A guide to your

2019 Employee Benefits

benefit guide for contract employees

January 1, 2019 – December 31, 2019
Enroll Online at www.Populusbenefits.com
people. service. performance.

At Populus Group, we believe everyone should have the opportunity to succeed. We understand that having the benefits you need is a part of that. 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 2019 Benefits-at-a-Glance
- Who is eligible and how to enroll
- Summaries of each benefit plan

table of contents

Benefits At-a-Glance / 4
Eligibility / 6
Disabled Dependents / 6
When Benefits Begin / 7
How to Enroll / 8
Beneficiaries / 10
Paying for your Benefits / 11
BlueCross BlueShield Basic Medical Plan / 12
BlueCross BlueShield Bronze Medical Plan / 13
BlueCross BlueShield HSA Eligible High Deductible Medical Plan / 13
Health Savings Account / 15
Symetra Medical and Prescription Medical Plan / 17
Symetra Hospital Bridge Insurance Plan / 20
Symetra Critical Illness Insurance / 22
Symetra Accident Insurance / 23
Symetra Hospital Indemnity Plan / 24
Symetra Major Expense Protection Plan / 25
Health Advocate Advocacy Services / 26
Health Advocate Employee Assistance Program (EAP) and Work/Life Benefit / 27
MetLife Dental Plan / 28
Vision Service Plan / 29
The Hartford Short Term Disability / 30
Family and Medical Leave / 31
The Hartford Long Term Disability / 32
Life Insurance / 33
Accidental Death and Dismemberment Insurance / 34
Filing Claims / 35
Changing Benefits / 37
When Coverage Ends / 38
Contact Information / 42
Important Medical Plan Notices / 43
at-a-glance: your populus group benefits

<table>
<thead>
<tr>
<th>Insurance Company</th>
<th>Basic Medical Plan</th>
<th>Health Savings Account</th>
<th>Advanced Medical Plan</th>
<th>Critical Illness Insurance</th>
<th>Hospital Indemnity</th>
</tr>
</thead>
<tbody>
<tr>
<td>BlueCross BlueShield</td>
<td>Features the national BlueCross BlueShield network</td>
<td>Annual family deductible of $10,000</td>
<td>Annual family deductible of $4,000</td>
<td>Pays a fixed dollar amount for certain medical expenses</td>
<td>Provides direct payment to the insured for medical expenses for the option you purchased, regardless of the actual cost of service</td>
</tr>
<tr>
<td>BlueCross BlueShield</td>
<td>Annual individual deductible of $5,000</td>
<td>Includes prescription drug coverage through Caremack</td>
<td>Includes prescription drug coverage through Caremack</td>
<td>Access to the Multiplan network of providers</td>
<td>Deductible $50 per person</td>
</tr>
<tr>
<td>BlueCross BlueShield</td>
<td>Features the national BlueCross BlueShield network</td>
<td>Includes prescription drug coverage through Caremack</td>
<td>Allows you to set aside pre-tax dollars to pay for current or future medical expenses</td>
<td>Choice of three fixed indemnity medical insurance plans (Essential Plan, Enhanced Plan, Advanced Plan)</td>
<td>Employees can only apply for a coverage of $3,500 per accident, regardless of the actual cost of service.</td>
</tr>
<tr>
<td>Health Savings Account</td>
<td>Plan pays 100% with no deductible for most medical expenses</td>
<td>Benefits are paid at a fixed amount regardless of the actual cost of service</td>
<td>Benefits are paid at a fixed amount regardless of the actual cost of service</td>
<td>Coverage is paid at a fixed amount regardless of the actual cost of service</td>
<td>Benefits may be paid at a fixed amount regardless of the actual cost of service.</td>
</tr>
<tr>
<td>Symetra Life Insurance Company</td>
<td>Annual family deductible of $4,000</td>
<td>Benefits are paid at a fixed amount regardless of the actual cost of service</td>
<td>Benefits are paid at a fixed amount regardless of the actual cost of service</td>
<td>Benefits are paid at a fixed amount regardless of the actual cost of service</td>
<td>Benefits are paid at a fixed amount regardless of the actual cost of service.</td>
</tr>
<tr>
<td>Hospital Bridge Insurance Plan</td>
<td>Includes prescription drug coverage through Caremack</td>
<td>Benefits are paid at a fixed amount regardless of the actual cost of service</td>
<td>Benefits are paid at a fixed amount regardless of the actual cost of service</td>
<td>Access to the Multiplan network of providers</td>
<td>Benefits are paid at a fixed amount regardless of the actual cost of service.</td>
</tr>
<tr>
<td>Symetra Life Insurance Company</td>
<td>Features the national BlueCross BlueShield network</td>
<td>Allows you to set aside pre-tax dollars to pay for current or future medical expenses</td>
<td>Features the national BlueCross BlueShield network</td>
<td>Provides direct payment to the insured for medical expenses for the option you purchased, regardless of the actual cost of service</td>
<td>Benefits are paid at a fixed amount regardless of the actual cost of service.</td>
</tr>
<tr>
<td>Critical Illness Insurance</td>
<td>Annual family deductible of $4,000</td>
<td>Benefits are paid at a fixed amount regardless of the actual cost of service</td>
<td>Annual family deductible of $4,000</td>
<td>Access to the Multiplan network of providers</td>
<td>Benefits are paid at a fixed amount regardless of the actual cost of service.</td>
</tr>
<tr>
<td>Symetra Life Insurance Company</td>
<td>Features the national BlueCross BlueShield network</td>
<td>Benefits are paid at a fixed amount regardless of the actual cost of service</td>
<td>Access to the Multiplan network of providers</td>
<td>Benefits are paid at a fixed amount regardless of the actual cost of service</td>
<td>Benefits are paid at a fixed amount regardless of the actual cost of service.</td>
</tr>
<tr>
<td>Accident Insurance</td>
<td>Features the national BlueCross BlueShield network</td>
<td>Allows you to set aside pre-tax dollars to pay for current or future medical expenses</td>
<td>Features the national BlueCross BlueShield network</td>
<td>Provides direct payment to the insured for medical expenses for the option you purchased, regardless of the actual cost of service</td>
<td>Benefits are paid at a fixed amount regardless of the actual cost of service.</td>
</tr>
</tbody>
</table>

1. You may make or change these benefits during the annual open enrollment period or anytime during the year with a qualifying status change.
2. You may make or change these benefits anytime during the year with medical underwriting requirements.
3. You may make or change these benefits during the annual Open Enrollment period or anytime during the year with a qualifying status change.
4. You may make or change these benefits during the annual open enrollment period or anytime during the year with a qualifying status change.
5. You may make or change these benefits during the annual open enrollment period or anytime during the year with a qualifying status change.
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:

**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.

**Child**
1. Is under the age of 26 or is permanently and totally disabled (and meets the eligibility requirements described below); and
2. Is related to you in one of the following ways:
   - You or your spouse’s or same-sex domestic partner’s child by birth or legal adoption;
   - 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;
   - 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;
   - 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.

