C3R®
CONCORD CROSSROADS, LLC

Employee Benefits Guide 2021

Welcome!

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. Anthem booklets 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 web site. A list of participating carriers and their contact information is on the back cover 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 a Basic Life insurance paid by the C3R that has a base benefit of $20,000.

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.

If you have any questions concerning this information please feel free to contact our office at 703-670-8770. We wish you a successful 2021 year at C3R.

Sincerely,

Your Executive Team

SUPPORT CENTER
2525 Pointe Center Court,
Suite 350
Dumfries, VA 22026
PHONE: 703-670-8770

This Benefit Summary does not provide all of the details about all of the benefit programs. Additional information is available in each program's Certificate of Coverage (COC). The COC's are available by request from the Human Resources Department. This brochure summarizes the coverage that is available during the upcoming 2021 plan year. If you have any questions, please contact Human Resources. Additional contact information is shown at the end of this guide.

Eligibility and Enrollment

Eligibility

Medical: To be eligible for Anthem Medical Plans you must be an active employee working 30 or more regularly scheduled hours each week. Please refer to the C3R Enrollment Guide for details.

Dental, Vision, Life, Disability & Other Programs: To be eligible to enroll in these programs you must be an active employee working 30 or more regularly scheduled hours each week. Please refer to the C3R Enrollment Guide for details.

Enrollment

New Hires your date of eligibility is the first of the month following your date of hire.

Newly Eligible Dependents, such as a new spouse or child, must be enrolled within 31 days of the date they become eligible, such as date of marriage or date of birth.

Effective Date

The following information assumes you enroll within the timeframes outlined above:

Medical: Coverage is effective on the first of the month following your date of eligibility.

Dental/Vision/Basic and Voluntary Life/Disability: Coverage is effective on the first of the month following your date of eligibility.

Notice of 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, you may be able to enroll yourself and your dependents later, if you have a qualifying event if you or your dependents lose eligibility for that other coverage (or, if the other coverage is through an employer, if that employer stops contributing towards 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 other employer stops contributing towards 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 date of marriage, birth, adoption, or placement for adoption.

To request **special enrollmen**t or obtain more information please contact your C3R Benefits Specialist as identified on the Contact Information page in this booklet.

Eligibility:

You are eligible for C3R benefits on the first day of the first full month following date of hire if you are scheduled to work 30 hours or more per week. You may enroll your eligible dependents in most of the plans you choose for yourself. Eligible dependents include your legal spouse, domestic partner (same and opposite sex), and your children up to age 26.

When to Enroll:

You can enroll for coverage within 30 days of your eligibility date or during the annual open enrollment period. If you do not enroll for coverage within 30 days of your eligibility date, you will not be able to elect coverages during the Plan Year January 1, 2021 through December 31, 2021, unless you have a qualified change in family status (See Making changes for details).

Making Changes:

The choices you make when you are first eligible remain in effect for the plan year which ends on December 31, 2021. Once you enroll for coverage, you must wait until the next open enrollment period to change your benefits or add or remove coverage for dependents, unless you have a qualified change in family status as defined by the IRS.

The following are a few examples:

- Marriage, divorce, legal separation, or annulment
- Birth or adoption of a child
- Change in your residence or workplace (if your benefit options change)
- Loss of other health coverage
- Change in your dependent's eligibility status because of marriage age, etc.

Making Changes During the Plan Year

Benefits elections made during Open Enrollment, as well as elections made by New Hires during their initial enrollment period, will remain in force through December 31, 2021. You can only make a change to your benefits election(s) if you experience a qualified Change in Status as defined by federal law. Once you experience such a change you must make any corresponding changes to your benefits elections within 30days from the date of the event. For clarification of Change in Status rules please refer to the C3R Cafeteria Plan Summary Plan Description or contact the Benefits Department at 703-670-8770.

Anthem Medical Insurance Options

C3R, offers two medical plans. A traditional Preferred Provider Organization (PPO) plan, which includes copays for many common services, and available to employees living outside the Virginia Metropolitan area, and a Point of Service (POS) plan available to employees living in the Virginia Metropolitan area.

Both medical plans cover preventive care at 100%. Services will be covered at 100% with no deductible and no copay when they are performed in a preventive capacity by an in-network provider. The types of tests or procedures covered include mammograms, pap smears, prostate specific antigen (PSA) tests, colonoscopies, preventive screenings for newborns, children and more.

