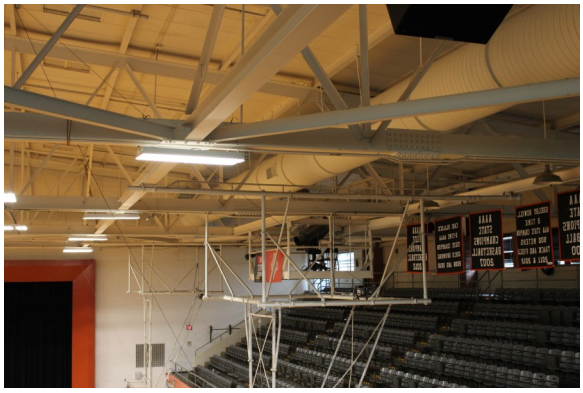
EMPLOYEE BENEFIT GUIDE

2020-2021



T.A. WOODS COMPANY

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Welcome

At **TA Woods** we're proud of our accomplishments and especially our people. Your health and the health of your family are important to us. Please take the time to review it and share the information with your family.

Each year, **TA Woods** holds Open Enrollment in November. Elections you make during Open Enrollment will remain in effect through the plan year, from December 1st through November 30th

- Medical Coverage will remain with BCBS of NC with a dual choice option— some plan changes
- Flexible Spending Account will continue through Health Equity
- Dental & Vision plans will continue through Principal—no plan or rate changes
- Group Term Life/AD&D will continue through Principal - paid by TA Woods
- Voluntary Life & Voluntary Short-term disability plans offered through Principal
- Voluntary Worksite plans will remain with Guardian
- NEW PRODUCT OFFERING! Voluntary Long Term Disability will be offered through Principal

ELIGIBILITY AND ENROLLMENT

You may enroll in our benefits program if you are an active, full-time regular employee working a minimum of 30 hours per week. Your benefits become effective on the 91st day of full time service.

As you become eligible for benefits, so do your eligible dependents. In general, eligible dependents includes:

- your legal spouse
- your children to age 26
- unmarried children of any age if totally disabled and claimed as a dependent on your federal tax return

DURING OPEN ENROLLMENT

You can change your plan elections for the following plan year. Only during Open Enrollment or after a Qualifying Life Event can you:

- Add or delete dependents from coverage
- Move from one plan to another
- Enroll for the first time
- Drop existing coverages

COMMON LIFE STATUS CHANGES

- Birth or adoption
- Marriage, divorce, legal separation
- 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 Support Order

NOTE: You can make some limited changes during the year if there is a Qualified Life Status Change and such change is consistent with the event. You must notify Human Resources within 30 days.

CLAIM QUESTIONS OR ISSUES

1. Call your insurance carrier's customer service department. Phone numbers can be found on your ID cards and on page 14 of this booklet.

2. If the carrier does not resolve your problem, contact Jenny Dickerson at McGriff Insurance at **919-281-4560** or Jenny.Dickerson@McGriff.com

3. If you're not satisfied after steps 1 and 2, please contact Teresa Woods-Cox at TA Woods at **910-452-7900** or tcox@tawoods.com

BENEFIT COSTS - PAYROLL DEDUCTIONS - WEEKLY

BCBSNC Core Medical Plan	Weekly
EE Only	$28.73
EE + Spouse	$149.46
EE + Child(ren)	$131.34
EE + Family	$282.25

BCBSNC Buy Up Medical Plan	Weekly
EE Only	$49.69
EE + Spouse	$191.38
EE + Child(ren)	$170.12
EE + Family	$347.23

Dental	EE ONLY	EE + SPOUSE	EE + CHILD(REN)	EE + FAMILY
Weekly	$5.06	$12.66	$14.92	$23.70

Vision	EE ONLY	EE + SPOUSE	EE + CHILD(REN)	EE + FAMILY
Weekly	$0.52	$1.88	$2.16	$3.85

Basic Life/AD&D	Paid by TA Woods - See benefits on page 10
Voluntary Term Life/AD&D	The cost of your additional insurance is dependent upon your age and selected amount. **See benefits on page 10** **See rates in Employee Navigator**
Voluntary Short-Term Disability Voluntary Long-Term Disability	Cost of Coverage is based on salary and benefit amount See benefits on page 11 See rates in Employee Navigator
Voluntary Worksite Benefit	See benefits/rates on page 13 and in Employee Navigator

MEDICAL BENEFITS PROVIDED THROUGH BLUE CROSS BLUE SHIELD OF NC

TA Woods provides medical group benefits with Blue Cross Blue Shield for the 2020 – 2021 plan year. We will offer two medical plans for you to choose from. Access the BCBSNC of NC website at www.blueconnectnc.com to search for doctors and facilities and use the cost-transparency and quality rating tools.

