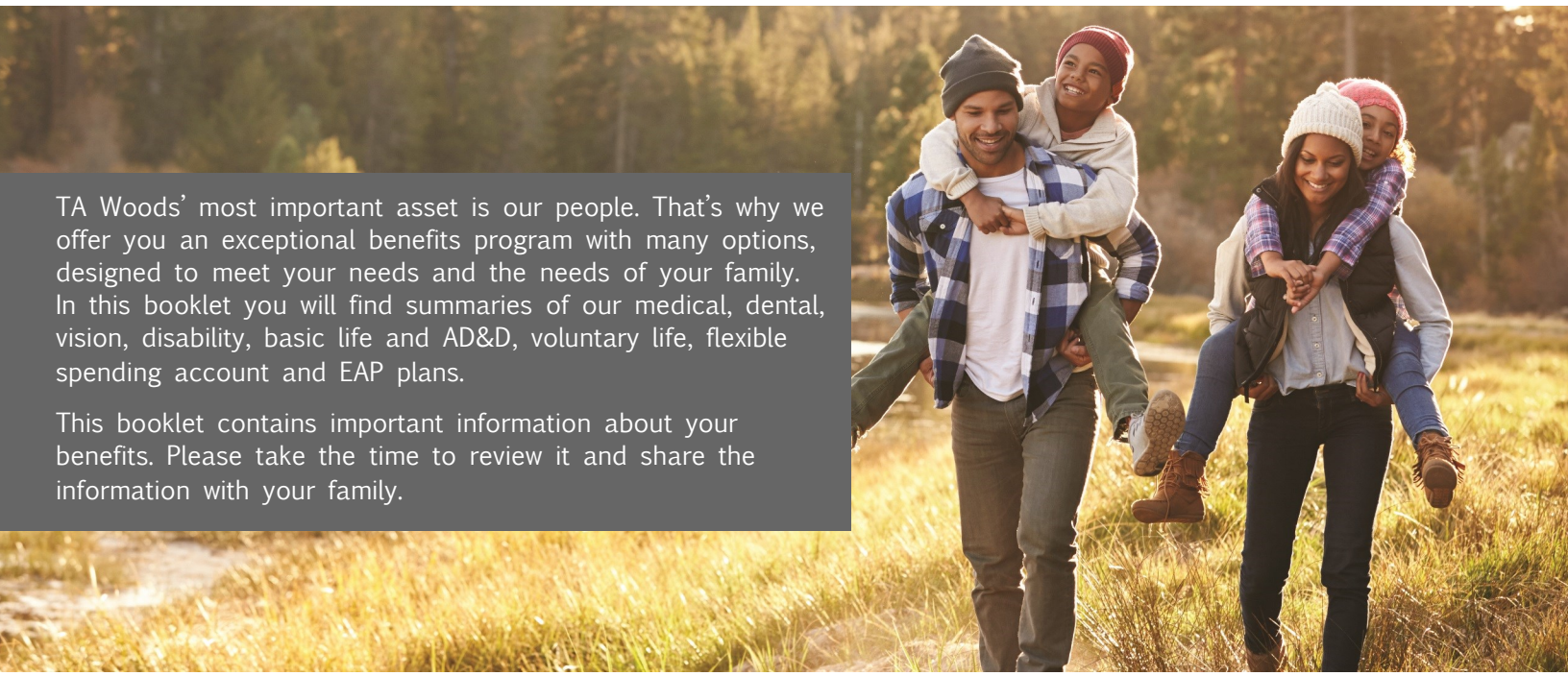
2019-2020 EMPLOYEE BENEFITS

Eligibility ■ Enrollment ■ Medical ■ Dental
Vision ■ Life ■ Disability ■ EAP Program
Worksite Benefits ■ Voluntary Benefits

T.A. WOODS COMPANY



TA Woods' most important asset is our people. That's why we offer you an exceptional benefits program with many options, designed to meet your needs and the needs of your family. In this booklet you will find summaries of our medical, dental, vision, disability, basic life and AD&D, voluntary life, flexible spending account and EAP plans.

This booklet contains important information about your benefits. Please take the time to review it and share the information with your family.

NEW FOR 2019-2020

» Medical will renew with BCBSNC - some plan design changes
» Dental, Vision, Life, Disability coverages will renew with Principal
» Adding a Flexible Spending Account with HealthEquity
» Voluntary worksite coverages offered through Guardian

We ask you to continue to help us better manage our medical costs by leading a healthy lifestyle. You can impact the bottom line by:

- Using the ER only for true emergencies
- Taking advantage of generic prescriptions when available
- Utilizing the preventive care benefit
- Staying in-network whenever possible

CLAIM QUESTIONS OR ISSUES

McGriff Insurance Services is the advisory firm representing TA Woods. We have a team of account managers to help you resolve any problems you have with your employee benefits. If you have a problem or a question about a claim:

1

Call your insurance carrier's customer service department. Phone numbers can be found on your ID cards and on page **17** of this booklet.

2

If the carrier does not resolve your problem, contact Jenny Dickerson at **919-281-4560** or jenny.dickerson@mcgriffinsurance.com.

3

If you are still not satisfied after steps 1 and 2, please contact Teresa Woods-Cox at TA Woods.

BENEFITS ELIGIBILITY

Full-time employees are eligible for benefits on the 91st day for medical, dental, vision, life, disability, and voluntary life.

Spouses and dependent children of the employee are also eligible to participate in our benefit plans. Dependent children include natural children, legally adopted children, stepchildren, and children for whom the employee has been appointed guardian.

