SUMMARY OF BENEFITS FOR CONTRACT EMPLOYEES

Thank you for your interest in employment with Johnson Service Group, Inc. Our Company provides its contract employees with the following Affordable Care Act compliant benefits:

PORTABLE MAJOR MEDICAL HEALTH PLANS
All employees have the option of designing a portable health plan tailored to suit the individual’s specific healthcare needs. These medical benefit options can be accessed exclusively through the Health Care Solutions Team, JSG’s partner in providing this benefit option. Healthcare Solutions Team provides access to world class benefits from the nation’s top rated insurance carriers including Assurant Healthcare and United Healthcare.

Employees may select from several benefit options. The options are comprised of benefits that are more traditional in nature, benefits that include a Health Savings Account component, short term major medical benefits, benefits that address high risk individuals (for those individuals with most pre-existing conditions), and guaranteed acceptance plans.

There is no waiting period to enroll and upon acceptance coverage can begin. An employee pays 100% of the premium cost, has the option to have the premiums deducted from their weekly paycheck, and can elect to have the premiums deducted on a pre-tax basis. These benefits are individually tailored to an employee’s personal circumstances and remain with the individual upon termination from JSG employment.

For more information, please go to www.jsghealthplans.com or contact the Healthcare Solutions Team directly at (866) 934-9013. There is also a link to this web site in the Employee Toolbox located on the JSG web site at www.jsginc.com.

LIMITED FIXED INDEMNITY GROUP BENEFITS PLAN, specific plan information attached
Enrollment for the voluntary health benefits through Century Healthcare (CHC) must be made within thirty days of an employee’s hire date. Employees must enroll through CHC’s telephonic enrollment center at (888)232-9431, Monday through Friday, from 7:30 AM to 5:30 PM CST. For claims and customer service please call (877)685-2432.

Note: Please be sure to provide the password “Johnson” when enrolling.

If an employee wishes to enroll in these benefits after 30 days of employment, they will be allowed to enter into plans during the annual open enrollment period. Open enrollment periods will be communicated to employees as they become available. For qualifying life events such as child birth, divorce, loss of coverage though the spouse’s employer, etc., changes to the employee’s health insurance benefits can be made at the time of the event, as long as the change is requested within 30 days. **Upon successful completion of a twelve month measurement period (as defined by the Affordable Care Act), where the employee has worked more than 1,560 hours, additional medical benefit options will be made available.**

This limited fixed indemnity insurance plan is not comprehensive major medical insurance. It is a package of services and fixed indemnity benefits that pays benefits for specified medical services and is designed to help take care of the basic medical care needs of insured employees and their families. This plan pays in addition to any other insurance in force and is not a Medicare Supplement plan. All premiums for benefits are deducted from paychecks on a weekly basis. Additional information, including brochures and prices, can be found in the Employee Toolbox on the JSG web site at www.jsginc.com.

PERSONAL ACCIDENT PLAN
Accident insurance can help an employee with the multiple costs of an unexpected accident. The plan pays a cash benefit to an employee for all types of off-the-job accidents. Coverage is available for employees, spouses, and dependent children. This 100% employee paid plan is offered through Aflac on a pre-tax and is portable after one month of participation should an employee leave JSG.

MAXIMUM DIFFERENCE - CANCER INDEMNITY INSURANCE
This plan offers protection in the event an employee or a family member is diagnosed with cancer. Even with major medical insurance, the financial obligation can be devastating to an employee’s savings or future income in a cancer.
situation. The benefits in this policy pay cash directly to the employee for treatments such as an initial diagnosis, surgery, hospitalization, radiation and chemotherapy, and bone marrow transplant. Since 96% of all cancers are now treatable if diagnosed early, this plan also offers a benefit for cancer screening. The plan also has a specified disease rider covering thirty diseases. This rider pays directly to the employee for an initial diagnosis of one of the specified diseases and if the employee or a covered person is confined in a hospital for treatment of one of the specified diseases. Coverage is available for employees, spouses, and dependent children. **This 100% employee paid plan is offered through Aflac on a pre-tax and is portable after one month of participation should an employee leave JSG.**

**SPECIFIED HEALTH EVENT INSURANCE**
The Specified Health Event Protection Plan provides hospital intensive care coverage for sickness and injury, and provides specified health event coverage for critical illness. This plan offers protection should an employee or their spouse have a catastrophic event, such as a heart attack, stroke, kidney failure, major third degree burns, or coronary artery bypass surgery. The plan is to protect an employee against the financial burden created by these types of events. **This 100% employee paid plan is also offered through Aflac on a pre-tax basis and is portable after one month of participation should an employee leave JSG.**

**SECTION 125 PREMIUM ONLY PLAN**
All employees may take advantage of certain provisions permitted by Section 125 of the Internal Revenue Code. Under this program, employees may choose to pay for company sponsored benefits with a portion of their pay before federal or Social Security taxes are withheld. When an employee selects this program, their premium payment will be deducted from their gross income.

All employees must complete a Section 125 form indicating if they are electing or declining to have their voluntary health insurance benefits handled on a pre-tax basis. These forms are located on the JSG web site under the Employee Toolbox, and they are to be completed and sent to the Payroll Department with the other completed new hire forms.

**401(K) RETIREMENT PLAN**
Johnson Service Group, Inc. offers a 401(k) investment option through Transamerica Retirement Services to aid employees in planning and meeting the financial needs for their retirement years.

Participation in the plan is voluntary and available to all full-time employees any time on or after the first of the month after completing thirty days of service.

