Bravo™ TECH

Benefit Enrollment Guide

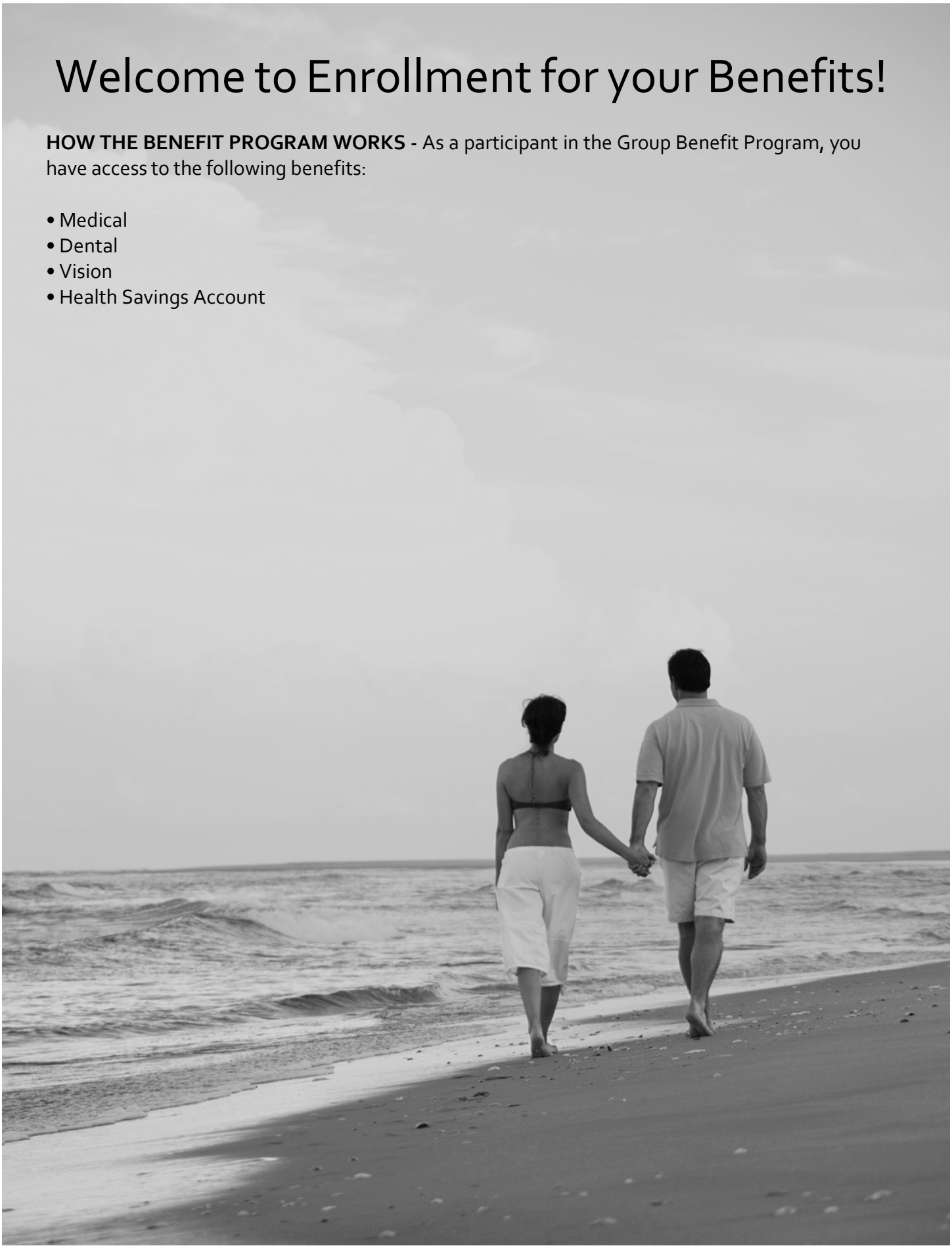
Annual Federal Notices are included in the back of this guide.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage.

Welcome to Enrollment for your Benefits!

HOW THE BENEFIT PROGRAM WORKS - As a participant in the Group Benefit Program, you have access to the following benefits:

- Medical
- Dental
- Vision
- Health Savings Account



Who is Eligible?

If you are a full-time employee (working 30 or more hours per week), you are eligible to enroll in the benefits described in this guide. New Hires are eligible for benefits on the first of the month following 60 days. The following family members are eligible for medical, dental, and vision: legal spouse, your children, or your spouse's natural or adopted children under age 26. Your legal spouse and your children up to age 25 are eligible to enroll in dependent life insurance. Should your employment with The Company terminate, your coverage and associated premiums will continue through the end of the month of your termination. If you are enrolled in medical, dental, or vision coverage, you will be eligible for COBRA continuation of coverage.

How to Enroll?

