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Employee Benefits Materials

TAB 4

Benefits Orientation

Complete upon meeting: full-time six-month employee status

New Employee Name	Department	Supervisor

Policy, Paperwork, Training or Task	Initials Completed	Date Completed
1. **Company Benefits Review**		
2. **Insurance Election Form**		
3. **Application of Insurance Coverage/Eligibility Date:**		
Health Insurance		
Dental Insurance		
Life/STD/LTD		
C & I		
Cafeteria Plan		
4. **Review COBRA related materials with employee**		
5. **General COBRA Notice Review**		
6. **401K Eligibility / Election**		

Rexius Forest By-Products, Inc. Health & Welfare Benefit Plan

And Summary Plan Description

Attached you will find the Plan Document and Summary Plan Description (SPD) "Wrap" document for the Rexius Forest By-Products, Inc. Health and Welfare Benefit Plan. ERISA (Employee Retirement Income Security Act) is a law that governs welfare benefit plans. If an employer provides benefits that are subject to ERISA the law requires that the benefits must be described in a written document or Summary Plan Description. The attached "Wrap" document together with the group insurance carrier documents, and our annual Employee Memo make up the written plan document required by ERISA for the Health & Welfare Benefit Plan.

Insurance carriers provide plan documents (benefit summaries, insurance policies, contracts, etc.) but these documents may not contain all of the information that is important to you and specific to Rexius Forest By-Products, Inc.'s plan. The SPD Wrap document contains the missing provisions and terms and wraps itself around the insurance plan documents to become a single ERISA plan document.

The annual employee memo that is distributed at open enrollment includes information about how to obtain the carrier or third party administrator plan documents. You may also request a printed copy from me at any time.

We are providing this document so that you can better understand your health and benefit welfare plans. Please contact me if you have any questions.

Thank you,

Jerry Cunningham
Chief Financial Officer

REXIUS FOREST BY-PRODUCTS, INC.

HEALTH & WELFARE BENEFIT PLAN

AND

SUMMARY PLAN DESCRIPTION

August 1 through July 31

This Plan Document and Summary Plan Description together with the applicable certificates of insurance, insurance booklets, benefit summaries and/or group insurance contracts constitute the written plan document required by ERISA §402 and summary plan description for the component employee benefit plans offered under the Rexius Forest By-Products, Inc. Health & Welfare Benefit Plan.

For employers required to submit form 5500 reports (usually 100+ participants on any group plan as of the beginning of the plan year), this document is considered a "wrap" plan so the report is done on the wrap plan as a whole, not each individual plan.

This plan is available to the following categories of employees:

Regular eligible employees as defined within this document.

Effective Date: August 01, 2020

Revised Date: June 23, 2020

Original Date: August 01, 2015

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Rexius Forest By-Products, Inc.

Health & Welfare Benefit Plan Document

And

Summary Plan Description

SECTION 1: INTRODUCTION

This document contains a summary of your rights and benefits under Rexius Forest By-Products, Inc. Health & Welfare Benefit Plan (the "Plan"). Complete details can be found in the underlying component benefit program documents which govern the operation of the Plan, and are available with this document or through the Plan Administrator. In the event of any difference or ambiguity between your rights or benefits described in this document and the underlying component benefit program documents, the underlying component benefit program documents will control with regard to the specific benefits provided under the particular plan. For purposes of this document, component benefit programs are those benefit programs specified under Provider Companies found towards the end of this document and contained in the applicable component plan documents. Component benefit program documents include certificates of insurance, group insurance contacts, ERISA plan documents (if self-funded) and governing benefit plan documents for non-insurance benefit programs.

A copy of each certificate, summary or other governing document is included with this document, was previously provided, or can be obtained from the Plan Administrator. Information contained in the underlying component benefit program documents defines and governs specific benefits including your rights and obligations for each plan. If you have any questions about this document or the component plan information, contact your Plan Administrator listed on the next page.

Each benefit option is summarized in component benefit program documents issued by providers, Third Party Administrators, or the Company. When the Plan refers to these documents, it also refers to any attachments to such contracts, as well as documents incorporated by reference into such contract (such as the application, certificate of insurance, ERISA plan documents and any amendments).

SECTION 2: PLAN INFORMATION

The following information concerns the Plan. If you need more information, contact the Plan Administrator.

NAME OF PLAN
Rexius Forest By-Products, Inc. Health & Welfare Benefit Plan

EMPLOYER
Rexius Forest By-Products, Inc., PO Box 22838, Eugene, OR, 97402, (541) 342-1835

PLAN SPONSOR
Rexius Forest By-Products, Inc.

PLAN SPONSOR'S EMPLOYER IDENTIFICATION NUMBER
93-0925466

TYPE OF PLAN
This Plan provides comprehensive Medical, Dental, Vision, Life/AD&D, Supplemental, Long Term Disability, Short Term Disability, Flexible Spending Account and Telemedicine benefits and is considered a "Health & Welfare Benefit Plan" under ERISA.

PLAN YEAR: August 1 - July 31

PLAN NUMBER: 501

PLAN ADMINISTRATOR AND LEGAL PROCESS AGENT
Rexius Forest By-Products, Inc., Attn: Jerry Cunningham, Chief Financial Officer, PO Box 22838, Eugene, OR 97402, (541) 342-1835, jerryc@rexius.com.

2.1. ADMINISTRATION & FIDUCIARY

This document and the component plan documents describe the various benefits, whether each benefit is insured or self-funded, and Claims Administration and other services under the group benefit contracts.

- For self-insured benefits under this Plan, the Plan Administrator may elect to use a Third Party Administrator (TPA) to administer these benefits and adjudicate claims. In such case, the TPA may be the Claims Administrator and the Named Fiduciary for purposes of Claims Administrator, but the Plan Administrator will remain your point of contact for questions.
- For fully-insured benefits, the insurance company is the Named Fiduciary and has complete discretion to determine benefit payment amounts and to adjudicate claims. The Plan Sponsor has no fiduciary responsibility in these areas. See providers, policy numbers and their related contact information toward the end of this document.

Plan Administration

The administration of the Plan is under the supervision of the Plan Administrator. The principal duty of the Plan Administrator is to interpret and construe the provisions of the Plan, to decide all questions that arise including any dispute which may arise regarding the rights of participants and beneficiaries under the Plan; provided, however, that if an insurance certificate sets forth a specific claims procedure, such provisions shall apply for the purpose of that component plan. It also is the Plan Administrator's duty to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan. The administrative duties of the Plan Administrator include, but are not limited to, interpreting the Plan, prescribing applicable procedures, allocating fiduciary responsibilities, determining eligibility for and the amount of benefits, employing legal, actuarial, medical, accounting, clerical, and other assistance as it may deem appropriate in carrying out the terms of the Plan, and authorizing benefit payments and gathering information necessary for administering the Plan.

The Plan Administrator may delegate any of these administrative duties among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegate(s) and expressly describes the nature and scope of the delegated responsibility.

Except as provided below, under "Power and Authority of Insurer or Third Party Administrator", the Plan Administrator has the discretionary authority to interpret the Plan in order to make eligibility and benefit determinations as it may determine in its sole discretion. The Plan Administrator also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the Plan.

The Company will bear the incidental costs of administering the Plan. The Company may shift from time to time certain administration costs to Participants. The Company shall communicate to the Participants the details of any cost shifting arrangements.

Power and Authority of Insurer or Third Party Administrator

The Insurers or Third Party Administrator are responsible for

(1) Determining eligibility for and the amount of any benefits payable under the respective component benefit program, and
(2) Prescribing claims procedures (that comply with ERISA requirements) to be followed and the claims forms to be used by Employees to obtain their respective benefits.

The Insurers, not the Company, are responsible for paying claims with respect to these programs. The Company shares responsibility with the Insurers or Third Party Administrators for administering these program benefits.

Exclusive Benefit
All Plan assets shall be used for the exclusive benefit of eligible Employees, their Spouses, their other designated Dependents and their designated beneficiaries, in accordance with the provisions of the Plan, and/or for paying reasonable expenses associated with administering the Plan.

2.2. ELIGIBILITY AND PARTICIPATION

Premium contributions for each of the health and welfare benefit plans provided by Rexius Forest By-Products, Inc. are either attached to this document, given out separately or may be obtained from the Plan Administrator upon request.

Flexible Spending Accounts
This is a voluntary only benefit plan with employees estimating anticipated expenses for qualifying uncovered medical and work related dependent care costs, then authorizing payroll deductions for these amounts. See attached plan provisions.

Eligibility
Employee benefits begin the first day of the month following 60 days of eligible employment (unless stated below) provided the employee meets the applicable requirements and satisfies the enrollment requirements established under the Plan.

A. Full-Time Ongoing and New Hire Employees - Eligibility and Participation

Hourly employees working an average of 30 hours per week are eligible to participate in Plan benefits on the first day of the month following 60 days of eligible service.
Salaried employees working an average of 20 hours per week are eligible to participate in Plan benefits on the first day of the month following 30 days of eligible service.
New employees who are anticipated to work 30 or 20 hours or more (respectively) become eligible to participate based on the waiting period specified in the above paragraph.

B. Variable Hours Ongoing and New Hire Employees - Eligibility and Participation

For new employees hired into an employment category that may work less than an average of 30 hours per week, their hours of service will be tracked during Rexius Forest By-Products, Inc.'s defined measurement period. Rexius Forest By-Products, Inc. has elected the monthly measurement method of determining eligibility to participate in The Company's Medical Insurance Plan. Employees who work an average of 30 hours or more, during this measurement period, generally will be offered the opportunity to participate in The Company's Medical Insurance Plan. The employer reserves the right to review hours of eligibility in making these determinations. This will

be done during the administrative period, which may last up to 30 days.