To have your information entered in the Transamerica database, please contact Johnson Service Group’s Human Resources Department at (630)655-3500 or at benefits@jsginc.com. Once your information has been entered into the Transamerica database, salary reduction contribution amounts may be changed, discontinued, and then resumed again at any time throughout the year. Also, participants may change their investment direction of their contributions at any time. Additional information is available on the JSG website at [www.jsginc.com](http://www.jsginc.com).

**DIRECT DEPOSIT**
Employees may elect to have their payroll checks directly deposited into their bank accounts. Once an employee has been set up for direct deposit, they have electronic access to their payroll information via [www.my-estub.com](http://www.my-estub.com).

Also, electronic pay advice information, FAQ, and electronic W-2 enrollment can also be found on the JSG website through the Employee Toolbox E-Pay Page.

**Please note:** Direct deposit may take up to 3 weeks to become active; in the interim you will receive a live check.

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*Revised: 09-2015*
MEC BASIC

PREVENTIVE SERVICES
All preventive services as specified by the Affordable Care Act such as annual physicals, mammograms, pap smears, preventive cancer screenings, routine lab and x-rays, and immunizations. Only covered at 100% through in-network providers.

Included
See the MEC Summary Page

DISCOUNT RX PROGRAM
Employees and their dependents pay the lesser of the pharmacy's usual and customary fee or the contract rate. Discounts are available on both generic and brand name drugs. Contraceptive drugs are included. Savings range from 15% to 80% based on the drug type (brand or generic) and the participating pharmacy filling the claim. No claim forms required. Prescriptions for 30-day supplies can be filled at more than 55,000 participating pharmacies nationwide including all of the national chains and over 90% of independent pharmacies. For additional savings, you may also utilize our mail order pharmacy for 90 day supplies. To learn more about the benefits or to locate a participating pharmacy call (800) 454-9399 or visit www.century.data-rx.com.

Included

PHCS PREVENTIVE ONLY NETWORK
Covered individuals need to obtain all preventive services through providers that participate in the PHCS Preventive Only Network in order for the services to be covered at 100%. To locate participating providers call (888) 371-7427 or visit www.multiplan.com/chcmec.

Included

Please note that this plan only covers preventive services as required under the Affordable Care Act. To learn more visit www.healthcare.gov. The preventive services will only be covered at 100% when utilizing in-network providers.

Century Healthcare’s Customer Service Department
(877) 685-2432
Monday-Friday; 7:00 AM – 7:00 PM CST

Century Healthcare’s Telephonic Enrollment Center
(888) 232-9431
Monday-Friday; 7:30 AM – 5:30 PM CST

Client Web Portal
(Access important plan documents, claim forms & temporary ID cards)
www.centuryhealthcare.com
Username: CHC5121
Password: johnson

WEEKLY COST

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$12.26</td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$17.19</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>$18.52</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$24.23</td>
</tr>
</tbody>
</table>
### Benefit Description

#### Preventive Services Covered at 100%

All preventive services as specified by the Affordable Care Act such as annual physicals, mammograms, pap smears, preventive cancer screenings, routine lab and x-rays, and immunizations. Only covered at 100% through in-network providers.

<table>
<thead>
<tr>
<th>Value</th>
<th>Select</th>
<th>Premier</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Included</strong></td>
<td>See MEC Summary Page</td>
<td>See MEC Summary Page</td>
</tr>
</tbody>
</table>

#### Doctor’s Office Visit

Benefits paid if a covered person visits a doctor’s office for medically necessary treatment, care or advice of an injury or sickness covered under the policy.

<table>
<thead>
<tr>
<th>Value</th>
<th>Select</th>
<th>Premier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pays $75 per day (6 days)</td>
<td>Pays $60 per day (6 days)</td>
<td>Pays $90 per day (10 days)</td>
</tr>
</tbody>
</table>

#### Outpatient Physical Therapy

Benefits paid if a covered person requires Outpatient Physical Therapy, as a result of an injury or sickness, for the treatment of physical dysfunction or injury by the use of therapeutic exercise and the application of modalities, intended to restore or facilitate normal function or development. Physical Therapy does not include speech therapy or occupational therapy.

<table>
<thead>
<tr>
<th>Value</th>
<th>Select</th>
<th>Premier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pays $50 per day (10 days)</td>
<td>Pays $50 per day (10 days)</td>
<td>Pays $100 per day (10 days)</td>
</tr>
</tbody>
</table>

#### Outpatient Manipulative Therapy

Benefits paid if a Covered Person, while insured, requires Manipulative Therapy as an Outpatient as a result of Accident or Sickness.

<table>
<thead>
<tr>
<th>Value</th>
<th>Select</th>
<th>Premier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pays $50 per day (10 days)</td>
<td>Pays $50 per day (10 days)</td>
<td>Pays $100 per day (10 days)</td>
</tr>
</tbody>
</table>

#### Outpatient X-Ray & Lab

Benefits paid for outpatient laboratory tests and x-rays if a covered person is not confined in a hospital and the tests or x-rays are ordered by a doctor and performed by an appropriately licensed technician.

<table>
<thead>
<tr>
<th>Value</th>
<th>Select</th>
<th>Premier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pays $100 per day (3 days)</td>
<td>Pays $100 per day (4 days)</td>
<td>Pays $125 per day (5 days)</td>
</tr>
</tbody>
</table>

#### Advanced Studies

Limited to, CT scan, PET scan, MRI.

