ARENA

TECHNICAL RESOURCES, LLC

Benefit Booklet

August 1, 2018 - July 31, 2019

GBS

Group Benefit Services

Welcome to Your Resources

Dear Employee,

We appreciate all of the hard work and effort that you put forth each and every day at Arena Technical Resources, LLC. It's the dedication of our employees that separates us from our competitors. That's why we offer a comprehensive employee benefits program so that, in addition to your paycheck, you and your family may be relieved of some of the financial burdens of health care expenses.

We hope this employee benefit booklet helps you to better understand your benefits.

Once again, thank you for your commitment and dedication.

Benefit	Name (Carrier/Rep)	Phone	Website/Email
Medical	CareFirst	(888) 567-9155	www.carefirst.com
Dental	Dominion Dental	(888) 681-5100	www.dominiondental.com
Vision	NVA Vision Program	(443) 589-1240	www.e-nva.com
Short Term Disability	Mutual of Omaha	(800) 769-7159	www.mutualofomaha.com
Long Term Disability	Mutual of Omaha	(800) 769-7159	www.mutualofomaha.com
Your Dedicated GBS VIP Customer Service Team			
GBS Customer Service Rep	Brianna Mistler	(443) 589-1206	gbscustomerservice@gbsio.net
GBS Customer Service Rep	Karen Munn	(443) 589-1273	gbscustomerservice@gbsio.net

Health Care Reform Updates

GENERAL OVERVIEW

Beginning in 2011, several changes in health care regulations affected the way certain aspects of the health care industry are treated. It is important that, as an employee, you understand these changes and how they impact your health insurance benefits.

NOTE: This is meant to be an overview only. Please contact your HR administrator, broker, or GBS representative with more detailed questions.

- Adult children coverage allowed to age 26
- No charge for preventive care
- Unlimited Lifetime Maximum
- Tax penalty for non-qualified HSA withdrawal increased from 10% to 20%
- Over-the-Counter medications no longer treated as non-taxable unless prescribed by a doctor
- Medical Flexible Spending Account (FSA) contributions are capped at $2,650 per employee, per year (amount subject to change)

WOMEN'S PREVENTIVE CARE

The following list of women's preventive care services is an extension of the existing preventive care services that went into effect under the health reform law dated Sept 23, 2010.

- Breast-feeding support, supplies & counseling
- Contraception methods & counseling
- Gestational diabetes screening
- HIV screening & counseling
- Domestic violence screening & counseling
- Sexually transmitted disease counseling
- Well-woman visits

INDIVIDUAL MANDATE

Effective 2014, most individuals must be covered by a Qualified Health Insurance Plan that meets Minimum Essential Coverage guidelines according to the Affordable Care Act (ACA). The chart below is an example of tax penalties in 2015 for non-compliance.

Adjusted Gross Income	Annual Tax Penalty	
(Household)	2015 - 2%	2016 - 2018- 2.5%
$40,000	$800	$1,000
$60,000	$1,200	$1,500
$80,000	$1,600	$2,000
$100,000	$2,000	$2,500
$120,000	$2,400	$3,000

PRE-TAX

IRS Section 125 allows employees to make contributions for benefit costs on a pre-tax basis through salary reductions. The employee will save Federal, State, Local, and Social Security/Medicare Tax on all of their tax-free premium contributions. Depending on their income tax bracket, these savings could range anywhere from 30% to 55%.

Eligibility & Enrollment

ELIGIBILITY & ENROLLMENT GUIDELINES

Employees working 30+ hours per week and their dependents are eligible to enroll in the company benefits. New employees will become eligible for coverage on the 1st of the month following their date of hire. All elections will remain in effect and cannot be changed until the next open enrollment period (usually 12 months) unless a qualifying life event occurs.

Qualifying Events

•Marriage or divorce
•Death of a spouse or child
•Loss of coverage
•Termination of a spouse's employment or significant change in health coverage (cost) attributable to the spouse's employment
•Loss of dependent child status

Employees or dependents that choose not to participate in the benefit program at time of initial eligibility will be considered late applicants, subject to the next open enrollment.

Exceptions

•Newborn or adopted dependents and newly eligible grandchildren can be added within 31 days of birth, adoption, or legal custody (proper documentation is required to support adoption or legal custody)
•A newly married spouse can apply for coverage within thirty (30) days of the date of marriage
•A dependent who loses coverage through a former employer

Eligible Dependents

•Your spouse
•Your children (until the last day of the month of their 26th birthday)
•Your unmarried child who, before the age of 19, became disabled by a mental or physical handicap and is incapable of self-support

Medical Plans

Each eligible employee will be able to choose from the available medical plans. For an overview of each medical plan, please refer to this page. To find a provider, go to www.carefirst.com and utilize the 'Find a Provider' feature, or call (888) 567-9155 for a list of providers near you.

Enrollment Tier	Per Pay Deduction: 26 Pays - Bi-Weekly		
Employee Only	$45.39	$73.09	$166.28
Employee/Spouse	$230.39	$294.11	$508.45
Employee/Child(ren)	$166.35	$217.60	$390.01
Family	$335.70	$419.92	$703.22

	BC HMO Option MV2 **MD, DC & NoVa ONLY**	**BC Advantage Option MV1**	**BC Advantage Option 4-S**
Benefits	**In-Network**	**In-Network**	**In-Network**
Cost Share Information			
Deductible (Ind/Fam)	$5,000/$10,000	$5,000/$10,000	$2,000/$4,000
Out-of-Pocket Max (Ind/Fam)	$6,850/$13,700	$6,350/$12,700	$6,850/$13,700
Co-Insurance	40%	20%	0%
Office Visits			
Primary Care	$30 after ded	$40 after ded	$20 ded waived
Specialist	$60 after ded	$40 after ded	$40 ded waived
Inpatient Services			
Inpatient Hospital	40% after ded	20% after ded	$300 day/5 day max after ded
Mental Health Inpatient	40% after ded	20% after ded	$300 day/5 day max after ded
Outpatient Services			
Outpatient Facility	40% after ded	20% after ded	Hosp-$200 after ded; FS-$100 ded waived
Lab/X-Ray	Lab-$150 after ded Hospital/$30 after ded Free Standing; X-ray-$200 after ded Hospital/$60 after ded Free Standing	$40 after ded	Lab-$100 after ded Hospital/$20 ded waived Free Standing; X-ray-$150 after ded Hospital/$40 ded waived Free Standing
Mental Health Outpatient	$100 after ded	20% after ded	$80 ded waived
Emergency Care			
Emergency Room	$300 (waived if admitted) after ded	$250 (waived if admitted) after ded	$200 (waived if admitted) after ded
Urgent Care	$100 after ded	$50 after ded	$60 ded waived
Prescription Drugs			
Prescription Drugs	$15/$35/$60/ 50%to150/$500Ded	$15/$35/$60/ 50%to150/$500Ded	$15/$35/$60/ 50%to150/$0Ded
Legend: Generic/Preferred Brand/Non-Preferred Brand/Specialty/Deductible			

The rates and benefits in this report are for presentation purposes only and do not constitute an offer of insurance.

Arena Technical Resources, LLC
Employee Benefit Selection - August 1, 2018 - July 31, 2019

Dental & Vision Insurance Payroll Deductions

Bi-Weekly - 26 Pays

Dominion Dental	
Enrollment Tier	**Deduction Amount**
Employee Only	$13.39
Employee/Spouse	$25.96
Employee/Child(ren)	$31.61
Family	$42.35

NVA Vision	
Enrollment Tier	**Deduction Amount**
Employee Only	$2.09
Employee/Spouse	$4.18
Employee/Child(ren)	$6.68
Family	$7.93

BlueChoice HMO

Non-Integrated Deductible

Summary of Benefits

Services	In-Network You Pay[1]
	Visit **www.carefirst.com/doctor** to locate providers and facilities
FIRSTHELP—24/7 NURSE ADVICE LINE	
Free advice from a registered nurse. Visit **www.carefirst.com/needcare** to learn more about your options for care.	When your doctor is not available, call FirstHelp at 800-535-9700 to speak with a registered nurse about your health questions and treatment options.
BLUE REWARDS	
Visit **www.carefirst.com/bluerewards** for more information	Blue Rewards is an incentive program where you can earn up to $300 for taking an active role in getting healthy and staying healthy.
ANNUAL MEDICAL DEDUCTIBLE (Benefit Period)[2]	
Individual	$5,000
Family	$10,000
ANNUAL OUT-OF-POCKET MAXIMUM (Benefit Period)[3]	
Medical[4]	$6,850 Individual/$13,700 Family
Prescription Drug[4]	Combined with in-network out-of-pocket maximum
PREVENTIVE SERVICES	
Well-Child Care (including exams & immunizations)	No charge*
Adult Physical Examination (including routine GYN visit)	No charge*
Breast Cancer Screening	No charge*
Pap Test	No charge*
Prostate Cancer Screening	No charge*
Colorectal Cancer Screening	No charge*
PCP AND SPECIALIST SERVICES	
FACILITY CHARGE[5]—In addition to the physician copays/coinsurances listed below, if a service is rendered on a hospital campus, ADD facility charge if applicable	$200 per visit
Office Visits for Illness—PCP[5,6]	Deductible, then $30 per visit
Convenience Care (retail health clinics such as CVS MinuteClinic or Walgreens Healthcare Clinic)	Deductible, then $30 per visit
Office Visits for Illness—Specialist[5,6]	Deductible, then $60 per visit
Allergy Testing[5]	Deductible, then $60 per visit
Allergy Shots[5]	Deductible, then $60 per visit
Physical, Speech, and Occupational Therapy[5,7] (limited to 30 visits/injury/benefit period)	Deductible, then $60 per visit
Chiropractic Services[5] (limited to 20 visits/benefit period)	Deductible, then $60 per visit
Acupuncture[5] (limited to 20 visits/benefit period)	Deductible, then $60 per visit
EMERGENCY SERVICES	
Urgent Care Center (such as Patient First or Express Care)	Deductible, then $100 per visit
Hospital Emergency Room Services	
▪ Facility	Deductible, then $300 per visit (waived if admitted)
▪ Physician	No charge* after deductible
Ambulance (if medically necessary)	Deductible, then $50 per service

