EMPLOYEE BENEFITS GUIDE

ARCH TELECOM
EMPLOYEE OWNED

2024

For more information, you can contact HR at benefits@archtelecom.net

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TABLE OF CONTENTS

Welcome!

At Arch Telecom, we are proud to offer a benefits program that provides various coverage options to meet your personal needs. We encourage you to focus on things that matter: making time for preventive care, living a healthier life, and choosing the Arch Telecom benefits program that works best for you and your family. We encourage you to take the time to read this benefit guide.

This guide is designed to assist you in making benefit choices. It provides key information on the various aspects of the plans and helps you sort through your options. Please review the material, discuss it with your family, and make an informed choice when selecting coverage.

Additional benefit details can be found on our dedicated Benefits website (archtelecombenefits.net), in the Plan documents, available from Human Resources, or at the various carrier websites and customer service numbers for each Plan. If there is a conflict between the group insurance contracts and this guide, the group insurance contracts prevail.

Benefits At A Glance

We've Got You Covered

The Benefits Plan year begins on January 1, 2024 and ends the following December 31, 2024. You and Arch Telecom share the cost of your medical coverage. Arch Telecom pays the majority of the premium for your medical and prescription drug benefits. Your cost will vary based on the plan you select and whether you elect single or family coverage. Arch Telecom offers you and your eligible dependents a variety of benefits options, including:

- Medical and Prescription Drug coverage
- Dental coverage
- Vision coverage
- Flexible Savings Account (FSA) for Healthcare and Dependent Care
- Employee Assistance Program (EAP)

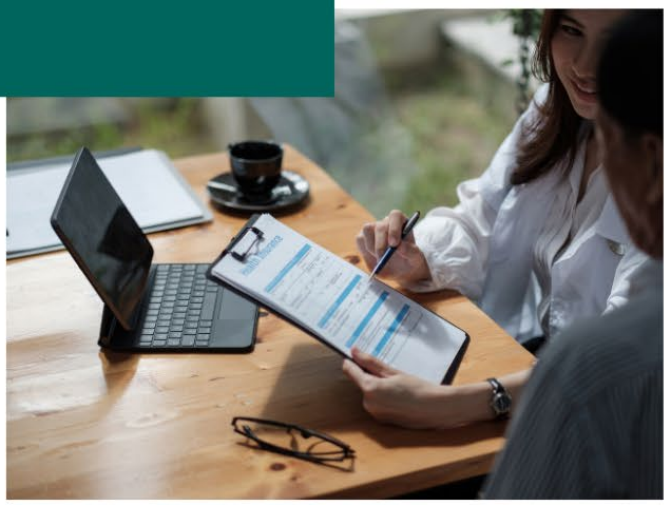
Eligibility

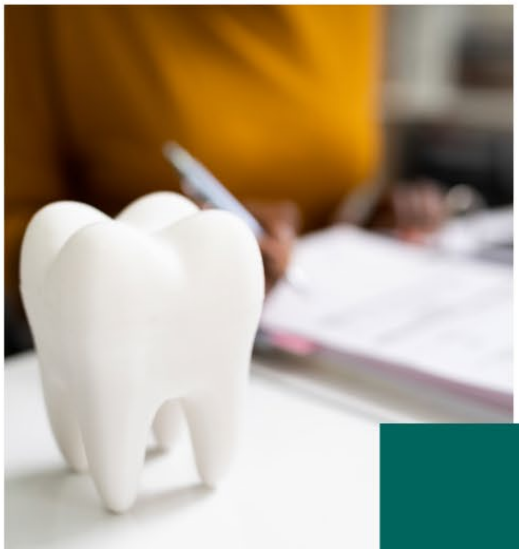
All full-time employees regularly scheduled to work at least 30 hours per week are eligible to participate in the Benefits Plan. If you are enrolling during Open Enrollment, coverage begins January 1, 2024. If you are enrolling as a New Hire, coverage starts on the first day of the month following 60 days from the date of hire.

Eligible Dependents

Your eligible dependents include:

- Your spouse (unless you are legally separated) or registered domestic partner
- Your unmarried dependent children up to age 26; also includes step-children through marriage or a domestic partnership, legal guardianship of a child, a foster child is placed with the employee, legal adoption or placement for adoption; a child who is mentally or physically incapable of sustaining his or her living, regardless of age.





Changing Benefit Elections

Once you make your election, your benefits will be effective until the end of the Plan Year (December 31, 2024) unless you have a **qualifying change** in status. The following list highlights the most common qualifying events:

- change in marital status (marriage, death of spouse, divorce, legal separation);
- change in the number of dependents (birth, death, adoption, eligibility status, child support order);
- change in employment status for you or your spouse or domestic partner (commencement, termination, leave of absence, full-time to part-time or vice versa);
- change in residence or worksite for you, your spouse or your child;
- special enrollment rights under HIPAA; or
- you, your spouse or domestic partner, or your child gains or loses Medicare or Medicaid coverage.

For further information on eligible qualifying events, please contact Human Resources at benefits@archtelecom.net.

