BENEFIT GUIDE FOR CONTRACT EMPLOYEES

January 1, 2018 – December 31, 2018

Enroll Online at PopulusBenefits.com

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PEOPLE. SERVICE. PERFORMANCE.

That is what Populus Group is all about. One way we recognize our employee's contributions is by offering an extensive benefits package. The Populus Group Benefit Program gives access to plans that help you protect the health and security of you and your family. We realize benefit needs vary from person to person so we provide a range of plans that allows you to choose the level of coverage and the combination of benefits you want and need. This guide highlights the benefits available to you and explains how to enroll.

In this guide, you will find:

Your 2018 Benefits-at-a-Glance
Who is eligible and how to enroll
Summaries of each benefit plan

At-a-Glance: Your Populus Group Benefits

Medical (with prescription drug benefit)[1]*	BlueCross BlueShield - Basic Medical Plan • Features the national BlueCross BlueShield network • Plan pays 100% with no deductible for most preventive care in-network • Plan pays 100% of basic services, such as in-network office visits and in- network generic drugs (no coverage for major services such as hospitalization and surgery) • Includes prescription drug coverage through Caremark • Allows you to satisfy the Individual Mandate under the ACA and avoid the IRS tax penalty
Medical (with prescription drug benefit)[1]*	BlueCross BlueShield Bronze Plan - Bronze Plan • Features the national BlueCross BlueShield network • Annual individual deductible of $5,000 • Annual family deductible of $10,000 • Includes prescription drug coverage through Caremark • Allows you to satisfy the Individual Mandate under the ACA and avoid the IRS tax penalty
Medical (with prescription drug benefit)[1]*	Symetra Life Insurance Company • Choice of three fixed indemnity medical insurance plans (Essential Plan, Enhanced Plan, Advanced Plan) • Access to the Multiplan network of providers • Benefits are paid at a fixed amount regardless of the actual cost of service • Plans include prescription drug • Not Minimum Essential Coverage under the ACA. These plans do not help you satisfy your Individual Mandate
Hospital Bridge Insurance Plan[1]	Symetra Life Insurance Company • Pays a daily benefit for medical services such as hospitalization, major diagnostic testing, emergency room visits, and more, up to the annual maximum

	• Three options available, with different maximum benefits per covered • person per year: Traditional – $25,000; Enhanced – $35,000; and Premium: • $45,000 • Designed to be used in combination with Basic Medical Plan, or coverage can be purchased separately • Not Minimum Essential Coverage under the ACA. These plans do not help you satisfy your Individual Mandate

[1] You may elect or change these benefits during the annual open enrollment period or anytime during the year with a qualifying status change.

[2] You may elect or change these benefits anytime during the year with medical underwriting requirements.

^Except in NY, this plan is filed as a major medical plan that contains an annual benefit maximum and a number of additional coverage limitations and exclusions.

Critical Illness Insurance[1]	Symetra Life Insurance Company • Pays a fixed dollar amount if you or a covered family member is diagnosed for the first time with a serious illness or condition such as invasive cancer, heart attack, stroke, end- stage renal failure, major organ transplant, paralysis, or coma • Two options available, with different lump sum benefits: Option 1 – $10,000 or Option 2 - $20,000 • Benefits for the employee or spouse are 100% of the lump sum benefit you enrolled for; benefits for children are 25% of the adult benefit • Coverage can be purchased separately or in addition to a medical plan • Not Minimum Essential Coverage under the ACA. These plans do not help you satisfy your Individual Mandate
Accident Insurance[1]	Symetra Life Insurance Company • Covers any type of accidental injury not incurred at work (up to three accidents per calendar year per covered person) and pays your actual billed expenses up to the maximum benefit for the option you purchased; can help you meet your deductible or pay other expenses that are not covered by a comprehensive medical plan • Two options available, with different benefit levels: Option 1 – Up to $3,500 per accident or Option 2 – Up to $10,000 per accident • Not Minimum Essential Coverage under the ACA. These plans do not help you satisfy your Individual Mandate
Hospital Indemnity[1]*	Symetra Life Insurance Company • Provides direct payment to the insured for inpatient hospitalization • Coverage can be purchased separately to any one of the three medical options • If hospitalized, plan pays $1,000 for three hospital stays per covered person • per calendar year, and $300 per day (at least 24 hours in a hospital) for up to 30 days per year • Includes a Prescription Drug Discount Program and Health Advocate Services • Not Minimum Essential Coverage under the ACA. These plans do not help you satisfy your Individual Mandate

[1] You may elect or change these benefits during the annual open enrollment period or anytime during the year with a qualifying status change.

[2] You may elect or change these benefits anytime during the year with medical underwriting requirements.

^Except in NY, this plan is filed as a major medical plan that contains an annual benefit maximum and a number of additional coverage limitations and exclusions.

Health Advocate	Health Advocate • Access to a Personal Health Advocate, typically a registered nurse, supported by a team of physicians and administrative experts, who will help in handling health care and insurance related issues • You, your spouse, children, parents and the parents of your spouse are eligible to use • this service • You automatically receive this benefit when you enroll in a BlueCross medical plan or one of the three Symetra fixed indemnity medical insurance plans
Dental[1]	MetLife Dental • Pays 100% for preventive and diagnostic care • Pays 50% to 80% for other services • Deductible $50 per person
Vision[1]	Vision Service Plan (VSP) • In and out-of-network option (eye exam every 12 months, lenses/frames/contacts every 24 months) • Interim Benefits for lenses and frames
Short Term Disability[2]	The Hartford • Plan pays 60% of pre-disability weekly pay up to a maximum benefit of $600 per week • Benefits begin on the 8th day of total disability and will be paid for up to 13 weeks • Weekly premiums are based on age and weekly benefit amount
Long Term Disability[2]	MetLife • 2 plan options – five-year option or to age 65 option • Plan pays 60% of pre-disability monthly base pay after 90 days of disability • Maximum monthly benefit is $5,000 • Weekly premiums are based on age, monthly earnings, and plan option
Voluntary Life[2]	Reliance Standard Life • Employee Voluntary Life - up to $150,000, cost is based on age and level of coverage • Spouse Voluntary Life - up to $30,000, cost is based on age and level of coverage • Child Voluntary Life - up to $10,000 - cost is based on level of coverage
Voluntary AD&D[2]	Reliance Standard Life • Employee Voluntary AD&D – up to $500,000 • Family Voluntary AD&D – spouse's benefit is 60% of employee's, dependent children's benefit is 15% of employee's

[1] You may elect or change these benefits during the annual open enrollment period or anytime during the year with a qualifying status change.
[2] You may elect or change these benefits anytime during the year with medical underwriting requirements.
^Except in NY, this plan is filed as a major medical plan that contains an annual benefit maximum and a number of additional coverage limitations and exclusions.

ELIGIBILITY

Generally, if you are an active employee working at least 20 hours a week, you are eligible for benefits. The following individuals are also eligible:

- A spouse: (1) a person who is legally recognized as the Employee's spouse pursuant to a legally recognized ceremony between a man and a woman, or (2) a same sex partner who is legally recognized as the Employee's spouse or partner pursuant to a state-sanctioned legal union between two individuals of the same-sex, which affords substantially similar rights to the parties thereto as those imposed by an opposite sex marriage.
- A child who:
    A. Is under the age of 26 or is permanently and totally disabled (an meets the eligibility requirements described below); and
    B. Is related to you in one of the following ways:
        1) You or your spouse's or same-sex domestic partner's child by birth or legal adoption;
        2) Under testamentary or court appointed guardianship, other than temporary guardianship of less than 12 months duration, and who resides with, and is the dependent of you or your spouse or same-sex domestic partner;
        3) A child who is the subject of a Medical Child Support Order or a Qualified Medical Support Order that creates or recognizes the right of the child to receive benefits under a parent's health insurance coverage;
        4) A grandchild who is in the court-ordered custody, and who resides with, and is the dependent of you or your spouse or same-sex domestic partner.

Children whose relationship to you is not listed above, including, but not limited to grandchildren (except as provided above), foster children or children whose only relationship is one of legal guardianship (except as provided above) are not eligible, even though the child may live with you and be dependent upon you for support.

Please note the Populus Group Fixed Indemnity Medical Insurance Plans Options for Contract Employees does not recognize common law marriage. Employee contributions for health care coverage are generally taken on a pre-tax basis, however, according to federal law, employee benefit contributions for same-sex spouses who are not dependents as defined in the Internal Revenue code, and children of same sex married couples who are not dependents of the employee as defined in the Internal Revenue code cannot be taken pre-tax.

If you and your spouse both work for Populus Group, each family member—you, your spouse, and your eligible children— can be covered only once for medical, dental and vision. One of you can enroll in a plan and cover all eligible children, and the other can waive coverage, or you can both enroll. Children cannot be covered by each parent separately.

DISABLED DEPENDENTS

Coverage may be available to your disabled child who is over age 26, provided the child is financially dependent on you, is unmarried and was enrolled in the plan prior to attaining age 26. If you have an over age disabled dependent child, documentation of the disability may be required to continue coverage under the Plan.

Note: Enrolling an individual that is not eligible for Populus' plans is a fraudulent act and could result in disciplinary action up to and including termination.

WHEN BENEFITS BEGIN

If you are a new hire, your benefit coverage begins on the first of the month following your hire date if you are on active service. Active service means you are doing your regular duties in the usual manner on a scheduled work day at one of the places of business where you normally work or where your work sends you.

Coverage for your dependents begins when yours does, unless you add them to your coverage later. You have 30 days from your effective hire date.

Example 1:	Example 2:
Hired 2/5/18	Hired 3/1/18
Benefit Coverage Begins 3/1/18	Benefit Coverage Begins 4/1/18
Must Enroll By: 12 Midnight EST, 3/31/18	Must Enroll By: 12 Midnight EST, 4/30/18

Please keep in mind, you pay for benefits through weekly payroll deductions and if you miss deductions, payment will automatically be made up with double deductions. Please see the "Paying for Your Benefits" section of the guide for more detailed information.

HOW TO ENROLL

Enroll online at www.populusbenefits.com

PopulusBenefits.com is an online benefits service that puts benefits information and enrollment at your fingertips, 24 hours a day, seven days a week. PopulusBenefits.com lets you look at your personal benefits record, including current coverage, dependents, and costs. You can also find details about all the available plans, so you can choose benefits that will work best for you and your family. In addition:

- You DO NOT have to fill out a paper enrollment form.
- PopulusBenefits.com is private and accessible via the internet, anywhere, anytime.
- You can enroll online and print a confirmation.
- You can print a Temporary Benefit Confirmation to present to your providers in the event you have not received your ID cards.
- You can access PopulusBenefits.com after the enrollment period whenever you have questions about your benefits.
- You cannot enroll over the phone.