Services	In-Network You Pay[1]
DIAGNOSTIC SERVICES	
Labs[8]	
▪ LabCorp	Deductible, then $30 per visit
▪ Hospital (Preauthorization required)	Deductible, then $150 per visit
X-ray	
▪ Non-Hospital/Freestanding Facility	Deductible, then $60 per visit
▪ Hospital (Preauthorization required)	Deductible, then $200 per visit
Imaging	
▪ Non-Hospital/Freestanding Facility	Deductible, then $100 per visit
▪ Hospital (Preauthorization required)	Deductible, then $250 per visit
HOSPITALIZATION—(Members are responsible for both physician and facility fees)	
Outpatient Surgical Center Services	
▪ Facility	Deductible, then 40% of Allowed Benefit
▪ Physician	Deductible, then 40% of Allowed Benefit
Outpatient Hospital Surgical Services	
▪ Facility	Deductible, then 40% of Allowed Benefit
▪ Physician	Deductible, then 40% of Allowed Benefit
Inpatient Hospital Services	
▪ Facility	Deductible, then 40% of Allowed Benefit
▪ Physician	Deductible, then 40% of Allowed Benefit
HOSPITAL ALTERNATIVES	
Home Health Care	No charge*
Hospice (Inpatient—limited to 30 days; Outpatient—unlimited during Hopsice eligibility period)	No charge*
Skilled Nursing Facility (limited to 60 days/benefit period)	Deductible, then 30% of Allowed Benefit
MATERNITY	
Preventive Prenatal and Postnatal Office Visits	No charge*
Delivery and Facility Services	Deductible, then 40% of Allowed Benefit
Artificial and Intrauterine Insemination[5,9] (limited to 6 attempts per live birth)	Deductible, then 50% of Allowed Benefit
In Vitro Fertilization Procedures[5,9] (limited to 3 attempts per live birth up to $100,000 lifetime maximum)	Deductible, then 50% of Allowed Benefit
MENTAL HEALTH AND SUBSTANCE ABUSE—(Members are responsible for both physician and facility fees)	
Office Visits	Deductible, then $30 per visit
Outpatient Services	
▪ Facility	Deductible, then $100 per visit
▪ Physician	Deductible, then $60 per visit
Inpatient Services	
▪ Facility	Deductible, then 40% of Allowed Benefit
▪ Physician	Deductible, then 40% of Allowed Benefit
MEDICAL DEVICES AND SUPPLIES	
Durable Medical Equipment	Deductible, then 50% of Allowed Benefit
Hearings Aids for ages 0-18 (limited to one hearing aid per hearing-impaired ear every 3 years)	No charge*
VISION	
Routine Exam (limited to 1 visit/benefit period)	$10 per visit at participating vision provider
Eyeglasses and Contact Lenses	Discounts from participating vision centers

Note: Allowed Benefit is the fee that participating, in-network providers have agreed to accept for a particular covered service. The provider cannot charge the member more than this amount for any covered service. Example: Dr. Carson charges $100 to see a sick patient. To be part of CareFirst's network, he has agreed to accept $50 for the visit. The member will pay their copay/coinsurance and deductible (if applicable) and CareFirst will pay the remaining amount up to $50.

* No copayment or coinsurance.

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

[2] 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.

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

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

[5] If a service is rendered on a hospital campus you could receive two bills, one from the physician and one from the facility.

[6] "Telemedicine services" refers to the use of a combination of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment. Use of audio-only telephone, electronic mail message (e-mail), or facsimile transmission (FAX) is not considered a telemedicine service.

[7] There are no limits for children until the end of the month in which the insured or enrollee turns 19 years of age when Physical, Speech or Occupational Therapy is included as part of Habilitative Services.

[8] Members accessing laboratory services inside the CareFirst Service area (Maryland, D.C., Northern Virginia) must use LabCorp as their Lab Test facility and a non-hospital/ freestanding facility for X-rays and specialty Imaging.

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

Note: Upon enrollment, you will need to select a Primary Care Provider (PCP). To select a PCP, go to www.carefirst.com/doctor for the most current listing of PCPs from our online provider directory. You may also call the Member Services toll free phone number on the front of your CareFirst BlueChoice ID card for assistance in selecting a PCP or obtaining a printed copy of the CareFirst BlueChoice provider directory.

Not all services and procedures are covered by your benefits contract. This summary is for comparison purposes only and does not create rights not given through the benefit plan.

The benefits described are issued under form numbers: MD/CFBC/GC (R. 1/13); MD/CFBC/EOC (R. 4/08); MD/CFBC/DOL APPEAL (R. 9/11); MD/CFBC/LG/HMO-POS IN/ DOCS (6/16); MD/CFBC/LG/HMO-POS IN/SOB (6/16); MD/CFBC/ELIG (R.7/09); MD/CFBC/RX (R. 1/16); MD/CFBC/INCENT (1/16) and any amendments.

CareFirst BlueChoice

www.carefirst.com

CareFirst BlueChoice, Inc. is an independent licensee of the Blue Cross and Blue Shield Association.
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®′ Registered trademark of CareFirst of Maryland, Inc.

SUM3276-1P (5/17) ■ MD ■ 51+ Option MV2

Pharmacy Program Summary of Benefits

Formulary 3 ■ 5-Tier ■ Minimum Value ■ $500 Deductible ■ $15/35/60 ■ Specialty 50%/50%

Plan Feature	Amount You Pay	Description
Individual Deductible	$500	If you meet your deductible, you will pay a different copay or coinsurance depending on the drug tier. Drugs not subject to any deductible are noted below.
Family Deductible	$1,000	If your family has met the deductible, all members will pay the copays associated with the drugs prescribed. No one family member may contribute more than the individual deductible amount to the family deductible.
Out-of-Pocket Maximum	See medical summary of benefits for annual out-of-pocket amount	If you reach your out-of-pocket maximum, CareFirst or CareFirst BlueChoice will pay 100% of the applicable allowed benefit for most covered services for the remainder of the year. All deductibles, copays, coinsurance and other eligible out-of-pocket costs count toward your out-of-pocket maximum, except balance billed amounts.
Preventive Drugs (up to a 34-day supply)	$0 (not subject to deductible)	A preventive drug is a prescribed medication or item on CareFirst's Preventive Drug List.*
Oral Chemotherapy Drugs and Diabetic Supplies (up to a 34-day supply)	$0 (not subject to deductible)	Diabetic supplies include needles, lancets, test strips and alcohol swabs.
Generic Drugs (Tier 1) (up to a 34-day supply)	$15	Generic drugs are covered at this copay level.
Preferred Brand Drugs (Tier 2) (up to a 34-day supply)	$35	All preferred brand drugs are covered at this copay level.
Non-preferred Brand Drugs (Tier 3) (up to a 34-day supply)	$60	All non-preferred brand drugs on this copay level are not on the Preferred Drug List.* Discuss using alternatives with your physician or pharmacist.
Preferred Specialty Drugs (Tier 4) (up to a 34-day supply)	50% up to a $100 maximum	You pay 50% coinsurance up to a maximum of $100 for all preferred specialty drugs. **Must be filled through Exclusive Specialty Pharmacy Network**.
Non-preferred Specialty Drugs (Tier 5) (up to a 34-day supply)	50% up to a $150 maximum	You pay 50% coinsurance up to a maximum of $150 for all non-preferred specialty drugs. **Must be filled through Exclusive Specialty Pharmacy Network.**
Maintenance Drugs (up to a 90-day supply)	Generic: $30 Preferred Brand: $70 Non-preferred Brand: $120 Preferred Specialty: 50% up to a $200 maximum Non-preferred Specialty: 50% up to a $300 maximum	Maintenance generic, preferred brand and non-preferred brand drugs up to a 90-day supply are available for twice the copay through Mail Service Pharmacy or a retail pharmacy. Maintenance preferred and non-preferred specialty drugs up to a 90-day supply **must be filled through Exclusive Specialty Pharmacy Network** and you pay 50% coinsurance up to a maximum copay.
Mandatory Generic Substitution	If a provider prescribes a non-preferred brand drug when a generic is available, you will pay the non-preferred brand copay or coinsurance PLUS the cost difference between the generic and brand drug up to the cost of the prescription. If a generic version is not available, you will only pay the copay or coinsurance.	

Visit **carefirst.com/rx** *for the most up-to-date drug lists, including the prescription guidelines. Prescription guidelines indicate drugs that require your doctor to obtain prior authorization from CareFirst before they can be filled and drugs that can be filled in limited quantities.*

This plan summary is for comparison purposes only and does not create rights not given through the benefit plan.

Policy Form Numbers: MD/CFBC/RX (R. 1/18) • CFMI/RX (R. 1/18) • CFMI/Matrix/PRESC DRUG (R. 1/18) • MD/CF/RX (R. 1/18)

CareFirst
Family of health care plans

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. CareFirst MedPlus is the business name of First Care, Inc. CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., First Care, Inc., and CareFirst BlueChoice, Inc., and The Dental Network are independent licensees of the Blue Cross and Blue Shield Association.
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BlueChoice Advantage Minimum Value