How to Enroll

All enrollments are completed in Paycom. During Open Enrollment, if you do not want to make any changes to your current benefits, you do not need to do anything. Existing benefits will roll over to the new plan year. However, if you do want to make changes, now is your time. If you are a new hire, you will be notified via an alert from Paycom 21 days after your start date. You will then have 21 days to elect coverage. Coverage will begin on the 1st day of the month following your 60th day of employment.

When you login to Paycom you'll be prompted to complete your open enrollment.

Termination of Benefits

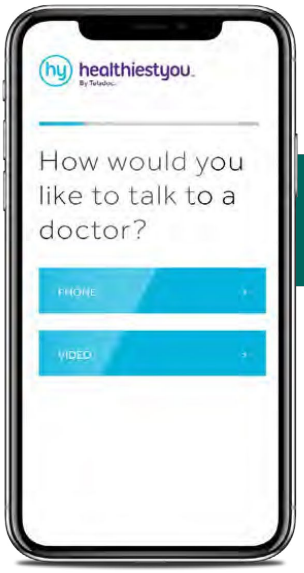
Your coverage will end on the day you terminate employment from Arch Telecom. This would apply to your dependents as well. You may be eligible to continue your benefits under COBRA. For more details regarding termination of benefits and COBRA, please refer to the Employee Handbook and Summary Plan Description. Both documents can be found at archtelecombenefits.net.

Medical Plans

Take Advantage of Free Benefits

There are free benefits included with your medical plan – use them! Going to the doctor for preventive visits when you are healthy helps you stay healthy. With Arch Telecom's medical plan, you have access to free preventive care such as:

- Free annual wellness exams
- Free mammograms
- Free routine baby and child exams and immunizations



healthiestyou By Teladoc. | Be your Healthiest You

HealthiestYou provides a free, fast, and easy way to take care of your health. You'll have access to a doctor via phone or video 24/7. Download the app to get started.

Value-Based Payments

A key feature of your medical plan is value-based payments. This is a new way of covering medical care, designed to keep your medical costs low without sacrificing quality. You'll be hearing more about value-based payments as more companies adopt them.

Value-based payment is a transparent way of paying for medical care at hospitals and other facilities. For members like yourself, it works a lot like other plans: once your deductible has been met, the plan will pay their portion of costs following any coinsurance. Also, you can choose from many different hospitals.

How Value-Based Payments Lowers Your Hospital Bills

Hospitals set their own prices with most plans; some charge a lot more than others! With value-based payments, your medical plan sets the amount based on a reference determined by Medicare. Since the price is based on the hospitals' actual costs, we can ensure that the price is fair for everybody. The result: lower prices across the board, with the savings passed on to you.

Physicians Use the Private Healthcare Systems (PHCS)/MultiPlan Network

Value-based payments affect care at hospitals and emergency rooms. Physicians and other non-hospital providers are covered under their network (PHCS/MultiPlan). You will pay less for care when you see a physician within that network. Copays for physician and specialist office visits are the same for both in and out-of-network providers. If a provider does not take any insurance, we recommend you find a doctor who will accept a PPO plan.

To locate an in-network provider, simply go to www.phcs.com or archtelecombenefits.net.

What You Need to Know

When your provider recommends a procedure that requires a hospital visit, they call to pre-certify the service. Precertification confirms the estimated price with the hospital before you even receive the service. Your bill – generally the deductible and coinsurance – is based on that price, which is almost always lower than what the hospital would have charged on a traditional plan.

Pricing Example

What will you pay for care? Your costs will be different for each procedure and each hospital, but they will be lower than with a traditional health plan. Here is an example:

Sample Procedure	Traditional PPO	Our VBP Plan
Starting Price:	$75,000 (What the hospital wants to bill)	$15,000 (What Medicare would pay for the same procedure)
Plan Price:	$45,000 (Hospital agrees to 60% of the bill)	$22,500 (Hospital agrees to 150% of the standard Medicare price)
Coinsurance:	You pay 20%	You pay 20%
Your Bill:	**$9,000**	**$4,500**

You would pay your deductible and coinsurance, up to the annual out-of-pocket maximum. As you can see, value-based payments can save you thousands of dollars per procedure.

Billing Issues? Contact the Patient Advocacy Center (PAC)

Since our plan is based on fair and transparent pricing, you should not have to worry about unexpected bills. However, as with any plan, you may occasionally receive a bill above and beyond what was agreed on in your statement. (This is known as “balance billing”.)

Do not pay a balance bill! Instead, contact the PAC. A patient advocate will take over your case and deal directly with the hospital or physician so you don’t have to. The PAC is operated by HS Technology, a company retained specifically to manage medical costs.

Tel: (888) 837-2237 Toll-Free
E-mail: PAC@hstechnology.com
Fax: (949) 891-0420

You can also send it to benefits@archtelecom.net or contact HR directly.

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Comparative Shopping for Care

When you are scheduling service at a hospital – knee surgery or maternity care, for example – where you go affects what you pay. Usually, your doctor will recommend a facility for your procedure. If the facility costs are unusually expensive, you will be notified through the pre-certification process of other high-rated facilities where you can receive care for less. **By choosing wisely, you can keep your costs as low as possible.** Bear in mind that you will still need to choose hospitals that accept your insurance. If you're not sure, you can always call the facility directly and ask. Have your identification card on hand when you do.