For ongoing employees hired into an employment category that may work less than an average of 30 hours per week, their hours of service will be tracked during Rexius Forest By-Products, Inc.'s defined measurement period. Rexius Forest By-Products, Inc. has elected the monthly measurement period of determining eligibility to participate in The Company's Medical Insurance Plan. Employees who work an average of 30 hours or more, during this measurement period, generally will be offered the opportunity to participate in The Company's Medical Insurance Plan. The employer reserves the right to review hours of eligibility in making these determinations.

Employees who average less than 30 hours per week during the measurement periods will generally not be eligible to participate. Refer to your plan administrator or plan information for details.

While it is important to note that the administrative period can be up to 90 days, you must also take into consideration that the administrative period can neither reduce nor lengthen the standard measurement period or the corresponding stability period. To prevent gaps in coverage the administrative period will overlap with the prior year's stability period during which time an employee's classification (full-time or not full-time) will remain unchanged from the prior stability period classification.

Once an Employee has met the eligibility requirements and an appropriate Enrollment Form has been submitted to the Plan Administrator, the Employee’s coverage will commence on the date specified in the eligibility requirements at the beginning of this section and in the applicable component benefits program documents.

Special Situations

1) If a full-time employee changes employment status to part-time during a stability period, and meets all of the criteria below, the employee will cease to be considered a full-time employee on the last day of the third calendar month after the change in employment status occurs. This section applies only if:

a) The employee was offered minimum value coverage continuously during the period beginning on the first day of the calendar month following the employee's initial three full calendar months of employment and ending on the last day of the calendar month in which the change in employment status described in this section occurs;

b) The employee has a change in employment status to a position or status in which the employee would not have reasonably been expected to be a full-time employee if the employee had begun employment in that position or status; and

c) The employee actually is credited with less than 130 hours of service for each of the three full calendar months following the change in employment status.

A full-time employee who experiences a reduction in hours, but who does not experience a change in position, will continue to be considered full-time for the balance of the stability period.

2) If an employee is absent due to special unpaid leave, for purposes of determining an employee's average hours of service during a measurement period, the average hours of service for that measurement period will be determined by computing the average after excluding all periods of special unpaid leave during that measurement period. "Special unpaid leave" means unpaid leave that is subject to FMLA, subject to USERRA, or on account of jury duty.

Rehired Employees

The following rules only apply to applicable large employers or to small employers who have elected to establish Measurement and Stability Periods for Medical Insurance. Other benefits follow guidelines established in component plan documents.

An individual hired after a break in service of less than 13 weeks is considered a rehire for the purpose of benefit administration under the ACA. An individual with a break in service of more than 13 weeks (26 weeks in the case of an educational institution), is considered a new hire for the purpose of benefit administration. A returning Employee with a break in service of less than 13 weeks will be considered as continuing his or her employment. A rehired Employee will step back in where he or she left off as follows:

- Monthly Measurement Method: If the rehired Employee satisfied a waiting period during his or her previous period of employment, coverage will be offered the first day the Employee is credited with an hour of service or the first day of the calendar month following resumption of services (if immediate coverage is not administratively practicable).
- Look-Back Measurement Method (if variable hour employee): A rehired Employee will be credited for hours worked during the most recent measurement/look-back period and offered immediate healthcare enrollment if the Employee's average hours worked or paid meet the full-time threshold during the time that the Employee worked.

In accordance with the "rule of parity", an exception can be made if an Employee works for less than 13 weeks prior to the termination.

C. Eligible Family Members

You may also enroll eligible family members in the Medical, Dental, Vision, Life/AD&D and/or

Supplemental plans. Eligible Dependents are generally described below but the governing eligibility rules for Dependents are set forth in the applicable component benefit plan documents.

Eligible family members include:

- Legal Spouse or Registered Domestic Partner ("spouse" means an individual who is legally married to a participant as determined under Revenue Ruling 2013-17, in accordance with federal and state law and as specified in each benefit plan)
- Child (ren) up to age 26 or as defined in component plan documents; and/or
- Unmarried child (ren) of any age who depend upon the employee for support because of a mental or physical disability (For specified benefits only as defined in component plan documents).

Refer to underlying component benefit program documents for more information about Dependent eligibility, definitions of Dependents, and overall coverage. Your benefits eligibility may be affected if your status changes to inactive due to a family, medical, or personal leave of absence. Contact your Plan Administrator for additional information.

Certain benefits require that an eligible Employee make an annual election to enroll for coverage. Information regarding enrollment procedures, including when coverage begins and ends for the various benefits under the Benefit options, is set forth in the certificate of insurance, component Summary Plan Descriptions or other governing documents. An eligible Employee may begin participating in any benefit based on his or her election to participate in accordance with the terms and conditions established for each benefit.

D. Qualified Medical Child Support Orders

With respect to component benefit programs that are group health plans, the Plan will also provide benefits as required by any qualified medical child support order (QMCSO) (defined in ERISA Section 609(a)). The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

In the event the Plan Administrator receives a qualified medical child support order, the Plan Administrator will notify the affected Participant and any alternate recipient identified in the order of the receipt of the order and the Plan's procedures for determining whether such an order is a QMCSO. Within a reasonable period the Plan Administrator will determine whether the order is a qualified medical child support order and will notify the Participant and alternate recipient of such determination.

E. Furlough

The number of hours required for eligibility for the Health Insurance Plan may be modified at the discretion of the Directors or Officers, in the extremely rare instance where a government-required furlough or mandated work reduction order has been issued by government authorities.

2.3. ANNUAL OPEN ENROLLMENT PERIOD

Each year Rexius Forest By-Products, Inc. has an open enrollment that takes place during July when participants can make plan changes or new participants can enroll. Changes and elections made during the open enrollment period are generally effective (upon plan renewal) following the open enrollment period.

2.4. ENROLLMENT IN THE PLAN

A. Enrollment Procedures

An Employee who is eligible to participate in this Plan shall commence participation after the eligibility requirements have been satisfied, provided that any enrollment forms are submitted to the Plan Administrator before the date that participation would commence. Such enrollment forms shall identify the Spouse and other Dependents who are eligible for benefits under the elected benefit plan.

B. Mid-Year Enrollment Changes (Only if Qualified Change in Status)

If benefits are paid on a pre-tax basis through a Cafeteria Plan, legal rules require that benefit choices made must remain in effect for the entire Plan Year, August 1 to July 31 (or the balance of the Plan Year for Employees hired and who enroll during the Plan Year), unless the Employee experiences a Qualified Change in Status. While the list of possible events that could allow you to make mid-year election changes is set by the IRS and the Internal Revenue Code, Rexius Forest By-Products, Inc. and its Insurance Carriers or Third Party Administrator can select a sub-group of these events to allow changes under a particular plan. Under the Code you must enroll within a reasonable time period from your eligibility date. Once you are enrolled, you may only make changes to your benefit elections during Open Enrollment or if you have a Qualifying Change in Status that affects the eligibility of you or your dependents, and the requested election change is consistent with your Qualifying Change in Status.

The following are examples of what might be considered a Qualifying Change in Status, refer to your Cafeteria Plan for an accurate list of qualifying events:

A Qualifying Life Event/Qualifying Change in Status includes:

- A change in your Legal Marital Status such as marriage, death of a spouse, divorce, legal separation or annulment.

- A change in your Number of Dependents such as birth, adoption, placement for adoption, or death of a child.

- A change in Employment Status such as commencement or termination of employment for you, your spouse, or your dependent.

- A change in Work Schedule such as a reduction or increase in hours, including a switch between part-time and full-time, a strike or lockout, or commencement or return from an unpaid leave of absence for you, your spouse, or your dependent.

- If Dependent Satisfies or Ceases to Satisfy the Requirements for Dependents due to factors such as age.

- A change in Residence or Worksite for you, your spouse, or your dependent.

- The receipt of a Qualified Medical Child Support Order or National Medical Support Notice.

- A change in Entitlement to Medicare or Medicaid for you, your spouse, or your dependent.

- A change in Eligibility for COBRA for you, your spouse, or your dependent while you are still an active employee.

- A change in a spouse's coverage such as benefit reduction, cost increase or decision to join or not to join a plan during open enrollment.

- A change where an Employee may qualify for exchange coverage because the employer coverage does not meet the affordability requirements.

- An Employee may drop coverage if their hours drop below 30 hours/week on average, even if the Employee does not lose eligibility for coverage due to Affordable Care Act rules on eligibility.

All election changes must be requested within 30 days of the event in question unless otherwise required by state or federal laws or healthcare mandates (e.g. loss of coverage under Medicaid or CHIP allows up to 60 days to obtain coverage). *To make an election change, contact your Plan Administrator listed above.*

2.5. PLAN BENEFITS AND COST SHARING PROVISIONS

A. Participant Contributions

Participant premium contributions for coverage are fixed, and the employer bears the risk of premium and/or administrative cost above that amount.

If the Plan has cost sharing with a Cafeteria Plan, employee contributions for qualifying benefits will be paid through a pre-tax payroll deduction starting the first pay period following enrollment, unless they are benefits that are not eligible for pre-tax deduction such as life or disability insurance or the Employee requests post-tax deductions. Contributions will be paid semi-monthly for all employees. Actual contribution rates will be published each year during the open enrollment period. See summary of coverage for additional deductible, coinsurance, copayments, services, and coverage, and enrollment documents for applicable rates and contribution levels.

B. Company Contribution Levels

The Company will make its contributions in an amount that (in the Company's sole discretion) is at least sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by the eligible Employee's contributions. The Company will pay its contribution and the eligible Employee's contributions to the Insurer or Third Party Administrator or, with respect to benefits that are self-insured, will use these contributions to pay benefits directly to or on behalf of the Participants from the Company's general assets. The eligible Employee's contributions toward the cost of a particular benefit will be used in their entirety prior to using Employer contributions to pay for the cost of such benefit.

