C3R®
CONCORD CROSSROADS, LLC

Employee Benefits Guide

2022-2023

YOUR 2022-2023 EMPLOYEE BENEFITS GUIDE

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At Concord Crossroads, LLC (C3R), we are committed to the health and well-being of our employees and your families. We recognize that employee benefits are an important part of your total compensation package. We support individuals in making informed choices regarding health benefits by offering freedom and flexibility of options and by empowering employees with information and tools to evaluate those options.

C3R provides you with a comprehensive benefits package complete with medical, dental, vision, evacuation, life/AD&D, short-term disability, long-term disability, and Employee Assistance Plan designed to meet your needs throughout the year.

This guide provides an overview of the benefits available to you as a C3R employee.

Welcome To Your Benefits

Welcome to Concord Crossroads, LLC!

This booklet is designed to provide a summary of the employee benefits plans available to Concord Crossroads, LLC (C3R) employees. If you wish to obtain more detailed information about these programs, please refer to the benefits booklet issued by the insurance carrier handling the particular benefit you wish to research. The MetLife booklet can be found in the benefits section of the C3R employee portal. If you have any trouble locating the carrier's booklet you can generally download the booklet by logging in to the carrier's website. A list of participating carriers and their contact information is can be found on page 16 of this benefits guide.

We are excited to be able to offer a very competitive benefits program, including an employer-paid, medical and vision insurance plan for the employee, dental insurance that is partially paid by the C3R, and Basic Life insurance paid by C3R that has a base benefit of $100,000.

There are numerous other benefits programs outlined in this booklet to help you as you seek to build a program that provides the safety you need for yourself and your family.

While every effort has been made to ensure the accuracy of the following information, this guide does not provide the limitations and exclusions that apply to each benefit. Administration of the plans is governed by plan documents and insurance agreements. In the event of a discrepancy between this guide and the plan documents and agreements, the plan documents and agreements will prevail.

If you have any questions concerning this information, please feel free to contact our office at 703-670-8770. We wish you much success at C3R.

Sincerely,

Your Executive Team

When Can I Enroll?

ELIGIBILITY

When Benefits Coverage Begins and Ends

All full-time C3R employees working at least 30 hours per week are eligible for benefits. As a new hire you are eligible for benefits the first day of employment.

Eligible Dependents

Once you become eligible, so do your dependents. In general, eligible dependents include your spouse, domestic partner, and natural, step or adopted children up to age 26. If your child is mentally or physically disabled, coverage may continue beyond as 26 with proof of an ongoing disability.

Open Enrollment

Each year, we have an annual "open enrollment" period for benefit plans. During open enrollment, you may make changes to your benefits program (change plans, elect new coverage, add or delete eligible dependents). **All changes take effect on October 1.**

Making Changes

Employees are only able to make changes during open enrollment, unless you experience a "Qualifying Event" during the plan year. Below are examples of qualifying life events:

- Birth, adoption, placement for foster care, legal custody of a child
- Marriage, divorce, legal separation
- Gain or loss of spouse's coverage due to change in employment
- Gain or loss of child's eligibility
- Gain or loss of coverage under Medicare or Medicaid
- Death of spouse or child
- COBRA coverage expires
- Start or end of unpaid leave of absence
- Spouse moves into or out of the United States
- Significant change in health care cost of spouse
- Gain or loss of coverage during spouse's annual enrollment
- Loss of child(ren) coverage under a parent's plan (due to eligibility requirements)

How long do I have to request an enrollment due to a qualifying event?

The employee or dependent must request enrollment ***within 30 days*** after losing eligibility for coverage or after a marriage, birth, adoption, or placement for adoption.

The employee or dependent must request enrollment ***within 60 days*** of the loss of coverage under a State CHIP or Medicaid program or the determination of eligibility for premium assistance under those programs.

Medical Benefits

MetLife

BENEFITS AT-A-GLANCE

MetLife Global

Before your health insurance policy starts paying benefits, there are usually some costs you're responsible for – such as your deductible. You're probably also responsible for co-insurance. Oh, and don't forget your out-of-pocket maximum. Puzzled? Let's break it down.

What Is a Deductible? A deductible refers to the amount of money you have to pay before the insurance company pays for any health benefits. Once you meet this amount, your insurance benefits go into effect. A deductible amount is calculated yearly, so you will have to meet a new deductible for each year of the policy. Once you meet this deductible; however, the health insurance benefits kick in, and you're then responsible only for co-pays and coinsurance, if applicable. Deductible amounts vary by plan and can be separated into individual or family deductibles. In general, a family deductible is double an individual deductible, but it can include several members of a family.