You have from your date of hire through the end of your first full calendar month of employment to enroll. If you wait until the latter part of your effective month to enroll, your benefits will still begin on the first of the month and you will be responsible for all missed premiums.

LOGGING ON TO POPULUSBENEFITS.COM

First Time PopulusBenefits.com Users

- Send an Email to pgbenefits@populusgroup.com to obtain access to www.PopulusBenefits.com.
- Go to www.PopulusBenefits.com. (We strongly recommend the most recent version of Internet Explorer or Firefox).
- Click on the "Register Now" link located on the right-hand side of your screen.
- When prompted, enter your Last Name, Date of Birth, and your Social Security Number. For security purposes you will also be asked to type a randomly generated security code that will be presented when the page loads.
- Select Next.
- Follow the directions provided on the site to complete your registration and setup your online account.

Returning PopulusBenefits.com Users

- Go to www.PopulusBenefits.com. (We strongly recommend the most recent version of Internet Explorer or Firefox).
- You will see a "Login" on the right of your screen where you can enter your Username and Password. Enter your Username and Password and then select Login.

Please note: If you have forgotten your username and/or password, click on "Login Help" link.

THE ENROLLMENT PROCESS

Once you log in, just follow these steps:

1. Review your personal information,
    a. Demographic (if you need to make changes, you may do so at this screen. If you need to change a field you do not have access to, please contact your local office)
    b. Employment information (if this information is incorrect, please contact your local office)
    c. Dependent Review. If you need to add or remove a dependent, you should do so from this screen. Please note, adding a dependent here DOES NOT enroll them in benefits. You must add them to each plan you wish to enroll them in. Review your current benefits and details of your 2018 options.
2. Review your current benefits and details of your 2018 options.
3. Elect your 2018 benefits or waive those you do not wish to elect. Choose your coverage level (Employee, Employee + Child, Employee + Spouse, Family) or waive medical coverage. If you choose coverage other than employee only, you must add your dependents to the plan.
    a. Medical (*The Basic Medical Plan and BlueCross Blue Shield Bronze Plan offered here will allow you to satisfy your Individual Mandate under the Affordable Care Act)
    b. Hospital Bridge Insurance Plan
    c. Critical Illness Insurance
    d. Accident Insurance
    e. Hospital Indemnity Plan
    f. Major Expense Protection Plan (MEPP)
    g. Dental
    h. Vision
    i. Life Insurance (If you enroll outside of your eligibility period or increase your existing coverage you will be subject to approval by Reliance).
    j. AD&D
    k. Short Term Disability (STD)
    l. Long Term Disability (LTD)
4. Review all of your elections and continue through the enrollment process.
5. Review the Online Enrollment User Acknowledgment and complete the online enrollment process.
6. Print your online Enrollment Election form and keep this copy for your records.

BENEFICIARIES

Many people overlook and underestimate the importance of designating a beneficiary. In many cases, people don't designate a beneficiary at all, and in other cases, the information is outdated. Taking the time to designate or update your beneficiaries today can eliminate many challenges for your family in the event of your death.

Below is a list of the benefits that need a beneficiary as well as step-by-step instructions on how to check and update your beneficiaries.

- Life Insurance
- AD&D

How to Designate or Update Your Beneficiaries

- Log on to www.PopulusBenefits.com.
- Click on the "My Benefits & Personal Information" tab at the top of the page.
- Click "Change Beneficiary Designations".

BENEFIT IDENTIFICATION (ID) CARDS

Your medical and hospital bridge insurance plan ID cards will arrive at your home approximately 3 weeks from the time your enrollment is received at Symetra or BCBS. You will not receive ID cards for the critical illness, accident, hospital indemnity, dental and vision plans, as Symetra, MetLife and VSP do not require you to have an ID card for these plans. You may print a Temporary Benefit Confirmation if you have not received your medical id card or if you would prefer to have your dental and vision information on hand when you visit your provider. To print your Temporary Benefit Confirmation, log on to PopulusBenefits.com and select the "My Benefits & Personal Information" tab at the top of the Homepage. Under the Benefits Information Column, select "Print Temporary Benefit Confirmation". Select the benefits you would like to print a temporary confirmation for and select "Retrieve ID Cards."

IF YOU DO NOT ENROLL

If you do not enroll during your initial eligibility period (generally 30 days from the first day of the month following your date of hire), you cannot enroll or make changes to your coverage under the following plans until the next Open Enrollment period, or unless you have a qualifying status change, described later in this guide; medical/prescription, hospital bridge plan, critical illness insurance, accident insurance, hospital indemnity, major expense protection, dental, and vision.

You may enroll for short-term disability, long-term disability, life and/or AD&D insurance at any time, but you must complete the Evidence of Insurability (EOI) questionnaire if you do not elect during your initial eligibility period.

IF YOU DO NOT HAVE WEB ACCESS

If you do not have access to PopulusBenefits.com, you may complete a paper enrollment to enroll in your benefits. To obtain a paper enrollment form, please contact your local office. You may send your completed forms to:

Populus Group Benefits Department, 3001 W. Big Beaver Rd, Suite 400, Troy, MI 48084. Fax Number: 248-712-8099

PAYING FOR YOUR BENEFITS

You pay for your benefits through weekly payroll deductions. Your premiums for your medical, hospital bridge plan, critical illness insurance, accident insurance, hospital indemnity, major expense protection plan, dental, and vision coverage will be deducted from your paycheck on a pre-tax or post-tax basis, depending on the option you choose. However, according to federal law, premiums for a same- sex spouse and his/her children cannot be paid on a pre-tax basis unless, the spouse or child qualifies as your dependent as defined under the Internal Revenue Code.

Under Section 125 of the Internal Revenue Code, if you choose pre-tax contributions, you may not change or cancel your benefits unless you incur a qualifying life status change, described later in this guide. If you choose post-tax contributions you may completely cancel all of the benefit plans you are enrolled in at any time during the year without restriction, however, you may not just cancel one benefit plan and keep the others (i.e., cancel medical, keep dental and vision) or change medical plans. In addition, you cannot change your benefits (i.e. adding/removing dependents) unless you incur a qualifying life status change.

Deductions for Disability, Life, and AD&D insurance are made on a post-tax basis. Please keep in mind:

- Weekly payroll deductions begin the first full week of benefit coverage;
- If you wait until the latter part of your effective month to enroll, your benefits will still begin on the first of the month and you be responsible for all missed premiums.
- Missed deductions will be made up with double deductions in subsequent weeks.
- You must pay for your benefits every week, regardless of how often you use them.

IF YOU HAVE QUESTIONS

If you have questions about your benefit choices or the enrollment process, contact your local office or the Benefits Service Center at 1-888-858-6310, Monday through Friday 8am to 6pm EST, or send an email to pgbenefits@populusgroup.com. Phone numbers and web addresses for the various benefit plan providers are found on the back of this guide.

MEDICAL & PRESCRIPTION BENEFITS – BlueCross BlueShield Basic Medical Plan ("Basic Plan")

Benefit	In-Network
Benefit Period1 Maximum[2]	Unlimited
Lifetime Maximum	Unlimited
Benefit Period1 Deductible[2]	
Individual	$0.00
Employee + 1/Family	$0.00
Benefit Period1 Out-of- Pocket Maximum[3]	
Individual	$0.00
Family	$0.00
Office Visits	
PCP Visit	Covered at 100%
Specialist Visit	Covered at 100%
Preventive Care[4]	
Well Child Care (through age 17)	Covered at 100%
Immunizations (through age 17)	Covered at 100%
Annual Physicals	Covered at 100%
Routine GYN Exam	Covered at 100%
Mammography	Covered at 100%
Hospitalization (Inpatient & Outpatient)	Not covered
X-Ray & Lab	X-ray & diagnostic imaging: not covered; Outpatient lab work: covered at 100%
Mental Health and Substance Abuse (Inpatient4 & Outpatient)	Not covered
Prescription Drug	$0.00
Deducible	$0.00
Generic copay	$0.00
Preferred Brand copay	Not Covered
Non-Preferred Brand copay	

[1] Benefit Period is January through December of each calendar year.
[2] Per covered member for all medical services.
[3] Includes deductible, coinsurance and copayments.
[4] As defined under the Affordable Care Act.

Basic Medical Plan – 2018 Weekly Premiums

Coverage Level	Basic Plan
Employee	$42.44
Employee plus Child*	$65.23
Employee plus Spouse*	$73.14
Family	$99.05

*Please see the Eligibility section of this guide for the definition of an eligible dependent.

MEDICAL & PRESCRIPTION BENEFITS – BlueCross BlueShield Bronze Medical Plan ("Bronze Plan")

Benefit	Bronze	
	In-Network	Out-of Network
Annual Deductible[1]	$5,000 Individual $10,000 Family	$10,000 Individual $20,000 Family
Annual Out-of-Pocket Maximum[1] (combined medical/prescription)	$6,350 Individual $12,700 Family	$12,700 Individual $25,400 Family
Lifetime Maximum Benefit	None	None
Office Visits, Labs and Testing Office Visits for Illness	You pay $40 per visit after deductible is met	You pay 50% of Allowed Benefit after deductible is met
Imaging (MRA/MRS, MRI, PET & CAT scans)	You pay $40 per visit after deductible is met	You pay 50% of Allowed Benefit after deductible is met
Lab	You pay $40 per visit after deductible is met	You pay 50% of Allowed Benefit after deductible is met
X-ray	You pay $40 per visit after deductible is met	You pay 50% of Allowed Benefit after deductible is met
Physical/Speech/Occupational Therapy (limited to 30 visits per injury per benefit period)	You pay $40 per visit after deductible is met	You pay 50% of Allowed Benefit after deductible is met
Chiropractic (limited to 20 visits per benefit period)	You pay $40 per visit after deductible is met	You pay 50% of Allowed Benefit after deductible is met
Preventive Services Well Child Care (including exams & immunizations)	Covered at 100%	You pay 50% of Allowed Benefit
Adult Physical Exam (including routine GYN visit)	Covered at 100%	You pay 50% of Allowed Benefit after deductible is met
Breast Cancer Screening	Covered at 100%	You pay 50% of Allowed Benefit
Pap Test	Covered at 100%	You pay 50% of Allowed Benefit after deductible is met
Prostate Cancer Screening	Covered at 100%	You pay 50% of Allowed Benefit after deductible is met
Colorectal Cancer Screening	Covered at 100%	You pay 50% of Allowed Benefit after deductible is met
Emergency Care and Urgent Care Urgent Care Center	You pay $50 per visit after deductible is met	You pay $50 per visit after in-network deductible is met
Emergency Room – Facility Services	You pay $250 per visit (waived if admitted) after deductible met	You pay $250 per visit (waived if admitted) after in-network deductible is met
Emergency Room – Physician Services	Covered at 100% after deductible is met	Covered at 100% after in-network deductible is met
Ambulance (if medically necessary)	You pay 20% of Allowed Benefit after deductible is met	You pay 20% of Allowed Benefit after in-network deductible is met