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.

<table>
<thead>
<tr>
<th>example 1</th>
<th>example 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Hire</td>
<td>2/5/19</td>
</tr>
<tr>
<td>Date Coverage Begins</td>
<td>3/1/19</td>
</tr>
<tr>
<td>Enroll By Date</td>
<td>12 Midnight EST, 3/31/19</td>
</tr>
</tbody>
</table>

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

www.PopulusBenefits.com is an online benefits service that puts benefits information and enrollment at your fingertips, 24 hours a day, seven days a week. www.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.
▶ www.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 www.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 www.PopulusBenefits.com

First Time Users
1. Send an Email to pgbenefits@populusgroup.com to obtain access to www.PopulusBenefits.com.
2. Go to www.PopulusBenefits.com. (We strongly recommend the most recent version of Internet Explorer or Firefox).
3. Click on Register located on the right-hand side of your screen.
4. 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.
5. Follow the directions provided on the site to complete your registration and setup your online account.

Returning Users
1. Go to www.PopulusBenefits.com. (We strongly recommend the most recent version of Internet Explorer or Firefox).
2. 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 Login Help.

the enrollment process

Once you log in, just follow these steps:

1. Review your personal information,
   ▶ 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)
   ▶ Employment information (if this information is incorrect, please contact your local office)
   ▶ 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 2019 options.
2. Review your current benefits and details of your 2019 options.
3. Elect your 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.
   ▶ Medical
   ▶ Health Savings Account (only if you are enrolled in the HSA Eligible High Deductible medical plan)
   ▶ Hospital Bridge Insurance Plan
   ▶ Critical Illness Insurance
   ▶ Accident Insurance
   ▶ Hospital Indemnity Plan
   ▶ Major Expense Protection Plan (MEPP)
   ▶ Dental
   ▶ Vision
   ▶ Life Insurance (If you enroll outside of your eligibility period or increase your existing coverage you will be subject to approval by Reliance).
   ▶ AD&D
   ▶ Short Term Disability (STD)
   ▶ 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.

How To Designate Or Update Your Beneficiaries

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 and AD&D

Log on to www.PopulusBenefits.com. Click My Benefits & Personal Information at the top of the page. Under the Benefits section on the left side of the page, click Beneficiaries.

Health Savings Account (HSA)

Log on to www.PopulusBenefits.com. Click Manage Profile at the bottom of the page. Click Beneficiary Designation to complete your beneficiary information.

Benefit Identification (ID) Cards

Your medical and hospital bridge insurance plan ID cards will arrive at your home approximately three 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, major expense protection plan, 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 www.PopulusBenefits.com and select My Benefits & Personal Information 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 plan, 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.
BlueCross BlueShield Basic Medical Plan ("Basic Plan")

<table>
<thead>
<tr>
<th>Benefit</th>
<th>In-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Period Maximum</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Lifetime Maximum</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Benefit Period Deductible*</td>
<td>$0.00</td>
</tr>
<tr>
<td>Benefit Period Out-of-Pocket Maximum</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

Office Visits
- PPO Visit: Covered at 100%
- Standard Visit: Covered at 100%
- Well-Child Care & Immunizations (through age 17): Covered at 100%
- Annual Physicals: Covered at 100%
- Routine SVX Exam: Covered at 100%
- Mammography: Covered at 100%

Hospitalization
- Inpatient & Outpatient: Not covered
- Labs, and Testing: Not covered
- X-Ray & Diagnostic Imaging: Not covered
- Outpatient Lab Work: Covered at 100%

Mental Health & Substance Abuse
- Inpatient & Outpatient: Not covered
- Prescription Drugs: Covered at 100%
- Deductible: $0.00
- Generic Drugs: $0.00 copay
- Preferred Brand Drugs: $0.00 copay
- Non-Preferred Brand and Specialty Drugs: Not Covered

BlueCross BlueShield Medical Plans – 2019 Weekly Premiums

<table>
<thead>
<tr>
<th>Coverage Level</th>
<th>Basic Plan</th>
<th>Bronze Plan</th>
<th>HSA Eligible Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$46.68</td>
<td>$99.43</td>
<td>$99.04</td>
</tr>
<tr>
<td>Employee &amp; Child*</td>
<td>$71.75</td>
<td>$183.93</td>
<td>$183.21</td>
</tr>
<tr>
<td>Employee &amp; Children*</td>
<td>$71.75</td>
<td>$183.93</td>
<td>$183.21</td>
</tr>
<tr>
<td>Employee &amp; Spouse*</td>
<td>$80.45</td>
<td>$228.68</td>
<td>$227.78</td>
</tr>
<tr>
<td>Family</td>
<td>$108.96</td>
<td>$302.25</td>
<td>$301.07</td>
</tr>
</tbody>
</table>

Medical & Prescription Benefits

BlueCross BlueShield Medical Plans – 2019 Weekly Premiums

<table>
<thead>
<tr>
<th>Benefit Period Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Period Deductible*</td>
</tr>
<tr>
<td>Benefit Period Out-of-Pocket Maximum</td>
</tr>
</tbody>
</table>

Office Visits
- PPO Visit: Covered at 100%
- Standard Visit: Covered at 100%
- Well-Child Care & Immunizations (through age 17): Covered at 100%
- Annual Physicals: Covered at 100%
- Routine SVX Exam: Covered at 100%
- Mammography: Covered at 100%

Hospitalization
- Inpatient & Outpatient: Not covered
- Labs, and Testing: Not covered
- X-Ray & Diagnostic Imaging: Not covered
- Outpatient Lab Work: Covered at 100%

Mental Health & Substance Abuse
- Inpatient & Outpatient: Not covered
- Prescription Drugs: Covered at 100%
- Deductible: $0.00
- Generic Drugs: $0.00 copay
- Preferred Brand Drugs: $0.00 copay
- Non-Preferred Brand and Specialty Drugs: Not Covered

BlueCross BlueShield Medical Plans – 2019 Weekly Premiums

<table>
<thead>
<tr>
<th>Coverage Level</th>
<th>Basic Plan</th>
<th>Bronze Plan</th>
<th>HSA Eligible Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$46.68</td>
<td>$99.43</td>
<td>$99.04</td>
</tr>
<tr>
<td>Employee &amp; Child*</td>
<td>$71.75</td>
<td>$183.93</td>
<td>$183.21</td>
</tr>
<tr>
<td>Employee &amp; Children*</td>
<td>$71.75</td>
<td>$183.93</td>
<td>$183.21</td>
</tr>
<tr>
<td>Employee &amp; Spouse*</td>
<td>$80.45</td>
<td>$228.68</td>
<td>$227.78</td>
</tr>
<tr>
<td>Family</td>
<td>$108.96</td>
<td>$302.25</td>
<td>$301.07</td>
</tr>
</tbody>
</table>