- **What Is Co-Insurance?** With co-insurance, you're required to pay a certain percentage of the covered costs after your deductible is met. For example, an 80/20 coinsurance plan with a $300 deductible requires you to pay 20% of the covered costs after the $300 deductible has been paid, while the insurance company will be liable for the remaining 80%. Co-insurance and co-payments are not the same. A co-payment is the specific amount you pay at the doctor's office, for example, before you meet your deductible, while co-insurance is a percentage of the covered service that you are required to pay. Depending on your plan, you may have to pay both co-insurance and co-pays for a given doctor's visit.

- **What Is an Out-of-Pocket Maximum?** The annual out-of-pocket maximum is the highest or total amount the health insurance company requires you to pay toward the cost of your health care. The out-of-pocket maximum helps protect you from high additional costs. An out-of-pocket expense maximum, or cap, is the amount you need to meet for the insurance company to pay 100% of your health expenses considered medically necessary. Normally, your deductible, co-pays and co-insurance are applied toward this maximum amount. Your monthly insurance premiums aren't included in this cap.

Medical Benefits – Open Choice PPO

BENEFITS AT-A-GLANCE

We are pleased to offer a comprehensive medical insurance plan through MetLife to help protect you and your family from the high cost of health care. This information is provided for Summary purposes only. Please refer to the Summary Plan Description for specific plan information. In the event of a discrepancy, the official plan document prevails. The following charts outline the medical plans effective October 1, 2022.

Plan Design (U.S. Care Included)	International	In-Network U.S.	Out-of-Network U.S.
Deductible Coinsurance Out-of-Pocket	None / None 100% None / None	$2,500 / $5,000 80% $3,500 / $7,000	$5,000 / $10,000 60% $7,000 / $14,000
Physician Office Visit	100%	80% after deductible	60% after deductible
Specialist Office Visit	100%	80% after deductible	60% after deductible
Preventive Care (Adult, Well Baby/Child)	Covered at 100%	100% (deductible waived)	100% (deductible waived)
Inpatient Hospital	100%	80% after deductible	60% after deductible
Lab/X-Ray Facility	100%	80% after deductible	60% after deductible
Outpatient Services	100%	80% after deductible	60% after deductible
Emergency Room	100%	100% after deductible	100% after in-network deductible
Urgent Care	100%	80% after deductible	60% after deductible
Physical Therapy (up to a combined 60 visits per Calendar Year)	100%	80% after deductible	60% after deductible
Prescription Drug Coverage			
• Retail Generic Drug	100%	100% After $5 Co-pay (Deductible Waived)	60% After Deductible
• Retail Formulary Brand Name Drug	100%	100% After $30 Co-pay (Deductible Waived)	60% After Deductible
• Retail Non-Formulary Brand Name Drug	100%	100% After $90 Co-pay (Deductible Waived)	60% After Deductible
• Mail Order Generic Drug	Not Available	100% After $15 Co-pay (Deductible Waived)	Not Available
• Mail Order Formulary Brand Name Drug	Not Available	100% After $90 Co-pay (Deductible Waived)	Not Available
• Mail Order Non-Formulary Brand Name Drug	Not Available	100% After $270 Co-pay (Deductible Waived)	Not Available
Vision	**Out-of–Network**	**Out-of–Network**	**Out-of–Network**
Exams	100% once every 24 months (Deductible Waived)		
Lenses, Frames, Hardware	100% up to $250 once every 24 months (Deductible Waived)		

Additional Service Riders

BENEFITS AT-A-GLANCE

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Members may use any licensed health care provider in the US and worldwide.

You are responsible for paying any applicable deductible (excess), coinsurance, or non-covered amounts directly to the provider, usually collected at the time of service.

If you need assistance with payment, provider referrals, or medical advice, you may contact MetLife 24 hours a day/7 days a week. Refer to the contact information of your Regional Service Center using the information on the back of your Global ID card (or your U.S. ID card, if in the U.S.).