Benefits shown are Member Responsibility

EFFECTIVE DECEMBER 1, 2020	Core PPO Plan Blue Options	Buy Up PPO Plan Blue Options
Deductible » Individual » Family	Embedded $5,000 $10,000	Embedded $3,000 $6,000
Office Visits » Preventive Care* » Primary Care Physician » Specialist » MDLIVE *(Telemedicine)*	 Covered 100% $35 Copay $70 Copay $10 Copay	 Covered 100% $35 Copay $70 Copay $10 Copay
Urgent Care Emergency Room	$75 Copay $500 Copay	$75 Copay $500 Copay
Hospital » Inpatient » Outpatient	 Deductible, then 40% Deductible, then 40%	 Deductible, then 20% Deductible, then 20%
Out-of-Pocket Maximum » Individual » Family	 $7,150 $14,300	 $6,000 $12,000

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

IN-NETWORK DRUGS	Core PPO Plan Blue Options	Buy Up PPO Plan Blue Options
RX Formulary	Essential 5 Tier Commercial Limited Network	Enhanced 4 Tier Commercial Broad Network
Preventive & Contraception See list at: https:/www.bcbsnc.com/content/campaigns/preventive/index.htm	Plan pays 100% No Deductible Applies	Plan pays 100% No Deductible Applies
Retail (30 day supply) » Tier 1 Drugs » Tier 2 Drugs » Tier 3 Drugs » Tier 4 Drugs » Tier 5 Drugs	 $25 Copay $40 Copay $80 Copay $105 Copay 50% up to $200	 $25 Copay $75 Copay $100 Copay 50% up to $200 N/A
Up to 30 day supply. 31-60 day supply is two copayments and 61-90 day supply is three copayments. Prescription Drug copayments*, coinsurance* and deductibles* (*if applicable) apply to the Out-of-Pocket limit. MAC B Pricing (Brand Penalty when Generic Equivalent is available and Provider does not require Brand to be dispensed). Penalty does not count toward OOP Limit. Prior Plan approval, step therapy and quantity limits may apply.		

BlueCross BlueShield of North Carolina

An independent licensee of the Blue Cross and Blue Shield Association

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 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 pharmacy of your 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

You pay for an MDLIVE video consult the same as a visit with your primary doctor. For plans with a copay, you'll pay the usual copay for a doctor's visit. For plans with a deductible and coinsurance, you'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 you.

Safe and trusted

MDLIVE is a HIPAA- and PHI-compliant solution that uses secure video via computer, tablet or mobile app. You 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 problems.

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 equals an 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
To locate a provider go to www.principal.com/find-dentist and search 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 protect your health, and we are talking about more than just your mouth. Recent studies have linked gum disease 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.

Dental (PPO)	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Deductible	$50 individual / $150 family	$50 individual / $150 family
Calendar Year Maximum	$1,000	
Reimbursement *(provider may balance bill)	Fee schedule	90th U&C*
Preventive Services Routine oral exams, Cleanings, X-rays, Fluoride treatments, Sealants for children	100% no deductible	100% no deductible
Basic Services Fillings, Endodontics (root canals), Periodontal maintenance and surgery, Simple and Complex extractions, Simple and Complex Oral Surgery	100% after deductible	80% after deductible
Major Services Bridges & Dentures, Crowns, General anesthesia	50% after deductible	50% after deductible

VISION BENEFITS 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 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	IN-NETWORK	OUT-OF-NETWORK
Exam	$10 copay	Up to $45
Standard Plastic Lenses ▪ Single Vision ▪ Bifocal ▪ Trifocal ▪ Lenticular	Covered 100% after $25 Materials Copay	 Up to $30 Up to $50 Up to $65 Up to $100
Frames	$150 allowance	Up to $70
Contact Lenses* ▪ Fitting & Evaluation ▪ Elective ▪ Necessary	 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.

FLEXIBLE SPENDING ACCOUNTS PROVIDED THROUGH HEALTH EQUITY

With a Flexible Spending Account (FSA), 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 you elect is taken on a pre-tax basis, you have the opportunity to save up to an estimated 25% on out-of-pocket expenses!