Medical & Prescription Benefits

BlueCross BlueShield Medical Plans – 2019 Weekly Premiums

<table>
<thead>
<tr>
<th>Benefit Period Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Period Deductible*</td>
</tr>
<tr>
<td>Benefit Period Out-of-Pocket Maximum</td>
</tr>
</tbody>
</table>

Office Visits
- PPO Visit: Covered at 100%
- Standard Visit: Covered at 100%
- Well-Child Care & Immunizations (through age 17): Covered at 100%
- Annual Physicals: Covered at 100%
- Routine SVX Exam: Covered at 100%
- Mammography: Covered at 100%

Hospitalization
- Inpatient & Outpatient: Not covered
- Labs, and Testing: Not covered
- X-Ray & Diagnostic Imaging: Not covered
- Outpatient Lab Work: Covered at 100%

Mental Health & Substance Abuse
- Inpatient & Outpatient: Not covered
- Prescription Drugs: Covered at 100%
- Deductible: $0.00
- Generic Drugs: $0.00 copay
- Preferred Brand Drugs: $0.00 copay
- Non-Preferred Brand and Specialty Drugs: Not Covered

BlueCross BlueShield Medical Plans – 2019 Weekly Premiums

<table>
<thead>
<tr>
<th>Coverage Level</th>
<th>Basic Plan</th>
<th>Bronze Plan</th>
<th>HSA Eligible Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$46.68</td>
<td>$99.43</td>
<td>$99.04</td>
</tr>
<tr>
<td>Employee &amp; Child*</td>
<td>$71.75</td>
<td>$183.93</td>
<td>$183.21</td>
</tr>
<tr>
<td>Employee &amp; Children*</td>
<td>$71.75</td>
<td>$183.93</td>
<td>$183.21</td>
</tr>
<tr>
<td>Employee &amp; Spouse*</td>
<td>$80.45</td>
<td>$228.68</td>
<td>$227.78</td>
</tr>
<tr>
<td>Family</td>
<td>$108.96</td>
<td>$302.25</td>
<td>$301.07</td>
</tr>
</tbody>
</table>
No copayment or coinsurance.

AB=Allowed Benefit

After deductable is met.

(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. These 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. 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 includes deductibles, copays and coinsurance.

(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) There are no limits for children until the end of the month in which they turn 19 years of age when Physical, Speech or Occupational Therapy is included as part of Habilitative Services.

(9) Limited to 30 visits per injury per benefit period

(10) Limited to 20 visits per injury per benefit period

(11) Waived if admitted

After deductible is met.

(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. These 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. 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 includes deductibles, copays and coinsurance.

(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) There are no limits for children until the end of the month in which they turn 19 years of age when Physical, Speech or Occupational Therapy is included as part of Habilitative Services.

(9) Limited to 30 visits per injury per benefit period

(10) Limited to 20 visits per injury per benefit period

(11) Waived if admitted

health savings account (HSA)

Who Can Have An HSA?

To be eligible to open an HSA, you must be covered by a qualified high deductible health plan such as the Populus Group BlueCross BlueShield HSA Eligible High Deductible Medical Plan*. You are not eligible if:

- You can be claimed as a tax dependent of another individual;
- You are currently enrolled in Medicare; or
- You have medical plan coverage other than a high deductible health plan, including secondary coverage under your spouse/domestic partner’s plan. There cannot be coordination of benefits with another plan.

What Is An HSA?

An HSA is a tax-advantaged savings account that allows you to put aside pre-tax income, invest your savings, and use your tax-free savings for eligible medical expenses. Unlike other medical savings accounts, any money you do not use stays in your account.

An HSA helps you save for health care expenses over your lifetime. If you use the account to pay for eligible medical expenses, (a list can be found at [www.irs.gov/pub/irs-pdf/p502.pdf](http://www.irs.gov/pub/irs-pdf/p502.pdf)), you will not have to pay federal income taxes on your savings. You may choose to use the funds for ineligible expenses, but you will be taxed on the amount, and if you are under age 65, you will also be subject to an additional 20% tax penalty. (Please note you may want to keep your receipts for IRS purposes).

In addition to being an excellent way to put money aside for current expenses, an HSA is a tax-free way to save for future expenses—such as the need to cover retiree health premiums (excluding Medicare Supplement plans) or to pay for uncovered healthcare expenses at some time in the future.

Your HSA is your personal account and is entirely portable. This means if you leave Populus Group, you can take the account with you. Populus Group has partnered with Optum to manage your Health Savings Account. Once you set up your HSA, you will receive a Welcome Package from Optum (which will include your Healthcare Payment card), quarterly Health Savings Account statements and other information pertaining to your HSA.

You may contribute to your HSA through pre-tax payroll deductions or through post-tax contributions of your own (you will set this up directly with Optum), up to the amount allowed by the IRS. If you choose to contribute through post-tax contributions, you will adjust your gross income when filing your income tax return the following year.

It is important to note although some expenses are eligible for reimbursement from your HSA, they may not count toward your annual deductible or annual out-of-pocket maximum (such as certain over-the-counter medications or long term care insurance premiums). For additional information about eligible and ineligible expenses, please refer to IRS Publication 502 [www.irs.gov/pub/irs-pdf/p502.pdf](http://www.irs.gov/pub/irs-pdf/p502.pdf).
HSA Contributions
You determine how much you want to contribute to your HSA on an annual basis. You may contribute up to the following IRS maximums:

<table>
<thead>
<tr>
<th>pre-tax contributions</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$3,500</td>
</tr>
<tr>
<td>Employee &amp; Child(ren)</td>
<td>$7,000</td>
</tr>
<tr>
<td>Employee &amp; Spouse</td>
<td>$7,000</td>
</tr>
<tr>
<td>Family</td>
<td>$7,000</td>
</tr>
</tbody>
</table>

HSA Annual Contributions – 2019

If you are age 55 or older, for the 2019 plan year and beyond you are also eligible to make an additional contribution of $1,000 to your HSA by logging into your account at www.optumbank.com. From the main dashboard page, click on "make a deposit" and follow the prompts to make a deposit from the bank account of your choosing. Call Optum customer service at 1-844-326-7967 if you have questions or need assistance.

How To Set Up Your HSA
You will set up your HSA with Optum via www.PopulusBenefits.com at the time you enroll in the BlueCross BlueShield HSA High Deductible Bronze Medical Plan. After enrolling in your medical benefits, you will be asked to enter an annual election amount you wish to contribute to your HSA. Once you complete this step, choose your other benefits and submit your enrollment, your information will be sent to Optum and your HSA will be established.

HSA Changes
You may change your HSA contributions at any time during the year by logging on to www.PopulusBenefits.com. A voluntary HSA contribution change will take effect on the following week’s paycheck.