Insurance premiums for Employees and their eligible family members are paid in part by the Company out of its general assets and in part by employees' pre-tax payroll deductions, where applicable. The Plan Administrator provides a schedule of the applicable premiums during the initial and subsequent open enrollment periods and on request for each of the component benefit programs, as applicable. Contributions for the self-insured component benefit programs are also made in part or in whole by the Company and/or in part or in whole by employees' pre-tax or post tax payroll deductions.

C. Ordering of Participant and Company Contributions

This section applies unless the plan sponsor has adopted specific written procedures or a document that specifies a different ordering for plan contributions or for plan receipts to plan contributions.

- All participant contributions will be applied first to cover premiums or benefit costs, and then Employer contributions will be applied to cover any remaining premiums or benefit costs plus the cost of other plan expenses, including stop-loss premiums if applicable.

- If any component of the Plan is self-insured and the Employer has purchased a stop-loss policy (and the employer, not the Plan, is the policyholder), any stop-loss proceeds will be treated as fully allocable to employer contributions. This applies even if stop-loss premiums were included in calculating total plan costs. Participant contributions will not be used to pay stop-loss premiums. (If the Employer is the policyholder, the employer is entitled to reimbursement for amounts it pays above a specified threshold level for allowed claims during the relevant period. The stop-loss policy is not a plan asset and does not reimburse participants for claims costs.)

- In the event a medical loss ratio (MLR) rebate or other type of rebate is paid to the Plan, the portion of the rebate that does not exceed the Employer's total amount of prior contributions during the relevant period will be attributable to Employer contributions, not to participant contributions.

2.6. COMPONENT BENEFIT PLAN DOCUMENTS

All documents relating to the Rexius Forest By-Products, Inc. Health & Welfare Benefits Plan, including the Evidence/Certificate of Coverage for each plan, Listing of Network Providers, Contribution Rates, General COBRA Notice, Medicare Creditable Coverage Notice, and any other relevant Plan Documents or Notices, are available to Employees and their dependents by contacting the Plan Administrator. Plan participants may receive a paper copy of any of the above documents free of charge by contacting the Plan Administrator.

Please refer to the component plan documents for each plan's specific details, including a description of benefits, cost-sharing provisions, requirements for use of network providers, and circumstances by which benefits may be denied.

2.7. POSSIBLE LIMITS ON OR LOSS OF BENEFITS

Summary of Benefits and Coverage
See component plan documents and Summary of Benefits and Coverage (SBC) for details regarding deductibles, co-pays, coverage, claims procedures, resources and provider company information.

A. Coordination of Benefits
For Participants and Dependents who do not maintain coverage under a health and welfare plan sponsored by another unrelated employer's health and welfare plan, the Plan will be the primary payer for all eligible claims and benefits as defined in the underlying component

benefit program documents. If participants or dependents are covered by another medical or insurance plan, the two plans will coordinate together eliminating duplication of payments as explained in the component plan documents. The insurer has primary responsibility to coordinate benefits for eligible expenses for other employer plans, government plans, Medicare or other coverage such as motor vehicle insurance.

B. Subrogation of Benefits

The Insurer or third-party administrator shall undertake reasonable steps to identify which Plan has a subrogation interest and shall manage subrogation cases on behalf of the Plan. You are required to cooperate with the Insurer or Third-Party Administrator to facilitate enforcement of its rights and interests. Participants must fully cooperate and do their part to ensure the Plan's right of recovery and subrogation are secured. If the Participant fails or refuses to honor the Plan's recovery and subrogation rights, the Plan may recover any cost to enforce its rights. This includes, but is not limited to, attorney fees, litigation court cost and other expenses as covered in the underlying component benefit program documents.

C. Rescission

Benefits for you and/or your enrolled dependent(s) will be terminated retroactively (this is known as *"rescission"*) if the Carrier or Plan Administrator determines that you obtained benefits under the Plan as a result of fraud or intentional misrepresentation of a material fact. You will be given 30 days prior written notice, and coverage will be terminated back to the date of the fraud or intentional misrepresentation. You will be required to reimburse the Plan for any benefits you or your eligible dependent(s) received since the date of the fraud or material misrepresentation, and such amount will be offset against the premiums you paid before they are refunded to you, to the extent allowed by applicable law.

D. Denial or Loss of Benefits

A Participant's benefits under the Plan will cease when the eligible Employee's participation in the Plan terminates. A Participant's benefits will also cease on termination of the Plan. Other circumstances can result in termination, reduction or denial of benefits. Refer to the component benefit program documents for details regarding when a plan may terminate.

2.8. TERMINATION OF BENEFITS

Benefits under any Component Benefit Program will terminate for all participants if that Component Benefit Program is terminated, and will terminate for a particular participant if his or her participation is ended due to loss of eligibility or termination of employment or other reason.

Plans may or may not have conversion options (check with Plan Administrator). See continuation options available for such benefits as medical, dental, vision and health flexible spending accounts, if applicable, under COBRA (Consolidated Omnibus Budget Reconciliation Act) as explained below. Check with the Plan Administrator for possible conversion options or questions on possible continuation rights. See each component benefit program documents for termination provisions.

An eligible Employee's participation and the participation of his or her eligible Dependents in the Plan will terminate on the date specified in the component benefit program documents. Other circumstances can result in the termination of benefits as described in the component benefit program documents.

Participation in the Plan may be terminated due to disqualification, ineligibility, or denial, loss, forfeiture, suspension, offset, reduction, etc. Refer to the corresponding component benefit program documents for detailed information. Rexius Forest By-Products, Inc. reserves the right to change, cancel, or alter all or any portion of the Employee Welfare Benefit Plan as it deems necessary.

The Company has the right to terminate the Plan in its entirety, or any portion thereof at any time. In the event that the Plan is terminated, a written notice shall be given 60 days in advance.

An officer, as designated by the Company, may sign insurance contracts for this Plan on behalf of the Company, including amendments to those contracts, and may adopt (by a written instrument) amendments to the Plan that he or she considers to be administrative in nature or advisable to comply with applicable law.

Other circumstances can result in the termination of benefits. The insurance contracts (including the certificate of insurance booklets), plans, and other governing documents in the applicable Attachments, previously sent documents or available through the Plan Administrator, provide additional information.

2.9. PLAN AMENDMENT AND TERMINATION

Amendment of the Plan

The Employer reserves the right to amend, modify, or discontinue the Plan in any respect, including but not limited to, implementing a change in the amount or percentage of premiums or cost that must be paid by the Participant. No Participant shall have any vested right to any benefits under the Plan, subject to any duty to bargain that may exist. The Company shall have the right to amend the Plan at any time and to any extent deemed necessary or advisable; provided, however, that no amendments shall:

1. Have the effect of discriminatorily depriving, on a retroactive basis, any eligible Employee, dependent or beneficiary of any beneficial interest that has become payable prior to the date such amendment is effective; or

2. Have the result of diverting the assets of the Plan to any purpose other than those set forth in this Plan.

An officer, as designated by the Company, may sign insurance contracts for this Plan on behalf of the Company, including amendments to those contracts, and may adopt (by a written instrument) amendments to the Plan that he or she considers to be administrative in nature or advisable to comply with applicable law.

In the event that the Plan is terminated, a written notice shall be given to participants 60 days in advance. If the Plan is amended, the employer will promptly provide notice to participants as required under applicable law and shall execute any instruments necessary in connection therewith. The Company shall promptly notify the Plan Administrator and all interested parties of any amendment adopted pursuant to this Section.

2.10. CLAIMS PROCEDURES

A. Overview of Claims Procedures

Details regarding the Plan's claim procedures are furnished automatically, without charge, as a separate document, copies of which are included with this document, were previously provided, or can be obtained from the Plan Administrator. These will comply with applicable ERISA requirements.

Generally, to obtain benefits from the Insurer or Third Party Administrator (TPA) of a provided component benefit program, you must follow the claims procedures under the applicable component benefit program documents, which may require you to complete, sign, and submit a written claim on the Insurer's or Third Party Administrator's form. In that case, the form is available from the Plan Administrator.

Summary of the ERISA claims and appeals process, for any type of ERISA benefits:

1) Claim is filed – by the plan participant or his/her authorized representative.
2) Claim is either paid in full or denied in whole or in part – by the Claims Administrator. If the claim is denied in whole or in part, this is called an "Adverse Benefit Determination."
3) Appeal of Adverse Benefit Determination – by the plan participant or his/her authorized representative.
4) Final decision on the appeal – by the Claims Fiduciary (not the same individual who made the initial claims denial, nor a subordinate of that person).

If your appeal is denied, or if the claims fiduciary does not comply with the ERISA timeframes specified below, you can file a civil action (lawsuit) in Federal court, under ERISA section 502(1).

B. Standard Claims Procedures for Medical Benefit

1) Fully-Insured Medical Benefits

For purposes of determining the amount of, and entitlement to benefits under a component medical program whose benefits are paid under an insurance policy, the Insurance Company is the Named Fiduciary and shall have the full power to make factual determinations and to interpret and apply the terms of the policy as they relate to the benefits provided through the insured arrangement, unless the Plan Administrator has explicitly and in writing retained the right to make a final determination. The Insurance Company is also the Claims Administrator for purposes of claims determinations.

2) Self-Funded Medical Benefits

For purposes of determining the amount of, and entitlement to benefits under a component medical program whose benefits are paid from the Company's general assets, the Plan Administrator shall have the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to the benefits provided through a self-funded arrangement, except to the extent the Plan Administrator has appropriately delegated such responsibility to a Claims Administrator. This is specified in the appropriate Component Benefit Program documents.

