

Fringe Benefit Group
11910 ANDERSON MILL RD
AUSTIN, TX 78726-1135



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FORWARDING SERVICE REQUESTED

J031 1

JANE DOE
11910 ANDERSON MILL RD
AUSTIN TX 78726

This booklet includes a brief summary of your coverage. Please retain a copy of this book for your records as it contains important plan information. You can request a complete Certificate of Coverage by calling our Member Services team at 855-495-1190. Please review the information below and contact Member Services if you have any questions.

Employee Name: JANE DOE
Effective Date: 03/01/2019
Member No.: F00988422
Group Name: Weis Markets, Inc.-Benefits Plan
Group Number: FV0903

Coverage Summary*:

JANE (DOB-1/1/1980) - Medical Dental Vision Critical Illness Drug Card
JANE (DOB-1/1/1980) - Medical Dental Vision Critical Illness Drug Card

*For specific benefit information and to determine whether you or your dependents are covered under your employer's benefit plan(s), please refer to your Certificate of Coverage or your Summary Plan Description. The plan documents shall control in the event of any discrepancy between this coverage summary and the plan documents.

CARRIER INFORMATION

Medical - Nationwide
Fringe Benefit Group
PO Box 21854
Eagan, MN 55121
Smart Data Solutions (SDS) EDI Payer ID#45289
For benefit or claims questions, call (855) 495-1190
Ventanex Payments (888) 473-9025
For EOBs, Eligibility or Benefits 24/7
www.theamericanworker.com

Drug Card - PRAM

RxEDO
Member Services: (888) 879-7336
Fax (214) 291-5281
Rx Group Number: 720158
BIN: 610220
PCN: 03980000

PPO - First Health

To locate a provider, visit www.FirstHealthLBP.com
For claim questions, call (855) 495-1190

Telemedicine - Teladoc

Customer Service: 1-800-Teladoc (800-835-2362)
Registration - Online at www.teladoc.com, with mobile app, or over the phone
Telephone medical consult with licensed physicians available 24 hours a day, 365 days a week.

Ameritas - Dental:

Ameritas
P.O. Box 82520
Lincoln, NE 68501-2520
For eligibility, call (855) 495-1188.
To check dental claim status or verify benefits, call (800) 487-5553 or visit www.ameritas.com. You will not receive an ID card for this benefit. Your SSN # is to be used for benefit verification and claim submission.

Ameritas - Vision:

Ameritas
P.O. Box 82520
Lincoln, NE 68501-2520
For eligibility, call (855) 495-1188.
To check vision claim status or verify benefits, call (800) 877-7195. You will not receive an ID card for this benefit. Your SSN # is to be used for benefit verification and claim submission.

Critical Illness - Metlife

For questions regarding benefits or to file a claim online visit www.mybenefits.metlife.com
Member Services: 866-626-3705
Your Certificate of Coverage for this benefit will be mailed to you separately by MetLife.

Accident - Metlife

For questions regarding benefits or to file a claim online visit www.mybenefits.metlife.com
Member Services: 866-626-3705
Your Certificate of Coverage for this benefit will be mailed to you separately by MetLife.



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*When setting up your account online, you will be asked for a username. Your username can be found on your Teladoc membership card which will be mailed separately. If you do not have a membership card, simply select "No" and enter Company Code THA0414.



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**Description of Coverage For
Outpatient Prescription Drug Insurance
Underwritten by: Companion Life Insurance Company**

This is a description of coverage available to you under the Prescription Drug Plan sponsored by your employer. It is a summary only, and is not a policy or a contract of insurance.

Who is Eligible for Outpatient Prescription Drug Insurance: Each person who is actively enrolled for the Employer's Limited Medical Plan(s) and his or her Eligible Dependents.

Effective Date of Insurance: Insurance will become effective the later of the Policy effective date, or on the first day of the calendar month following receipt of the completed enrollment application, provided the required premium is paid.

Termination Date of Insurance: Insurance will end on the date the Policy terminates, the date the covered person is no longer eligible as described above, or the date the period ends for which premium has been paid.

How This Plan Works: The covered person will be given a prescription drug card. The covered person is required to present the prescription drug card to the contracted Participating Pharmacy. The maximum covered supply is 30 days at a Retail pharmacy. When a Prescription Drug card is used at a contracted Participating Pharmacy, benefits are assigned to the Participating Pharmacy. If a covered person purchases a Prescription Drug at a Non-Participating Pharmacy or purchases a Prescription Drug at a contracted Participating Pharmacy without the prescription drug card, the covered person must pay the full cost for the Prescription Drug at the time of purchase and complete a claim form. Reimbursement, subject to the contracted Participating Pharmacy Rate and the Co-payment, will be made directly to the covered person when a Non-Participating Pharmacy is used, or where purchase is made without the Prescription Drug card at a contracted Participating Pharmacy.

Outline of Plan Benefits:

- Retail Pharmacy Formulary Generic Co-payment: \$10.00
- Retail Pharmacy Formulary Brand Co-payment: \$30.00
- Mail Service Pharmacy Formulary Generic Co-payment: \$30.00
- Mail Service Pharmacy Formulary Brand Co-Payment: \$90.00
- Monthly Benefit Maximum: \$250 Per Member
- Limited to a maximum 30 day supply at Retail Pharmacies
- Limited to a maximum 90 day supply at the Mail Service Pharmacy

Benefits are payable for Medically Necessary Covered Charges incurred by a covered person for the purchase of outpatient Prescription Drugs from a contracted Participating or Non-Participating Pharmacy. A co-payment must be paid for each Prescription Drug filled or authorized refill.