<table>
<thead>
<tr>
<th>Value</th>
<th>Select</th>
<th>Premier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pays $500 per day (1 day)</td>
<td>Pays $1,000 per day (1 day)</td>
<td>Pays $1,000 per day (1 day)</td>
</tr>
<tr>
<td>Pays $250 per day (1 day)</td>
<td>Pays $250 per day (1 day)</td>
<td>Pays $500 per day (2 days)</td>
</tr>
</tbody>
</table>

#### Emergency Room Benefit

Benefits paid for emergency room visits for a medical emergency for a sickness.

<table>
<thead>
<tr>
<th>Value</th>
<th>Select</th>
<th>Premier</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Patient Pays $1,000.00</td>
<td>In-Patient Pays $2,000.00</td>
<td>In-Patient Pays $3,000.00</td>
</tr>
<tr>
<td>Out-Patient Pays $500.00</td>
<td>Out-Patient Pays $1,000.00</td>
<td>Out-Patient Pays $1,500.00</td>
</tr>
<tr>
<td>(1 IP or 1 OP surgery)</td>
<td>(1 IP or 1 OP surgery)</td>
<td>(1 IP or 1 OP surgery)</td>
</tr>
</tbody>
</table>

#### In-Patient/Out-Patient Surgery Benefits

Benefits paid if a covered person undergoes medically necessary surgery at the direction of a doctor for a covered injury or sickness.

<table>
<thead>
<tr>
<th>Value</th>
<th>Select</th>
<th>Premier</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Patient Pays $1,000.00</td>
<td>In-Patient Pays $2,000.00</td>
<td>In-Patient Pays $3,000.00</td>
</tr>
<tr>
<td>Out-Patient Pays $500.00</td>
<td>Out-Patient Pays $1,000.00</td>
<td>Out-Patient Pays $1,500.00</td>
</tr>
<tr>
<td>(1 IP or 1 OP surgery)</td>
<td>(1 IP or 1 OP surgery)</td>
<td>(1 IP or 1 OP surgery)</td>
</tr>
</tbody>
</table>

#### In-Patient/Out-Patient Anesthesia Benefits

Benefits paid at 25% of the surgery benefit for anesthesia services for preoperative screening and the administration of anesthesia during a surgical procedure whether on an inpatient or outpatient basis.

<table>
<thead>
<tr>
<th>Value</th>
<th>Select</th>
<th>Premier</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Patient Pays $250.00</td>
<td>In-Patient Pays $500.00</td>
<td>In-Patient Pays $750.00</td>
</tr>
<tr>
<td>Out-Patient Pays $125.00</td>
<td>Out-Patient Pays $250.00</td>
<td>Out-Patient Pays $375.00</td>
</tr>
<tr>
<td>(1 IP or 1 OP surgery)</td>
<td>(1 IP or 1 OP surgery)</td>
<td>(1 IP or 1 OP surgery)</td>
</tr>
</tbody>
</table>

#### Outpatient Minor Surgical

Benefits paid if a covered person has a covered outpatient minor surgery as defined in the policy.

<table>
<thead>
<tr>
<th>Value</th>
<th>Select</th>
<th>Premier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pays $75 per day (1 day)</td>
<td>Pays $80 per day (1 day)</td>
<td>Pays $90 per day (1 day)</td>
</tr>
</tbody>
</table>

#### Ambulance

Benefits paid if a covered person requires transportation in an ambulance to the nearest hospital for treatment of an injury or sickness.

<table>
<thead>
<tr>
<th>Value</th>
<th>Select</th>
<th>Premier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pays $500 per day (1 day)</td>
<td>Pays $500 per day (1 day)</td>
<td>Pays $500 per day (1 day)</td>
</tr>
</tbody>
</table>

#### Hospital Confinement

Benefits paid if a covered person is confined as an inpatient in a hospital because of a covered injury or sickness.

<table>
<thead>
<tr>
<th>Value</th>
<th>Select</th>
<th>Premier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pays $500 per day (Maximum of 30 days)</td>
<td>Pays $1,000 per day (Maximum of 30 days)</td>
<td>Pays $1,500 per day (Maximum of 30 days)</td>
</tr>
</tbody>
</table>

#### Maternity

Benefits paid under the applicable provision for Doctor’s Office Visits, Outpatient X-ray & Lab, Surgery or Hospital Confinement for pregnancy-related expenses.

<table>
<thead>
<tr>
<th>Value</th>
<th>Select</th>
<th>Premier</th>
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</thead>
<tbody>
<tr>
<td>Included</td>
<td>Included</td>
<td>Included</td>
</tr>
</tbody>
</table>

#### ICU Confinement

Pays in lieu of the Hospital Confinement Benefit.

<table>
<thead>
<tr>
<th>Value</th>
<th>Select</th>
<th>Premier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pays $1,000 per day (Maximum of 30 days)</td>
<td>Pays $2,000 per day (Maximum of 30 days)</td>
<td>Pays $3,000 per day (Maximum of 30 days)</td>
</tr>
</tbody>
</table>

#### Substance Abuse Confinement

Benefits paid for confinement in a rehab facility for substance abuse.

<table>
<thead>
<tr>
<th>Value</th>
<th>Select</th>
<th>Premier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pays $300 per day (Maximum of 30 days)</td>
<td>Pays $500 per day (Maximum of 30 days)</td>
<td>Pays $750 per day (Maximum of 30 days)</td>
</tr>
</tbody>
</table>

#### Mental Illness Disorder Confinement

Benefits paid for confinement in a rehab facility for mental or nervous disorders.