Plan Design (U.S. Care Included)	International	In-Network U.S.	Out-of-Network U.S.
Preferred Telemedicine Services	24-hr, 7 days per week access to medical consultations with a network of licensed providers on any mobile device. Covered at 100% (Deductible Waived) when accessed through this preferred network.		
Second Medical Opinion	For complex medical diagnoses, you and your dependents can have your diagnosis confirmed and treatment plans reviewed remotely by teams of specialized physicians at world-class hospitals in the US so that you can make more informed treatment decisions without needing to fly home. A Second Medical Opinion from specialist at top medical centers is provided for serious illnesses upon request. These medical experts review the patient's medical records and provide a customized report, reviewing the diagnosis and recommending a personalized treatment plan based on the latest medical research.		
Global Emergency Assistance	Emergency assistance services and arrangements can be made to evacuate or repatriate you or your dependents from your location to the nearest medical facility equipped to handle the emergency. 24-hr, 7 days per week assistance services including telephonic translation, medical and legal referrals, evacuation/repatriation, dependent return, and concierge-level travel assistance. Covered at 100% (Deductible Waived) up to $25,000 for Repatriation of Remains, $250,000 per occurrence for Medical Evacuation, $10,000 for Emergency Family Travel and $10,000 for Return of Dependents.		

Dental Benefits

BENEFITS AT-A-GLANCE

Your oral health is an important part of your overall well-being. We want to make it easy to understand how to use your MetLife Worldwide Benefits Dental benefits to stay healthy. Below are some tips and tricks to help you understand and utilize your benefits

You can seek care from any licensed dental care provider that you choose. There are no networks to consider. Claims will be paid based on the usual, customary, and reasonable rate for that service, and reimbursement will be issued based on your plan provisions

BENEFIT	Worldwide
Annual Deductible Individual (Preventive/Diagnostic, Basic and Major)	Combined $50
Annual Deductible Family (Preventive/Diagnostic, Basic and Major)	Combined $150
Annual Plan Maximum (Preventive/Diagnostic, Basic and Major)	Combined $1,000
Preventive/Diagnostic Services Oral Exam | X-Rays | Cleanings | Sealants	100% (Deductible Waived)
Basic Basic Restorations | Endodontics | Periodontics | Prosthodontic Maintenance | Oral Surgery	80% After Deductible
Major Services Crowns | Dentures | Bridges	50% After Deductible

Life/AD&D Benefits

BENEFITS AT-A-GLANCE

Concord Crossroads, LLC provides employer-paid Basic Life and Accidental Death and Dismemberment (AD&D) benefits that helps meet a portion of income needs in the event of a premature death. The both benefits offers a solid foundation of protection.

BENEFIT	Benefit Amounts and Highlights
Basic Life Insurance*	Flat $100,000
Maximum Basic Life Benefit	$100,000
Guaranteed Issue Amount	$100,000
Disability Provision	Extended Death
*If you are age 65 and under age 70 on Your Effective Date of insurance, Your Life Insurance will be limited to 65% of the amount shown. If you are age 70 or older on Your Effective Date of insurance, Your Life Insurance will be limited to 50% of the amount shown. If You are under age 65 on Your Effective Date of insurance, your Life Insurance will be reduced by 35% on the date You attain age 65 and 50% on the date you attain age 70.	

Accidental Death And Dismemberment Insurance (AD&D) On You	Benefit Amounts and Highlights
Basic AD&D Full Amount	An amount equal to Basic Life Insurance on You
Maximum Basic AD&D Benefit	$100,000

Short-Term & Long-Term Disability – The Hartford

BENEFITS AT-A-GLANCE

So what if a disabling injury or sickness kept you from the workplace? How long would your savings last? How would you maintain your independence? Certainly, there's a lot depending on your income. That's why C3R has teamed up with The Hartford to offer disability income protection insurance. Should a disability prevent you from working and earning a living, this insurance can help. It's valuable insurance designed to help protect against the big "what ifs" in life.

- It can help replace a portion of your income when you are disabled as the result of a covered sickness or injury.
- Benefits paid year-round regardless of whether school is in session
- Maternity is covered the same as illness
- It is available to you at affordable group rates.
- Premiums are conveniently payroll-deducted.

Benefit Waiting Period:

The benefit waiting period is the time that you must be continuously disabled before benefits become payable.

Disability Insurance Highlights	
Short-Term Disability	
Benefit Amount	60%
Maximum Benefit	$1,000 weekly not to exceed 60% of Basic Monthly Wage
Benefit Waiting Periods	Benefits begin the 8th day of an and 8th day of a sickness
Benefit Period	12 weeks
Pre-existing Condition Limitation	12 months
Long-Term Disability	
Benefit Amount	60%
Maximum Period Payable	To age 65
Minimum Monthly Benefit	$100 or 10%
Maximum Monthly Benefit	$5,000
Elimination Period	90 Days

Defense Base Act (DBA) Insurance

BENEFITS AT-A-GLANCE

Defense Base Act (DBA) insurance, provides employees with an insurance solution to protect them against employment-related injuries while working outside of the United States.