Key Terms

- **Balance bill:** A bill sent to a patient by a provid for charges not covered by the medical plan.
- **Coinsurance:** The additional amount of the medical bill that you pay once you meet your deductible; applicable for the Silver and Gold plans only.
- **Copay:** The flat dollar amount that you pay for certain services and prescriptions.
- **Deductible:** The amount you pay out of your pocket for covered health expenses before your plan begins paying a percentage of your costs.
- **In-Network**: Healthcare providers that offer services to participants in a medical plan at a negotiated rate.
- **Out-of-Network:** Healthcare providers that do not participate in your health plan. If you visit a provider out-of-network, your cost may be higher.
- **Out-of-Pocket Maximum:** The most you will pay each year in deductibles and your share of coinsurance before your plan begins paying most of your covered expenses at 100% for the rest of the year.
- **Pre-certification:** When your physician recommends an expensive test or procedure, they first authorize it with the medical plan, who ensures that both cost and quality of the provider are appropriate.

Your Out-of-Pocket (OOP) Maximum

Your medical plan includes an annual Out-of-Pocket (OOP) maximum. Once you have paid the OOP maximum, you will no longer pay copayments or coinsurance for your covered services for the remainder of the plan year. You will only be responsible for non-covered services. Your prescription drug costs are included in the OOP Maximum.

Prescription Drug Coverage

Prescription Drug coverage is provided through THP Rx with a nationwide network of participating pharmacies and a mail-order prescription service. **You can learn more about your plan at www.healthplan.org or by calling 800-624-6961 ext. 7914.**

Key Terms

- **Generic:** Generic drugs contain the same active ingredients as brand-name drugs, but they cost less.
- **Formulary:** Your medical plan has a list of approved brand-name drugs called a "formulary," chosen for their price and effectiveness. Your costs for these drugs are typically lower than with other brand-name drugs.
- **Non-Formulary:** These are brand-name drugs that are not on the formulary list. These drugs will cost you more.

Use Generics and Save

You will save money when you fill your prescriptions with generic medication. They are cost-effective alternatives over their brand-name equivalents. Generic drugs have the same active ingredients as brand-name medications and work in the same way.

Mail Order

If you take maintenance medications for long-term conditions like arthritis, asthma, diabetes, high blood pressure, or high cholesterol you could save by using your mail service benefit. It's easy and the medication will be delivered right to your door. Standard shipping is free!

Ask your doctor if a generic drug is available for your medical condition.

For more information and to see which prescription medications are generic, preferred brand or non-preferred brand **go to www.healthplan.org**

Medication Example (Silver Plan)

Cholesterol Medication

Non-Preferred Brand Name:
– Zocor $60/Rx

Generic Equivalent:
– Simvastatin $20/Rx

Medical Plan Coverage Overview

The table below outlines coverage for some of the most common services. The deductible is based on the plan year (January 1st – December 31st).

Plan Name	Bronze Plan	Silver Plan	Gold Plan
Benefits			
Deductible (Ded)			
Individual	$6,000	$1,500	$500
Family	$12,000	$4,500	$1,000
Coinsurance	100%	60%	80%
Out-of-pocket max.			
Individual	$6,000	$6,000	$2,000
Family	$12,000	$12,000	$4,000
Hospitalization	100% after Ded	$250 copay / 80% after Ded	80% after Ded
Outpatient Surgery	100% after Ded	$250 copay / 60% after Ded	80% after Ded
Emergency room	100% after Ded	60% after Ded	$250 Copay
Ambulance	100% after Ded	80% after Ded	80% after Ded
Urgent care	$40 Copay	$35 Copay	$35 Copay
Physician office visit	$0 Copay	$0 Copay	$0 Copay
Specialist visit	$40 Copay	$50 Copay	$50 Copay
Preventive care	100%	100%	100%
Mental Health Office	$40 Copay	$50 Copay	$50 Copay
Durable Medical Equipment	100% after Ded	60% after Ded	80% after Ded
Physical Therapy	100% after Ded (20 Visits/Year)	60% after Ded (20 Visits/Year)	$50 Copay (20 Visits/Year)
Lab & X-Ray	In-Office: Included in Copay; Outpatient:100% after Ded	In-Office: Included in Copay; Outpatient: 60% after Ded	In-Office: Incl in Copay; Outpatient: 80% after Ded
Advanced Imaging	100% after Ded	60% after Ded	80% after Ded
Prescription drugs			
Deductible	None	None	None
Generic brand	$20	$20	$20
Preferred brand	$60	$30	$30
Non-preferred brand	$90	$60	$60
Mail order	2x Retail	2x Retail	2x Retail

Your Medical Cost

Your pre-tax cost for medical and prescription drug coverage will vary depending on the plan you choose. Your pre-tax cost is only one portion of your health care costs. Your out-of-pocket costs, incurred when you or a covered family member utilizes the plan, should also be factored into the total cost when determining which plan is best for you.