<table>
<thead>
<tr>
<th>Value</th>
<th>Select</th>
<th>Premier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pays $300 per day (Maximum of 30 days)</td>
<td>Pays $500 per day (Maximum of 30 days)</td>
<td>Pays $750 per day (Maximum of 30 days)</td>
</tr>
</tbody>
</table>

#### Skilled Nursing Facility Confinement

Benefits paid for confinement in a skilled nursing facility. Confinement must begin within 3 days of hospital confinement.

<table>
<thead>
<tr>
<th>Value</th>
<th>Select</th>
<th>Premier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pays $300 per day (Maximum of 30 days)</td>
<td>Pays $500 per day (Maximum of 30 days)</td>
<td>Pays $750 per day (Maximum of 30 days)</td>
</tr>
</tbody>
</table>
MINIMUM ESSENTIAL COVERAGE PLUS PLANS

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Value</th>
<th>Select</th>
<th>Premier</th>
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</thead>
<tbody>
<tr>
<td>Accident Medical</td>
<td>($100 deductible per occurrence)</td>
<td>Up to $5,000 per occurrence</td>
<td>Up to $5,000 per occurrence</td>
</tr>
<tr>
<td>Accidental Death &amp; Dismemberment</td>
<td>Employee</td>
<td>$15,000</td>
<td>$15,000</td>
</tr>
<tr>
<td></td>
<td>Spouse</td>
<td>$7,500</td>
<td>$7,500</td>
</tr>
<tr>
<td></td>
<td>Children</td>
<td>$3,000</td>
<td>$3,000</td>
</tr>
<tr>
<td>Term Life</td>
<td>Employee</td>
<td>$10,000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Plan 1:</td>
<td>Copay Rx – Plan 1</td>
<td>Copay Rx – Plan 2</td>
</tr>
<tr>
<td></td>
<td>Tier 1 (Most Generics):</td>
<td>$10 Co-Pay.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 2 (Some Generics &amp; Preferred/Formulary Brand Name):</td>
<td>$50 or 50%; whichever is greater.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 3 (Non-Preferred / Non-Formulary Brand Name): Employees pay 100% of the cost after pharmacy discounts. Monthly Maximum of $100 Employee / $200 Family. No Deductible. Restricted Formulary.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Plan 2:</td>
<td>Tier 1 (Most Generics):</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 2 (Some Generics &amp; Preferred/Formulary Brand Name):</td>
<td>$50 or 50%; whichever is greater.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 3 (Non-Preferred / Non-Formulary Brand Name): Employees pay 100% of the cost after pharmacy discounts. Monthly Maximum of $250 Employee / $500 Family. No Deductible. Restricted Formulary.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PHCS PPO Limited Benefit Network</td>
<td>All plan designs provide covered individuals access to a PPO Network that allows them to take advantage of network negotiated rates prior to the above benefits being applied.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employee Cost per Week</th>
<th>Value</th>
<th>Select</th>
<th>Premier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$37.94</td>
<td>$52.24</td>
<td>$70.71</td>
</tr>
<tr>
<td>Employee &amp; Spouse</td>
<td>$78.64</td>
<td>$107.94</td>
<td>$151.79</td>
</tr>
<tr>
<td>Employee &amp; Child(ren)</td>
<td>$68.89</td>
<td>$90.81</td>
<td>$118.50</td>
</tr>
<tr>
<td>Employee &amp; Family</td>
<td>$119.13</td>
<td>$164.59</td>
<td>$225.75</td>
</tr>
</tbody>
</table>

All benefits except Accident Medical, AD&D, and Term Life are subject to Benefit Year Maximums as shown above. Benefit Year means the 12 consecutive months from the group’s original effective date.
Preventive Services are covered at 100% through participating providers. The following is a brief description of the preventive benefits available to members and it is subject to change under the Affordable Care Act. To learn more visit [www.healthcare.gov](http://www.healthcare.gov).

- Routine physical exam
- Well women exam (annual)
- Annual mammogram
- Annual pap smear and other routine lab
- Breast thermography
- Bone density test
- Well baby / well child care exam
- Routine immunizations
- Flu and pneumonia vaccines
- Routine lab, x-rays, diagnostic testing
  and other medical screenings including:
  - Blood pressure
  - Diabetes
  - Cholesterol tests
- Many cancer screenings including:
  - Cervical cancer
  - Breast cancer
  - Colorectal cancer
- Contraception (FDA):
  - Approved contraceptive methods
  - Sterilization procedures
  - Patient education and counseling
  (Covered contraceptives do not include abortifacient drugs)
- Counseling on topics such as:
  - Obesity & eating healthy
  - Treating Depression
  - Alcohol & drug abuse
  - Smoking cessation
  - Domestic & interpersonal violence
  - Sexually transmitted diseases

**IMPORTANT DETAILS**

**Network providers:** Health plans are required to provide these preventive services only through an in-network provider.

**Office visit fees:** Your doctor may provide a preventive service, such as a cholesterol screening test, as part of an office visit. Be aware that your plan can require you to pay some costs of the office visit, if the preventive service is not the primary purpose of the visit, or if your doctor bills you for the preventive services separately from the office visit.

**Coverage:** Coverage is provided for preventive services only. Once a diagnosis has been made, the services are not covered under the MEC.

**Talk to your health care provider:** To know which covered preventive services are right for you — based on your age, gender, and health status — ask your health care provider.

