SOCIAL MODEL RECOVERY SYSTEMS

EMPLOYEE BENEFITS GUIDE

July 1, 2023 – June 30, 2024

SOCIAL MODEL RECOVERY SYSTEMS

Welcome to Social Model Recovery Systems Employee Benefits Program!

Social Model Recovery Systems envisions a world where communities can pursue social, economic, educational, and spiritual wellness free from alcohol, other drug, and mental health problems. Thousands of individuals have found help in our programs since 1987. We know that ultimately recovery is a personal choice, but we here at Social Model Recovery Systems are here to assist our participants in their steps to a healthier lifestyle.

As an employee of Social Model Recovery Systems, you are a vital member of a team effort to realize our success. All of our employees have been carefully selected not only for your skills but your passion about our mission. Because we consider our employees our most valuable resource, Social Model Recovery Systems strives to keep our benefits and compensation plans comprehensive.

Social Model Recovery Systems encourages everyone to proactively participate. We welcome feedback and suggestions at all levels of the organization. There is always room for improvement and we are committed to quality. With everyone's help we can continue to operate at the highest possible level.

We are delighted that you have joined us and we hope that you will have a successful and rewarding career with Social Model Recovery Systems.

Sincerely,

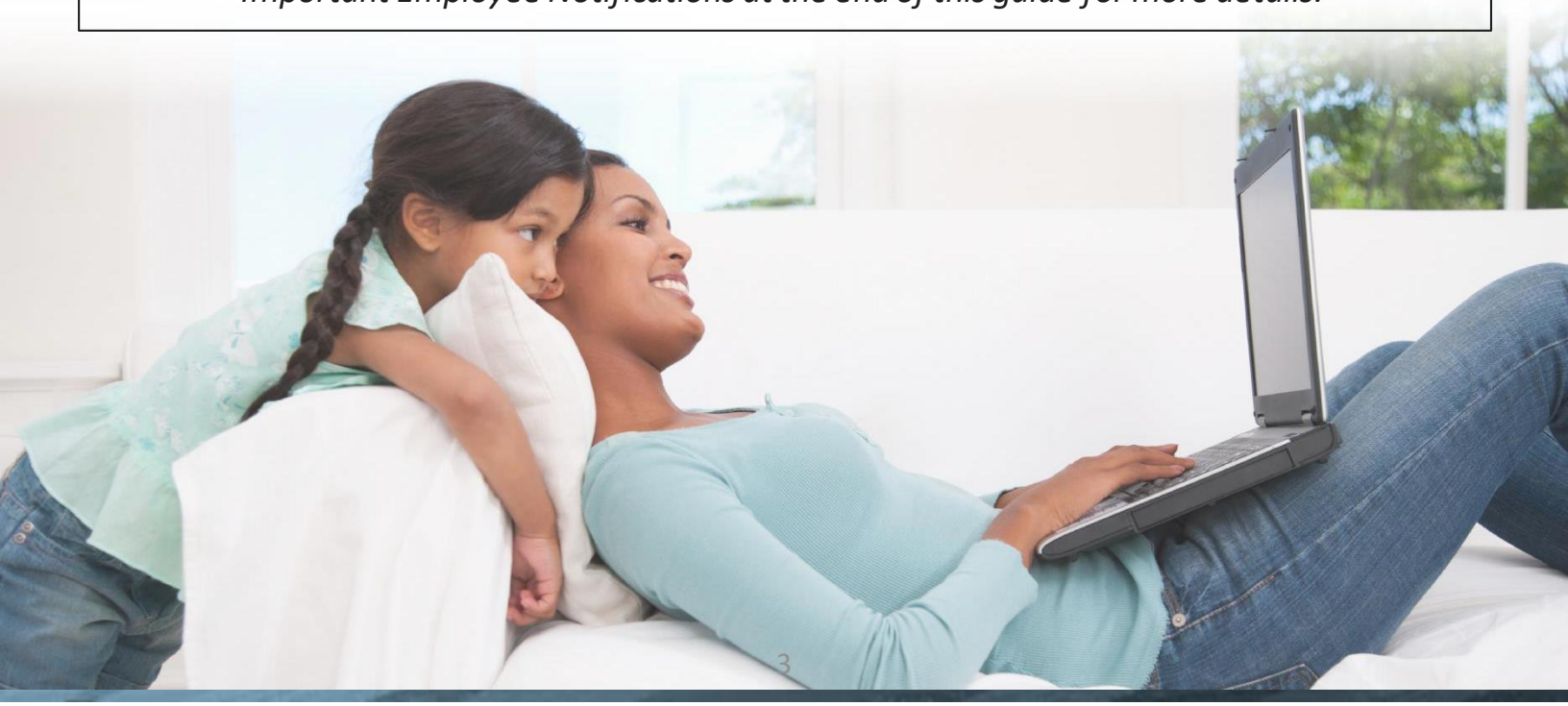
Bruce Boardman, Chief Executive Officer

Tim Stevens, Chief Operating Officer

BENEFITS AT A GLANCE

BENEFITS	COVERAGE OPTIONS
Medical	• Blue Shield HMO Trio Zero Admit 10 • Blue Shield HMO Local Access+ Per Admit 20-500 • Blue Shield HMO Access+ Per Admit 20-250 • Blue Shield PPO Combined Deductible 15-250 90/70
Dental	• Blue Shield Dental HMO • Blue Shield Dental PPO
Vision	• Blue Shield Vision Standard 15/25/130
Life & Disability	• Lincoln Basic Life/AD&D • Lincoln Voluntary Life/AD&D • Lincoln Long Term Disability
Additional Benefits	• Lincoln Employee Assistance Program (EAP) • Empower Retirement 401(k)

Please Note: *If you have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see Important Employee Notifications at the end of this guide for more details.*



YOUR EMPLOYEE SUPPORT CENTER (ESC)

FLEXIBLE SOLUTIONS FOR *your* BENEFITS NEEDS

Gallagher's Employee Support Center provides a dedicated team of specialized representatives ready to assist employees and dependents. Your Employee Support Center (ESC) is available to you via a toll-free hotline Monday through Friday, 8a.m. to 4p.m. (PST) or via email inquiry.

