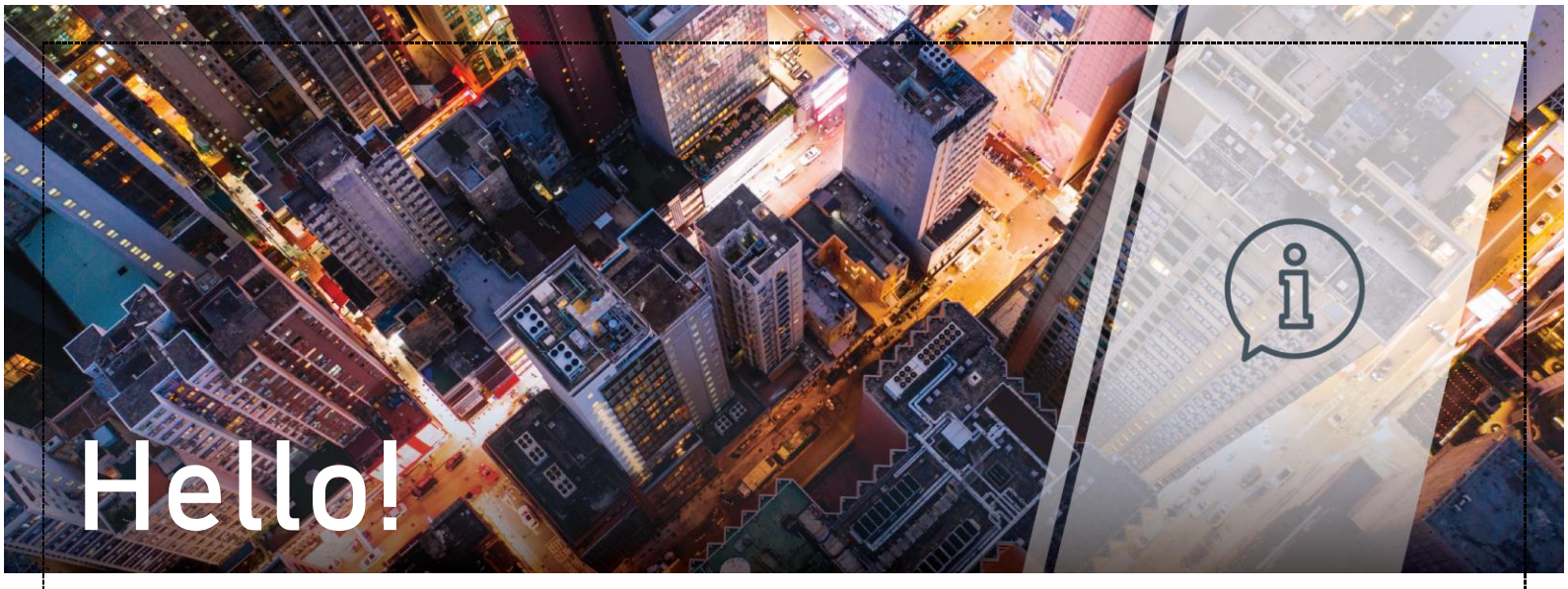
MMGY Global

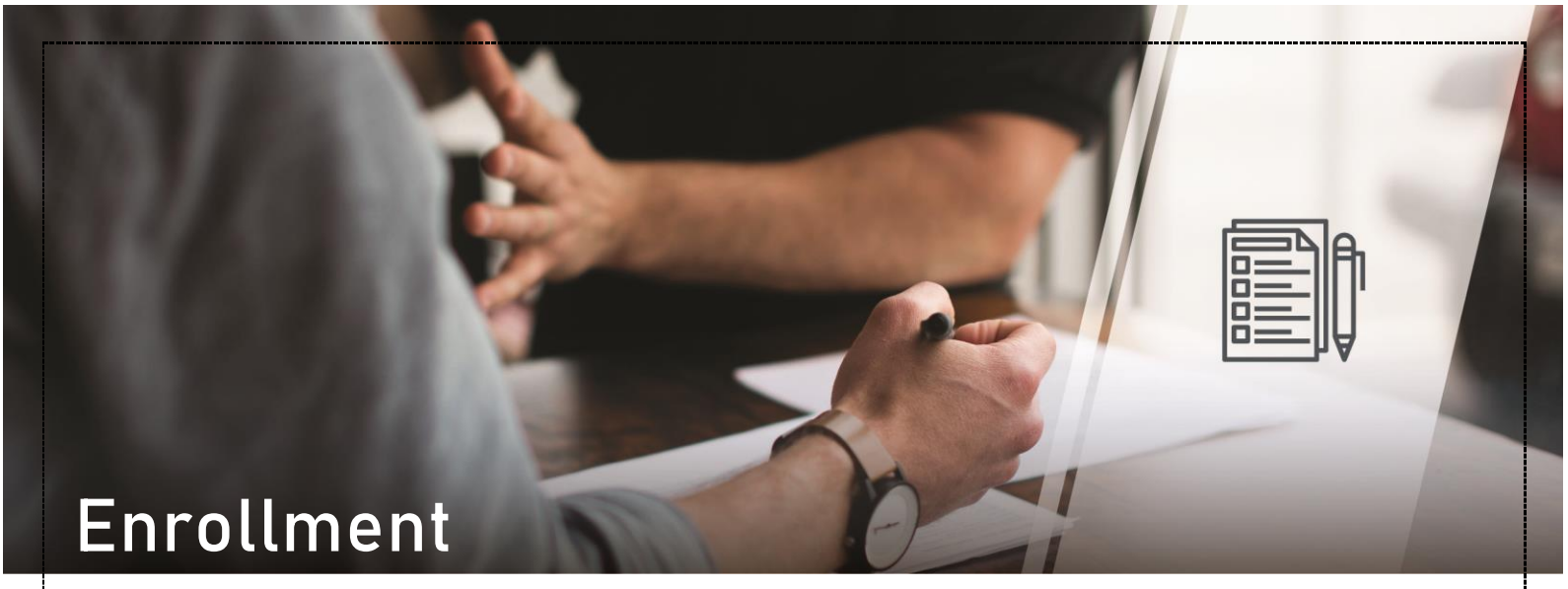
2021 BENEFIT INFORMATION GUIDE

Understanding Your Options



Hello!

Welcome to your 2021 Benefits Plan Year. MMGY Global is proud to offer a range of employee benefit plans to help protect you in the case of illness or injury. This Benefits Information Guide is a comprehensive tool designed to familiarize you with the plans and programs you and your family can enroll in for the plan year. If you have any questions regarding your benefits, please contact Human Resources.



Enrollment

Who can Enroll?

If you are an MMGY Global employee who works a minimum of 30 hours per week you are eligible to enroll in the benefits described in this guide. Eligible employees may also choose to enroll family members, including a legal spouse/registered domestic partner and/or eligible children.

When Does Coverage Begin?

Your enrollment choices remain in effect through the end of the benefits plan year, January 1, 2021 – December 31, 2021. Benefits for eligible new hires will commence as outlined below:

Eligibility Date	Benefit Plan
You become eligible for benefits the first of the month following date of hire.	• Medical • Dental • Vision • Life • Disability • FSA

TIP

If you miss the enrollment deadline, you may not enroll in a benefit plan unless you have a change in status during the plan year. Please review details on IRS qualified change in status events for more information.

How do I Enroll?

ADP Workforce Now

Enrollment is made easy with ADP Workforce Now! You will need your credentials (created by you during the new hire process) to access the benefit enrollment portal. To enroll, simply follow these steps:

- Go to https://workforcenow.adp.com.
- Click on “User Login” tab and log in.
- Once you are logged into the system, mouse over the “Myself Tab”, navigate to “Benefits” and select “Enrollments”.
- Read the enrollment instructions and select the “Start” button towards the bottom of the page.

Please note: Dependents must be added to ADP first before they can be added to a plan.

What if My Needs Change During the Year?

You are permitted to make changes to your benefits outside of the open enrollment period if you have a qualified change in status as defined by the IRS. Generally, you may add or remove dependents from your benefits, as well as add, drop, or change coverage if you submit your request for change within 30 days of the qualified event. Change in status examples include:

- Marriage, divorce or legal separation.
- Birth or adoption of a child.
- Death of a dependent.
- You or your spouse's/registered domestic partner's loss or gain of coverage through our organization or another employer.

If your change during the year is a result of the loss of eligibility or enrollment in Medicaid, Medicare or state health insurance programs, you must submit the request for change within 60 days. For a complete explanation of qualified status changes, please refer to the "Legal Information Regarding Your Plans" contents.

Do I Have to Enroll?

Although the federal penalty requiring individuals to maintain health coverage has been reduced to $0, some states have their own state-specific individual mandates.

To avoid paying the penalty in some states, you can obtain health insurance through our benefits program or purchase coverage elsewhere, such as coverage from a State or Federal Health Insurance Exchange.

For information regarding Health Care Reform and the Individual Mandate, please visit www.cciio.cms.gov. You can also visit your state exchange website to review information specific to the State Health Insurance Exchange.

You may elect to waive medical, dental, and vision coverage if you have access to coverage through another plan. It is also important to note that if coverage is waived, the next opportunity to enroll in our group benefit plans would be on January 1, 2022 or if a qualifying status change occurs.

Benefits Information on the Go

iBenefits

Available for iOS and Android mobile devices, the iBenefits app makes checking your benefits information easier than ever!

With iBenefits, you can:

- View our company's benefit plans, 24/7.
- Access group numbers and review detailed plan information.
- Quickly contact an insurance company.
- Keep up with important benefit plan announcements such as open enrollment dates, deadlines, and more.
- Store images of your ID cards directly in the app.

Download it now from the App Store or Google Play and use our Company Code MMGY2021 to login to the app.

Blue Cross Blue Shield – On the Go!

The Blue Shield app provides you with greater access to your insurance information. Use the app to:

- View your personalized insurance dashboard.
- Display your Blue Shield ID Card.
- Locate physicians, hospitals, or other healthcare professionals nationwide.
- Learn about benefit discount programs, like dental, vision and pharmacy.

Search for Blue Shield's mobile app in the App Store or Google Play to get started!

Medical

What are my options?

Use the chart below to help compare medical plan options and determine which would be the best for you and your family.