Medical Plan Contributions (Biweekly)	Bronze	Silver	Gold
Employee only	$40.00	$85.00	$237.60
Employee + Spouse	$150.69	$266.76	$501.60
Employee + Child(ren)	$139.10	$244.46	$514.80
Family	$211.93	$300.54	$726.00

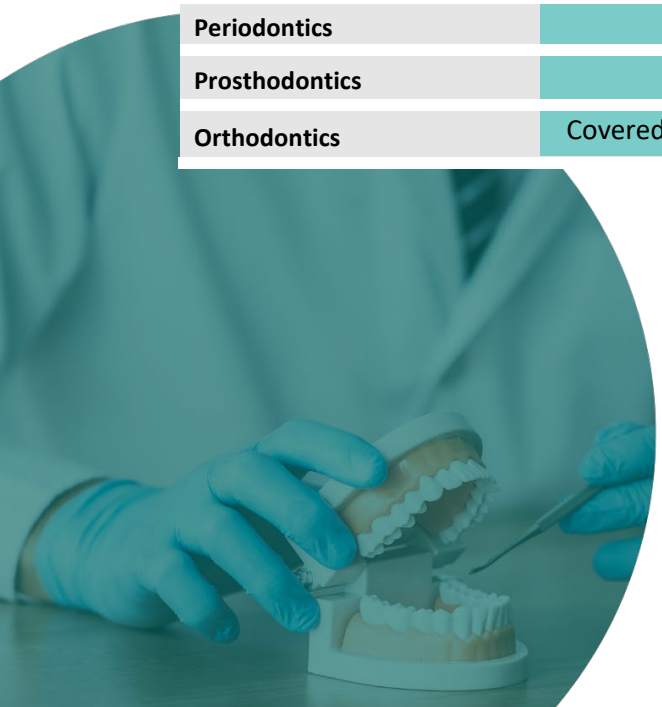
Dental Coverage

Dental care is an important part of overall health with prevention as the key. You can choose between two PPO plans or an HMO plan. The deductible for dental insurance is based on the calendar year (January 1st – December 31st). Cigna is your dental provider.

DPPO Plan

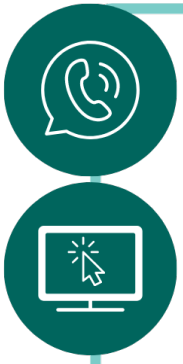
You can select the dentist of your choice, but seeing a participating dentist reduces your costs. There are deductibles and coinsurance, but preventive care is covered 100% if you use a network dentist. Orthodontics is included for both adults and children. To locate a provider in your network, visit www.myCigna.com or call 800-CIGNA24.

	PPO – Option 1	PPO Max – Option 2
	In & Out of Network Benefits	
Deductible	$100 single, $300 family	$100 single, $300 family
Annual Benefit Max.	$1,000	$5,000
Diagnostic & Preventive	Covered 100%	Covered 100%
Basic Restorative	Covered 80%	Covered 80%
Major Restorative	Covered 50%	Covered 50%
Oral Surgery	Covered 50%	Covered 50%
Endodontics	Covered 50%	Covered 50%
Periodontics	Covered 50%	Covered 50%
Prosthodontics	Covered 50%	Covered 50%
Orthodontics	Covered 50%, $1,500 Lifetime Max	Covered 50%, $1,500 Lifetime Max



DHMO Plan

The DHMO plan requires that you select a Primary Care Dentist and obtain referrals to a specialist. Members must use providers within the network. Employees that use providers outside of the network will not have coverage for these claims. (Please note, the DHMO plan is not available in AK, ME, MT, NH, NM, ND, SD, VT, and WY.)



To locate a provider in your network and to view the fee schedule, visit **www.myCigna.com** or **call 800-CIGNA24**

	Patient Charge Schedule (In-Network Only)
Deductible	$0
Annual Benefit Max.	Unlimited
Office Visit	$5 Copay
Preventive	Covered 100% after Copay
Basic Services	See Fee Schedule
Major Services	See Fee Schedule
Orthodontics	See Fee Schedule

Dental Pricing Summary

Dental PPO Plan Contributions (Biweekly)	PPO	PPO Max
Employee only	$14.92	$17.19
Employee + Spouse	$29.44	$33.92
Employee + Child(ren)	$37.48	$43.18
Family	$51.24	$59.04

Dental HMO Plan Contributions (Biweekly)	
Employee only	$5.74
Employee + Spouse	$9.50
Employee + Child(ren)	$11.42
Family	$16.17

Vision Care

Your vision benefits are provided through VSP. To locate a vision provider, visit www.vsp.com.

Vision Service	Frequency	In-Network Member Cost	Out-of-Network Benefit
Routine Eye Exam	Every 12 Months	$10 Copay	Up to $52
Prescription Lenses **Single Vision** **Lined Bifocal** **Lined Trifocal**	 Every 12 Months Every 12 Months Every 12 Months	 $25 Copay $25 Copay $25 Copay	 Up to $55 Up to $75 Up to $95
Frames	Every 24 Months	$130 Allowance	$57
Contacts* (Including Exam)	Every 12 Months	$130 Allowance	Up to $105

* If you choose contact lenses you will be eligible for frames 12 months from the date the contact lenses were obtained.