Your dependent children may be covered until the end of the month in which they turn 26. Access claims payments, provider directories, and request ID cards. You may visit Anthem website www.anthem.com and use the “Find a Doctor” resource to find in-network providers. Once you are enrolled for coverage you can register for access to your account, which will allow you to view coverage details, check status of your claims, and request ID cards.

TRADITIONAL PPO PLAN

The PPO plan includes copays for office visits, urgent care, and prescriptions. Your deductible and coinsurance will apply for most services performed outside of a physician’s office. A PPO plan may be a good choice for you if you are willing to have a larger amount withheld from each paycheck in exchange for lower out-of-pocket costs at time of claim. The PPO plan is ideal for those that require geographic flexibility.

POINT OF SERVICE PLAN

The POS plan includes copays for office visits, urgent care, and prescriptions. Your deductible and coinsurance will apply for most services performed outside of a physician’s office. A POS plan may be a good choice for you that do not require a national network .

ANTHEM HEALTH PLANS

What's New

- Anthem is moving over to a 90 day mail order requirement for maintenance medications. You will have the option to opt out of this service, and continue to receive the 30 day refills. In order to opt out of this service, your must call Anthem, using the phone number on the back of your ID card.
- Walgreens will no longer be a participating pharmacy in the Anthem Network. If you currently have prescriptions that you have filled at Walgreens, they will need to be transferred to an in-network pharmacy.

Leverage Your $0 Preventive Care*

- Annual routine physicals (ages 12+)
- Annual mammogram (ages 40+)
- Annual OBGYN exam & pap smear (ages 18+)
- Annual prostate cancer screening (ages 45+)
- Well-child care (unlimited up to age 12)
- Healthy diet/obesity counseling (unlimited to age 22; ages 22+ get twenty-six visits per year)
- Smoking cessation counseling (8 visits per year)
- Breastfeeding support (number per year)
- Colonoscopy (ages 50+ once every ten years)

** Available for all plans. See benefits guides for more details.*

Did You Know?

- Provider search tool available at www.anthem.com.
- Choosing a PCP helps you meet your health goals faster.
- Generic medications save money! Ask your provider if your medicine has a generic.
- LiveHealth Online: www.livehealthonline.com
- Anthem 24/7 NurseLine: 1-800-337-4770.
- Blue View Vision: Search BlueView Vision providers on www.Anthem.com.

Covered Medical Benefits	Healthkeepers POS OA 20/20%/4000		KeyCare 25 – PPO 500/20%/4000	
Plan summary	• Lower premium • Copays for doctor visits before you meet deductible • Statewide network with out-of-network coverage		• Higher premium • Nationwide network with out-of-network coverage • No requirement for PCPs or referrals • Must meet deductible before plan pays for major medical services	
Type of Coverage	In-Network	Out-of-Network	In-Network	Out-of-Network
Individual/Family Deductible	$0 / $0	$1,000/ $2,000	$500 / $1,000	$1,000 / $2,000
Coinsurance	You pay 20% after deductible	You pay 30% after deductible	You pay 20% after deductible	You pay 40% after deductible
Individual/Family Maximum Out-of-Pocket	$4,000 / $8,000	$10,000 / $20,000	$4,000 / $8,000	$10,000 / $20,000
Network	Statewide Network		Nationwide Network	
Primary Care Provider (PCP) Required	No		No	
Doctor Visits				
Primary Care	$20 copay	You pay 30% after deductible	$25 Copay	You pay 40% after deductible
Specialist	$40 copay	You pay 30% after deductible	$50 Copay	You pay 40% after deductible
LiveHealth Online Virtual Health	$10 copay	You pay 30% after deductible	$25 Copay	You pay 40% after deductible
Immediate Care				
Urgent Care	$40 copay	You pay 30% after deductible	$50 copay	You pay 40% after deductible
Emergency Care	You pay 20% after deductible	Covered as In-Network	You pay 20% after deductible	Covered as In-Network
Prescription Drugs				
Drug Deductible	Integrated with medical		Integrated with medical	
Generics (30-Day Supply / 90-Day Supply)	$10 Copay	You pay 30%	$10 Copay	You pay 40%
Preferred Brand	$40 Copay	You pay 30%	$40 Copay	You pay 40%
Non-preferred Brand	$70 Copay	You pay 30%	$70 Copay	You pay 40%
Specialty	You pay 20% up to $300	You pay 30%	You pay 20% up to $300	You pay 40%

ANTHEM CONTACTS

Medical	855-330-1214	www.Anthem.com
24-Hour Nurse Line	800-337-4770	

This is a summary of benefits for informational purposes only. Please refer to the Carrier Certificate of Coverage for complete terms of coverage and eligibility.

