-of-pocket maximum, UHC pays all covered costs for the rest of the plan year.

Compare each plan's Deductibles and Out-of-Pocket Maximums on the following page.

UHC Health4Me Mobile App

UnitedHealthcare's Health4Me provides instant access to you and your family's critical health information – anytime/anywhere. Whether you want to find physicians near you, check the status of a claim or speak directly with a nurse, Health4Me is your go-to resource for everything related to your health. Features include:

- Search for physicians or facilities by location or specialty
- Store favorite physicians and facilities
- View and share health plan ID card information
- Contact an experienced registered nurse 24/7
- Locate Urgent Care facilities and Emergency Rooms
- Check status of deductible and out-of-pocket spending
- Compare procedures, providers and prices with myHealthcare Cost Estimator
- Complete confidentiality

UHC Choice Plus Options

Key Medical Benefits	UHC AS-JC Gold Plan		UHC AS-JO Silver Plan		UHC AFAQ Bronze Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible (per plan year)						
Individual	$1,000	$1,500	$2,500	$3,000	$3,000	$4,000
Family	$3,000	$4,500	$5,000	$6,000	$6,000	$8,000
Out-of-Pocket Maximum (per plan year)						
Individual	$3,000	$6,000	$6,250	$8,000	$5,000	$6,000
Family	$6,000	$12,000	$12,500	$16,000	$10,000	$12,000
Health Savings Account						
Eligible to Enroll	No		Yes		Yes	
Co-insurance						
Your share of expenses after the deductible has been reached	20%	40%	30%	50%	20%	40%
Covered Services						
Routine Preventive Care	100% covered	40%*	100% covered	50%*	100% covered	40%*
Primary Physician Office Visit - Sickness & Injury	$30 co-pay	40%*	$30 co-pay	50%*	20%*	40%*
Specialist Office Visit	$60 co-pay	40%*	$60 co-pay	50%*	20%*	40%*
Diagnostic Lab & X-ray	100% covered	40%*	100% covered	50%*	20%*	40%*
Emergency Room	$150 co-pay	$150 co-pay	$150 co-pay	$150 co-pay	20%*	20%*
Urgent Care Facility	$75 co-pay	40%*	$75 co-pay	50%*	20%*	40%*
Inpatient Hospital Stay	20%*	40%*	30%*	50%*	20%*	40%*
Outpatient Surgery	20%*	40%*	30%*	50%*	20%*	40%*
Prescription Drugs (Tier 1/Tier 2/Tier3)						
Retail Pharmacy (30-day supply)	$10 / $35 / $60		$10 / $35 / $60		$10* / $35* / $60*	
Mail Order (90-day supply)	$25 / $87.50 / $150	n/a	$25 / $87.50 / $150	n/a	$25* / $87.50* / $150*	n/a

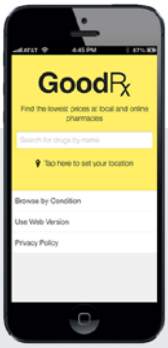
** You pay applicable co-insurance after the deductible is reached, up until Out-of-Pocket Maximum is reached.*

***Deductible does not apply** to services not marked with an asterisk. UHC covers costs after applicable copay.*

This Summary is for informational purposes only. For specific benefit information, please refer to the applicable Insurance Contract.

Medicare Part D

The prescription drug benefit is creditable coverage. Medicare-eligible participants need not enroll in a separate Medicare D drug plan.



GoodRx Mobile App

Regardless of which plan you decide to enroll in, we encourage you to download and use the GoodRx Mobile App to help you save on your prescription drug costs. The cost of a prescription may differ by more than $100 between two pharmacies across the street from each other. GoodRx doesn't sell the medications, they will tell you where you can get the best deal on them. GoodRx will show you prices, coupons, discounts and savings tips for your prescription at pharmacies near you.

MetLife Dental

MetLife Dental PPO

With the MetLife Dental plan, you can see any dentist you would like, but receiving care from a network provider lowers your out-of-pocket costs and makes benefits go further. In addition, you will never have to submit a claim form for visits to dentists in the network.

Preventive Care Coverage

Preventive care is covered at little or no cost to you. A broad range of additional services is also covered. The plan also includes:

- Pregnancy dental benefit: MetLife covers extra visits for dental cleanings and gum treatments, if needed, during pregnancy and the first three months after baby is born because a woman is more likely to develop dental disease during this time.
- Annual oral cancer screenings for all adult patients

	Non-Orthodontics		Orthodontics	
	Network	**Out-of-Network**	**Network**	**Out-of-Network**
Individual Annual Deductible	$50	$50	$0	$0
Family Annual Deductible	$150	$150	$0	$0
Annual Maximum Benefit (The total benefit payable by the plan will not exceed the highest listed maximum amount for either Network or Non-Network services.)	$3000 per person per calendar year	$3000 per person per calendar year	$1000 per person per lifetime	$1000 per person per lifetime
Annual Deductible Applies to Preventive and Diagnostic Services	No			
Annual Deductible Applies to Orthodontic Services	No			
Waiting Period	No waiting period			
Orthodontic Eligibility Requirement	Up to age 19			