Members are also eligible for 30% off additional glasses and sunglasses, including lens options, from the same VSP doctor on the same day as your exam. Or, get 20% off from any VSP doctor within 12 months of your last exam.

Vision Plan Contributions (Biweekly)	
Employee	$5.38
Employee + Spouse	$9.23
Employee + Child(ren)	$9.42
Family	$15.18

Flexible Spending Account (FSA)

An FSA is a way to set aside money on a pre-tax basis for your out-of-pocket medical, dental, vision, and dependent care expenses.

Advantages:

- Saves you tax dollars – set aside out-of-pocket expenses on a pre-tax basis
- Gives you flexibility –you can choose one or both FSA options

Healthcare FSA	
Eligible Expenses	Ineligible Expenses
Deductible	Over-the-Counter Drugs
Copayments	Health Insurance Premiums
Coinsurance	Cosmetic Items
Dental Expenses	Cosmetic Surgery
Vision Expenses	Controlled Substances
Prescriptions	Items that Improve General Health

Dependent Care FSA	
Eligible Expenses	Ineligible Expenses
Day Care Center	Overnight Camp
In-Home Care	Nursing Home Expenses
Nursery & Preschool	Educational Expenses (Kindergarten and above)
After School Care	Registration Fees
Summer Day Camp	Transportation Fees
Sick Child Facility	

Annual Contributions

(Contributions are based on the calendar year – January 1st to December 31st)

Healthcare FSA - $3,050 maximum annual contribution

Dependent Care FSA - $2,500 maximum annual contribution for a single employee, $5,000 maximum annual contribution for a married couple filing jointly

Debit Card

The debit card is convenient, automatic, and simple to track. You do not have to pay cash up front, file a claim or wait for reimbursement.

- Swipe the card like any debit/credit card
- Funds are immediately transferred from your FSA
- Track your card balance on the website listed on the back of the card or the mobile app
- Save your EOBs and detailed bills for possible substantiation requests (Prescriptions and co-pays are automatically substantiated)

Reimbursements

Documents can also be uploaded through the online portal or sent by mail. For healthcare, submit your Explanation of Benefits. For dependent care, submit a bill. The typical turnaround for reimbursement is 7 business days and the reimbursement is sent in the form of a check. Direct deposit is also available through the online portal.

Online Portal

The consumer online portal is available 24/7. Use it to:

- Sign up for direct deposit
- Track available balances
- Submit reimbursement requests
- Submit receipts
- View account history

Mobile App

The mobile app has similar functionality to the portal.

- Available for iOS and Android devices.
- Sign up for text messages and alerts.
- View, your balance from the convenience of your mobile device.

Employee Assistance Program (EAP)

Life can pull you in many directions. Arch Telecom provides a confidential Employee Assistance Program (EAP) with easy access to tools and resources to help you lead a healthier, happier life. The EAP is free and available to those employees enrolled in the medical plan as well as your family. It is accessible 24 hours a day, 365 days a year. The program is administered by ComPsych.

EAP specialists will provide you and your family with the resources and referrals you need when you need it, including:

- Local in-person EAP assessment, referral counseling, and brief treatment (up to 3 sessions per issue per employee/family member per year)
- Stress management
- Relationship and parenting issues
- Grief and loss
- Addiction
- Serious illness

DailyPay

Arch Telecom offers a cutting-edge Pay program through DailyPay. DailyPay allows you to access your pay on-demand. You can think of DailyPay as an online ATM, with real-time visibility into pay, along with the option to access those earnings. Signing up for DailyPay is free. Similar to an ATM, you only pay a fee when you make an early transfer.

With DailyPay, you can track, save, and transfer your earnings on your schedule. Benefits of DailyPay include the ability to get paid on day one, track your daily income with updates after every shift you work, transfer your pay instantly or the next day, and automatically save a portion of your paycheck. You can also use DailyPay to avoid late fees and interest charges and to help you plan for expenses.

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EMPLOYEE REFERRAL PROGRAM

Employee referrals are a valuable and cost-effective source of hiring new employees! To encourage and reward the recruiting efforts of employees, Arch Telecom has established the program of providing a bonus to employees whose referrals are hired!

MAKE UP TO $500 PER REFERRAL!

$200 BONUS
After 30 days of employment

+

$100 BONUS
After 60 days of employment

+

$200 BONUS
After 90 days of employment

There is no limit to the number of applicants an employee may refer!

DETAILS

- If the new hire successfully completes their 1st 30 days of employment the referring Arch Telecom employee will receive a $200 referral bonus (minus applicable state and federal taxes).
- If the new hire successfully completes their 1st 60 days of employment the referring Arch Telecom employee will receive another $100 referral bonus (minus applicable state and federal taxes).
- If the new hire successfully completes their 1st 90 days of employment the referring Arch Telecom employee will receive a final $200 referral bonus (minus applicable state and federal taxes) for a total potential of a $500 referral bonus.