The ESC team can support you as you utilize your benefits by providing education and issue advocacy when necessary. The licensed representatives will work with both providers and the insurance companies on your behalf while protecting the privacy of your healthcare information. You can also contact the ESC if you have questions or need assistance selecting the right health insurance plan for you and your family.

HOW CAN WE HELP?

Don't know where to turn?
We guide the way.
Find providers, arrange treatments and tests, coordinate pre-authorizations and referrals.

Confused by health insurance?
We bring clarity.
Full plan education, plan benefits comparison, transition of care for new members, review of claims, payments and outstanding invoices.

Want to save on healthcare?
We help find solutions.
Investigate coverage denials, negotiate payment arrangements with providers, provide information for non-covered services.

Look for this icon throughout this guide for helpful tips from your Employee Support Center!

RELIABLE, CONFIDENTIAL ANSWERS.

Our personal, one-on-one, bilingual and highly experienced team members will explain every step of the way as they confidentially navigate your issue until it has been resolved.

YOUR PERSONAL ADVOCATE

Mon-Fri | 8am-4pm (PST)
Toll Free: **855.670.2222**
Local: **818.539.8804**
LosAngeles.ESC@ajg.com

Due to privacy regulations, our representatives will be required to obtain personal identifying information such as full name, contact information, address, date of birth and in some cases SSN or Member ID #. **Please have this information ready.**

Some inquiries may require for you to provide HIPAA release in order for our advocates to work efficiently in resolving your issue with your provider or carrier.

ELIGIBILITY & ENROLLMENT

Who Can Enroll?

All full-time employees working at least 30 hours per week are eligible for group insurance benefits.

If you are an eligible employee, you may enroll the following dependents:

- Your spouse or registered domestic partner.
- Your children up to age 26, including stepchildren, legally adopted children, children for whom you are the legal guardian, foster children, or children for whom you are legally responsible to provide health coverage under a Qualified Medical Child Support Order (QMCSO). Due to Affordable Care Act, your medical plan covers dependents to age 26.
- Children are eligible for coverage regardless of their student status or whether they live with you.
- Children of children may not be covered unless they meet the plan's dependent eligibility rules as specified above.
- Disabled children over age 26 if unmarried, incapable of self-support, dependent on you for primary support and the disability occurred before the age of 26. Requirements for such coverage and documentation of disability depend on the insurance carrier.

Premiums for domestic partners who do not meet the tax dependent definition of IRS section 152 for the employee, may be considered taxable income (unregistered domestic partners will not meet the relationship test under IRS section 152). Premiums for children/registered Domestic Partners step-children under age 26 are not taxable. Premiums for children/stepchildren over age 26 are taxable if not an IRS section 152 tax dependent.

When Does Coverage Begin?

Your benefits are effective 1st of the month following 30 days from your date of hire. Once you have completed your new hire waiting period, you must enroll by the deadline date. If you do not enroll within that time period, you will not be eligible for benefits until the next Open Enrollment, unless you have a Qualifying Family Status Change.

Do I have to Enroll?

For information regarding Health Care Reform and the Individual Mandate, please contact HR or visit www.cms.gov/cciio. You can also visit www.healthcare.gov to review information specific to the Health Insurance Marketplace.

You may elect to "waive" medical coverage if you have access to coverage through another plan. It is important to note that if you waive our medical coverage, you must maintain minimum essential health insurance through another source. It is also important to note that if coverage is waived, the next opportunity to enroll in our group benefit plans will be during Open Enrollment in 2024 or if a qualifying status change occurs.

Qualifying Events

Open Enrollment elections will be effective July 1st. You are permitted to make changes to your benefits outside of the Open Enrollment period if you have a qualified change in status as defined by the IRS. Generally, you may add or remove dependents from your benefits, as well as add, drop, or change coverage if you submit your request for change **within 30 days of the qualified event, not from written notice or proof**. Change in status examples include:

- Newly hired as full-time benefits-eligible
- Marriage, divorce or legal separation
- Birth or adoption of a child
- Death of a dependent
- Qualified Medical Child Support Order (QMCSO)
- Change in residence causing loss of coverage
- Change in work schedule for you or your spouse (part-time to full-time)
- You or your spouse's / domestic partner's loss or gain of coverage through our organization or another employer
- You enroll, or intend to enroll, in a Qualified Health Plan (QHP) through the State Marketplace (i.e. Exchange) and it is effective no later than the day immediately following the revocation of your employer sponsored coverage.

If your change during the year is a result of the loss of eligibility or enrollment in Medicaid, Medicare or state health insurance programs, you must submit the request for change within 30 days.

Doctors and hospitals may leave or join health plan networks at any time. If your provider leaves your plan's network during the year, this does not qualify as a change in status. As a result, you cannot change your medical coverage.

MONTHLY CONTRIBUTIONS

COVERAGE	TRIO HMO PLAN	SAVENET HMO PLAN	ACCESS+ HMO PLAN	PPO PLAN
	Employee Cost	Employee Cost	Employee Cost	Employee Cost
Employee	$55.00	$110.00	$165.00	$1,471.87
Employee + Spouse	$984.65	$1,747.40	$2,109.78	$4,101.75
Employee + Child(ren)	$674.78	$1,298.85	$1,595.33	$3,225.14
Employee + Family	$1,681.99	$2,756.69	$3,267.44	$6.074.19

COVERAGE	DENTAL HMO PLAN	DENTAL PPO PLAN
	Employee Cost	Employee Cost
Employee	$0.00	$31.12
Employee + One Dependent	$13.76	$74.73
Employee + Two or More Dependents	$33.75	$138.20

COVERAGE	VISION PLAN
	Employee Cost
Employee	$0.00
Employee + Spouse	$3.81
Employee + Child(ren)	$4.01
Employee + Family	$9.75

MEDICAL PLAN OPTIONS

blue california

Blue Shield HMO

If you choose the HMO plan, you must select a primary care physician who will manage your care and refer you to a specialist when it is needed. Most services are covered at 100% after you pay a copayment.