	PPO & HDHP
	Blue Cross and Blue Shield of Kansas City
Required to select and use a Primary Care Physician (PCP)	No
Seeing a Specialist	No referral required
Deductible Required	Yes, in most cases
Finding a Provider	Visit: www.BlueKC.com Select: Find a Doctor Select a Plan: Preferred-Care Blue (PCB) Search Location: Your home city and state Select a Category: Search all, by name, by specialty or places by name or type
Claims Process	PPO providers will submit claims You submit claims for other services
Compatible with your Health Savings Account (HSA)	No, unless PPO is also a HDHP
Other Important Tips	• You may choose in or-out-of network care, however in-network care provides you a higher level of benefit. • Emergencies covered worldwide. • Out-of-network providers will bill the balance to the member for amounts not covered by Blue Cross Blue Shield of Kansas City.

Please note, the above examples are used for general illustrative purposes only. Please consult with your Human Resources department for more specific information as it relates to your specific plan. For a detailed view of your medical plan summaries, visit www.BlueKC.com.

USING A PPO

In-Network or Out-of-Network

Plan Highlights	BCBS of KC Silver PPO plan	
	In-network	**Out-of-network**
Annual Calendar Year Deductible		
Individual	$2,000	$3,500
Family	$4,000	$7,000
Calendar Year Out-of-pocket Maximum [1]		
Individual	$5,000	$10,000
Family	$10,000	$20,000
Professional Services		
Primary Care Physician (PCP)	$20 Copay	40% After Deductible
Specialist	$40 Copay	40% After Deductible
Preventive Care Exam	No Charge	40% After Deductible
Well-baby Care	No Charge	40% After Deductible
Diagnostic X-ray and Lab	20% After Deductible	40% After Deductible
Complex Diagnostics (MRI/CT Scan)	20% After Deductible	40% After Deductible
Therapy, including Physical, Occupational and Speech	20% After Deductible	40% After Deductible
Hospital Services		
Inpatient	20% After Deductible	40% After Deductible
Outpatient Surgery	20% After Deductible	40% After Deductible
Emergency Room	$150 Copay (waived if admitted) + 20% After Deductible	$150 Copay (waived if admitted) + 20% After Deductible
Urgent Care	$40 Copay	40% After Deductible
Maternity Care		
Physician Services (prenatal or postnatal)	$20 Copay	40% After Deductible
Hospital Services	20% After Deductible	40% After Deductible
Mental Health & Substance Abuse		
Inpatient	20% After Deductible	40% After Deductible
Outpatient	20% After Deductible	40% After Deductible
Retail Prescription Drugs (34-day supply)		
Tier 1	$10 Copay	$10 Copay + 50%
Tier 2	$30 Copay	$30 Copay + 50%
Tier 3	$50 Copay	$50 Copay + 50%
Mail Order Prescription Drugs (102-day supply)		
Tier 1	$25 Copay	Not Covered
Tier 2	$75 Copay	Not Covered
Tier 3	$125 Copay	Not Covered

[1] Out-of-pocket maximum is based on the maximum allowable charge the carrier allows. This does not include any balance billing that may occur when using an out-of-network provider.

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

Plan Highlights	BCBS of KC Gold PPO Plan	
	In-network	**Out-of-network**
Annual Calendar Year Deductible		
Individual	$750	$1,500
Family	$1,500	$3,000
Calendar Year Out-of-pocket Maximum [1]		
Individual	$3,500	$7,000
Family	$7,000	$14,000
Professional Services		
Primary Care Physician (PCP)	$20 Copay	40% After Deductible
Specialist	$40 Copay	40% After Deductible
Preventive Care Exam	No Charge	40% After Deductible
Well-baby Care	No Charge	40% After Deductible
Diagnostic X-ray and Lab	20% After Deductible	40% After Deductible
Complex Diagnostics (MRI/CT Scan)	20% After Deductible	40% After Deductible
Therapy, including Physical, Occupational and Speech	20% After Deductible	40% After Deductible
Hospital Services		
Inpatient	20% After Deductible	40% After Deductible
Outpatient Surgery	20% After Deductible	40% After Deductible
Emergency Room	$150 Copay (waived if admitted) + 20% After Deductible	$150 Copay (waived if admitted) + 20% After Deductible
Urgent Care	$40 Copay	40% After Deductible
Maternity Care		
Physician Services (prenatal or postnatal)	$20 Copay	40% After Deductible
Hospital Services	20% After Deductible	40% After Deductible
Mental Health & Substance Abuse		
Inpatient	20% After Deductible	40% After Deductible
Outpatient	20% After Deductible	40% After Deductible
Retail Prescription Drugs (34-day supply)		
Tier 1	$10 Copay	$10 Copay + 50%
Tier 2	$25 Copay	$25 Copay + 50%
Tier 3	$45 Copay	$45 Copay + 50%
Mail Order Prescription Drugs (102-day supply)		
Tier 1	$25 Copay	Not Covered
Tier 2	$62.50 Copay	Not Covered
Tier 3	$112.50 Copay	Not Covered

[1] Out-of-pocket maximum is based on the maximum allowable charge the carrier allows. This does not include any balance billing that may occur when using an out-of-network provider.

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Plan Highlights	BCBS of KC HDHP w/HSA Plan	
	In-network	**Out-of-network**
Annual Calendar Year Deductible		
Individual	$2,800	$2,800
Family	$5,600	$5,600
Calendar Year Out-of-pocket Maximum [1]		
Individual	$3,500	$7,000
Family	$7,000	$14,000
Professional Services		
Primary Care Physician (PCP)	20% After Deductible	40% After Deductible
Specialist	20% After Deductible	40% After Deductible
Preventive Care Exam	No Charge	40% After Deductible
Well-baby Care	No Charge	40% After Deductible
Diagnostic X-ray and Lab	20% After Deductible	40% After Deductible
Complex Diagnostics (MRI/CT Scan)	20% After Deductible	40% After Deductible
Therapy, including Physical, Occupational and Speech	20% After Deductible	40% After Deductible
Hospital Services		
Inpatient	20% After Deductible	40% After Deductible
Outpatient Surgery	20% After Deductible	40% After Deductible
Emergency Room	20% After Deductible	20% After Deductible
Urgent Care	20% After Deductible	40% After Deductible
Maternity Care		
Physician Services (prenatal or postnatal)	20% After Deductible	40% After Deductible
Hospital Services	20% After Deductible	40% After Deductible
Mental Health & Substance Abuse		
Inpatient	20% After Deductible	40% After Deductible
Outpatient	20% After Deductible	40% After Deductible
Retail Prescription Drugs (34-day supply)		
Tier 1	$10 Copay After Deductible	$10 Copay + 50% After Deductible
Tier 2	$30 Copay After Deductible	$30 Copay + 50% After Deductible
Tier 3	$50 Copay After Deductible	$50 Copay + 50% After Deductible
Mail Order Prescription Drugs (102-day supply)		
Tier 1	$25 Copay After Deductible	Not Covered
Tier 2	$75 Copay After Deductible	Not Covered
Tier 3	$125 Copay After Deductible	Not Covered

[1] Out-of-pocket maximum is based on the maximum allowable charge the carrier allows. This does not include any balance billing that may occur when using an out-of-network provider.

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

Spending Accounts

Health Savings Account (HSA)

What is it?

By enrolling in the Blue Cross Blue Shield of KC high-deductible health plan, you will have access to a Health Savings Account (HSA), which provides tax advantages and can be used to pay for qualified health care expenses, such as your deductible, copayments, and other out-of-pocket expenses.

What are the benefits?

Administered by NueSynergy, an HSA accumulates funds that can be used to pay current and future health care costs.

- You can contribute to your HSA on a pre-tax basis, for federal tax purposes, or you can contribute on a post-tax basis and take the deduction on your tax return.
- Generally, HSA funds can grow on a tax-free basis, subject to state law.[1]
- An HSA reduces your taxable income and may allow you to make tax-free withdrawals from the account when paying for qualified health care expenses (tax regulations vary by state).
- Because you own the HSA, there are no "Use it or Lose it" provisions, so unused HSA funds roll over from year-to-year, and can be used to reimburse future eligible out-of-pocket expenses.
- You may enjoy lower monthly premium payments as compared to traditional PPO medical plans.
- Because you own the HSA, the money in your account is yours to keep if you leave the company.

How do I qualify for an HSA?

The IRS has guidelines regarding who qualifies for an HSA. You are considered eligible if:

- You are covered under a qualified medical plan.
- You are not enrolled in non-qualified health insurance outside of Blue Cross Blue Shield of KC high-deductible health plan.
- You are not enrolled in Medicare.
- You are not claimed as a dependent on someone else's tax return (excluding a spouse).
- You are not enrolled in a general Health Care Flexible Spending Account (Health FSA) or general Health Reimbursement Arrangement (HRA).

How do I get started?

If you're ready to activate your HSA, you can do so by:

- Step 1: MMGY Global contributes up to $480 annually on a per pay period basis for Individual/Family
- Step 2: A NueSynergy Debit Card will be issued for your convenience.

Once the HSA is activated, you can manage and access your account at any time by visiting www.nuesynergy.com. If questions arise regarding account activation, contact NueSygnergy or visit www.nuesynergy.com. Consult your tax advisor for taxation information or advice.

(1) Please consult your tax advisor for applicable tax laws in your state.