Prescription Drug means all outpatient Medically Necessary Legend non-injectable medications, unless otherwise specifically excluded. Outpatient means a Prescription Drug is not taken in or administered by a hospital or any other health care facility or office. All over-the-counter and injectable medications are excluded. If classifications contain both prescribed and over-the-counter or both injectable and non-injectable products, only the non-injectable, prescribed products will be covered.

Exclusions: Prescription Drug benefits are not payable for the following items:

1. All over-the-counter products and medications, including, but not limited to, electrolyte replacement, infant formulas, miscellaneous nutritional supplements and all other over-the-counter products and medications.
2. Blood glucose meters; insulin injecting devices.
3. Depo-Provera; condoms, contraceptive sponges, and spermicides; sexual dysfunction drugs.
4. Biologicals (including allergy tests); blood products; growth hormones; hemophilic factors; MS injectables; immunizations; all other injectables unless shown in the definition of Prescription Drug.
5. All medical supplies and durable medical equipment unless shown in the definition of Prescription Drug.
6. Liquid nutritional supplements; pediatric Legend Drug vitamins; prescribed versions of Vitamins A, D, K, B12, Folic Acid and Niacin - used in treatment versus as a dietary supplement; all other Legend Drug vitamins and nutritional supplements.
7. Anorexiant; Any cosmetic drugs including, but not limited to, Renova, skin pigmentation preps; Any drugs or products used for the treatment of baldness; Topical dental fluorides.
8. Refills in excess of that specified by the prescribing Doctor; or refills dispensed after one year from the original date of the prescription

9. All newly marketed pharmaceuticals or currently marketed pharmaceuticals with a new FDA approved indication for a period of one year from such FDA approval for its intended indication.
10. Any drug labeled "Caution - limited by Federal Law for Investigational Use" or experimental drugs.
11. Any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment.
12. Drugs needed due to conditions caused, directly or indirectly, by a covered person taking part in a riot or other civil disorder; or the covered person taking part in the commission of a felony.
13. Drugs needed due to conditions caused, directly or indirectly, by declared or undeclared war or an act of war; or drugs dispensed to a covered person while on active duty in any armed forces.
14. Any expenses related to the administration of any drug.
15. Drugs or medicines taken while in or administered by a hospital or any other health care facility or office.
16. Drugs covered under Worker's Compensation, Medicare, Medicaid or other Governmental programs.
17. Drugs, medicines, or products, which are not Medically Necessary.
18. All drugs not included on the formulary.
19. Diaphragms; Erectile dysfunction Legend drugs; Infertility Legend drugs.
20. Epi-Pen, Epi-Pen Jr, Ana-Kit, Ana-Guard; Glucagon-auto injection; Imitrex-auto injection.
21. Smoking deterrents, Legend or over-the-counter drugs.
22. Replacement of stolen medication (except under circumstances approved by Us), or lost, spilled, broken or dropped Prescription Drugs.
23. Vacation supplies of Prescriptions Drugs (except under circumstances approved by Us).

Definitions:

"Co-payment" means a fixed dollar amount that the Covered Person must pay for each Prescription Drug before benefits are payable under the Policy.

"Dependent" means an employee's lawful spouse; or an employee's unmarried child, from the month of birth to age 26, who is chiefly dependent on the Insured for support. A child, for eligibility purposes, includes an Insured's natural child; adopted child, beginning with any waiting period pending finalization of the child's adoption; or a stepchild who resides with the employee or depends chiefly on the Insured for financial support. Also, Dependent includes a newborn child of any covered person. A Dependent may also include any person related to the employee by blood or marriage and for whom the employee is allowed a deduction under the Internal Revenue Code.

"Formulary" means a list of prescription drugs, provided by us, that are covered under the plan.

"Legend Drug" means any medical substance whose label is required to bear the legend "Caution: Federal Law Prohibits Dispensing Without A Prescription"; or state restricted drug that may not require a prescription under Federal Law, but does require one under state law.

"Medically Necessary" means that the Prescription Drug is necessary and appropriate for the diagnosis or treatment of a condition based on generally accepted current medical practices. A Prescription Drug will not be considered Medically Necessary if: 1) it is provided only as a convenience to the Covered Person; 2) it is not appropriate treatment for the Covered Person's diagnosis or symptoms; 3) it exceeds in scope, duration or intensity that level of care needed to provide safe, adequate and appropriate diagnosis or treatment, or 4) it is part of a plan of treatment that is experimental, unproven or related to a research protocol. Because any particular Doctor may prescribe, order, recommend, or approve a Prescription Drug does not, of itself, make the service or supply Medically Necessary.

"Non-Participating Pharmacy" means a pharmacy that does not participate in a program used by Us to provide Prescription Drugs in accordance with the provisions of the Policy.

"Participating Pharmacy" means a pharmacy that has agreed to participate in a program used by Us to provide Prescription Drugs in accordance with the provisions of the Policy.

This Description of Coverage is a brief description of the important features of the Outpatient Prescription Drug Insurance Plan. It is not a contract of insurance. The terms and conditions of coverage are set forth in the policy. The policy is subject to the laws of the state in which it was issued. Coverage may not be available in all states or certain terms or conditions may be different if required by state law. Please keep this information as a reference.