Summary of Benefits

Services	In-Network You Pay[1,2]	Out-of-Network You Pay[1,3]
	Visit www.carefirst.com/doctor to locate providers	
FIRSTHELP—24/7 NURSE ADVICE LINE		
Free advice from a registered nurse. Visit **www.carefirst.com/needcare** to learn more about your options for care.	When your doctor is not available, call FirstHelp at 800-535-9700 to speak with a registered nurse about your health questions and treatment options.	
BLUE REWARDS		
Visit **www.carefirst.com/bluerewards** for more information	Blue Rewards is an incentive program where you can earn up to $300 for taking an active role in getting healthy and staying healthy.	
ANNUAL DEDUCTIBLE (Benefit period)[4]		
Individual	$5,000	$10,000
Family	$10,000	$20,000
ANNUAL OUT-OF-POCKET MAXIMUM (Benefit period)[5]		
Medical[6]	$6,350 Individual/$12,700 Family	$12,700 Individual/$25,400 Family
Prescription Drug[6]	Combined with in-network medical out-of-pocket maximum	All drug cost are subject to in-network out-of-pocket maximum
LIFETIME MAXIMUM BENEFIT		
Lifetime Maximum	None	None
PREVENTIVE SERVICES		
Well-Child Care (including exams & immunizations)	No charge*	50% of Allowed Benefit
Adult Physical Examination (including routine GYN visit)	No charge*	Deductible, then 50% of Allowed Benefit
Breast Cancer Screening	No charge*	50% of Allowed Benefit
Pap Test	No charge*	Deductible, then 50% of Allowed Benefit
Prostate Cancer Screening	No charge*	Deductible, then 50% of Allowed Benefit
Colorectal Cancer Screening	No charge*	Deductible, then 50% of Allowed Benefit
OFFICE VISITS, LABS AND TESTING		
Office Visits for Illness	Deductible, then $40 per visit	Deductible, then 50% of Allowed Benefit
Imaging (MRA/MRS, MRI, PET & CAT scans)[7]	Deductible, then $40 per visit	Deductible, then 50% of Allowed Benefit
Lab[7]	Deductible, then $40 per visit	Deductible, then 50% of Allowed Benefit
X-ray[7]	Deductible, then $40 per visit	Deductible, then 50% of Allowed Benefit
Allergy Testing	Deductible, then $40 per visit	Deductible, then 50% of Allowed Benefit
Allergy Shots	Deductible, then $40 per visit	Deductible, then 50% of Allowed Benefit
Physical, Speech and Occupational Therapy[8] (limited to 30 visits/injury/benefit period)	Deductible, then $40 per visit	Deductible, then 50% of Allowed Benefit
Chiropractic (limited to 20 visits/benefit period)	Deductible, then $40 per visit	Deductible, then 50% of Allowed Benefit
Acupuncture	Not covered (except when approved or authorized by Plan when used for anesthesia)	Not covered (except when approved or authorized by Plan when used for anesthesia)
EMERGENCY SERVICES		
Urgent Care Center	Deductible, then $50 per visit	In-network deductible, then $50 per visit
Emergency Room—Facility Services	Deductible, then $250 per visit (waived if admitted)	In-network deductible, then $250 per visit (waived if admitted)
Emergency Room—Physician Services	No charge* after deductible	No charge* after in-network deductible
Ambulance (if medically necessary)	Deductible, then 20% of Allowed Benefit	In-network deductible, then 20% of Allowed Benefit

Services	In-Network You Pay[1,2]	Out-of-Network You Pay[1,3]
HOSPITALIZATION (Members are responsible for applicable physician and facility fees)		
Outpatient Facility Services	Deductible, then 20% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Outpatient Physician Services	Deductible, then 20% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Inpatient Facility Services	Deductible, then 20% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Inpatient Physician Services	Deductible, then 20% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
HOSPITAL ALTERNATIVES		
Home Health Care	Deductible, then 20% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Hospice (Inpatient—limited to 30 days; Outpatient—unlimited during Hospice eligibility period)	Deductible, then 20% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Skilled Nursing Facility (limited to 100 days/benefit period)	Deductible, then 20% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
MATERNITY		
Preventive Prenatal and Postnatal Office Visits	No charge*	Deductible, then 50% of Allowed Benefit
Delivery and Facility Services	Deductible, then 20% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Nursery Care of Newborn	Deductible, then 20% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Artificial and Intrauterine Insemination[9] (limited to 6 attempts per live birth)	Deductible, then 20% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
In Vitro Fertilization Procedures[9] (limited to 3 attempts per live birth up to $100,000 lifetime maximum)	Deductible, then 20% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
MENTAL HEALTH AND SUBSTANCE ABUSE (Members are responsible for applicable physician and facility fees)		
Inpatient Facility Services	Deductible, then 20% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Inpatient Physician Services	Deductible, then 20% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Outpatient Facility Services	Deductible, then 20% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Outpatient Physician Services	Deductible, then 20% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Office Visits	Deductible, then $40 per visit	Deductible, then 50% of Allowed Benefit
Medication Management	Deductible, then $40 per visit	Deductible, then 50% of Allowed Benefit
MEDICAL DEVICES AND SUPPLIES		
Durable Medical Equipment	Deductible, then 20% of Allowed Benefit	Deductible, then 50% of Allowed Benefit
Hearing Aids for ages 0-18 (limited to 1 hearing aid per hearing impaired ear every 3 years)	No charge*	No charge*
VISION		
Routine Exam (limited to 1 visit/benefit period)	$10 per visit at participating vision provider	Total charge minus $33 Allowed Benefit
Eyeglasses and Contact Lenses	Discounts from participating vision centers	Not covered

Note: Allowed Benefit is the fee that participating providers in the network have agreed to accept for a particular service. The participating provider cannot charge the member more than this amount for any covered service. Example: Dr. Carson charges $100 to see a sick patient. To be part of CareFirst's network, he has agreed to accept $50 for the visit. The member will pay their copay/coinsurance and deductible (if applicable) and CareFirst will pay the remaining amount up to $50.

* No copayment or coinsurance.

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

[2] In-Network: When covered services are rendered in Maryland, Washington D.C. and/or Northern Virginia, collectively known as the CareFirst BlueChoice service area, by a provider in the CareFirst BlueChoice Provider network, care is reimbursed at the in-network level. In-network benefits are based on the CareFirst BlueChoice Allowed Benefit. The CareFirst BlueChoice Allowed Benefit is generally the contracted rates or fee schedules that CareFirst BlueChoice providers have agreed to accept as payment for covered services. These payments are established by CareFirst BlueChoice, Inc., however, in certain circumstances, an allowance may be established by law. Outside of the CareFirst BlueChoice service area, when covered services are rendered by a provider in the preferred provider network, care is also covered at the in-network level. These in-network benefits are based on the contracted rates or fee schedules that preferred providers have agreed to accept as payment for covered services that are established by the local Blue Cross and Blue Shield Plan, however, in certain circumstances, an allowance may be established by law.

[3] Out-of-Network: When covered services are rendered by a provider that is not in the CareFirst BlueChoice network in Maryland, Washington D.C. or Northern Virginia, or is not in the preferred provider network outside of CareFirst BlueChoice service area, the care is reimbursed as out-of-network. Out-of-network benefits are based on the Allowed Benefit. The Allowed Benefit is generally the contracted rates or fee schedules that are established by CareFirst BlueChoice, or the local Blue Cross and Blue Shield Plan, however, in certain circumstances, an allowance may be established by law.

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

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

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

[7] If you receive laboratory services inside the CareFirst Service area (Maryland, D.C., Northern Virginia) members should use LabCorp to receive In-Network benefits. Services performed by any other provider, while inside the CareFirst Service area will be considered out-of-network. If you receive laboratory services outside of Maryland, D.C. or Northern Virginia, you may use any participating BlueCard PPO laboratory and receive in-network benefits.

[8] There are no limits for children until the end of the month in which the insured or enrollee turns 19 years of age when Physical, Speech or Occupational Therapy is included as part of Habilitative Services.

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

Not all services and procedures are covered by your benefits contract. This summary is for comparison purposes only and does not create rights not given through the benefit plan.

The benefits described are issued under form numbers: MD/CFBC/GC (R. 1/13); MD/CFBC/HPN/EOC (R. 6/10); MD/CFBC/DOL APPEAL (R. 9/11); MD/CFBC/PPN/DOCS (R. 6/10); MD/CFBC/PPN SOB (R. 6/10); MD/CFBC/ELIG (R. 7/09); MD/CFBC/RX (R. 7/12) and any amendments.

CareFirst

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Pharmacy Program Summary of Benefits

Formulary 3 ■ 5-Tier ■ Minimum Value ■ $500 Deductible ■ $15/35/60 ■ Specialty 50%/50%

Plan Feature	Amount You Pay	Description
Individual Deductible	$500	If you meet your deductible, you will pay a different copay or coinsurance depending on the drug tier. Drugs not subject to any deductible are noted below.
Family Deductible	$1,000	If your family has met the deductible, all members will pay the copays associated with the drugs prescribed. No one family member may contribute more than the individual deductible amount to the family deductible.
Out-of-Pocket Maximum	See medical summary of benefits for annual out-of-pocket amount	If you reach your out-of-pocket maximum, CareFirst or CareFirst BlueChoice will pay 100% of the applicable allowed benefit for most covered services for the remainder of the year. All deductibles, copays, coinsurance and other eligible out-of-pocket costs count toward your out-of-pocket maximum, except balance billed amounts.
Preventive Drugs (up to a 34-day supply)	$0 (not subject to deductible)	A preventive drug is a prescribed medication or item on CareFirst's Preventive Drug List.*
Oral Chemotherapy Drugs and Diabetic Supplies (up to a 34-day supply)	$0 (not subject to deductible)	Diabetic supplies include needles, lancets, test strips and alcohol swabs.
Generic Drugs (Tier 1) (up to a 34-day supply)	$15	Generic drugs are covered at this copay level.
Preferred Brand Drugs (Tier 2) (up to a 34-day supply)	$35	All preferred brand drugs are covered at this copay level.
Non-preferred Brand Drugs (Tier 3) (up to a 34-day supply)	$60	All non-preferred brand drugs on this copay level are not on the Preferred Drug List.* Discuss using alternatives with your physician or pharmacist.
Preferred Specialty Drugs (Tier 4) (up to a 34-day supply)	50% up to a $100 maximum	You pay 50% coinsurance up to a maximum of $100 for all preferred specialty drugs. **Must be filled through Exclusive Specialty Pharmacy Network**.
Non-preferred Specialty Drugs (Tier 5) (up to a 34-day supply)	50% up to a $150 maximum	You pay 50% coinsurance up to a maximum of $150 for all non-preferred specialty drugs. **Must be filled through Exclusive Specialty Pharmacy Network.**
Maintenance Drugs (up to a 90-day supply)	Generic: $30 Preferred Brand: $70 Non-preferred Brand: $120 Preferred Specialty: 50% up to a $200 maximum Non-preferred Specialty: 50% up to a $300 maximum	Maintenance generic, preferred brand and non-preferred brand drugs up to a 90-day supply are available for twice the copay through Mail Service Pharmacy or a retail pharmacy. Maintenance preferred and non-preferred specialty drugs up to a 90-day supply **must be filled through Exclusive Specialty Pharmacy Network** and you pay 50% coinsurance up to a maximum copay.
Mandatory Generic Substitution	If a provider prescribes a non-preferred brand drug when a generic is available, you will pay the non-preferred brand copay or coinsurance PLUS the cost difference between the generic and brand drug up to the cost of the prescription. If a generic version is not available, you will only pay the copay or coinsurance.	