You can enroll the following dependents in our group benefit plans:

- Your legal spouse
- Children under age 26 no matter marital or student status
- Unmarried children of any age if totally disabled and claimed as a dependent on your federal income tax return (documentation of handicapped status must be provided)

Other dependents who may live with you, but are NOT eligible to be added to your benefit plans:

- Grandchildren, nieces, nephews or other children who do not meet specifications listed above
- Common law spouses or domestic partners (same or opposite sex)
- Ex-spouses, unless required via court order (documentation required)
- Parents, step-parents, grandparents, aunts, uncles, or other relatives who are not qualified legal dependents (even if they live in your house)

MAKING CHANGES TO YOUR BENEFITS

Most benefit deductions are withheld from your paycheck on a pre-tax basis (medical, dental, vision) and therefore your ability to make changes to these benefits is restricted by the IRS. Once enrolled, most pre-tax benefit elections cannot be changed until the next annual Open Enrollment period, unless you have a qualifying life status change.

Open Enrollment generally occurs in November with plan changes effective from December 1st through November 30th of the following year.

To make benefit changes as a result of a Life Status Change as allowed under Section 125 of the IRS Code, you must:

- Notify Human Resources within 30 days* of the date of the qualifying event
- Provide proof of your life status event
- Log into Employee Navigator to complete enrollment/change or contact TA Woods' Human Resources Department

*Refer to your Plan Administrator as some events may allow for up to 60 days

The Most Common Life Status Changes

- Marriage, divorce, legal separation
- Birth or adoption
- Change in your or your spouse's work status that affects your benefits or an eligible dependent's benefits
- Change in health coverage due to your spouse's annual Open Enrollment period
- Change in eligibility for you or a dependent for Medicaid or Medicare
- Receipt of a Qualified Medical Child

MEDICAL BENEFITS PROVIDED THROUGH BCBSNC

BCBSNC is not just a health plan. They are also a team of health care providers — including doctors, nurses, pharmacists, and specialists — all working together to provide the right care for you and your family. With a network of providers throughout North Carolina, they are in your neighborhood. Access the BCBSNC website at www.blueconnectnc.com to search for doctors and facilities and use the cost-transparency and quality rating tools.

No matter which plan you choose, we encourage you and your dependents to have annual wellness exams. Most in-network preventive exams and well-child exams (including immunizations) are 100% covered by our plans. Preventive exams can detect if you are at risk for or already have a chronic disease such as heart disease, diabetes, hypertension and certain cancers, which are preventable. Talk to your health care provider to find out which screenings are recommended for you and when you need them.

MEDICAL BENEFITS	CORE PLAN	BUY UP PLAN
Deductible *(Embedded)*		
» Individual	Tier 1: $5,000/Tier 2: $7,000	$3,000
» Family	Tier 1: $10,000/Tier 2: $14,000	$6,000
Office Visits		
» Preventive Care*	Covered 100%	Covered 100%
» Primary Care Physician	$40 copay	$50 Copay
» MDLIVE *(Telemedicine)*	$40 copay	$50 Copay
» Specialist	Tier 1: $120 copay/Tier 2: $160 copay	$100 Copay
Urgent Care	$120 copay	$100 Copay
Emergency Room	$1000 copay	$750 Copay
Hospital		
» Inpatient	Tier 1: Deductible, then 30% Tier 2: $500 PAC, Deductible, then 50%	Deductible, then 30%
» Outpatient	Tier 1: Deductible, then 30% Tier 2: Deductible, then 50%	Deductible, then 30%
Out-of-Pocket Maximum		
» Individual	$7,900	$7,900
» Family	$15,800	$15,800

*Only state mandated services. See BCBS Member Guide for details.

IN-NETWORK DRUGS	CORE PLAN	BUY UP PLAN
Prescription Deductible	None	$100 tiers 1-6
Preventive & Contraception See list at bcbsnc.com/preventive	Plan pays 100% No Deductible Applies	Plan pays 100% No Deductible Applies
Retail (30 day supply)		$100 Rx Deductible, then:
» Tier 1 Drugs	$20 copay	$20 copay
» Tier 2 Drugs	$35 copay	$35 copay
» Tier 3 Drugs	$45 copay	$45 copay
» Tier 4 Drugs	$90 copay	$90 copay
» Tier 5 Drugs	25% coinsurance up to $200	25% up to $200
» Tier 6 Drugs	50% coinsurance up to $300	50% up to $300

31-60 day supply is two copayments and 61-90 day supply is three copayments. Prescription Drug copayments and coinsurance apply to the Out-of-Pocket limit. MAC A/B Pricing (You will pay a penalty when Generic Equivalent is available and Provider requires or you choose the Brand to be dispensed). Essential 6 closed formulary. Prior Plan approval, step therapy and quantity limits may apply.

TELEMEDICINE PROVIDED THROUGH MDLIVE

Blue Cross and Blue Shield of North Carolina (Blue Cross NC) is pleased to offer telehealth services from MDLIVE. It's a convenient, cost-effective care option is for minor health issues. Today, nearly 64% of companies offer telehealth services — compared with just 11% in 2012. This explosive growth is fueled by employees looking for quality care options that are more efficient and cost less. Plus, mobile technology now allows you to get that care at home, at work or on the go.

Easy access

MDLIVE's doctors can diagnose symptoms, prescribe non-narcotic medication and send e-prescriptions right to the patient's pharmacy of choice. Video consults are available 24 hours a day, seven days a week — including holidays. No appointment is necessary, and it takes just minutes to connect with an MDLIVE doctor. Conditions commonly treated through a virtual visit:

- Acne / Rash
- Allergies
- Cold / Flu
- Constipation
- Cough
- Diarrhea
- Ear problems
- Fever
- Headache
- Insect bites
- Nausea / Vomiting
- Pink Eye
- Respiratory problems
- Sore throats
- Urinary problems / UTI
- And more…

Attractive savings

Employees pay for an MDLIVE video consult the same as a visit with their primary doctor. For plans with a copay, they'll pay the usual copay for a doctor's visit. For plans with a deductible and coinsurance, they'll pay no more than $45. It's also a qualified expense for HSAs, HRAs and FSAs.