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SCHEDULE OF BENEFITS

Policy Holder: Weis Markets, Inc.
Policy Number: FV0903
Effective Date: 3/2/2018
Policy Anniversary: 2/28/2020
Program Manager: Fringe Benefit Group, Inc.

This product is (a) not a substitute for minimum essential health coverage under the Affordable Care Act (ACA); and (b) does not qualify as minimum essential coverage under the ACA.

Who Pays For the Coverage

- The coverage under this policy is contributory. This means you make contributions towards its cost.

We will provide the benefits shown. Any change in amount is subject to the Change in Amounts of Benefits provision.

DAILY IN-HOSPITAL AND SKILLED NURSING FACILITY INDEMNITY BENEFIT

- Daily In-Hospital Benefit:** Daily Benefit \$500. Up to a Lifetime Maximum of 500 days of confinement (except for Substance Abuse, Mental Illness Disorder, and In-patient Skilled Nursing Facility).
- Intensive Care Unit:** Double the Daily In-Hospital Benefit above, up to a maximum of 30 days per Calendar Year.
- Mental Illness Disorder:** 50% of the Daily In-Hospital Benefit above will be paid, up to a maximum of 30 days per Calendar Year. Lifetime Maximum \$30,000.
- Substance Abuse:** 50% of the Daily In-Hospital Benefit above will be paid, up to a maximum of 30 days per Calendar Year. Lifetime Maximum \$30,000.
- In-patient Skilled Nursing Facility:** 50% of the Daily In-Hospital Benefit above, Maximum Benefit per Covered Person per period of confinement: 60 days. The confinement is covered only if it follows a covered Hospital stay of at least 3 days.

DOCTOR'S OFFICE INDEMNITY BENEFIT due to Illness, Accident or Medical Emergency

- Maximum per Covered Person per day: \$75
- Maximum days per Covered Person per Calendar Year: 6 days

Routine exams, medical treatment, immunizations, and injections are not covered under this benefit.

OUTPATIENT DIAGNOSTIC X-RAY AND LAB INDEMNITY BENEFIT

Maximum per Covered Person per testing day when Hospital Confinement is not required:

Diagnostic X-Ray Benefit

- Per Covered Person per testing day: \$125
- Maximum testing days per Covered Person per Calendar Year: 3 days

Lab Indemnity Benefit

- Per Covered Person per testing day: \$100
- Maximum testing days per Covered Person per Calendar Year: 3 days

Routine exams are not covered under this Benefit.

OUTPATIENT ADVANCED STUDIES INDEMNITY BENEFIT

- Per Covered Person per testing day: \$ 100
- Maximum days per Calendar Year per Covered Person: 3 days

This Benefit includes the cost of reading the Advanced Studies.

INPATIENT, OUTPATIENT, OR OUTPATIENT MINOR SURGICAL INDEMNITY BENEFIT

Daily Inpatient Surgical Indemnity Benefit:

\$1,000 per Covered person to a maximum of 1 day per Calendar Year.

Daily Outpatient Surgical Indemnity Benefit:

\$500 per Covered Person.

Daily Outpatient Minor Surgical Indemnity Benefit:

\$100 per Covered Person.

The amount payable for the Outpatient Benefit is limited to a maximum of 1 day per Covered Person per Calendar Year.

ACCIDENT EXPENSE BENEFIT

- 100% of charges incurred within 365 days of an Accidental Bodily Injury.
- Per Accidental Bodily Injury maximum: \$1,000.

CHANGE IN AMOUNTS OF BENEFITS

Any change in the amount of benefits due to a change in Your Eligible Class will be effective on the Policy Anniversary Date provided:

- You are actively at work, and
- You make any required payment for the change to be effective.

If You are not actively at work, such change will be effective on the first day on which You return to work. If You or Your Policyholder do not make the required payment within 31 days of the change, any increased benefits will not be effective until You give Proof of Good Health satisfactory to Us. Such increased benefits will be effective on a date set by Us.

Changes in benefits due to an Amendment to the Policy will take effect:

- **For You:**
 - On the Amendment date, if You are actively at work performing all the normal duties of Your job for a full work day:
 - While physically present at Your normal place of employment; or
 - At some other place of business that the Policyholder requires You to go; or
 - On the day You return to work, if You are not actively at work on the Amendment date.
- **For Your Dependent** (if applicable):
 - On the Amendment date, if the Dependent is not confined to a Hospital; or
 - On the day after the Dependent is released from a Hospital, if Hospital confined on the Amendment date.

Payment will be based on the benefits in effect at the time of death, loss, or the service is rendered.

Any reduction in the amount of benefits due to Your reaching an Age specified in the Schedule of Benefits will be made if You are actively at work or not.