Services	In-Network Plan Pays	Out-of-Network Plan Pays
Diagnostic Services		
Periodic Oral Evaluation	100%	100%
Preventive Services		
Dental Prophylaxis (Cleanings), Fluoride Treatments, Sealants, Bitewing Radiographs	100%	100%
Basic Dental Services		
Radiographs, Lab and Other Diagnostic Tests, Space Maintainers, Restorations, Palliative Treatment, Simple Extractions, Periodontal Maintenance	80%	80%
Major Dental Services		
Oral Surgery (includes surgical extractions), Endodontics, Periodontics, General Anesthesia, Occlusal Guard, Inlays/Onlays/Crowns, Dentures and other Removable Prosthetics, Fixed Partial Dentures (Bridges),	50%	50%
Orthodontic Services (for children up to age 19)		
Diagnose or correct misalignment of the teeth or bite	50%	50%

Vision Service Plan

Vision coverage is provided through Vision Service Plan (VSP). Please note you will not receive an ID card for vision care coverage.

In order to get the most from this plan, you should select a participating doctor from their nationwide network of providers. If you use a participating doctor, covered services are paid in full after you pay the required copayment. VSP also provides coverage for non-network providers; however, you will receive a greater benefit by using their network doctors.

How to Find an In-Network Provider

- For a VSP participating provider, log on to www.VSP.com and click the find a VSP doctor link.
- Or call the customer service number 1-800-877-7195.

VSP Benefits subject to applicable copays			
Exam Services	**Comprehensive WellVision Exam® covered-in-full after copay** ➤ Contact lens exam - fitting and evaluation (when choosing contacts): Standard and Premium fit: Covered in full with a copay. Member receives 15% off of contact lens exam services; member's copay will never exceed $60 ➤ Routine retinal screening covered after an up to $39 copay		
Lenses	Glass or plastic:	Single vision Lined bifocal Lined trifocal Lenticular	Covered-in-full after copay Covered-in-full after copay Covered-in-full after copay Covered-in-full after copay
Frame	➤ Frames covered-in-full after copay up to the retail allowance of $130 ➤ Frame allowance is guaranteed by a $50 wholesale allowance at VSP doctors, ensuring more than 13,000 frames are covered-in-full ➤ Members who select a featured frame brand including Ann Klein, bebe®, Calvin Klein, Flexon, Lacoste, Nike, Nine West, and more will receive an extra $20 toward their frame allowance. ➤ 20% off any amount above the retail frame allowance ➤ Members can choose from virtually any frame on the market		
Lens Enhancements	The most popular lens enhancements are covered after a copay, saving members an average of 20-25%; members should see their VSP network provider for special pricing on additional lens enhancements. Maximum copay on standard lens enhancements:		
	Lens Enhancement	**Single Vision**	**Multifocal**
	Standard progressives plastic	N/A	$55
	Premium progressives plastic	N/A	$95-105
	Custom progressives plastic	N/A	$150-175
	Standard anti-reflective coating	$41	$41
	Solid tints & dyes (pink I&II)	No copay	No copay
	Solid plastic dye (except pink I&II)	$15	$15
	Plastic gradient dye	$17	$17
	UV protection	$16	$16
	Factory applied scratch-resistant coating	$17	$17
	Polycarbonate for children	No copay	No copay
	Polycarbonate	$31	$35
	Photochromic plastic	$70	$82
Elective Contact Lenses (instead of lenses & frame)	➤ Prescription contact lens materials covered-in-full up to $130 retail allowance ➤ VSP members get exclusive mail-in rebate savings7 on eligible Bausch + Lomb contacts at VSP doctors ➤ Members can choose from any available prescription contact lens materials		
Necessary Contact Lenses (instead of lenses & frame)	➤ Covered-in-full after copay for members who have specific conditions at VSP doctors ➤ Covered up to $210 after copay for members who have specific conditions at participating retail chains		

Flexible Spending Account

Flexible Spending Accounts 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. Employees need not be enrolled in a company-sponsored medical plan to participate in the FSA.

If you enroll, you fund the accounts via a payroll deduction each pay period. The minimum contribution is $10 per pay. Money that you contribute to your FSAs is not subject to social security taxes, federal, and in most cases, state income taxes.

Health Care Flexible Spending Account

Eligible health care expenses include many of the out-of-pocket expenses you pay to maintain your health and well-being. These include deductibles and coinsurance expenses not covered by your medical plan, expenses for glasses or contact lenses, and more.

Contribution Limits: The maximum annual amount you may contribute to a HCFSA is $2,650.

If you have specific questions related to eligible and non-eligible FSA expenses call the Crawford Advisors FSA Customer Service Line at 1-800-657-6265.