- **Trio Zero Admit 10**: an HMO plan with a smaller physician network
- **Local Access+ Per Admit 20-500**: an HMO plan with a medium physician network
- **Access+ Per Admit 20-250**: an HMO plan with a full physician network

Blue Shield PPO

The PPO plan offers a network of providers who have agreed to discount their fees for their services. You may choose to have your treatment provided by a PPO provider and receive a higher level of benefit with a lower out-of-pocket cost to you. You may also choose to go outside the network; however, generally, benefits are reimbursed at a lower level and you may have higher out-of-pocket costs.

HMO MEDICAL PLANS

WHAT YOU PAY	Trio Zero Admit 10	Local Access+ 20-500	Access+ Per Admit 20-250
Calendar Year Deductible (Single/Family)	No Deductible	No Deductible	No Deductible
Calendar Year Out-of-Pocket Maximum (Single/Family)	$1,500/$3,000	$2,500/$5,000	$2,000/$4,000
Preventive Services	No Charge	No Charge	No Charge
Office Visits (Primary/Specialist/Network Specialist/Teledoc)	$10/$10/$10/$0	$20/$20/$30/$0	$20/$20/$30/$0
Chiropractic/Acupuncture	$10 (up to 30 visits max)	$10 (up to 30 visits max)	$10 (up to 30 visits max)
Lab/X-ray	No Charge	No Charge	No Charge
Complex Radiology (Includes CT, PET and MRI)	No Charge	No Charge	No Charge
Inpatient Hospital Services (Includes maternity)	No Charge	$500/admission	$250/admission
Outpatient Surgery	No Charge	Ambulatory Center: $100 Outpatient Hospital: $300	Ambulatory Center: $50 Outpatient Hospital: $200
Urgent Care (Co-pay waived if admitted)	$10/visit	$20/visit	$20/visit
Emergency Room (Co-pay waived if admitted)	$100/visit	$100/visit	$150/visit
Ambulance	$100	$100	$100
PRESCRIPTION DRUGS			
Calendar Year Drug Deductible	No Deductible	No Deductible	No Deductible
Retail Prescription (Tier 1/Tier 2/Tier 3/Tier 4) (up to 30-day supply	$10/$25/$40/20% (up to $250 max)	$10/$25/$40/20% (up to $250 max)	$10/$25/$40/20% (up to $250 max)
Mail-Order Prescription (Tier 1/Tier 2/Tier 3/Tier 4) (up to 90-day supply)	$20/$50/$80/20% (up to $500 max)	$20/$50/$80/20% (up to $500 max)	$20/$50/$80/20% (up to $500 max)

[1]Annual deductible must be satisfied first before any benefits are paid (unless specified otherwise).

PPO MEDICAL PLANS

	Full Combined Deductible 15-250 90/70	
WHAT YOU PAY	**In-Network**	**Out-of-Network**
Calendar Year Deductible (Single/Family)	$250/$750	
Calendar Year Out-of-Pocket Maximum (Single/Family)	$2,750/$5,500	$10,250/$20,500
Preventive Services	No Charge	Not Covered
Office Visits (Primary/ Specialist/Telehealth)	$15/$15/$0	30%[1]/30%[1]/Not Covered
Chiropractic/Acupuncture	$15 (20 visits max)	30%[1]
Lab/X-ray	$15[1]	30%[1]
Complex Radiology (Includes CT, PET and MRI)	$15[1]	30%[1]
Inpatient Hospital Services (Includes maternity)	10%[1]	30%[1]
Outpatient Surgery	Ambulatory Center: 5%[1] Outpatient Hospital: 15%[1]	30%[1]
Urgent Care (Co-pay waived if admitted)	$15	30%[1]
Emergency Room (Co-pay waived if admitted)	$150 + 10%	$150 + 10%
Ambulance	10%[1]	10%[1]
PRESCRIPTION DRUGS		
Calendar Year Drug Deductible	None	
Retail Prescription (Tier 1/Tier 2/Tier 3/Tier4) (up to 30-day supply)	$10/$25/$40/30% (up to $250 max)	Tiers 1-3: Retail copay + 25% Tier 4: 30% up to $250 + 25%
Mail-Order Prescription (Tier 1/Tier 2/Tier 3/Tier 4) (up to 90-day supply)	$20/$50/$80/30% (up to $500 max)	Not Covered

[1]Annual deductible must be satisfied first before any benefits are paid (unless specified otherwise). Out-of-Network services are limited to maximum allowed amount/fee schedule reimbursement. Members are responsible for the difference between provider charges and Blue Shield's allowed charges/reimbursement.

MEDICAL PREVENTIVE SERVICES

The following are examples of Preventive Services covered by your policy. For a complete list of these services, please refer to your combined Evidence of Coverage and Disclosure Form. Preventive Services are covered 100%.

CHILD PREVENTIVE CARE

Screening Tests

- Behavioral counseling to promote a healthy diet
- Blood pressure
- Cervical dysplasia screening
- Cholesterol and lipid level
- Depression screening
- Type 2 diabetes screening
- Hearing screening
- Height, weight and body mass index (BMI)
- Hemoglobin (blood count)
- HPV screening
- Lead testing
- Newborn screening
- Screening and counseling for obesity
- Oral (dental health) assessment
- Screening and counseling for STIs
- Vision screening

Immunizations

- Diphtheria, tetanus and pertussis (whooping cough)
- Haemophilus influenza type b
- Hepatitis A and Hepatitis B
- Human papillomavirus (HPV)
- Influenza
- Measles, mumps and rubella
- Meningococcal (meningitis)
- Pneumococcal (pneumonia)
- Polio
- Rotavirus
- Varicella (Chicken Pox)