For information on preventive practices, check out [healthcare.gov](http://healthcare.gov).

**Questions:** If you have questions regarding your coverage, please call Customer Service at (877) 685-2432.
How does the Program Work? - It’s Simple!

What is a Limited Fixed Indemnity Program?
A Limited Fixed Indemnity Benefit Program is designed to help you deal with covered medical expenses from covered accident (or sickness) events such as physician office visits, emergency room trips, hospitalization, diagnostic tests and even prescription drugs up to certain preset limited benefit levels. This program is not basic health insurance or major medical insurance; and is not designed to replace, provide or modify major medical insurance.

What is a Minimum Essential Coverage (MEC) Plus Plan?
A Minimum Essential Coverage Plus Plan consists of a Fully Insured or Self-Funded Limited Fixed Indemnity Benefit Plan and a Self-Funded 100% Preventive Care Plan. The Limited Fixed Indemnity Plan is designed to help you deal with covered medical expenses from a covered accident (or sickness) such as physician office visits, emergency room trips, hospitalization, diagnostic lab and X-rays, surgeries and prescription drugs up to certain benefit levels. This program is not major medical insurance. The Self-Funded100% Preventative Care plan is designed to be compliant with the Affordable Care Act by meeting the Minimum Essential Coverage requirements of Healthcare Reform. This plan satisfies the Individual Mandate requirement that began in 2014. Self-Funded plans in the large group market are not required to cover all of the essential benefits. An employer can offer minimum essential coverage and avoid the 4980 H (a) “no offer” penalty/tax/assessment.

The Century Healthcare program is packaged with access to limited fixed indemnity accident and sickness insurance, certain non-insured benefits and PPO savings. This program is not designed to cover the level of expense found with treatment or care for rare disease or catastrophic illness.

How do I use the program if I need care or treatment for an accident or sickness?

Network:
If you chose an in network provider, you are entitled to a discount on your services. This means that you are able to save out of pocket expenses. Century Healthcare discounts the bill and sends the provider the benefit payment along with an explanation of benefits. Please note that in order to receive 100% coverage for preventive services in an MEC Plus Plan the services must be received from an in-network provider.

Find a Provider:
To locate a participating PHCS Limited Benefit Network provider in your area, please call PHCS at (877) 796-7427 or visit www.multiplan.com/chc.

Schedule an Appointment:
Call your selected provider and set up an appointment to see your doctor. We recommend you confirm your provider’s continued participation in the PHCS Limited Benefit Network when you make your appointment.

Benefit Amounts:
Century Healthcare pays based on a fixed schedule of benefits. If the plan states you are entitled to a $75 office visit benefit per day, the benefit you are entitled to is $75 even if you choose an out of network provider. This does not apply to the preventive services covered under the MEC, the benefits need to be obtained through an in-network provider.

How to Use the Plan:
When a member goes in for service, the member simply has to show his/her Century Healthcare ID card. You do not need to pay anything at point of service, nor do you need to fill out a claim form. The provider will submit the claim to Century Healthcare and we will pay the provider directly. If the benefit amount is greater than the billed amount, Century Healthcare will pay the difference to the member. For example: Member goes to get an X-Ray which costs $100 and the benefit for X-Ray & Lab is $125; Century Healthcare will pay the $100 to the facility and then pay the remaining $25 to the member.

Assignment of Benefits:
Century Healthcare allows assignment of benefits. There are no deductibles or coinsurance. Only prescriptions are subject to co-pays.

Payment:
The provider will bill Century Healthcare directly. If the provider wishes you pay up front, have them call Century Healthcare customer service while you are at the provider’s office. If you elect to pay up front you can easily file a claim with Century Healthcare.

If you have questions about your benefits or the status of claims, please call CHC Customer Service at (877) 685-2432 from 7:00 a.m. to 7:00 p.m. CDT/CST. WebTPA pays the claims for Century Healthcare.
### Preventive Care Services
All preventive care services as specified by the Affordable Care Act such as immunizations, mammograms and pap smears. Paid at 100% of eligible charges.

**Office Visit Copay**
- Employee Only: $25 Copay / 50% Coinsurance
- Employee + Spouse: $400 Copay / 50% Coinsurance
- Employee + Child(ren): $400 Copay* / 50% Coinsurance
- Employee + Family: $1,850 / $3,700 per individual

**Outpatient Laboratory & Diagnostics Including X-rays**
- $50 Copay / 50% Coinsurance

**Complex Imaging**
- $400 Copay / 50% Coinsurance

**Emergency Room Services**
- $400 Copay* / 50% Coinsurance

**Outpatient Prescription Drugs**
- $10 Generic
- $30 Preferred Brand
- $75 Non-Preferred Brand
- Tier IV Specialty Drugs Not Covered

**Pregnancy as any other illness**
Physician Visits and Diagnostic Charges Included

### MEC Enhanced – PHCS PPO Network

#### Benefit Description

**Preventive Care Services**
All preventive care services as specified by the Affordable Care Act such as immunizations, mammograms and pap smears. Paid at 100% of eligible charges.