To obtain benefits from a self-funded arrangement, the Participant must complete, execute and timely submit to the Claims Administrator or Plan Administrator a written claim on the form available from either the Claims Administrator or Plan Administrator.
The Claims Administrator or Plan Administrator will decide the claim in accordance with reasonable claims procedures, as required by ERISA. ERISA imposes specific maximum timeframes for different types of medical claims (e.g., pre-authorization, emergency, post-treatment), and these are specified in the applicable documents for Component medical benefits. The Plan Administrator or the Claims Administrator has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide his or her claim. If the Claims Administrator or Plan Administrator denies the Participant's claim, in whole or in part, it will send written notification setting forth the reason(s) for the denial.

If a Participant's claim is denied, he or she may appeal to the Named Fiduciary, for a review of the denied claim. The Named Fiduciary will decide the appeal in accordance with reasonable claims procedures, as required by ERISA. If the Participant doesn't appeal on time, he or she will lose his or her right to file suit in a state or federal court, as he or she has not exhausted the internal administrative appeal rights (which is generally a prerequisite to bringing a suit in state or federal court). The insurance documents or other governing documents for the Component Benefits contain more information about how to file a claim and details regarding the claims procedures applicable to the claim.

After a Participant's appeal for Medical Benefits has been denied by Named Fiduciary, he or she shall be eligible to file a request for review under the external review procedure as provided under Treasury Regulations Section 54.9815-2719T(d)(1)(i); DOL Regulations Section 2590.715-2719(d)(1)(i) and HHS Regulations Section 147.136(d)(1)(i), if applicable.

C. Claims Procedure for Benefits Based on a Determination of Disability

ERISA claims procedures apply specifically to claims made on or after April 1, 2018, under the Plan for benefits based on a determination of disability. However, if the Plan Administrator has delegated and named an insurer or third party administrator as the claims fiduciary, then such entity shall have full discretion and authority to determine eligibility for such benefits, and the insurer's or third party administrator's claims procedures shall apply as long as such other claims procedures comply with current Department of Labor Regulations. For additional information, please contact the disability insurer.

Additionally, if a disability determination is made outside the plan for reasons other than determining eligibility for plan benefits, the new ERISA disability claims procedures shall not apply. Examples of when the ERISA disability claims provisions do not apply are where the disability determination is based solely on whether the claimant is entitled to disability benefits under either the Social Security Act or the employer's long term disability plan.

Below is a short summary of the disability claims procedures effective for claims filed on or after April 1, 2018, if: a) the Plan Administrator makes the disability determination, or b) the Plan Administrator has designated a separate claims fiduciary but that entity's claims procedures are not compliant with applicable DOL regulations.

1) If the claims administrator denies your claim, it must notify you of its decision within 45 days of receipt of your completed claim, except that it may extend the time by not more than two additional 30-day periods if it first notifies you in writing and if certain other requirements are met.

2) Any adverse benefits determination will include the specific information specified in the DOL final regulations.

3) You have 180 days to appeal an adverse benefit determination. You may request, free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits. You may submit information and opinions from experts who were not involved in the initial claim.

4) Within 45 days after the Claims Administrator receives your appeal request, it will notify you of its decision on your appeal, except that this period may be extended for an additional 45-day period if special circumstances (such as the need to hold a hearing) require an extension of time. In such case, you will be notified in writing of the need for the extension. The individual reviewing your appeal shall not be the same individual who made the initial benefit decision, shall give no deference to the initial benefit decision and shall not be a subordinate of the initial decision maker. If your appeal is granted, the decision will contain information sufficient to reasonably inform you of that decision. If the reviewing fiduciary anticipates denying your appeal, whether in whole or in part, the fiduciary must provide you certain information (free of charge) as soon as possible and sufficiently in advance

of the date the final decision must be rendered, to provide you a reasonable opportunity to review the information and submit a response. If your appeal is denied, you will be sent written notice which includes the information specified in the final regulations.

2.11. AFFORDABLE CARE ACT COMPLIANCE

The Plan complies with all applicable Patient Protection and Affordable Care Act (PPACA) provisions, as detailed in component plan documents. PPACA applies only to health benefits. It does not apply to other benefits under the Plan, such as dental, vision, life, disability, “excepted” benefits (as defined by law and regulations) or other categories of benefits.

Exceptions: Plans are not required to comply with certain PPACA requirements if they are “grandfathered” as defined under PPACA or “grandmothered” (certain non-ACA-compliant small insured plans that were allowed to renew for a limited period of time, under PPACA and certain states’ laws). See component plan document to clarify if your plan is "grandfathered" or "grandmothered".

PPACA compliance (for plans that are not grandfathered or grandmothered) includes, but is not limited to:

- Coverage of dependents up to age 26
- No annual or lifetime dollar limits on “Essential Health Benefits” as defined in PPACA and regulations
- No pre-existing conditions exclusions
- Prohibition on rescissions
- Patient protections – coverage and payment for emergency services, primary care provider designation, designation of pediatric physician as primary care provider, no prior authorization for access to obstetrical or gynecological care.
- Preventive care – specified preventive care services are covered on a first-dollar basis, not subject to co-payments, co-insurance, deductibles or other cost-sharing requirements.
- Nondiscrimination testing – this Plan is intended to comply with current nondiscrimination rules.

2.12. ERISA NOTICES

With respect to offered group Health Plans, the Plan will provide benefits in accordance with the requirements of all applicable laws, such as COBRA, HIPAA, HITECH, MHPA, NMHPA, USERRA, GINA, MHPAEA, WHCRA, HCERA and PPACA.

Notice of Rights Under the Newborns & Mothers Health Protection Act

Group Health Plans and Health Insurance Issuers or Third Party Administrators 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).

Notice of Women's Health & 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 lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the applicable component benefit. Refer to the insurance certificate or benefit booklet for information on the deductibles and coinsurance that apply.
If you would like more information on WHCRA benefits, contact the plan administrator.

HIPAA Portability Rights

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that we notify you about a very important provision in the Plan. It is your right to enroll in the Plan under its "special enrollment provision" if you marry, acquire a new dependent, or if you decline coverage under the Plan for an eligible dependent while other coverage is in effect and later the dependent loses that other coverage for certain qualifying reasons. Special enrollment must take place within 30 days of the qualifying event or as required by state or federal law (60 days if enrollment in or eligibility for, or loss of eligibility for Medicaid or CHIP).

Family Medical Leave
To the extent the Plan is subject to The Family and Medical Leave Act of 1993 (FMLA), the Plan Administrator will permit a Participant taking unpaid leave under the FMLA to continue group health benefits under such applicable law. Non-medical benefits will continue according to the established Company policy. Participants continuing participation pursuant to the foregoing will pay for such coverage (on a pre-tax or after-tax basis) under a method as determined by the Plan Administrator satisfying applicable regulations. If the Participant's coverage under the Plan terminates while the Participant is on FMLA leave, the Participant is not entitled to receive reimbursements for claims incurred during the period when the coverage is terminated. Upon reinstatement into the Plan upon return from FMLA leave, the Participant has the right to resume coverage at the level in effect before the FMLA leave and make up the unpaid premium payments, or resume coverage at a level that is reduced by the amount of unpaid premiums and resume premium payments at the level in effect before the FMLA leave.

Mental Health Parity & Addiction Equity Act (MHPAEA)
The MHPAEA applies only to employers with more than 50 employees. If applicable to this Plan, the MHPAEA applies to class health benefits provided under this Plan that provide both medical and surgical benefits as well as mental health or substance use disorder benefits. The MHPAEA requires that:

- The financial requirements that apply to mental health or substance use disorder benefits cannot be more restrictive than the predominant financial requirements that apply to substantially all medical and surgical benefits under the Plan, and no separate cost-sharing requirements can be applied only to mental health or substance use disorder benefits.

- The treatment limitations that apply to mental health or substance use disorder benefits cannot be more restrictive than the predominant treatment limitations that apply to substantially all medical and surgical benefits under the Plan, and no separate treatment limitations can be applied only to mental health or substance use disorder benefits.

The component plan determines what mental health condition and/or substance use disorder coverage is provided.

USERRA
The Plan Administrator will also permit you to continue benefit elections as required under the Uniformed Services Employment and Reemployment Rights Act (USERRA) and will provide such reinstatement rights as required by such law. The Plan Administrator will also permit you to continue benefit elections as required under any other applicable state law to the extent that such law is not pre-empted by federal law.

Special Enrollment Notice
If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in

this plan if you or ***your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage)***. However, you must request enrollment within the allowable period outlined in the component plan documents, after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within allowable period outlined in the component plan documents, after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact the Plan Administrator.

Genetic Information Nondiscrimination Act of 2008 ("GINA")

The Genetic Information Nondiscrimination Act of 2008 ("GINA") prohibits the Plan from discriminating against individuals on the basis of genetic information in providing any of the benefits under provided benefit plans.

GINA generally:

- Prohibits the Plan from adjusting premium or contribution amounts for a group on the basis of genetic information;

- Prohibits the Plan from requesting or mandating that an individual or family member of an individual undergo a genetic test, provided that such prohibition does not limit the authority of a health care professional to request an individual to undergo a genetic test, or preclude a group health plan from obtaining or using the results of a genetic test in making a determination regarding payment;

- Allows the Plan to request, but not mandate, that a participant or beneficiary undergo a genetic test for research purposes if the Plan does not use the information for underwriting purposes and meets certain disclosure requirements; and

- Prohibits the Plan from requesting, requiring, or purchasing genetic information for underwriting purposes, or with respect to any individual in advance of or in connection with such individual's enrollment.

Michelle's Law

Michelle's Law is a federal law that requires certain group health plans to continue eligibility for adult dependent children who are students attending a post-secondary school, where the children would otherwise cease to be considered eligible students due to a medically necessary leave of absence from school. In such a case, the Plan must continue to treat the child as eligible up to the earlier of:

- The date that is one year following the date the medically necessary leave of absence began; or the date coverage would otherwise terminate under the Plan.

For the protections of Michelle's Law to apply, the child must:

- Be a dependent child, under the terms of the Plan, of a participant or beneficiary; and
- Have been enrolled in the Plan, and as a student at a post-secondary educational institution, immediately preceding the first day of the medically necessary leave of absence.