MEN & WOMEN PREVENTIVE CARE

Men

- Aortic aneurysm screening (men who have smoked)
- Prostate cancer

Women

- Well-woman visits
- Breast cancer testing for BRCA 1 and BRCA 2 when certain criteria are met
- Breastfeeding: primary care intervention to promote breastfeeding support, supplies and counseling
- Contraceptive (birth control) counseling
- FDA-approved contraceptive services provided by a doctor
- Counseling related to chemoprevention for women with a high risk of breast cancer
- Counseling related to genetic testing for women with a family history of ovarian or breast cancer
- HPV screening
- Screening and counseling for interpersonal and domestic violence
- Pregnancy screenings: includes, but is not limited to, gestational diabetes, hepatitis, iron deficiency, anemia, and STDs
- Pelvic exam and Pap test, including screening for cervical cancer

ADULT PREVENTIVE CARE

Screening Tests

- Behavioral counseling to promote a healthy diet
- Blood pressure
- Bone density test to screen for osteoporosis
- Cholesterol and lipid (fat) level
- Colorectal cancer, including fecal occult blood test, barium enema, flexible sigmoidoscopy, screening colonoscopy and related prep kit and CT colonography (as appropriate)
- Depression screening
- Hepatitis C virus (HCV) for people at high risk for infection and a one-time screening for adults born between 1945 and 1965
- Type 2 diabetes screening
- Eye chart test
- Obesity
- STIs
- Tobacco use: related screening and behavioral counseling
- Violence, interpersonal and domestic: related screening and counseling

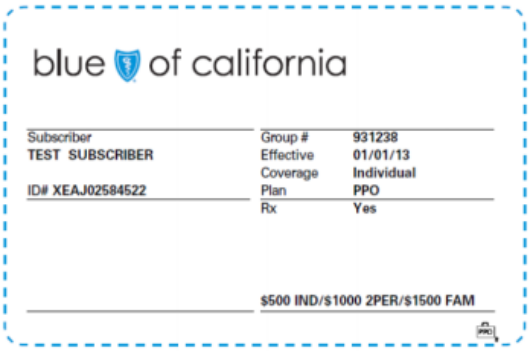
Immunizations

- Diphtheria, tetanus and pertussis
- Hepatitis A and Hepatitis B
- HPV
- Influenza
- Meningitis
- Measles, mumps and rubella
- Pneumococcal
- Varicella (Chicken pox)
- Zoster (shingles)

MEDICAL PROVIDER SEARCH

1. Visit:
   - **Trio HMO**: www.blueshieldca.com/networktriohmo
   - **Local Access+ HMO**: www.blueshieldca.com/networklocalaccess
   - **Access+ HMO**: www.blueshieldca.com/networkhmo
   - **PPO**: www.blueshieldca.com/networkppo
2. Select the type of provider you need.
3. Enter Zip Code then select Continue.
4. Choose to search by either Doctor Type or Doctor Name.
5. Once you press "Search" you will see a listing of doctors. You can refine your search results to show you providers accepting new patients, or who specialize in specific areas.

Remember: if you choose the HMO plan, make sure to check that any provider or facility you visit is both in-network with Blue Shield and part of your Medical Group. Medical Group information will be displayed on the website. Provider contracts are always changing with the carriers. Please call your provider to ensure that they are still in-network before going to see them. Contact Blue Shield before the 15th of the month to change your assigned Primary Care Doctor or Medical Group.



Steps to print temporary ID cards

1. Register or log in to **www.blueshieldca.com**
2. From the *My Plan & Claims* drop-down menu, select *ID Card*.
3. Click on *View/Print a Temporary ID Card*.
4. To order a new ID card, select *Order Cards by Mail*.

Blue Shield NurseHelp 24/7

Get immediate answers and reliable information about minor illnesses and injuries, chronic conditions, medical tests and medications. Just call **(877) 304-0504** to talk to a nurse anytime, day or night. This phone number is on your Blue Shield of California ID card.

Looking for your Medication?

- **Blue Shield**: visit www.blueshieldca.com/wellness/drugs/formulary and select the "Plus Drug Formulary" or visit PLUS DRUG FORMULARY (DMHC) (adaptiverx.com)

MEMBER TOOLS

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Virtual Visits

When you need care — anytime, day or night — virtual visits can be a convenient option. Talk with a doctor 24/7 about mild conditions such as flus, fevers, colds, sore throats, migraines, rashes, allergies, stomach aches, pink eye, and more.

Mobile App & Member ID Cards

Access the convenient features of the free mobile app offered by your insurance carrier. View details about your plan benefits, search for in-network providers, and view claim history. You can also view an electronic copy of your member ID card.

Member Discounts & Wellness

Being healthy can be affordable, too. Take advantage of healthy discounts and extras included with your health plan to help you live better. Find discounts and perks on a variety of services including fitness and weight loss programs, eye care and hearing aids, health assessments, chiropractor and acupuncture visits, and more.

Care While Traveling

If you get hurt or sick while traveling, you are covered for emergency care anywhere in the world. If you have an emergency while traveling, call 911 or go to the nearest emergency facility. Examples of emergency conditions are shortness of breath, excessive bleeding and severe pain to body parts or organs. If you need routine care while outside of your service area, contact your insurance carrier prior to your travel plans.

*For these and more helpful resources from **Blue Shield** please scan the QR code!*

DENTAL & VISION PLANS

Blue Shield Dental HMO

If you enroll in the Dental HMO plan, you and your enrolled dependents must first select a primary care dentist who participates in the HMO dental network. To receive benefits in the Dental HMO plan, your dental care must either be provided by or referred to a specialist by your primary care dentist. If you receive services from a dentist other than who you are assigned to, you would be responsible for paying the entire dental bill yourself.

Blue Shield Dental PPO

The Dental PPO plan is designed to give you the freedom to receive dental care from any licensed dentist of your choice. Savings are greater when you visit an in-network provider because contracted dentists have agreed to provide care at a negotiated rate.

If you have services with a non-participating dentist, you will be responsible for the difference between what the plan pays the dentist and the dentist's charges.