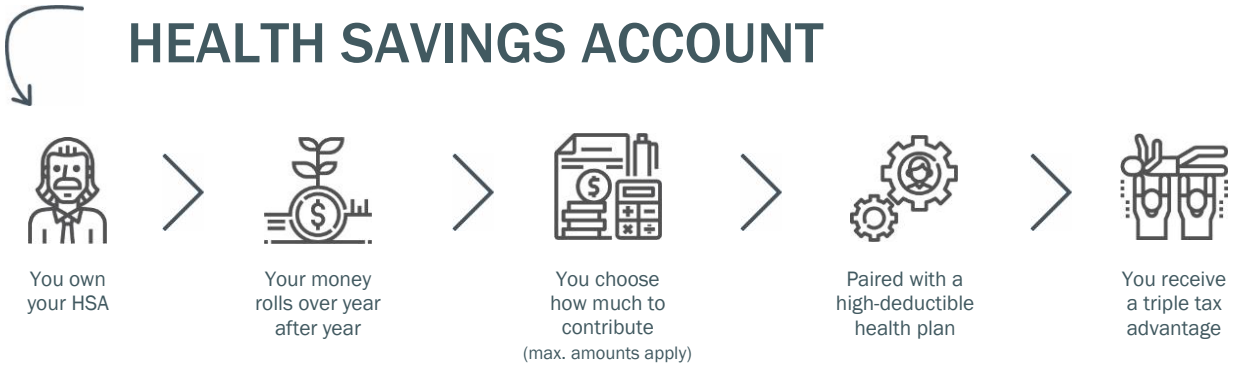
A few rules you need to know:

- For 2021, the maximum contribution limit for employee and employer contributions in an employee's HSA account is $3,600 if you are enrolled in the HSA-PPO for employee-only coverage, and $7,200 for employees with dependent coverage.
- It's important to monitor your contributions to avoid going over the IRS limit, as contributions in excess of the IRS limit are subject to standard income tax rates, plus a 6% excise tax.
- There is a 20% penalty for using HSA funds on non-qualified health care expenses if you are under age 65. For more details about what are considered qualified health care expenses, visit www.nuesynergy.com.
- You may not be able to contribute to your HSA if you are entitled to Medicare. However, funds accumulated before Medicare entitlement may be used to reimburse your qualified medical expenses.
- You may not contribute to your HSA if you are covered under any medical benefits plan which is not an HSA-qualified high deductible medical plan (e.g., a spouse's non-HDHP medical plan, a general purpose Health Care FSA, or Medicare). However, you may be covered by a Limited Purpose Health Care FSA, or an FSA which can be used after your HDHP deductible is met.
- Typically, the maximum amount an employee is eligible to contribute to an HSA per calendar year is based upon a **pro-rata** portion of the number of months an employee is eligible to contribute to an HSA. For example, an employee would normally be able to contribute 4/12 of the maximum annual limit in his/her first year of enrollment into the HSA plan, if the employee first joins the HSA plan on September 1. However, under the full contribution rule, an employee is allowed to contribute the maximum annual amount, regardless of the number of months he/she was eligible to contribute to an HSA in the first year, if he/she is eligible to contribute to an HSA on December 1 of the first year and continues to be eligible to contribute to an HSA until December 31 of the following year (i.e., for the entire subsequent year).

TIP

How do I manage my HSA?

- **The most convenient way to pay for qualified expenses is to utilize the debit card**
- **You can also use your own cash or a personal credit card and reimburse yourself through your online HSA account**
- **It is recommended that you keep receipts of HSA purchases, should you ever be audited by the IRS**
- **View the status of your claims and check your HSA balance at www.nuesynergy.com.**



Flexible Spending Accounts (FSA)

A flexible spending account lets you use pre-tax dollars to cover eligible health care and dependent care. There are different types of FSAs that help to reduce your taxable income when paying for eligible expenses for yourself, your spouse, and any eligible dependents, as outlined below:

FSA Type	Detail
Health Care FSA	• Can reimburse for eligible health care expenses not covered by your medical, dental and vision insurance. • Maximum contribution for 2021 is $2,750.
Limited Purpose FSA	• Option for employees enrolled in a Health Savings Account (HSA) eligible plan. • Use this FSA to reimburse for eligible preventive care, dental and vision expenses. • Maximum contribution for 2021 is $2,750.
Dependent Care FSA	• Can be used to pay for a child's (up to the age of 13) child care expenses and/or care for a disabled family member in the household, who is unable to care for themselves. • Maximum contribution for 2021 is $5,000.

What are the benefits?

- Your taxable income is reduced and your spendable income increases!
- Save money while keeping you and your family healthy.

How do I use it?

You must enroll in the FSA program within 30 days of your hire date or during annual open enrollment. At this time, you must establish an annual contribution amount within the maximum limit. Once enrolled, you will have online access to view your FSA balance, check on a reimbursement status, and more. Visit www.nuesynergy.com to access NueSynergy's online portal.

A few rules you need to know:

- You may carryover up to $550 from your 2020 Health FSA to the 2021 plan year
- Although the plan year runs from January 1, 2021 through December 31, 2021, the plan allows an annual run-out period, allowing you to seek reimbursement 90-days after the end of the plan year for any expenses incurred from January 1st – December 31st.

For more details about using an FSA, contact Human Resources.

Dental Plan

Your Dental PPO Plan

This year, you and your eligible dependents have the opportunity to enroll in a Dental Preferred Provider Organization (PPO) plan offered by Delta Dental of Kansas.

Using the Plan

The Dental PPO plan is designed to give you the freedom to receive dental care from any licensed dentist of your choice. Keep in mind, you'll receive the highest level of benefit from the plan if you select an in-network PPO dentist versus an out-of-network dentist who has not agreed to provide services at the negotiated rate. Additionally, no claim forms are required when using in-network PPO dentists.

Plan Highlights	Delta Dental Base PPO		
	PPO Dentist	**Premier Dentist**	**Out-of-Network**
Calendar Year Deductible			
Individual	$50	$50	$50
Family	$150	$150	$150
Annual Maximum	$1,000	$1,000	$1,000
Preventive	100%	100%	100%
Basic Services	80%	80%	80%
Major Services	50%	50%	50%
Orthodontia Services	Not Covered	Not Covered	Not Covered

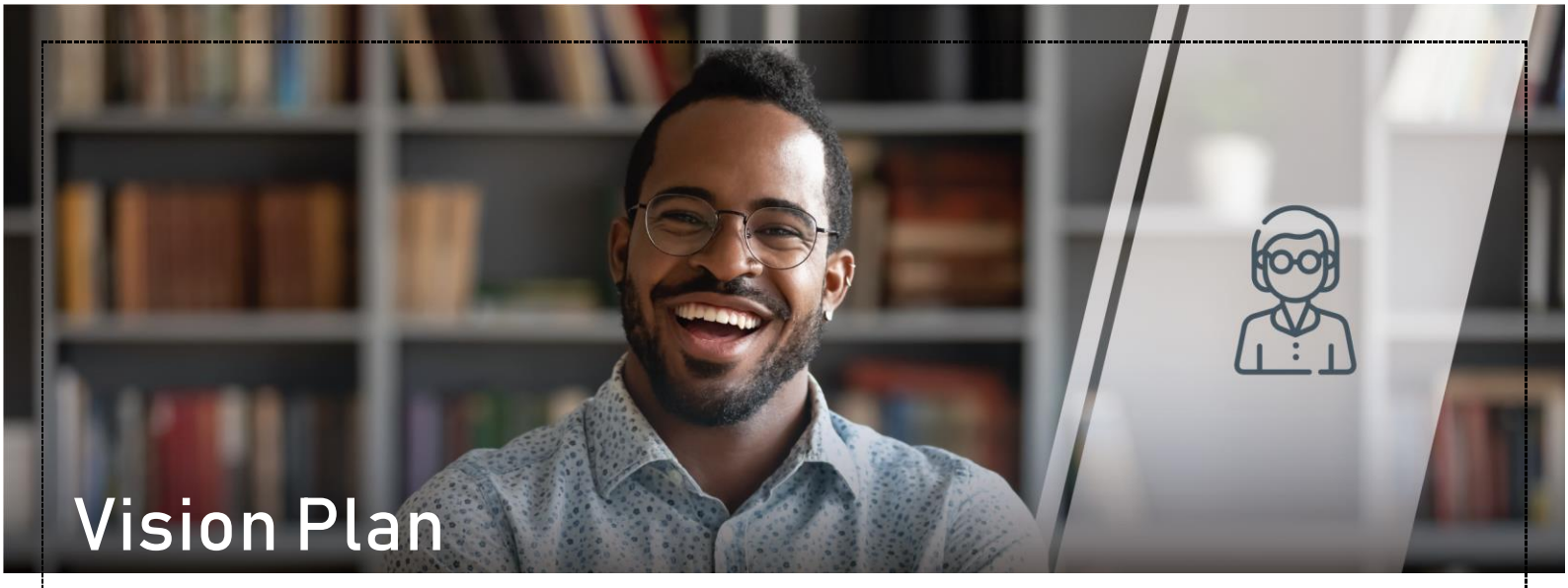
Plan Highlights	Delta Dental Buy-Up PPO		
	PPO Dentist	**Premier Dentist**	**Out-of-Network**
Calendar Year Deductible			
Individual	$50	$50	$50
Family	$150	$150	$150
Annual Maximum	$1,500	$1,500	$1,500
Preventive	100%	100%	100%
Basic Services	90%	80%	80%
Major Services	60%	50%	50%
Orthodontia Services			
Adult	Not Covered	Not Covered	Not Covered
Child up to age 19	50%	50%	50%
Lifetime Maximum	$1,000	$1,000	$1,000

TIP

Choose your Primary Care Dentist

It's important to carefully select a dental provider, and based on the plan you enroll in, the best choice for you may vary. To determine whether your dentist is in or out of your insurance network, go to www.deltadentalks.com and search the provider network, or call Delta Dental at 1-800-234-3375 .

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.



Vision Plan

Your Vision Plan

Vision coverage is offered by VSP as a Preferred Provider Organization (PPO) plan.

Using the Plan

As with a traditional PPO, you may take advantage of the highest level of benefit by receiving services from in-network vision providers and doctors. You would be responsible for a copayment at the time of your service. However, if you receive services from an out-of-network doctor, you pay all expenses at the time of service and submit a claim for reimbursement up to the allowed amount.

To view a complete plan summary, contact Human Resources. To locate an in-network vision provider, visit www.vsp.com.