Since the average member cost for urgent care is $59 and $667 for the emergency room (ER), telehealth can significantly reduce out-of-pocket expenses for your employees.

Safe and trusted

MDLIVE is a HIPAA- and PHI-compliant solution that uses secure video via computer, tablet or mobile app. Employees gain easy access to U.S. board-certified doctors licensed to practice in the state. Specialties range from primary care and internal medicine to pediatrics and family medicine — so they can treat many different nonemergency health

MDLIVE at a glance

+ One of the nation's largest virtual care networks
+ 22+ million members
+ Average wait time under 10 minutes
+ State-licensed, board-certified physicians averaging 15 years of practice experience
+ NCQA-certified/accredited and follows URAC guidelines for quality care
+ HIPAA-compliant

MDLIVE.com
+1 (800) 400 MDLIVE

BlueCross BlueShield of North Carolina

MD

Download on the App Store

Google play

WHERE TO GO GUIDE

The cost for care and time you wait can vary greatly depending on where you go. Below is a simple guide to choosing the right place to go for health care. In addition to clinical settings, you have access to MDLive for virtual visits.

	Conditions Treated*	Your Cost & Time
Emergency Room		
For the immediate treatment of critical injuries or illness. If a situation seems life-threatening, call 911 or go to the nearest emergency room. Open 24/7.	▪ Sudden numbness, weakness ▪ Uncontrolled bleeding ▪ Seizure or loss of consciousness ▪ Shortness of breath ▪ Chest pain ▪ Head injury/major trauma ▪ Blurry or loss of vision ▪ Severe cuts or burns ▪ Overdose	▪ Costs are highest ▪ No appointment needed ▪ Wait times may be long, averaging over 4 hours
Urgent Care Center		
For conditions that are not life threatening. Staffed by nurses and doctors and usually have extended hours.	▪ Minor cuts, sprains, burns, rashes ▪ Fever and flu symptoms ▪ Headaches ▪ Chronic lower back pain ▪ Joint pain ▪ Minor respiratory symptoms ▪ Urinary tract infections	▪ Costs are lower than an ER visit ▪ No appointment needed ▪ Wait times vary
Doctor's Office		
The best place to receive routine or preventive care, track medications, or get a referral to see a specialist.	▪ General health issues ▪ Preventive services ▪ Routine checkups ▪ Immunizations and screenings	▪ May include coinsurance and/or deductible ▪ Appointment usually needed ▪ May have little wait time
Convenience Care Clinic		
Staffed by nurse practitioners and physician assistants. Treat minor medical concerns that are not life threatening. Located in retail stores and pharmacies, they're often open nights and weekends.	▪ Common cold/flu ▪ Rashes or skin conditions ▪ Sore throat, earache, sinus pain ▪ Minor cuts or burns ▪ Pregnancy testing ▪ Vaccinations	▪ Costs are same or lower than office visit ▪ No appointment needed ▪ Wait times typically 15 minutes or less
MDLive		
Virtual visits with a doctor anytime 24/7/365 via computer with webcam capability or smartphone mobile app.	▪ Cold and flu symptoms such as a cough, fever and headaches ▪ Allergies ▪ Sinus infections ▪ Family health questions	▪ Cost is lower than office visit ▪ No appointment needed ▪ Immediate, private, and secure visits

*List is not all inclusive. To find a specific health care facility or doctor, go to your medical carrier's website or call the number on your ID card. The listing of a health care professional or facility in the online directory does not guarantee that the services rendered by that professional or facility are covered under your specific medical plan. Check your official plan document for information about the services covered under your plan benefits. The information provided here is for informational purposes only. During a medical emergency, you should always visit the nearest hospital or call 911 for assistance.

DENTAL BENEFITS PROVIDED THROUGH PRINCIPAL

Finding a Provider

Principal's online directory makes it easy to find in-network dentists. Just follow these easy steps:

- Visit www.principal.com/dentist
- Search for a PPO network provider by location

To find out if your dentist is in-network, call 800-247-4695

It's About More Than a Pretty Smile

Our oral health affects our ability to speak, smell, taste, chew, and swallow. However, oral diseases, which can range from cavities to oral cancer, cause pain and disability for millions of people each year.

Visit Your Dentist Regularly

Regular preventive visits to your dentist can help protect your health, and we are talking about more than just your mouth. Recent studies have linked gum disease to damage elsewhere in the body. According to the Centers for Disease Control and Prevention, there may be associations between oral infections and diabetes, heart disease, stroke, and preterm, low-weight births. Research is underway to further examine these connections.

Our plan covers preventive services at 100% in-network, with no deductible for preventive services.

Dental Benefit Rollover Feature

Principal automatically rolls over a portion of each member's unused annual maximum for use in future years, if a member reaches the plan's Annual Maximum.

To qualify, a member must submit at least one claim during the calendar year and all member claims for the calendar year cannot exceed $500 Members can rollover $250 per year for a maximum rollover amount of $1,000 That amount can be used in later years in addition to the maximum annual benefit The employee and each dependent insured maintain separate rollover balances based on their own claim activity.

	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Deductible	$50 individual $150 family	$50 individual $150 family
Out-of-Network Reimbursement (In-network claims paid at the contracted rate)	Fee schedule	90th percentile
Preventive Services Oral exams, dental cleanings, X-rays, fluoride treatments, sealants, etc.	100% no deductible	100% no deductible
Basic Services Fillings, oral surgery, endodontics, periodontics	100% after deductible	80% after deductible
Major Services Crowns, inlays, onlays, bridges and dentures, anesthesia	50% after deductible	50% after deductible
Maximum Annual Benefit **(Per individual per calendar year)**	$1,000	$1,000

VISION CARE PROVIDED THROUGH PRINCIPAL/VSP

Principal members can take care of their vision and have routine eye exams, while saving money on all of their eye care needs. To start using your benefit, visit www.principal.com/vsp to find a provider or call the number on the back of your ID card.