Visit **carefirst.com/rx** *for the most up-to-date drug lists, including the prescription guidelines. Prescription guidelines indicate drugs that require your doctor to obtain prior authorization from CareFirst before they can be filled and drugs that can be filled in limited quantities.*

This plan summary is for comparison purposes only and does not create rights not given through the benefit plan.

Policy Form Numbers: MD/CFBC/RX (R. 1/18) • CFMI/RX (R. 1/18) • CFMI/Matrix/PRESC DRUG (R. 1/18) • MD/CF/RX (R. 1/18)

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BlueChoice Advantage

Non-Integrated Deductible

Summary of Benefits

Services	In-Network You Pay[1,2]	Out-of-Network You Pay[1,3]
	Visit **www.carefirst.com/doctor** to locate providers and facilities	
FIRSTHELP—24/7 NURSE ADVICE LINE		
Free advice from a registered nurse. Visit **www.carefirst.com/needcare** to learn more about your options for care.	When your doctor is not available, call FirstHelp at 800-535-9700 to speak with a registered nurse about your health questions and treatment options.	
BLUE REWARDS		
Visit **www.carefirst.com/bluerewards** for more information	Blue Rewards is an incentive program where you can earn up to $300 for taking an active role in getting healthy and staying healthy.	
ANNUAL MEDICAL DEDUCTIBLE (Benefit Period)[4]		
Individual	$2,000	$4,000
Family	$4,000	$8,000
ANNUAL OUT-OF-POCKET MAXIMUM (Benefit Period)[5]		
Medical[6]	$6,850 Individual/$13,700 Family	$7,850 Individual/$15,700 Family
Prescription Drug[6]	Combined with in-network out-of-pocket maximum	All drug costs are subject to in-network out-of-pocket maximum
PREVENTIVE SERVICES		
Well-Child Care (including exams & immunizations)	No charge*	No charge*
Adult Physical Examination (including routine GYN visit)	No charge*	No charge* after deductible
Breast Cancer Screening	No charge*	No charge*
Pap Test	No charge*	No charge* after deductible
Prostate Cancer Screening	No charge*	No charge* after deductible
Colorectal Cancer Screening	No charge*	No charge* after deductible
PCP AND SPECIALIST SERVICES		
FACILITY CHARGE[7]—In addition to the physician copays/coinsurances listed below, if a service is rendered on a hospital campus, ADD facility charge if applicable	$200 per visit	Deductible, then 20% of Allowed Benefit
Office Visits for Illness—PCP[7,8]	$20 per visit	Deductible, then 20% of Allowed Benefit
Convenience Care (retail health clinics such as CVS MinuteClinic or Walgreens Healthcare Clinic)	$20 per visit	Deductible, then 20% of Allowed Benefit
Office Visits for Illness—Specialist[7,8]	$40 per visit	Deductible, then 20% of Allowed Benefit
Allergy Testing[7]	$40 per visit	Deductible, then 20% of Allowed Benefit
Allergy Shots[7]	$40 per visit	Deductible, then 20% of Allowed Benefit
Physical, Speech, and Occupational Therapy[7,9] (limited to 30 visits/benefit period)	$40 per visit	Deductible, then 20% of Allowed Benefit
Chiropractic Services[7] (limited to 20 visits/benefit period)	$40 per visit	Deductible, then 20% of Allowed Benefit
Acupuncture[7,9] (limited to 20 visits/benefit period)	$40 per visit	Deductible, then 20% of Allowed Benefit
EMERGENCY SERVICES		
Urgent Care Center[10] (such as Patient First or Express Care)	$60 per visit	$60 per visit
Hospital Emergency Room Services[10]		
▪ Facility	Deductible, then $200 per visit (waived if admitted)	In-network deductible, then $200 per visit (waived if admitted)
▪ Physician	No charge* after deductible	No charge* after in-network deductible
Ambulance[10] (if medically necessary)	Deductible, then $50 per service	In-network deductible, then $50 per service

Services	In-Network You Pay[1,2]	Out-of-Network You Pay[1,3]
DIAGNOSTIC SERVICES		
Labs[11]		
▪ Non-Hospital/Freestanding Facility	$20 per visit	Deductible, then 20% of Allowed Benefit
▪ Hospital	Deductible, then $100 per visit	Deductible, then 20% of Allowed Benefit
X-ray		
▪ Non-Hospital/Freestanding Facility	$40 per visit	Deductible, then 20% of Allowed Benefit
▪ Hospital	Deductible, then $150 per visit	Deductible, then 20% of Allowed Benefit
Imaging		
▪ Non-Hospital/Freestanding Facility	$80 per visit	Deductible, then 20% of Allowed Benefit
▪ Hospital	Deductible, then $200 per visit	Deductible, then 20% of Allowed Benefit
HOSPITALIZATION—(Members are responsible for both physician and facility fees)		
Outpatient Surgical Center Services		
▪ Facility	$100 per visit	Deductible, then 20% of Allowed Benefit
▪ Physician	$40 per visit	Deductible, then 20% of Allowed Benefit
Outpatient Hospital Surgical Services		
▪ Facility	Deductible, then $200 per visit	Deductible, then 20% of Allowed Benefit
▪ Physician	Deductible, then $40 per visit	Deductible, then 20% of Allowed Benefit
Inpatient Hospital Services		
▪ Facility	Deductible, then $300 per day ($1,500 maximum per admission)	Deductible, then 20% of Allowed Benefit
▪ Physician	Deductible, then $40 per visit	Deductible, then 20% of Allowed Benefit
HOSPITAL ALTERNATIVES		
Home Health Care	No charge*	Deductible, then 20% of Allowed Benefit
Hospice (Inpatient—limited to 30 days; Outpatient—unlimited during Hospice eligibility period)	No charge*	Deductible, then 20% of Allowed Benefit
Skilled Nursing Facility (limited to 60 days/benefit period)	Deductible, then $200 per admission	Deductible, then 20% of Allowed Benefit
MATERNITY		
Preventive Prenatal and Postnatal Office Visits	No charge*	Deductible, then 20% of Allowed Benefit
Delivery and Facility Services	Deductible, then $300 per day ($1,500 maximum per admission)	Deductible, then 20% of Allowed Benefit
Artificial and Intrauterine Insemination[7,12] (limited to 6 attempts per live birth)	Deductible, then 25% of Allowed Benefit	Deductible, then 45% of Allowed Benefit
In Vitro Fertilization Procedures[7,12] (limited to 3 attempts per live birth up to $100,000 lifetime maximum)	Deductible, then 25% of Allowed Benefit	Deductible, then 45% of Allowed Benefit
MENTAL HEALTH AND SUBSTANCE ABUSE—(Members are responsible for both physician and facility fees)		
Office Visits	$20 per visit	Deductible, then 20% of Allowed Benefit
Outpatient Services		
▪ Facility	$80 per visit	Deductible, then 20% of Allowed Benefit
▪ Physician	$40 per visit	Deductible, then 20% of Allowed Benefit
Inpatient Services		
▪ Facility	Deductible, then $300 per day ($1,500 maximum per admission)	Deductible, then 20% of Allowed Benefit
▪ Physician	Deductible, then $40 per visit	Deductible, then 20% of Allowed Benefit
MEDICAL DEVICES AND SUPPLIES		
Durable Medical Equipment	Deductible, then 25% of Allowed Benefit	Deductible, then 45% of Allowed Benefit
Hearings Aids for ages 0-18 (limited to one hearing aid per hearing-impaired ear every 3 years)	No charge*	Deductible, then 20% of Allowed Benefit
VISION		
Routine Exam (limited to 1 visit/benefit period)	$10 per visit at participating vision provider	Total charge minus $33 Allowed Benefit
Eyeglasses and Contact Lenses	Discounts from participating vision centers	Not covered

Note: Allowed Benefit is the fee that participating, in-network providers have agreed to accept for a particular covered service. The provider cannot charge the member more than this amount for any covered service. Example: Dr. Carson charges $100 to see a sick patient. To be part of CareFirst's network, he has agreed to accept $50 for the visit. The member will pay their copay/coinsurance and deductible (if applicable) and CareFirst will pay the remaining amount up to $50.

* No copayment or coinsurance.

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

[2] In-Network: When covered services are rendered in Maryland, Washington D.C. and/or Northern Virginia, collectively known as the CareFirst BlueChoice service area, by a provider in the CareFirst BlueChoice Provider network, care is reimbursed at the in-network level. In-network benefits are based on the CareFirst BlueChoice Allowed Benefit. The CareFirst BlueChoice Allowed Benefit is generally the contracted rates or fee schedules that CareFirst BlueChoice providers have agreed to accept as payment for covered services. These payments are established by CareFirst BlueChoice, Inc., however, in certain circumstances, an allowance may be established by law. Outside of the CareFirst BlueChoice service area, when covered services are rendered by a provider in the preferred provider network, care is also covered at the in-network level. These in-network benefits are based on the contracted rates or fee schedules that preferred providers have agreed to accept as payment for covered services that are established by the local Blue Cross and Blue Shield Plan, however, in certain circumstances, an allowance may be established by law.

[3] Out-of-Network: When covered services are rendered by a provider that is not in the CareFirst BlueChoice network in Maryland, Washington D.C. or Northern Virginia, or is not in the preferred provider network outside of CareFirst BlueChoice service area, the care is reimbursed as out-of-network. Out-of-network benefits are based on the Allowed Benefit. The Allowed Benefit is generally the contracted rates or fee schedules that are established by CareFirst BlueChoice, or the local Blue Cross and Blue Shield Plan, however, in certain circumstances, an allowance may be established by law.

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

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

[6] Plan has separate out-of-pocket maximums for medical and drug expenses which accumulate independently.

[7] If a service is rendered on a hospital campus you could receive two bills, one from the physician and one from the facility.

[8] "Telemedicine services" refers to the use of a combination of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment. Use of audio-only telephone, electronic mail message (e-mail), or facsimile transmission (FAX) is not considered a telemedicine service.

[9] There are no limits for children until the end of the month in which the insured or enrollee turns 19 years of age when Physical, Speech or Occupational Therapy is included as part of Habilitative Services.

[10] If the out-of-network benefit is listed as contributing toward the in-network deductible, then it also contributes toward the in-network out-of-pocket maximum.