**Office Visit Copay**
- $25 Copay / 50% Coinsurance

**Deductible**
- $0 / $500

**Coinsurance**
100% / 50%

**Out of Pocket Maximum**
- $1,850 / $3,700 per individual
- Family limit for out of pocket max is 2x individual limit

**Outpatient Laboratory & Diagnostics Including X-rays**
- $50 Copay / 50% Coinsurance

**Complex Imaging**
- $400 Copay / 50% Coinsurance

**Emergency Room Services**
- $400 Copay* / 50% Coinsurance

**Outpatient Prescription Drugs**
- $10 Generic
- $30 Preferred Brand
- $75 Non-Preferred Brand
- Tier IV Specialty Drugs Not Covered

**Pregnancy as any other illness**
Physician Visits and Diagnostic Charges Included

### PPO
PHCS

#### Member Web Portal
(Use to access important plan documents, claim forms & temporary ID cards)
www.centuryhealthcare.com

Username: CHC5121
Password: johnson

### Weekly Cost

<table>
<thead>
<tr>
<th>MEC Enhanced – PHCS PPO Network</th>
<th>Weekly Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$57.09</td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$99.08</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>$97.99</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$139.98</td>
</tr>
</tbody>
</table>

*All services for life threatening situations performed in an emergency room including physician charges, laboratory or diagnostic services and surgery. Includes charges for ground ambulance charges to the emergency room. Only charges for services conducted in the emergency room are covered. If the member is admitted on an inpatient basis or transferred to an ambulatory surgical area those charges are not covered. Air ambulance charges are not covered. Copay applies per emergency visit.*
**MEC ENHANCED PLAN INFORMATION**

**Calendar Year and Life Time Maximum Benefit:** Unlimited

<table>
<thead>
<tr>
<th>Service Category</th>
<th>What Is Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Care Services</td>
<td>All preventive care services as specified by the Affordable Care Act such as immunizations, mammograms and pap smears. Paid at 100% of eligible charges.</td>
</tr>
<tr>
<td>Physician Office Visits</td>
<td>All services performed by a nurse or physician (primary care or specialist) while in a doctor’s office or clinic, including urgent care specialist while in a doctor’s office or clinic, including urgent care facility. Includes treatment for orthopedic manipulation (up to 20 visits per year) and allergy testing. Copay applies per visit.</td>
</tr>
<tr>
<td>All Other Physician Services</td>
<td>Any other service billed by a physician or physician’s office except for items specifically excluded below. Includes professional charges for outpatient surgery, outpatient laboratory or diagnostic services, outpatient imaging (such as X-Rays, MRIs, &amp; CT scans). Copay applies per bill.</td>
</tr>
<tr>
<td>Outpatient Laboratory &amp; Diagnostics including X-rays</td>
<td>All charges for outpatient laboratory and diagnostic services including facility charges for X-Rays. Copay applies per bill. Charges for interpretation, if billed separately, are covered under Other Physician Services and are subject to a separate copay.</td>
</tr>
<tr>
<td>Complex Imaging</td>
<td>Facility charges for complex imaging services such as MRIs, CT Scans and PET Scans. Copay applies per bill. Charges for interpretation, if billed separately, are covered under Other Physician Services and are subject to a separate copay.</td>
</tr>
<tr>
<td>Emergency Room Services</td>
<td>All services for life threatening situations performed in an emergency room including physician charges, laboratory or diagnostic services and surgery. Includes charges for ground ambulance charges to the emergency room. Only charges for services conducted in the emergency room are covered. If the member is admitted on an inpatient basis or transferred to an ambulatory surgical area those charges are not covered. Air ambulance charges are not covered. Copay applies per emergency visit.</td>
</tr>
<tr>
<td>Outpatient Prescription Drugs</td>
<td>All outpatient prescription drugs except tier IV specialty drugs are covered. Each prescription is subject to a copay according to the formulary classification of the drug. Copay is per prescription fill.</td>
</tr>
</tbody>
</table>

**Excluded Services:**

The following services are not covered under the MEC Enhanced plan. In addition to these services, the Plan includes additional exclusions and limitations (see SPD for details).

- Inpatient services – any charge for services that take place on an in-patient basis are not covered. This includes any facility, physician, laboratory, diagnostic or imaging charges regardless of cause or diagnosis including pregnancy.

- Facility charges for any outpatient surgery or treatment. This includes surgery center, dialysis, radiation treatment, chemo therapy and any other service not specifically listed above as included. Physician charges for outpatient surgery are covered under Other Physician Services.

- Specialty drugs – tier IV (specialty) outpatient prescription drugs and chemotherapy drugs are not covered.

- Any services for mental/behavioral health (inpatient or outpatient) including substance abuse/chemical dependency are not covered.

- Rehabilitative therapy including speech therapy, physical therapy, occupational therapy and cardiac rehabilitation are not covered.

- Skilled nursing, home health care and hospice are not covered.

- Infertility testing and treatment are not covered.

- Durable medical equipment, including hearing aids, orthotics and orthopedic devices, are not covered.

- **Provider Choice Program Only:** Charges in excess of the allowed fee schedule are not allowed. The allowed fee schedule is based on the current Medicare fee schedule. Physician charges are paid at up to 125% of Medicare and facility charges are paid at up to 150% of Medicare.
### WEEKLY COST

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$7.86</td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$16.00</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>$17.62</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$27.57</td>
</tr>
</tbody>
</table>

### METLIFE DENTAL PLAN

#### Class Description

- **Reimbursement**
- **Calendar Year Maximum**
- **Calendar Year Deductible Applies to:**
  - Individual
  - Family

#### In-Network

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Maximum</th>
<th>Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>B&amp;C</td>
<td>$1,000</td>
<td>$50</td>
</tr>
<tr>
<td>$150 Aggregate</td>
<td>$1,000</td>
<td>$50</td>
</tr>
<tr>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>80%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>