Did you know?

Taking care of your vision can also mean early detection for symptoms of:

- Diabetes
- Hypertension
- High cholesterol
- Tumors
- Thyroid disorders
- Neurological disorders

A qualified vision care professional can help treat and manage:

- Cataracts
- Corneal diseases
- Diabetic retinopathy
- Eye infections
- Glaucoma
- Macular degeneration

	VSP CHOICE NETWORK	OUT-OF-NETWORK
Exam	$10 copay	Up to $45
Standard Plastic Lenses ▪ Single Vision ▪ Bifocal ▪ Trifocal ▪ Lenticular	$25 copay	 Up to $30 Up to $50 Up to $65 Up to $100
Frames (any frame available at provider location)	$150 allowance after $25 copay	Up to $70
Contact Lenses* ▪ Fitting and Evaluation ▪ Conventional ▪ Disposables	 Up to $60 copay $150 allowance Covered 100% after $25 copay	 No Benefit Up to $105 Up to $210
Frequency ▪ Examination ▪ Frames ▪ Lenses and Contact Lenses	 Once every 12 months Once every 24 months Once every 12 months	 Once every 12 months Once every 24 months Once every 12 months

*Contacts are in lieu of lenses and frames benefits.

BASIC LIFE AND AD&D, VOLUNTARY LIFE INSURANCE

Basic Life and AD&D

TA Woods provides you a benefit equal to $25,000 of basic employee life insurance and basic employee accidental death and dismemberment insurance at **NO COST** through Principal. Additional coverage for your spouse ($7,500) and children (up to $2,500) may also be purchased.

Voluntary Life Insurance

In addition to the insurance provided free by TA Woods, you can purchase additional voluntary life coverage for yourself, and additional life for your spouse and child(ren). You must purchase employee coverage to be able to purchase coverage for your spouse and/or child(ren).

EMPLOYEE VOLUNTARY LIFE
$10,000 increments to $300,000 maximum Guarantee Issue: Under age 70 $100,000 Guarantee Issue: Age 70 and over $10,000
SPOUSE VOLUNTARY LIFE
Increments of $5,000 to a $100,000 maximum Guarantee Issue: Under age 70 $30,000 Guarantee Issue: Age 70 and over $10,000 Coverage cannot exceed 100% of the employee's coverage
CHILD VOLUNTARY LIFE
Child Benefit: Under 14 days: $1,000 Over 14 days: $2,500, $5,000 or $10,000

Why buy Voluntary Life coverage?

Voluntary Life provides a lump sum cash benefit to surviving dependents to cover immediate costs such as funeral expenses or ongoing living expenses. Voluntary life insurance benefits often help survivors adjust to the loss of income related to the death of a wage earner, or provide funds for college or retirement for the survivors.

VOLUNTARY LIFE/AD&D WEEKLY PRICES

EE & SP	<29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
$10,000	$0.29	$0.31	$0.40	$0.54	$0.82	$1.30	$2.48	$2.90	$4.95	$7.12
$15,000	$0.43	$0.47	$0.61	$0.81	$1.23	$1.96	$3.72	$4.34	$7.43	$10.68
$20,000	$0.58	$0.62	$0.81	$1.08	$1.64	$2.61	$4.96	$5.79	$9.90	$14.24
$25,000	$0.72	$0.78	$1.01	$1.36	$2.05	$3.26	$6.20	$7.24	$12.38	$17.80
$30,000	$0.87	$0.93	$1.21	$1.63	$2.46	$3.91	$7.44	$8.69	$14.85	$21.36
$35,000	$1.01	$1.09	$1.41	$1.90	$2.87	$4.56	$8.68	$10.14	$17.33	$24.92
$40,000	$1.15	$1.25	$1.62	$2.17	$3.28	$5.22	$9.92	$11.58	$19.80	$28.48
$45,000	$1.30	$1.40	$1.82	$2.44	$3.69	$5.87	$11.16	$13.03	$22.28	$32.04
$50,000	$1.44	$1.56	$2.02	$2.71	$4.10	$6.52	$12.40	$14.48	$24.75	$35.60
$55,000	$1.59	$1.71	$2.22	$2.98	$4.51	$7.17	$13.64	$15.93	$27.23	$39.16
$60,000	$1.73	$1.87	$2.42	$3.25	$4.92	$7.82	$14.88	$17.38	$29.70	$42.72
$65,000	$1.88	$2.03	$2.63	$3.53	$5.33	$8.48	$16.13	$18.83	$32.18	$46.28
$70,000	$2.02	$2.18	$2.83	$3.80	$5.73	$9.13	$17.37	$20.27	$34.65	$49.83
$75,000	$2.16	$2.34	$3.03	$4.07	$6.14	$9.78	$18.61	$21.72	$37.13	$53.39
$80,000	$2.31	$2.49	$3.23	$4.34	$6.55	$10.43	$19.85	$23.17	$39.60	$56.95
$85,000	$2.45	$2.65	$3.43	$4.61	$6.96	$11.08	$21.09	$24.62	$42.08	$60.51
$90,000	$2.60	$2.80	$3.63	$4.88	$7.37	$11.73	$22.33	$26.07	$44.55	$64.07
$95,000	$2.74	$2.96	$3.84	$5.15	$7.78	$12.39	$23.57	$27.51	$47.03	$67.63
$100,000	$2.88	$3.12	$4.04	$5.42	$8.19	$13.04	$24.81	$28.96	$49.50	$71.19
$110,000	$3.17	$3.43	$4.44	$5.97	$9.01	$14.34	$27.29	$31.86	$54.45	$78.31
$120,000	$3.46	$3.74	$4.85	$6.51	$9.83	$15.65	$29.77	$34.75	$59.40	$85.43
$130,000	$3.75	$4.05	$5.25	$7.05	$10.65	$16.95	$32.25	$37.65	$64.35	$92.55
$140,000	$4.04	$4.36	$5.65	$7.59	$11.47	$18.25	$34.73	$40.55	$69.30	$99.67
$150,000	$4.33	$4.67	$6.06	$8.13	$12.29	$19.56	$37.21	$43.44	$74.25	$106.79
$160,000	$4.62	$4.98	$6.46	$8.68	$13.11	$20.86	$39.69	$46.34	$79.20	$113.91
$170,000	$4.90	$5.30	$6.87	$9.22	$13.93	$22.17	$42.17	$49.23	$84.15	$121.03
$180,000	$5.19	$5.61	$7.27	$9.76	$14.75	$23.47	$44.65	$52.13	$89.10	$128.15
$190,000	$5.48	$5.92	$7.67	$10.30	$15.57	$24.77	$47.13	$55.03	$94.05	$135.27
$200,000	$5.77	$6.23	$8.08	$10.85	$16.38	$26.08	$49.62	$57.92	$99.00	$142.38
$210,000	$6.06	$6.54	$8.48	$11.39	$17.20	$27.38	$52.10	$60.82	$103.95	$149.50
$220,000	$6.35	$6.85	$8.88	$11.93	$18.02	$28.68	$54.58	$63.72	$108.90	$156.62
$230,000	$6.63	$7.17	$9.29	$12.47	$18.84	$29.99	$57.06	$66.61	$113.85	$163.74
$240,000	$6.92	$7.48	$9.69	$13.02	$19.66	$31.29	$59.54	$69.51	$118.80	$170.86
$250,000	$7.21	$7.79	$10.10	$13.56	$20.48	$32.60	$62.02	$72.40	$123.75	$177.98
$260,000	$7.50	$8.10	$10.50	$14.10	$21.30	$33.90	$64.50	$75.30	$128.70	$185.10
$270,000	$7.79	$8.41	$10.90	$14.64	$22.12	$35.20	$66.98	$78.20	$133.65	$192.22
$280,000	$8.08	$8.72	$11.31	$15.18	$22.94	$36.51	$69.46	$81.09	$138.60	$199.34
$290,000	$8.37	$9.03	$11.71	$15.73	$23.76	$37.81	$71.94	$83.99	$143.55	$206.46
$300,000	$8.65	$9.35	$12.12	$16.27	$24.58	$39.12	$74.42	$86.88	$148.50	$213.58