Plan Highlights	VSP Vision PPO	
	In-Network	**Out-of-Network**
Exam – Every 12 months	$10 Copay	Up to $45
Lenses – Every 12 months		
Single	$25 Copay	Up to $30
Bifocal	$25 Copay	Up to $50
Trifocal	$25 Copay	Up to $65
Frames – Every 24 months	$140 Allowance + 20% off Remaining Balance	Up to $70
Contacts – Every 12 months, in lieu of lenses & frames		
Cosmetic	$140 Allowance	Up to $105
Additional Benefits		
Additional Pairs of Glasses	20% savings on additional glasses	Not Applicable
LASIK	Discount Available	Not Applicable

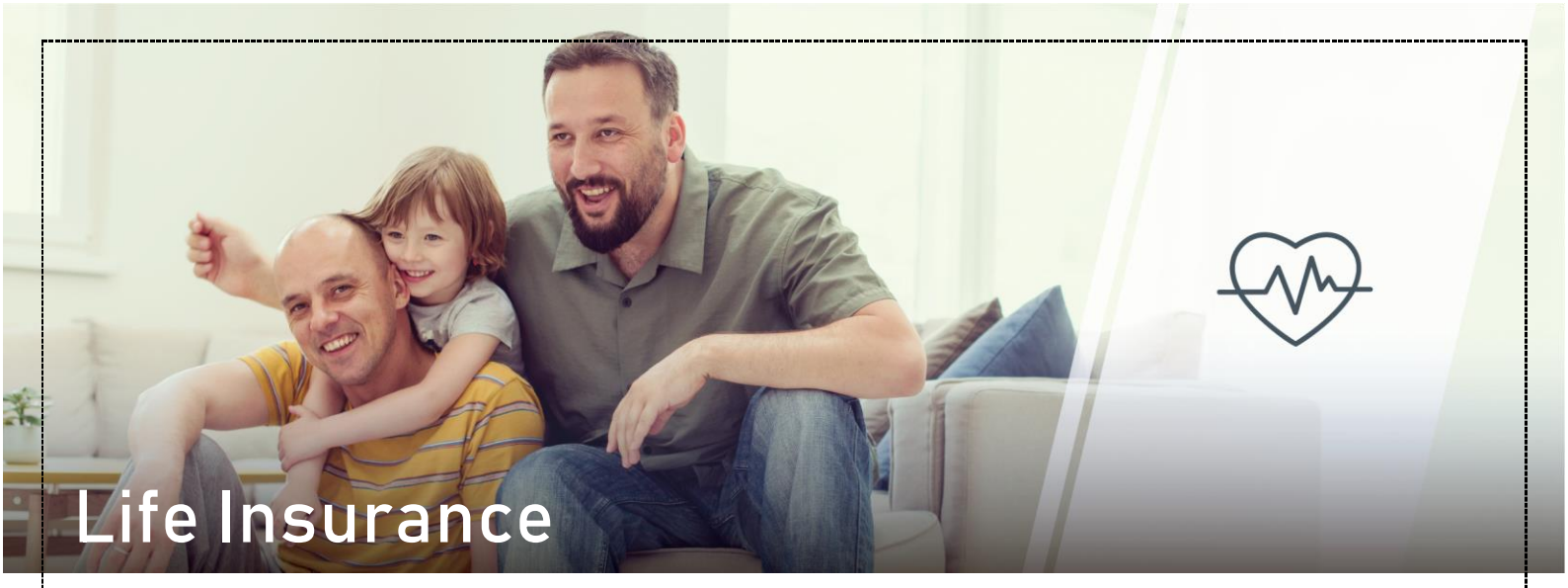
The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

TIP

Five Tips for Superior Vision

Don't take your eyes for granted! The following pointers can help you keep your vision strong:

- **Eat lots of leafy greens and dark berries.**
- **Get regular eye exams.**
- **Give your eyes a rest from staring into the computer screen.**
- **Wear sunglasses to protect your eyes from bright light.**
- **Wear safety eyewear whenever necessary.**



Life Insurance

Basic Life and AD&D

In the event of your passing, Life Insurance will provide your family members or other beneficiaries with financial protection and security. Additionally, if your death is a result of an accident or if you become dismembered, your Accidental Death & Dismemberment (AD&D) coverage may apply.

Paid for in full by MMGY Global, the benefits outlined below are provided by UNUM:

- Basic Life Insurance of 1x annual earnings up to $100,000.
- AD&D of 1x annual earnings up to $100,000.
- Please note, benefits may reduce when you reach age 65.

IRS Regulation: Employees can receive employer paid life insurance up to $50,000 on a tax-free basis and do not have to report the payment as income. However, an amount in excess of $50,000 will trigger taxable income for the “economic value” of the coverage provided to you.

What else is included?

Work-life balance EAP
Get access to professional help for a range of personal and work-related issues, including counselor referrals, financial planning and legal support.

Worldwide emergency travel assistance
One phone call gets you and your family immediate help anywhere in the world, as long as you’re traveling 100 or more miles from home. However, a spouse traveling on business for his or her employer is not covered.

Survivor benefit
If you die while you’ve been disabled and receiving benefits for at least 180 days, your family could get a benefit equal to 3 months of your gross disability payment.

Waiver of premium
If you’re disabled and receiving benefit payments, Unum waives your cost until you return to work.

Voluntary Life and AD&D

If you would like to supplement your employer paid insurance, additional Life and AD&D coverage for you and your dependents is available for purchase on a payroll deduction basis through UNUM.

- **For employees:** 5x annual earnings up to a $500,000 maximum with a guarantee issue benefit of $150,000 if you enroll in the plan within 30 days of your initial eligibility.
- **For your spouse:** 100% of employee's benefit up to $500,000 maximum with a guarantee issue benefit of $50,000 if you enroll in the plan within 30 days of your initial eligibility.
- **For your child(ren):** Live birth up to 6 months of age, $1,000; 6 months old up to age 26, $10,000.
- **Optional AD&D:** Coverage is available for purchase in the same amounts as optional life insurance amounts above.

Any amounts of insurance over the guarantee issue benefit are subject to review of good health by the insurance company. Insurance amounts subject to review will not be effective until the insurance company approves.

If you do not enroll in the plan within the initial enrollment period, **any** amount of supplemental life insurance will require proof of good health, which is subject to approval by the insurance company before the insurance is effective. For more information regarding this plan, review the plan summary detail.

Please note: Benefits coverage may reduce when you reach age 65. Restrictions may apply if you and/or your dependent(s) are confined in the hospital or terminally ill. Please refer to your Summary Plan Description for exclusions and further detail.

Cost of Employee Voluntary Coverage

Age of Insured	Monthly Rate per $10,000	
	Non-Tobacco	Tobacco
Less than 25	$0.300	$0.800
25–29	$0.300	$0.800
30–34	$0.400	$1.000
35–39	$0.700	$1.600
40–44	$1.500	$3.000
45–49	$2.700	$5.500
50–54	$4.200	$8.600
55–59	$7.100	$13.500
60–64	$10.800	$19.500
65–69	$19.900	$33.800
70–74	$33.300	$52.700
75–99	$45.400	$61.700
AD&D	**$0.200**	

Cost of Spousal Voluntary Coverage

Age of Insured	Monthly Rate per $5,000
Less than 25	$0.150
25–29	$0.155
30–34	$0.200
35–39	$0.300
40–44	$0.700
45–49	$1.250
50–54	$1.950
55–59	$3.300
60–64	$5.050
65–69	$9.350
70–74	$16.465
75–99	$16.465
AD&D	**$0.100**

Dependent Child Coverage

Benefit Amount	Monthly Premium per $2,000
Life	$0.300
AD&D	$0.080

TIP

Required! Are Your Beneficiaries Up to Date?

Beneficiaries are individuals or entities that you select to receive benefits from your policy.

- **You can change your beneficiary designation at any time.**
- **You may designate a sole beneficiary or multiple beneficiaries to receive payment in the percent allocated.**
- **To select or change your beneficiary, please contact Human Resources.**

Disability Insurance

Added protection

Should you experience a non-work related illness or injury that prevents you from working, disability coverage acts as income replacement to protect important assets and help you continue with some level of earnings. Benefits eligibility may be based on disability for your occupation or any occupation.

Your Plans	Coverage Details
Short-Term Disability (STD)	• Administered by Unum, STD coverage provides a benefit equal to 60% of your earnings, up to $1,000 per week for a period up to 11 weeks. • The plan begins paying these benefits at the time of disability after you have been absent from work for 14 consecutive days. An employee could still be working and still satisfy the elimination period as long as 1) they are limited from performing regular occupation due to sickness or injury and 2) have a 20% loss in earnings. If an employee is medically supported and is working periodically and has 20% loss in earnings this time (even the time the employee was working) would count towards the elimination period.
State Disability Insurance	• The state you reside in may provide a partial wage-replacement disability insurance plan. • For more information regarding statutory disability programs, contact Human Resources.
Voluntary Long-Term Disability (LTD)	• Administered by Unum, LTD coverage provides a benefit equal to 60% of pre-tax monthly earnings to a maximum monthly benefit of $9,000. • The plan begins paying these benefits after 90 days of disability. • You pay 100% of the cost for this plan which means you could be taxed on the benefit at the time of claim if your deductions are taken pre-tax.

TIP

Disability Facts and Figures

- **One in every 7 people will become disabled for five years or more in their lifetime.**
- **30% of people use disability coverage.**
- **Nearly half (46%) of all foreclosures are caused by financial hardship due to a disability.**

Source: www.affordableinsuranceprotection.com/disability_facts

Tax considerations

Because the short term disability coverage is an employer-paid benefit and is available for employees at no cost, any STD payments made to you will be taxable. The voluntary long term disability benefits, however, will not be taxable as long as your deduction is taken out of your paycheck after tax.

Please note: Consult your tax advisor for additional taxation information or advice.

Long Term Disability (LTD) Coverage

You are eligible for coverage if you are an active employee in the United States working a minimum of 30 hours per week. Administered by UNUM, LTD coverage provides a benefit equal to 60% of pre-tax monthly earnings to a maximum monthly benefit of $9,000.

Your elimination period is 90 days. This is the number of days that must pass after a covered accident or illness before you can begin to receive benefits. You can receive benefits up to the Social Security (SS) normal retirement age. Benefit begins after 90 days of disability. The monthly benefit may be reduced or offset by other sources of income.

Age at Disability Maximum Period of Payment	
Less than Age 62 To Social Security Normal Retirement Age	
Age 62 60 months	Age 66 3 0 months
Age 63 48 months	Age 67 24 months
Age 64 42 months	Age 68 18 months
Age 65 36 months	Age 69 or older 12 months

Year of Birth Social Security Normal Retirement Age	
1937 or before 65 years	1955 66 years 2 months
1938 65 years 2 months	1956 66 years 4 months
1939 65 years 4 months	1957 66 years 6 months
1940 65 years 6 months	1958 66 years 8 months
1941 65 years 8 months	1959 66 years 10 months
1942 65 years 10 months	1960 and after 67 years
1943-1954 66 years	

If you didn't get coverage when you were first eligible, you'll have to answer medical questions now. If you're newly eligible, you are guaranteed coverage now with no medical questions. New coverage may be subject to pre-existing condition limitations. Please contact Human Resources for additional information.

What are some common covered benefits?