[11] Members accessing laboratory services inside the CareFirst Service area (Maryland, D.C., Northern Virginia) must use LabCorp as their Lab Test facility and a non-hospital/ freestanding facility for X-rays and specialty Imaging for In-Network benefits. Services performed by any other provider, while inside the CareFirst Service area will be considered Out-of-Network. Members accessing laboratory, X-rays, and specialty Imaging services outside of Maryland, D.C. or Northern Virginia, may use any participating BlueCard PPO facility and receive in-network benefits.

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

Not all services and procedures are covered by your benefits contract. This summary is for comparison purposes only and does not create rights not given through the benefit plan.

The benefits described are issued under form numbers: MD/CFBC/GC (R. 1/13); MD/CFBC/HPN/EOC (R. 6/10); MD/CFBC/DOL APPEAL (R. 9/11); MD/CFBC/LG/POS/DOCS (6/16); MD/CFBC/LG/POS/SOB (6/16); MD/CFBC/ELIG (R. 7/09); MD/CFBC/RX (R. 1/16); MD/CFBC/INCENT (1/16) and any amendments.

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Pharmacy Program Summary of Benefits

Formulary 3 ■ 5-Tier ■ $0 Deductible ■ $15/35/60 ■ Specialty 50%/50%

Plan Feature	Amount You Pay	Description
Individual Deductible	None	Your benefit does not have a deductible.
Family Deductible	None	Your benefit does not have a family deductible.
Out-of-Pocket Maximum	See medical summary of benefits for annual out-of-pocket amount	If you reach your out-of-pocket maximum, CareFirst or CareFirst BlueChoice will pay 100% of the applicable allowed benefit for most covered services for the remainder of the year. All deductibles, copays, coinsurance and other eligible out-of-pocket costs count toward your out-of-pocket maximum, except balance billed amounts.
Preventive Drugs (up to a 34-day supply)	$0	A preventive drug is a prescribed medication or item on CareFirst's Preventive Drug List.*
Oral Chemotherapy Drugs and Diabetic Supplies (up to a 34-day supply)	$0	Diabetic supplies include needles, lancets, test strips and alcohol swabs.
Generic Drugs (Tier 1) (up to a 34-day supply)	$15	Generic drugs are covered at this copay level.
Preferred Brand Drugs (Tier 2) (up to a 34-day supply)	$35	All preferred brand drugs are covered at this copay level.
Non-preferred Brand Drugs (Tier 3) (up to a 34-day supply)	$60	All non-preferred brand drugs on this copay level are not on the Preferred Drug List.* Discuss using alternatives with your physician or pharmacist.
Preferred Specialty Drugs (Tier 4) (up to a 34-day supply)	50% up to a $100 maximum	You pay 50% coinsurance up to a maximum of $100 for all preferred specialty drugs. **Must be filled through Exclusive Specialty Pharmacy Network**.
Non-preferred Specialty Drugs (Tier 5) (up to a 34-day supply)	50% up to a $150 maximum	You pay 50% coinsurance up to a maximum of $150 for all non-preferred specialty drugs. **Must be filled through Exclusive Specialty Pharmacy Network**.
Maintenance Drugs (up to a 90-day supply)	Generic: $30 Preferred Brand: $70 Non-preferred Brand: $120 Preferred Specialty: 50% up to a $200 maximum Non-preferred Specialty: 50% up to a $300 maximum	Maintenance generic, preferred brand and non-preferred brand drugs up to a 90-day supply are available for twice the copay through Mail Service Pharmacy or a retail pharmacy. Maintenance preferred and non-preferred specialty drugs up to a 90-day supply **must be filled through Exclusive Specialty Pharmacy Network** and you pay 50% coinsurance up to a maximum copay.
Restricted Generic Substitution	If a provider prescribes a non-preferred brand drug when a generic is available, you will pay the non-preferred brand copay or coinsurance PLUS the cost difference between the generic and brand drug up to the cost of the prescription. If a generic version is not available, you will only pay the copay or coinsurance. Also, if your prescription is written for a brand-name drug and DAW (dispense as written) is noted by your doctor, you will only pay the copay or coinsurance.	

Visit **carefirst.com/rx** *for the most up-to-date drug lists, including the prescription guidelines. Prescription guidelines indicate drugs that require your doctor to obtain prior authorization from CareFirst before they can be filled and drugs that can be filled in limited quantities.*

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DOMINION NATIONAL DENTAL

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Choice 100/80/50/50

	In Network	Out of Network
DIAGNOSTIC & PREVENTIVE		
Oral examinations	100%	100%
Teeth cleaning	100%	100%
X-rays	100%	100%
BASIC RESTORATIVE		
Fillings	80%	80%
Simple extractions	80%	80%
Denture repairs	80%	80%
General anesthesia	80%	80%
ENDODONTICS		
Root canals	80%	80%
PERIODONTICS		
Scaling and root planing	80%	80%
Gingevectomy/gingivoplasty	80%	80%
ORAL SURGERY		
Extraction of impacted teeth	80%	80%
MAJOR RESTORATIVE		
Inlays and onlays	50%	50%
Crowns	50%	50%
Dentures	50%	50%
Implants (in lieu of a 3-unit bridge)	50%	50%
Fixed bridges	50%	50%
ORTHODONTICS	50%	50%
ORTHODONTICS AGE LIMIT	19	
ORTHODONTICS LIFETIME MAXIMUM	$1500	
CALENDAR YEAR DEDUCTIBLE (waived for Preventive)		
Individual	$50	$50
Family	$150	$150
CALENDAR YEAR MAXIMUM	$1500	$1500
OUT OF POCKET MAXIMUM	N/A	N/A
MAXIMUM ROLLOVER	$1250	
DEPENDENT AGE LIMIT	26	
OUT OF NETWORK REIMBURSEMENT*	MAC	
WAITING PERIODS	None	

The dental plan is underwritten by Dominion Dental Services, Inc. d/b/a Dominion National.

* Out-of-Network Allowance: A limitation on a billed charge, as determined by the Plan, by geographic area where the expenses are incurred. Please note when using out-of-network services members may incur any charges exceeding the allowed amount.

Plan will pay either the Participating Dentist's negotiated fee or the Maximum Allowable Charge (subject to benefit coverage percentage) for dental procedures and services as shown below, after any required Annual Deductible.

Benefits

You have the right to benefits on a non-discriminatory basis for the following services, EXCEPT as limited or excluded elsewhere in this Subscriber Certificate. The benefits are limited to a maximum dollar payment for each *covered individual* for each benefit period. The extent of your benefits is explained in the *Schedule of Benefits* your *Plan Sponsor* has purchased and which is incorporated as a part of this Subscriber Certificate.

- Initial oral examination (including the initial dental history and charting of teeth); once per dentist.
- Periodic exam; once every six (6) months.
- X-rays of the entire mouth; once every sixty (60) months.
- Bitewing x-rays (x-rays of the crowns of the teeth); once every six (6) months or when oral conditions indicate need.
- Single tooth x-rays; as needed.
- Study models and casts used in planning treatment; once every sixty (60) months.
- Routine cleaning, scaling and polishing of teeth; once every six (6) months.
- Periodontal maintenance, including cleaning and scaling and root planing procedures, following active periodontal therapy when preceded by active periodontal therapy.
- Fluoride treatment for children under nineteen (19) years; once every six (6) months.
- Fluoride treatment for adults following osseous surgery or new decay.
- Space maintainers required due to the premature loss of teeth; only for children under age fourteen (14) and not for the replacement of primary or permanent anterior teeth.
- Sealants on unrestored permanent molars; once per tooth for children through age fifteen (15).
- Fillings consisting of silver amalgam and (in the case of front teeth) synthetic tooth color fillings, but limited to one filling for each tooth surface for each twenty-four (24) month period. However, synthetic (white) fillings are limited to single surface restorations for posterior teeth. Multi-surface synthetic restorations on posterior teeth will be treated as an alternate benefit and an amalgam allowance will be allowed. The patient is responsible up to the dentist's charge. No benefits are provided for replacing a filling within twenty-four (24) months of the date that the prior filling was furnished.
- Sedative fillings; once per tooth.
- Stainless steel crowns on deciduous (baby) teeth; once every twenty-four (24) months.
- Simple tooth extractions.
- General anesthesia only when necessary and appropriate for covered surgical services only when provided by a licensed, practicing dentist.
- Repair of dentures or fixed bridges; once every twelve (12) months. Recementing of fixed bridges; once each twelve (12) months.
- Rebase or reline dentures; once every thirty-six (36) months.
- Tissue conditioning; two treatments every thirty-six (36) months.
- Repair or recement crowns and onlays. Recementing is limited to once every twelve (12) months per tooth.
- Adding teeth to existing partial or full dentures.
- Palliative (emergency) treatment of dental pain – minor procedures.
- Certain surgical services to treat oral disease or injury. This includes surgical tooth extractions and extractions of impacted teeth.
- Periodontal services to treat diseased gum tissue or bone including the removal of diseased gum tissue (gingivectomy) and the removal or reshaping of diseased bone (osseous surgery).
- Endodontic services for root canal treatment of permanent teeth except for permanent molars including the treatment of the nerve of a tooth, the removal of dental pulp, and pulpal therapy. Vital pulpotomy is limited to deciduous teeth.
- Dentures and Bridges
    - Complete or partial dentures and fixed bridges including services to measure, fit, and adjust them; once every sixty (60) months.
    - Replacement of dentures and fixed bridges, but only when they cannot be made serviceable and were inserted at least sixty (60) months before replacement.
    - Temporary partial dentures as follows:
        - To replace any of the six (6) upper or lower front teeth, but only if they are installed immediately following the loss of teeth during the period of healing.
        - For the replacement of permanent teeth for Covered Individuals who are under sixteen (16) years.
- Crowns and Onlays as follows, but only when the teeth cannot be restored with the fillings described in the Schedule of Benefits due to severe decay or fractures:
    - Initial placement of crowns and onlays.
    - Replacement of crowns and onlays; once each sixty (60) months per tooth.
- Endosteal implant, a device surgically inserted into the bone to provide support for a single restoration when used in lieu of a three unit bridge and adjacent abutment teeth are not to be restored, age sixteen (16) or older, once per tooth per sixty (60) months.