Hospitalization **Outpatient Facility Services**	**You pay 20% of Allowed Benefit after deductible is met**	**You pay 50% of Allowed Benefit after deductible is met**
Outpatient Physician Services	You pay 20% of Allowed Benefit after deductible is met	You pay 50% of Allowed Benefit after deductible is met
Inpatient Facility Services	You pay 20% of Allowed Benefit after deductible is met	You pay 50% of Allowed Benefit after deductible is met
Inpatient Physician Services	You pay 20% of Allowed Benefit after deductible is met	You pay 50% of Allowed Benefit after deductible is met
Maternity Preventive Prenatal and Postnatal Office Visits	Covered at 100%	You pay 50% of Allowed Benefit after deductible is met
Delivery and Facility Services	You pay 20% of Allowed Benefit after deductible is met	You pay 50% of Allowed Benefit after deductible is met
Nursery Care of Newborn	You pay 20% of Allowed Benefit after deductible is met	You pay 50% of Allowed Benefit after deductible is met
Mental Health and Substance Abuse Inpatient Facility Services	Not covered	You pay 50% of Allowed Benefit after deductible is met
Inpatient Physician Services	You pay 20% of Allowed Benefit after deductible is met	You pay 50% of Allowed Benefit after deductible is met
Outpatient Facility Services	You pay 20% of Allowed Benefit after deductible is met	You pay 50% of Allowed Benefit after deductible is met
Outpatient Physician Services	You pay 20% of Allowed Benefit after deductible is met	You pay 50% of Allowed Benefit after deductible is met
Office Visits	You pay $40 per visit after deductible is met	You pay 50% of Allowed Benefit after deductible is met
DEDUCTIBLES:	See Medical Summary	
Prescription Drugs: Up to a 34-day supply	Generic drugs: You pay $15.00 per prescription Preferred brand drugs: You pay $50.00 per prescription Non-preferred brand drugs: You pay $100.00 per prescription	
Maintenance Drugs: Up to a 90-day supply	Generic drugs: You pay $30.00 per prescription Preferred brand drugs: You pay $70.00 per prescription Non-preferred brand drugs: You pay $120.00 per prescription	

No copayment or coinsurance.

[1] When multiple services are rendered on the same day by more than one provider, Member payments are required for each provider.

[2] In-Network: When covered services are rendered in Maryland, Washington D.C. and/or Northern Virginia, collectively known as the CareFirst BlueChoice service area, by a provider in the CareFirst BlueChoice Provider network, care is reimbursed at the in-network level. In-network benefits are based on the CareFirst BlueChoice Allowed Benefit. The CareFirst BlueChoice

Allowed Benefit is generally the contracted rates or fee schedules that CareFirst BlueChoice providers have agreed to accept as payment for covered services. These payments are established by CareFirst BlueChoice, Inc., however, in certain circumstances, an allowance may be established by law. Outside of the CareFirst BlueChoice service area, when covered services are rendered by a provider in the preferred provider network, care is also covered at the in-network level. These in-network benefits are based on the contracted rates or fee schedules that preferred providers have agreed to accept as payment for covered services that are established by the local Blue Cross and Blue Shield Plan, however, in certain circumstances, an allowance may be established by law.

[3] Out-of-Network: When covered services are rendered by a provider that is not in the CareFirst BlueChoice network in Maryland, Washington D.C. or Northern Virginia, or is not in the preferred provider network outside of CareFirst BlueChoice service area, the care is reimbursed as out-of-network. Out- of-network benefits are based on the Allowed Benefit. The Allowed Benefit is generally the contracted rates or fee schedules that are established by

CareFirst BlueChoice, or the local Blue Cross and Blue Shield Plan, however, in certain circumstances, an allowance may be established by law.

[4] For family coverage only: When one family member meets the individual deductible, they can start receiving benefits as indicated above. Each family member cannot contribute more than the individual deductible amount. The family deductible must be met before the remaining family members can start receiving benefits.

[5] For Family coverage only: When one family member meets the individual out-of-pocket maximum, their services will be covered at 100% up to the Allowed Benefit. Each family member cannot contribute more than the individual out-of-pocket maximum amount. The family out-of-pocket maximum must be met before the services for all remaining family members will be covered at 100% up to the Allowed Benefit.

[6] Plan has an integrated medical and prescription drug out-of-pocket maximum.

[7] If you receive laboratory services inside the CareFirst Service area (Maryland, D.C., Northern Virginia) members should use LabCorp to receive In- Network benefits.

Services performed by any other provider, while inside the CareFirst Service area will be considered out-of-network. If you receive laboratory services outside of Maryland, D.C. or Northern Virginia, you may use any participating BlueCard PPO laboratory and receive in-network benefits.

[8] Members who are unable to conceive have coverage for the evaluation of infertility services performed to confirm an infertility diagnosis, and some treatment options for infertility. Preauthorization required.

BlueCross BlueShield Bronze Medical Plans 2018 Weekly Premiums

Coverage Level	Bronze Plan
Employee	$98.40
Employee plus Child*	$182.03
Employee plus Spouse*	$226.31
	$299.12

*Please see the Eligibility section of this guide for the definition of an eligible dependent.

MEDICAL & PRESCRIPTION BENEFITS – SYMETRA LIFE INSURANCE COMPANY

You may choose one of three fixed indemnity medical plans coverage options. The plans offer access to the MultiPlan national network of providers. For a network provider near you, visit PopulusBenefits.com for a direct link to the MultiPlan website or got to www.multiplan.com. The following charts highlights commonly covered services under the Symetra Life Insurance Company Fixed Indemnity Medical Insurance Plans.

Essential Plan			
Benefit Provision	***Basic Plan Benefits***	***Per Provision Limit***	***Collective Benefit Limit***

Doctor Office Visits	$80 per day	none	15 visits per covered person per calendar year
Outpatient Diagnostic X-Ray	$80 per day	none	
Preventive Care	$80 per day	none	$1,200
Emergency Room	$200 per day (outpatient DXL benefits may also apply)	$600 pcppcy*	$600 pcppcy
Hospital Admission	$1,500 per first day	1 pcppcy*	$1,500 pcppcy
Hospital Stay[1], regular room	$500 per day	10 days pcppcy*	$5,000 pcppcy
Hospital Stay[1], ICU	$1,000 per day	10 days pcppcy*	$10,000 pcppcy
Hospital Stay[1], Substance Abuse Facility	$500 per day	10 days pcppcy*	$5,000 pcppcy
Hospital Stay[1], Mental Health (180 day lifetime limit)	$250 per day	10 days pcppcy*	$2,500 pcppcy
Post-Hospital Nursing Facility Stay[1]	$250 per day	*60 days per stay[3]	$15,000 pcppcy
Surgery (based upon site of service) maximum 1 surgical benefit per day		$3,000 maximum benefit per covered person per year	$3,000 maximum benefit per covered person per year
Outpatient Doctor's Office	$75 per day		
Outpatient Surgical Facility	$550 per day		
Inpatient	$2,000 per day		
Preferred generic Rx[5]	$10 co-pay	$5,000 pcppcy*; $10,000 family benefit	$5,000 pcppcy
Non-preferred generic and brand Rx[5]	Discount	none	n/a

In-Network Discounts	when services are received through a MultiPlan PPO Network provider[2]	none	n/a
Non-Network Penalties	none	none	none

**This is a summary of benefits for illustration purposes only. Policy provisions govern. See policy for details, exclusions and limitations. *pcppcy means per covered person per calendar year

[1]500 days per lifetime maximum except that mental health facility stay is limited to 180 days' lifetime maximum.

[2]Access to the MultiPlan PPO Network is included. There is a $4.00 PEPM fee included in the monthly premiums shown for this access. Benefits are payable per policy without regard to network status of provider.

[3]This benefit is paid only if following a covered hospital stay of at least 3 consecutive days and the insured is under age 65.

[4]This collective benefit could be higher if more than one confinement in a single calendar year.

[5]Program insured by PRAM Insurance Services, Inc., Brea, CA, administered by RxEDO.

This discount program is not an insured benefit. Insurance benefits are provided under the Select Benefits Indemnity Policy, form number LGC-8786 2/03, and/or Critical Illness Policy, form number LGC-9095 2/07. they are insured by Symetra Life Insurance Company, 777 108th Ave NE, Suite 1200, Bellevue, WA 98004. The **coverage is not a** substitute for major medical or other comprehensive coverage. Benefits are subject to exclusions, limitations, reductions and termination of benefits provisions. Please review the description of benefits for additional details. For more information, contact your Symetra agent.

Enhanced Plan			
Benefit Provision	Basic Plan Benefits	Per Provision Limit	Collective Benefit Limit
Doctor Office Visits	$80 per day	none	20 visits per covered person per calendar year $1,600
Outpatient Diagnostic X-Ray	$80 per day	none	
Preventive Care	$80 per day	none	
Emergency Room	$200 per day (outpatient DXL benefits may also apply)	$600 pcppcy*	$600 pcppcy
Hospital Admission	$1000 per first day	2 pcppcy*	$2,000 pcppcy
Hospital Stay[1], regular room	$1,200 per day	none	$15,000 pcppcy
Hospital Stay[1], ICU	$2,400 per day	none	
Hospital Stay[1], Substance Abuse	$1,200 per day	none	
Hospital Stay[1], Mental Health (180 day lifetime limit)	$600 per day	none	
Post-Hospital Nursing Facility	$600 per day	*60 days per stay[3]	
Surgery (based upon site of service) maximum 1 surgical benefit per day		none	
Outpatient Doctor's Office	$65 per day		
Outpatient Surgical Facility	$1500 per day		
Inpatient	$3500 per day		
Surgical Anesthesia	$400 per surgery with anesthesia	none	
Outpatient Surgical Facility (OPSF)	$900 per surgery with OPSF	none	
Generic Rx[5]	$10 co-pay	$5,000 pcppcy*, $10,000 family benefit	$5,000 pcppcy
Brand Rx[5]	Discount	none	n/a
In-Network Discounts	when services are received through a MultiPlan PPO Network provider[2]	none	n/a
Non-Network Penalties	none	none	none

**This is a summary of benefits for illustration purposes only. Policy provisions govern. See policy for details, exclusions and limitations.