The first step is to review your current benefit elections. Verify and update your personal information with HR and make any changes if necessary. Using the enrollment form, add family information for any dependents that will be enrolled in the plans. Once you have made your elections, you will not be able to change them until the next open enrollment period unless you have a qualified change in status.

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How to Make Changes?

Unless you have a qualified change in status, you cannot make changes to the benefits you elect until the next open enrollment period. Qualified changes in status include: marriage, divorce, legal separation, birth or adoption of a child, change in child's dependent status, death of spouse, child or other qualified dependent, change in residence due to an employment transfer for you, commencement or termination of adoption proceedings, or change in spouse's benefits or employment status. Please note that some documentation may be required. Contact Human Resources within 30 days if you have a qualified change in status.

BASIC DEFINITIONS

CASE MANAGEMENT: The medical management process wherein health plans identify patients with specific or chronic health conditions, and interact with their physician(s) to ensure that these individuals receive medically necessary and appropriate health care services.

COINSURANCE: The money that an individual is required to pay for services, after a deductible has been paid. It is often a specified percentage of the charges.

COPAYMENT: An arrangement where an individual pays a specified amount for various health care services and the health plan or insurance company pays the remainder. The individual must usually pay his or her share when services are rendered. The concept is similar to coinsurance, except that copayments are usually a set dollar amount (such as $25 per office visit), rather than a percentage of the charges.

DEDUCTIBLE: A set dollar amount that a person must pay before insurance coverage for certain medical expenses can begin. They are usually charged on an annual basis.

DISEASE MANAGEMENT: The process of identification and evaluation of patients with chronic diseases, using interventions designed to promote ongoing management and prevent worsening of the disease.

EXCLUSIONS AND LIMITATIONS: Specific conditions or circumstances for which an insurance policy or plan will not provide coverage (exclusions), or for which coverage is specifically limited (limitations).

IN-NETWORK: Typically refers to physicians, hospitals, or other health care providers who contract with the insurance plan to provide services to its members. Coverage for services received from in-network providers will typically be greater than for services received from out-of-network providers, depending on the plan.

MAXIMUM BENEFIT: The maximum dollar amount that an insurance company will pay for claims, either for a specific service or procedure, or during a specified period of time.

OUT-OF-NETWORK: Typically refers to physicians, hospitals, or other health care providers who do not contract with the insurance plan to provide services to its members. Depending upon the insurance plan, expenses incurred for services provided by out-of-network providers might not be covered, or coverage may be less than for in-network providers.

PREVENTIVE CARE: Health care services that are for prevention, not for the treatment of active diseases or illnesses. This type of care focuses on wellness, health promotion and other initiatives that reduce the risk of future illnesses or injuries such as routine physical exams, mammograms or colon cancer screenings.

QUALIFIED MEDICAL EXPENSE: These generally include expenditures for medical care that you may be able to deduct on your income taxes. The IRS imposes strict guidelines on claims for medical care, so check their guidelines for allowable expenses not reimbursed by insurance or another source.

URGENT CARE CENTER: A health care facility whose primary purpose is the provision of immediate, short-term medical care for minor but urgent medical conditions. Serves as an alternative to the hospital emergency room.

EVIDENCE OF INSURABILITY FORM (EOI): The documentation of good health condition in order to be approved for coverage. The form may include questions pertaining to your health or medical history. This document may be required when applying for life insurance or other voluntary benefits.