This coverage is designed to provide workers compensation insurance for contractors working on military bases outside of the United States.

DBA insurance protects employees performing assigned duties overseas.

DBA provides coverage for employees working internationally.

Employee Assistance Program (EAP) - Anthem

BENEFITS AT-A-GLANCE

This benefit is provided at no cost to you and your family members.

C3R has contracted with Anthem to provide an Employee Assistance Program (EAP) for you, your spouse and eligible dependents. Anthem EAP provides free, confidential counseling by experienced licensed counselors. You can easily access a comprehensive network of providers with expertise in the following:

- Counseling
- Legal Consultation
- Financial Consultation
- ID Recovery
- Emotional Well-being Resources
- Dependent Care and Daily Living Resources
- Crisis Consultation
- Other anthemEAP.com Resources

An EAP is a great and confidential way for you to learn more about services available to you that you might not even be aware exist.

You and your immediate family members will have access to six free face-to-face or via LifeHealth Online counseling sessions per employee/household member per issue.

For more information visit anthemEAP.com and enter your company code: Concord Crossroads or call 800-865-1044.

401 (k) Retirement Savings Plan – Ascensus

BENEFITS AT-A-GLANCE

Did you know you could spend as much as one-third of your life in retirement? Like most people, you probably have a vision of how you want to spend your retirement years.

A 401(k) is one of the best tools available to help you make that vision a reality. The 401(k) allows you the opportunity to save for retirement by contributing to the plan on a pre-tax basis and Roth post-tax basis. Your 401(k) balance can add up quickly and there is no minimum – you can contribute as much or as little as you want up to the annual IRS maximum.

Who is Eligible and When

All employees 21 years of age and older are eligible to participate in the 401(k) plan. Employees are eligible to participate starting on the first day of employment.

Automatic Enrollment

C3R has made it convenient for new employees to enter the plan. Through an automatic enrollment program, 3% of your pay will be automatically deposited into your pre-tax retirement savings account each pay period or choose to make specific savings and investment elections. You have the opportunity to opt out of this program at any time.

Company Match

C3R contributes to employee 401(k) plans via annual company match. The match contribution will be determined annually.

Catch Up Contributions

If you are age 50 or older, you can contribute up to an additional $6,500 a year in catch-up contributions. You may change your salary deferral percentage or current investment at any time by contacting Ascensus at 1-866-809-8146 or visiting: myaccount.ascensus.com/rplink.

Flexible Spending Accounts – Paychex

BENEFITS AT-A-GLANCE

If you're interested in reducing your income taxes, you should consider contributing to a Flexible Spending Account (FSA). FSAs offer a convenient way to reimburse yourself for certain healthcare and dependent care expenses with pre-tax dollars

C3R offers two types of FSAs:

1. **Healthcare FSA** used to reimburse out-of-pocket medical expenses incurred by you and your dependents. Use your healthcare FSA for:

- Major dental work or orthodontia
- Deductibles and copays for medical, Rx, dental and vision
- Qualified out-of-pocket healthcare expenses not reimbursed by a medical plan

2. **Dependent Care FSA** used to reimburse expenses related to the care of your eligible dependents while you and your spouse work. Use your dependent care account for:

- Care or services for children under 13 years, including before- or after-school care
- Elder care

Eligible and Ineligible Expenses

The IRS determines what expenses are eligible and ineligible, and they may, from time to time, change these lists. You can view eligible and ineligible expenses, for both healthcare and dependent care accounts on the C3R benefits website. If you are unsure about whether an expense is eligible or not, contact PAYCHEX at 877-244-1771.

Knowing how much to set aside for your FSA is the only important decision you have to make. You may want to consider:

- Last year's medical and/or dependent care expenses.
- Any medical, dental, or vision care costs you foresee that might not be covered under your healthcare plan.
- Any changes in your family status that might have an impact on your medical, dental/vision or dependent care expenses, e.g. having a baby.

Health FSA Carryover for Plan Year 2022

The IRS amended the original use-or-lose rule for FSAs to allow some funds to roll over at the end of the plan year. Up to $570 in unused funds can roll over into the following plan year. COMPANY offer a grace period of up to 2 1/2 months for employees to use the money or carry over $570 to the next year.