**Indicates Spouse Maximum Benefit*

CHILD(ren) (No AD&D)

$2,500	$0.12
$5,000	$0.23
$10,000	$0.46

SHORT-TERM DISABILITY

Why is Disability Insurance is important?

One third of all Americans between the ages of 35 and 65 will become disabled for more than 90 days, according to the American Council of Life Insurers. TA Woods provides the ability for employees to purchase short-term disability insurance through Principal, which provides income continuation if you are ever unable to work due to an accident or illness.

SHORT-TERM DISABILITY (UP TO 26 WEEKS)

Your short-term disability (STD) insurance provides coverage of 66.67% of gross wages up to a maximum of $250 per week for a qualified disability. Benefits are payable on the 1st day of an injury or 8th day of an illness for a maximum of 26 weeks, including the elimination period. Pregnancy is covered under short-term disability the same as any other disability, however, benefits may only be payable for a maximum of 6-8 weeks depending on the method of delivery.

*Pre-existing condition limitations may apply.

Your Cost for Coverage

The cost for short-term disability coverage is based on your salary and age. The following chart shows your cost per pay period.

Salary	Weekly Benefit	Premium
$20,000	$231	$3.57
$21,675	$250	$3.87

FLEXIBLE SAVINGS ACCOUNT

With a Flexible Spending Account, you can set aside pre-tax dollars to pay for out-of-pocket expenses incurred for either health care or dependent day care. Because the amount that you elect is taken on a pre-tax basis, you have the opportunity to save up to an estimated 25% of out-of-pocket expenses!

HEALTH CARE - $1,000 maximum

The annual amount you elect is evenly deducted out of each paycheck throughout the year. Once you have elected your FSA amount, you may not change it without a qualifying life event. Please be aware that any unused balance over $500 will be forfeited back into the plan. Please note: employees enrolled in a HDHP w/HSA medical plan may use FSA funds for dental and/or vision expenses only.

DEPENDENT CARE - $5,000 maximum

A Dependent Care FSA is available to employees who have a dependent child or parent for which they pay expenses such as daycare, preschool, or after school care. Funds in the Dependent Care FSA are not to be used for medical care.

HEALTH CARE FSA Calculation Worksheet	AMOUNT SPENT IN AVG YEAR
Doctor visits? Hospital services?	
X-rays, lab exams, tests?	
Eye doctor visits? Glasses/ contacts?	
Prescriptions?	
Dental expenses?	
Total: regular expenses (max. yearly = $1000)	
÷ Number of paychecks per/yr	
= Amount to deposit into your health care reimbursement plan each pay period	

DEPENDENT CARE FSA Calculation Worksheet	AMOUNT SPENT IN AVG YEAR
Last year's tax credit-eligible day care expenses?	
Day care/preschool programs?	
After-school programs?	
Adult day care or elder care?	
Total: regular expenses (max. yearly = $5,000)	
÷ Number of paychecks you receive each year	
= Amount to deposit into your dependent care reimbursement plan each pay period	