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GENERAL EXCLUSIONS AND LIMITATIONS

Benefits are not provided for Loss, Injury or Illness which results directly or indirectly, wholly or partly from:

1. Insurrection, rebellion, participation in a riot, commission of or attempting to commit an assault, battery, felony, or act of aggression,
2. Declared or undeclared war or acts thereof.
3. Accidental Bodily Injury occurring while serving on full-time active duty in any Armed Forces of any country or international authority (any premium paid will be returned by Us pro-rata for any period of active-full time duty).
4. Any Injury or Illness arising out of or in the course of work for wage or profit.
5. Any Injury or Illness covered by any Workers' Compensation Act, Occupational Disease law or similar law.
6. Except in regard to Limited Medical Benefits, Accidental Bodily Injuries received while the Covered Person was operating a motor vehicle under the influence of alcohol as evidenced by a blood alcohol level in excess of the state legal intoxication limit.
7. Charges for which:
 - there is no legal obligation to pay, or
 - no charge is made, or
 - in the absence of Coverage, no charge would be made.
8. Charges incurred after Termination of Coverage, except as provided under the Extension Due to Total Disability provision.
9. Charges for care or services furnished by any agency or program funded by federal, state or local government. This does not apply to Medicaid or where prohibited by law.
10. Charges which are not Medically Necessary (as defined) for treatment of Illness or Injury.
11. Charges for services which are not related to and consistent with the treatment of any Injury or Illness of the Covered Person.
12. Charges for medical care, services, or supplies which are not furnished or prescribed by a Doctor (as defined).
13. Charges for Experimental or Investigational treatment, procedures for research purposes, or practices when not generally recognized as accepted medical practices.
14. Charges for care, treatment, services or supplies that are not approved or accepted as essential to the treatment of an Injury or Illness by any of the following:
 - The American Medical Association;
 - The U.S. Surgeon General;
 - The U.S. Department of Public Health;
 - The National Institutes of Health; or
15. Charges related to cosmetic surgery or dental care done to beautify a person without medical or dental indication of Injury or Illness.
16. Unless specifically provided in the Policy:
 - charges for dental treatment.
 - charges for oral surgery.
 - charges for treatment of Mental Illness Disorders.
 - charges for treatment of Substance Abuse Disorders.
 - charges for routine physicals or general health exams, unless they are necessary for the diagnosis and treatment of an Illness.
 - charges for refractions, eyeglasses or hearing aids or their fitting.
 - charges in connection with obesity, weight reduction, or dietetic control, except for morbid obesity or disease etiology.
 - charges for treatment or services for temporomandibular joint dysfunction or TMJ pain syndrome, orofacial, or myofascial syndrome whether medical or dental in scope.
 - charges for routine immunizations and vaccinations, including but not limited to polio, mumps, measles, small pox, DPT, Influenza or tine tests.
 - Birth control medication in any form.
 - Prescription medication recommended or dispensed by; a physician, surgeon, nurse or other Doctor.
17. Charges for reversal procedures in connection with previous male or female sterilization.
18. Charges for services in the nature of educational or vocational testing or training.
19. Any charges for elective abortions.
20. Any charges for outpatient food, food supplements or vitamins.

GENERAL EXCLUSIONS AND LIMITATIONS continued

21. Radial keratotomies.
22. Charges for treatment of male or female infertility; in vitro and in vivo fertilization of an ovum; or artificial insemination including but not limited to:
 - Drugs and medicines;
 - Diagnostic and surgical procedures including but not limited to:
 - Aspiration of ovarian cysts;
 - Harvesting or obtaining eggs;
 - Other surgical treatment of infertility;
 - Diagnostic laboratory and pathology procedures; and
 - Diagnostic radiology, nuclear medicine and ultra sound procedures.
23. Charges for stand-by Doctors to include but not limited to surgeons, pediatricians, anesthesiologists, anesthesiologists, or other Doctor as defined by the Policy; or stand-by supplies, equipment, rooms, or any other service, supply or treatment not actually used in the care or treatment of an Illness or Injury.
24. Charges for Custodial Care.
25. Charges for durable medical equipment.
26. Charges related to smoking cessation.
27. Charges for the treatment of the following:
 - Codependency;
 - Social, occupational, or religious maladjustments;
 - Compulsive gambling;
 - Chronic marital or family problems when not related to the primary focus of treatment which must be a diagnosable Mental Illness Disorder.



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CONTINUATION OF COVERAGE

THIS PROVISION IS SUBJECT TO THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA) AND ALL SUBSEQUENT LAWS EFFECTING THIS ACT.

This provision applies to an Employer with twenty (20) or more Employees on a typical business day during the preceding Calendar Year if group health Coverage was provided to Employees. Due to COBRA's complexity, this provision only includes information that would allow a qualified beneficiary to make a general determination of his rights under the law.

This provision is not a detailed account of the law and does not contain the full text of the law or regulations. Therefore, it is imperative that legal counsel or other appropriate counsel be sought for additional needed information.

Generally, all group health plans with over twenty (20) Employees are directly affected under COBRA or, under a federal law that COBRA may have amended. The only plans that may be exempt are church plans, state and local government group health plans and plans maintained by the Government of the District of Columbia or any territory or possession of the United States. Your Employer or plan administrator may be contacted for the plan's exempt or nonexempt status.

An individual may be eligible for Coverage if on the day before a qualifying event he was covered under his Employer's group health plan. If Coverage was lost due to a qualifying event, continuation of Coverage may be available for a certain period of time. Non-resident aliens who do not receive any United States income are not qualified B-beneficiaries and cannot continue under COBRA.

The term "qualified beneficiary" means, with respect to a covered Employee any other individual who, on the day before the qualifying event for that Employee, is a beneficiary under the plan as:

- a. The spouse of the covered Employee;
- b. The Dependent child of the covered Employee;
- c. The surviving Spouse of the covered Employee; or
- d. A child born to or adopted by a covered Employee during a period of COBRA Coverage.

The term "qualifying event" means, with respect to any covered Employee, any of the following events which would result in the loss of Coverage of a qualified beneficiary.