*pcppcy means per covered person per calendar year

[1]500 days per lifetime maximum except that mental health facility stay is limited to 180 days' lifetime maximum.

[2]Access to the MultiPlan PPO Network is included. There is a $4.00 PEPM fee included in the monthly premiums shown for this access. Benefits are payable per policy without regard to network status of provider.

[3]This benefit is paid only if following a covered hospital stay of at least 3 consecutive days and the insured is under age 65.

[4]This collective benefit could be higher if more than one confinement in a single calendar year.

[5]Program insured by PRAM Insurance Services, Inc., Brea, CA, administered by RxEDO. This discount program is not an insured benefit.

Insurance benefits are provided under the Select Benefits Indemnity Policy, form number LGC-8786 2/03, and/or Critical Illness Policy, form number LGC-9095 2/07. they are insured by Symetra Life Insurance Company, 777 108th Ave NE, Suite 1200, Bellevue, WA 98004. The coverage is not a substitute for major medical or other comprehensive coverage. Benefits are subject to exclusions, limitations, reductions and termination of benefits provisions. Please review the description of benefits for additional details. For more information, contact your Symetra agent.

ADVANTAGE PLAN			
Benefit Provision	Basic Plan Benefits	Per Provision Limit	Collective Benefit Limit
Doctor Office Visits	$80 per visit	none	$150,000 pcppcy
Outpatient Major Diagnostic Tests	$375 per day	none	
Emergency Room	200 per day (outpatient DXL benefits may also apply)	none	
Hospital Stay1, regular room	$2,000 per day	none	
Hospital Stay1, ICU	$4,000 per day	none	
Hospital Stay1, Substance Abuse Facility	$2,000 per day	none	
Hospital Stay1, Mental Health (180 day lifetime limit)	$1,000 per day	none	
Post-Hospital Nursing Facility	$1,000 per day	*60 days per stay3	
Surgery (based upon site of service) maximum 1 surgical benefit per day			
Outpatient Doctor's Office	$5 per day	none	
Outpatient Surgical Facility	$1,500 per day	none	
Inpatient	$3,500 per day	none	
Surgical Anesthesia	$550 per surgery with anesthesia	none	
Outpatient Surgical Facility (OPSF)	$900 per surgery with OPSF	none	
Preventive Care	$100 per day	$100 pcppcy	$100 pppcy
Hospital Admission	$1,000 per admission	3 pcppcy*	$3,000 pppcy
Generic Rx5	$10 co-pay	$5,000 pcppcy*; $10,000 family benefit maximum	
Brand Rx5	Discount	None	
In-Network Discounts	When services are received through a MultiPlan PPO Network		
Non-Network Penalties	None		

**This is a summary of benefits for illustration purposes only. Policy provisions govern. See policy for details, exclusions and limitations.
*pcppcy means per covered person per calendar year
[1]500 days per lifetime maximum except that mental health facility stay is limited to 180 days' lifetime maximum.
[2]Access to the MultiPlan PPO Network is included. There is a $4.00 PEPM fee included in the monthly premiums shown for this access. Benefits are payable per policy without regard to network status of provider.
[3]This benefit is paid only if following a covered hospital stay of at least 3 consecutive days and the insured is under age 65.
[4]This collective benefit could be higher if more than one confinement in a single calendar year.
[5]Program insured by PRAM Insurance Services, Inc., Brea, CA, administered by RxEDO. This discount program is not an insured benefit.
Insurance benefits are provided under the Select Benefits Indemnity Policy, form number LGC-8786 2/03, and/or Critical Illness Policy, form number LGC-9095 2/07. they are insured by Symetra Life Insurance Company, 777 108th Ave NE, Suite 1200, Bellevue, WA 98004. The coverage is not a substitute for major medical or other comprehensive coverage. Benefits are subject to exclusions, limitations, reductions and termination of benefits provisions. Please review the description of benefits for additional details. For more information, contact your Symetra agent.

SYMETRA LIFE INSURANCE COMPANY FIXED INDEMNITY MEDICAL INSURANCE PLANS – 2018 WEEKLY PREMIUMS

Coverage Level	Essential Plan	Enhanced Plan	Advantage Plan

Employee	$27.62	$37.01	$68.40
Employee Plus Child*	$68.54	$92.73	$173.16
Employee Plus Spouse*	$68.54	$92.73	$173.16
Family*	$98.44	$132.94	$248.55

*Please see the Eligibility section of this guide for the definition of an eligible dependent.

HOSPITAL BRIDGE INSURANCE PLAN – SYMETRA LIFE INSURANCE COMPANY

Offered through Symetra, the Hospital Bridge Insurance Plan is designed to supplement the Basic Medical Plan, but can also be purchased on a stand-alone basis or as a supplement to another medical plan. The Hospital Bridge Insurance Plan pays a fixed daily benefit directly to you for medical services such as hospitalization, major diagnostic testing, emergency room visits, outpatient surgical facility, mental healthcare room, and more, up to the annual maximum.

When you are admitted to the hospital, you may "assign" your benefits to the hospital or you may choose not to.

This is your choice regardless of any major medical or other coverage you may have, but if you do not have major medical coverage the hospital may require you to assign your benefits as a condition of admittance. If you assign benefits, the hospital should file the claim and payment will be made by Symetra directly to the hospital up to the amount the hospital shows due or up to the limit of the plan. Excess benefits, if any, will be paid directly to you. If you do not assign your benefits, you will need to file the claim with Symetra yourself and benefits will be paid directly to you. Paid benefits are not taxed.

Coverage is guaranteed issue, which means you cannot be denied coverage, regardless of current or prior personal or family health history, and there are no pre-existing limitations.

You may choose from three plan options:

- Traditional: $25,000 maximum benefit per covered person per year
- Enhanced: $35,000 maximum benefit per covered person per year
- Premium: $45,000 maximum benefit per covered person per year

Please note: The Hospital Bridge Insurance Plan does not satisfy your individual mandate under the Affordable Care Act.

Personalize Your Coverage: Consider the Basic Medical Plan + Hospital Bridge Insurance Plan

The Basic Medical Plan features low premiums and no deductible while providing you with 100% coverage for unlimited sick and well visits to doctors and coverage for generic and preferred brand name prescription drugs. However, the Basic Medical Plan does not cover surgery, hospitalization, emergency room services, x-ray/diagnostic imaging or non- preferred brand name or specialty prescription drugs. Combining the Basic Medical Plan with a Hospital Bridge Plan allows you to expand your coverage

and build a personalized program that suits your needs and is budget friendly. Any one of the Hospital Bridge Plans can supplement the Basic Medical Plan or any other coverage you may have. You can also further expand your coverage by choosing Critical Illness Protection and/or Accident Protection Plans.

Basic Medical Plan	
Benefit Period Maximum, Lifetime Maximum	Unlimited
Deductible, Out-of-Pocket Maximum, Coinsurance (per calendar year)	$0
Office Visits	Covered at 100% in-network
Preventive Care (annual physical, well- child care/immunizations, routine GYN exam)	Covered at 100% in-network
Lab Work, X-ray/Imaging (e.g., MRI)	X-ray & Diagnostic Imaging: Not Covered Outpatient lab work covered at 100%
Hospitalization	Not covered
Prescription Drugs	Generic & Preferred Brand Drugs: Covered at 100% in-network Non-Preferred Brand and Specialty Drugs: Not Covered

	Hospital Bridge Insurance Plan		
	Three Options:		
Benefit Period Maximum	Traditional Plan - $25,000/ Covered Person/Year	Enhanced Plan - $35,000/ Covered Person/Year	Premium Plan -$45,000/ Covered Person/Year
Regular Hospital Room	$1,200	$1,200	$1,500
Intensive Care Unit Hospital room	$2,400	$2,400	$3,000
Substance Abuse Room	$1,200	$1,200	$1,500
Mental Health Care Room	$600	$600	$750
Post-Hospital Nursing Facility	$600	$600	$750
Major Diagnostic Test	$300	$400	$500
Routine Diagnostic Test	$30	$40	$50
Emergency Room	$150	$200	$200
Outpatient Surgical Facility	$300	$400	$500

Symetra Life Insurance Company: Hospital Bridge Insurance Plans 2018 WEEKLY PREMIUMS

Coverage Level	Traditional	Enhanced	Premium
Employee	$27.70	$33.51	$41.35
Employee plus Child*	$53.61	$65.04	$80.46
Employee plus Spouse*	$53.61	$65.04	$80.46
Family	$76.87	$93.35	$115.58

*Please see the Eligibility section of this guide for the definition of an eligible dependent.

CRITICAL ILLNESS INSURANCE – SYMETRA LIFE INSURANCE COMPANY

Critical Illness Insurance pays you a fixed dollar amount if you or a covered family member is diagnosed for the first time with a serious illnesses or condition such as invasive cancer, heart attack, stroke, end-stage renal failure, major organ transplant, paralysis, and coma. The plan is "guaranteed issue" coverage, which means you cannot be denied coverage, regardless of current or prior personal or family health history. (Please note: while you cannot be denied for your prior personal or family history, you cannot obtain coverage for a specific covered critical illness if you have previously been diagnosed with that critical illness.) You may elect $10,000 (Option 1) or $20,000 (Option 2) worth of coverage for yourself and your spouse. Benefits for children are 25% of the adult benefit.

Critical illness insurance is intended to supplement a comprehensive medical plan. It provides a lump sum cash benefit for expenses that may not be covered by a traditional medical plan.

Critical Illness Insurance can be purchased as a stand-alone plan or in addition to any of the medical plan options, Hospital Bridge Insurance Plans, Accident Insurance, Hospital Indemnity Plan and Major Expense Protection Plan.

The benefits of critical illness insurance include:

- Helps you have money for deductibles, copays, lost income, experimental treatment, spousal income when using FMLA, etc.
- Benefits are paid directly to you in addition to the major medical insurance you may already have in place
- Benefits for the employee or spouse are always 100% of the lump sum benefit you enrolled for ($10,000 or
- $20,000); benefits for children are 25% of the adult benefit
- With this "first occurrence ever" policy, each condition is independent. So, if you have your first ever heart attack while covered and a year later you are diagnosed with invasive cancer, then you get paid the full benefit amount twice.
- Payroll deductions can be taken pre-tax and paid benefits are not taxed (except for domestic partners and same- sex civil unions).

Critical Illness Insurance 2018 Weekly Premiums

Critical Illness Insurance

Coverage Level	Option 1 - $10,000	Option 2 - $20,000
Employee	$4.14	$8.28
Employee plus Child*	$5.52	$11.04
Employee plus Spouse*	$8.28	$16.55
Family	$9.66	$19.31

*Please see the Eligibility section of this guide for the definition of an eligible dependent.