* Referral bonus payments will be payable in line with regular paycheck payment schedules each month and are subject to all applicable taxes. Referring employee must ensure that their referred candidate indicates the Arch Telecom employee name in the Applicant Tracking System on the application at the time of applicant's application and prior to the New Hire start date. Please see official policy for detailed rules and procedure.

Pricing - Summary

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Employee + Spouse	$9.23
Employee + Child(ren)	$9.42
Family	$15.18

Questions and Contacts

Topic	Who You Can Contact	How
Questions about your health plan, enrollment, and eligibility	Human Resources	(714) 829-1618 benefits@archtelecom.net
Questions about specific medical claims and coverage, as well as prescriptions	The Health Plan (THP)	(888) 816-3096 www.healthplan.org
What physicians are in-network?	PHCS / MultiPlan	www.phcs.com (Physician and Ancillary Only Network)
You have received a balance bill	Patient Advocacy Center (PAC)	Phone: (888) 837-2237 Email: PAC@hstechnology.com Fax: (949) 891-0420
Telehealth	HealthiestYou	(866) 703-1259, HealthiestYou.com
Dental Insurance Questions	Cigna	(800) 244-6224, www.mycigna.com
Vision Insurance Questions	VSP	(800) 877-7195, www.vsp.com
Flexible Spending Account (FSA) Questions	The Health Plan (THP)	(866) 347-3640 www.healthplan.org
Employee Assistance Program (EAP)	ComPsych	(800) 272-7255, guidanceresources.com
Escalated Benefit Related Questions	Risk Management Advisors (Consultant)	(562) 472-2846

Definitions

Glossary

THP – The Health Plan (Medical Insurance Provider)
PHCS – Physician Network
VBP – Value-Based Payments
HST – HS Technology (The vendor that handles the Value-Based Payments negotiations as well as manages the PAC)
PAC – Patient Advocacy Center (Balance Billing)
CIGNA – Dental Provider
VSP – Vision Provider
EAP – Employee Assistance Program (ComPsych)
Paycom – HRIS System/Benefits Portal
RMA – Risk Management Advisors (Broker)

Key Medical Terms

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- **Non-Formulary:** These are brand-name drugs that are not on the formulary list. These drugs will cost you more.

Important Notices

COBRA RIGHTS

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Company 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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. 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 doesn't accept late enrollees.

What is COBRA Continuation Coverage?
COBRA continuation coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." 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. Employees and their qualified dependents are responsible for notifying the Company of any change in address or status (e.g., divorce, insurance eligibility, child becoming ineligible due to age, etc.) within 30 days of the event. If applicable, your participation in the Health Care Flexible Spending Account (FSA) can also continue on an after-tax basis through the remainder of the plan year in which you qualify for COBRA. The opportunity to elect the same coverage that you had at the time the qualifying event occurred extends to all qualified beneficiaries. If you make contributions to the Health Care FSA for the year in which your qualifying event occurs, you may continue to make these contributions on an after-tax basis. This way, you can be reimbursed for certain medical expenses you incur after your qualifying event, but before the end of the plan year.

You may be offered to continue your coverage under the Health Care FSA if you have not overspent your account. The determination of whether your account for a plan year is overspent or underspent as of the date of the qualifying event depends on three variables: (1) the elected annual limit for the qualified beneficiary for the plan year; (2) the total reimbursable claims submitted to the Cafeteria Plan for that plan year before the date of the qualifying event; and (3) the maximum amount that the Cafeteria Plan is permitted to require to be paid for COBRA coverage for the remainder of the plan year. The elected annual limit less the claims submitted is referred to as the "remaining annual limit." If the remaining annual limit is less than the maximum COBRA premium that can be charged for the rest of the year, then

the account is overspent. You may not re-enroll in the Health Care FSA during any annual enrollment for any plan year that follows your qualifying event.

Supporting documentation like a divorce decree, death certificate or proof of other insurance may be required as proof of a qualifying event. This general notice does not fully describe COBRA or the plan. More complete information is available from the Plan Administrator and in the summary plan document.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:
Your hours of employment are reduced; or 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 any of the following qualifying events happens:
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.

When is COBRA 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. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), the employee must notify the Plan Administrator of the qualifying event.

How is COBRA Coverage Provided?
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. When the qualifying event is the death of the employee, the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of

employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage.
If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total 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 continuation coverage.
Documentation from the Social Security administration certifying a disability will be required.

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

If your family experiences another qualifying event while receiving 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 notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the 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**

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you

If you have questions
Questions concerning your plan or your COBRA continuation coverage rights should be addressed to the Plan Administrator indicated above or in the summary plan description. 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.