QUALIFYING EVENTS AND MAXIMUM CONTINUATION PERIODS:

1. 18 Months:
 - Termination of covered Employee's employment (except for gross misconduct)
 - The covered Employee's reduction of work hours.
2. 36 Months:
 - The death of the covered Employee.
 - The covered Employee's legal separation or divorce from the Employee's spouse.
 - The covered Employee's entitlement to Medicare.
 - The Dependent child ceasing to be a Dependent child under the terms of the Plan.
3. 29 Months:
 - Only applies if the qualifying event was a termination of employment (except for gross misconduct) or a reduction in work hours that allowed an eighteen (18) month period of continuation.

In order to qualify for the additional eleven (11) months of coverage, the Social Security Administration must make a determination that the qualified beneficiary was disabled at the time of a termination or reduction in hours of employment or that covered Employee or qualified beneficiary became disabled at any time during the first sixty (60) days of COBRA continuation coverage. If the covered Employee or qualified beneficiary entitled to the additional eleven (11) months of coverage has non-disabled family members who are entitled to COBRA continuation coverage, those non-disabled family members are also entitled to the additional eleven (11) months of coverage. If the covered Employee or qualified beneficiary is determined to be disabled, the covered Employee or qualified beneficiary must give notice to the plan administrator within sixty (60) days of the Social Security determination and before the end of the original eighteen (18) month continuation period. The plan administrator may charge an additional amount for this Coverage.

CONTINUATION OF COVERAGE

Coverage will terminate if a covered Employee or qualified beneficiary recovers from the disability during the eleven (11) month period. The covered Employee or qualified beneficiary is responsible for notifying the plan administrator within thirty (30) days of the date the Social Security Administration no longer finds the disability to exist. Coverage can terminate in the month that begins more than thirty (30) days after the determination date of the Social Security Administration.

4. Certain Bankruptcy Proceeding Under Title 11, United States Code: Under this special proceeding, loss of Coverage means a substantial elimination of Coverage within one (1) year before or after the Employer has entered into a bankruptcy proceeding.

For the purpose of this special proceeding, a qualified beneficiary may be a covered Employee who retired on or before the date of the loss of coverage and any other individual who on the date before the event was:

- a. The Spouse of the covered Employee;
- b. The Dependent child of the covered Employee;
- c. The surviving Spouse of the covered Employee; or
- d. A child born to or adopted by a covered Employee during a period of COBRA coverage.

It appears that Coverage may continue until the death of the covered Employee or qualified beneficiary, or up to thirty-six (36) months for the surviving Spouse or Dependent child(ren) of the covered Employee after the date of the death of the covered Employee.

As Bankruptcy Laws and COBRA are two (2) very distinct and unique laws, legal counsel should be consulted before determinations and actions commence under this qualifying event. For notification and election termination, reduction of hours, death, bankruptcy, the Plan Participant must notify the plan administrator within thirty (30) days of the qualifying event. The plan administrator will then provide written notice to the covered Employee or qualified beneficiary within fourteen (14) days. The covered Employee or qualified beneficiary must then elect COBRA coverage within sixty (60) days.

The election period will end sixty (60) days after the date of the qualifying event or sixty (60) days after the date the written notice was received, whichever is later. In addition, the required Premium must be paid within forty (45) days of the date of election.

For divorce, legal separation or ineligibility of a Dependent under the plan each covered Employee or qualified beneficiary must notify the Employer or plan administrator within sixty (60) days of the event. If the notice is not sent to the Employer or plan administrator within sixty (60) days, the group health plan does not have to offer the qualified beneficiary an opportunity to elect continuation Coverage.

Once the plan administrator is notified of the event, the plan administrator will provide written notice to the qualified-beneficiary. The qualified beneficiary must then elect COBRA coverage within sixty (60) days. The election period will end sixty (60) days after the date of the qualifying event or sixty (60) days after the date the written notice was received, whichever is later. In addition, the required Premium must be paid within forty-five (45) days of the date of election.

Notification to an individual who is qualified as the Spouse of the covered Employee, will be treated as notification to all other qualified beneficiaries residing with the Spouse at the time of the notification.

Each qualified beneficiary has the opportunity to make an independent election. However, if a qualified beneficiary who is the Spouse of a covered Employee makes an election to provide any other qualified beneficiary with COBRA coverage, the election will be binding on that qualified beneficiary.

Waiver:

If a covered Employee or qualified beneficiary waives the right to continue under COBRA and later revokes the waiver, he must do so within the election period. Coverage will not be provided during the period of time when coverage was waived. Waivers and revocations are considered made on the date they are sent to the Employer or plan administrator.



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CONTINUATION OF COVERAGE

Other Reasons Why Cobra Coverage May Terminate:

COBRA continuation coverage can end prior to the maximum continuation period due to any of the following events:

- A. The first day on which timely Premium payment is not made.
- B. The date upon which the Employer ceases to maintain any group health plan.
- C. The date upon which the covered Employee or qualified beneficiary is covered under any other group health plan whether or not such new plan contains limitation periods with respect to any pre-existing condition as long as the limitation period does not apply to the covered Employee or qualified beneficiary.
- D. The date the covered Employee or qualified beneficiary is entitled to Medicare. However, this event by itself may not end coverage for a covered Employee or qualified beneficiary who has End Stage Renal Disease. "Entitled" means - having made application and qualified for Medicare.
- E. The date on which Coverage would terminate for similarly situated active Employees to whom a qualifying event had not occurred.

Any alternative continuation coverage will not extend the maximum COBRA coverage period and will run concurrent with COBRA continuation.