ACCIDENT INSURANCE – SYMETRA LIFE INSURANCE COMPANY

Accident Insurance is another option for supplementing a comprehensive medical plan. When accidents happen, out-of- pocket costs for things such as doctor visits, x-rays and physical therapy can add up fast. This plan can help. You can choose from two options:

- Coverage of up to $3,500 per accident (Option 1), or
- Coverage of up to $10,000 per accident (Option 2)

The Accident Insurance plan covers any type of accidental injury not incurred at work (up to 3 per calendar year per covered person) and pays your actual billed expenses up to the maximum benefit for the option you purchased. As with the other supplementary plans available, this plan can help you meet your deductible or pay other expenses that are not covered by a comprehensive plan.

Accident Insurance can be purchased as a stand-alone plan or in addition to any of the medical plan options, Hospital Bridge Insurance Plans, Critical Illness Insurance, Hospital Indemnity Plan and Major Expense Protection Plan.

Here are two examples of how benefits would be paid if Option 1—Up to $3,500 was elected.

Example 1:	Example 2:
Ambulance service $800	Urgent Care $310
Emergency room $1,525	Lab tests $235
Diagnostic testing (MRI) $750	X-rays $280
Physician fees $300	Physician fees $120
Physical therapy $500	Chiropractic services $390
Total expenses $2,875	Prescriptions (inpatient) $75
Benefits paid to insured = $2,875	Total expenses $1,410

Premiums are based on the coverage level you choose and whether you cover yourself only or yourself and your dependents.

Accident Insurance 2018 Weekly Premiums

Accident Insurance		
Coverage Level	Option 1 - $3,500	Option 2 - $10,000
Employee	$6.87	$8.26

Employee plus Child*	$11.27	$13.54
Employee plus Spouse*	$14.64	$17.60
Family	$20.39	$24.51

*Please see the Eligibility section of this guide for the definition of an eligible dependent.

HOSPITAL INDEMNITY PLAN – SYMETRA LIFE INSURANCE COMPANY

If you are hospitalized as an inpatient, the plan will pay you $1,000 in cash per admission, up to 3 admissions per covered person per calendar year. Each covered person will also receive a benefit for each day (24 hour period) hospitalized as illustrated by the chart below subject to all policy provisions.

The plan also includes a Pharmacy Discount Program at no additional cost. The Pharmacy Discount Program is a benefit for those without prescription drug coverage on a Populus medical plan or another medical plan that includes prescription drug coverage. A discount from usual and customary drug charges will be given to you when prescriptions are purchased through an in-network pharmacy. This is not a prescription drug benefit but a discount program provided through ReStat (www.restat.com). Most national pharmacies are included in the ReStat network as are many regional and local pharmacies. You can verify participation by asking your pharmacy or checking on-line. You should not attempt to use this discount program if you have prescription drug coverage through you medical plan with Populus or another plan. You can use only one pharmacy benefit program. Benefits cannot be duplicated.

This plan can be purchased as a stand-alone plan, or in addition to any one of the three fixed indemnity medical plan options (Essential, Enhanced, or Advantage), the Hospital Bridge Insurance Plan, Critical Illness Insurance, Accident Insurance, and/or the Major Expense Protection Plan.

Benefit	Coverage
Deductible	None
Copay	None
Lifetime Maximum	500 days lifetime maximum for each benefit per person (except for Mental Illness)
Hospital Admission	$1,000 per admission, per covered person, per calendar year
Hospital Stay[1] (ICU)	$300 per day, 30 days maximum per covered person, per calendar year
Hospital Stay[1] (regular room)	$600 per day, 30 days maximum per covered person, per calendar year
Hospital Stay[1] (Substance Abuse Facility)	$300 per day, 30 days maximum per covered person, per calendar year
Hospital Stay[2] (Mental Health Facility)	$300 per day, 30 days maximum per covered person, per calendar
Post Hospital Nursing Facility Stay[1,3]	$150 per day, 60 days maximum per confinement per covered person under the age of 65

This is a summary of benefits for illustration purposes only. Policy provisions govern. See policy for details, exclusions and limitations.

[1]500 days per lifetime maximum

[2]180 days per lifetime maximum
[3]Following a hospital stay of at least 3 days

HOSPITAL INDEMNITY PLAN WEEKLY PREMIUMS

Coverage Level	2018 Weekly Premium
Employee	$6.32
Employee plus Child*	$12.43
Employee plus Spouse*	$12.43
Family*	$17.92

MAJOR EXPENSE PROTECTION PLAN – SYMETRA LIFE INSURANCE COMPANY

The Major Expense Protection Plan offers you the opportunity to buy additional emergency room and inpatient hospital coverage, which includes inpatient hospitalization for substance abuse, and mental health. This plan can be purchased as a stand-alone plan, or in addition to any one of the three fixed indemnity medical plan options (Essential, Enhanced, or Advantage), the Hospital Bridge Insurance Plan, Critical Illness Insurance, Accident Insurance, and/or the Hospital Indemnity Plan. The MEPP does not issue restrictions on hospitals, meaning there is no requirement to use participating providers. The following chart is a summary of the plan.

Deductible	None
Copay	None
Lifetime Maximum	500 days lifetime maximum for each benefit per person (except for Mental Illness)
Emergency Room Benefit: Covered events that are the result of an illness or accident are paid at a pre-selected fixed dollar amount per visit up to a calendar year maximum. This benefit will be paid only for procedures received in an emergency room.	$200 per visit/$500 calendar year maximum per person, per calendar year
Inpatient Hospital Benefit: Coverage for inpatient hospital stays is provided and benefits are paid at a pre-selected fixed dollar amount per day of confinement up to a maximum number of days per calendar year.	
Daily Hospital	$1,500 per daily hospital stay / 30 days maximum per calendar year
Substance Abuse	$1,500 per day, per person for stays in a substance abuse facility / 30 days maximum per calendar year
Intensive Care Unit	$3,000 per day, per person for stays in the Intensive Care Unit / 30 days maximum per calendar year
	$750 per day, per person for stays in a mental health facility

Mental Health Facility	/ 30 days maximum per calendar year, 180 days per lifetime
Nursing Facility	$750 per day, per person for stays in a nursing facility (only if following a covered hospital stay of at least 3 consecutive days and the person is less than age 65) / maximum 60 consecutive days per stay
	Covered as any other condition

The Major Expense Protection Plan is not a replacement for a major medical policy or other comprehensive policy. It is designed to cover benefits used on a routine basis at a preselected, fixed dollar amount. Coverage may be subject to exclusions, limitation, reductions, and termination of benefit provisions. Exclusions, limitations, definitions, and benefits may vary by state. Please see the policy for details. The Major Expense Protection Plan is insured by Symetra Life Insurance Company, 777 108th Avenue NE, Suite 1200, Bellevue, WA, 98004. SymetraSM is a service mark of Symetra Life Insurance Company.

MAJOR EXPENSE PROTECTION PLAN WEEKLY PREMIUMS

Coverage Level	2018 Weekly Premium
Employee Only	$23.29
Employee plus Child*	$48.43
Employee plus Spouse*	$48.43
Family*	$55.45

*Please see the Eligibility section of this guide for the definition of an eligible dependent.

HEALTH ADVOCATE

Health Advocate, the nation's leading health advocacy company, provides confidential, personalized, one-on-one assistance to you and eligible family members to help navigate many aspects of the health care world. You will have access to a Personal Health Advocate, typically a registered nurse, supported by a team of physicians and administrative experts, who will help in handling healthcare and insurance related issues. Eligible family members who can use Health Advocate include you, your spouse, your children, your parents, and your spouse's parents.

1. Finding the best doctors, hospitals, dentists, and other leading healthcare providers anywhere in the country.
2. This includes locating providers in your health insurance plan's network.
3. Scheduling appointments with providers including hard to reach specialists and critical care providers and arranging for specialized treatments and tests.
4. Helping to resolve insurance claims and assisting with negotiating billing and payment arrangements, and related administrative issues.
5. Working with our insurance companies to obtain appropriate approvals for needed services often fostering communications between physicians and insurance companies.
6. Assisting with eldercare and related healthcare issues facing your parents and parents-in-law. They work with
7. Medicare and other government insurance programs and help make arrangements following discharge from a hospital for in-home or needed institutional service.

8. Answering questions about test results, treatment recommendations and medications recommended or prescribed by your physician.
9. Obtaining unbiased health information to help make an informed decision.
10. Assisting in the transfer of medical records, x-rays and lab results.
11. Locating and researching the newest treatments for a medical condition.
12. Assisting with finding qualified wellness programs, providers and services.

Employees who participate in one of three fixed indemnity medical insurance plans are eligible to use Health Advocate. To utilize the services offered by Health Advocate, simply call 1-866-695-8622 or send an email to answers@HealthAdvocate.com. When you request service, you will be asked to complete a Medical Information Release Form. Please be assured Health Advocate will keep all information strictly confidential and will protect your privacy. For more information about the company and services, visit www.HealthAdvocate.com.

DENTAL BENEFITS – MetLife Dental Plan

The MetLife dental plan covers preventive, basic, and major dental services and supplies. Generally, when you receive care from a MetLife participating dentist, your out-of-pocket expenses will be lower than if you receive services from a non-participating dentist.

For a participating dentist near you, visit PopulusBenefits.com for a direct link to the MetLife website or go to

www.metlife.com/dental or www.metlife.com/mybenefits. You can also call MetLife at 1-800-942-0854.

This chart provides highlights of some covered services. For a full description of covered services and exclusions, please see the detailed plan description provided on www.PopulusBenefits.com. Please note, deductibles and annual plan limits are per coverage year (January 1 – December 31).

Benefit	In-Network	Out-of-Network
Annual (calendar year) Deductible (for Type B and C Expenses Combined)	$50 per person	$50 per person
Annual (calendar year) Plan Limit Maximum Benefit	$1,000 per person	$1,000 per person
Type A Expenses Preventive Oral Exams once every six months Cleaning, polishing once every six months	Plan pays 100%* no deductible	Plan pays 100%** no deductible
Type B Expenses X-rays, fillings, minor oral surgery	Plan pays 80%* after deductible	Plan pays 80%** after deductible
Type C Expenses Crowns, dentures, bridgework, complex oral surgery	Plan pays 50%* after deductible	Plan pays 50%** after deductible
Type D Expenses Orthodontia	Not Covered	

Additional Type A, B & C information can be found in the MetLife Dental Plan Certificate of Insurance. *Plan Benefits subject to the Maximum Allowed

Charge for the types of dental services shown in section C of the Plan Certificate of Insurance. The Maximum Allowed Charge is the lower of: a. the amount charged by the Participating Provider for the service or supply; and b. the maximum amount that the Participating Provider agreed with us to charge for that service or supply. This maximum amount is specified or based on the amounts specified in the Preferred Dentist Program Table of Maximum Allowed Charges. ** Plan Benefits subject to Reasonable and Customary (R&C) limits for the types of dental services shown in section C of the Plan Certificate of Insurance. The Reasonable and Customary Charge is the lowest of: a. the usual charge by the Dentist or other provider of the services or supplies for the same or similar services or supplies; or b. the usual charge of most other Dentists or other providers in the same geographic area for the same or similar services or supplies; or c. the actual charge for the services or supplies.