"Medically necessary leave of absence" means any change in enrollment at the post-secondary school that begins while the child is suffering from a serious illness or injury, is medically necessary, and causes the child to lose student status for purposes of coverage under the Plan.

If you believe your child is eligible for this continued eligibility, you must provide to the Plan a written certification by his or her treating physician that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary.

If you have any questions regarding the information contained in this notice or your child's right to Michelle's Law's continued coverage, you should contact the Plan Administrator.

Discrimination is Against the Law

The Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Company does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Company:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact the Plan Administrator.

If your Company has fifteen (15) or more Employees and you believe that The Company has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, refer to the Plan Administrator for Grievance Procedures or if you need help filing a grievance. A grievance can be filed in person, by mail, fax, or email.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services 200
Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Participant's Responsibilities
Each Participant shall be responsible for providing the Plan Administrator, Claims Administrator, if applicable, and the Company and, if required by an Insurance Company or Third Party Administrator, with respect to a fully-insured benefit, the Insurance Company with his or her current address. If required by the Insurance Company, with respect to a fully-insured benefit, each Employee who is a Participant shall be responsible for providing the Insurance Company with the address of each of his or her covered eligible dependents. Any notices required or permitted to be given to a Participant hereunder shall be deemed given if directed to the address most recently provided by the Participant and mailed by first class United States mail. The Insurance Companies, the Plan Administrator and the Company shall have no obligation or duty to locate a Participant.

Documenting Eligibility for Enrollment and Benefits Any person claiming benefits under the Plan shall furnish the Plan Administrator or, with respect to a fully-insured benefit, the Insurance Company or Third Party Administrator with such information and documentation as may be necessary to verify eligibility for and/or entitlement to benefits under the Plan. Refer to details in the component benefit program documents.

The Plan Administrator, Claims Administrator, if applicable, (and, with respect to a fully-insured benefit, the Insurance Company) shall have the right and opportunity to have a Participant examined when benefits are claimed, and when and as often as it may be required during the pendency of any claim under the Plan.

2.13. HIPAA PRIVACY AND SECURITY COMPLIANCE

Application
The Privacy and Security Rules in the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA) apply only to those Component Benefit Programs that constitute group health plans that are subject to HIPAA, and that are self-funded or for which the plan sponsor uses or discloses “protected health information” (PHI). Such group health plans are "Covered Programs" under HIPAA.

Privacy and Security Policy
The Covered Programs will adopt HIPAA privacy and security policies, as appropriate.

Business Associate Agreement
The Covered Programs will enter into a business associate agreement with any persons or entities as may be required by applicable law, as determined by the Plan Administrator.

Notice of Privacy Practices
The Covered Programs will provide each Participant with a notice of privacy practices to the extent required by applicable law.

DISCLOSURE TO THE COMPANY

In General
This Subsection permits the Covered Programs to disclose PHI to the Company to the extent that such PHI is necessary for the Company to carry out its administrative functions related to the Covered Programs.

If part of their job responsibilities include administration or management of the group health plan, there may be times that the following departments have access to an employees PHI: Accounting, IT, Legal, HR, Benefits. Examples of how their job responsibilities may require access to PHI or ePHI include (but are not limited to): payment of claims; review of amounts paid for medical services; legal review of claims or appeals or benefits issues; or access to ePHI that is at rest on (or in transit using) the employer's server, network, Intranet or Internet.

If you have any questions as to the person/persons that have access to this information, please see your plan administrator.

Permitted Disclosure
1) Permitted Disclosure of Enrollment/Disenrollment Information. The Covered Programs may disclose to the Company information on whether an individual is participating in the Covered Programs. Enrollment and disenrollment functions performed by the Company are performed on behalf of Participant and beneficiaries of the Covered Programs, and are not plan administration functions. Enrollment and disenrollment information held by the Company is held in its capacity as an employer and is not PHI.

2) Permitted Uses and Disclosure of Summary Health Information (SHI). The Covered Programs may disclose Summary Health Information, as defined in the HIPAA privacy rules, to the Company, provided that the Company requests the Summary Health Information for the purpose of (i) obtaining premium bids from health plans for providing health insurance coverage under the Covered Programs; or (ii) modifying, amending, or terminating the Covered Programs.

3) Information Disclosed Pursuant to a Signed Authorization. Information disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR 164.508 is not subject to any restrictions, except as specified on the signed authorization.

4) Permitted and Required Uses and Disclosure of Protected Health Information (PHI) for Plan Administration Purposes. If the component health plans have not already been amended to include this information, this Wrap document amends them to incorporate the following provisions, which allow the Covered Programs to disclose PHI to the Plan Sponsor for "plan administration purposes" as defined in HIPAA regulations. This includes quality assurance, claims processing, auditing, and monitoring. The Plan Sponsor shall only use such PHI for purposes of plan administration and not for any employment-related actions or decisions. This section also serves as Certification from the Plan Sponsor that its component Health Programs have been amended to include the following limitations/restrictions:

- *Use and Further Disclosure:* The Company will not use or further disclose PHI other than as permitted or required by the Plan document or as required by all applicable law, including but not limited to the HIPAA privacy rules. When using or disclosing PHI or when requesting PHI from the Covered Programs, the Company will make reasonable efforts to limit the PHI to the minimum amount necessary to accomplish the intended purpose of the use, disclosure or request.
- *Agents and Subcontractors:* The Company will require any agents, including subcontractors, to whom it provides PHI received from the Covered Programs to sign Business Associate Agreements and to agree to the same restrictions and conditions that apply to the Employer, Company or Plan Sponsor with respect to such information.

  Questions regarding use of PHI should be directed to the Insurer or Third Party Administrator in question. The Insurer or Third Party Administrator will advise a Plan Participant who wants to exercise any of his/her rights concerning PHI, of the procedures to be followed.
- *Employment-Related Actions:* Except as permitted by the HIPAA privacy rules and other applicable federal and state privacy laws, the Company will not use PHI for employment-related actions and decisions, or in connection with any other employee benefit plan of the Company.
- *Reporting of Improper Use or Disclosure:* In accordance with (16 CFR Part 318), Health Breach Notification Rule, where applicable, agrees to notify both the participants, the Federal Trade Commission and Covered Programs of any use or disclosure of any PHI or electronic PHI provided for Plan Administration purposes that is inconsistent with the uses or disclosures provided for, or that represents a PHI Security Incident, or which the Plan Sponsor or any Business Associate of the Plan Sponsor becomes aware.

- *Adequate Separation. The Company will ensure that adequate protection of PHI and separation between the Covered Programs and the Company (i.e., a "firewall") is established and maintained.*
- *Comply with Individual's Privacy Rights:* The Company will make available PHI to comply with an individual's right to access PHI, or to amend PHI (and the Company will make any appropriate amendments); the Company will make available the information required to provide an accounting of disclosures when requested by an individual.
- *Information to HHS:* The Company will make its internal practices, books, and records relating to the use and disclosure of PHI received from the Health Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Health Plan with HIPAA's privacy requirements.
- *Return or Destroy PHI:* If feasible, the Company will return or destroy all PHI received from the Health Plan that the Company still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, it will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

2.14. COBRA

COBRA NOTICE

The Plan Administrator of any group health plan that is a Component Benefit Program under this Plan will provide (or have provided) to group health plan participants appropriate COBRA notices, if applicable, both upon initial enrollment and if a Qualifying Event occurs. Plan participants can request a copy of these COBRA notices from the Human Resources Department at any time.

2.15. STATEMENT OF ERISA RIGHTS

The Employee Retirement Income Security Act of 1974 (ERISA) provides that all Plan participants shall be entitled to the rights discussed below. Note that Cafeteria Plans, including any Dependent Care Flexible Spending Arrangement offered under the Cafeteria Plan, is not subject to ERISA.

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts and if the group has 100 or more participants, a copy of the latest annual report (Form 5500 Series) filed by the Plan with the US Department of Labor. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series, if 100 or more participants) and updated Summary Plan Description. Receive a summary of the Plan's annual financial report. If a pension plan is provided, obtain a statement telling you whether you have a right to receive a

pension at normal retirement age (age 65) and if so, what your benefits would be at normal retirement age if you stop working under the Plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every 12 months.

Foreign Language

This document contains a summary in English of your plan rights and benefits under the group health plan. If you have difficulty understanding any part of this document, contact the Plan Administrator indicated above.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interests of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension or welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a pension/welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the US Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefit Security Administration (EBSA) US Department of Labor, listed in your

telephone directory or (866) 444-3272. You may also obtain EBSA contact information at: https://www.dol.gov/ebsa/contactEBSA/consumerassistance.html. You may further obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the EBSA.

SECTION 3: GENERAL PROVISIONS

3.1. NO RIGHT TO EMPLOYMENT

Nothing contained in this Plan will be construed as a contract of employment between the Company and you, or as a right of any Employee to continue in the employment of the Company, or as a limitation of the right of the Company to discharge any of its employees, with or without cause "at will".

3.2. GOVERNING LAW

The Plan will be construed in accordance with and governed by the laws of the state or commonwealth of organization of the Plan Sponsor to the extent not preempted by federal law. The Plan hereby incorporates by reference any provisions required by state law to the extent not preempted by Federal law.

3.3. TAX EFFECT – NOTICE ABOUT PRE-TAX PAYMENTS AND POSSIBLE EFFECT ON FUTURE SOCIAL SECURITY BENEFITS

Where possible, the Company provides benefits under the Plan on a pre-tax basis in accordance with federal tax law. Some benefits may be obtained on an after tax basis. The Company does not represent or guarantee that any particular federal, state or local income, payroll, personal property or other tax consequence will result from participation in this Plan. You should consult with your professional tax advisor to determine the tax consequences of your participation in this Plan.