THE GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 ("GINA")

GINA protects employees against discrimination based on their genetic information. Unless otherwise permitted, your employer may not request or require any genetic information from you or your family members. The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to any requests for medical information, if applicable. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

HEALTH INSURANCE EXCHANGE NOTICE

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?
For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

HIPAA SPECIAL ENROLLMENT RIGHTS

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 or any longer period that applies under the plan, after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact the Plan Administrator mentioned above.
If you have declined enrollment for yourself or your dependents (including your spouse) while coverage under Medicaid or a state Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and your dependents in this program if you or your dependents lose eligibility for that

other coverage. You must, however, request enrollment within 60 days after you or your dependents' Medicaid or CHIP coverage ends. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or a CHIP program with respect to coverage under this plan, you may be able to enroll yourself and your dependents (including your spouse) in this plan. You must, however, request enrollment within 60 days after you or your dependents become eligible for the premium assistance. To request special enrollment or obtain more information, contact the Plan Administrator indicated in this notice

MEDICARE PART D NOTICE (NOTICE OF CREDITABLE COVERAGE)

About Your Prescription Drug Coverage and Medicare
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.

Two important things to know about your current coverage and Medicare's prescription drug coverage:

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
- We have determined the prescription drug coverage offered by your provider 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 to December 7th. Plan participants are eligible if they are within three months of turning age 65, are already 65 years old or if they are disabled. 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 Wall Street Holding Group coverage will not be affected, and benefits will be coordinated with Medicare. Refer to your plan documents provided upon eligibility and open enrollment or contact your provider or the Plan Administrator for an explanation and/ or copy of the prescription drug coverage plan provisions/options under the plan available to Medicare-eligible individuals when you become eligible for Medicare Part D.

Visit www.cms.hhs.gov/CreditableCoverage which outlines the prescription drug plan provisions/options 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 current coverage is dropped, be aware you and your dependents will not be able to get this coverage back. Refer to plan documents or contact your provider or the Plan Administrator before making any decisions.

Note: In general, different guidelines exist for retirees regarding cancellation of coverage and the ability to get that coverage back. Retirees who terminate or lose coverage will not be able to get back on the plan unless specific contract language or other agreement exists. Contact the Plan Administrator for details.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?
You should also know 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 19 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 Plan Administrator for details. You will get this notice each year. You will also get it before the next Medicare part D drug plan enrollment period 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.

For more information about Medicare prescription drug coverage:
Visit www.Medicare.gov or 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 800- MEDICARE (800-633-4227) (TTY: 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 800-772- 1213 (TTY: 800- 325-0778).
Remember to 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).

MENTAL HEALTH PARITY

The Mental Health Parity and Addiction Equity Act (MHPA/ MHPAEA) of 2008 requires that group health plans must not unfairly restrict treatment with respect to coverage and cost sharing requirements for mental health or substance use disorders relative to the coverage and cost sharing requirements offered under the plan's medical and surgical benefits. Additional information and details can be found by visiting

the Department of Labor's Mental Health Parity website: www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health- and-substance-use-disorder-parity

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

The Newborns' and Mothers' Health Protection Act (NMHPA) requires that group health plans and health insurance issuers who offer childbirth coverage 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Refer to your plan document for specific information about childbirth coverage or contact your Plan Administrator.

For additional information about NMHPA provisions and how self-funded non-Federal governmental plans may opt- out of the NMHPA requirements, visit www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance- Protections/nmhpa_factsheet.html.

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-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.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, 2022. Contact your State for more information on eligibility.

ALABAMA – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA – Medicaid	**COLORADO – Health First**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	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 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS – Medicaid	**FLORIDA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance- premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
INDIANA – Medicaid	**MINNESOTA – Medicaid**
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: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care- programs/programs-and-services/other- insurance.jsp Phone: 1-800-657-3739

PENNSYLVANIA – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	**WYOMING – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2022, 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

PREVENTIVE CARE

Health plans will provide in-network, first-dollar coverage, without cost-sharing, for preventative services and immunizations as determined under health care reform regulations. These include, but are not limited to, cancer screenings, well-baby visits and influenza vaccines. For a complete list of covered services, visit: www.HealthCare.gov/coverage/preventive-care-benefits

PRIVACY PRACTICES NOTICE REMINDER

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that we maintain the privacy of protected health information, give notice of our legal duties and privacy practices regarding health information about you and follow the terms of our notice currently in effect.
You may request a copy of the current Privacy Practices from the Plan Administrator explaining how medical information about you may be used and disclosed, and how you can get access to this information.
We will disclose Health Information when required to do so by international, federal, state or local law.
You have the right to inspect and copy, right to an electronic copy of electronic medical records, right to get notice of a breach, right to amend, right to an accounting of disclosures, right to request restrictions, right to request confidential communications, right to a paper copy of this notice and the right to file a complaint if you believe your privacy rights have been violated.

SUMMARIES OF BENEFITS AND COVERAGE (SBCs)

You may request a paper copy of the SBCs (free of charge), from your employer. Your employer is required to make SBCs available that summarize important information about health benefit plan options in a standard format, to help you compare across plans and make an informed choice. The health benefits available to you
provide important protection for you and your family and choosing a health benefit option is an important decision.