MEDICAL
BCBS of Texas

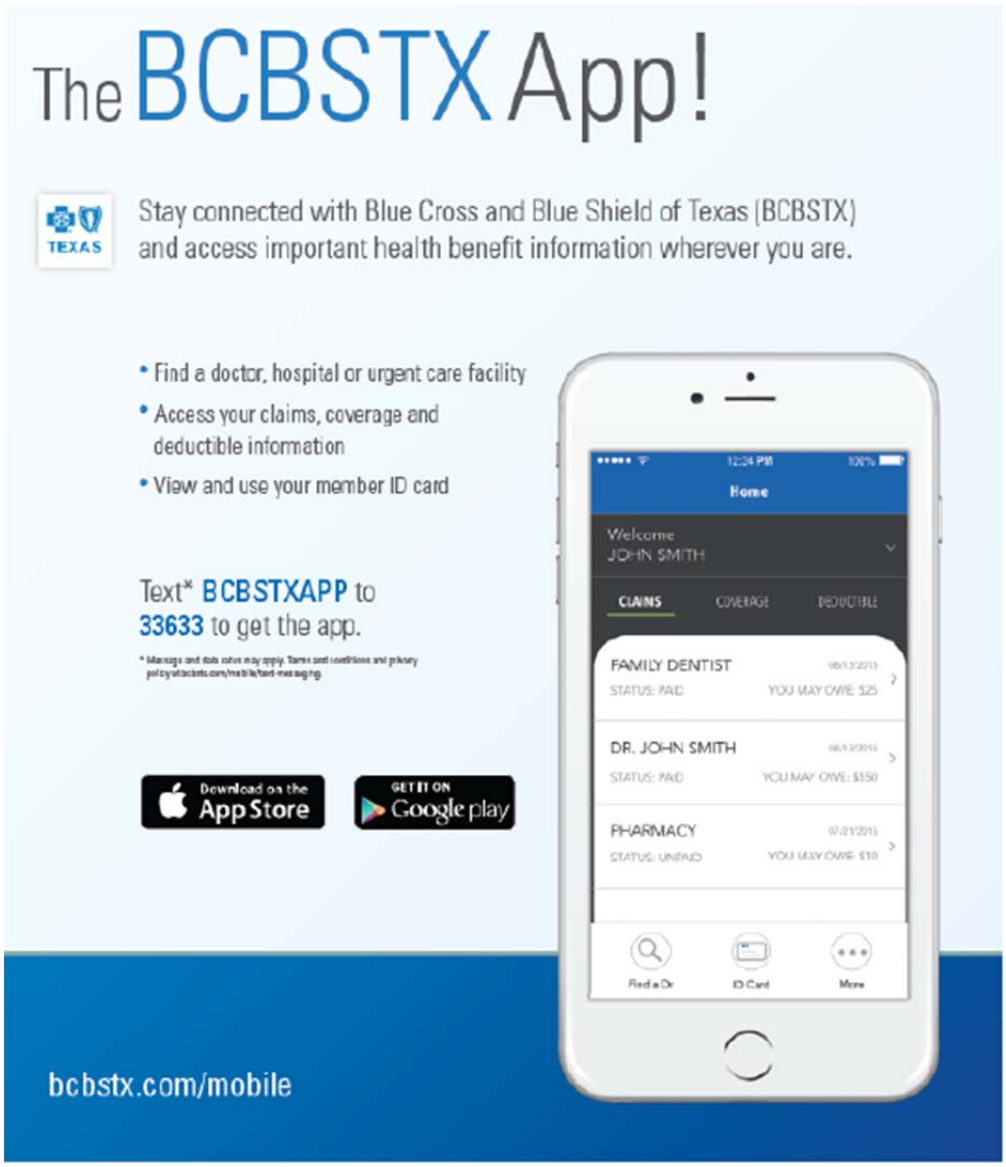
This chart gives a snapshot of the benefit and amounts covered under the plan. For a complete list of covered services, see your Certificate of Coverage. Network physicians and hospitals can be found at www.bcbstx.com. Summary Benefits of Coverage available in HR.

Medical Benefits	HSA MTBCPC1CH
Coinsurance	
Network	100%
Non-Network	50%
Deductible	**Embedded**
Network	$6,650 / $13,300
Non-Network	$13,300 / $26,600
Out-of-Pocket Maximum	
Deductible Included	Included
Network	$6,650 / $13,300
Non-Network	Unlimited
Office Visit	
Preventive Network	100% Covered
Primary Network	100% after Deductible
Specialist Network	100% after Deductible
Urgent Care Network	100% after Deductible
Chiropractic or other Network	100% after Deductible
Office Services Non-Network	50% after Deductible
Hospital	
Emergency Room	100% after Deductible
Inpatient Network	100% after Deductible
Outpatient Network	100% after Deductible
Complex Imaging Network	100% after Deductible
Hospital & Imaging Services Non-Network	50% after Deductible
Prescription Drugs	
Rx Deductible	None
Retail Gen./Pref./Non-Prefer.	100% after Deductible
Mail Gen./Pref./Non-Prefer.	100% after Deductible
Specialty Gen./Pref./Non-Prefer.	100% after Deductible
Network Name	Blue Choice
Network Web Address	www.bcbstx.com

Affordable Care Act and My Options

It is important to note that this medical plan offered by The Company meets all Affordable Care Act requirements. This Plan exceeds minimum value, minimum essential coverage and affordability standards. Because of this, you will not be eligible for a subsidy on the healthcare marketplace.

Hourly Rate			Per Paycheck Contributions (48)			
			Employee Only	Employee Spouse	Employee Child	Employee Family
$7.25	-	$12.50	$39.25	$194.37	$161.14	$304.11
$12.51	-	$14.50	$46.75	$201.87	$168.64	$311.61
$14.51	-	$16.50	$54.25	$209.37	$176.14	$319.11
$16.51	-	$18.50	$61.75	$216.87	$183.64	$326.61
$18.51	-	$20.50	$69.25	$224.37	$191.14	$334.11
$20.51	-	$22.50	$76.75	$231.87	$198.64	$341.61
$22.51	-	$24.50	$84.25	$239.37	$206.14	$349.11
$24.51	-	$26.50	$91.75	$246.87	$213.64	$356.61
$26.51	-	& Up	$111.66	$266.78	$233.54	$376.52



BlueCross BlueShield of Texas

Because Your Health Counts

It's Important to Know Where to Go When You Need Care

Sometimes it's easy to know when you should go to an emergency room (ER), at other times, it's less clear. You have choices for receiving in-network care that will work with your schedule and also give you access to the kind of care you need. Know when to use each for non-emergency treatment.