If this Plan allows you to pay for benefits on a pre-tax basis, you will not pay Social Security taxes on the pre-tax dollars you use to pay for coverage. As a result, the earnings used to calculate your Social Security benefits at retirement will not include these contributions. This could result in a small reduction in the Social Security benefit you receive at retirement. However, your savings on current taxes under the Plan normally will be greater than any eventual reduction in Social Security benefits.

3.4. REFUND OF PREMIUM CONTRIBUTIONS

For fully-insured component benefit programs, the Plan will comply with Department of Labor (DOL) guidance regarding refunds (e.g., dividends, demutualization, experience adjustments, and/or medical loss ratio rebates (MLR) of insurance premiums). To the extent that the Company receives rebates determined to be plan assets to the extent amounts are attributable to insurance premiums paid by Participants, the rebates will (a) be distributed within 90 days of receipt to the Participants covered by the policy to which the rebate relates under a reasonable, fair, and objective allocation method or (b) if distributing the rebates would not be cost-effective because the amounts are small or would give rise to tax consequences to the Participants, the rebates may be used to pay future Participant premiums or for benefit enhancements which benefit the

Participants covered by the policy to which the rebate relates. Such determination will be made by the Plan Administrator, acting in its fiduciary capacity, after weighing the cost to the Plan and the competing interest of participants. Any rebates attributable to insurance premiums paid by the Company shall be retained by the Company.

3.5. FACILITY OF PAYMENT

When, in the Company or its designated representative's opinion, any Participant under the Plan is under a legal disability or is incapacitated in any way so as to be unable to manage his financial affairs, the Company or its representative may direct that payments be made to such Participant's legal representative or withhold payment pending an adjudication of the Participant's legal capacity and the appointment of a legal representative. The Company or its designated representative may also direct that payment be applied for the benefit of the Participant any way the Company considers advisable. Any payment made by the Plan in good faith pursuant to this provision shall fully discharge the Plan, the Company or the Employer to the extent of such payment. Any payment requirement shall include payments to a Participant’s beneficiary in the case of death benefits paid under the Plan.

3.6. DATA

Participants who may receive benefits under the Plan must furnish the Company, or its designated representatives such documents, evidence, information, releases or authorizations, as it considers necessary or desirable for the purpose of administering the Plan, or to protect the Company. It shall be a condition of the Plan that each such person must furnish such information promptly and sign such documents as the Company may require before any benefits become payable under the Plan.

3.7. ELECTRONIC COMMUNICATIONS

Whenever an Employee, Participant, Spouse, other Dependent or beneficiary is required to provide information or perform a written process, the Plan Administrator may, in its discretion, permit or require that electronic means be used. In addition, meetings with the Plan Administrator may be held in person or through electronic or telephonic means or a combination thereof and written actions of the Plan Administrator may be taken using electronic or conventional means. In the use of electronic communication, the Plan Administrator shall follow all guidelines published by the Department of Labor and the Internal Revenue Service.

3.8. NON-ASSIGNABILITY AND SPENDTHRIFT CLAUSE

To the extent permitted by law, the benefits or payments under the Plan will not be subject to alienation, sale, assignment, pledge, attachment, garnishment, execution, encumbrance or other transfer, nor will they be subject to any claim by any creditor of any Participant under the Plan other than a physician or treatment facility so authorized by the Participant or to legal process by an creditor of any Participant (except in the case of death or obligations owed to the Company). Any attempt to circumvent these provisions shall be considered null and void.

3.9. SEVERABILITY OF PROVISIONS

If any provision of the Plan is held invalid or unenforceable, such invalidity or unenforceability will not affect any other provisions hereof, and the Plan will be construed and enforced as if such provisions had not been included.

3.10. EFFECT OF MISTAKES

In the event of a mistake as to the eligibility or participation of an Employee, or the allocations made to the account of any Participant, or the amount of distributions made or to be made to a Participant or other person, the Plan Administrator will, to the extent it deems possible, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as will in its judgment accord to such Participant or other person the credits to the account or distributions to which he is properly entitled under the Plan. Such action by the Administrator may include withholding of any amounts due the Plan or the Company from Compensation paid by the Company.

3.11. COMPLIANCE WITH STATE AND FEDERAL MANDATES

With respect to all Component Programs, the Plan will comply, to the extent applicable, with the requirements of all applicable laws, such as USERRA, COBRA, FMLA, HIPAA, WHCRA, the Health Information Technology for Economic and Clinical Health Act, the Newborns' and Mothers' Health Protection Act of 1996, as amended, the Mental Health Parity Act, the Mental Health Parity Addiction Equity Act, and the Genetic Information Nondiscrimination Act of 2008 ("GINA").

3.12. COMPONENT BENEFIT PROGRAM - PROVIDER COMPANIES

Type: Medical Insurance
Name of Provider: Providence Health Plan
Type or Plan Name: HSA Plan
Plan Funding: Fully-Insured, Group Medical Insurance
Policy Number: 100375
Administration: Shared between Rexius Forest By-Products, Inc. & Providence Health Plan
Provider Phone: (877) 245-4077
Provider URL: www.ProvidenceHealthPlan.com

Type: Medical Insurance
Name of Provider: Providence Health Plan
Type or Plan Name: PPO Plans
Plan Funding: Fully-Insured, Group Medical Insurance
Policy Number: 100375
Administration: Shared between Rexius Forest By-Products, Inc. & Providence Health Plan
Provider Phone: (877) 245-4077
Provider URL: www.providencehealthplan.com

Type: Dental Insurance
Name of Provider: Met Life Insurance
Plan Funding: Fully-Insured, Group Dental Insurance
Policy Number: 5596137
Administration: Shared between Rexius Forest By-Products, Inc. & Met Life Insurance
Provider Phone: (800) 275-4638
Provider URL: www.metlife.com/dental

Type: Vision
Name of Provider: Providence Health Plan
Plan Funding: Fully-Insured, Group Vision Insurance
Policy Number: 100375
Administration: Shared between Rexius Forest By-Products, Inc. & Providence Health Plan
Provider Phone: (877) 245-4077
Provider URL: www.providencehealthplan.com

Type: Life/AD&D
Name of Provider: Lincoln Financial
Policy Number: 100227713
Administration: Shared between Rexius Forest By-Products, Inc. & Lincoln Financial
Provider Phone: (800) 423-2765
Provider URL: www.LFG.com

Type: Supplemental
Type or Plan Name: Voluntary Worksite Benefits
Name of Provider: AFLAC
Policy Number: 0X7MB
Administration: Shared between Rexius Forest By-Products, Inc. & AFLAC
Provider Phone: (800) 992-3522
Provider URL: www.aflac.com

Type: Long-Term Disability
Name of Provider: Lincoln Financial
Policy Number: 100227715
Administration: Shared between Rexius Forest By-Products, Inc. & Lincoln Financial
Provider Phone: (800) 423-2765
Provider URL: www.LFG.com

Type: Short-Term Disability
Name of Provider: Lincoln Financial

Policy Number: 100227714
Administration: Shared between Rexius Forest By-Products, Inc. & Lincoln Financial
Provider Phone: (800) 423-2765
Provider URL: www.LFG.com

Health Savings Account (HSA)
Participants in the medical insurance may be eligible to participate in a Health Savings Account (HSA) allowing them to make contributions to the HSA which can be used towards eligible uncovered medical expenses (e.g. copays and deductibles).

For eligible employees, the employer makes a contribution towards HSAs in the amount of $160.00 for the employee only, $270.00 for the employee and spouse, $365.00 for the employee and family and $220.00 for the employee and child(ren) in a monthly period.

Employees must meet IRS requirements for an HSA and set up an account before contributions can be made.

Any late entrants will receive the monthly employer HSA contributions in accordance with their enrollment listed above the month they become eligible and enroll in coverage.

If any employee changes from employee only to family coverage or vice versa, the employer HSA contribution will change the same month the employee's medical plan election changes.

Type: Flexible Spending Account (FSA)
Name of Provider: PacificSource Administrators
Policy Number: FSA
Administration: Shared between Rexius Forest By-Products, Inc. & PacificSource Administrators
Provider Phone: (800) 422-7038
Provider URL: https://hrbenefitsdirect.com/PSA

Type: Telemedicine
Name of Provider: Express Care Virtual through Providence Health Plan
Plan Funding: Fully-Insured, Group Medical Insurance
Policy Number: 100375
Administration: Shared between Rexius Forest By-Products, Inc. & Express Care Virtual through Providence Health Plan
Provider Phone: (877) 245-4077
Provider URL: www.providencehealthplan.com

The Telemedicine plan benefit is part of the group health plan.

SECTION 4: DEFINITIONS

The following words and phrases used herein shall have the following meanings, unless a different meaning is plainly required by the context. Masculine pronouns used in this Plan shall include masculine and feminine gender unless the context indicates otherwise, and words in the singular also include the plural. These are general definitions and the presence of any definition in this section is not, in and of itself, an indication of the existence of a benefit.

"Cafeteria Plan" means a cafeteria plan under Code Section 125 sponsored by the Company.

"Claims Administrator" means the entity or provider responsible for reviewing and approving insurance claims.

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"Code" means the Internal Revenue Code of 1986, as amended.

"Company" means the entity or entities or any successor to it by merger, purchase or otherwise and any predecessor which has maintained this Plan or any corporation, sole proprietor, partnership or association that assumes the obligations of this Plan.

"Component Benefit Programs" are those benefit programs specified under Provider Companies and contained in previously provided documents, included with this document or available through the Plan Administrator.

"Component benefit program or plan documents" include certificates of insurance, group insurance contacts, ERISA plan documents (if self-funded) and governing benefit plan documents for non-insurance benefit programs.

"Dependent" means an Employee's Spouse or other dependents that satisfies the dependent eligibility requirements of the applicable insurance plans.