USERRA NOTICE

The Uniformed Services Employment and Reemployment Rights Act (USERRA) protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

Reemployment Rights
You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- You ensure that your employer receives advance written or verbal notice of your service;
- You have five years or less of cumulative service in the uniformed services while with that particular employer;
- You return to work or apply for reemployment in a timely manner after conclusion of service; and
- You have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

Right to Be Free From Discrimination and Retaliation
If you are a past or present member of the uniformed service, have applied for membership in the uniformed service or are obligated to serve in the uniformed service, an employer may not deny you initial employment, reemployment, retention in employment, promotion or any benefit of employment because of this status. In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

Health Insurance Protection
If you leave your job to perform military service, you have the right to elect to continue your existing employer- based health plan coverage for you and your dependents for up to 24 months while in the military. Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed generally without any waiting periods or exclusions (e.g., pre- existing condition exclusions) except for service-connected illnesses or injuries.

Enforcement
The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is is authorized to investigate and resolve complaints of USERRA violations. For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 866-4-USA-DOL or visit www.dol.gov/vets. An interactive online USERRA Advisor can be viewed at www.dol.gov/elaws/userra.htm.

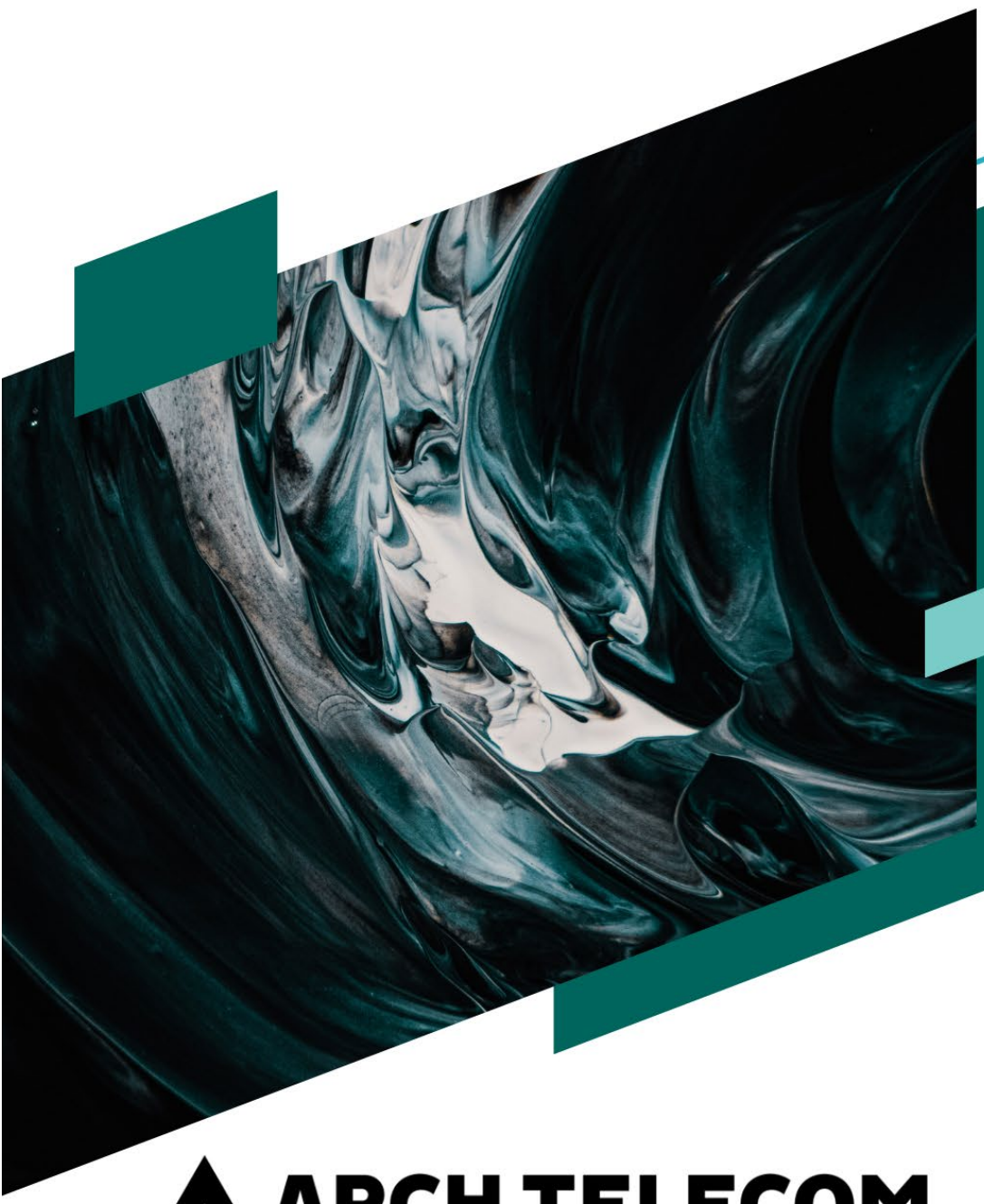
If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation. You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.
The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the Internet at this address: www.dol.gov/vets/programs/userra/poster.htm.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

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.



ARCH TELECOM
EMPLOYEE OWNED

220 Commerce, Suite 250
Irvine, CA 92602

THE RIGHT PLACE.
THE RIGHT CONNECTIONS.

For more information, you can contact
HR at benefits@archtelecom.net