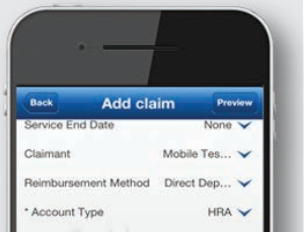
FSA Debit Card

A debit card makes using your FSA dollars easier than ever. It is provided to all HCFSA participants. The Card is similar to a bank account debit card that allows you to remove funds from your FSA at a merchant payment terminal. By using the Card to purchase eligible expenses, you avoid paying for a purchase with money out of your pocket. Remember, you still must keep your receipts even when you use the debit card. Periodically, the IRS requires proof of purchase.

Be sure to take advantage of CrawfordAdvisors' FSA Mobile App!

Get your benefits on the go! Save time and hassles with the WealthCare Mobile App. Check your account balance, transactions, and claim details. Take pictures of statements to submit as claims!

For more information and to download the app, visit http://fsa.crawfordadvisors.com and click the link for "Crawford Mobile."



Claims and Reimbursement

New Account Users

1. Please visit http://fsa.crawfordadvisors.com to register for the FSA web site.
2. Please enter your desired User Name.
3. Enter a Password meeting the minimum security requirements. Please do not use your name within your password.
4. Enter your First Name and Last Name as they were provided to your employer at enrollment. No suffixes or commas please.
5. Provide an Email Address.
6. Enter your Employee ID (your Social Security Number).
7. For Registration ID use our Employer's ID which is CRWPSP.
8. Check the Accept the Terms of Service check box.
9. Click Register.

That's it! You can begin to submit claims online for your FSA.

Status Changes

Federal regulation prohibits 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 status change. Only benefit changes consistent with the change in status are permitted. Status Changes that may warrant a change in benefit elections are described on page 2 of this guide.

Basic Life and AD&D Insurance

Basic Life Insurance

Life insurance provides financial protection for your family in the event of your death. PSP Holdings offers all team members life and accidental death and dismemberment insurance through Lincoln Financial. The amount of Basic Life and AD&D you receive depends on your job category. See your manager for more details.

Voluntary Life and AD&D Insurance

You may elect to increase your life insurance coverage for yourself, your spouse and your dependent children – all at an affordable group rate provided by Lincoln Financial. This coverage comes in the following increments:

Employee Voluntary Life

Benefit Amount: increments of $10,000

Non-Medical Maximum Benefit: $100,000

Maximum Benefit: the lesser of 5x Annual Base Earnings or $200,000

Spousal Voluntary Life

Benefit Amount: increments of $5,000

Non-Medical Maximum Benefit: $10,000

Maximum Benefit: $100,000

Spouse amount cannot exceed 50% of the employee's Supplemental Life benefit

Dependent Child Voluntary Life

Benefit Amount: $10,000

Child amount cannot exceed spouse amount.

Employee and Spouse Voluntary AD&D

You may also elect separate accidental death & dismemberment (AD&D) coverage for yourself and your spouse.

Benefit Amount: increments of $10,000

Maximum Employee Benefit: $100,000

Maximum Spouse Benefit: $50,000

Portability Options for Basic & Voluntary Life

If your coverage under the Policy ends prior to age 70, for any of the following reasons:

a. termination of employment; or

b. termination of membership in an eligible class under the Policy;

Life Insurance Benefits may be continued up to the Maximum Benefit shown in the Schedule of Benefits for this option.

You must apply to the Insurance Company and pay the required premium. If you continue coverage, coverage for your Spouse or Dependent Child may also be continued by you. Your Spouse or Dependent Child must be covered under the Policy on the date coverage would otherwise end. The application must be submitted:

a. within 31 days of your termination of employment or membership in an eligible class under the Policy; or

b. during the time that you have to exercise the Conversion Privilege.

Coverage under this option may not be elected at a later date.

Employee Contributions

	Per Pay Contributions
Medical	
Please see your manager for more information	
Dental	
MetLife Dental	
Employee Only	$25.02
Employee + Spouse	$50.03
Employee + Child(ren)	$51.86
Employee + Family	$80.47
Vision	
Vision Service Plan	
Employee Only	$4.52
Employee + Spouse	$7.61
Employee + Child(ren)	$7.77
Employee + Family	$12.52
Life Insurance	
Employee & Spouse Voluntary Life (age banded monthly rates per $1,000 of coverage)	
<20	$0.060
20-24	$0.060
25-29	$0.060
30-34	$0.070
35-39	$0.090
40-44	$0.140
45-49	$0.230
50-54	$0.430
55-59	$0.690
60-64	$0.810
65-69	$1.460
70-74	$2.840
75-79	$7.600
80+	$17.460
Dependent Child	
$10,000 benefit	$0.200
Employee & Spouse Voluntary AD&D	
Rate per $10,000	$0.025

How to Calculate Voluntary Life and AD&D Insurance Contributions

Volume		Rate				
	÷ 1,000 x		=		÷ 2 =	
i.e. $10,000		from chart above		monthly premium		payroll deduction

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.

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.

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/same-sex domestic partners 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.

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.

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