States Not Recognizing The Tax-Free Status Of HSA Contributions
While the pre-tax contributions to your HSA made through payroll always provide tax savings on the federal level, the following states do not currently recognize those contributions for state income tax purposes: Alabama, California, and New Jersey. Please note, this is the most current list at the time this guide was created.

Account Balance
Depending on your health care expenses in a given year, you may not need to use all of the funds in your HSA. In this event, the remaining balance in your HSA will be available for your use in future years.

Interest And Earnings On Your Account Balance
Initially, the contributions made by you through payroll are deposited into an FDIC Insured interest bearing account. Once your account balance reaches $1,000, you may choose to invest your HSA savings in a variety of mutual funds. Please keep in mind mutual funds carry a certain level of risk and return. You should consult a financial advisor when making investment decisions.

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 www.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.

<table>
<thead>
<tr>
<th>Plan</th>
<th>Benefit Provision</th>
<th>Per Provision Limit</th>
<th>Collective Benefit Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Essential</td>
<td>Basic Plan Benefits</td>
<td>Per Provision Limit</td>
<td>Collective Benefit Limit</td>
</tr>
<tr>
<td>Havana Stay</td>
<td>Hospital Room</td>
<td>$300 per day</td>
<td>10 days*</td>
</tr>
<tr>
<td></td>
<td>ICU</td>
<td>$1,000 per day</td>
<td>10 stays*</td>
</tr>
<tr>
<td></td>
<td>Substance Abuse Facility</td>
<td>$50 per day</td>
<td>10 stays*</td>
</tr>
<tr>
<td></td>
<td>Mental Health (180 day lifetime limit)</td>
<td>$250 per stay</td>
<td>10 stays*</td>
</tr>
<tr>
<td></td>
<td>Post-Hospital Nursing Facility Stay</td>
<td>$250 per day</td>
<td>60 days per stay**</td>
</tr>
<tr>
<td></td>
<td>Surgery (based upon site of services) maximum* surgical benefits per day</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Outpatient Doctor’s Office</td>
<td>$15 per visit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Outpatient Surgical Facility</td>
<td>$55 per visit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Inpatient</td>
<td>$2,000 per day</td>
</tr>
<tr>
<td></td>
<td>Prescription</td>
<td>Preferred generic Rx*</td>
<td>$15 co-pay</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Non-preferred generic and brand Rx*</td>
<td>Discount</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Out-Of-Network Discounts</td>
<td>when services are received through a MultiPlan HMO Network provider*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Non-Network Penalties</td>
<td></td>
</tr>
</tbody>
</table>

*Per covered person per calendar year
**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 except that mental health facility stay is limited to 180 days’ lifetime maximum.
(2) Access to the MultiPlan HMO Network is included. There is a $4 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 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 REO.
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

<table>
<thead>
<tr>
<th>Benefit Provision</th>
<th>Basic Plan Benefits</th>
<th>Per Provision Limit</th>
<th>Collective Benefit Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor Office Visits</td>
<td>$80 per day</td>
<td>none</td>
<td>20 visits*, $1,600</td>
</tr>
<tr>
<td>Outpatient Diagnostic X-Ray</td>
<td>$80 per day</td>
<td>none</td>
<td>none</td>
</tr>
<tr>
<td>Preventive Care</td>
<td>$80 per day</td>
<td>none</td>
<td>none</td>
</tr>
<tr>
<td>Emergency Room (outpatient DSL benefits may also apply)</td>
<td>$100 per day</td>
<td>$600*</td>
<td>$600*</td>
</tr>
<tr>
<td>Hospital Admission</td>
<td>$1,000 per first day</td>
<td>2*</td>
<td>$2,000*</td>
</tr>
<tr>
<td><strong>Hospital Stay</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Regular Room</strong></td>
<td>$1,200 per day</td>
<td>none</td>
<td>none</td>
</tr>
<tr>
<td><strong>ICU</strong></td>
<td>$2,400 per day</td>
<td>none</td>
<td>none</td>
</tr>
<tr>
<td><strong>Substance Abuse Facility</strong></td>
<td>$1,300 per day</td>
<td>none</td>
<td>none</td>
</tr>
<tr>
<td><strong>Mental Health (180-day lifetime limit)</strong></td>
<td>$900 per day</td>
<td>none</td>
<td>none</td>
</tr>
<tr>
<td><strong>Post-Hospital Nursing Facility Stay</strong></td>
<td>$900 per day</td>
<td>60 days per stay*</td>
<td>$15,000*</td>
</tr>
<tr>
<td><strong>Surgery (based upon site of service) maximum</strong></td>
<td>$15,000*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Doctor’s Office</td>
<td>$25 per day</td>
<td>none</td>
<td>none</td>
</tr>
<tr>
<td>Outpatient Surgical Facility</td>
<td>$1,500 per day</td>
<td>none</td>
<td>none</td>
</tr>
<tr>
<td>Inpatient</td>
<td>$3,500 per day</td>
<td>none</td>
<td>none</td>
</tr>
<tr>
<td>Surgical Anesthesia</td>
<td>$400 per surgery with anesthesia</td>
<td>none</td>
<td>none</td>
</tr>
<tr>
<td>Outpatient Surgical Facility (OPSF)</td>
<td>$900 per surgery with OPSF</td>
<td>none</td>
<td>none</td>
</tr>
</tbody>
</table>

### advantage plan

<table>
<thead>
<tr>
<th>Benefit Provision</th>
<th>Basic Plan Benefits</th>
<th>Per Provision Limit</th>
<th>Collective Benefit Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor Office Visits</td>
<td>$80 per visit</td>
<td>none</td>
<td>none</td>
</tr>
<tr>
<td>Outpatient Major Diagnostic Tests</td>
<td>$250 per day</td>
<td>none</td>
<td>none</td>
</tr>
<tr>
<td>Emergency Room (outpatient DSL benefits may also apply)</td>
<td>$300 per day</td>
<td>none</td>
<td>none</td>
</tr>
<tr>
<td><strong>Hospital Stay</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Regular Room</strong></td>
<td>$2,000 per day</td>
<td>none</td>
<td>none</td>
</tr>
<tr>
<td><strong>ICU</strong></td>
<td>$4,000 per day</td>
<td>none</td>
<td>none</td>
</tr>
<tr>
<td><strong>Substance Abuse Facility</strong></td>
<td>$2,000 per day</td>
<td>none</td>
<td>none</td>
</tr>
<tr>
<td><strong>Mental Health (180-day lifetime limit)</strong></td>
<td>$1,000 per day</td>
<td>none</td>
<td>none</td>
</tr>
<tr>
<td><strong>Post-Hospital Nursing Facility Stay</strong></td>
<td>$1,000 per day</td>
<td>60 days per stay*</td>
<td>$100,000*</td>
</tr>
<tr>
<td><strong>Surgery (based upon site of service) maximum</strong></td>
<td>$100,000*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Doctor’s Office</td>
<td>$5 per day</td>
<td>none</td>
<td>none</td>
</tr>
<tr>
<td>Outpatient Surgical Facility</td>
<td>$1,500 per day</td>
<td>none</td>
<td>none</td>
</tr>
<tr>
<td>Inpatient</td>
<td>$3,500 per day</td>
<td>none</td>
<td>none</td>
</tr>
<tr>
<td>Surgical Anesthesia</td>
<td>$550 per surgery with anesthesia</td>
<td>none</td>
<td>none</td>
</tr>
<tr>
<td>Outpatient Surgical Facility (OPSF)</td>
<td>$900 per surgery with OPSF</td>
<td>none</td>
<td>none</td>
</tr>
<tr>
<td>Preventive Care</td>
<td>$100 per day</td>
<td>$100*</td>
<td>$100*</td>
</tr>
<tr>
<td>Hospital Admission</td>
<td>$1,000 per admission</td>
<td>3*</td>
<td>$3,000*</td>
</tr>
</tbody>
</table>