When a covered Employee or qualified beneficiary's coverage ends under COBRA, and if the policy provides the right to convert to a health plan, the covered Employee or qualified beneficiary will be entitled to the conversion privilege.

The plan administrator may be contacted for additional information on COBRA. If further information is needed the U.S. Department of Labor, Pension and Welfare Benefits Administration, 200 Constitution Avenue, N.W. - Room N-5658, Washington, DC 20210 may be contacted.

CONTINUANCE OF COVERAGE

Benefits for the Plan Participant and his Dependents may continue past the day they would otherwise cease as provided under Termination of Coverage upon payment of the required premium.

The Plan Participant's coverage will continue:

- A. For up to two (2) months after he ceases full-time work due to temporary layoff or leave of absence; or
- B. For up to six (6) months after he ceases full-time work due to Illness or Injury; or
- C. Until the first day of the Plan month following any month in which the number of hours worked falls below the required minimum. Dependent coverage will continue if A. or B. above apply to the Plan Participant.

This coverage will not continue if the Plan Participant begins work for pay or profit with another employer.

The Plan Sponsor must follow a plan which prevents individual selection. If benefits are to be continued under this provision, written notice must be provided to Us by the Plan Sponsor if a Plan Participant is pensioned, retired or absent from work for any other reason. State law may provide a special continuance of coverage when You terminate. See your Plan Sponsor for details.



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Nationwide®

NATIONWIDE® HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices (the “Notice”) applies to Nationwide¹ and describes the legal obligations of Nationwide, and your legal rights regarding your protected health information held by Nationwide under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). Among other things, this Notice describes how your Protected Health Information (“PHI” as that term is defined below) may be used or disclosed to carry out treatment, payment, or healthcare operations, or for any other purposes that are permitted or required by law.

Nationwide is required by HIPAA and certain state laws to maintain the privacy of your PHI and to provide you with notice of our legal duties and privacy practices with respect to your PHI. We are required to abide by the terms of this Notice so long as it remains in effect. Nationwide reserves the right to change the terms of this Notice and to make the new Notice effective for all PHI maintained by us, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of the revised Notice by mail to your last-known address on file.

Protected Health Information (PHI) includes individually identifiable health information that is created or received by Nationwide and that relates to: (1) your past, present, or future physical or mental health or condition, (2) the provision of health care to you, or (3) the past, present, or future payment for the provision of health care to you. PHI includes information of persons living or deceased.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Your Authorization. Certain uses and disclosures of PHI require your authorization. For example, most uses and disclosures of PHI for marketing purposes and disclosures that constitute a sale of PHI require a written authorization. Except as outlined below, we will not use or disclose your PHI without your written authorization. If you have given us an authorization, you may revoke it in writing at any time, unless we have already acted on the authorization. Once we receive your written revocation, it will only be effective for future uses and disclosures.

Disclosures for Treatment, Payment or Health Care Operations. We may use or disclose your PHI as permitted by law for your treatment, payment, or health care operations. For instance, for your treatment, a doctor or health facility involved in your care may request information we hold in order to make decisions about your care. For payment, we may disclose your PHI to our pharmacy benefit manager for administration of your prescription drug benefit. For health care operations, we may use and disclose your PHI for our health care operations, which include responding to customer inquiries regarding benefits and claims.

¹ Nationwide Life Insurance Company®, National Casualty Company and the area within Nationwide Mutual Insurance Company® that performs healthcare functions.

Family and Friends Involved In Your Care. With your approval, we may from time to time disclose your PHI to designated family, friends, and others who are involved in your care or in payment for your care in order to facilitate that person's involvement in caring for you or paying for your care.

If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited PHI with such individuals without your approval.

Business Associates. Certain aspects and components of our services are performed through contracts with outside persons or organizations. At times it may be necessary for us to provide your PHI to one or more of these outside persons or organizations. For example, we may disclose your PHI to a business associate to administer claims or to provide support services. In all cases, we require these business associates by contract to appropriately safeguard the privacy of your information.

Other Health-Related Products or Services. We may, from time to time, use your PHI to determine whether you might be interested in or benefit from treatment alternatives or other health-related programs, products, or services which may be available to you as a member of the health plan. For example, we may use your PHI to identify whether you have a particular illness, and advise you that a disease management program to help you manage your illness better is available to you. We will not use your information to communicate with you about products or services which are not health-related without your written permission.

Plan Administration. We may release your PHI to your plan sponsor for administrative purposes, provided we have received certification that the information will be maintained in a confidential manner and not used in any other manner not permitted by law.

Other Uses and Disclosures. We are permitted or required by law to make certain other uses and disclosures of your PHI without your authorization. We may release your PHI for any purpose required by law. This may include releasing your PHI to law enforcement agencies; public health agencies; government oversight agencies; workers compensation; for government audits, investigations, or civil or criminal proceedings; for approved research programs; when ordered by a court or administrative agency; to the armed forces if you are a member of the military; and other similar disclosures we are required by law to make.

OTHER PRIVACY LAWS AND REGULATIONS

Certain other state and federal privacy laws and regulations may further restrict access to and uses and disclosures of your personal health information or provide you with additional rights to manage such information. If you have questions regarding these rights, please send a written request to your designated contact as explained in the "Contact Information" section, below.