"Employee" means any current or former employee of the Employer who satisfies the eligibility provisions as specified in the applicable benefit plans. The determination of whether an individual is an Employee, an independent contractor or any other classification of worker or service provider and the determination of whether an individual is classified as a member of any particular classification of employees shall be made solely in accordance with the classifications used by the Company and shall not be dependent on, or change due to, the treatment of the individual for any purposes under the Code, common law or any other law, or any determination made by any court or government agency.

"Employer" means the Company and any related employers who are participating under this Plan.

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

"Form 5500" The Form 5500 Series is an important compliance, research, and disclosure tool for the Department of Labor, a disclosure document for plan participants and beneficiaries, and a source of information and data for

use by other Federal agencies, Congress, and the private sector in assessing employee benefit, tax, and economic trends and policies. For employers required to submit form 5500 reports (usually 100+ participants on any group plan as of the beginning of the plan year), this document is considered a "wrap" plan so the report is done on the wrap plan as a whole, not each individual plan.

"FMLA" means the Family Medical Leave Act of 1993, as amended. FMLA only applies to covered organizations with 50 or more employees within a 75 mile radius.

"GINA" means the Genetic Information Nondiscrimination Act of 2008.

"HCERA" means the Health Care and Education Reconciliation Act of 2010.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

"HITECH" means the Health Information Technology for Economic and Clinical Health Act.

"Hour of service" means (1) each hour for which an employee is paid, or entitled to payment, for the performance of duties for the employer, and (2) each hour for which an employee is paid, or entitled to payment, by the employer for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence. Hours of service for all employees are credited using actual hours of service from records of hours worked and hours for which payment is made or due.

"Insurer" means any insurance company, health maintenance organization, preferred provider organization or any similar organization with whom the Company has contracted for an insured or contractually-established benefit.

"MHPA" means the Mental Health Parity Act of 1996.

"MHPAEA" means the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act.

"New hire employee" means an employee who has been employed for less than one complete standard measurement period.

"Named Fiduciary" means the individual(s) or entity or entities responsible for either administering benefit plans or the insurance company providing coverage.

"NMHPA" means the Newborns' and Mothers' Health Protection Act of 1996, as amended.

"Ongoing employee" means an employee who has been employed for at least one complete standard measurement period.

"Participant" means an eligible enrolled Employee and/or eligible covered Dependents.

"Plan" means this employee benefit plan, which includes all benefits described in this document.

"Plan Administrator" means the person, the committee or the entity specified in this document to be the Administrator, as defined in ERISA Section 3(16)(A).

"Plan Year" means a twelve (12) month period specified in this document. The Plan Year also is the accounting period for the Plan.

"Protected Health Information" ("PHI") is individually identifiable health information that is maintained or transmitted by a covered entity, subject to specified exclusions as provided in 45 CFR § 150.103.

"PPACA" means the Patient Protection and Affordable Care Act.

"Spouse" means an individual who is legally married to a Participant as determined under Revenue Ruling 2013-17 or otherwise defined in component plan documents.

"Stability Period" means a designated period of not less than six months (and not less than the corresponding measurement period) during which the employer must offer coverage to all individuals identified as full-time employees during the measurement period, regardless of hours worked during the stability period.

"USERRA" means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

"Variable-hour employee" means a new employee if, based on the facts and circumstances at the employee's start date, the employer cannot determine whether the employee is reasonably expected to be employed on average at least 30 hours of service per week during the initial measurement period because the employee's hours are variable or otherwise uncertain. For purposes of determining whether an employee is a variable-hour employee, the likelihood that the employee may terminate employment before the end of the initial measurement period will not be considered.

"WHCRA" means the Women's Health and Cancer Rights Act of 1998, as amended.

SECTION 5: ADDENDUMS

5.1. FAMILIES FIRST CORONAVIRUS RESPONSE ACT (FFCRA) AND CORONAVIRUS AID RELIEF AND ECONOMIC SECURITY ACT (CARES) ADDENDUM

Sick Leave & Extended Family Medical Leave

In accordance with provisions of the Families First Response Act (FFCRA), qualifying employees may receive paid time off for eligible sick leave and extended family medical leave as explained in this notice: https://www.dol.gov/sites/dolgov/files/WHD/posters/FFCRA_Poster_WH1422_Non-Federal.pdf with the right to continue medical insurance while out on approved leave. If any of these leave provisions apply to eligible employees, they are to contact the Plan Administrator for leave approval, additional details, as well as information explaining how employee's share of insurance premiums will be handled, if applicable.

FFCRA and Cares ACT Provisions

The following provisions are added as part of changes related to the FFCRA and CARES Act. There benefits are subject to the Acts applicable timelines (e.g. FFCRA 4/1/20 to 12/31/20).

Health Savings Accounts for Telehealth Services

Participants who elect a high-deductible health plan (HDHP) with a health savings account (HSA), if applicable, will be allowed to cover telehealth services prior to a patient reaching the deductible, increasing access for patients who may have the COVID-19 virus and protecting other patients from potential exposure.

Over-the-Counter Medical Products without Prescription

Participants in Health Savings Accounts (HSAs) and Flexible Spending Accounts (FSAs), if applicable, are allowed to use funds for the purchase of over-the-counter medical products, and menstrual care products are now included under the term "qualified medical expenses", including those needed in quarantine and social distancing, without a prescription from the physician.

Coverage of Diagnostic Testing for COVID-19

Participants receiving testing for COVID-19 will be covered by private insurance plans without cost sharing, including those tests without a EUA by the FDA.

Pricing of Diagnostic Testing

For COVID-19 testing covered with no cost to patients, requires an insurer to pay either the rate specified in a contract between the provider and the insurer, or, if there is no contract, a cash price posted by the provider.

Rapid Coverage of Preventive Services and Vaccines for Coronavirus

Participants receive free coverage without cost-sharing of a vaccine within 15 days for COVID-19 that has in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force or a recommendation from the Advisory Committee on Immunization Practices (ACIP).

Rexius Forest By-Products, Inc. Group Benefit Plan
Plan Document and Summary Plan Description Wrap document
Signature Page

IN WITNESS WHEREOF, the Employer, has caused its plan administrator, duly authorized by the Employer, to execute the plan, effective on this 1st day of August, 2020

By: _____

Title: CFO

INSURANCE COVERAGE COST TO EMPLOYEE MONTHLY
(Full time positions of at least 30 hrs/wk – eligible 1st of month after 60 days from hire date which includes 30 day orientation period)

PROVIDENCE HEALTH PLAN ("BASE" PLAN)

8/01/20
Employee - Rate $582.01- Company pays $432.01; cost to hourly employee $150.00

Family Coverage - Rate $1660.23 - Company pays $432.01; cost to employee $1228.22

Employee & Children - Rate $1035.96 - Company pays $432.01; cost to employee $603.95

Employee & Spouse - Rate $1253.33 - Company pays $432.01; cost to employee $821.32.

Met Life (Dental)

8/01/20
Employee rate - $42.98 Employee pays all

Employee & Spouse - $84.24 Employee pays all

Family coverage - $132.20 Employee pays all

Employee & Children - $90.82 Employee pays all

Lincoln National Life Insurance Co. - LIFE - $20,000 & SHORT TERM DISABILITY

Employer covers cost

NOTE: An electronic version of the Rexius Employee Benefit Plan Summary Plan Description ("SPD") is available to all employees and the Company will provide a printed copy upon request.

Your Benefit Summary

Option Advantage Premium (B)

PROVIDENCE Health Plan

Copay	What You Pay In-Network	What You Pay Out-of-Network	Calendar Year In-Network Out-of-Pocket Maximum	Calendar Year Out-of-Network Out-of-Pocket Maximum	Calendar Year In-Network Deductible	Calendar Year Out-of-Network Deductible
$25	20% coinsurance (after deductible)	40% coinsurance (after deductible; UCR applies)	$5,000 per person $10,000 per family (2 or more)	$10,000 per person $20,000 per family (2 or more)	$2,000 per person $4,000 per family (2 or more)	$4,000 per person $8,000 per family (2 or more)

Important information about your plan

This summary provides only highlights of your benefits. To view your plan details, register and log in at www.myProvidence.com.

- The individual deductible applies if there are no dependents enrolled. If two or more members are enrolled, the individual deductible applies for each member only until the family deductible is met.
- The individual out-of-pocket maximum applies if there are no dependents enrolled. If two or more members are enrolled, the individual out-of-pocket applies for each member only until the family out-of-pocket is met.
- Your deductible(s) are included in the out-of-pocket maximum amount(s) listed above.
- In-network and out-of-network services accumulate separately.
- Some services and penalties do not apply to out-of-pocket maximums.
- Prior authorization is required for some services.
- To get the most out of your benefits, use the providers within the Providence Signature network. View a list of network providers and pharmacies at http://phppd.providence.org.
- If you choose to go outside the network, you may be subject to billing for charges that are above Usual, Customary and Reasonable charges (UCR). Benefits for out-of-network services are based on these UCR charges.
- Limitations and exclusions apply to your benefits. See your Member Handbook for details.