### Symetra Life Insurance Company Medical Plans – 2019 Weekly Premiums

<table>
<thead>
<tr>
<th>coverage level</th>
<th>essential</th>
<th>enhanced</th>
<th>advantage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$2762</td>
<td>$3701</td>
<td>$6840</td>
</tr>
<tr>
<td>Employee &amp; Child*</td>
<td>$68.54</td>
<td>$92.73</td>
<td>$173.16</td>
</tr>
<tr>
<td>Employee &amp; Children*</td>
<td>$68.54</td>
<td>$92.73</td>
<td>$173.16</td>
</tr>
<tr>
<td>Employee &amp; Spouse*</td>
<td>$68.54</td>
<td>$92.73</td>
<td>$173.16</td>
</tr>
<tr>
<td>Family</td>
<td>$98.44</td>
<td>$132.94</td>
<td>$248.65</td>
</tr>
</tbody>
</table>

*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.

customize 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.

<table>
<thead>
<tr>
<th>basic medical plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Period Maximum, Lifetime Maximum</td>
</tr>
<tr>
<td>Deductible, Out-Of-Pocket Maximum, Coinsurance (per calendar year)</td>
</tr>
<tr>
<td>Office Visits</td>
</tr>
<tr>
<td>Preventive Care (annual physical, well-child care/immunizations, routine E/R exams)</td>
</tr>
<tr>
<td>Labs and Testing</td>
</tr>
<tr>
<td>Outpatient Lab Work</td>
</tr>
<tr>
<td>Hospitalization</td>
</tr>
<tr>
<td>Prescription Drug</td>
</tr>
<tr>
<td>Generic and Preferred Brand Drugs</td>
</tr>
<tr>
<td>Non-Preferred Brand and Specialty Drugs</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospital Bridge Insurance Plans – 2019 Weekly Premiums</th>
</tr>
</thead>
<tbody>
<tr>
<td>coverage level</td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td>Employee</td>
</tr>
<tr>
<td>Employee &amp; Child*</td>
</tr>
<tr>
<td>Employee &amp; Children*</td>
</tr>
<tr>
<td>Employee &amp; Spouse*</td>
</tr>
<tr>
<td>Family</td>
</tr>
</tbody>
</table>

*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 Plans – 2019 Weekly Premiums**

<table>
<thead>
<tr>
<th>coverage level</th>
<th>option 1 - $10,000</th>
<th>option 2 - $20,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$4.14</td>
<td>$8.28</td>
</tr>
<tr>
<td>Employee &amp; Child*</td>
<td>$5.52</td>
<td>$11.04</td>
</tr>
<tr>
<td>Employee &amp; Children*</td>
<td>$5.52</td>
<td>$11.04</td>
</tr>
<tr>
<td>Employee &amp; Spouse*</td>
<td>$8.28</td>
<td>$16.55</td>
</tr>
<tr>
<td>Family</td>
<td>$9.66</td>
<td>$19.31</td>
</tr>
</tbody>
</table>

*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:

- **Option 1**: Coverage of up to $3,500 per accident
- **Option 2**: Coverage of up to $10,000 per accident

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:

<table>
<thead>
<tr>
<th>example 1</th>
<th>example 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance service</td>
<td>$800</td>
</tr>
<tr>
<td>Emergency room</td>
<td>$1,525</td>
</tr>
<tr>
<td>Diagnostic testing (MRI)</td>
<td>$750</td>
</tr>
<tr>
<td>Physician fees</td>
<td>$300</td>
</tr>
<tr>
<td>Physical therapy</td>
<td>$500</td>
</tr>
<tr>
<td>Total expenses</td>
<td>$2,975</td>
</tr>
<tr>
<td>Benefits paid to insured = $2,875</td>
<td></td>
</tr>
</tbody>
</table>

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

**Accident Insurance Plans – 2019 Weekly Premiums**

<table>
<thead>
<tr>
<th>coverage level</th>
<th>option 1 - $3,500</th>
<th>option 2 - $10,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$6.87</td>
<td>$8.26</td>
</tr>
<tr>
<td>Employee &amp; Child*</td>
<td>$11.27</td>
<td>$13.54</td>
</tr>
<tr>
<td>Employee &amp; Children*</td>
<td>$11.27</td>
<td>$13.54</td>
</tr>
<tr>
<td>Employee &amp; Spouse*</td>
<td>$14.64</td>
<td>$17.60</td>
</tr>
<tr>
<td>Family</td>
<td>$20.39</td>
<td>$24.51</td>
</tr>
</tbody>
</table>

*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 your 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.

**Hospital Indemnity Plan – 2019 Weekly Premiums**

<table>
<thead>
<tr>
<th>coverage level</th>
<th>HEPP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$6.32</td>
</tr>
<tr>
<td>Employee &amp; Child*</td>
<td>$12.43</td>
</tr>
<tr>
<td>Employee &amp; Children*</td>
<td>$17.92</td>
</tr>
<tr>
<td>Employee &amp; Spouse*</td>
<td>$12.43</td>
</tr>
<tr>
<td>Family</td>
<td>$17.92</td>
</tr>
</tbody>
</table>

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

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.