RIGHTS THAT YOU HAVE

Access to Your PHI. You have the right to copy and/or inspect much of the PHI that we retain on your behalf. All requests for access must be made in writing and signed by you or your personal representative. We may charge you a fee if you request a copy of the information. The amount of the fee will be indicated on the request form. A request form can be obtained by writing your designated contact at the address provided in the "Contact Information" section.

Amendments to Your PHI. You have the right to request that the PHI that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. If the information is incorrect or incomplete and we decide to make an amendment or correction, we may also notify others who work with us and have copies of the uncorrected record if we believe that such



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notification is necessary. A request form can be obtained by writing to your designated contact at the address provided in the “Contact Information” section.

Accounting for Disclosures of Your PHI. You have the right to receive an accounting of certain disclosures made by us of your PHI. Requests must be made in writing and signed by you or your personal representative. A request form can be obtained by writing your designated contact at the address provided in the “Contact Information” section.

Restrictions on Use and Disclosure of Your PHI. You have the right to request restrictions on some of our uses and disclosures of your PHI. We will consider, but are not required to agree to, your restriction request. A request form can be obtained by writing your designated contact at the address provided in the “Contact Information” section.

Request for Confidential Communications. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your PHI information from us by alternative means or at alternative locations. A request form can be obtained by writing your designated contact at the address provided in the “Contact Information” section.

Right to be Notified of a Breach. You have the right to be notified in the event we discover a breach of your unsecured PHI.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice, even if you have requested such copy by e-mail or other electronic means.

Complaints. If you believe your privacy rights have been violated, you can file a written complaint with your designated contact as explained in the “Contact Information” section, below. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights, in writing within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

CONTACT INFORMATION

If you have any questions about this Notice, need copies of any forms or require further assistance with any of the rights explained above, contact us by calling 1-800-635-6585, or mail your request to:

Fringe Benefit Group, Inc.
Attn: Carol Adams, Privacy Officer
11910 Anderson Mill Road
Austin, TX 78726

EFFECTIVE DATE

This Notice is effective 9/15/2015

Dental Care Highlights



Brushing, flossing and expert preventative care all help keep your smile bright. But, did you know that poor oral health can result in pain, embarrassing tooth decay and loss and even cause illness? A quality dental plan helps you take charge of your teeth by offering low cost preventative care by an accredited dentist. Even if you have unexpected tooth decay and need fillings or surgical care, insurance can not only negotiate with your dentist to ensure you receive negotiated costs, but help pay for that care too.

Coinsurance	
Type 1 (Preventative)	80%
Type 2 (Basic)	80%
Type 3 (Major)	50%
Deductible	\$50 per calendar year Waived for Type 1 No Family Maximum
Maximum (per person)	\$500 per calendar year
Allowance	Discounted Fee
Waiting Period	None
Orthodontia (dependent children only)	
Plan Benefit	50%
Lifetime Maximum (per person)	\$250
Waiting Period	None

Sample Procedure Listing (Current Dental Terminology ©American Dental Association.)

Type 1 - Preventative	Type 2 - Basic	Type 3 - Major
<ul style="list-style-type: none"> Routine Exam (2 per benefit period) Bitewing X-rays (2 per benefit period) Full Mouth/Panoramic X-rays (1 in 3 years) Periapical X-rays Cleaning (2 per benefit period) Fluoride for Children 13 and under (1 per benefit period) Sealants (age 13 and under) Space Maintainers 	<ul style="list-style-type: none"> Restorative Amalgams Restorative Composites Endodontics (nonsurgical) Endodontics (surgical) Periodontics (nonsurgical) Periodontics (surgical) Simple Extractions Complex Extractions Anesthesia 	<ul style="list-style-type: none"> Onlays Crowns (1 in 10 years per tooth) Crown Repair Denture Repair Prostodontics (fixed bridge; removable complete/partial dentures) (1 in 10 years)

Rx Savings

Our valued plan members and their covered dependents can save on prescription medications at over 60,000 pharmacies across the nation including CVS, Walgreens, Rite Aid and Walmart. This Rx discount is offered at no additional cost, and it is not insurance.

To receive the Rx discount, Ameritas plan members just need to visit us at ameritas.com and sign into (or create) a secure member account where they can access and print an online-only Rx discount savings ID card.

Eyewear Savings

Ameritas plan members may receive up to 15% off eyewear frames and lenses purchased at any Walmart Vision Center nationwide. Members may also bring in their current vision prescription from any vision care provider and purchase eyewear at Walmart. This savings arrangement is not insurance: it is available to members at no additional cost to their plan premium.

To receive the eyewear savings identification card, Ameritas plan members can visit ameritas.com and sign-in (or create) a secure member account. Members must present the Ameritas Eyewear Savings Card at time of purchase to receive the discount.

Contracted Provider Information

To find a provider, visit ameritas.com and select FIND A PROVIDER, then DENTAL, click on the NETWORK PROVIDER link to search for a provider. Enter your criteria to search by location or for a specific dentist or practice. California Residents: When prompted to select your network, choose PPO Dental Network.

Pretreatment

While we don't require a pretreatment authorization form for any procedure, we recommend them for any dental work you consider expensive. As a smart consumer, it's best for you to know your share of the cost up front. Simply ask your dentist to submit the information for a pretreatment estimate to our customer relations department. We'll inform both you and your dentist of the exact amount your insurance will cover and the amount that you will be responsible for. That way, there won't be any surprises once the work has been completed.

Open Enrollment

If a member does not elect to participate when initially eligible, the member may elect to participate at the policyholder's next enrollment period. This enrollment period will be held each year and those who elect to participate in this policy at that time will have their insurance become effective on March 1.