Blue Shield Vision

The Vision plan provides professional vision care and high quality lenses and frames through a broad network of specialists. The plan also includes discounts for several lens enhancements and vision services. You will receive richer benefits if you utilize an in-network provider.

If you have services with a non-participating vision provider, you will be responsible for the difference between what the plan will reimburse you and the provider's charges.

BLUE SHIELD DENTAL HMO PLAN

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	WHAT YOU PAY*
Plan Maximums	
Calendar Year Deductible	**None**
Calendar Year Maximum Benefit	**None**
Preventive Procedures	
Office Visit	**$6**
D1110/D1120 Cleaning Adult/Child	**$0**
D0210 – D0330 X-rays & Imaging	**$0**
Restorative Procedures	
D2391 White Filling (posterior)	**$61**
D3330 Molar Endodontics (root canal)	**$145**
D4261 Periodontal Osseous Surgery (gum disease)	**$63**
D4342 Periodontal Scaling & Root Planing (gum disease)	**$5**
Major Procedures (additional charges if high noble or titanium metal is used)	
D5110 – D5120 Complete Denture (maxillary or mandibular)	**$100**
D5211 – D5212 Partial Denture (maxillary or mandibular)	**$175**
D6241 Pontic (porcelain fused to a high noble metal)	**$125**
D6750 Crown (porcelain fused to a high noble metal)	**$125**
D7220 Surgery to remove impacted tooth (soft tissue)	**$20**
Orthodontia	
Comprehensive Orthodontic Treatment (child)	**$1,200**
Comprehensive Orthodontic Treatment (adult)	**$1,500**

**** Please view the carrier's schedule of benefits for a more comprehensive outline.***

Key Facts:

- No plan maximum, unlimited benefit coverage
- You must make all appointments with your assigned DHMO dentist
- You must contact the carrier before the 15th of the month to change your dentist
- Always request a treatment plan before you have services done!

BLUE SHIELD DENTAL PPO PLAN

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	WHAT YOU PAY	
	In Network*	**Out Of Network***
Plan Maximums		
Calendar Year Deductible (single/family)	**$50/$150**	**$50/$150**
Calendar Year Maximum Benefit	**$1,500 + Rollover**	
Preventative Procedures		
Oral Examinations, Bitewing or Full Mouth X-rays, Cleanings	**0% (deductible waived)**	**0%** (deductible waived)**
Basic Procedures		
Fillings, Endodontics (root canal therapy), Periodontics, Sealants, Simple Oral Surgery and Simple Extractions	**20%**	**20%****
Major Procedures		
Crowns, Inlays, Onlays and Cast Restorations, Bridges and Dentures	**50%**	**50%****
Orthodontic Procedures		
Orthodontics Lifetime Maximum	**Not Covered**	
Orthodontia (children up to age 19 and adults)	**Not Covered**	

Reimbursement is based on PPO contracted fees for PPO dentists, and Out-of-Network Reimbursement is based on provider usual, reasonable, and customary charges at the 90th percentile.

****Reimbursement based on Blue Shield's Program Allowance. Members may be subject to balance billing.***

Key Facts:

- Free exams, cleanings, & x-rays
- Plan allowance (calendar year maximum benefit) resets every January 1
- Always request a treatment plan before you have services done!

BLUE SHIELD MES VISION PLAN

blue california
mesvision

	WHAT YOU PAY	
	In Network	**Out of Network**
Exams (every 12 months)		
Vision Exam	**$15**	**Reimbursement up to $50**
Standard Plastic Lenses (every 24 months)		
Single Bifocal Trifocal	**$25**	**Reimbursement up to:** **$43** **$60** **$75**
Frames (every 24 months)		
Frames	**$25 + all charges above $130**	**Reimbursement up to $40**
Contacts (in lieu of glasses) (every 12 months)		
Medically Necessary	**$25**	**Reimbursement up to:** **$200 (Hard Lenses)** **$250 (Soft Lenses)**
Elective	**$25 + all charges above $130**	**Reimbursement up to $130**

Key Facts:

- Services are covered based on your **most recent service date**. You can have a new eye exam 12 months after your last eye exam. Purchase new lenses and frames 24 months after your most recent purchase.
- Additional lens enhancements available at a co-pay or discount.
- Out of Network services may require you to make a full payment at the time or services, and submit a claim form for reimbursement.

DENTAL/VISION PROVIDER SEARCH

1. Visit www.blueshieldca.com/fad
2. Select "Dentists". You can either continue as a guest, or log in to your Blue Shield account.
3. Enter your city, state, or zip code.
4. Under "Plan type" choose your plan.
    - **Dental HMO**: select "Dental HMO (Individual/Family or Group Plans)"
    - **Dental PPO** : select "Dental PPO (Group Plans)"
5. Click "Continue with this plan" and select the specialty you'd like to search.
6. Click "Search" and your list will be generated.

Remember: if you choose the Dental HMO plan, you will need to select a primary dental provider. If you choose the Dental PPO plan, you do not need to elect a primary dental provider, but we recommend requesting pre-determination for all proposed services prior to receiving treatment to determine what the plan will cover and what your out of pocket cost will be.

1. Visit www.blueshieldca.com/fad
2. Select "Vision Care". You can either continue as a guest, or log in to your Blue Shield account.
3. Enter your city, state, or zip code.
4. Under "Plan type" choose "Vision Plans (Individual and Family or Group Plans)".
5. Click "Continue with this plan" and select the specialty you'd like to search.
6. Click "Search" and your list will be generated.

LIFE INSURANCE

All benefit eligible employees are provided with employer-paid Life and Accidental Death & Dismemberment (AD&D) coverage. All eligible employees are automatically enrolled in Life and AD&D plans. This benefit is paid for 100% by your employer.

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

- Benefit amount of 2 times annual salary up to $250,000
- AD&D provides 100% of the Basic Life benefit
- In the event of death that occurs from a covered accident, both Life and AD&D benefit would be payable each in the amount of the basic life insurance.