Health Care – $1,000 Maximum ($500 minimum) 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 day care, preschool, or after school care. Funds in the Dependent Care FSA are not to be used for medical care.

Setting Your Contributions Outside of Open Enrollment, you are only able to make a change to your elections if you experience certain qualified life events. It is advised that you think wisely about the amount you choose to contribute and seek advice from your tax preparer.

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 year	
= 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	

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 a HDHP w/HSA Medical Plan may use FSA funds for dental and/or vision expenses only

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 and accidental death and dismemberment insurance through Principal at **NO COST to you.** You may also elect benefits for your spouse and children. Benefit amounts reduce to 65% at age 65 and to 50% at age 70.

Voluntary Life Insurance

In addition to the Group Basic Life/AD&D Insurance provided free by TA Woods, you can purchase additional Voluntary Life coverage for yourself, and additional life for your spouse and children. Benefit amounts reduce to 50% at age 70.

EMPLOYEE VOLUNTARY LIFE
$10,000 increments to $300,000 maximum Guarantee Issue: $100,000 Under age 70 Guarantee Issue: $10,000 age 70+
SPOUSE VOLUNTARY LIFE
$5,000 increments to $100,000 maximum Guarantee Issue: $30,000 Under age 70 Guarantee Issue: $10,000 age 70+ Cannot exceed 100% of employee amount
CHILD VOLUNTARY LIFE
Under 14 days: **$1,000** 14 days to 26 years: **$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.

Open Enrollment

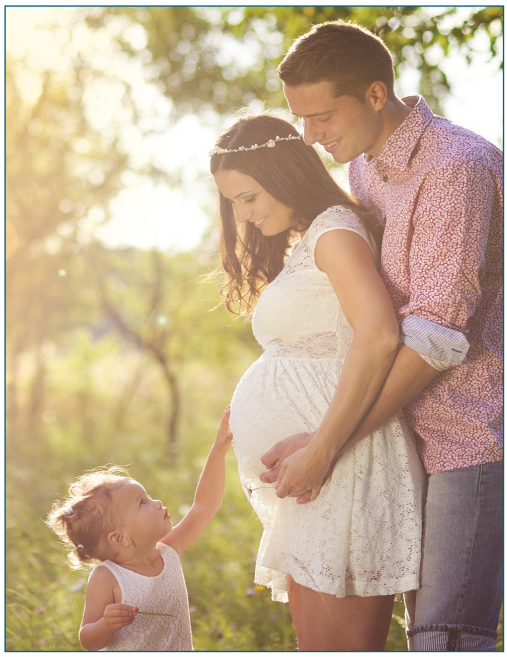
During Open Enrollment, you can request to add or increase existing Voluntary life insurance coverage for yourself or eligible dependents up to two benefit increments without providing proof of good health (not to exceed the maximum life insurance benefit allowed). You can also request higher amounts of coverage which will require approval of proof of good health.

VOLUNTARY SHORT-TERM and LONG-TERM DISABILITY

PROVIDED THROUGH PRINCIPAL

Why is Disability Insurance 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 offers disability insurance through Principal, which provides income continuation if you are ever unable to work due to an accident or illness.

SHORT-TERM DISABILITY	All Eligible Employees
Benefit Percentage	66.67%
Maximum Weekly Benefit	$250
Elimination Period (Injury/Sickness)	0 days / 7 days
Benefit Duration	Up to 26 weeks
Pre-Existing Exclusion	3 months / 12 months



LONG-TERM DISABILITY	All Eligible Employees
Benefit Percentage	60%
Maximum Monthly Benefit	$100 increments between $500 and $6,000
Elimination Period	180 days
Benefits Duration	Up to 5 years*
Pre-Existing Exclusion	3 months / 12 months

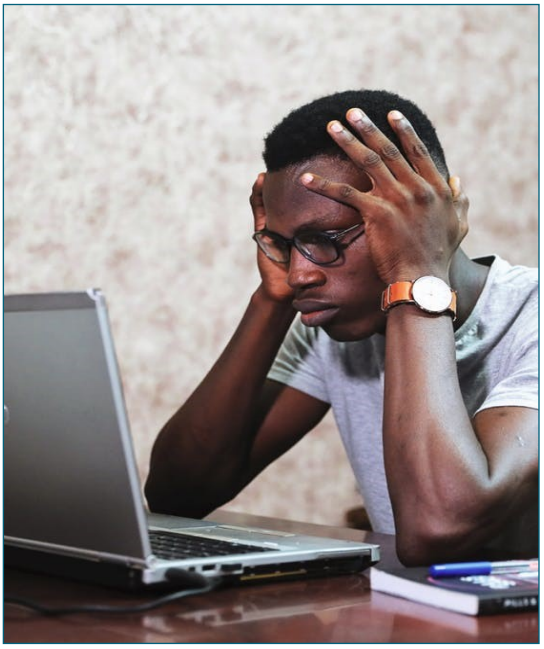
*Your age at the time disability occurs determines the length of time you are eligible to receive disability benefits.