Virtual Visits

There's never a convenient time to get sick. But now you have access to a board-certified doctor around the clock for non-emergency health issues. Connect by mobile app, online video or telephone. Register at **MDLIVE.com/bcbstx** or by calling **888-680-8646**.

Your Doctor's Office

Your own doctor's office may be the best place to go for non-emergency care, such as health exams, routine shots, colds, flu and minor injuries. Your doctor knows your health history, the medicine you take, your lifestyle and can decide if you need tests or specialist care. Your doctor can also help you with care for a chronic health issue, such as asthma or diabetes.

Retail Health Clinic

When you can't get to your regular doctor, walk-in clinics – available in many retail stores – can be a lower-cost choice for treatment. Many stores have a physician assistant or nurse practitioner who can help treat ear infections, rashes, minor cuts and scrapes, allergies and colds.

Urgent/Immediate Care Clinic

These facilities can treat you for more serious health issues, such as when you need an X-ray or stitches. You will probably have a lower out-of-pocket cost than at a hospital ER, and you may have a shorter wait.

Hospital Emergency Room

Any life-threatening or disabling health problem is a true emergency. You should go to the nearest hospital ER or call **911**. When you use the ER for true emergencies, you help keep your out-of-pocket costs lower.

Knowing where to go for care can make a big difference in cost and time. Here's how your options compare[†]:

	Average Costs	Average Wait Times	Examples of Health Issues	
Virtual Visits Convenient and lower cost	$	10 minutes or less	• Allergies • Cold and flu • Nausea	• Sinus infections • Asthma • Pinkeye
Your Doctor's Office Your doctor knows your medical history best	$	24 minutes*	• Fever, colds and flu • Sore throat • Minor burns • Stomach ache	• Ear or sinus pain • Physicals • Shots • Minor allergic reactions
Retail Health Clinic Convenient, low-cost care in stores and pharmacies	$	15 minutes	• Infections • Cold and flu • Minor injuries or pain • Shots	• Flu shots • Sore and strep throat • Skin problems • Allergies
Urgent Care Clinic Immediate care for issues that are not life-threatening	$$$$	11-20 minutes**	• Migraines or headaches • Cuts that need stitches • Abdominal pain • Sprains or strains	• Urinary tract infection • Animal bites • Back pain
Hospital Emergency Room For serious or life-threatening conditions	$$$$$$	4 hours, 7 minutes***	• Chest pain, stroke • Seizures • Head or neck injuries • Sudden or severe pain	• Fainting, dizziness, weakness • Uncontrolled bleeding • Problem breathing • Broken bones

* Medical Practice Pulse Report 2009, Press Ganey Associates.

** Urgent Care Benchmarking Study Results. Journal of Urgent Care Medicine. January 2012.

*** Emergency Department Pulse Report 2010 Patient Perspectives on American Health Care. Press Ganey Associates.

Urgent Care or Freestanding Emergency Room

Urgent care centers and freestanding ERs can be hard to tell apart. Freestanding ERs often look a lot like urgent care centers and treat most major injuries, except for trauma, but costs are higher. Unlike urgent care centers, freestanding ERs are often out of network and can charge patients up to 10 times more for the same services.[1] Here are some ways to know if you are at a freestanding ER.

Freestanding ERs:

- Look like urgent care centers, but have EMERGENCY in the facility name.
- Are separate from a hospital but are equipped and work the same as an ER.
- Are staffed by board-certified ER physicians and are subject to the same ER copay.

Find urgent care centers[2] near you by texting[3] **URGENTTX** to **33633**.

Need help finding a network provider?

Use Provider Finder® at **bcbstx.com** or call the Customer Service number on the back of your member ID card. If you need emergency care, call **911** or seek help from any doctor or hospital right away.

[†] Relative costs described are for independently contracted network providers. Costs for out-of-network providers may be higher.

[1] The Texas Association of Health Plans.

[2] The closest urgent care center may not be in your network. Be sure to check Provider Finder to make sure the center you go to is in-network.

[3] Message and data rates may apply. Read terms, conditions and privacy policy at bcbstx.com/mobile/text-messaging.

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BlueCross BlueShield of Texas

Powered by MDLIVE®

Care When and Where You Need It Just Got Easier

Virtual Visits

Convenient health care at your fingertips

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

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

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

General Health
- Allergies
- Asthma
- Nausea
- Sinus infections

Pediatric Care
- Cold/flu
- Ear problems
- Pinkeye

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

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Connect[2]
Access via telephone 24/7/365

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

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

Telephone:

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

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

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

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

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

HSA (HEALTH SAVINGS ACCOUNT) – HSA Bank

If you are enrolled in the high deductible health plan you are eligible to open a health savings account. A health savings account (HSA) is a trust or custodial account established exclusively for the purpose of paying qualified medical expenses of the account holder, their spouse, and/or their tax dependents. Payments for qualified medical, dental and vision expenses are tax-free.