DENTAL PLAN WEEKLY PREMIUMS

Coverage Level	2018 Weekly Premium
Employee Only	$8.08
Employee plus Child*	$16.24
Employee plus Spouse*	$18.50
Family*	$20.91

*Please see the Eligibility section of this guide for the definition of an eligible dependent.

VISION BENEFITS – Vision Service Plan (VSP)

Vision care benefits are provided through Vision Service Plan, or VSP. Generally, when you receive care from a VSP participating provider, your out-of-pocket expenses will be lower than if you receive services from a nonparticipating provider. To find a VSP provider, visit PopulusBenefits.com for a direct link to the VSP website or go to www.vsp.com. Select "Members and Consumers" and "Find a VSP Network Doctor." Or, call VSP at 1-800-877-7195. When you make an appointment, indicate you are a VSP member. The provider will obtain the necessary approvals. If you use nonparticipating providers, you must pay for services and then submit a claim form to VSP for reimbursement.

This chart provides highlights of some covered services. For a full description of covered services and exclusions, please see the detailed plan description provided on www.PopulusBenefits.com.

Benefit	Frequency*	In-Network	Out-of-Network
Eye Exam	Well/Vision - Once every 12 months	$15 co-pay, then plan pays 100%	Plan pays up to $50
Frames	Once every 24 months	Plan pays 100% for selected frames up to $130	Plan pays up to $70
Lenses:	Once every 24 months	Combined $15 co-pay for lenses and frames, then Plan pays 100%	Plan pays up to:
Single vision			$50
Bifocal (lined)			$75
Trifocal (lined)			$10
Lenticular			$12
INTERIM BENEFITS for lenses (including contact lenses) and frames every 24 months - If your lens prescription changes before you are eligible for new lenses and those prescriptions meet at least one of the following criteria, lenses & frames will be replaced at a 12 month frequency; a) a new prescription differs from the original by at least a .50 diopter sphere or cylinder; b) an axis change of 15 degrees for more; c) a. 5 prism			
Visually Necessary contact lenses	Once every 24 months	$15 co-pay, then plan pays 100%	Plan pays up to $210
Elective contact lenses	Once every 24 months	Plan pays up to $130	Plan pays up to $105

*Frequency is based on your last date of service with any VSP plan. VSP will not cover eye exams more than once in a 12-month period, or contact

lenses and eyeglasses/frames in the same 24-month period.

VISION PLAN WEEKLY PREMIUMS

Coverage Level	2018 Weekly Premium
Employee Only	$2.06
Employee plus Child*	$3.24
Employee plus Spouse*	$3.30
Family*	$5.33

*Please see the Eligibility section of this guide for the definition of an eligible dependent.

SHORT TERM DISABILITY – The Hartford

The company offers a Short-Term Disability (STD) plan through The Hartford that protects you against loss of income if you cannot work due to a sickness or injury that is not work related.

- If you become totally disabled, your benefit will be 60% of your pre-disability weekly pay up to a maximum benefit of $600 a week.
- Benefits begin on the 8th day of total disability, and will be paid for up to 13 weeks.
- If you enroll during your initial eligibility period, you will not be subject to approval by The Hartford. Late enrollees are subject to approval by The Hartford and medical questions will be required to be answered.
- Deductions are taken on a post-tax basis, so any benefit paid is tax free.
- Coverage ends on your last day of employment.
- If you become disabled in the first 12 months after you enroll for STD coverage, benefits will not be paid for a disability caused by any medical condition for which you have been treated or diagnosed within the six months before joining the STD plan, including pregnancy.

The cost of coverage is based on your age and weekly benefit amount, as shown in the following chart. When completing your new hire enrollment on www.PopulusBenefits.com, you will be able to automatically calculate your weekly STD premium.

Your Age	STD Weekly Premium Multiplier*
Under Under 25	$0.182
25-29	$0.155
30-34	$0.155
35-39	$0.136
40-44	$0.143
45-49	$0.162
50-54	$0.203
55 and over	$0.242

*The costs shown above are per $10 of weekly benefit.

Example – An individual age 36 with $480 in weekly pay, the weekly benefit is $288 and the weekly cost to the employee is $3.92. The weekly benefit of $288is based on 60% of the $480 weekly pay. Weekly premiums are calculated for every $10 of weekly benefit amount (i.e. $288/$10 = 28.80). Using the age of the employee and the chart above the premium multiplier is determined. In this example the employee is 36 years old therefore the multiplier is $.136. When the $.136 is multiplied by 28.80 the employee arrives at their weekly premium of $3.92

FAMILY AND MEDICAL LEAVE (FMLA)

The company provides Family and Medical Leaves of Absence without pay to eligible employees. Qualified individuals must have worked for the Company for at least 12 months in the last seven (7) years, and must also have worked at least 1,250 hours during the 12 months immediately preceding the request. Qualified individuals may be eligible to take up to 12 weeks of unpaid Family and Medical Leave within a rolling 12 month period for the following reasons:

- To care for the employee's child during the first 12 months following birth, adoption or foster care.
- To care for the employee's spouse, child or parent with a serious health condition.
- For incapacity due to the employee's pregnancy or child birth.
- For the employee's own serious health condition.

Furthermore, qualified individuals may be eligible to take up to 26 weeks of unpaid Family and Medical Leave within a rolling 12 - month period for the following reasons:

- To care for the employee's spouse, child, parent or next of kin who is a service member recovering from serious illness or injury sustained in the line of active duty.
- Due to a qualifying exigency arising because the employee's spouse, child or parent is on active duty or has been notified of an impending call to order to active duty in support of a contingency operation.

In addition to FMLA leave, employees may also be eligible for leave under a similar state law. For information about the availability of state leave, please contact the Benefits Department.

LONG TERM DISABILITY - MetLife

The company offers a Long-Term Disability (LTD) plan through MetLife that pays benefits if total disability lasts more than 90 days.

- The monthly LTD benefit is 60% of your pre-disability monthly base pay, reduced by Social Security and other disability income benefits.
- The maximum monthly LTD benefit is $5,000.
- The minimum monthly benefit is the greater of $100 or 10% of your monthly benefit before reductions for Social Security and other income benefits.
- Deductions are taken on a post-tax basis.
- Coverage ends on your last day of employment.
- When you enroll, you can choose a five year benefit period or a benefit period to age 65.
- LTD benefits are not paid for more than 24 months for mental or nervous disabilities.
- A work incentive benefit lets you return to work during partial disability.
- If you die while on LTD, three months of benefits will be paid to your survivor.
- If you enroll during your initial eligibility period, you will not be subject to approval by MetLife. Late enrollees are subject to approval by MetLife and medical questions will be required to be answered.
- Conditions existing within three months of your effective date of coverage are considered pre-existing and are not covered until you are continuously insured for 12 months.

The cost of coverage is based on your age, monthly earnings, and benefit period you choose, as shown in the following chart. When completing your new hire enrollment on www.PopulusBenefits.com, you will be able to automatically calculate your weekly LTD premium.

Your Age	LTD Weekly Premium Multiplier*	
	Five-year	To age 65
Under 25	$0.032	$0.048
25-29	$0.038	$0.059
30-34	$0.053	$0.085
35-39	$0.071	$0.124
40-44	$0.095	$0.165
45-49	$0.151	$0.267
50-54	$0.248	$0.373
55+	$0.424	$0.475

The costs shown above are per $100 of monthly earnings.

Example – for an individual age 36 with $3,000 in monthly earnings who chooses benefits to age 65, the weekly cost is $3.93 [$.131 (weekly rate for age times 30 (monthly earnings divided by 100)].

(Please note, the maximum insurable monthly earnings amount is $8,333.33 ($100,000 annually)

LIFE INSURANCE

The Populus Group Voluntary Term Life Insurance plans let you choose coverage for yourself, your spouse, and dependent children under age 19 (26 if full-time student). You may elect coverage for your spouse without buying coverage for yourself. However, in order to buy coverage your child(ren), either you or your spouse must elect coverage. Coverage is portable – you may purchase an individual policy if your Populus Group employment ends.

Employee Life Insurance – You may buy up to $150,000 in term life insurance coverage. Evidence of Insurability is not required if you enroll within your original eligibility period. If you enroll outside of your original eligibility period, you must provide Evidence of Insurability. Coverage is available in increments of $10,000. When you enroll, you must name a beneficiary. The Amount of Insurance in effect is subject to automatic reduction beginning at age 75.

Life Insurance for your Spouse – You may buy up to $30,000 in term life insurance for your spouse. Evidence of Insurability is not required if you enroll your spouse within your original eligibility period. If you enroll outside of your original eligibility period, you must provide Evidence of Insurability. Coverage is available in increments of $10,000. You are the beneficiary for spouse's coverage. On the date of application, your spouse must be under age 70. Insurance on a spouse terminates at age 75.

Life Insurance for Dependent Children – You may elect $2,500, $5,000, $7,500, or $10,000 for dependent children up to age 19 (26 if full-time student). This benefit covers all of your eligible children. Coverage for children 14 days of age but less than 6 months is $1,000. Coverage for children age 6 months but less than 26 years is the elected amount. You are the beneficiary.

The cost of employee and spouse's term life insurance is based on age and the amount of coverage you select. The rates are the same for the employee and spouse's coverage. Weekly Premium Multiplier's are shown on the following chart. When completing your new hire enrollment on www.PopulusBenefits.com, you will be able to automatically calculate your weekly Life Insurance premiums.

Age	Employee/Spouse Life Insurance Weekly Premium Multiplier*
Under 30	$0.141
30-34	$0.171
35-39	$0.247
40-44	$0.351
45-49	$0.653
50-54	$1.057
55-59	$1.638
60-64	$2.993
65-69	$4.403

*The costs shown above are per $10,000 of life insurance coverage. Example – for an individual age 46 with $50,000 in life insurance, the weekly cost is $3.27 [$.653 (weekly rate for age 46) times 5].