This insurance may cover a variety of conditions and injuries. This plan does not cover pre-existing conditions. Here are Unum's top reasons for long term disability claims

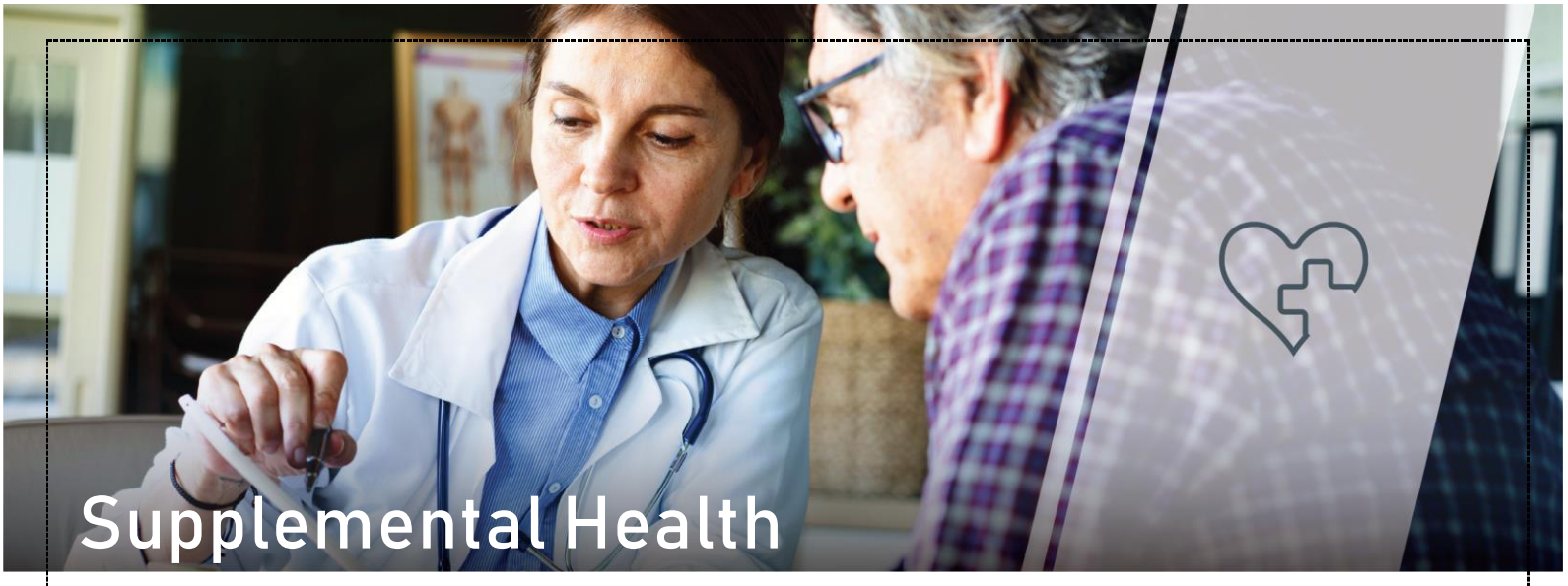
- Cancer
- Back disorders
- Injuries
- Cardiovascular
- Joint disorders

Calculate your cost

- Use $180,000 if your annual earnings exceed this amount. This is the maximum coverage amount offered in this plan.
- Multiply by your rate. Use the rate table to find the rate based on your age.

Disability worksheet					
1 Enter your annual earnings and calculate your maximum monthly benefit available.					
$_____ ÷ 12 = $_____ x Your annual earnings	Your monthly earnings	60% = (Max % of income covered)	$_____ Max monthly benefit available		
2 Calculate your cost per paycheck					
$_____ ÷ 100 = $_____ x Your annual earnings	$_____ = Rate	$_____ ÷ Number of paychecks per year	12 =	$_____ Total cost per paycheck	

Age	Rates
15-24	$0.120
25 -29	$0.120
30 -34	$0.120
35-39	$0.140
40 -44	$0.230
45 -49	$0.330
50 -54	$0.520
55 -59	$0.750
60 -64	$1.050
65 -69	$0.970
70+	$0.590



Supplemental Health

Critical Illness Coverage

Critical Illness coverage offered on a voluntary basis through UNUM pays you a lump sum benefit if you are diagnosed with a covered illness or condition. All benefits are paid directly to you and you may use the funds as you see fit. If you apply during your initial enrollment you can get coverage without a health exam or medical questions. If this isn't your initial enrollment, you will need to submit medical questions and/or have a health exam.

What can Critical Illness coverage pay for?

- Medical expenses, such as copays, deductibles or co-insurance
- Lost Income
- Everyday expenses such as groceries and utilities.
- Alternative treatments
- Lodging and travel to a specialist

What are examples of covered illnesses or conditions?

- Cancer
- Heart Attack
- Stroke
- Alzheimer's
- Kidney Failure

Here's an example of how Critical Illness coverage can help support you

Denise is 45 years old and had a heart attack. She was out of work for a couple of months recovering and although she had disability insurance, it didn't cover all of her lost income and medical bills. Thankfully, Denise had a $10,000 Critical Illness policy. She filed her claim and received her cash benefit so that she could pay her bills and medical expenses. With her Critical Illness policy, Denise had peace of mind and was able to focus on improving her health.

100% Employee-paid

If you elect the voluntary Critical Illness plan, 100% of the cost is deducted through payroll deductions. Monthly post-tax rates are outlined below:

Monthly rates per $1,000 of benefit

Age	Employee	Spouse
<25	$0.15	$0.15
25 –29	$0.23	$0.23
30 –34	$0.34	$0.34
35–39	$0.53	$0.53
40 –44	$0.77	$0.77
45 –49	$1.08	$1.08
50 –54	$1.61	$1.61
55 –59	$2.32	$2.32
60 –64	$3.42	$3.42
65 –69	$5.10	$5.10
70-74	$7.81	$7.81
74-79	$11.17	$11.17
80-84	$15.75	$15.75
85-89	$25.16	$25.16

Benefit options

Election	Benefit Amounts & Guaranteed Issue
Employee	$10,000, $20,000, or $30,000
Spouse	50% of Employee coverage amount (All Guaranteed Issue)
Child(ren)	Children from live birth to age 26 are automatically covered at no extra cost. Their coverage amount is 50% of yours.

Wellness Rider Rate	Employee	Spouse
$50	$1.52	$1.52
$75	$3.03	$3.03
$100	$4.55	$4.55

Accident Insurance Plan

Accident Insurance offered on a voluntary basis through UNUM provides coverage for specific injuries and treatments resulting from a covered accident. The amount of the benefit paid depends on the type of injury and care received.

How can Accident Insurance help?

Since benefits are paid directly to you, you choose how to use them, such as paying medical bills, subsidizing lost income, or covering everyday expenses.

What are some common covered benefits?

- Emergency room visit
- Ambulance
- Doctor visits
- Hospital admission
- Surgery
- Medical equipment
- Outpatient therapy
- Diagnostic imaging

Covered Event/Injury	Benefit Amount
Ambulance (ground)	$400
Emergency room care	$150
Physician follow-up ($75 x 2)	$150
X-ray	$50
Concussion	$150
Broken tooth (repaired by crown)	$300
Total benefit paid by Kathy's Accident Plan	**$1,200**

Here's an example of how Accident Insurance can help support you

Kathy's daughter, Molly, plays soccer. During a recent game, she collided with a player, was knocked unconscious and taken to the emergency room (ER) by ambulance. The ER doctor diagnosed a concussion and a broken tooth. He ordered an x-ray scan to check for facial fractures due to swelling. Molly was released to her primary care physician for follow-up treatment and her dentist repaired her broken tooth with a crown. Thanks to Accident Insurance, Kathy will receive $1,200 to help pay for Molly's expenses associated with her accident.

100% Employee-paid

If you elect the voluntary Accident Insurance plan, 100% of the cost is deducted through payroll deductions.
Monthly post-tax rates are outlined below:

Election	Monthly Contribution
Employee Only	$13.30
Employee + Spouse	$22.19
Employee + Child(ren)	$24.45
Family	$33.34

Want to learn more?

If you're considering this type of coverage, you must enroll when you first become eligible or during the annual open enrollment period.

Employee Assistance Program (EAP)

MMGY Global understands that you and your family members might experience a variety of personal or work-related challenges. Through the EAP, you have access to resources, information, and counseling that are fully confidential and no cost to you.

Program Component	Coverage Details
Eligibility	Offered to all benefit eligible employees working 30+ hours per week
Who Can Utilize	All employees, dependents of employees, and members of your household
Work/Life Balance	• Stress, depression, anxiety • Family and parenting problems • Anger, grief and loss • Childcare • Eldercare • Legal questions • Identity theft • Financial services, debt management, credit report issues • Even reducing your medical/dental bills
Number of Sessions	Unlimited online/phone support Up to 3 face to face visits

TIP

How to Access:

- **By Phone: 800.854.1446**
- **Online: www.unum.com/lifebalance**

Total Brain Mental Health and Fitness

Understand your brain better and how to improve your mental health and fitness. Total Brain can help you learn more about your brain and how to improve it. Founded on the principle that our mental health can be measured, improved and managed like our physical health, Total Brain measures the 12 brain capacities that define your mental health. Total Brain provides you with specific mental fitness programs designed to strengthen your brain capacities and improve your overall mental health.

Benefits

Self-Awareness – Learn about your strengths, weaknesses and potential risks

Effectiveness Monitoring – Monitor the impact of mental fitness programs and treatment

Improved Performance – Measurable improvement across each of the 12 brain capacities, yielding an improvement in overall mental health

How do I access Total Brain?

Create your own confidential account by going to https://totalbrain.com/MMGY. Once you have created your account, you can access it by using www.totalbrain.com or by downloading the Total Brain app to your phone from the app store of choice.

Supplemental Services

Pet Insurance

MMGY Global provides the opportunity to their employees to elect several different Pet Insurance plans through Nationwide. Coverage spans from everyday cat and dog wellness to avian and exotic pet plans.
To enroll visit www.petinsurance.com/mmgyglobal.

Telehealth Services

With telehealth services, you can connect with leading board-certified physicians for many non-emergency illnesses through the internet, your tablet or mobile phone. By leveraging these virtual visits, you can avoid emergency rooms and urgent care centers and quickly refill your prescriptions so you can get back on your feet in no time.

Telehealth can be used for:

General Health Issues

COVID-19 Virtual Visit

Prescribing Prescriptions

If your telehealth doctor prescribes you medication, Blue KC will ensure you are able to conveniently pick up your prescription in your local area. You may also use mail-order services for delivery of your prescription.

Start your BlueKC Virtual Care visit today!