Benefits Age Reduction

Your life benefits will reduce after a certain age, and the reduction schedule is as follows:

- Reduce by 33% at age 65, reduce to 66% at age 70, benefits terminate upon retirement

- You may update your Life Insurance Beneficiary any time during the year as often as you would like.

As an added benefit, you may purchase Supplemental Life and Accidental Death & Dismemberment insurance for you and your dependents. This benefit is voluntary and paid for 100% by eligible employees through post-tax payroll deductions.

Supplemental Employee Life/AD&D

Employees may purchase additional coverage in $10,000 increments not to exceed 5 times salary or $500,000. For employees age 70 and over, the maximum is $50,000. The New Hire Guaranteed Issue* amount is $100,000.

Supplemental Spouse Life/AD&D

You may purchase additional coverage for your spouse in $5,000 increments to the lesser of 50% of the employee's coverage amount, not to exceed $250,000. The New Hire Guaranteed Issue* amount is $10,000.

Supplemental Child(ren) Life/AD&D

You may purchase additional coverage for your child(ren). For children from birth to 14 days you may purchase $250 of coverage. For children from 14 days to 25 years (if unmarried, full-time student), you may purchase $1,000, $5,000, or $10,000 of coverage.

Should you choose to elect coverage outside of your initial eligibility period, or you elect coverage above the Guaranteed Issue amount, you or your spouse will need to complete the Evidence of Insurability (EOI) Form for medical underwriting purposes*

To complete online, visit www.lincoln4benefits.com and click "Complete Evidence of Insurability"

BASIC LIFE INSURANCE IMPUTED INCOME

What is Imputed Income?
Imputed income is the value that the Internal Revenue Service (IRS) puts on employer-provided group-term life insurance coverage in excess of $50,000. That "value" is determined by your age and the schedule established by the IRS (see table below). This tax liability is called "imputed income." It is added to your gross wages and is included on your form W-2 at the end of the year.

Age*	Cost per $1,000 per month
Under age 25	$0.05
25 to 29	$0.06
30 to 34	$0.08
35 to 39	$0.09
40 to 44	$0.10
45 to 49	$0.15
50 to 54	$0.23
55 to 59	$0.43
60 to 64	$0.66
65 to 69	$1.27
70 and Over	$2.06

**Age is based on the last day of the covered calendar year.*

How Do I Calculate Imputed Income?
The basic formula to calculate imputed income is as follows:
(Total group term coverage - $50,000) / 1,000 x Table 1 rate for employee's age - employee after-tax contributions for the year x 12 months.

The below assume a basic life benefit of 1 x salary

Example 1: 47-year-old employee earning $65,800
Basic Life Benefit = $66,000 benefit
$66,000 benefit - $50,000 = $16,000
$16,000 / 1,000 = $16.00
$16.00 x $0.15 = $2.40/month or $28.80/year additional taxable income

Example 2: 31-year-old employee earning $120,600
Basic Life Benefit = $121,000 benefit
$121,000 benefit - $50,000 = $71,000
$71,000 / 1,000 = $71.00
$71.00 x $0.08 = $5.68/month or $68.16/year additional taxable income

Example 3: 52-year-old employee earning $55,150
Basic Life Benefit = $56,00 benefit
$56,000 benefit - $50,000 = $6,000
$6,000 / 1,000 = $6.00
$6.00 x $0.23 = $1.38/month or $16.56/year additional taxable income

Can I Opt Out?
Yes, you may elect to waive the employer-paid life insurance coverage in excess of $50,000 to avoid imputed income. Please notify Human Resources and you will be asked to complete a Group Term Life Opt Out form to limit your coverage to $50,000.

VOLUNTARY LIFE/AD&D MONTHLY RATES

Lincoln Financial Group®

Age Band	Monthly Rate Per $1,000 (Employee/Spouse)
<20	$0.051
20-24	$0.064
25-29	$0.076
30-34	$0.100
35-39	$0.132
40-44	$0.212
45-49	$0.306
50-54	$0.570
55-59	$1.104
60-64	$1.616
65-69	$2.746
70-74 (Employee Only)	$4.914
75+ (Employee Only)	$18.032
Child(ren) Rate Per $1,000:	$0.180
Optional AD&D Per $1,000	Employee Only: $0.050

Calculate Your Cost

Use the appropriate rate provided in the tables above to calculate your cost based on the amount of coverage you select. The following example calculates the monthly cost for a 36-year-old employee who would like to purchase $100,000 in employee voluntary term life insurance coverage.

Calculation Example		Example	You	Spouse
Step 1	Using the table above, enter the rate that corresponds with your age.	$0.132		
Step 2	Enter the desired coverage amount in dollars.	$100,000		
Step 3	Enter the desired coverage amount in increments of $1,000. *To calculate, divide the coverage amount by $1,000*	100		
Step 4	Calculate the monthly cost. *Multiply Step 1 by Step 3*	$13.20		

Note: Rates are subject to change and can vary over time.

LONG TERM DISABILITY

This benefit is paid for 100% by your employer. There is no cost to you, the employee.

All benefit eligible employees are provided with group Long Term Disability overage for those unexpected situations that may keep you from performing the daily responsibilities of your job. Your disability plan is available to help supplement your income when you are not able to continue employment for a certain period of time. This benefit is paid for 100% by your employer.

Elimination Period

Benefits begin after the end of the elimination period. The elimination period begins on the day you become disabled and is the number of consecutive days you are disabled before you are eligible to receive a benefit. Your elimination period for is 90 days.

Coverage Period

Benefits continue for as long as you are considered disabled per the definitions in the plan document.

Benefit Amount

The disability benefit replaces a portion of your basic monthly earnings. The benefit amount is 60% of your basic monthly earnings up to $7,500 per month.

Pre-Existing Condition

Your plan is subject to a pre-existing condition limitation. The pre-existing condition under this plan is 3/12 which means any condition that you receive medical attention, treatment or medication for in the 3 months prior to your effective date of coverage that results in a disability during the first 12 months of coverage, would not be covered. Once you have been insured under the plan for 12 months, the pre-existing condition limitation does not apply.