What is a "qualified medical expense?"

In general; any expense for the diagnosis, cure, mitigation, treatment or prevention of diseases and for treatments affecting any part or function of the body. A list of qualified expenses can be found in Code Sec. 213(d) (See IRS Publication 502). The expense cannot be reimbursed elsewhere (for example through a MERP/HRA or FSA account).

Some examples of a qualified medical expense are: doctor's office fees, hospital services, dental services, vision services, eyeglasses, contacts, braces, prescription drugs.

Non-qualified expenses include anything cosmetic or expenses for items that are only beneficial to your general health (for example: teeth whitening, herbal supplements, and vitamins). Over-the-counter medications are nonqualified expenses unless you have received a prescription from your provider.

Who is eligible to establish and contribute to an HSA?

Any individual who during any month: (1) is covered under a high deductible health plan ("HDHP") on the first day of such month; (2) is not also covered by any other health plan* that is not an HDHP (with certain exceptions for plans providing certain limited types of coverage); (3) is not enrolled in Medicare (mere eligibility is disregarded); and (4) may not be claimed as a dependent on another person's tax return (not including the spouse).

*This includes your spouse's health FSA. There are a few exceptions for vision, dental, wellness programs, preventive benefits, etc.

How much can I contribute?

The U.S. Treasury Department issues HSA contribution limits each year. The maximum contributions for 2019 are: $3,450 self-only coverage and $6,900 family coverage. Effective January 1, 2020 you can increase your contribution to: $3,500 self-only coverage and $7,000 family coverage. A catch-up contribution of $1,000 is allowed for individuals who reach age 55 during the calendar year and for every year after reaching age 55.

Who owns the funds in these accounts?

The employee owns the funds in the account and is responsible for all recordkeeping.

If the HSA is under a cafeteria plan, can the participant change his election mid-year?

Yes, because the eligibility requirements and contribution limits for HSAs are determined on a month-by-month basis, rather than on an annual basis, an employee who elects to make HSA contributions under a cafeteria plan may start or stop the election or increase or decrease the election at any time as long as the change is effective in the future.

To open and contribute to a Health Savings Account with, you need to:

1) Enroll in the HDHP medical plan
2) Complete the HSA Bank application/election form with your annual deduction amount
3) Begin funding your HSA through pre-tax automatic payroll deduction or tax-deductible lump-sum deposit
4) Receive and begin using your HSA Bank HSA debit card
5) Review your investment options when your account reaches a certain limit. You have a choice of mutual fund options and a registered representative ready to assist you by phone.

REMINDER: The IRS penalty for the use of funds for expenses other than qualified expenses is 20% penalty plus applicable income tax. This applies to HSA account holders under the age of 65. If funds are used for non-qualified expenses after age 65 the penalty will not apply however payment of income tax would be required.

DENTAL
BCBS of Texas

The Company offers you two different dental plans to choose from. This chart shows covered benefits and costs. Network dentists can be found at www.bcbstx.com.

Dental Benefits	DTNHM11 Low	DTNLM24 High
Annual Maximum	$750 (incl. preventative)	$1,000 (Incl. preventative)
Deductible		
Individual	$25	$50
Family	$75	$150
Type I - Preventive		
Waiting Period		
Oral Exams	100%	100%
X-Rays - *Bite Wings* - *Full Mouth*	100%	100%
Cleanings	100%	100%
Sealants	100%	80%
Fluoride Treatment	100%	100%
Space Maintainers	100%	80%
Palliative Treatment (relief of pain)	0%	80%
Type II - Basic		
Waiting Period		
Fillings	0%	80%
Root Canal Treatment	0%	50%
Simple Extractions	0%	80%
Endodontics	0%	80%
Periodontics	0%	80%
General Anesthesia	0%	80%
Type III - Major		
Waiting Period	None	None
Crowns	0%	50%
Inlays & Onlays	0%	50%
Removable/Fixed Bridge-work	0%	50%
Partial or Complete Dentures	0%	50%
Denture Relines/Rebases	0%	50%
Orthodontics		
Waiting Period		12 month
Ortho Lifetime Max	0%	$1,000
Services	0%	50%
Network Name	BlueCare Enhanced	BlueCare Enhanced

YOUR PER PAYCHECK RATES
Dental

EMPLOYEE DEDUCTIONS PER WEEKLY PAY PERIOD				
	Employee Only	**Employee & Spouse**	**Employee & Children**	**Employee & Family**
Low DTNHM11	$3.31	$6.61	$10.27	$15.18
High DTNHM24	$7.51	$15.02	$21.05	$31.66

VISION
EyeMed

The Company offers the Vision Choice plan through EyeMed. This chart shows covered benefits and costs. Network vision providers can be found at **www.eyemed.com**.