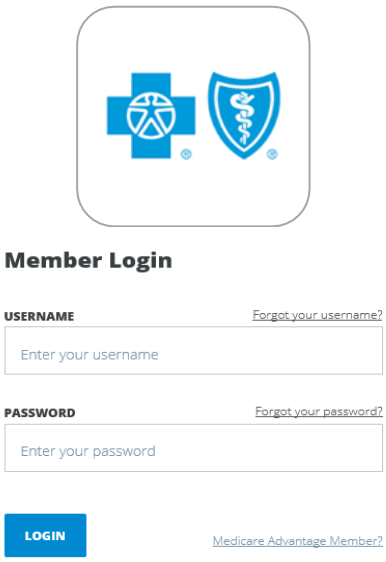
There is no reason to leave home. You can access a video (face-to-face) visit right from your smartphone, tablet or computer with a virtual care doctor who has also been trained to evaluate for COVID-19. Both Urgent Care Visits and Behavioral Health Therapy visits provided in the Blue KC mobile app are no cost. (subject to change based on federal mandates).

In addition, you can see your in-network providers, at no cost for virtual (face-to-face), telephone, e-mail or text visits for medical services or behavioral health therapy. With the increased use of virtual care, please understand that wait time may be longer.

Download the app on the Apple App Store and Google Play or go to www.BlueKCVirtualCare.com.

- Download the Blue KC Virtual Care app on the Apple App Store, Google Play, or go to www.BlueKCVirtualCare.com.
- Create an account in a few simple steps. Be sure to use your Blue KC insurance information when creating an account. Also be sure to choose Blue KC from the plan drop-down list.
- View a list of available doctors, their experience and ratings, and select one.
- Engage in a secure live video visit directly from your desktop or mobile device in high-quality streaming video.

My BlueKC: Online or On-the-go!



Register to be able to access:

- Your coverage details
- Your claims history
- Doctor and hospital finder
- Cost savings tools
- Health information
- ID cards
- Symptom checker

Rx Savings Solutions:

- Switch Pharmacies
- Trying Generic or a different generic medication
- Trying Therapeutic Alternatives

Visit www.MyBlueKC.com and click on:
"SAVE ON Prescriptions"

Cost Breakdown

The rates below are effective January 1, 2021 – December 31, 2021.

Coverage Level

Payroll Deduction

Blue Cross Blue Shield of KC Medical Silver PPO	Employee	Employee +Spouse	Employee +Child(ren)	Family
Total Plan Cost Per Month	$869.59	$1,795.28	$1,628.40	$2,460.57
MMGY Global Pays Per Month	$678.68	$958.82	$908.50	$1,321.06
Employee Pays Per Month*	$190.91	$836.46	$719.90	$1,139.51
Employee Pays Per Pay Period	$88.11	$386.06	$332.26	$525.93
Blue Cross Blue Shield of KC Medical Gold PPO				
Total Plan Cost Per Month	$987.00	$2,041.86	$1,851.71	$2,800.01
MMGY Global Pays Per Month	$673.35	$935.07	$884.42	$1,307.64
Employee Pays Per Month*	$313.65	$1,106.79	$967.29	$1,492.37
Employee Pays Per Pay Period	$144.76	$510.83	$446.44	$688.79
Blue Cross Blue Shield of KC Medical HDHP PPO				
Total Plan Cost Per Month	$634.50	$1,301.47	$1,181.24	$1,780.80
MMGY Global Pays Per Month	$623.22	$834.78	$799.76	$1,136.94
Employee Pays Per Month*	$11.28	$466.69	$381.48	$643.86
Employee Pays Per Pay Period	$5.21	$215.40	$176.07	$297.17
Delta Dental Base PPO Plan				
Total Plan Cost Per Month	$35.18	$70.37	$71.99	$112.09
MMGY Global Pays Per Month	$21.14	$25.31	$25.11	$30.45
Employee Pays Per Month*	$14.04	$45.06	$46.88	$81.64
Employee Pays Per Pay Period	$6.48	$20.80	$21.64	$37.68
Delta Dental Buy-Up Plan				
Total Plan Cost Per Month	$50.35	$100.75	$103.09	$160.46
MMGY Global Pays Per Month	$22.31	$27.41	$27.59	$33.20
Employee Pays Per Month*	$28.04	$73.34	$75.50	$127.26
Employee Pays Per Pay Period	$12.94	$33.85	$34.85	$58.74
VSP Vision PPO				
Employee Pays Per Month	$8.70	$13.92	$14.20	$22.90
Employee Pays Per Pay Period	$4.02	$6.42	$6.55	$10.57

MMGY Global annual HSA employer contribution up to $480 individual/family on a per pay period basis.

*Medical Tenure Base Rate Cost Per Month
0-3 years = Monthly Employee Cost listed above
4-6 years = Monthly Employee Cost listed above less $56/month tenure discount
7+ years = Monthly Employee Cost listed above less $112/month tenure discount

*Dental Tenure Base Rate Cost Per Month
0-3 years = Monthly Employee Cost listed above
4-6 years = Monthly Employee Cost listed above less $3/month tenure discount
7+ years = Monthly Employee Cost listed above less $6/month tenure discount

Employer Contribution cannot exceed monthly premium

Directory & Resources

Below, please find important contact information and resources for MMGY Global.

Information Regarding	Group / Policy #	Contact Information	
Enrollment & Eligibility			
Human Resources: • Kelley Bausch, HR Generalist Online Enrollment Vendor: • ADP		816.300.5184	kbausch@mmgyglobal.com www.workforcenow.adp.com
Medical Coverage			
Blue Cross Blue Shield of KC • PPO • HDHP w/HSA	36598000	816.395.3558	www.BlueKC.com
Dental Coverage			
Delta Dental • PPO Base Plan • PPO Buy-Up Plan	54092-0-1-0 54093-0-1-0	800.234.3375	www.deltadentalks.com
Vision Coverage			
VSP • PPO	30052484	800.877.7195	www.vsp.com
Life, AD&D and Disability			
Unum • Basic Life/AD&D • Short Term Disability • Voluntary Life/AD&D • Voluntary Long Term Disability • Accident Insurance • Critical Illness Insurance	912162 912164 912163 R0755132 912166	866.679.3054	www.unum.com
Pet Insurance			
Nationwide		877.738.7874	www.petinsurance.com/mmgyglobal
Flexible Spending Accounts			
NueSynergy		855.890.7239	www.nuesynergy.com
Health Savings Account			
NueSynergy		855.890.7239	www.nuesynergy.com
Employee Assistance Plan			
Unum		800.854.1446	www.unum.com/lifebalance
Mental Health and Fitness			
Total Brain		202.679.3325	www.totalbrain.com
Benefits Broker			
Marsh & McLennan Insurance Agency LLC 350 S. Grand Avenue, Suite 3410 Los Angeles, CA 90071	Adriana Sanchez Katie Jones Stacy Hubbard Brian Hegarty	213.237.8030 213.237.8019 213.237.8018 213.237.8010	Adriana.Sanchez@marshmma.com Katie.Jones@marshmma.com Stacy.Hubbard@marshmma.com Brian.Hegarty@marshmma.com

Guidelines/Evidence of Coverage

The benefit summaries listed on the previous pages are brief summaries only. They do not fully describe the benefits coverage for your health and welfare plans. For details on the benefits coverage, please refer to the plan's Evidence of Coverage. The Evidence of Coverage or Summary Plan Description is the binding document between the elected health plan and the member.

A health plan physician must determine that the services and supplies are medically necessary to prevent, diagnose, or treat the members' medical condition. These services and supplies must be provided, prescribed, authorized, or directed by the health plan's network physician unless the member enrolls in the PPO plan where the member can use a non-network physician.

For details on the benefit and claims review and adjudication procedures for each plan, please refer to the plan's Evidence of Coverage. If there are any discrepancies between benefits included in this summary and the Evidence of Coverage or Summary Plan Description, the Evidence of Coverage or Summary Plan Description will prevail.

Medicare Part D Notice

Important Notice about Your Prescription Drug Coverage and Medicare

Model Individual CREDITABLE Coverage Disclosure (Gold & Silver PPO)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage 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 prescription drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Your employer has determined that the prescription drug coverage offered is expected to pay, on average, as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare prescription drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Prescription Drug Plan?

Individuals who are eligible for Medicare should compare their current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in their area.

If you are eligible for Medicare and do decide to enroll in a Medicare prescription drug plan and drop your employer's group health plan prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

Please contact Human Resources for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

Your medical benefits brochure contains a description of your current prescription drug benefits.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with your employer and don't join a Medicare prescription drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

Contact your Human Resources Department for further information NOTE: You will receive this notice annually, before the next period you can join a Medicare prescription drug plan, and if this coverage through your employer 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 the Social Security Administration (SSA) online at www.socialsecurity.gov, or call SSA at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: **Keep this Creditable Coverage notice. If you decide to join one of the Medicare prescription drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).**

Medicare Part D Notice

Important Notice about Your Prescription Drug Coverage and Medicare

Model Individual NON-CREDITABLE Coverage Disclosure (HDHP)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage 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. For information about where you can get help to make decisions about your prescription drug coverage, contact your Human Resources Department.

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

3. 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.
4. Your employer has determined that the prescription drug coverage offered is NOT expected to pay, on average, as much as standard Medicare prescription drug coverage pays and is therefore 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 your employer. This is also 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.
5. You can keep your current coverage from your employer. 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 15 to December 7.

If Your Plan is an Employer/Union Sponsored Group Plan: However, if you decide to drop your current coverage with MMGY Global, 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 employer/union sponsored group plan.

If Previous Coverage Provided was Creditable Coverage: Since you are losing creditable prescription drug coverage, you are also eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

When will you pay a higher premium (penalty) to join a Medicare drug plan?

Since the coverage provided by your employer, 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 is 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 prescription drug plan?

If you decide to join a Medicare drug plan, your current coverage will be affected.

For individuals who elect Part D coverage, coverage under the employer plan will end for the individual and all covered dependents.

See pages 9–11 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

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

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

Contact your Human Resources Department for further information NOTE: You'll receive this notice annually, before the next period you can join a Medicare drug plan, and if this coverage through your employer 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 the Social Security Administration (SSA) online at www.socialsecurity.gov or call SSA at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in one of the plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Legal Information Regarding Your Plans

REQUIRED NOTICES

Women's Health & Cancer Rights Act

The Women's Health and Cancer Rights Act (WHCRA) requires group health plans to make certain benefits available to participants who have undergone or who are going to have a mastectomy. In particular, a plan must offer mastectomy patients benefits for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

Your plans comply with these requirements.