MEDICAL PLAN RATES (PER PAYCHECK)

(Payroll deduction amounts are based on 26 pay periods.)

Anthem POS OA	Monthly	Payroll Deduction
Employee	$735.99	$00.00
Employee + Spouse	$912.64	$421.22
Employee + Child	$269.38	$124.33
Employee + Child(ren)	$760.28	$350.90
Family	$1,534.55	$708.26

Anthem KeyCare 25	Monthly	Payroll Deduction
Employee	$822.05	$00.00
Employee + Spouse	$1,019.27	$470.44
Employee + Child	$300.83	$138.85
Employee + Child(ren)	$849.12	$391.91
Family	$1,713.88	$791.03

Aetna Dental Plans

C3R continues to offer three dental plans, all administered by Aetna. These plans provide very comprehensive dental coverage but are very different in terms of how you access care and what rules you must follow. Below is a description of some of the similarities and differences between the three dental plans.

Dental Plan Similarities

All dental options cover four main types of dental expenses:

1. Preventive and diagnostic care: routine exams and cleanings, fluoride treatments, sealants and X-rays
2. Basic treatment: pulling teeth, fillings, and some oral surgeries
3. Major treatment: dentures, bridges and crowns, root canals, and some oral surgeries
4. Orthodontic braces: including installation, removal and follow-up care

AETNA DENTAL PLAN DIFFERENCES

Dental Plan Feature	FOC DNO PPO Max 1000 Child Ortho	PPO 2000 B Child Ortho	PPO Max 100/70/40 with Ortho
Choice of Dentists	Under the DMO benefit plan you choose a primary care dentist from Aetna's network. For greater freedom, under the PPO you have the freedom to visit any dentist and no referrals required.	Under the Dental Preferred Provider Organization you may choose at the time of service either a PPO participating dentist or nonparticipating dentist.	Under the Dental Preferred Provider Organization Maz\x you may choose at the time of service either a PPO participating dentist or nonparticipating dentist.
Coverage	Eligible charges are payable as follows: Preventive: 100% Basic*: 90% (DNO)/70% (PPO) Major*: 60% (DNO)/40% (PPO) Orthodontia: $2300 (DNO)/50% (PPO) *subject to individual deductible of $50	Eligible charges are payable as follows: Preventive: 100% Basic*: 80% Major*: 50% Orthodontia: 50% *subject to individual deductible of $50.	Eligible charges are payable as follows: Preventive: 100% Basic*: 70% Major*: 40% Orthodontia: 50% *subject to individual deductible of $50.
Maximum Benefit	Preventive/Basic/Major: $1,000 per person per "Plan Year" maximum payout Orthodontia: $1,000 per person per Lifetime maximum payout	Preventive/Basic/Major: $2,000 per person per "Plan Year" maximum payout Orthodontia: $1,500 per person per Lifetime maximum payout	Preventive/Basic/Major: $1,000 per person per "Plan Year" maximum payout Orthodontia: $1,000 per person per Lifetime maximum payout
Balance Billing	Means if you use an out of network (Non-Contracted) provider they can bill you whatever they like and Aetna is only going to pay what they would pay in network and you could be balance billed the difference.		
Late Enrollees	If you or your eligible dependent do not elect coverage under these plans when you are initially eligible and later enroll, you (your dependent) must wait 12 months before being eligible for Basic and Major charges, and 24 months before being eligible for orthodontia benefits.		

DENTAL PLAN RATES (PER PAYCHECK)

(Payroll deduction amounts are based on 26 pay periods.)

FOC DNO/PPO Max 1000 Child Ortho	Monthly	Payroll Deduction
Employee	$13.55	$6.26
Employee + Spouse	$38.45	$17.75
Employee + Child(ren)	$55.75	$25.74
Family	$80.55	$37.18

PPO 2000 B Child Ortho	Monthly	Payroll Deduction
Employee	$22.15	$10.23
Employee + Spouse	$62.65	$28.92
Employee + Child(ren)	$84.15	$38.84
Family	$124.55	$57.49

PPO Max 100/70/40 with Ortho	Monthly	Payroll Deduction
Employee	$15.55	$7.18
Employee + Spouse	$43.85	$20.24
Employee + Child(ren)	$58.85	$27.17
Family	$87.25	$40.27

EyeMed Vision Plan

C3R will offer EyeMed for our vision insurance. This benefit is designed to provide a basic level of coverage for eye exams, eyeglass lenses, and frames. If you use an In-Network EyeMed provider, your eye exam is covered once every 12 months for a $20 copay. The eyeglass lens benefit is also available from an in-network provider once every 12 months for a $45 copay and covers most basic types of lenses. Eyeglass frames can only be obtained once every 12 months and are subject to a $150 retail allowance, i.e. you pay 20% off the amount by which the cost of your frames exceed the allowable amount.