Your Cost for Coverage - The cost for short-term disability and long-term disability coverage is based on your salary and age and will be calculated in Employee Navigator when you enroll.

EMPLOYEE ASSISTANCE PROGRAM ADMINISTERED BY MAGELLAN

We all need help every now and then.

No matter where you are on your journey, there are times when a little help can go a long way. From checking off daily tasks to working on more complex issues, your program offers a variety of resources, tools and services available to you and your household members.



Core Services:

- Counseling—Counselors can provide support for challenges such as stress, anxiety, grief, relationship concerns and more.
- Coaching—When you have a goal to achieve, coaches help you create a plan of action and stay on track.
- Online programs—Self-guided, interactive programs help improve your emotional well-being for issues like depression and anxiety.

Key Features:

⇒**Provided at no cost**
⇒**Includes up to 3 counseling sessions**
⇒**Confidential service provided by a third party**
⇒**Available 24 / 7 / 365**

Work-life web services: Save time and money on life's most important needs. Access webinars, live talks and articles that offer insights and strategies focused on key life events and day-to-day challenges for parents and seniors. Topics include: child and elder care, education, parenting and more.

Smoking cessation: You may have tried to quit in the past without success. Now, you can quit using an innovative mobile app. Designed with clinically-driven technology, the app helps you create and stick to a quit plan and overcome nicotine cravings. Get the boost you need to quit for good.

Resiliency: Being resilient generally means you're able to adapt to hard times, to challenges, and to other sorts of adversity in life. Fortunately, you can develop skills to become more resilient and your program provides many resources to help you on your journey.

Here's how to get started

Getting the help you need, when you need it, can result in you leading a happier, more productive life.

Give us a call and we will connect you with the right resource or professional.

Learn more about all of the services available at MagellanAscend.com.

Employee Assistance Program

Up to 3 in-person sessions per concern

1-800-356-7089

TTY Users: 1-800-456-4006

To access MagellanAscend.com, enter company name

VOLUNTARY WORKSITE BENEFITS - AVAILABLE 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 off-the-job 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.

Accident Per Weekly Payroll	
EE Only	$3.15
EE + SP	$4.89
EE + CH	$5.15
Family	$6.89

- Benefits correspond with treatment for off-the-job accidental injuries including hospitalization, emergency treatment, intensive care, and more
- Pays benefits for open and closed fractures
- Wellness benefit of $50 per year for you and your dependents for receiving certain common routine wellness screenings or procedures
- Coverage is portable

Group Voluntary Cancer

The Guardian Cancer plan pays benefits that correspond to the treatment of cancer.

Cancer Per Weekly Payroll	
EE Only	$3.82
EE + SP	$8.70
EE + CH	$4.46
Family	$9.34

- Coverage is portable up to age 70
- Pre-existing condition limitations apply
- Pays benefits for radiation therapy or chemotherapy, ambulance trips, blood/plasma/platelets, bone marrow/stem cell transplants, extended care facilities, home health care, hospital/ICU confinement, reconstructive surgery, surgical benefit, and more

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.

- Wellness benefit of $50 for completing certain routine wellness screenings or procedures

	Employee Weekly Premium					
Benefit	**<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

	Spouse Weekly Premium					
Benefit	**<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

WHO TO CONTACT

YOUR BENEFIT RESOURCES	PHONE	WEB/EMAIL
Medical **BlueCross BlueShield of North Carolina**	877-258-3334	www.bluecrossnc.com
Telemedicine **MDLive**	800-400-6354	www.MDlive.com
Flexible Spending Account (FSA) **HealthEquity**	866-346-5800	www.healthequity.com
Dental Vision Basic Life/AD&D, Voluntary Life Short-term and Long-term Disability **Principal**	800-247-4695 800-877-7195 800-245-1522 800-245-1522	www.principal.com/find-dentist www.principal.com/vsp www.principal.com www.principal.com
Voluntary Accident / Cancer Voluntary Critical Illness **Guardian**	800-541-7846 800-268-2525	www.guardiananytime.com
Employee Assistance Program **Magellan Healthcare**	800-356-7089	MagellanHealth.com/member
Teresa Woods-Cox **CEO**	910-452-7900	tcox@tawoods.com
Jenny Dickerson **McGriff Insurance Services**	919-281-4560	Jenny.Dickerson@McGriff.com

TA WOODS COMPANY

Important: Required Notices

Updated for Plan Year: December 2020

Please read these important notices about your benefits.