Health Insurance Portability & Accountability Act Non-discrimination Requirements

Health Insurance Portability & Accountability Act (HIPAA) prohibits group health plans and health insurance issuers from discriminating against individuals in eligibility and continued eligibility for benefits and in individual premium or contribution rates based on health factors.

These health factors include: health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence and participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities), and disability.

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, HIPAA Special Enrollment Rights require your plan to allow you and/or your dependents to enroll in your employer's plans (except dental and vision plans elected separately from your medical plans) if you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days (60 days if the lost coverage was Medicaid or Healthy Families) after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Other midyear election changes may be permitted under your plan (refer to "Change in Status" section). To request special enrollment or obtain more information, contact your Human Resources Representative.

"HIPAA Special Enrollment Opportunities" include:

- COBRA (or state continuation coverage) exhaustion
- Loss of other coverage [1]
- Acquisition of a new spouse or dependent through marriage [1], adoption [1], placement for adoption [1] or birth [1]
- Loss of state Children's Health Insurance Program coverage (e.g., Healthy Families) (60-day notice) [1]
- Employee or dependents become eligible for state Premium Assistance Subsidy Program (60-day notice)

"Change in Status" Permitted Midyear Election Changes

- Due to the Internal Revenue Service (IRS) regulations, in order to be eligible to take your premium contribution using pre-tax dollars, your election must be irrevocable for the entire plan year. As a result, your enrollment in the medical, dental, and vision plans or declination of coverage when you are first eligible, will remain in place until the next Open Enrollment period, unless you have an approved "change in status" as defined by the IRS.
- Examples of permitted "change in status" events include:
- Change in legal marital status (e.g., marriage [2], divorce or legal separation)
- Change in number of dependents (e.g., birth [2], adoption [2] or death)
- Change in eligibility of a child
- Change in your / your spouse's / your registered domestic partner's employment status (e.g., reduction in hours affecting eligibility or change in employment)
- A substantial change in your / your spouse's / your registered domestic partner's benefits coverage
- A relocation that impacts network access
- Enrollment in state-based insurance Exchange
- Medicare Part A or B enrollment
- Qualified Medical Child Support Order or other judicial decree
- A dependent's eligibility ceases resulting in a loss of coverage [3]
- Loss of other coverage [2]
- Change in employment status where you have a reduction in hours to an average below 30 hours of service per week, but continue to be eligible for benefits, and you intend to enroll in another plan that provides Minimum Essential Coverage that is effective no later than the first day of the second month following the date of revocation of your employer sponsored coverage
- You enroll, or intend to enroll, in a Qualified health Plan (QHP) through the State Marketplace (i.e. Exchange) and it is effective no later than the day immediately following the revocation of your employer sponsored coverage.

You must notify Human Resources within 30 days of the above change in status, with the exception of the following which requires notice within 60 days:

- Loss of eligibility or enrollment in Medicaid or state health insurance programs (e.g., Healthy Families)

IMPORTANT INFORMATION ON HOW HEALTH CARE REFORM AFFECTS YOUR PLAN

Primary Care Provider Designations

For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries:

- Your HMO generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your Human Resources office

For plans and issuers that require or allow for the designation of a primary care provider for a child:

- For children, you may designate a pediatrician as the primary care provider

For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider:

- You do not need prior authorization from your insurance provider or from any other person (including a 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. The health care professional, however, 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. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your Human Resources office.

Grandfathered Plans

If your group health plan is grandfathered then the following will apply. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator.

Prohibition on Excess waiting Periods

Group health plans may not apply a waiting period that exceeds 90 days. A waiting period is defined as the period that must pass before coverage for an eligible employee or his or her dependent becomes effective under the Plan. State law may require shorter waiting periods for insured group health plans. California law requires fully-insured plans to comply with the more restrictive waiting period limitation of no more than 60-days.

Preexisting Condition Exclusion

Effective for Plan Years on or after January 1, 2014, Group health plans are prohibited from denying coverage or excluding specific benefits from coverage due to an individual's preexisting condition, regardless of the individual's age. A PCE includes any health condition or illness that is present before the coverage effective date, regardless of whether medical advice or treatment was actually received or recommended

CONTINUATION COVERAGE RIGHTS UNDER COBRA

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

[1] Indicates that this event is also a qualified "Change in Status"
[2] Indicates this event is also a HIPAA Special Enrollment Right
[3] Indicates that this event is also a COBRA Qualifying Event

CONTINUATION COVERAGE RIGHTS UNDER COBRA (CONTINUED)

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to anyone covered under the Plan who are spouses, dependent children, or anyone else eligible for COBRA continuation coverage under the Plan

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months 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.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

How is COBRA continuation coverage provided? (Continued)

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

[Enter name of the Plan and name (or position), address and phone number of party or parties from whom information about the Plan and COBRA continuation coverage can be obtained on request.]

EMPLOYEE RIGHTS & RESPONSIBILITIES UNDER THE FAMILY MEDICAL LEAVE ACT

Basic Leave Entitlement

Family Medical Leave Act (FMLA) requires covered employers to provide up to 12 weeks of unpaid, job protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, child or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements

Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member is: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness [1]; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness. [2]

Benefits & Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months [3], and if at least 50 employees are employed by the employer within 75 miles.

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.
[2] The FMLA definitions of "serious injury or illness" for current servicemembers and veterans are distinct from the FMLA definition of "serious health condition"
[3] Special hours of service eligibility requirements apply to airline flight crew employees

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days' notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions; the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider; or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.

For additional information: (866) 4US-WAGE ((866) 487-9243) TYY: (877) 889-5627
www.wagehour.dol.gov

UNIFORMED SERVICES EMPLOYMENT & REEMPLOYMENT RIGHTS ACT NOTICE OF 1994, NOTICE OF RIGHT TO CONTINUED COVERAGE UNDER USERRA

Right to Continue Coverage

Under the Uniformed Services Employment & Reemployment Rights Act of 1994 (USERRA), you (the employee) have the right to continue the coverage that you (and your covered dependents, if any) had under the Company Medical Plan if the following conditions are met:

- You are absent from work due to service in the uniformed services (defined below);
- You were covered under the Plan at the time your absence from work began; and
- You (or an appropriate officer of the uniformed services) provided your employer with advance notice of your absence from work (you are excused from meeting this condition if compliance is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances).

How to Continue Coverage

If the conditions are met, you (or your authorized representative) may elect to continue your coverage (and the coverage of your covered dependents, if any) under the Plan by completing and returning an Election Form 60 days after date that USERRA election notice is mailed, and by paying the applicable premium for your coverage as described below.

What Happens if You do not Elect to Continue Coverage?

If you fail to submit a timely, completed Election Form as instructed or do not make a premium payment within the required time, you will lose your continuation rights under the Plan, unless compliance with these requirements is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances.

If you do not elect continuation coverage, your coverage (and the coverage of your covered dependents, if any) under the Plan ends effective the end of the month in which you stop working due to your leave for uniformed service.

Premium for Continuing Your Coverage

The premium that you must pay to continue your coverage depends on your period of service in the uniformed services. Contact Human Resources for more details.

Length of Time Coverage Can Be Continued

If elected, continuation coverage can last 24 months from the date on which employee's leave for uniformed service began. However, coverage will automatically terminate earlier if one of the following events takes place:

- A premium is not paid in full within the required time;
- You fail to return to work or apply for reemployment within the time required under USERRA (see below) following the completion of your service in the uniformed services; or
- You lose your rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA.

Reporting to Work / Applying for Reemployment

Your right to continue coverage under USERRA will end if you do not notify Human Resources of your intent to return to work within the timeframe required under USERRA following the completion of your service in the uniformed services by either reporting to work (if your uniformed service was for less than 31 days) or applying for reemployment (if your uniformed service was for more than 30 days). The time for returning to work depends on the period of uniformed service, as follows:

Period of Uniformed Service	Report to Work Requirement
Less than 31 days	The beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight-hour rest period, or if that is unreasonable or impossible through no fault of your own, then as soon as is possible
31–180 days	Submit an application for reemployment within 14 days after completion of your service or, if that is unreasonable or impossible through no fault of your own, then as soon as is possible
181 days or more	Submit an application for reemployment within 90 days after completion of your service
Any period if for purposes of an examination for fitness to perform uniformed service	Report by the beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight-hour rest period, or if that is unreasonable or impossible through no fault of your own, as soon as is possible
Any period if you were hospitalized for or are convalescing from an injury or illness incurred or aggravated as a result of your service	Report or submit an application for reemployment as above (depending on length of service period) except that time periods begin when you have recovered from your injuries or illness rather than upon completion of your service. Maximum period for recovering is limited to two years from completion of service but may be extended if circumstances beyond your control make it impossible or unreasonable for you to report to work within the above time periods

Definitions

For you to be entitled to continued coverage under USERRA, your absence from work must be due to "service in the uniformed services."

- "Uniformed services" means the Armed Forces, the Army National Guard, and the Air National Guard when an individual is engaged in active duty for training, inactive duty training, or full-time National Guard duty (i.e., pursuant to orders issued under federal law), the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency
- "Service in the uniformed services" or "service" means the performance of duty on a voluntary or involuntary basis in the uniformed services under competent authority, including active duty, active and inactive duty for training, National Guard duty under federal statute, a period for which a person is absent from employment for an examination to determine his or her fitness to perform any of these duties, and a period for which a person is absent from employment to perform certain funeral honors duty. It also includes certain service by intermittent disaster response appointees of the National Disaster Medical System (NDMS)

HIPAA PRIVACY NOTICE

Notice of Health Information Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can obtain access to this information. Please review it carefully.

This notice is EFFECTIVE: January 1, 2020

This notice is required by law under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is intended to provide information about the legal protections that apply to your health information. HIPAA includes numerous provisions that are designed to maintain the privacy and confidentiality of your Protected Health Information (PHI). PHI is health information that contains identifiers (such as your name, address, social security number, or other information that identifies you) and information related to your past, present or future health condition and treatments.

This notice is for participants in the Company Health & Welfare Plan (referred to as the "Plan"), including its component plans.

Required by Law

- The Plan must make sure that health information that identifies you is kept private.
- The Plan must give you this notice of our legal duties and privacy practices with respect to health information about you.
- The Plan must obtain written authorization from you for the use and disclosure of your PHI related to psychotherapy notes; when for purposes of marketing; and/or for disclosures constituting a sale of PHI.
- The Plan must follow the terms of the notice that are currently in effect.

Permitted Plan use of Your Health Information

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, contact the Plan Privacy Officer.