Contact Lenses:

You can choose to use your annual lens benefit on contacts instead of eyewear. You would pay a $0 copay for a standard contact lens fitting and evaluation, and the cost of your contacts would be covered 100% up to $150 per year with 15% off the remaining balance. Medically necessary contact lenses are covered at $0 copay. *Please refer to the EyeMed Certificate of Coverage for details on the vision plan benefits.*

How to find a participating network provider:

You may go to www.eyemed.com and select the Insight network. Please note: During Open Enrollment prior to January 1, 2021, you can contact EyeMed for information at 866-804-0982.

EYEMED VISION PLAN SCHEDULE OF BENEFITS

Service	In-Network (Copay)	Non-Network (Max Reimbursement)	Frequency
Eye Exam	$20	Up to $40	1x/12 mo.
Lenses/Frames	$0		
Single	$20 Copay	Up to $30	1x/12 mo.
Bifocal		Up to $50	
Trifocal		Up to $70	
Standard Progressive		Up to $50	
Lenticular		Up to $70	
Polycarbonate		Not Covered	
Frames	$0; 20% off balance over $150 allowance	Up to $105	1x/12 mo.
Contact Lenses			
Elective	Conventional: $0; 15% off balance over $150 allowance Disposable: $0; plus balance over $150 allowance	Up to $105	1x/12 mo.
Medically Necessary	$0; Paid-in-full	Up to $210	
Fitting Exam	Standard: $40 10% off retail price, then apply $150 allowance	Not Covered	1x/12 mo.

VISION PLAN RATES (PER PAYCHECK)

(Payroll deduction amounts are based on 26 pay periods.)

Vision Cost	Monthly	Payroll Deduction
Employee	$6.79	$0.00
Employee + Child	$6.79	$3.14
Employee + Children	$6.79	$3.14
Employee + Spouse	$6.11	$2.82
Family	$13.17	$6.08

Our Mobile Tools:

Vision benefits are easy to use, and access through the web, and on mobile devices.

Visit www.Eyemed.com to register and find nearby in-network doctors, schedule appointments, view member ID cards, and more!

Members can access additional discounts to help keep money in their pockets.

Discounts for hearing exams and a low price gurantee on leading brands of hearing aids.

Additional discounts include:

- *40% off additional complete pair of glasses*
- *20% off non-prescription sunglasses*
- *15% off at LASIKplus Vision Centers*
- *And a long list of additional offers listed at www.eyemed.com*

The Hartford Life Insurance

Voluntary Life Insurance Rates

Cost per Paycheck

Employee: Supplemental Life

Rate per $10,000:

Age	Rates
<30	0.090
30-34	0.090
35-39	0.110
40-44	0.180
45-49	0.320
50-54	0.470
55-59	0.780
60-64	1.310
65-69	2.290
70-74	3.520
75+	5.990

For example: If you choose to purchase $20,000 of additional life insurance and you are a 35-year-old your cost will be $1.29 per paycheck for 26 pay periods.

Spouse: Supplemental Life

Rate per $10,000:

Age	Rates
<30	0.090
30-34	0.090
35-39	0.110
40-44	0.180
45-49	0.320
50-54	0.470
55-59	0.780
60-64	1.310
65-69	2.290
70-74	3.520
75+	5.990

Supplemental Dependent Life

Dependent Child

0.92 for $10,000

Basic Life Insurance and Accidental Death and Dismemberment (AD&D)

All benefit eligible employees automatically receive $20,000 in Basic Term Life Insurance provided for you through The Hartford. An additional $20,000 is payable in the event of an accidental death. The death benefit begins to reduce starting at age 70. In addition to coverage for yourself, C3R also offers basic dependent life for your children and spouses. Spouses have a benefit of $5,000 and children $1,000.

Voluntary Life Insurance and Accidental Death and Dismemberment (AD&D)

In addition to basic life insurance, you are able to purchase additional life insurance for yourself, your spouse, and/or your child(ren).