The cost of life insurance for dependent children is based on the coverage level you choose, regardless of how many eligible children you have. Weekly Premium Multiplier's are shown on the following chart.

When completing your new hire benefits on www.PopulusBenefits.com, you will be able to automatically calculate your weekly life insurance premium.

Amount of Insurance	Age	Dependent Child(ren) Life Insurance Weekly Premium Multiplier
$2,500*	6 months but less than 26 years	$0.01
$5,000*	6 months but less than 26 years	$0.02
$7,500*	6 months but less than 26 years	$0.02
$10,000*	6 months but less than 26 years	$0.03

*Please note, Life Insurance is not a COBRA eligible plan. However, if your employment ends you may elect to continue Life Insurance for yourself and your dependents under the Portability and Conversion terms of the plan. You have 30 days to send your completed application to the Populus Group benefits department. Please refer to the plan certificate, which can be located on www.PopulusBenefits.com for more details.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE – RELIANCE STANDARD LIFE

Accidental Death and Dismemberment (AD&D) insurance covers you if you die or suffer serious injury as a result of an accident.

- You may buy AD&D coverage of up to $500,000 in $10,000 increments.
- Benefits are paid to your beneficiary if you die, or to you if you suffer certain injuries as a result of an accident.

- AD&D benefits are paid in addition to your life insurance coverage if you die as a result of an accident.
- Proof of good health is not required.
- You may choose employee-only coverage or family coverage (family includes coverage for yourself).
- If you choose family coverage, your spouse's benefit is 60% of yours and dependent children's benefit is 15% of yours. You are the beneficiary for your dependents' AD&D coverage.

The cost of AD&D coverage depends on the coverage level you choose, as shown on the following chart. When completing your new hire enrollment on www.PopulusBenefits.com, you will be able to automatically calculate your weekly AD&D premiums.

Coverage Level	Employee/Family AD&D Weekly Premium Multiplier
Employee Only	$0.090
Family	$0.210

*The costs shown above are per $10,000 of coverage. Example: For an individual who chooses family AD&D coverage of $50,000, the weekly cost is $1.05 [$.210 (weekly rate for family coverage) times 5].

Please note: AD&D Insurance is not a COBRA eligible plan. However, if your employment ends you may elect to continue AD&D Insurance for yourself and your dependents under the Portability and Conversion terms of the plan. Please refer to the plan certificate, which can be located on www.PopulusBenefits.com for more details.

FILING CLAIMS

Below are instructions on how to file a claim with each of the benefit carriers. All claim forms (where applicable) can be found on www.PopulusBenefits.com.

FOR BLUECROSS BLUESHIELD BASIC AND BRONZE MEDICAL PLAN CLAIMS:

In-Network—provider should submit claims to BlueCross BlueShield

Out-of-Network— the employee will pay the claim out-of-pocket and submit the claim to the address located on the BlueCross BlueShield Medical Claim Form

FOR PRESCRIPTION REIMBURSMENT CLAIMS:

Submit the CVS/Caremark claim form, along with your register receipt and the appropriate drug receipt with name of pharmacy, name of the drug etc. to the address located on the claim form.

FOR FIXED INDEMNITY MEDICAL CLAIMS:

In Network Providers

Present your Select Benefits ID card at the time of service and ask your provider to file the claim with Select Benefits Administrators (SBA) and accept an assignment of benefits. Your provider may or may not agree to accept the assignment. SBA will process the claim and send payment to your provider. Both you and your provider will receive an Explanation of Benefits (EOB) showing what was paid.

Out of Network Providers

Ask the provider to file the claim with Select Benefits Administrators (SBA). If the provider is unwilling to submit the claim, you will need to file the claim with SBA, and they will pay benefits based upon the amount covered by your Select Benefits plan. For faster response, please request a copy of the itemized bill from the provider listing dates of service and procedure and diagnosis codes.

Ask for Health Care Financing Administration (HCFA) forms for doctor's office visits and Universal Billing (UB92) forms for hospital care.

All claims must be submitted within 90 days from the date of service. Mail or fax claim forms to:

Attention: Claims Department PO Box 440
Select Benefit Administrators Ashland, WI 54806
Fax: (715) 68-5919

A few weeks later you will be mailed an Explanation of Benefits showing what was paid.

FOR HOSPITAL BRIDGE INSURANCE PLAN, CRITICAL ILLNESS INSURANCE, ACCIDENT INSURANCE, HOSPITAL INDEMNITY PLAN OR MAJOR EXPENSE PROTECTION PLAN (MEPP) CLAIMS:

Simply mail a copy of your itemized receipt for services (given to you by your provider) to the address below:

CLAIMS: Select Benefit Administrators of America
Box 440
Ashland, WI 54806

- Make sure the following information is shown on your service receipt:
- Insured's ID (Social Security Number)
- Patient Name
- Provider name, address and ID
- Diagnosis or ICD-9 code(s) [description of your medical condition]
- Procedure or CPT or revenue codes [that indicate services rendered]
- Associated charges
- Date of service.

If any of this information is missing, simply write it in.

FOR DENTAL CLAIMS:

In Network-the dentist should submit the claim to MetLife.
Out-of Network-the employee should submit the Dental Claim form to: MetLife (National)
P.O. Box 981282 El Paso, TX 79998

FOR VISION CLAIMS:

In Network-the employee pays appropriate co-pay, the physician submits the claim to Vision Service Plan.

Out-of-Network-the employee should pay the provider the full amount of the bill and request an itemized copy of the bill that shows the amount of the eye examination, lens type, and frame (if applicable). The employee should send a copy of the itemized bill to:

All claims must be submitted within 6 months from the date of service.

Vision Service Plan
Attn: Non-Member Doctor Claims
Box 997105
Sacramento, CA 95899-7100

The following information must be included:

- Member's name and mailing address
- Member's social security number
- Member's employer (Populus Group)
- Patient's name, relationship to member, and date of birth
- Submit the above information on any generic insurance claim form that may be available upon request from your Non-Participating provider. We do not have the claim forms available at Corporate.

FOR LIFE INSURANCE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) CLAIMS:

The appropriate Reliance Standard Life Insurance Company Claim Form should be completed in full. The form, along the required documentation (listed on the form) should be mailed to:

Populus Group
Benefits
Department
3001 W. Big Beaver Road, Suite
400 Troy, MI 48084

FOR SHORT TERM DISABILITY (STD) CLAIMS:

You may file a claim by calling The Hartford's toll-free number 1-866-945-7781 8:00 a.m. - 8:00 p.m. EST, or you file a claim online at www.TheHartfordAtWork.com. You will be asked to provide:

- Your name and social security number
- Department and last day of active full-time work
- Manager's name & phone number
- Nature of claim and whether it's work-related
- Treating physician's name, address & phone number

FAMILY AND MEDICAL LEAVE (FMLA)

Complete the following forms:

- Family and Medical Leave of Absence Form
- Certification of Health Provider Form

You must contact your local office to make a request for leave. Both forms must be completed in full and sent together to: Populus Group Benefits Department, Attn: Leah Koskinen, 3001 W. Big Beaver Rd., Suite 400, Troy, MI 48084.

FOR LONG TERM DISABILITY (LTD) CLAIMS:

- The physician must complete the Long Term Disability Claim Form-Attending Physician, in full
- The employee must complete the Long Term Disability Claim Form-Employee Statement, in full
- The employer must complete the Long Term Disability Claim Form-Employer Statement, in full

All three fully completed forms must be sent together to:

MetLife
Box 14590
Lexington, KY 40511-4590

CHANGING YOUR BENEFITS DURING THE PLAN YEAR

Once you enroll for pre-tax Medical, Dental, and Vision, Hospital Indemnity, Major Expense Protection, Critical Illness and Accident Insurance coverage you generally cannot change elections during the plan year unless you have a qualifying life status change as defined by the IRS.

QUALIFYING LIFE STATUS CHANGES AND EFFECTIVE DATES

Marriage[1]	Add yourself, spouse, child(ren) and/or stepchild(ren) to existing coverage	First of the month following event
Birth or adoption of a child(ren)	Add yourself, spouse, and child(ren)	Date of the event
Divorce/Legal Separation (only in states that recognize legal separation)	Cancel coverage for your spouse and stepchildren if enrolled in your employer's plan/Add coverage for yourself and your children if enrolled in your spouse's plan	First of the month following the event
Spouse or child(ren) loses other coverage[2]	Add yourself, spouse or child(ren)	First of the month coinciding with or following the event
You, spouse, or child(ren) gains other group coverage	Cancel coverage for yourself, spouse, and/or child(ren) who gain coverage	End of the week in which coverage is gained
Change in dependent's eligibility for benefits, such as age	Cancel coverage for your dependent	End of the month following the event

[1]Cancelling an individual health plan is not ordinarily considered a qualifying change and does not allow you to add coverage with Populus Group.

[2]Purchasing an individual health plan is not considered a qualifying change and does not allow you to cancel your coverage with Populus Group

This is a brief overview of potential qualifying events. Eligible qualifying events are dictated by Internal Revenue Code Section 125.

You have 30 days from the date of the status change to change your benefits. If you or your dependent becomes eligible for a state premium subsidy for Medicaid or through a state children's health insurance program with respect to coverage under this plan, you have 60 days from the date of such eligibility determination to enroll in the plan. If you or your dependent decline to participate in the plan because you have Medicaid coverage or coverage under a state children's health insurance program and you later lose that coverage you have 60 days from the date of such loss of coverage to enroll in the plan.

You may make your change on PopulusBenefits.com or submit a change form. In either case, you need to submit hard copy proof of the change, such as a birth or marriage certificate. You can only make changes consistent with the status change. For instance: If you add a child, you may add dependent life insurance and change your medical plan coverage level (i.e. employee plus one or family), but you may not change or cancel your medical plan.

Please note, if you choose pre-tax contributions you may not change or cancel your benefits unless you incur a qualifying status change. If you choose post-tax contributions you may completely cancel all of the benefit plans you are enrolled in at any time during the year without restriction, however, you may not just cancel one benefit plan and keep the others (i.e., cancel medical, keep dental and vision) or change medical plans. In addition, you cannot change your benefits (i.e., adding/removing dependents) unless you incur a qualifying status change.

WHEN COVERAGE ENDS

Your coverage under the following plans will end at midnight on the Saturday following your last day of employment: BlueCross BlueShield Basic Medical Plan, Symetra Fixed Indemnity Medical Insurance Plans, Hospital Bridge Insurance Plan, Critical Illness Insurance, Accident Insurance, Hospital Indemnity Plan, Major Expense Protection Plan, and Dental.