FSA Reminders

- "Use-it-or-lose-it" unused Health Care amounts over $500 or any unused Dependent Care funds will be forfeited, so estimate wisely
- You cannot mix funds from one account to another. You may only use Health Care FSA money for health care expenses and Dependent Care FSA for funds for dependent care (day care) expenses
- Save your receipts - No matter how you access your FSA funds, be sure to keep your receipts to validate your reimbursements
- You can incur expenses only during the plan year you are enrolled
- Your entire Health Care FSA balance – even money you have not yet contributed – is available as of December 1st.
- Dependent care funds are only available as you contribute to them through payroll deductions
- You must re-enroll each year if you wish to continue funding the account(s)
- Employees enrolled in the HDHP w/HSA Medical Plan may use FSA funds for dental and/or vision

VOLUNTARY BENEFITS PROVIDED THROUGH GUARDIAN

Group Voluntary Accident (Off-the-Job)

Accident Coverage provides cash benefits for out-of-pocket expenses associated with an accidental injury and can help protect hard-earned savings should an accidental injury occur. No one plans to have an accident, but it can happen at any moment throughout the day. Accident coverage from Guardian can help pick up where other insurance leaves off.

- Benefits that correspond with treatment for off- the-job accidental injuries including hospitalization, emergency treatment, and intensive care, plus more
- Pays benefits for open and closed fractures
- You have two benefit levels to choose from
- Please review your Guardian benefits brochure for more plan option details

	Per Week
Employee	$3.15
Employee & Spouse	$4.89
Employee & Child	$5.15
Full Family	$6.89

Group Voluntary Critical Illness

Guardian's Critical Illness insurance pays benefits that can be used for critical illness-related expenses that your health insurance might not cover. This benefit is in the form of a lump-sum payment, which is paid to you at diagnosis, and is not limited to cover medical expenses. Funds can be used under the discretion of the insured for things such as childcare, transportation, and to fill in the gaps in their medical plan, like copays and deductibles.

Benefit Amount	Employee					
	<30	30-39	40-49	50-59	60-69	70+
$5,000	$1.13	$1.59	$3.12	$5.88	$9.21	$17.70
$10,000	$2.26	$3.18	$6.23	$11.77	$18.42	$35.40
$15,000	$3.39	$4.78	$9.35	$17.65	$27.62	$53.10
$20,000	$4.52	$6.37	$12.46	$23.54	$36.83	$70.80

Benefit Amount	Spouse					
	<30	30-39	40-49	50-59	60-69	70+
$2,500	$0.57	$0.80	$1.56	$2.94	$4.60	$8.85
$5,000	$1.13	$1.59	$3.12	$5.88	$9.21	$17.70
$7,500	$1.70	$2.39	$4.67	$8.83	$13.81	$26.55
$10,000	$2.26	$3.18	$6.23	$11.77	$18.42	$35.40

Group Voluntary Cancer

Cancer insurance from Guardian pays benefits when you have been diagnosed with a disease manifested by the presence of a malignant tumor characterized by the uncontrolled growth and spread of malignant cells in any part of the body. This includes leukemia, Hodgkin's disease, lymphoma, sarcoma, malignant tumors and melanoma. Cancer includes carcinomas in-situ (in the natural or normal place, confined to the site of origin, without having invaded neighboring tissue). This benefit is in the form of a lump-sum payment, which is paid to you at diagnosis.

	Per Week
Employee	$3.82
Employee & Spouse	$8.70
Employee & Child	$4.46
Full Family	$9.34

- Please review your Guardian benefits brochure for more plan option details

EMPLOYEE ASSISTANCE PROGRAM PROVIDED THROUGH PRINCIPAL

Help handling life's ups and downs

Life can be unpredictable. And its not always easy. So it's a big deal to know there's help available when you need it. That's what the Employee Assistance Program (EAP), provided by Magellan Healthcare, is all about.

With an EAP, you and your immediate family have access to free, confidential resources to help handle life's every-day - and not so everyday - challenges.

Services for you and your family

Your EAP offers these services to help you and your family deal with the big and little things:

- LifeMart Discount Center, with savings on a variety of products and services
- Self-assessments for identifying issues with stress, depression or substance abuse
- Health and wellness articles, guides, webinars, podcasts and calculators
- Online assistance with eldercare, child care and other family life resources
- Help with teen and adolescent issues, including eating disorders and relationships
- Tips on parenting and grandparenting
- 24/7 phone consultation with licensed mental health professionals and referrals to supportive resources
- Ongoing personal coaching sessions with scheduled telephonic appointments

Help is just a click or phone call away

Life challenges don't always happen during regular business hours. That's why you and your family have 24/7 access to your EAP.

Log on to www.magellanhealth.com/member

Call Toll-Free: 800-450-1327

International: 800-662-4504

TTY: 800-456-4006

Magellan HEALTH®

YOUR BENEFITS RESOURCES	PHONE	WEB/EMAIL
Medical - BlueCross BlueShield	800-446-8053	www.blueconnectnc.com
Dental - Principal	800-247-4695	www.principal.com/dentist
Vision - Principal (VSP)	800-877-7195	www.principal.com/vsp
Flexible Spending Accounts - HealthEquity	866-346-5800	www.healthequity.com/members
Life Insurance - Principal	800-245-1522	www.principal.com
Disability - Principal	800-245-1522	www.principal.com
Voluntary Accident/Cancer - Guardian **Voluntary Critical Illness** - Guardian	800-541-7846 800-268-2525	www.guardiananytime.com
Employee Assistance Program - Magellan Healthcare	800-450-1327	www.magellanhealth.com/member
Teresa Woods - TA Woods	910-452-7900	tcox@tawoods.com
Jenny Dickerson - McGriff Insurance Services	919-281-4560	Jenny.dickerson@mcgriffinsurance.com

TERMS TO KNOW

Deductible - Amount an employee pays out of pocket prior to the insurance company paying a percentage of the provider charges.