Limitations and Exclusions

1. BENEFITS ARE PROVIDED ONLY FOR NECESSARY AND APPROPRIATE SERVICES

We will not provide benefits for a dental service that is not covered under the terms of the Subscriber Certificate. We will not provide benefits for a covered dental service that is not necessary and appropriate to diagnose or to treat your dental condition. We will not cover experimental care procedures that have not been sanctioned by the American Dental Association and for which no procedure codes have been established.

A. To be necessary and appropriate, a service must be consistent with the prevention of oral disease or with the diagnosis and treatment on (1) those teeth that are decayed or *fractured* or (2) those teeth where supporting periodontium is weakened by disease in accordance with standards of good dental practice not solely for your convenience or the convenience of your dentist.

B. Who determines what is necessary and appropriate under the terms of the Subscriber Certificate: That decision is made based on a review of dental records describing your condition and treatment. We may decide a service is not necessary and appropriate under the terms of the Subscriber Certificate even if your dentist has furnished, prescribed, ordered, recommended or approved the service.

2. WE DO NOT PROVIDE BENEFITS FOR:

- Experimental care procedures that have not been sanctioned by the American Dental Association, or for which no procedure codes have been established.
- A service or procedure that is not described as a benefit in this Subscriber Certificate.
- Services that are rendered due to the requirements of a third party, such as an employer or school.
- Travel time and related expenses.
- An illness or injury that we determine arose out of and in the course of your employment.
- A service for which you are not required to pay, or for which you would not be required to pay if you did not have coverage under this Subscriber Certificate.
- An illness, injury or dental condition for which benefits in one form or another are covered, in whole or in part, through a government program. A government program includes a local, state or national law or regulation that provides or pays for dental services. It does not include Medicaid or Medicare.
- A method of treatment more costly than is customarily provided. Benefits will be based on the least costly method of treatment.
- A separate fee for services rendered by interns, residents, fellows or dentists who are salaried employees of a hospital or other facility.
- Appointments with your dentist that you fail to keep.
- Dietary advice and instructions in dental hygiene including proper methods of tooth brushing, the use of dental floss, plaque control programs and caries susceptibility tests.
- A service rendered by someone other than a licensed dentist or a hygienist who is employed by a licensed dentist.
- Prescription drugs.
- A service to treat disorders of the joints of the jaw (temporomandibular joints).
- A service, supply or procedure to increase the height of teeth (increase vertical dimension) or restore occlusion.
- Restorations for reasons other than decay or fracture, such as erosion, abrasion, or attrition.
- Services that are meant primarily to change or to improve your appearance.
- Occlusal guards for the treatment of disorders of the joints of the jaw or for bruxism (grinding).
- Repair or reline of an occlusal guard.
- Implants, other than covered endosteal implants.
- Transplants.
- Replacement of dentures, bridges, space maintainers or periodontic appliances due to theft or loss.
- Services, supplies or appliances to stabilize teeth when required due to periodontal disease such as periodontal splinting.
- Lab exams.
- Photographs.
- Laminate veneers.
- Duplicate dentures and bridges.
- Temporary, complete dentures and temporary fixed bridges or crowns.
- Stainless steel crowns on permanent teeth.
- Cast restorations, copings and attachments for installing over dentures.
- Services related to congenital anomalies. However, this exclusion does not apply to orthodontic services that may be covered by your group's orthodontic rider.
- Tooth desensitization.
- Occlusal adjustment.

National Vision Administrators, L.L.C.

Your NVA Vision Benefit Summary

Arena Technical Resources, LLC
Effective 08/01/2017
Group Number# 8936

Schedule of Vision Benefits

Benefit Frequency	Participating Provider	Non-Participating Provider
Examination Once Every Plan Year	▪ Covered 100% After $10 copay	Reimbursed Amount ▪ Up to $35
Lenses Once Every Plan Year ▪ Single Vision ▪ Bifocal ▪ Trifocal ▪ Lenticular	Standard Glass or Plastic ▪ Covered 100% After $25 copay	 ▪ Up to $30 ▪ Up to $45 ▪ Up to $75 ▪ Up to $75
Frame Once Every Two Plan Years	Retail Allowance ▪ Up to $130 (20% discount off balance)*	▪ Up to $50
Contact Lenses Once Every Plan Year	In lieu of Lenses	In lieu of Lenses
Elective Contact Lenses	▪ Up to $130 Retail (15% discount (Conventional) or 10% discount (Disposable) off balance)**	▪ Up to $98
Contact Lens Evaluation/Fitting***	▪ Covered 100% after $20 Daily Wear / $30 Extended Wear copay	Daily Wear: $20 Extended Wear: $30
Medically Necessary****	▪ Covered 100%	▪ Up to $210

How Your Vision Care Program Works

Eligible members and dependents are entitled to receive a vision examination and one (1) pair of lenses once every plan year and a frame once every two plan years or contact lenses and contact lens evaluation/fitting once every plan year.

For your convenience, at the start of the program, you will receive two identification cards with participating providers in your zip code area listed on the back. At the time of your appointment, simply present your NVA identification card to the provider or indicate that your benefit is administered by NVA. The provider will contact NVA to verify eligibility. A vision claim form is not required at an NVA participating provider.

Be sure to inform the provider of your medical history and any prescription or over-the-counter (OTC) medications you may be taking.

To verify your benefit eligibility prior to calling or visiting your eye care provider, please visit our website at www.e-nva.com or contact NVA's Customer Service Department toll-free at 1.800.672.7723 (TDD line 1-888-820-2990) or NVA's Interactive Voice Response (IVR). Customer Service is available 24 hours a day, 7 days a week, 365 days a year. Any question any time.

If you are not a registered subscriber, you can still search our providers online by selecting the "Find a Provider" link on our home page. Enter group number 8936000001 or the group number on the identification card and enter in your search parameters. It's that easy!

*Does not apply to Wal-Mart / Sam's Club locations or for certain proprietary brands. **Does not apply to Wal-Mart/Sam's Club, Contact Fill (NVA Mail Order) or certain locations at: Target, Sears, Pearle, & K-Mart and may be prohibited by some manufacturers. ***Only covered if you choose Contact Lenses. ****Pre-approval from NVA required.

Due to their everyday low prices (EDLP) the amounts listed below may not be applicable at Wal-Mart/Sam's Club.

Lens options purchased from a participating NVA provider will be provided to the member at the amounts listed in the fixed option pricing list below:

- $10 Solid Tint
- $12 Fashion / Gradient Tint
- $10 Standard Scratch-Resistant Coating
- $12 Ultraviolet Coating
- $40 Standard Anti-Reflective
- $20 Glass Photogrey (Single Vision)
- $30 Glass Photogrey (Multi-Focal)
- $75 Polarized
- $50 Progressive Lenses Standard*
- $65 Transitions Single Vision Standard
- $70 Transitions Multi-Focal Standard
- $25 Polycarbonate (Single Vision)
- $30 Polycarbonate (Multi-Focal)
- $30 Blended Bifocal (Segment)
- $55 High Index
- $100 Progressive Lenses Premium*

***Fixed Pricing not available on certain brands**

Options not listed will be priced by NVA providers at their R&C retail price less 20%. In MD, members may be required to pay the full retail cost and not the negotiated discount amount at certain participating providers.

Participating providers are not contractually obligated to offer sale prices in addition to outlined coverage. Regardless of medical or optical necessity, vision benefits are not available more frequently than specified in your policy.

Get a Better View

Plan Specific Details Online: The NVA website is easy to use and provides the most up to date information for program participants:
-Locate a nearby participating provider by name, zip code, or City/State, Verify eligibility for you or a dependent
-View benefit program and specific detail, Review claims, Print ID cards (when applicable), Nominate a non-participating provider to join the NVA network

Examinations*:* The comprehensive exam includes case history, examination for pathology or anomalies, visual acuity (clearness of vision), refraction, tonometry (glaucoma test) and dilation (if professionally indicated).

Lenses: NVA provides coverage in full for standard glass or plastic eyeglass lenses.

Frames: Select any frame from the participating provider's inventory. Any amount in excess of your plan allowance is the member's responsibility. Frame choices vary from office to office. (Visit NVA's website to view the Benefit maximizer Program)

Contact Lenses: The contact lens benefit includes all types of contact lenses such as hard, soft, gas permeable and disposable lenses. Medically necessary contact lenses includes fitting and follow up and may be covered with prior authorization when prescribed for: post cataract surgery, correction of extreme visual acuity problems that cannot be corrected to 20/70 with spectacle lenses, Anisometropia or Keratoconus.

Non-Participating Providers: You will be responsible for one hundred percent (100%) of the cost at the time of service at a non-participating provider. You can request a claim form from NVA via the website www.e-nva.com or you may submit receipts along with a letter containing the member's full name, patient's full name, address, ID# and sponsoring organization to NVA, P.O. Box 2187, Clifton, NJ 07015.

Laser Eye Surgery: NVA has chosen **The National LASIK Network** to serve their members. This network was developed by **LCA Vision** in 1999 and is one of the largest panels of LASIK surgeons in the U.S. Members are entitled to significant discounts and a free initial consultation with all in-network providers.

Hearing Discount: You will receive up to 30-60% off retail at participating provider locations through EPIC Hearing.

Discounts: In addition to your funded benefit you are eligible to access the **EyeEssential® Plan discount** (in Network Only) on additional purchases during the plan period. Please see table for more detail regarding NVA's discount plan:

*Discount is not applicable to mail order; however, you may get even better pricing on contact lenses through Contact Fill.

In MD, members may be required to pay the full retail cost and not the negotiated discount amount at certain participating providers.

Your NVA EyeEssential® Plan Discount – In Network Only

Service	Participating Provider	Lens Options
	Member Cost:	
Eye Examination:	Retail Less $10	$12 Solid Tint/ Gradient Tint $50 Standard Progressive Lenses
Contact Lens Fitting:	Retail Less 10%	$75 Polarized Lenses $65 Transitions Single Vision Standard
Lenses:	Glass or Plastic	$70 Transitions Multi-Focal Standard $15 Standard Scratch Coating
Single Vision	$35.00	$12 UV Coating
Bifocal	$55.00	$35 Polycarbonate
Trifocal or Lenticular	$70.00	$45 Standard Anti-Reflective
Frame:	Retail Less 35%	
Contact Lenses*:	**Member Cost:**	
Conventional	Retail Less 15%	
Disposable	Retail Less 10%	

Lens options purchased from a participating NVA provider will be provided to the member at the amounts listed in the fixed option price list above.