Late Entrant Provision

We strongly encourage you to sign up for coverage when you are initially eligible. If you choose not to sign up during this initial enrollment period, you will become a late entrant. Late entrants will be eligible for only exams, cleanings, and fluoride applications for the first 12 months they are covered.

Section 125

This plan may be provided as part of the Policyholder's Section 125 Plan. Each employee has the option under the Section 125 Plan of participating or not participating in this plan. If an employee does not elect to participate when initially eligible, he/she may elect to participate at the Policyholder's next Annual Election Period.

This document is a highlight of plan benefits provided by Ameritas Life Insurance Corp. It is not a certificate of insurance and does not include exclusions and limitations. For exclusions and limitations, or a complete list of covered procedures, contact Fringe Benefit Group, Inc.

Eye Care Highlights



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ViewPointe® Plan Highlights

	EyeMed Insight Network	Out of Network
Deductibles	\$10 Exam \$10 Eye Glass Lenses	No deductible
Annual Eye Exam	Covered in full	Up to \$35
Lenses (per pair)		
Single Vision	Covered in full	Up to \$25
Bifocal	Covered in full	Up to \$40
Trifocal	Covered in full	Up to \$55
Lenticular	20% discount	No benefit
Progressive	See lens options	NA
Contact Lenses		
Fit & Follow Up Exams	Standard: Member cost up to \$40 Premium: 10% off of retail	No benefit No benefit
Contacts		
Elective	Up to \$120	Up to \$104
Medically Necessary	Covered in full	Up to \$200
Frames	\$120	Up to \$65
Frequencies (months)		
Exam/Lens/Frame	12/12/12 Based on date of service	12/12/12 Based on date of service

Lens Options (member cost)

	EyeMed Insight Network	Out of Network
Progressive Lenses		
Standard	\$65 + lens deductible	No benefit
Premium		
Tier 1	\$85 + lens deductible	No benefit
Tier 2	\$95 + lens deductible	No benefit
Tier 3	\$110 + lens deductible	No benefit
Tier 4	\$65 + 80% of charge less \$120 allowance	No benefit
Std. Polycarbonate	\$40	No benefit
Scratch Resistant Coating	\$15	No benefit
Anti-Reflective Coating		
Standard	\$45	No benefit
Premium		
Tier 1	\$57	No benefit
Tier 2	\$68	No benefit
Tier 3	80% of the charge	No benefit
Ultraviolet Coating	\$15	No benefit
LASIK or PRK	Average discount of 15% off retail price or 5% off promotional price at US Laser Network participating providers.	No benefit

Additional ViewPointe® Features (In Network)

Discounts	15% discount on the remaining balance in excess of the conventional contact lens allowance. 20% discount on the remaining balance in excess of the frame allowance. 20% discount on items not covered by the plan at network providers, which may not be combined with any other discounts or promotional offers. This discount does not apply to EyeMed Provider's professional services, or contact lenses.
Lens Options (Member Cost)	\$15 – Tint (Solid & Gradient).
Secondary Purchase Plan	Members receive a 40% discount on a complete pair of glasses once the funded benefit has been exhausted. Members receive a 15% discount off the retail price on conventional contact lenses once the funded benefit has been exhausted. Discount applies to materials only.
Contact Lens Replacement by Mail Program	After exhausting the contact lens benefit, replacement lenses may be obtained at significant discounts on-line. Visit EyeMedvisioncare.com for details.

Rx Savings

Our valued plan members and their covered dependents can save on prescription medications at over 60,000 pharmacies across the nation including CVS, Walgreens, Rite Aid and Walmart. This Rx discount is offered at no additional cost, and it is not insurance.

To receive the Rx discount, Ameritas plan members just need to visit us at ameritas.com and sign into (or create) a secure member account. That's where they can access and print an online-only Rx discount savings ID card.

ViewPointe Plan Members Use the EyeMed Insight Network

ViewPointe plan members have access to over 91,000 EyeMed providers nationwide at over 25,000 locations, with a choice between independent and retail providers located at one of their many chains. EyeMed's network of optical chains includes LensCrafters®, Target® Optical, Shopko®, and most Pearle Vision® and Sears® Optical locations. Retail chain advantages can include same-day service, evening and weekend hours, walk-in appointments, and specific guarantees on eyeglasses.

As with every Ameritas Group plan, members may visit any eye doctor. When ViewPointe plan members see non-EyeMed doctors, benefits are reimbursed according to the plan schedule.

Eye Care Plan Member Service

ViewPointe eye care from Ameritas Group features the money-saving eye care network of EyeMed Vision Care. Customer service is available to plan members through EyeMed's well-trained and helpful service representatives. Call or go online to locate the nearest EyeMed network provider, view plan benefit information and more.

EyeMed Customer Care Center: 1-866-289-0614

- Service representative hours: 8 a.m. to 11 p.m. ET Monday through Saturday, 11 a.m. to 8 p.m. ET Sunday
- Interactive Voice Response available 24/7

Locate an EyeMed provider at: ameritas.com

View plan benefit information at: eyemedvisioncare.com

Section 125

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This document is a highlight of plan benefits provided by Ameritas Life Insurance Corp. as selected by your employer. It is not a certificate of insurance and does not include exclusions and limitations. For exclusions and limitations, or a complete list of covered procedures, contact Fringe Benefit Group, Inc.