**Major Expense Protection Plan – 2019 Weekly Premiums**

<table>
<thead>
<tr>
<th>coverage level</th>
<th>MEPP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$23.29</td>
</tr>
<tr>
<td>Employee &amp; Child*</td>
<td>$48.43</td>
</tr>
<tr>
<td>Employee &amp; Children*</td>
<td>$55.45</td>
</tr>
<tr>
<td>Employee &amp; Spouse*</td>
<td>$48.43</td>
</tr>
<tr>
<td>Family</td>
<td>$55.45</td>
</tr>
</tbody>
</table>

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

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. This includes locating providers in your health insurance plan’s network.
2. Scheduling appointments with providers including hard to reach specialists and critical care providers and arranging for specialized treatments and tests.
3. Helping to resolve insurance claims and assisting with negotiating billing and payment arrangements, and related administrative issues.
4. Working with our insurance companies to obtain appropriate approvals for needed services often fostering communications between physicians and insurance companies.
5. Assisting with eldercare and related healthcare issues facing your parents and parents-in-law. They work with Medicare and other government insurance programs and help make arrangements following discharge from a hospital for in-home or needed institutional service.
6. Answering questions about test results, treatment recommendations and medications recommended or prescribed by your physician.
7. Obtaining unbiased health information to help make an informed decision.
8. Assisting in the transfer of medical records, x-rays and lab results.
9. Locating and researching the newest treatments for a medical condition.
10. 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.

employee assistance program (EAP) & work life benefit

Populus Group is pleased to announce that an Employee Assistance Program (EAP) and Work Life Benefits will be provided to you at no cost and you will be automatically enrolled!

What is EAP and Work/Life?
The EAP and Work/Life program is designed to help you lead a happier and more productive life at home and at work. Balancing the needs of work, family and personal responsibilities isn’t always easy. This program offers the right support at the right time.

What does it do?
The EAP and Work/Life program provides a professional counselor or work life specialist to listen and:

- Help define the problem clearly,
- Assess the type of help needed, and
- Either provide the required help or make the most appropriate, cost-effective referral for you.

How Does It Work?
Your counselor can address:
- Stress, depression, anxiety
- Marital relationships, family/parenting issues
- Work conflicts
- Anger, grief and loss
- Drug and alcohol abuse

Work/Life Specialist can assist with:
- Eldercare, childcare, in-home care
- Legal, financial issues
- Summer camps
- Time management
- Parenting and Adoption
- Pet sitting

Simply call 1-866-799-2728 (toll-free) or visit online at www.HealthAdvocate.com/members to access EAP or Work/Life services.
**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 [www.PopulusBenefits.com](http://www.PopulusBenefits.com) for a direct link to the MetLife website or go to [www.metlife.com/dental](http://www.metlife.com/dental) or [www.metlife.com/mybenefits](http://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](http://www.PopulusBenefits.com). Please note, deductibles and annual plan limits are per coverage year (January 1 – December 31).

<table>
<thead>
<tr>
<th>Benefit</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual (calendar year) Deductible (for Type B and C Expenses Combined)</td>
<td>$50 per person</td>
<td>$50 per person</td>
</tr>
<tr>
<td>Annual (calendar year) Plan Limit Maximum Benefit</td>
<td>$1,000 per person</td>
<td>$1,000 per person</td>
</tr>
</tbody>
</table>

**Type A Expenses**

- Preventive Oral Exams, 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 100%* after deductible
  - Plan pays 100%** after deductible

- Crowns, Dentures, Bridgework, Complex Oral surgery
  - Plan pays 100%* after deductible
  - Plan pays 100%** after deductible

**Type D Expenses**

- Orthodontia
  - Not covered
  - 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; or 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 Dental Program Table of Maximum Allowed Charges.

**vision benefits**

**Vision Service Plan (VSP)**

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Frequency*</th>
<th>Vision Service Plan (VSP)</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye Exam</td>
<td>Once every 12 months (Well/Vision)</td>
<td>$10 co-pay, then plan pays 100%</td>
<td>Plan pays up to $50</td>
</tr>
<tr>
<td>Frames</td>
<td>Once every 24 months</td>
<td>Plan pays 100% for selected frames up to $100</td>
<td>Plan pays up to $70</td>
</tr>
</tbody>
</table>

**Vision Plan – 2019 Weekly Premiums**

<table>
<thead>
<tr>
<th>coverage level</th>
<th>vision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$20.6</td>
</tr>
<tr>
<td>Employee &amp; Child*</td>
<td>$3.24</td>
</tr>
<tr>
<td>Employee &amp; Children*</td>
<td>$3.24</td>
</tr>
<tr>
<td>Employee &amp; Spouse*</td>
<td>$3.3</td>
</tr>
<tr>
<td>Family</td>
<td>$5.33</td>
</tr>
</tbody>
</table>

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

**Dental Plan – 2019 Weekly Premiums**

<table>
<thead>
<tr>
<th>coverage level</th>
<th>dental</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$8.08</td>
</tr>
<tr>
<td>Employee &amp; Child*</td>
<td>$16.24</td>
</tr>
<tr>
<td>Employee &amp; Children*</td>
<td>$16.24</td>
</tr>
<tr>
<td>Employee &amp; Spouse*</td>
<td>$18.50</td>
</tr>
<tr>
<td>Family</td>
<td>$20.91</td>
</tr>
</tbody>
</table>

*Please see the Eligibility section of this guide for the definition of an eligible dependent.
short term disability (STD)

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.

<table>
<thead>
<tr>
<th>your age</th>
<th>STD weekly premium multiplier*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 25</td>
<td>$0.182</td>
</tr>
<tr>
<td>25-29</td>
<td>$0.155</td>
</tr>
<tr>
<td>30-34</td>
<td>$0.155</td>
</tr>
<tr>
<td>35-39</td>
<td>$0.136</td>
</tr>
<tr>
<td>40-44</td>
<td>$0.143</td>
</tr>
<tr>
<td>45-49</td>
<td>$0.162</td>
</tr>
<tr>
<td>50-54</td>
<td>$0.203</td>
</tr>
<tr>
<td>55 and over</td>
<td>$0.242</td>
</tr>
</tbody>
</table>

*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 $33.2. The weekly benefit of $288 is 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 $1.36. When the $1.36 is multiplied by 28.80 the employee arrives at their weekly premium of $39.2.

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.
- Weekly premium multiplier

Deductions are taken on a post-tax basis.

The minimum monthly benefit is the greater of $100 or 10% of your monthly benefit before reductions for Social Security and other income benefits. The maximum monthly LTD benefit is $5,000.

Life insurance

Reliance Standard Life
The Populus Group Voluntary Term Life Insurance plan lets 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. 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 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.

<table>
<thead>
<tr>
<th>age</th>
<th>weekly premium multiplier*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 30</td>
<td>$0.141</td>
</tr>
<tr>
<td>30-34</td>
<td>$0.171</td>
</tr>
<tr>
<td>35-39</td>
<td>$0.247</td>
</tr>
<tr>
<td>40-44</td>
<td>$0.351</td>
</tr>
<tr>
<td>45-49</td>
<td>$0.653</td>
</tr>
<tr>
<td>50-54</td>
<td>$1.057</td>
</tr>
<tr>
<td>55-59</td>
<td>$1.638</td>
</tr>
<tr>
<td>60-64</td>
<td>$2.993</td>
</tr>
<tr>
<td>65-69</td>
<td>$4.403</td>
</tr>
</tbody>
</table>

*The costs shown above are per $10,000 of monthly earnings. 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.