#### Out-of-Network

- **R&C 90th Percentile**
- **Calendar Year Maximum** $1,000
- **Calendar Year Deductible** $50

#### Type A – Preventive Services
- 100%

#### Type B - Basic Services
- 80%

#### Type C - Major Services
- 50%

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To Find a MetLife Dental Provider:
To find dental providers in your neighborhood visit [www.metdental.com](http://www.metdental.com) or call (877) 638-3379
**VSP Signature Plan**

**Benefit Description**

- **$25.00 co-pay**
- **1 Well Vision Exam**

**Prescription Glasses**

- Lenses
  - Single vision, lined bifocal, and lined trifocal lenses
  - Polycarbonate lenses for dependent children

**Frames**

- $150.00 allowance for a wide selection of frames
- 20% off the amount over your allowance

**Contact Lens Care**

- $150.00 allowance for contact lenses
- Up to $60.00 for fitting and evaluation

**Additional Benefits**

**Glasses & Sunglasses**

- Average 35-40% savings on all non-covered lens options
- 30% off additional glasses and sunglasses, including lens options, from any VSP doctor within 12 months of your last Well Vision Exam

**Contacts**

- 15% off the cost of a contact lens exam (fitting and evaluation)

**Laser Vision Correction**

- Average 15% off the regular price or 5% off the promotional price
- After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor

*Discounts are only available through participating providers.*

You get the best value from your benefits when utilizing in-network providers. If you see an out of network provider, you’ll typically pay more out-of-pocket. To process an out-of-network claim, you pay the provider in full and you’ll have 6 months to submit a claim to VSP for partial reimbursement less copays. For more information or to locate participating providers visit [www.vsp.com](http://www.vsp.com) or call (800) 877-7195.

**Out-of-Network Reimbursement amounts:**

- **Exam:** Up to $50.00
- **Single Vision Lenses:** Up to $50.00
- **Lined Bi-focal Lenses:** Up to $75.00
- **Lined Trifocal Lenses:** Up to $100.00
- **Frame:** Up to $70.00
- **Contacts:** Up to $105.00

**Weekly Cost**

<table>
<thead>
<tr>
<th>Plan Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$2.32</td>
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<tr>
<td>Employee + Spouse</td>
<td>$3.79</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>$3.78</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$6.10</td>
</tr>
</tbody>
</table>
The Optional Life Insurance Benefit is offered through The Standard to help provide peace of mind in the event of an eligible employee’s covered death by promising to pay a pre-determined benefit amount. Additionally, employees may select Dependent Life to provide life insurance for eligible dependents. Please note that the Dependent Life benefit can only be selected in conjunction with the Employee Life benefit and the Dependent Life benefit cannot exceed 50% of the Employee Life benefit amount.

### Optional Life Schedule

<table>
<thead>
<tr>
<th>Benefit Amount</th>
<th>Under 45</th>
<th>45-59</th>
<th>60+</th>
</tr>
</thead>
<tbody>
<tr>
<td>$25,000</td>
<td>$1.40</td>
<td>$4.10</td>
<td>$19.50</td>
</tr>
<tr>
<td>$50,000</td>
<td>$2.08</td>
<td>$8.19</td>
<td>$39.00</td>
</tr>
<tr>
<td>$75,000</td>
<td>$3.12</td>
<td>$12.29</td>
<td>$58.50</td>
</tr>
<tr>
<td>$100,000</td>
<td>$4.15</td>
<td>$16.38</td>
<td>$78.00</td>
</tr>
<tr>
<td>$125,000</td>
<td>$5.19</td>
<td>$20.48</td>
<td>$97.50</td>
</tr>
</tbody>
</table>

### Optional Life Monthly Cost Per Benefit Amount & Age (Weekly Cost)

<table>
<thead>
<tr>
<th>Benefit Amount</th>
<th>Under 45</th>
<th>45-59</th>
<th>60+</th>
</tr>
</thead>
<tbody>
<tr>
<td>$150,000</td>
<td>$6.23</td>
<td>$24.58</td>
<td>$117.00</td>
</tr>
<tr>
<td>$175,000</td>
<td>$7.27</td>
<td>$28.67</td>
<td>$136.50</td>
</tr>
<tr>
<td>$200,000</td>
<td>$8.31</td>
<td>$32.77</td>
<td>$156.00</td>
</tr>
<tr>
<td>$225,000</td>
<td>$9.35</td>
<td>$36.87</td>
<td>$175.50</td>
</tr>
<tr>
<td>$250,000</td>
<td>$10.38</td>
<td>$40.96</td>
<td>$195.00</td>
</tr>
</tbody>
</table>

### Dependent Life

<table>
<thead>
<tr>
<th>Benefit Option</th>
<th>Benefit Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse</td>
<td>$25,000</td>
</tr>
<tr>
<td>Weekly Cost</td>
<td>$3.05</td>
</tr>
<tr>
<td>Child(ren)</td>
<td>$10,000</td>
</tr>
<tr>
<td>Weekly Cost</td>
<td>$0.42</td>
</tr>
<tr>
<td>Guarantee Issue</td>
<td>All Amounts</td>
</tr>
</tbody>
</table>

* Child(ren)’s benefit is in family units, therefore the cost remains the same regardless of the number of children in the family.
The Short-Term Disability is a benefit provided through The Standard and offers the possibility of financial protection for eligible employees in the event of a covered disability by promising to pay a percentage of weekly earnings for a pre-determined period of time.