Options not listed will be priced by NVA providers at their reasonable & customary retail price less 20%.

Wal-Mart / Sam's Club Stores: Due to their everyday low prices (EDLP) Wal-Mart / Sam's Club stores do not provide additional discounts.

At NVA, We Work Only for Our Clients.

Insurance coverage provided by National Guardian Life Insurance Company (NGLIC), 2E Gilman, Madison, WI 53703. Policy NVIGRP 5/07. NGLIC is not affiliated with the Guardian Life Insurance Company of America, a/k/a The Guardian or Guardian Life. A full description of your coverage, its limitations, exclusions and conditions is contained in the Insurance Policy issued to your Plan Sponsor at its place of business. That full description in the form of a Certificate of Coverage can be made available to you by requesting it from your Plan Sponsor.

Exclusions / Limitations*:* No payment is made for medical or surgical treatments / Rx drugs or OTC medications / non-prescription lenses / two pair of glasses in lieu of bifocals / subnormal visual aids / vision examination or materials required for employment / replacement of lost, stolen, broken or damaged lenses/ contact lenses or frames except at normal intervals when service would otherwise be available / services or materials provided by federal, state, local government or Worker's Compensation / examination, procedures training or materials not listed as a covered service / industrial safety lenses and safety frames with or without side shields / parts or repair of frame / sunglasses.

National Vision Administrators, L.L.C. ▫ PO Box 2187 ▫ Clifton, NJ 07015
Web: www.e-nva.com ▫ Toll-Free: 1.800.672.7723
NVA® and EyeEssential® are registered marks of National Vision Administrators, L.L.C.

This document is intended as a program overview only and is not a certified document of the individual plan parameters.

COUNCIL 13 AFSCME UNION LABEL

www.e-nva.com

› Short-Term Disability Insurance

How Would You Pay Your Bills if You Were Sick or Injured Temporarily?

Even a short illness or injury could seriously impact your paycheck. Sick time will get you by while it lasts, but what happens when your sick days run out? A short-term disability policy provides you with cash benefits when you need it.

We've Got You Covered

As an active employee of Arena Technical Resources, LLC, you have access to a disability income insurance policy from United of Omaha Life Insurance Company.

A disability income insurance policy can help provide security when you need it, plus give you peace of mind so you can recover faster and get back on the job sooner.

Coverage guidelines and benefits are outlined below.

ELIGIBILITY - ALL ELIGIBLE EMPLOYEES	
Eligibility Requirement	You must be actively working a minimum of 30 hours per week to be eligible for coverage.
Premium Payment	The premiums for this insurance are paid in full by the policyholder. There is no cost to you for this insurance.
BENEFITS	
Elimination Period	If you become disabled, there is an elimination period before benefits are payable. Your benefits begin: • On the 15th day of your disabling injury. • On the 15th day of your disabling illness.
Weekly Benefit	Your benefit is equivalent to 60% of your before-tax weekly earnings, not to exceed the plan's maximum weekly benefit amount less other income sources.
Maximum Benefit Period	Up to 11 weeks
Maximum Weekly Benefit	$1,000
Minimum Weekly Benefit	None
Partial Disability Benefits	If you become disabled and can work part-time (but not full-time), you may be eligible for partial disability benefits, which will help supplement your income until you are able to return to work full-time.

DEFINITIONS	
Definition of Disability	Disability and disabled mean that because of an injury or illness, a significant change in your mental or functional abilities has occurred, for which you are prevented from performing at least one of the material duties of your regular job and are unable to generate current earnings which exceed 99% of your weekly earnings from your regular job. You can be totally or partially disabled during the elimination period.
Definition of Weekly Earnings	Weekly earnings for salaried employees is the gross annual salary in effect immediately prior to the date disability begins, divided by 52. Weekly earnings for hourly employees is the hourly rate of pay multiplied by the average number of hours worked per week during the 12 month period immediately prior to the date disability begins. If employed for part of the prior 12 month period, weekly earnings is the hourly rate of pay multiplied by the average number of hours worked.
FEATURES	
Vocational Rehabilitation Benefit	If you become disabled and participate in the vocational rehabilitation program, you will be eligible for a monthly benefit increase of 5%.
SERVICES	
Hearing Discount Program	The Hearing Discount Program provides you and your family discounted hearing products, including hearing aids and batteries. Call 1-888-534-1747 or visit www.amplifonusa.com/mutualofomaha to learn more.

Frequently Asked Questions

Who is eligible for this insurance?

You must be actively working (performing all normal duties of your job) at least 30 hours per week.

How long will my benefits be paid?

Benefits begin after the end of the elimination period and can be payable up to the maximum benefit period as long as you remain disabled.

Will my benefits be reduced by other sources of income?

Yes, depending on the type of income you receive. Your benefit amount may be reduced by other sources of income such as retirement/government plans, other group disability plans, paid family leave, salary continuance/sick leave, settlements on payments received and no-fault benefits.

Does this plan cover me if I become disabled due to an injury at work?

No, your STD insurance only provides benefits for off-the-job coverage for disabilities due to injury or sickness.

Are there any limitations or exclusions?

The benefits payable are subject to the following:

- A pre-existing condition limitation does not apply.
- Benefits are not payable for any disability or loss that:
  - Results from an act of declared or undeclared war or armed aggression
  - Results from participation in a riot or commission of or attempt to commit a felony
  - Arises out of or in the course of employment with the policyholder for benefits under any workers' compensation or occupational disease law, or receives any settlement from the workers' compensation carrier
  - Results, whether the insured person is sane or insane, from an intentionally self-inflicted injury or illness, suicide, or attempted suicide
  - Occurs while incarcerated or imprisoned for any period exceeding 31 days
  - Is solely a result of a loss of a professional license, occupation license or certification

All exclusions may not be applicable, or may be adjusted, as required by state regulations.

This information describes some of the features of the benefits plan. Benefits may not be available in all states. Please refer to the certificate booklet for a full explanation of the plan's benefits, exclusions, limitations and reductions. Should there be any discrepancy between the certificate booklet and this summary, the certificate booklet will prevail. Benefits availability is subject to final acceptance and approval of the group application by the underwriting company. Disability income insurance is underwritten by United of Omaha Life Insurance Company, 3300 Mutual of Omaha Plaza, Omaha, NE 68175, 1-800-769-7159. United of Omaha Life Insurance Company is licensed nationwide, except in New York. Policy form number 7000GM-U-EZ-2010.

› Long-Term Disability Insurance

Your Ability to Earn an Income May Be Your Most Important Asset

Most people don't think twice about insuring their home, automobile or health. However, many people don't recognize just how important it is to insure their income.

We've Got You Covered

As an active employee of Arena Technical Resources, LLC, you have access to a disability income insurance policy from United of Omaha Life Insurance Company.

A lengthy disability can be devastating, and is more common than you might think. It may lead to a loss of income, independence and financial security.

A disability income insurance policy can help provide security when you need it most. It pays you cash benefits when you're sick or hurt and can't work.

Coverage guidelines and benefits are outlined in the chart below.

ELIGIBILITY - ALL ELIGIBLE EMPLOYEES	
Eligibility Requirement	You must be actively working a minimum of 30 hours per week to be eligible for coverage.
Premium Payment	The premiums for this insurance are paid in full by the policyholder. There is no cost to you for this insurance.
BENEFITS	
Elimination Period	Your benefits begin on the later of 90 calendar days after the onset of your disabling injury or illness or the date your short term disability ends.
Monthly Benefit	Your benefit is equivalent to 60% of your before-tax monthly earnings, not to exceed the plan's maximum monthly benefit amount less other income sources. The premium for your long-term disability coverage is waived while you are receiving benefits.
Maximum Monthly Benefit	$6,000
Minimum Monthly Benefit	$100
Maximum Benefit Period	If you become disabled prior to age 65, benefits are payable for five years. At age 65 through 68, benefits are payable to age 70. At age 69 (and older), benefits are payable for one year.
Partial Disability Benefits	If you become disabled and can work part-time (but not full-time), you may be eligible for partial disability benefits.
DEFINITIONS	

Own Occupation	2 Years
Own Occupation Earnings Test	99%
Definition of Monthly Earnings	Monthly earnings for salaried employees is the gross annual salary in effect immediately prior to the date disability begins, divided by 12. Monthly earnings for hourly employees is the hourly rate of pay multiplied by the average number of hours worked during the 12 month period immediately prior to the date disability begins. If employed for part of the prior 12 month period, monthly earnings is the hourly rate of pay multiplied by the average number of hours worked.
FEATURES	
Vocational Rehabilitation Benefit	If you become disabled and participate in the vocational rehabilitation program, you will be eligible for a monthly benefit increase of 5%.
Survivor Benefit	If you pass away while receiving disability benefits, a lump sum equal to 3 times your monthly benefit will be paid to your eligible survivor.
SERVICES	
Employee Assistance Program (EAP)	The EAP program provides you and your loved ones access to trained professionals and resources for assistance with personal and workplace issues.
Hearing Discount Program	The Hearing Discount Program provides you and your family discounted hearing products, including hearing aids and batteries. Call 1-888-534-1747 or visit www.amplifonusa.com/mutualofomaha to learn more.

Frequently Asked Questions

Who is eligible for this insurance?

You must be actively working (performing all normal duties of your job) at least 30 hours per week.

How long will my benefits be paid?

Benefits begin after the end of the elimination period and can be payable up to the maximum benefit period as long as you remain disabled.

Will my benefits be reduced by other sources of income?

Yes, depending on the type of income you receive. Your benefit amount may be reduced by other sources of income such as retirement/government plans, other group disability plans, salary continuance/sick leave, settlements on payments received and no-fault benefits.

Does this plan cover me if I become disabled due to an injury at work?

Yes, your LTD insurance provides benefits for both on-the-job and off-the-job coverage for disabilities due to injury or sickness.

Are there any limitations or exclusions?