Vision Benefits	
Exams	
Eye Exam Network	$10 Copay
Contact Fit & Follow up Network	$40 Copay
Retinal Imaging Network	Up to $39
Non-Network Exam Allowance	Up to $40
Lenses	
Single Vision Lenses Network	$10 Copay
Bifocal Lenses Network	$10 Copay
Trifocal Lenses Network	$10 Copay
Progressive Lenses Network	Up to $185
Non-Network Lenses Allowance	Up to $70
Frames	
Frames Network	$150 Allowance + 20% Off Balance
Non-Network Frame	Up to $105
Contacts	
Elective Network	$150 Allowance + 15% Off Balance
Non-Network Elective	Up to $105
Medically Necessary	Paid in Full
Non-Network Medically Necessary	Up to $210
Frequency Limits	Months
Exam / Lenses / Frames	12/12/24
Features	
Network Name **Network Web Address**	EyeMed www.eyemed.com

YOUR PER PAYCHECK RATES
Vision

EMPLOYEE DEDUCTIONS PER WEEKLY PAY PERIOD			
Employee Only	**Employee & Spouse**	**Employee & Children**	**Employee & Family**
$1.64	$3.12	$3.29	$4.83

BlueCross BlueShield of Texas

BlueExtras

offers members and covered dependents access to savings on a number of health care and wellness products and services. Simply show your BCBSTX ID card to a provider who takes part in these special offers. To learn more, log in to Blue Access for Members℠ (BAM) at *bcbstx.com*.

BlueExtras℠

Money-Saving Program

The BlueExtras program is just one more advantage of being a Blue Cross and Blue Shield of Texas (BCBSTX), a division of Health Care Service Corporation, member. With BlueExtras, you can save money on health care products and services that are most often not covered by your benefit plan. There are no claims to file and no referrals or pre-authorizations.

Complementary Alternative Medicine

(866) 656-6069

Complementary Alternative Medicine includes a number of treatments that may help improve your health. You can automatically get up to 30 percent off standard fees through the Healthways WholeHealthMD network of more than 35,000 practitioners, spas, and wellness and fitness centers. Log in to BAM. Then access the WholeHealthMD website to search for a network provider.

Davis Vision℠′

(800) 501-1459

TruVision

(877) 882-2020

Save on eyeglasses, as well as contact lenses, laser vision correction services, examinations and accessories. Find out more when you log in to BAM. For a list of Davis Vision providers near you, go to *bcbstx.com*, click *Find a Doctor* then select *Find a Vision Provider*. The Davis Vision network consists of major national and regional retail locations as well as independent ophthalmologists and optometrists. You and your eligible dependents can receive discounts on laser vision correction services through the TLC/TruVision network.

Jenny Craig®′

(877) JENNY70 (877-536-6970)

Jenny Craig can help you reach your weight loss goals. You will get one-on-one support given by a trained weight loss expert. Your consultant will give you a tailored program based on the essential components of successful weight management: food, body, mind. You can meet with your consultant in person at a local center. Or you can enjoy the ease of the Jenny Craig At Home program. To get a special savings coupon, log in to BAM.

For more facts about BlueExtras, log in to Blue Access for Members at *bcbstx.com*. Click the **My Health** tab, and then the **BlueExtras** link.

Life Time®* Fitness

Life Time Fitness offers a total health fitness experience no matter your fitness level, interests, schedule or budget. **For new members, Life Time Fitness offers a $0 enrollment fee when you sign up online.*** Log in to BAM and access the Life Time Fitness website to find a free, seven-day pass to try out the location nearest you.

Procter & Gamble (P&G) Dental Products

(877) 333-0121

Get savings on dental packages containing the latest in Oral B® power toothbrushes and Crest® products. The dental packages from P&G can help you improve the health of your teeth and gums. Packages may contain items such as an electronic toothbrush, mouth rinse, floss, and many more. Log in to BAM and access the P&G estore link to shop.

Seattle Sutton's Healthy Eating®*

(800) 442-DIET (800-442-3438)

These freshly prepared, calorie-controlled meals are designed to help with weight loss and managing certain health problems. Depending on your location, you can have Seattle Sutton's Healthy Eating bring your food to you or you can pick up your meals. Log in to BAM for more details and to access the Seattle Sutton's Healthy Eating website.

TruHearing®*

(800) 687-4617

Save on digital hearing aids through TruHearing. Get a hearing test at no extra charge when performed to fit a hearing aid. Enjoy a 45-day, money-back guarantee and a three-year warranty. Also get a choice of hearing aid styles at a number of price levels and enough batteries to last a year when you buy a hearing aid. Learn more when you log in to BAM.

The relationship between these vendors and Blue Cross and Blue Shield of Texas (BCBSTX) is that of independent contractors.