Coinsurance - The amount of payment split between the employee and the insurance company. Example: Insurance company pays 80% and employee pays 20% of the charges after the deductible is met.

Out of Pocket Maximum - The maximum an employee is responsible for paying out of pocket in any one calendar year prior to the insurance company paying the entire eligible amount for the remaining of the calendar year.

Network Providers - Doctors, Hospitals and other healthcare providers who have an agreement/ contract with insurance companies agreeing to charge a discounted amount for services they render.

Pre-Authorization - Certain procedures or hospitalizations may require that the provider receive authorization. The provider is typically the one to go through this process with the insurance company and obtain pre-authorization.

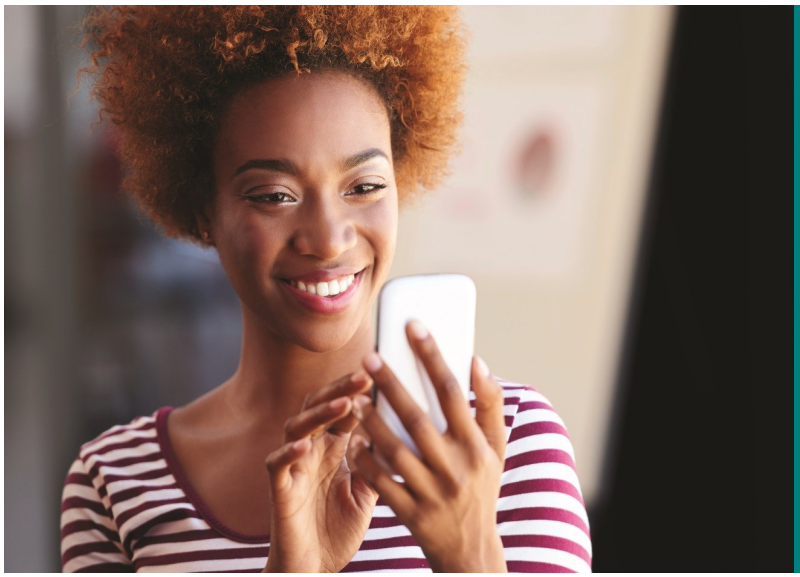
Pre-Determination - If you are having a major procedure done, your doctor or dentist can submit a pre-determination to the insurance company so you can know in advance of treatment how much of the bill you will be responsible for.

Explanation of Benefits (EOB) - The EOB is mailed to the employee after a claim is received and processed by the insurance company. The EOB will describe how the claim was processed and outline what portion of the charges are applied to the deductible, what portion the employee is responsible for, and explain if there is a denial or error processing the claim.

Appeal - If your health insurance company doesn't pay for a specific health care provider or service, you have the right to appeal the decision and have it reviewed by an independent third party.

Guaranteed Issue - The maximum amount of voluntary life insurance you can choose when making your initial election that does not require the answering of medical questions.

Evidence of Insurability (EOI) - The form containing medical questions that are required to be answered if you decide to elect voluntary life insurance after you have previously declined coverage, or if you decide to increase your current coverage. This may also be needed if you decide to add disability coverage after you have previously declined.



INSURANCE COMPANY WEBSITES AND APPS

Registering on your insurance company websites and downloading the smart phone apps gives you instant access to valuable resources. In most cases you can access:

- Specific plan details
- ID cards
- In-network provider search
- Your claims history
- And other tools and resources

NOTICES

Full versions of the below notices along with Summary Plan Descriptions (SPD) and Summary of Benefits and Coverage (SBC) can be found by logging into the TA Woods enrollment portal, Employee Navigator. If you are unable to access these for any reason, contact Human Resources for a printed copy.

HIPAA PRIVACY AND SECURITY – NOTICE OF PRIVACY PRACTICES

Summary: HHS regulations require that participants be provided with a detailed explanation of their privacy rights, the plan's legal duties with respect to protected health information, the plan's uses and disclosures of protected health information, and how to obtain a copy of the Notice of Privacy Practices.

HIPAA PORTABILITY – NOTICE OF SPECIAL ENROLLMENT RIGHTS

Summary: This notice describes a group health plan's special enrollment rules including the right to special enroll within 30 days of the loss of other coverage or of marriage, birth of a child, adoption, or placement of a child for adoption, or within 60 days of a determination of eligibility for a premium assistance subsidy under Medicaid or CHIP.

COBRA – FIRST NOTICE OF COBRA RIGHTS

Summary: This notice advises covered employees, covered spouses, and covered dependents of the right to purchase a temporary extension of group health coverage when coverage is lost due to a qualifying event.

CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT NOTICE (CHIPRA)

Summary: This annual notice notifies employees of potential state opportunities for premium assistance to help pay for employer- sponsored health coverage.

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE (WHCRA)

Summary: Participants and beneficiaries of group health plans who are receiving mastectomy-related benefits can choose to have breast reconstruction following a mastectomy.

PRESCRIPTION DRUG COVERAGE AND MEDICARE

Summary: Entities that offer prescription drug coverage on a group basis to active and retired employees and to Medicare Part D eligible individuals – must provide, or arrange to provide, a notice of creditable or non-creditable prescription drug coverage to Medicare Part D eligible individuals who are covered by, or who apply for, prescription drug coverage under the entity's plan. This creditable coverage notice alerts the individuals as to whether or not their prescription drug coverage is at least as good as the Medicare Part D coverage.

HEALTH CARE REFORM NOTICE: NOTICE OF EXCHANGE/ MARKETPLACE

Summary: Employer must provide all employees with an Exchange Notice that includes a description of services provided by the Exchange. The notice must explain the premium tax credit available if a qualified health plan is purchased through the Exchange. The employee must also be informed that they may lose the employer contribution to any benefit plans offered by the employer if a health plan through the Exchange is elected.