The benefits payable are subject to the following:

- Disabilities related to alcohol and drug abuse are only payable for up to 24 months while insured under the policy.
- Disabilities related to mental disorders are only payable for up to 24 months while insured under the policy.
- Your plan is subject to a pre-existing condition limitation. A pre-existing condition is one for which you have received medical treatment, consultation, care or services including diagnostic measures, or if you were prescribed or took prescription medications in the predetermined time frame prior to your effective date of coverage. The pre-existing condition under this plan is 3/12 which means any condition that you receive medical attention for in the 3 months prior to your effective date of coverage that results in a disability during the first 12 months of coverage, would not be covered.
- Benefits are not payable for any disability or loss that:
  - Results from an act of declared or undeclared war or armed aggression
  - Results from participation in a riot or commission of or attempt to commit a felony
  - Results, whether the insured person is sane or insane, from an intentionally self-inflicted injury or illness, suicide, or attempted suicide
  - Results from alcohol and drug abuse and/or substance abuse, except as noted above
  - Results from a mental disorder, except as noted above
  - Is caused by alcohol and drug abuse and/or substance abuse, while not being actively supervised by and receiving continuing treatment from a rehabilitation center or designated institution approved for such treatment by an appropriate body in the governing jurisdiction
  - Occurs while incarcerated or imprisoned for any period exceeding 31 days
  - Is solely a result of a loss of a professional license, occupation license or certification

All exclusions may not be applicable, or may be adjusted, as required by state regulations.

This information describes some of the features of the benefits plan. Benefits may not be available in all states. Please refer to the certificate booklet for a full explanation of the plan's benefits, exclusions, limitations and reductions. Should there be any discrepancy between the certificate booklet and this summary, the certificate booklet will prevail. Benefits availability is subject to final acceptance and approval of the group application by the underwriting company. Disability income insurance is underwritten by United of Omaha Life Insurance Company, 3300 Mutual of Omaha Plaza, Omaha, NE 68175, 1-800-769-7159. United of Omaha Life Insurance Company is licensed nationwide, except in New York. Policy form number 7000GM-U-EZ-2010.

Disclosure Notices

Consolidated Omnibus Budget Reconciliation Act (COBRA)

Requires group health plans sponsored by employers with 20 or more employees in the prior year to offer employees and eligible dependents a temporary extension of health coverage when group coverage would otherwise end. Under COBRA, plans must provide covered employees and dependents with specific notices explaining their COBRA rights. Coverage continues on a temporary basis due to various circumstances that initiate loss in coverage. If an employee retires, a divorce occurs, employee joins another organization, are the types of circumstances that allow COBRA to protect the employee. Please see the full notice at the end of this document.

Employee Retirement Income Security Act (ERISA)

The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that sets minimum standards for retirement and health benefit plans in private industry. ERISA covers retirement, health and other welfare benefit plans (e.g., life, disability and apprenticeship plans). Among other things, ERISA provides that those individuals who manage plans (and other fiduciaries) must meet certain standards of conduct. ERISA has also been expanded to include health laws. For example, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) amended ERISA to provide for the continuation of health care coverage for employees and their beneficiaries (for a limited period of time) if certain events would otherwise result in a reduction in benefits. In addition, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) amended ERISA to make health care coverage more portable and secure for employees.

HIPAA Information Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) impacts a wide variety of features of the U.S. health care system. The law establishes standards to protect individual's medical records and personal information. The regulation requires safeguards to protect the patient information, such as limiting the release of information without authorization. The rule gives the patient total control over their information, as to who has rights over the information and who can examine the information.

Janet's Law

On October 21, 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998.The law protects individuals post-mastectomy, and benefits must be provided to covered patients. The required coverage for the individuals includes:

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

Under Janet's Law, mastectomy benefits may be subject to annual deductibles and coinsurance consistent with those established for other benefits under the plan or coverage.

Newborn's Act

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

Disclosure Notices

Pre-Existing Condition Notification (HIPAA)

As part of the Health Care Reform law, employer-sponsored group health plans are no longer permitted to apply pre-existing condition exclusion periods to individuals covered under the plan.

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 for their Medicaid or CHIP programs. If you or your children aren't 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 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.

Qualified Medical Child Support Order (QMCSO)

A QMCSO is a court order or an order issued by a state administrative agency in accordance with federal and state laws that require an alternate beneficiary (for example, a child or stepchild) to be covered by a plan participant's group health plan. ERISA requires group health plans to provide health benefits coverage to children of a parent-employee who is divorced, separated, or never married in accordance with the applicable requirements of any qualified medical child support order (QMCSO) issued by a state court or agency. Each group health plan must establish reasonable procedures to determine whether medical child support orders are qualified.

Special Enrollment Rights

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

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within the specified period of time after the marriage, birth, adoption, or placement of adoption. Contact Group Benefit Services in order request special enrollment or for any other information regarding special enrollment rights.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

Under federal law, the Uniformed Services Employment and Reemployment Rights Act (USERRA) provide employees the right to be reemployed in their civilian job if they leave their job to perform service in the uniformed service. Military employees have the right to elect to continue health plan coverage, including dependents, for up to 24 months of service. If elected to end health plan, you must be reinstated to your employer's plan when reinstated; with no waiting period or exclusion for pre-exiting conditions unless related to military service.

COBRA

Under Federal law known as COBRA (continuation of coverage), as a covered employee, you have the right to obtain a temporary extension of your group health insurance.

INDIVIDUAL ELECTION RIGHTS

Each individual covered under your plan on the day before coverage was terminated is a "qualified beneficiary" and has independent election rights to continue coverage. This means that each dependent can elect independently to continue coverage, even if the covered employee chooses not to elect coverage.

ELECTING COVERAGE

During your COBRA election period, benefits are not available to you. Therefore, any access to care or claims submitted would be denied. Following receipt of your election form and any applicable premium due, your benefits will be reinstated retroactive to the termination date, and claims may be submitted for payment in accordance with your benefit plan.

PREMIUM PAYMENT

If you elect to continue your health insurance, you are responsible for the full premium payment for the coverage elected. The COBRA premium includes the employer and employee's share of the premium. Following your COBRA election, you have a maximum of 45 calendar days from the date of your election to pay all past due premiums.

LENGTH OF CONTINUATION COVERAGE

Coverage will continue for all qualified beneficiaries for a period of 18 months if coverage loss was the result of a covered employee's termination (except for gross misconduct) or reduction of work hours.

Coverage will extend to qualified beneficiaries for a period of 36 months if the coverage loss was a result of any of the following circumstances:

- Death of a covered employee
- Divorce or legal separation from a covered employee
- Dependent ceasing to qualify as an eligible dependent
- Covered employee losing coverage as a result of Medicare

DISABILITY EXTENSION PROVISION

The initial 18 month extension privilege may be extended for an additional 11 month period for a total of 29 months to all qualified beneficiaries if the Social Security Administration (SSA) determines that a qualified beneficiary was disabled according to Title II or XVI of the Social Security Act on the date of the qualifying event or at the time during the first 60 days of continuation coverage.

COBRA EMPLOYER REQUIREMENTS

Employers are only obligated to offer COBRA coverage if they offer an employer-sponsored health insurance plan and they have at least 20 employees.

YOUR RESPONSIBILITY

It is your responsibility to obtain the disability determination from SSA and to provide a copy to your employer within 60 days of the date of determination and before the original 18 months of COBRA expires. If you do not comply with these time frames, the additional 11 months of coverage will not be provided. It is also your responsibility to notify the HR Representative within 30 days if a final determination is made that you are no longer disabled.

SECONDARY EVENTS (IF APPLICABLE)

Extension privileges may be extended beyond the original 18 months if, during the initial 18 months, a second event such as divorce, legal separation, death, Medicare entitlement or a dependent child ceasing to be an eligible dependent takes place. If a second event occurs, the original 18 months will be extended to 36 months from the date of the original qualifying event for the qualified beneficiary spouse and/or dependent child. The extension does not apply to the employee. If a second event occurs, it is your responsibility to notify the HR representative within 60 days of the second event and before the end of the original 18 month COBRA expiration. In no event will continuation coverage last beyond three years from the date of the original qualifying event.

NEW DEPENDENT & OPEN ENROLLMENT

If you adopt a child or if a child is born to you within your COBRA extension period, your coverage may be changed to include the new dependent. The change to add a new dependent must be done according to the rules of your plan. The new dependent will gain the rights of all other "qualified beneficiaries".

CANCELLATION OF CONTINUATION

COBRA continuation will end prior to the 18, 29 or 36 month expiration period for any of the following reasons:

- Your former employer ceases to provide any group health plan to its employees
- Any required premium for continuation coverage is not paid within your grace period
- A qualified beneficiary becomes covered under another group health plan (provided the pre-existing condition limitation or exclusion does not apply to the qualified beneficiary)
- A qualified beneficiary becomes entitled to Medicare
- A qualified beneficiary covered under the disability extension provision receives SSA determination that he/she is no longer disabled
- A qualified beneficiary notifies the HR Representative of intention to cancel extended coverage

CONVERSION OPTIONS

When your extension period expires, qualified beneficiaries will be allowed to enroll in an individual conversion plan provided by the current carrier, if such an option is available. GBS will advise you in writing of your conversion option approximately 30 days prior to the expiration date of your continuation coverage. At that time, you must contact the carrier within 30 days to confirm applicable benefits and rates.

Program Administered by:

6 North Park Drive, Suite 310
Hunt Valley, MD 21030

Baltimore: (410) 832-1300
Toll Free: (877) 931-9660
Fax: (443) 541-1409

email: GBSHRBenefitSolutions@gbsio.net

GBSVIP Customer Service Team

GBSVIP is a powerful, one-stop contact center staffed by licensed professionals who adhere to the strictest standards of confidentiality. Your dedicated team of experienced benefit advocates are ready to help you and your family members. GBSVIP can resolve claim issues through carriers and service providers 3-4 time faster than members can on their own. We provide assistance with the following:

Benefits questions
ID Card issues
Prescription issues
Questions regarding billing and claim resolution
Provider network questions
HRA/FSA questions
…….and much more!

Monday - Friday, 7:30am - 6:00pm (EST)

For Services that's confidential and responsive, contact the GBSVIP team!

GBS Customer Service Representative	Brianna Mistler	(443) 589-1206
GBS Customer Service Representative	Karen Munn	(443) 589-1273

gbscustomerservice@gbsio.net
Fax #: 443-541-1409

For your convenience, here are wallet size information cards

GBSVIP Customer Service Team
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