* Proof of Blue Cross and Blue Shield of Texas coverage is needed. **The $0 enrollment fee offer is only for new members who enroll online through the link on BAM.** A $35 administrative fee applies to all memberships. Monthly dues and taxes may also apply. Members' prices, dues and fees may change at any time. Offer expires September 1, 2013. Other rules may apply. Always check with the Life Time Fitness club in your area for the most up-to-date offer. Offer not available in Minnesota.

BlueExtras is a discount program only for BCBSTX members. Some of the services offered through BlueExtras may be covered under your health plan. Please check your benefit booklet or call the customer service number on the back of your ID card for specific benefit facts. Use of BlueExtras does not change your monthly payment, nor do costs of BlueExtras' services or products count toward any maximums and/or plan deductibles. Discounts are only given through vendors who take part in this program. BCBSTX does not guarantee or make any claims or recommendations about the BlueExtras services or products. You may want to talk to your doctor before using these services and products. BCBSTX reserves the right to stop or change this program at any time without notice.

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BENEFIT	CARRIER / VENDOR	GROUP # / ID	CONTACT / WEBSITE
All of this information is accessible from the iBenefits app – Company Code – ' Imprimis '			
MEDICAL	BCBS of Texas	Group # 219590	800-521-2227 www.bcbstx.com
DENTAL	BCBS of Texas	Group # 219590	800-521-2227 www.bcbstx.com
VISION	EyeMed	Group #	866-939-3633 www.eyemed.com
HUMAN RESOURCES		Lisa Monk, PHR, SHRM-CP	972-419-1711 lmonk@imprimis.com

All Summary of Benefit and Coverages (SBCs), annual compliance notices, and other plan documents are available upon request from Human Resources.

MARSH & McLENNAN AGENCY

The information in this Enrollment Guide is intended for illustrative purposes and informational purposes only. The information contained herein was taken from various summary plan descriptions, certificates of coverage and benefit information. Every effort was taken to accurately report your benefits however discrepancies and errors are always possible. It is not intended to alter or expand rights or liabilities set forth in the official plan documents or contracts. It is not an offer to contract nor are there any express or implied guarantees. In case of a discrepancy between this information and the actual plan documents, the actual plan documents will prevail. If you have any questions about this summary, please contact Human Resources.

2019 Disclosure Notices

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see pages 7-9 for details.

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SPECIAL ENROLLMENT NOTICE

This notice is being provided so that you understand your right to apply for group health insurance coverage outside of Imprimis Group and Affliated Companies open enrollment period. You should read this notice regardless of whether or not you are currently covered under Imprimis Group and Affliated Companies Group Health Plan. The Health Insurance Portability and Accountability Act (HIPAA) requires that employees be allowed to enroll themselves and/or their dependent(s) in an employer's Group Health Plan under certain circumstances, described below, provided that the employee notifies the employer within 30 days of the following events:

- Loss of health coverage under another employer plan (including exhaustion of COBRA coverage);
- Acquiring a spouse through marriage; or
- Acquiring a dependent child through birth, adoption, placement for adoption or foster care placement.

Effective April 1, 2009, two new special enrollment rights were created under the Children's Health Insurance Program Reauthorization Act of 2009. All group health plans must also permit employees and dependents, who are otherwise eligible for the group health plan, to enroll in the plan within 60 days of the following events:

- Losing eligibility for coverage under a State Medicaid or CHIP program; or
- Becoming eligible for State premium assistance under Medicaid or CHIP.

The employee or dependent must request coverage within 60 days of being terminated from Medicaid or CHIP coverage or within 60 days of being determined to be eligible for premium assistance.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under federal law, group health plans and health insurance issuers offering health insurance coverage generally may not 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 delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse, midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plan or issuers may not set the level of benefits or out-of-pocket costs so that the later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or the newborn than the earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification.

WOMEN'S HEALTH & CANCER RIGHTS NOTICE

As required by the Women's Health and Cancer Rights Act of 1998 (WHCRA), this medical plan provides coverage for:

- All stages of reconstruction of the breast of which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information of WHCRA benefits, call your plan administrator.

CHOICE OF HEALTHCARE PROVIDER

If the group health plan in which you are enrolled requires the designation of a primary care provider, you have the right to designate any participating primary care provider who is available to accept you or your family members For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider and for a list of participating primary care providers, contact the Plan Administrator. You do not need prior authorization from the group health plan or from any other person, including your primary care provider, in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology; however, you may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

USERRA CONTINUATION

Your right to continued participation in a group health plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA). Accordingly, if you are absent from work due to a period of active duty in the military for less than 31 days, your plan participation will not be interrupted. If the absence is for more than 31 days and not more than 12 weeks, you may continue to maintain your coverage under a group health plan by paying premiums in the manner specified by the Plan Sponsor.