<table>
<thead>
<tr>
<th>amount</th>
<th>weekly premium multiplier</th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,500*</td>
<td>$0.01</td>
</tr>
<tr>
<td>$5,000*</td>
<td>$0.02</td>
</tr>
<tr>
<td>$7,500*</td>
<td>$0.02</td>
</tr>
<tr>
<td>$10,000*</td>
<td>$0.03</td>
</tr>
<tr>
<td>$10,000*</td>
<td>$0.03</td>
</tr>
</tbody>
</table>

*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.

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.

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.

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.

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.

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.
accidental death and dismemberment

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.

<table>
<thead>
<tr>
<th>coverage level</th>
<th>AD&amp;D weekly premium multiplier*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$0.090</td>
</tr>
<tr>
<td>Family</td>
<td>$0.210</td>
</tr>
</tbody>
</table>

*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 [$0.210 (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 filing claims with each of the benefit carriers. All claim forms (where applicable) can be found on www.PopulusBenefits.com.

For Bluecross Blueshield Basic, HSA Eligible High Deductible, 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 Reimbursement 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

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

<table>
<thead>
<tr>
<th>status change event</th>
<th>what you may change</th>
<th>effective date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marriage¹</td>
<td>Add yourself, spouse, child(ren) and/or stepchild(ren) to existing coverage</td>
<td>First of the month following event</td>
</tr>
<tr>
<td>Divorce/Legal Separation (only in states that recognize legal separation)</td>
<td>Cancel coverage for your spouse and stepchildren if enrolled in your employer’s plan/Ad cover for yourself and your children if enrolled in your spouse’s plan</td>
<td>First of the month following event</td>
</tr>
<tr>
<td>You, spouse, or child(ren) loses other coverage²</td>
<td>Add yourself, spouse or child(ren) who lost coverage</td>
<td>First of the month following event</td>
</tr>
<tr>
<td>You, spouse, or child(ren) gains other group coverage</td>
<td>Cancel coverage for yourself, spouse, and/or child(ren) who gain coverage</td>
<td>End of the week in which coverage is gained</td>
</tr>
<tr>
<td>You, spouse or child(ren) exhaust COBRA coverage³</td>
<td>Add yourself, spouse, child(ren) who were covered under COBRA</td>
<td>Date of Event</td>
</tr>
<tr>
<td>You, your spouse or child(ren) die</td>
<td>Cancel coverage for yourself, spouse or child(ren) who die</td>
<td>Date of Death</td>
</tr>
<tr>
<td>Change in dependent's eligibility for benefits, such as age</td>
<td>Cancel coverage for your dependent</td>
<td>End of the month following event</td>
</tr>
</tbody>
</table>

(1) Canceling 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.
(3) COBRA period must be fully exhausted. Choosing to discontinue COBRA during your COBRA period does not allow you to add coverage with Maxim, except during the annual open enrollment period.

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 www.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 14, 2019, then your coverage under any of the plans listed above will end at midnight on Saturday, June 15, 2019. 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 HSA Eligible High Deductible Medical Plan, 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).

**Fixed Indemnity Medical Plans – 2019 Monthly Premiums**

<table>
<thead>
<tr>
<th>coverage level</th>
<th>essential</th>
<th>enhanced</th>
<th>advantage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$119.68</td>
<td>$160.36</td>
<td>$296.42</td>
</tr>
<tr>
<td>Employee &amp; Child*</td>
<td>$297.00</td>
<td>$401.81</td>
<td>$750.34</td>
</tr>
<tr>
<td>Employee &amp; Children*</td>
<td>$297.00</td>
<td>$401.81</td>
<td>$750.34</td>
</tr>
<tr>
<td>Employee &amp; Spouse*</td>
<td>$297.00</td>
<td>$401.81</td>
<td>$750.34</td>
</tr>
<tr>
<td>Family</td>
<td>$426.56</td>
<td>$576.08</td>
<td>$1,077.06</td>
</tr>
</tbody>
</table>

**Major Expense Protection Plan – 2019 Monthly Premiums**

<table>
<thead>
<tr>
<th>coverage level</th>
<th>MEPP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$100.93</td>
</tr>
<tr>
<td>Employee &amp; Child*</td>
<td>$209.86</td>
</tr>
<tr>
<td>Employee &amp; Children*</td>
<td>$240.30</td>
</tr>
<tr>
<td>Employee &amp; Spouse*</td>
<td>$209.86</td>
</tr>
<tr>
<td>Family</td>
<td>$240.30</td>
</tr>
</tbody>
</table>

**Hospital Indemnity – 2019 Monthly Premiums**

<table>
<thead>
<tr>
<th>coverage level</th>
<th>HEPP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$273.9</td>
</tr>
<tr>
<td>Employee &amp; Child*</td>
<td>$53.87</td>
</tr>
<tr>
<td>Employee &amp; Children*</td>
<td>$77.67</td>
</tr>
<tr>
<td>Employee &amp; Spouse*</td>
<td>$53.87</td>
</tr>
<tr>
<td>Family</td>
<td>$77.67</td>
</tr>
</tbody>
</table>

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 any additional administrative fee.

When You Can Elect COBRA Coverage

You can continue your Blue Cross Basic Medical Plan, HSA Eligible High Deductible Bronze Medical Plan, Bronze Medical Plan, dental and vision coverage for yourself and your covered dependents for up to 18 months, if your group coverage ends because:

1. You separate from service with the Company (for reasons other than gross misconduct on your part).
2. 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

COBRA – 2019 Monthly Premiums

<table>
<thead>
<tr>
<th>coverage level</th>
<th>medical</th>
<th>dental</th>
<th>vision</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>basic</td>
<td>bronze</td>
<td>high deductible</td>
</tr>
<tr>
<td>Employee</td>
<td>$160.69</td>
<td>$439.47</td>
<td>$437.74</td>
</tr>
<tr>
<td>Employee &amp; Child*</td>
<td>$259.81</td>
<td>$812.99</td>
<td>$809.81</td>
</tr>
<tr>
<td>Employee &amp; Children*</td>
<td>$259.81</td>
<td>$812.99</td>
<td>$809.81</td>
</tr>
<tr>
<td>Employee &amp; Spouse*</td>
<td>$294.25</td>
<td>$1,010.76</td>
<td>$1,006.80</td>
</tr>
<tr>
<td>Family</td>
<td>$406.94</td>
<td>$1,335.96</td>
<td>$1,330.72</td>
</tr>
</tbody>
</table>

*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.
Populus Group has determined that the prescription drug coverage offered with the Symetra Life Insurance Company

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

Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Please refer to your enrollment guide and/or Summary of Benefits and Coverage for more information on the deductibles and coinsurance that apply under your plan. If you would like more information on WHCRA benefits, contact the Plan Sponsor.