You have both the right and choice to tell us to: share information with your family, close friends, or others involved in payment for your care; share information in a disaster relief situation; and contact you for fundraising efforts.

If you are not able to tell us your preference, for example if you are unconscious, the Plan may go ahead and share your information if it believes it is in your best interest. The Plan may also share your information when needed to lessen a serious and imminent threat to health or safety.

The Plan will never share your information unless you give us written permission for: marketing purposes and the sale of your information.

Treatment: The Plan may use your health information to assist your health care providers (doctors, pharmacies, hospitals and others) to assist in your treatment. For example, the Plan may provide a treating physician with the name of another treating provider to obtain records or information needed for your treatment.

Regular Operations: We may use information in health records to review our claims experience and to make determinations with respect to the benefit options that we offer to employees. We may also use and disclose your information to run our organization and contact you when necessary. If PHI is used or disclosed for underwriting purposes, the Plan is prohibited from using or disclosing any of your PHI that is genetic information for such purposes. The Plan is also not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Payment for Health Services and Administration of the Plan: The Plan can use and disclose your health information when paying for your health services. For example, the Plan may share information about you with your dental plan to coordinate payment for your dental work. The Plan may disclose your health information to your health plan sponsor for plan administration. For example, where your company contracts with an insurer to provide a health plan, and the Plan provides your company with certain statistics to explain the premiums charged.

Business Associates: There are some services provided in our organization through contracts with business associates. Business associates with access to your information must adhere to a contract requiring compliance with HIPAA privacy rules and HIPAA security rules.

As Required by Law: We will disclose health information about you when required to do so by federal, state or local law (this includes the Department of Health and Human Services if it wants to see that the Plan is complying with federal privacy law).

To Respond to Organ and Tissue Donation Requests and Work with a Medical Examiner or Funeral Director: We may share health information about you with organ procurement organizations; and may share health information with a coroner, medical examiner, or funeral director when an individual dies.

Workers' Compensation: We may release health information about you for workers' compensation programs or claims or similar programs. These programs provide benefits for work-related injuries or illness.

Law Enforcement and other Government Requests: We may disclose your health information for law enforcement purposes or with a law enforcement official, in response to a valid subpoena or other judicial or administrative request/order, with health oversight agencies for activities authorized by law, or for special government functions such as military, national security, and presidential protective services.

Public Health and Research: We may also use and disclose your health information to assist with public health activities (for example, reporting to a federal agency) or health oversight activities (for example, in a government investigation). Additionally we may share health information about you when: preventing disease; helping with product recalls; reporting adverse reactions to medications; reporting suspected abuse, neglect, or domestic violence; preventing or reducing a serious threat to anyone's health or safety or for purposes of health research.

Your Rights Regarding Your Health Information

Although your health record is the physical property of the entity that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information where concerning a service already paid for.
- Obtain a paper copy of the notice of health information practices promptly (even if you have agreed to receive the notice electronically) by requesting it from the Plan Privacy Officer.
- Ask to see or get a copy of your health and claims records and other health information we have about you. We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- Inspect and obtain a copy of your PHI contained in a "designated record set." A designated records set includes medical and billing records; enrollment, payment, billing, claims adjudication and case or medical management record systems; or other information used in whole or in part by or for the covered entity to make decisions about individuals. A written request to access your PHI must be submitted to your company Privacy Officer. Requested information will be provided within 30 days if maintained on site or 60 days if maintained off site.
- Request an amendment/correction to your health information: you can ask us to correct your health and claims records if you think they are incorrect or incomplete. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- Ask us to limit what we use or share. You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- Obtain an accounting of disclosures of your PHI during the preceding six years, who we shared it with, and why, with the exception of disclosures made for purposes of treatment, payment or health care operations, and certain other disclosures (such as any you asked us to make); made to individuals about their own PHI; or, made through use of an authorization form. A reasonable fee may be charged for more than one request per year.
- Request confidential communications of your health information be sent in a different way (for example, home, office or phone) or to a different place than usual (for example, you could request that the envelope be marked "confidential" or that we send it to your work address rather than your home address). We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
- Revoke in writing your authorization to use or disclose health information except to the extent that action has already been taken, in reliance on that authorization.
- Receive notification within 60 days (5 day for California residents) for any breaches of your unsecured PHI.
- Assign someone as your medical power of attorney or your legal guardian, who can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

Plan Responsibilities

The Plan is required to maintain the privacy of PHI and to comply with the terms of this notice. The Plan reserves the right to change our health privacy practices. Should we change our privacy practices in a material way, we will make a new version of our notice available to you within 60 days of the effective date of any material change to the rights and duties listed in this notice. The Plan is required to:

- Maintain the privacy and security of your health information.
- Make reasonable efforts not to use, share, disclose or request more than the minimum necessary amount of PHI needed to accomplish the intended purpose, unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- Follow the duties and privacy practices described in this notice with respect to information we collect and maintain about you and provide you a copy of the notice.
- Abide by the terms of this notice.
- Notify you if we are unable to agree to a requested restriction, amendment or other request.
- Notify you of any breaches of your protected health information that may have compromised the privacy or security of your information within 60 days (5 days for California residents).
- Accommodate any reasonable request you may have to communicate health information by alternative means or at alternative locations.

The Plan will not use or disclose your health information without your consent or authorization, except as provided by law or described in this notice. The Plan may use or disclose "summary health information" to the plan sponsor for obtaining premium bids or modifying, amending or terminating the Group Health Plan, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a Group Health Plan; and from which identifying information has been deleted in accordance with HIPAA. The plan is prohibited from using or disclosing PHI that is genetic information of an individual for any purposes, including underwriting.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Your Right to File a Complaint

If you believe your privacy rights have been violated, you can file a formal complaint with the Plan Privacy Officer; or with the U.S. Department of Health and Human Services (by mail or email). We will not retaliate against you and you will not be penalized for filing a complaint.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Contact Person

If you have questions or would like additional information, or if you would like to make a request to inspect, copy, or amend health information, or for an accounting of disclosures, contact the Plan Privacy Officer. All requests must be submitted in writing to the address shown below.

MMGY Global
Attention: Kelley Bausch
HR Generalist
7309 W. 80th Street
Suite 400
Overland Park, KS 66204
(816) 300.5184

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 January 31, 2020. Contact your State for more information on eligibility –

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	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
ALASKA – Medicaid	**FLORIDA – 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: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-800-541-5555	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
IOWA – Medicaid and CHIP (Hawki)	**MONTANA – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	**NEVADA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	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
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp [Under ELIGIBILITY tab, see "what if I have other health insurance?"] Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

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:

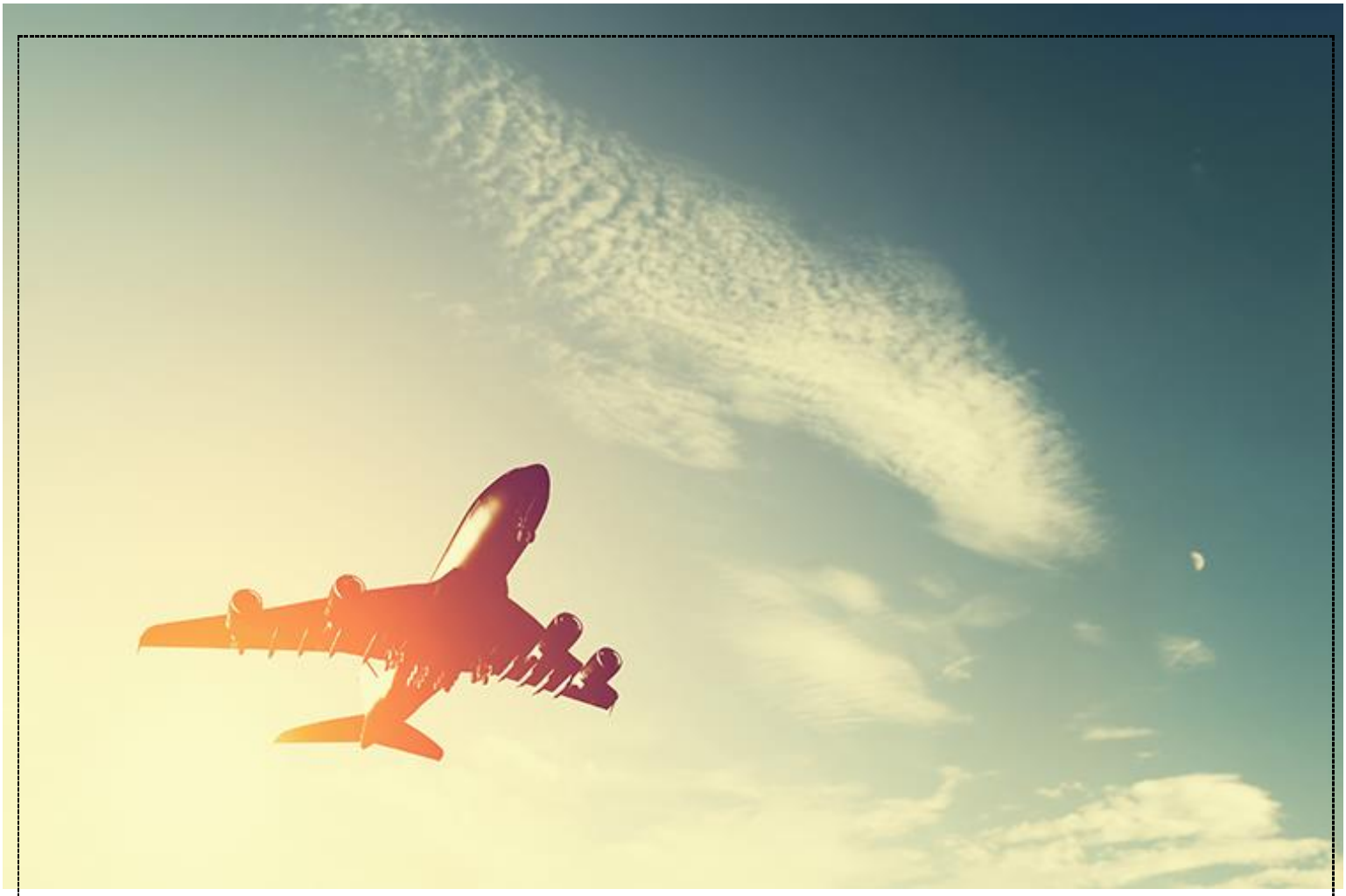
U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

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.



Marsh & McLennan Insurance Agency LLC
CA Insurance Lic: 0H18131