**BENEFIT OPTION**

- **Weekly Benefit**: 50%
- **Weekly Pre-disability Earnings**: $500
- **Weekly Benefit Maximum**: $250
- **Accident Benefits begin on day**: 15
- **Sickness Benefits begin on Day**: 15
- **Maximum Benefit Period**: 13 weeks
- **Weekly Cost**: $4.62
This document is a program highlight and it is not intended to be a complete or legal description of the program of benefits. The complete information will be in the group policy provided to the employer and the certificates of insurance that will be made available to all participating employees for the various programs selected.

2. Fairmont Specialty, a division of Crum & Forster Insurance Company, is the carrier for the Accident Medical and AD&D benefits.
3. The Term Life Insurance Plans are underwritten by The Standard Life Insurance.

Premium rates for the insurance plan may be changed upon written notice 31 days in advance and may be subject to an initial rate guarantee period selected by the employer when applying for coverage.

Important Details for MEC coverage:

- Network providers: Health plans are required to provide these preventive services only through an in-network provider.
- Office Visit Fees: Your doctor may provide a preventive service, such as a cholesterol screening test, as part of an office visit. Be aware that your plan can require you to pay some costs of the office visit, if the preventive service is not the primary purpose of the visit or if your doctor bills you for the preventive services separately from the office visit.
- Coverage: Coverage is provided for preventive services only. Once a diagnosis has been made, the services are not covered under the MEC. For more information regarding preventive services visit www.healthcare.gov.
- MEC Plan for Massachusetts Residents: This health plan does not meet the Minimum Creditable Coverage standards and therefore does not satisfy the Individual Mandate.

This program is not comprehensive major medical insurance; however, it is a cost-effective plan of limited medical benefits that provides an alternative to the high cost of healthcare.

Termination of Policy:

After the first anniversary date of the Policy, the Company may terminate any or all of the insurance benefits under the Policy, as of any premium due date, by giving written notice to the Policyholder at least 60 days prior to the termination date.

Eligibility:

These benefits are available to all employees in an eligible class designated by the employer and who are actively at work. Employees may enroll their spouse and children under 26 years of age.

Exclusions and Limitations:
The Limited Fixed Indemnity Insurance Plan underwritten by Companion Life Insurance Company will not pay benefits for any loss or injury that is caused by, or results from:

1. Suicide or any attempt thereat, while sane or insane (In Missouri, the reference to insanity does not apply and suicide is no defense to payment under this Policy where the Covered Person is a Missouri citizen unless the Company can show that the Covered Person intended suicide when he or she applied for coverage, regardless of any language to the contrary in the Policy.)
2. any intentionally self-inflicted injury or sickness;
3. rest care or rehabilitative care and treatment unless a separate Benefit Rider is purchased;
4. cosmetic surgery or care or treatment solely for cosmetic purposes, or complications there from. This exclusion does not apply to cosmetic surgery resulting from a covered Accident if initial treatment of the Covered Person is begun within 12 months of the date of the Accident;
5. immunization shots and routine examinations such as: health exams; periodic check-ups; pre-marital exams; and routine physicals unless a separate Benefit Rider is purchased;
6. routine newborn care, including routine nursery charges;
7. voluntary abortion, except with respect to the insured or covered Dependent spouse:
   A. where such person’s life would be endangered if the fetus were carried to term; or
   B. where medical complications have arisen from an abortion;
8. pregnancy of a Dependent child, unless required by law;
9. the treatment of:
   A. mental illness unless a separate Benefit Rider is purchased;
   B. functional or organic nervous disorder, regardless of cause unless a separate Benefit Rider is purchased;
   C. Alcohol abuse unless a separate Benefit Rider is purchased;
   D. drug use, unless such drugs were taken on the advice of a Physician and taken as prescribed, for more than 10 days in any Calendar Year, with respect to payment of the Daily In-Hospital Indemnity Benefit unless a separate Benefit Rider is purchased;
10. Participation in a riot, civil commotion, civil disobedience, or unlawful assembly. This does not include a loss which occurs while acting in a lawful manner within the scope of authority;
11. committing, attempting to commit, or taking part in a felony or assault, or engaging in an illegal occupation;
12. air travel, except:
   A. as a fare-paying passenger on a commercial airline on a regularly scheduled route; or
   B. as a passenger for transportation only and not as a pilot or crew member;
13. any Accident occurring as a result of the Covered Person being intoxicated (where the blood alcohol content meets the legal presumption of intoxication under the law of the state where the accident took place);
14. sex changes;
15. experimental treatments or surgery;
16. the reversal of tubal ligation and vasectomies;
17. artificial insemination, in vitro fertilization, and test tube fertilization, including any related testing, medications, or Physician’s services, unless required by law;
18. treatment of exogenous obesity or weight control;
19. an act of war, whether declared or undeclared, or while performing police duty as a member of any military or naval organization. This exclusion includes Accident sustained or Sickness contracted while in the service of any military, naval or air force of any country engaged in war. The Company will refund the pro rata unearned premium for any such period the Covered Person is not covered;
20. accident or sickness arising out of and in the course of any occupation for compensation, wage or profit. Expenses which are payable under Occupational Disease Law or similar law, whether or not application for such benefits have been made;
21. air ambulance;
22. ground ambulance unless a separate Benefit Rider is purchased;
23. loss incurred, care or treatment received, or hospital confinement occurring outside of the United States or its possessions except in the event of a Medical Emergency.

This insurance does not apply to the extent that trade or economic sanctions or regulations prohibit Companion Life Insurance Company from providing insurance, including, but not limited to, the payment of claim.