Employee: You can elect to buy additional life insurance for yourself in $10,000 increments up to a maximum of $300,000, not to exceed three times your annual earnings.

Dependents: You can buy life insurance coverage for your spouse (up to age 70) in $5,000 increments to a maximum of $150,000, not to exceed 50% of your Voluntary Life coverage amount. You are also able to buy $10,000 of coverage for your dependent child(ren).

Guarantee Issue: New Hires: applying for coverage within 30 days of their date of eligibility can elect up to $100,000 (not to exceed 3x your salary) in coverage on yourself, $30,000 on your spouse and $10,000 on all eligible dependents without providing Evidence of Insurability.

Late Entrants/Subsequent Increases:

During annual open enrollment, employees and spouses can add/increase their coverage by two increments ($10,000 for employees, $5,000 for spouses) without having to submit evidence of insurability, provided the resulting amount of insurance does not exceed the guarantee issue maximum or the maximum total eligible coverage as defined above. Amounts above the guarantee issue maximum are always subject to evidence of insurability, and total amounts are always subject to the maximums stated above.

Short-Term Disability, Long-Term Disability, and Employee Assistant Program Plans

Disability Insurance

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 period of 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	8 Day accident/8 Day 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

Employee Assistance Program

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

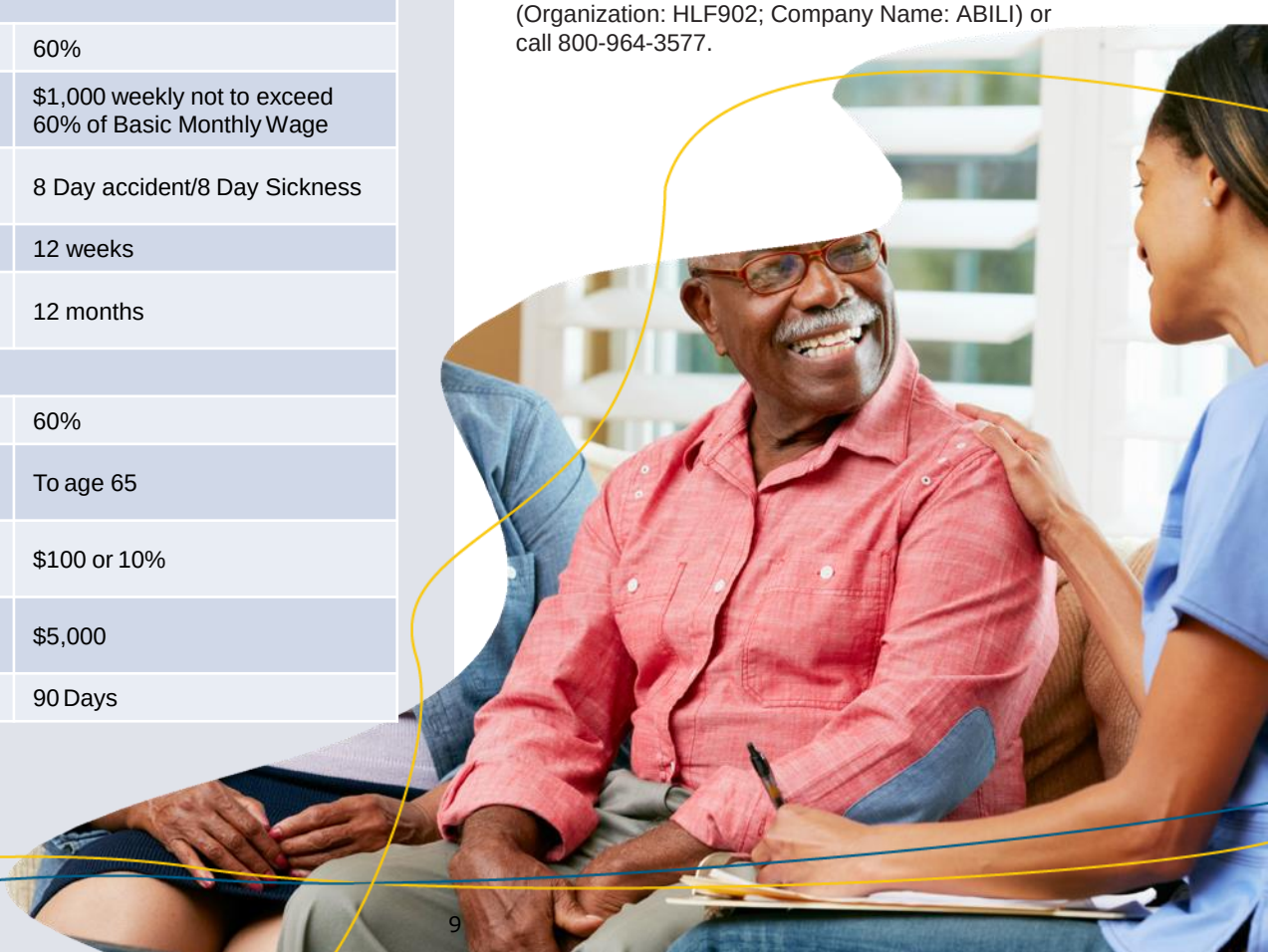
C3R has contracted with Ability Assist to provide an Employee Assistance Program (EAP) for you, your spouse and eligible dependents. Ability Assist EAP provides free, confidential counseling by experienced licensed counselors. You can easily access a comprehensive network of providers with expertise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