MEDICAL PRE-TAX PREMIUMS PLAN

Summary: Enrollment in a pre-tax premium plan authorizes premiums for group health plan benefits to be payroll deducted on a pre-tax basis.

WELLNESS PROGRAM DISCLOSURE

If it is unreasonably difficult due to a medical condition for you to achieve the standard for reward or if it is medially inadvisable for you to attempt to achieve the standard for reward under your employer's wellness program, please contact your employer's Human Resources representative to develop another way for your to qualify for the wellness program reward.

REQUIRED ANNUAL NOTICES

SPECIAL ENROLLMENT NOTICE

If you are declining enrollment for yourself or your dependents (including your spouse) because of 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 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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 30 days after the marriage, birth, adoption, or placement for adoption.

Finally, if you or an eligible dependent has coverage under a state Medicaid or child health insurance program and that coverage is terminated due to a loss of eligibility, or if you or an eligible dependent become eligible for state premium assistance under one of these programs, you may be able to enroll yourself and your eligible family members in the Plan. However, you must request enrollment no later than 60 days after the date the state Medicaid or child health insurance program coverage is terminated or the date you or an eligible dependent is determined to be eligible for state premium assistance.

To request special enrollment or obtain more information, contact the plan administrator identified at the end of these notices.

WELLNESS PROGRAM DISCLOSURE

If it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under this program, or if it is medically inadvisable for you to attempt to achieve the standards for the reward under this program, call the plan administrator identified at the end of these notices and we will work with you to develop another way to qualify for the reward.

NEWBORN'S AND MOTHER'S HEALTH PROTECTION ACT

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

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

REQUIRED ANNUAL NOTICES

IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE ON THE PPO PLANS

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

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

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

When Can You Join A Medicare Drug Plan?

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current coverage will be affected. See pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at www.cms.hhs.gov/CreditableCoverage), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D. If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information or call Medicare at 800-633-4227. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

REQUIRED ANNUAL NOTICES

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	December 1, 2019
Name of Entity/Sender:	TA Woods
Contact--Position/Office:	Teresa Woods-Cox / CEO
Physical Address:	6713 Netherlands Drive Wilmington, NC 28405
Mailing/Billing Address	6713 Netherlands Drive Wilmington, NC 28405
Phone Number:	910-452-7900

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State 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 pay the premiums for an employer-sponsored plan.

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2019. Contact your State for more information on eligibility

ALABAMA – Medicaid	FLORIDA – Medicaid
http://myalhipp.com/ PH: 1-855-692-5447	http://flmedicaidtplrecovery.com/hipp/ PH: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
http://myakhipp.com/ PH: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp PH: 678-564-1162 ext 2131
ARKANSAS – Medicaid	**INDIANA – Medicaid**
http://myarhipp.com/ PH: 1-855-MyARHIPP (855-692-7447)	For low-income adults 19-64 http://www.in.gov/fssa/hip/ PH: 1-877-438-4479 http://www.indianamedicaid.com PH: 1-800-403-0864

REQUIRED ANNUAL NOTICES

COLORADO – Health First Colorado & Child Health Plan Plus (CHP+)	IOWA – Medicaid
https://www.healthfirstcolorado.com/ 1-800-221-3943/ State Relay 711 https://www.colorado.gov/pacific/hcpf/child-health-plan-plus 1-800-359-1991/ State Relay 711	http://dhs.iowa.gov/Hawki PH: 1-800-257-8563
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
http://www.kdheks.gov/hcf/ PH: 1-785-296-3512	https://www.dhhs.nh.gov/oii/hipp.htm PH: 603-271-5218 / 1-800-852-3345, ext 5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
https://chfs.ky.gov PH: 1-800-635-2570	http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ CHIP: http://www.njfamilycare.org/index.html PH: 609-631-2392 CHIP PH: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 PH: 1-888-695-2447	https://www.health.ny.gov/health_care/medicaid/ PH: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
http://www.maine.gov/dhhs/ofi/public-assistance/index.html PH: 1-800-442-6003 TTY: Maine relay 711	https://medicaid.ncdhhs.gov/ PH: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
http://www.mass.gov/eohhs/gov/departments/masshealth/ PH: 1-800-862-4840	http://www.nd.gov/dhs/services/medicalserv/medicaid/ PH: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp PH: 1-800-657-3739	http://www.insureoklahoma.org PH: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm PH: 573-751-2005	http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html PH: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP PH: 1-800-694-3084	http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm PH: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid and CHIP**
http://www.ACCESSNebraska.ne.gov PH: (855) 632-7633 Lincoln: (402) 473-7000 / Omaha: (402) 595-1178	http://www.eohhs.ri.gov/ PH: 855-697-4347 401-462-0311 (Direct RIte Share Line)
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid https://dhcfp.nv.gov PH: 1-800-992-0900	https://www.scdhhs.gov PH: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
http://dss.sd.gov PH: 1-888-828-0059	https://www.hca.wa.gov/ PH: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
http://gethipptexas.com/ PH: 1-800-440-0493	http://mywvhipp.com/ PH: 1-855-699-8447
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
https://medicaid.utah.gov/ CHIP http://health.utah.gov/chip PH: 1-877-543-7669	https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf PH: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
http://www.greenmountaincare.org/ PH: 1-800-250-8427	https://wyequalitycare.acs-inc.com/ PH: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid http://www.coverva.org/programs_premium_assistance.cfm PH: 1-800-432-5924 CHIP http://www.coverva.org/programs_premium_assistance.cfm PH: 1-855-242-8282	

REQUIRED ANNUAL NOTICES

To see if any other states have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 12/31/2019)

Prepared by:

McGriff Insurance Services

6713 Netherlands Drive Wilmington, NC 28405

910-452-7900

www.tawoods.com