January 1, 2022 through December 31, 2022	
Healthcare FSA	$2,850
Dependent Care FSA	$5,000
At the end of the 2022-2023 Plan Year, you have 90 days to file any FSA claims for reimbursement from unused 2022 contributions. If you leave employment prior to the end of the Plan Year, you have 30 days from your date of termination to file claims. Any Dependent Care funds remaining in your account after your Claim Filing Deadline will be forfeited; any Healthcare FSA funds remaining in your account after the Claim Filing Deadline can only be reimbursed if they qualify under the New Health FSA Carryover provision described in this section.	

If you do not renew your flex account and your balance is less than $100, your balance will not roll over.

Holidays

BENEFITS AT-A-GLANCE

HOLIDAYS
Martin Luther King, Jr. Birthday
Washington's Birthday
Memorial Day
Juneteenth National Independence Day
Independence Day
Labor Day
Columbus Day
Veterans Day
Thanksgiving Day
Christmas Day
New Year's Day

Paid Time Off

BENEFITS AT-A-GLANCE

Employees of Concord Crossroads, LLC are encouraged to use the paid time off (PTO) made available to them. Paid time off can be used for vacation, as sick time, to handle personal matters, or to care for a sick child. PTO available to a new employee in their first calendar year will be pro-rated.

PAID TIME OFF				
Concord Crossroads, LLC provides paid time off PTO to full-time employees with earned days away from work with pay. PTO days may be used for vacation, personal time, illness, or time off to care for others. PTO is accrued based upon years of service. PTO is based on the following schedule:				
Tier	**Years of Service**	**Accrual Rate Per Bi-Weekly Pay Period**	**Annual/Maximum PTO Accrual**	**Availability**
One	Up to year 2	1.85 hours per pay period	6 days (48 hours)	**New Employees**: Days awarded are based on accrued leave earned (from date of hire through 31 December) and are available after successful completion of a 90 day probationary period. 1st year up to 2nd year, January 1st= 6 days *
One	2-4 years	3.08 hours per pay period	10 days (80 hours)	January 1st=6 days, and balance (4 days) awarded on employee anniversary date*
Three	5 or more years	4.31 hours per pay period	14 days (112 hours)	January 1st=10 days and balance (4 days) awarded on employee anniversary date*
SICK TIME OFF				
Concord Crossroads, LLC recognizes that employees will need days off from work to address their medical needs. Concord Crossroads, LLC provides sick leave to full-time employees with earned days away from work with pay. Paid sick days are accrued at 56 hours a year or 7 days a year.				

YOUR 2022-2023 CONTACTS

Medical/Dental/Vision/Evacuation

MetLife

Member Services Numbers

Global Health Benefits:
Customer Services: +1 302-661-8674

U.S. Claim & Service
Member Customer Service: 1-866-217-5631
Providers Customer Service: 1-866-217-5631

Pharmacy Services
Rx Member Service: 1-866-644-7527
Website: https://www.metlife.com/

Life/Accidental Death & Dismemberment (AD&D)

MetLife

Member Services Phone Number: 1-800-451-1847
Website: www.rsli.com

MetLife Member Knowledge Center and Member Materials

Website: www.metlife.com/MWBwelcome

Employee Assistance Program

Anthem

Member Services Phone Number: 1-800-865-1044
Website: www.anthemEAP.com

Short-Term Disability (STD)

The Hartford

Member Services Phone Number: 1-800-523-2233
Website: www.thehartford.com

Long-Term Disability (LTD)

The Hartford

Member Services Phone Number: 1-800-523-2233
Website: www.thehartford.com

Flexible Spending Account (FSA)

Paychex

Member Services Phone Number: 1-800-472-0072
Website: www.paychexflex.com

C3R 401(k) Profit Sharing and Trust

Ascensus

Member Services Phone Number: 1-866-809-8146
Website: myaccount.ascensus.com/rplink

SPECIAL ENROLLMENT NOTICE

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days 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.

Finally, if you or an eligible dependent has coverage under a state Medicaid or child health insurance program and that coverage is terminated due to a loss of eligibility, or if you or an eligible dependent become eligible for state premium assistance under one of these programs, you may be able to enroll yourself and your eligible family members in the Plan. However, you must request enrollment no later than 60 days after the date the state Medicaid or child health insurance program coverage is terminated or the date you or an eligible dependent is determined to be eligible for state premium assistance.

To request special enrollment or obtain more information, contact the plan administrator identified at the end of these notices.