How To Submit A Claim

Submit a claim online: www.LFG.com
Select "Contacts, Forms & Claims". Select "Disability Insurance", and from there you may start the online claim process.

Start a claim over the phone: (800) 487-1485, option 4

Submit a paper claim form:
Lincoln Disability Claims
PO Box 2609
Omaha, NE 68103-2609
Fax: (877) 843-3950
Email: CustServSupportTeam@LFG.com

EMPLOYEE ASSISTANCE PLAN (EAP)

This benefit is paid for 100% by your employer. There is no cost to you, the employee.
All members of your household can utilize the benefits of this program.

All benefit eligible employees are provided with employer paid Employee Assistance Plan (EAP). All eligible employees are automatically enrolled in the EAP. All members of your household can utilize the benefits of this program.

Life is full of challenges and sometimes balancing it is difficult. The EAP is there when you need it, offering the appropriate assistance for a wide range of issues and provides referrals to professional counselors or services that can help you resolve emotional health, family and work issues.

- Healthy Living
- Stress Management
- Mental Health
- Diet & fitness
- Overall wellness
- Parenting support
- Child & elder care
- Learning programs
- Special needs help
- Legal issues
- Will preparation
- Taxes
- Debt
- Financial planning

Lincoln Financial Group®

Along with unlimited telephonic access, the EAP also offers 6 face-to-face visits with a counselor per person per situation. Member Services Available 24/7!

Your privacy matters. EAP participation is totally confidential.

Phone: (855) 327-4463
Online: www.guidanceresources.com (username: **Lincoln**)
Mobile App: GuidanceNow℠

401(k) RETIREMENT PLAN

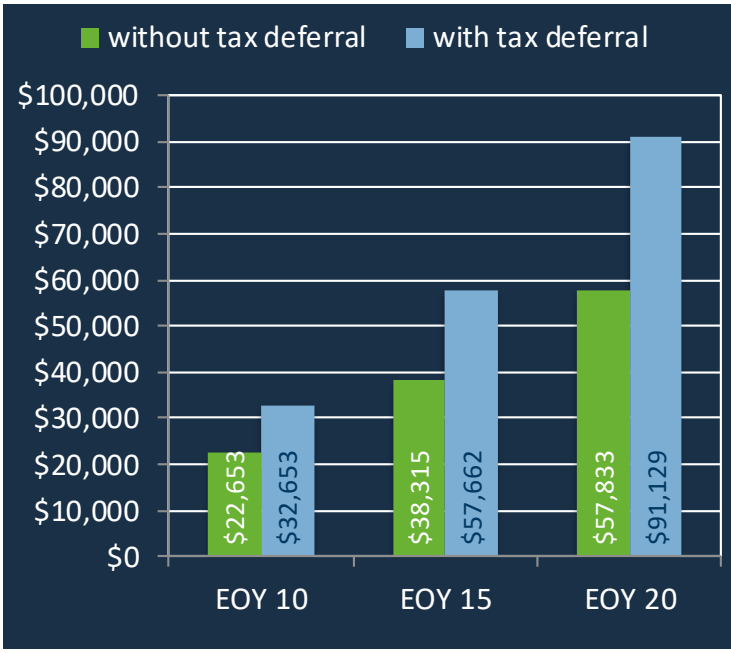
Eight in 10 American workers have the opportunity to join employer-sponsored retirement plans.[1]
Why should they join? Just ask anyone who participates in a plan. They're likely to tell you it's an effective way to save for retirement. Here are five reasons why.

- It's an investment of your future. You'll build a nest egg over the long term to supplement Social Security.
- It's convenient. You'll contribute every payday through payroll deductions. There are no checks to write; no bills to pay.
- It's flexible. You may suspend payments and restart them at a later date. You are never locked in to a fixed contribution schedule.
- It's tax-deferred. You'll reduce your current federal and state income taxes with each contribution.
- It's efficient. You may consolidate retirement accounts from previous employers and roll IRA funds over to your current employer's plan. Please check with your previous retirement plan provider to see if any fees apply.

EMPOWER RETIREMENT

(Previously Mass Mutual)

https://retirement.massmutual.com/rscorp
Toll free: 800.854.0647
Monday-Friday, 8:00am-8:00pm EST
Mailing Address: Empower Retirement
P.O. Box 1583
Hartford, CT 06144-1583



Harness the Power of Tax Deferral

This is a hypothetical example. It is not indicative of any product or performance and does not reflect any expense associated with investing. It assumes $200 monthly contributions, 6% interest, and a 25% tax bracket. Taxes will be due upon distribution of the tax-deferred amount, and if shown, results will be lower. Actual investment results will fluctuate with market conditions so that the amount withdrawn may be worth more or less than the original amount invested.

[1] *The 2010 Retirement Confidence Survey: Confidence Stabilizing, But Preparations Continue to Erode.* Employee Benefit Research Institute, March 2010: 18.

HEALTH INSURANCE MARKETPLACE

Notice of Medical Coverage Options:

THE NEW HEALTH INSURANCE MARKETPLACE

Under federal law, beginning January 1, 2014, individuals will be required to have minimum essential health coverage, or else be subject to a penalty. This is referred to as the "individual mandate." The Health Insurance Marketplace is intended to help individuals meet the individual mandate requirement by providing another marketplace to purchase coverage, and possibly qualify for federal assistance. Individuals who have insurance through their employers (or who are eligible for insurance through their employers) may opt out of the employer plan during their renewal period and go to the Health Insurance Marketplace to purchase health insurance (note employers are not required to pass on their employer contribution towards an employee's coverage election in the Health Insurance Marketplace). Based upon your specific income level and household size, you may receive more affordable coverage for yourself and/or dependents through the Health Insurance Marketplace. Individuals who have insurance through their employers (or who are eligible for insurance through their employers) are not eligible for federal assistance through the individual mandate.