- Marriage & Family Issues
- Adolescent Counseling
- Stress Management
- Substance Abuse
- Depression
- Anxiety

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.

Employees and their immediate family members will have access to three free face-to-face counseling sessions per problem, per family, per plan year.

For more information visit www.guidanceresources.com (Organization: HLF902; Company Name: ABILI) or call 800-964-3577.



401(k) Retirement Savings Plan

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

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.

There are 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

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 $500 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 $500 to the next year.

ANNUAL CONTRIBUTION LIMITS OVER 26 PAY PERIODS

January 1, 2021 through December 31, 2021	
Healthcare FSA	$2,750
Dependent Care FSA	$5,000

At the end of the 2020-2021 Plan Year, you have 90 days to file any FSA claims for reimbursement from unused 2021 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.

Tax-Free Basis & Pre-Tax Dollars = Less taxes you have to pay

When you contribute to an FSA account ($2,750 maximum for healthcare/$5,000 maximum for dependent care), deductions are taken out of your paycheck prior to having any taxes withheld. This means that you don't pay federal income tax on the portion of your paycheck you contribute to your FSA. Depending on your individual income and tax filing status, you could save as much as 20 to 50 percent on eligible healthcare services by utilizing an FSA.

TAX SAVINGS SAMPLE

	Without FSA	With FSA
Gross Pay	$25,000	$25,000
Health Care FSA Contributions	$0	–$2,000
Dep. Care FSA Contributions	$0	–$5,000
Salary You're Taxed On	$25,000	$18,000
Less Federal Income Taxes*	–$3,750	–$2,700
Less TRS/Medicare*	–$363	–$261
Less After-Tax Healthcare Expenses	–$2,000	$0
Less After-Tax Dep. Care Expenses	–$5,000	$0
Your Take-Home Pay	$13,887	$15,039

*Example based on effective federal income rate of 15% and Medicare of 1.45%.

PAID TIME OFF

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.

HOLIDAYS

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

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. Paid Time Off is accrued based upon years of service. PTO is based on the following schedule:

Tier	Complete Years of Employment	Paid Time Off Accrual	Availability
One	Up to and including year 2	6 days [1.85 hours per pay period]	January 1st and after 90 day Probationary Period
Two	Beginning year 2	10 days [3.08 hours per pay period]	January 1st = 6 days, and balance awarded on employee anniversary date
Three	Beginning year 5	6 days [4.31 hours per pay period]	January 1st = 10 days, and balance 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

Contact Information

Coverage	Carrier	Contact Info	Website/Email
Medical	Anthem	1-855-330-1214	www.anthem.com
Dental	Aetna Dental	1-855-319-7290	www.aetna.com
Vision	EyeMed	1-866-804--0982	www.eyemed.com
Life/AD&D	The Hartford	1-800-523-2233	www.thehartford.com
Short-Term & Long-Term Disability	The Hartford	1-800-523-2233	www.thehartford.com
Employee Assistance Program	Lincoln Financial/Guidance Resources	1-888-628-4824	www.guidanceresources.com
401(k) Retirement Plan	Ascensus	1-866-809-8146	myaccount.ascensus.com/rplink
Flexible Spending Account	Paychex	1-800-472-0072	www.paychex.com

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).

Health 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 teammate 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 Human Resources.

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, 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, 2018, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
teammate 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

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: Concord Crossroads, LLC– Human Resources

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.

NOTES

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.