Example: If you work your final day on Friday, June 15, 2018, then your coverage under any of the plans listed above will end at midnight on Saturday, June 16, 2018. Disability, Life and AD&D coverage end on your last day of work.

Your coverage under the following plans will end the last day of the month in which employment ends: BlueCross BlueShield Bronze Medical Plan and the Vision Plan.

Your benefit coverage also ends when you are no longer eligible, when you stop paying premiums, or when the group plan ends, whichever comes first. Coverage for dependents ends when they are no longer eligible, when dependent coverage is no longer offered, or when your coverage ends. Please see the Eligibility section of this guide for the definition of an eligible dependent.

CONTINUATION OF COVERAGE ELIGIBLE BENEFITS

While not COBRA eligible, the Fixed Indemnity Medical Plans, Major Expense Protection Plan, and Hospital Indemnity Plan can be continued for up to 18 months after termination. You will receive Continuation of Coverage paperwork from Select Benefits Administrators (SBA).

Monthly 2018 Continuation of Coverage Premiums – Fixed Indemnity Medical Plans			
Coverage Level	Essential Plan	Enhanced Plan	Advantage Plan
Employee Only	$119.68	$160.36	$296.42
Employee plus Child*	$297.00	$401.81	$750.34
Employee plus Spouse*	$297.00	$401.81	$750.34
Family*	$426.56	$576.08	$ 1,077.06

Monthly 2018 Continuation of Coverage Premiums – Major Expense Protection Plan	
Coverage Level	Monthly Premium
Employee Only	$100.93
Employee plus Child*	$209.86
Employee plus Spouse*	$209.86
Family*	$240.30

Monthly 2018 Continuation of Coverage Premiums – Hospital Indemnity	
Coverage Level	Monthly Premium
Employee Only	$27.39
Employee plus Child*	$53.87

Employee plus Spouse*	$53.87
Family*	$77.67

Please note, the Hospital Bridge Insurance Plan, Critical Illness Insurance, Accident Insurance are not COBRA eligible plans. They are portable, meaning you can elect to continue these plans after your coverage ends with Populus Group. Please contact Symetra directly for instructions.

Please also note, Life Insurance, AD&D Insurance and Disability Insurance are not COBRA or Continuation eligible plans. However, you may elect to continue Life Insurance & AD&D Insurance for yourself and your dependents under the Portability and Conversion terms of the plan, directly through the carrier. You have 30 days to send your completed application to the Populus Group Benefits Department. Please refer to the plan certificate, which can be located on www.PopulusBenefits.com for more details.

COBRA ELIGIBLE BENEFITS

COBRA (Consolidated Omnibus Budget Reconciliation Act) provides for continuation of health care coverage for employees and covered dependents that lose their group coverage for a variety of reasons. It requires employers to offer the same dental and vision coverage as is offered to active employees and their families. You and your eligible dependents covered at the time your Company medical coverage ends may elect to continue coverage, but you must pay the full (employee plus company) premium plus an additional administrative fee.

WHEN YOU CAN ELECT COBRA COVERAGE

You can continue dental and vision coverage for yourself and your covered dependents for up to 18 months, if your group coverage ends because:

You separate from service with the Company (for reasons other than gross misconduct on your part).

Your hours are reduced so that you are no longer eligible for the Company Plan.

If you – or a dependent – are determined to be disabled (for Social Security benefit purposes) when the group coverage ends or within the first 60 days of COBRA coverage, coverage for that person may continue for up to a total of 29 months.

Your spouse and covered children can elect to continue coverage for up to 36 months if their coverage ends due to:

Your death

Divorce or legal separation

If a termination or reduction of hours occurs less than 18 months after the employee's Medicare entitlement (36 months of COBRA coverage is allowed from the date of the Medicare entitlement).

APPLYING FOR COBRA COVERAGE

When your coverage under the Company Plan ends, you or your dependents have 60 days to elect continued coverage. If you lose coverage due to separation from service or a reduction in work hours, the Company will automatically notify you of your COBRA rights. In the case of a divorce, legal separation, or when a child no longer qualifies for dependent coverage, you, your spouse, or dependent child must notify the Company within 60 days of the event. You then will be provided with information on your COBRA rights.

The Company has the right to end your COBRA continued coverage if:

The Company stops providing medical coverage for all employees

You do not pay your premium on time

You become covered by another group health plan

You become covered by Medicare

You extended COBRA coverage to 29 months due to disability, but are no longer considered disabled

COBRA information will be mailed to you when your COBRA eligible coverage ends.. You may want to verify that your address is correct in the Benefits System to prevent any delays in receiving your information.

Monthly 2018 COBRA Premiums				
Coverage Level	Basic Medical Plan	Bronze Medical Plan	Dental	Vision
Employee	$146.57	$91.76	$35.71	$9.12
Employee plus Child*	$236.98	$169.76	$71.78	$14.32
Employee plus Spouse*	$268.39	$211.05	$81.76	$14.61
Family*	$371.18	$278.95	$92.40	$23.56

*Please see the Eligibility section of this guide for the definition of an eligible dependent.

Please note, Life Insurance, AD&D Insurance and Disability Insurance are not COBRA or Continuation eligible plans. However, you may elect to continue Life Insurance & AD&D Insurance for yourself and your dependents under the Portability and Conversion terms of the plan, directly through the carrier. You have 30 days to send your completed application to the Populus Group Benefits Department. Please refer to the plan certificate, which can be located on www.PopulusBenefits.com for more details.

KEY CONTACTS, TELEPHONE NUMBERS, & WEBSITES

For Enrollment, Eligibility or Administrative Questions, contact the Benefits Service Center	1-888-858-6310 www.PopulusBenefits.com pgbenefits@populusgroup.com
For Symetra Fixed Indemnity Medical Insurance Plans Claim Questions, or questions about how Medical/Prescriptions Benefits work, contact: Symetra Life Insurance Company	1-800-497-3699
For CareFirst BlueCross BlueShield Basic Medical Plan Claim Questions, or questions about how Medical/Prescriptions Benefits work, contact: CareFirst BlueCross BlueShield	1-866-945-9839 www.cfablue.com
For CareFirst BlueCross BlueShield Bronze Medical Plan Claim Questions, or questions about how Medical/Prescriptions Benefits work, contact: CareFirst BlueCross BlueShield	1-888-567-9155 www.carefirst.com
For Critical Illness Insurance Claim Questions, or Questions About How Hospital Indemnity Benefits Work, contact: Symetra Life Insurance Company	1-800-497-3699
For Accident Insurance Claim Questions, or Questions About How Hospital Indemnity Benefits Work, contact: Symetra Life Insurance Company	1-800-497-3699
For Hospital Indemnity Claim Questions, or Questions About How Hospital Indemnity Benefits Work, contact: Symetra Life Insurance Company	1-800-497-3699
For Major Expense Protection Plan (MEPP) Benefits or Claims Questions, contact: Symetra Life Insurance Company	1-800-497-3699
For Health Advocate	1-866-799-2728 answer@HealthAdvocate.com www.HealthAdvocate.com/members
For Dental Benefits, Claim Questions, or Participating Dentists, contact: MetLife	1-800-942-0854 www.metlife.com/dental
For Vision Benefits, Claim Questions, or Participating Eye Care Providers, contact: VSP	1-800-877-7195 www.vsp.com

For Short Term Disability, contact: The Hartford	1-866-945-7781
For Long Term Disability, contact: MetLife	1-800-300-4296
For Life and Accidental Death & Dismemberment (AD&D) Insurance, contact: Reliance Standard Life Insurance	1-800-351-7500

MEDICARE PART D

PLEASE NOTE: This Notice only applies to you if you are eligible for Medicare. If your covered spouse or dependent is covered by Medicare please share this notice with them.

Important Notice from Populus Group 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 Populus Group and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Populus Group has determined that the prescription drug coverage offered with the Symetra Life Insurance Company fixed indemnity medical insurance plans is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non- Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the Populus Group plan. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.
3. You can keep your current coverage from the Populus Group plan. However, because your coverage is non- creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully—it explains your options.

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

Since the coverage under the Populus Group is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?

If you decide to join a Medicare drug plan, your current Symetra Life Insurance Company fixed indemnity medical insurance plans coverage will not be affected. You can keep this coverage if you elect part D. While the Symetra Life Insurance Company fixed indemnity medical insurance plans do not coordinate benefits, Medicare may reach out to Symetra Life Insurance Company (SBA) when there is the potential of duplicate payment. If you do decide to join a Medicare drug plan and drop your current Symetra Life Insurance Company coverage, be aware that you and your dependents will not be able to get this coverage back until the plan's next open enrollment period unless you experience a Qualifying Life Event (QLE).

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE

Contact the person listed below for further information. 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 Populus Group 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:

1. Visit www.medicare.gov
2. 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
3. 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:

1. Visit Social Security on the web at www.socialsecurity.gov
2. Call them at 1-800-772-1213 (TTY 1-800-325-0778).

Date: October 2016

Name of Entity/Sender: Populus Group Inc. Position/Office: Corporate Benefits Department

Address: 850 Stephenson Hwy, Suite 500, Troy, MI 48083

Phone Number: 1-866-886-9798

The Health Insurance Marketplace Coverage Options & Your Health Coverage

PART A: GENERAL INFORMATION

Key parts of the health care law took effect in 2014, creating 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 and employment based health coverage

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. For coverage starting in 2017, the Open Enrollment period is November 1, 2016–January 31, 2017.

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 your 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% 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.1

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

HOW CAN I GET MORE INFORMATION?

For more information about your coverage offered by your employer, please check your summary plan description or contact the Allegis Benefits Service Center at 1-866-886-9798 or send an e-mail to AskBenefits@allegisgroup.com.

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, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] 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.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. T is information is numbered to correspond to the Marketplace application.

3. Employer Name Populus Group LLC	4. Employer Identification Number (EIN) 38-3659021
5. Employer Address 3001 West Big Beaver Road, Ste 400	6. Employer Phone Number 866-886-9798

7. City	8. State	9. Zip
Troy	MI	48084

10. Who can we contact about employee health coverage at this job?
The Populus Benefits Service Center

11. Phone Number (if different from above)	12. Email Address
	pgbenefits@populusgroup.com

Here is some basic information about health coverage offered by this employer:

As your employer, we offer a health plan to:

./ All Employees

./ Some employees. Eligible employees are set out in our benefits guide

With respect to dependents:

./ We do offer coverage. Eligible dependents are set out in our benefits guide

./ If checked, this coverage meets the minimum value standard and the cost of this coverage to you is intended to be affordable based on employee wages.

**Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income along with other factors to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid- year, or if you have other income losses, you may still qualify for a premium discount.