If you do not elect to continue to participate in a group health plan during an absence for military duty that is more than 31 days, or if you revoke a prior election to continue to participate for up to 12 weeks after your military leave began, you and your covered family members will have the opportunity to elect COBRA continuation coverage under a group health plan for up to the 24-month period that begins on the first day of your leave of absence. You must pay the premiums for continuation coverage with after-tax funds, subject to the rules that are set out in the applicable Plan features.

USERRA continuation coverage is considered alternative coverage for purposes of COBRA. Therefore, if you elect USERRA continuation coverage, COBRA coverage will generally not be available.

GENETIC INFORMATION NONDISCRIMINATION ACT (GINA)

Gina prohibits group health plans from discriminating on the basis of genetic information. Genetic information is:

1. Information about an individual's genetic tests;
2. Genetic tests of an individual's family members; and
3. The manifestation of a disease or disorder of an individual's family members.

The group health plan may collect genetic information after initial enrollment, it may not do so in connection with the annual renewal process. The group health plan may not adjust premiums or increase contributions based on genetic information, nor request or require genetic testing or use genetic information for underwriting purposes.

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, 2019. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – 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	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	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: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA - Medicaid**
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	Website: http://dhs.iowa.gov/hawk-i Phone: 1-800-257-8563

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll-Free: 1-800-852-3345, ext 5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://chfs.ky.gov Phone: 1-800-635-2570	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
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid and CHIP**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347 or 401-462-0311 (Direct Rite Share Line)
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.hca.wa.gov Phone: 1-800-562-3022 ext. 15473

TEXAS – Medicaid	WEST VIRGINIA – Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://health.wyo.gov/healthcarefin/medicaid/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since July 31, 2019, 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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 12/31/2019)

IMPORTANT NOTICE FROM IMPRIMIS GROUP AND AFFLIATED COMPANIES ABOUT 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 Imprimis Group and Affliated Companies 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

2. **Imprimis Group and Affliated Companies has determined that the prescription drug coverage offered by the Imprimis and Allfiliated Companies Health HSA 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 [Insert Name of 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.**

3. **You can keep your current coverage from Imprimis and Allfiliated Companies Health HSA Plans. 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 through December 7th.

However, if you decide to drop your current coverage with Imprimis Group and Affliated Companies, since it is employer/union 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 **Imprimis and Allfiliated Companies Health HSA Plans.**

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

Since the coverage under Imprimis and Allfiliated Companies Health HSA Plans, 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 Imprimis Group and Affliated Companies coverage MAY be affected. If you decide to join a Medicare drug plan, your current **Imprimis and Allfiliated Companies Health HSA Plans** coverage may be affected by the coordination of benefits provision in the **Imprimis and Allfiliated Companies Health HSA Plans**. If you choose to drop **Imprimis and Allfiliated Companies Health HSA Plans** coverage to join a Medicare drug plan, you may be able to get this plan back. However the Imprimis Group and Affliated Companies drug plan is included in the Imprimis Group and Affliated Companies group health plan and is not available as a separate benefit.

If you do decide to join a Medicare drug plan and drop your current Imprimis Group and Affliated Companies coverage, be aware that you and your dependents MAY be able to get this coverage back.

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

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through Imprimis Group and Affliated Companies 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).

Date:	8/29/2019
Name of Entity/Sender:	Lisa Monk, PHR, SHRM-CP
Contact--Position/Office:	Human Resources
Address:	4835 LBJ Freeway, Suite 1000, Dallas, Texas 75244
Phone Number:	972-419-1711

FAMILY MEDICAL LEAVE ACT

The Family and Medical Leave Act (FMLA) provides certain employees with up to 12 weeks of unpaid, job-protected leave per year. It also requires that their group health benefits be maintained during the leave.

FMLA is designed to help employees balance their work and family responsibilities by allowing them to take reasonable unpaid leave for certain family and medical reasons. It also seeks to accommodate the legitimate interests of employers and promote equal employment opportunity for men and women.

Covered employers must provide an eligible employee with up to 12 weeks of unpaid leave each year for any of the following reasons:

- for the birth and care of the newborn child of an employee;
- for placement with the employee of a child for adoption or foster care;
- to care for an immediate family member (spouse, child, or parent) with a serious health condition; or
- to take medical leave when the employee is unable to work because of a serious health condition.

Employees are eligible for leave if they have worked for their employer at least 12 months, at least 1,250 hours over the past 12 months, and work at a location where the company employs 50 or more employees within 75 miles. Whether an employee has worked the minimum 1,250 hours of service is determined according to FLSA principles for determining compensable hours or work.

When an employee requests FMLA leave due to his or her own serious health condition or a covered family member's serious health condition, the employer may require certification in support of the leave from a health care provider. An employer may also require second or third medical opinions (at the employer's expense) and periodic recertification of a serious health condition.

Upon return from FMLA leave, an employee will be restored to his or her original job or to an equivalent job with equivalent pay, benefits, and other terms and conditions of employment. Group health insurance coverage for an employee on FMLA leave is maintained under the same terms and conditions as if the employee had not taken leave.