- **Medicare Creditable Coverage Disclosure Notices:**
  - **Creditable Notice – PPO Plans**
  - **Wellness Program Disclosure Notice**
  - **Women's Health & Cancer Rights**
- **Newborns' and Mothers' Health Protection Act**
- **Notice of Cobra Continuation Coverage Rights**
- **Notice of HIPAA Special Enrollment Rights**
- **CHIPRA Premium Assistance Notice**

Medicare Part D Creditable Coverage Notice

Important Notice from TA Woods Company.
About your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage offered by the group health plan through TA Woods Company 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 Company has determined that the prescription drug coverage offered by the group health plan through TA Woods Company 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 for Medicare 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 through TA Woods Company will not be affected. You can keep this coverage if you elect Part D, and this plan will coordinate with Part D coverage. See pages 7-9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://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 decide to join a Medicare drug plan and drop your current group health coverage through TA Woods Company, be aware that you and your dependents will be able to get this coverage back. If you are able to get this coverage back, reentry into the plan is subject to the underlying terms of the Plan.

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 group health coverage through TA Woods Company 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. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through TA Woods Company changes. You may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web 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).

For purposes of this notice, the plan administrator is:
Teresa Woods-Cox
910-452-7900

WHCRA enrollment/annual notice

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator as identified at the end of these notices.

For purposes of this notice, the plan administrator is:

Teresa Woods-Cox
910-452-7900

Newborns' Act disclosure

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).

Model General Notice of COBRA Continuation Coverage Rights
(For use by single-employer group health plans)

****Continuation Coverage Rights Under COBRA****

Introduction:

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health

plan for which you are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

If the Plan provides retiree health coverage, sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in a bankruptcy is filed with respect to TA Woods Company and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of coverage under the Plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- If the Plan provides retiree health coverage, commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days. You must provide this notice to Teresa Woods-Cox.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**

If you have questions

Questions regarding your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website). For more information about the Marketplace, visit www.HealthCare.gov

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

PPO Medical Plans, Dental, Vision, Flexible Spending Account
TA Woods Company
6713 Netherlands Drive Wilmington, NC 28405
910-452-7900

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 listed below:

Teresa Woods-Cox
910-452-7900

CHIPRA premium assistance notice

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 Medicaid or CHIP office or dial **1-877-KIDSNOW**, or **www.insuredkidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.** If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.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, 2020. Contact your state for more information on eligibility –

ALABAMA – MEDICAID	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
Website: http://myalhipp.com Phone: 1-855-692-5477	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711
ALASKA – MEDICAID	**FLORIDA - Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ARKANSAS – MEDICAID	**GEORGIA - Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131

CALIFORNIA – Medicaid	**INDIANA - Medicaid**
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_co nt.aspx Phone: 1-800-541-5555	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
IOWA – Medicaid and CHIP (Hawki)	**NEBRASKA – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633

Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563	Lincoln: 402-473-7000 Omaha: 402-595-1178
KANSAS – Medicaid	**NEVADA – Medicaid**
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Phone: 1-800-792-4884 Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
KENTUCKY – Medicaid	**NEW HAMPSHIRE – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/publicassistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-andfamilies/health-care/health-care-programs/programs-andservices/medical-assistance.jsp [Under ELIGIBILITY tab, see "what if I have other health insurance?"] Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MISSOURI - Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742

MONTANA – Medicaid	**OREGON – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical /HIPP-Program.aspx	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

Phone: 1-800-692-7462	
SOUTH CAROLINA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
SOUTH DAKOTA – Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT – Medicaid	**WYOMING - Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2020, or for more information on special enrollment rights, contact either:

U.S. Department of Labor	U.S. Department of Health and Human Services
Employee Benefits Security Administration	Centers for Medicare & Medicaid Services
www.dol.gov/agencies/ebsa	www.cms.hhs.gov
1-866-444 EBSA (3272)	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 a 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 1/31/2023)