The Health Insurance Marketplace website will help people find out whether they qualify for federal financial assistance that will reduce their costs for medical coverage. Depending on your income and family size, you could be eligible for no-cost Medicare or for tax credits to help reduce your monthly premium costs. You do not need to purchase coverage through the Health Insurance Marketplace if you already have medical coverage. However, you have the option to do so if you wish.

Health Insurance Marketplace

If you have questions, please visit the Health Insurance Marketplace website at www.healthcare.gov

Your employer's medical plans meet the affordability and minimal value of coverage tests, and are in full compliance with the requirements of large group employers required by the Affordable Care Act. The medical plans do qualify as coverage required to fulfill individual mandate requirements. Full-time employees and dependents are NOT eligible for tax subsidies through the Health Insurance Marketplace.

IMPORTANT EMPLOYEE NOTIFICATIONS

Disclosure Notice This proposal (analyses, report, etc.) is an outline of the coverages proposed by the carrier(s) based upon the information provided by your company. It does not include all the terms, coverages, exclusions, limitations, and conditions of the actual contract language. See the policies and contracts for actual language. This proposal (analyses, report, etc.) is not a contract and offers no contractual obligation on behalf of Gallagher Benefit Services (GBS). Policy forms for your reference will be made available upon request.

Model General Notice of COBRA Continuation You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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

What is COBRA continuation coverage? COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage [choose and enter appropriate information: must pay or aren't required to pay] for COBRA continuation coverage.

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

· Your hours of employment are reduced, or

· Your employment ends for any reason other than your gross misconduct.

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

· Your spouse dies;

· Your spouse's hours of employment are reduced;

· Your spouse's employment ends for any reason other than his or her gross misconduct;

· Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both);

· OR You become divorced or legally separated from your spouse.

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

· The parent-employee dies;

· The parent-employee's hours of employment are reduced;

· The parent-employee's employment ends for any reason other than his or her gross misconduct;

· The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);

· The parents become divorced or legally separated; or

· The child stops being eligible for coverage under the Plan as a "dependent child."

If the Plan provides retiree health coverage, add the following paragraph:] Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to [enter name of employer sponsoring the Plan], and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

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

· The end of employment or reduction of hours of employment;

· Death of the employee;

· [add if Plan provides retiree health coverage: Commencement of a proceeding in bankruptcy with respect to the employer;]; or

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

- Death of the employee;
- The employee is becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days [or enter longer period permitted under the terms of the Plan] after the qualifying event occurs. You must provide this notice to: [Enter name of appropriate party]. [Add description of any additional Plan procedures for this notice, including a description of any required information or documentation.]

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

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. [Add description of any additional Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice.]

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

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

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends. In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period1 to sign up for Medicare Part A or B, beginning on the earlier of

· The month after your employment ends; or

· The month after group health plan coverage based on current employment ends.

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

IMPORTANT EMPLOYEE NOTIFICATIONS

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare. For more information visit https://www.medicare.gov/medicare-and-you. 1 https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods

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

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

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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

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

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

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

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

- You do not need prior authorization from your insurance provider or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your Human Resources office.

Women's Health & 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. Your plans comply with these requirements.

Newborns' and Mothers' 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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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

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

HIPPA Notice of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights Your employer is committed to the privacy of your health information. The administrators of the health plan use strict privacy standards to protect your health information from unauthorized use or disclosure. The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Human Resources.

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, 2023. Contact your State for more information on eligibility. To see if any other states have added a premium assistance program since January 31, 2023, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services Employee Benefits Security Administration Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

IMPORTANT EMPLOYEE NOTIFICATIONS

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://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442
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: https://health.alaska.gov/dpa/Pages/default.aspx	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov	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: https://www.in.gov/medicaid/ Phone 1-800-457-4584
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 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-766-9012	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/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 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: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102	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/other-insurance.jsp 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/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx (https://www.pa.gov/) CHIP Phone: 1-800-986-KIDS (5437)	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
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: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP 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/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

IMPORTANT EMPLOYEE NOTIFICATIONS

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

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

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

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

What happens to your current coverage if you decide to join a Medicare prescription drug plan? If you decide to join a Medicare drug plan, your current employer coverage will be affected. For individuals who elect Part D coverage, coverage under the employer plan will end for the individual and all covered dependents. See pages 9–11 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D. If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents may not be able to get this coverage back.

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

For More Information about This Notice or Your Current Prescription Drug Coverage Contact your Human Resources Department for further information NOTE: You will receive this notice annually, before the next period you can join a Medicare prescription drug plan, and if this coverage through your employer changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit the Social Security Administration (SSA) online at www.socialsecurity.gov, or call SSA at 1-800-772-1213 (TTY 1-800-325-0778). Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare prescription drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: July 1, 2023
Name of Entity/Sender: Social Model Recovery Systems
Address: 223 E. Rowland Street, Covina, CA 91723
Phone Number: 626-332-3145

HIPAA Special Enrollment Rights

Notice of Your HIPAA Special Enrollment Rights A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program) If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, 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).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption 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 new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

NOTES

BENEFIT PLAN CONTACT INFORMATION

Provider	Coverage Type	Phone and Web
blue california	Medical Dental	Blue Shield 800-325-5166 **www.blueshieldca.com**
blue california	Vision	Blue Shield 877-601-9083 **www.blueshieldca.com**
Lincoln Financial Group	Basic Life AD&D Supplemental Life AD&D Long Term Disability	Lincoln 877-275-5462 **www.lfg.com**
Lincoln Financial Group	EmployeeConnect Plus	Lincoln's EmployeeConnect℠ 855-327-4463 Web ID: Lincoln **www.GuidanceResources.com**
EMPOWER RETIREMENT	401(k)Plan Plan ID# 007823	Empower Retirement 800-854-0647 **www.retirement.massmutual.com/rscorp**

Employee Support Center

Call 855.670.2222

Monday - Friday | 8am - 4pm (PST)

LosAngeles.ESC@ajg.com

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Insurance | Risk Management | Consulting

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