MEDICARE PART D
Creditable Coverage Notice

Important Notice About Your Prescription Drug Coverage and Medicare. Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with your employer and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan. You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th . This may mean that you may have to wait to join a Medicare drug plan and that you may pay a higher premium (a penalty) if you join later. You may pay that higher premium (a penalty) as long as you have Medicare prescription drug coverage. However, if you lose creditable prescription drug coverage, through no fault of your own, you will be eligible for a sixty (60) day Special Enrollment Period (SEP) to join a Part D plan.
If you decide to join a Medicare drug plan, your coverage may be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan. If you do decide to join a Medicare drug plan and drop your prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. You should also know that if you drop or lose your coverage with your employer and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium may go up by at least 1% of the base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium may consistently be at least 19% higher than the 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 November to join.

For more information about this notice or your current prescription drug coverage, contact your employer's Benefits Department. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through your employer changes. You also may request a copy.
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage: Visit www.medicare.gov. Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help, Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

HEATH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

Beginning in 2014, there is a new way to buy health insurance: the **Health Insurance Marketplace**. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

Each year, the open enrollment period for health insurance coverage through the Marketplace runs from Nov. 1 through Dec. 15 of the previous year. After Dec. 15, you can get coverage through the Marketplace only if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP).

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if you employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards.

If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5 percent (as adjusted each year after 2014) of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. (An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.)

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Kiara Branch at (540) 658-1922.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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, 2021. 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, 2018, 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. 61565000

NEWBORNS' AND MOTHER'S HEALTH PROTECTION ACT

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, 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. If you would like more information on WHCRA benefits, call your plan administrator as identified at the end of these notices.

For purposes of this notice, the plan administrator is:

NOTICE OF PATIENT PROTECTIONS

The following notice is provided for all plans that require or allow for the designation of primary care providers by participants or beneficiaries:

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 the insurance carrier or the plan administrator identified below.

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

You do not need prior authorization from your insurance carrier 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, you may contact the insurance carrier or the plan administrator, Human Resources.

GENETIC NONDISCRIMINATION RULES FOR HEALTH PLANS (GINA)

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits the improper collection, use or disclosure of genetic information by employers and health plans. In general, GINA prohibits group health plans and insurance issuers from:

- Adjusting group premium or contribution amounts on the basis of genetic information;
- Requesting or requiring individuals (or their family members) to undergo a genetic test (with limited exceptions, such as for determinations regarding payment based on medical appropriateness); and
- Collecting genetic information prior to or in connection with enrollment, or at any time for underwriting purposes.

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you receive emergency care or are treated by an out-of-network provider at an in-network facility, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?
When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay, and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in- network facility but are unexpectedly treated by an out-of-network provider.

Insurers are required to tell you which providers and facilities are in their networks. Providers and facilities must tell you with which provider networks they participate. This information is on the insurer's, provider's or facility's website or on request.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of- network provider or facility, the most the provider or facility may bill you is your plan's in- network cost-sharing amount (such as deductibles, copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services at the same facility that you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at a hospital or ambulatory surgical center in your plan's network
When you get services from an in-network facility, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, laboratory, surgeon and assistant surgeon services, and professional ancillary services such as anesthesia, pathology, radiology, neonatology, hospitalist, or intensivist services. These providers **can't** balance bill you and **can't** ask you to give up your protections not to be balance billed.

If you receive other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS
(CONTINUED)

- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and in-network out-of-pocket limit.

If you believe you've been wrongly billed, you may call the federal agencies responsible for enforcing the federal balance billing protection law at: **1-800-985-3059** and/or file a complaint with the Virginia State Corporation Commission Bureau of Insurance at: scc.virginia.gov/pages/File-Complaint-Consumers or call **1-877-310-6560**.

Visit cms.gov/nosurprises for more information about your rights under federal law.

Consumers covered under (i) a fully-insured policy issued in Virginia, (ii) the Virginia state employee health benefit plan; or (iii) a self-funded group that opted-in to the Virginia protections are also protected from balance billing under Virginia law. Visit scc.virginia.gov/pages/Balance-Billing-Protection for more information about your rights under Virginia law.

NOTES

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This Guide is only intended to offer an outline of benefits. All details and contract obligations of plans are stated in the group contract/insurance documents, including any disclosures (whether regarding “grandfathering” of plans or others) required by the new health reform law, the Patient Protection and Affordable Care Act (PPACA). In the event of conflict between this guide and the group contract/insurance documents, the group contract/insurance documents will prevail. Please contact your Human Resources Department for further information.

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