Newborns’ And Mothers’ Health Protection Act Notice

Under federal law, employer health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. For information on pre-certification, contact your Plan Sponsor.

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:

- 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.
- 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.

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 its 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 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. Wile 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:

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help:

- Call them at 1-800-772-1213 (TTY 1-800-325-0778).

Date: October 2018

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

Address: 3001 West Big Beaver Road, Suite 400, Troy, MI 48084

Phone Number: 1-866-886-9798

Premium Assistance Under Medicaid & The Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage. Using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are not currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.usablebenefits.gov or call 1-866-444-EBTSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2018. Contact your State for more information on eligibility.

**ALABAMA – Medicaid**

Website: http://myalhipp.com/
Phone: 1-855-692-5447

**ALASKA – Medicaid**

Website: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
Phone: 1-855-692-4477

**ARKANSAS – Medicaid**

Website: http://myarkips.com
Phone: 1-800-231-4881

Email: CustomerServices@MyArkIPS.com

Medicaid Eligibility: http://myarkips.com/MyArkIPS/Pages/medicaid/default.aspx

**COLORADO – Health First Colorado (Medicaid) & Child Health Plan Plus (CHIP)**

Website: https://www.healthfirstcolorado.com/
Phone: 1-800-231-4881

Website: https://healthfirstcolorado.com/CHIP
Phone: 1-800-231-4881

Website: https://www.colorado.gov/CHP
Phone: 1-800-633-4227

**CONNECTICUT – Medicaid**

Website: https://www.ct.gov/cms/medicaid/providers
Phone: 1-800-633-4227

**GEORGIA – Medicaid**

Website: http://www.georgia.gov/medicaid
Phone: 1-855-299-0995

**GEORGIA – CHIP**

Website: http://www.chip.georgia.gov
Phone: 1-855-299-0995

**KANSAS – Medicaid**

Website: http://www.kansas.gov/cwu/medicaid/
Phone: 1-877-486-2048

**KENTUCKY – Medicaid**

Website: http://www.ky.gov/medicaid
Phone: 1-855-299-0995

**LOUISIANA – Medicaid**

Website: http://dhss.la.gov/medicaid/default.aspx
Phone: 1-855-299-0995

**MARYLAND – Medicaid**

Website: https://www.healthcare.gov
Phone: 1-877-486-2048

**MASSACHUSETTS – Medicaid**

Phone: 1-855-299-0995

**MICHIGAN – Medicaid**

Website: https://www.michigan.gov/medicaid
Phone: 1-855-299-0995

**MINNESOTA – Medicaid**

Website: https://www.healthcare.gov
Phone: 1-877-486-2048

**MISSISSIPPI – Medicaid**

Website: https://www.healthcare.gov
Phone: 1-877-486-2048

**MISSOURI – Medicaid**

Website: https://www.healthcare.gov
Phone: 1-877-486-2048

**NEW JERSEY – Medicaid**

Website: https://www.healthcare.gov
Phone: 1-877-486-2048

**NEW MEXICO – Medicaid**

Website: https://www.healthcare.gov
Phone: 1-877-486-2048

**NEW YORK – Medicaid**

Website: https://www.healthcare.gov
Phone: 1-877-486-2048

**OHIO – Medicaid**

Website: https://www.healthcare.gov
Phone: 1-877-486-2048

**OKLAHOMA – Medicaid**

Website: https://www.healthcare.gov
Phone: 1-877-486-2048

**OREGON – Medicaid**

Website: https://www.healthcare.gov
Phone: 1-877-486-2048

**PENNSYLVANIA – Medicaid**

Website: https://www.healthcare.gov
Phone: 1-877-486-2048

**RHODE ISLAND – Medicaid**

Website: https://www.healthcare.gov
Phone: 1-877-486-2048

**SOUTH CAROLINA – Medicaid**

Website: https://www.healthcare.gov
Phone: 1-877-486-2048

**TENNESSEE – Medicaid**

Website: https://www.healthcare.gov
Phone: 1-877-486-2048

**VERMONT – Medicaid**

Website: https://www.healthcare.gov
Phone: 1-877-486-2048

**VIRGINIA – Medicaid**

Website: https://www.healthcare.gov
Phone: 1-877-486-2048

**WISCONSIN – Medicaid**

Website: https://www.healthcare.gov
Phone: 1-877-486-2048

**WEST VIRGINIA – Medicaid**

Website: https://www.healthcare.gov
Phone: 1-877-486-2048
To see if any other states have added a premium assistance program since July 31, 2018, or for more information on special enrollment rights, contact either:

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

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

**Paperwork Reduction Act Statement**

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3512. According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, no person is required to respond to a collection of information unless it displays a currently valid OMB control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.
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 2019, the Open Enrollment period is November 1, 2018 – December 15, 2018.

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. 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, 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 in the Marketplace. 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.

How Can I Get More Information?
For more information about your coverage offered by your employer, please check your summary plan description or contact your employer. If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here’s the employer information you’ll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

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. It is information numbered to correspond to the Marketplace application.

<table>
<thead>
<tr>
<th>3. Employer name</th>
<th>4. Employer Identification Number (EIN)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Populus Group LLC</td>
<td>38-3659021</td>
</tr>
<tr>
<td>5. Employer address</td>
<td>6. Employer phone number</td>
</tr>
<tr>
<td>3001 West Big Beaver Road, Ste 400</td>
<td>866-886-9798</td>
</tr>
<tr>
<td>7. City</td>
<td>8. State</td>
</tr>
<tr>
<td>Troy</td>
<td>MI</td>
</tr>
<tr>
<td>9. ZIP code</td>
<td>10. Who can we contact about employee health coverage at this job?</td>
</tr>
<tr>
<td>48084</td>
<td>The Populus Benefits Service Center</td>
</tr>
<tr>
<td>11. Phone number (if different from above)</td>
<td>12. Email address</td>
</tr>
<tr>
<td><a href="mailto:pgbenefits@populusgroup.com">pgbenefits@populusgroup.com</a></td>
<td></td>
</tr>
</tbody>
</table>

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.
✓ We do not offer coverage.
✓ 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.

1 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.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here’s the employer information you’ll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.
Kelly & Associates Insurance Group, Inc. (KELLY) provides administrative services that include billing, enrollment and call center service for insurance benefits. The administration of benefits by KELLY does not guarantee coverage. Billing and collecting premiums or sending payroll deduction files, does not constitute coverage being bound. Please refer to specific insurance carrier contract for rules requiring evidence of insurability (EOI) or other underwriting requirements regarding final insurance carrier approval. KELLY is not an insurer and is not responsible for paying insurance benefit claims relative to KELLY’s involvement with billing and collecting insurance premiums.

*This booklet summary is only intended as a brief summary of your benefits. Benefits are subject to the contractual terms, limitations and exclusions as set forth in the master contracts.