Option Advantage Premium (B) Benefit Highlights	After you pay your calendar year deductible(s), then you pay the following for covered services:	
✓ No deductible needs to be met prior to receiving this benefit.	In-Network Copay or Coinsurance (after deductible, when you see an in-network provider)	Out-of-Network Copay or Coinsurance (after deductible, when you see a non-network provider)
On-Demand Provider Visits		
• Virtual visits to a Primary Care Provider by phone & video (ExpressCare Virtual) or by Web-direct Visits (where available)	Covered in full✓	Not covered
• Providence ExpressCare Retail Health Clinic	Covered in full✓	Not applicable
• Virtual visits to a Specialist by phone & video	$10 / visit✓	Not covered
Preventive Care		
• Periodic health exams and well-baby care	Covered in full✓	40%✓
• Colonoscopy (age 50 +)	Covered in full✓	40%
• Routine immunizations; shots	Covered in full✓	40%✓
• Gynecological exam (calendar year) and PAP test	Covered in full✓	40%✓
• Mammograms	Covered in full✓	40%
• Nutritional counseling	Covered in full✓	40%✓
• Tobacco cessation, counseling/classes and deterrent medications	Covered in full✓	Not covered
Physician / Provider Services		
• Office visits to Primary Care Provider	$25 / visit✓	40%✓
• Office visits to Alternative Care Provider (such as Naturopath) (Chiropractic manipulation & acupuncture services are covered only if a separate benefit has been purchased by your employer. Consult your member materials for these benefits.)	$25 / visit✓	40%✓
• Office visits to Specialists/Other Providers	$25 / visit✓	40%✓
• Allergy shots and serums	20%✓	40%
• Infusions and injectable medications	20%	40%
• Surgery; anesthesia in an office or facility	20%	40%
• Inpatient hospital visits	20%	40%
Diagnostic Services		
• X-ray, lab services, and testing services (includes ultrasound)	20%✓	40%
• High-tech imaging services (such as PET, CT or MRI)	20%✓	40%

Option Advantage Premium (B) Benefit Highlights (continued)	In-Network Copay or Coinsurance	Out-of-Network Copay or Coinsurance
Emergency and Urgent Services		
• Emergency services (For emergency medical conditions only. If admitted to hospital, copayment is not applied; all services subject to inpatient benefits.)	$250✓	$250✓
• Urgent care services (for non-life threatening illness/minor injury)	$25 / visit✓	40%✓
• Emergency medical transportation (air and/or ground) (Emergency medical transportation is covered under your in-network benefit, regardless of whether or not the provider is an in-network provider)	20%	20%
Hospital Services		
• Inpatient/Observation care	20%	40%
• Rehabilitative care (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services.)	20%	40%
• Habilitative care (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services.)	20%	40%
• Skilled nursing facility (Limited to 60 days per calendar year)	20%	40%
• Temporomandibular joint (TMJ) services (Inpatient and/or outpatient services combined limit of $1,000 per calendar year/$5,000 per lifetime)	50%	Not covered
Outpatient Services		
• Outpatient surgery, infusion, dialysis, chemotherapy, radiation therapy (Prior authorization required for outpatient hospital-based infusions)	20%	40%
• Outpatient Surgery at an Ambulatory Surgical Center (ASC)	10%	40%
• Temporomandibular joint (TMJ) service (Inpatient and/or outpatient services combined limit of $1,000 per calendar year/$5,000 per lifetime)	50%	Not covered
• Colonoscopy (Non-preventive) at a Hospital-based facility	20%	40%
• Colonoscopy (Non-preventive) at an Ambulatory Surgical Center (ASC)	10%	40%
• Outpatient rehabilitative services: physical, occupational, and speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services)	20%✓	40%
• Outpatient habilitative services: physical, occupational and speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.)	20%✓	40%
• Cardiac rehabilitation (In-network, first 16 visits covered in full, deductible waived, then deductible and coinsurance)	20%	40%
Maternity Services		
• Prenatal office visits	Covered in full✓	40%
• Delivery and postnatal services	$250 / delivery✓	40%
• Inpatient hospital/facility services	20%	40%
• Routine newborn nursery care	20%✓	40%
Medical Equipment, Supplies and Devices		
• Medical equipment, appliances, prosthetics/orthotics and supplies (Hearing aids limited to 1 per ear every 3 calendar years)	20%	40%
• Diabetes supplies (such as lancets, test strips and needles)	20%✓	40%
• Removable custom shoe orthotics (Limited to $200 per calendar year)	20%✓	40%✓
• Oral Sleep Apnea Appliance (Out-of-Network limited to $2,000 per calendar year)	20%	40%
Mental Health / Chemical Dependency (All services, except outpatient provider office visits, must be prior authorized. For information, please call 800-711-4577.)		
• Inpatient and residential services	20%	40%
• Day treatment, intensive outpatient and partial hospitalization services	20%	40%
• Applied behavior analysis	20%	40%
• Outpatient provider office visits	$25 / visit✓	40%✓
Home Health and Hospice		
• Home health care	20%	40%
• Hospice care	Covered in full✓	Covered in full✓
Routine Vision Exam Provided by VSP VSP Choice Network (for Customer Service call 800-877-7195) Your copays do not apply to your plan's medical out-of-pocket maximums		
• Pediatric WellVision Exam® (under age 19) - Every 12 months	Covered in full✓	Covered up to $45✓
• Adult WellVision Exam® - Every 12 months	$10✓	Covered up to $45✓

Your Benefit Summary

Prescription Drug Plan - Formulary B

PROVIDENCE Health Plan

Important information about your plan

This summary provides only highlights of your pharmacy benefits. Certain limitations and exclusions apply. To view all your plan details, register and log in at www.myProvidence.com.

- Medicare Part D creditable.
- To find out how a drug is covered under your plan, view the complete formulary and pharmacy information available online at www.ProvidenceHealthPlan.com or call us.
- You have broad access to our network of participating pharmacies and their services at discounted rates. Pharmacies are designated as participating retail, preferred retail, specialty or mail-order pharmacies.
- View a list of participating pharmacies, including specialty pharmacies, at www.ProvidenceHealthPlan.com or call us.
- Not sure what a word or phrase means? See the back for the definitions used in this summary.
- Copayments and coinsurance apply to your medical plan out-of-pocket maximum.

	Copay or Coinsurance		
Drug Coverage Category	All Participating and Preferred Retail Pharmacies (for up to a 30-day supply)	All Mail Order and Preferred Retail Pharmacies (for up to a 90-day supply of maintenance prescriptions)	All Participating Specialty Pharmacies (for up to a 30-day supply of specialty drugs)
1 - Preferred generic drug	$10	$20	N/A
2 - Non-preferred generic drug	$15	$30	
3 - Preferred brand-name drug	$30	$60	
4 - Non-preferred brand-name drug	$60	$120	
5 - Specialty drugs	N/A	N/A	50% up to $200

What you need to know about drug coverage categories

- Both generic and brand-name drugs are covered subject to the terms of your plan.
- FDA-approved women's contraceptives, as listed on your formulary, are covered at no cost for up to a 12-month supply, after a 3-month initial fill, at any participating pharmacy.
- ACA Preventive Drugs are covered in full for up to a 30-day supply purchased at a participating / preferred retail pharmacy. Covered in full for up to a 90-day supply of maintenance drugs at a preferred retail or mail order pharmacy.
- If the cost of your prescription is less than your copay, you will only be charged the cost of the prescription.
- If your brand-name benefit includes a copayment or a coinsurance and you or your provider request or prescribe a brand-name drug when a generic is available, regardless of reason, you will be responsible for the cost difference between the brand-name and generic drug in addition to the brand-name drug copayment or coinsurance indicated on the benefit summary. Your total cost, however, will never exceed the actual cost of the drug.
- Compounded medications are prescriptions that are custom prepared by your pharmacist. They may be obtained at your participating pharmacy and must contain at least one FDA-approved drug to be eligible for coverage under your plan. Compounded medications are covered for up to a 30-day supply at a 50% coinsurance. Claims are subject to clinical review for medical necessity and are not guaranteed for payment.
- Specialty drugs are prescriptions that require special delivery, handling, administration and monitoring by your pharmacist and are limited to 30 days. In rare circumstances, specialty medications may be filled for a great than 30-day supply; in these cases, additional specialty cost-share(s) may apply.
- Self-administered chemotherapy drugs are covered under your pharmacy benefits or your medical benefits, whichever allows for your lowest out-of-pocket cost.
- Approved non-formulary medications will be covered at the non-preferred brand-name drug tier. Approved non-formulary specialty drugs will be covered at the specialty cost sharing tier.

Using your prescription drug benefit

- Your prescription drug benefit requires that you fill your prescriptions at a participating pharmacy.
- Be sure you present your current Providence Health Plan member identification card, along with your copay or coinsurance when you use a participating pharmacy.
- You may be assessed multiple copayments for a multi-use or unit-of-use container or package depending on the medication and the number of days supplied.
- You may purchase up to a 90-day supply of maintenance drugs using preferred retail or mail order pharmacy after the initial 30-day supply purchase. Not all drugs are considered maintenance prescriptions, including compounded drugs and drugs obtained from specialty pharmacies.
- Most specialty and chemotherapy drugs are only available at our designated specialty pharmacies. For more information, visit us online at www.ProvidenceHealthPlan.com.
- Diabetes supplies may be obtained at your participating pharmacy, and are subject to your group's medical supplies and devices benefits, limitations, and coinsurance. See your Member Handbook for details.
- Certain drugs, devices and supplies obtained from your pharmacy may apply toward your medical benefit.
- Self-injectable medications are only covered when they are being self-administered and labeled by the FDA for self-administration; in some cases, a prior authorization may be required for the drug. Documentation of self-administration may also be required. Drugs labeled for self-administration that are being administered by a provider will fall to your medical benefit.

Using your prescription drug formulary

- The Providence formulary is a list of FDA-approved prescription brand-name and generic drugs developed by physicians and pharmacists. It is designed to offer drug treatment choices for covered medical conditions.
- The formulary can help you and your physician choose effective medications that are less costly and minimize your out-of-pocket expense.
- Some prescription drugs require prior authorization or a formulary exception in order to be covered; these may include select formulary agents, non-formulary agents, step therapy, and/or quantity limits as listed in our Prescription Drug Formulary available on our website.
- Effective generic drug choices are available to treat most medical conditions. Visit www.ProvidenceHealthPlan.com for answers to frequently asked questions about both generic drugs and the formulary.

Ordering prescriptions by mail

- To order prescriptions by mail, your provider may call in the prescription or you can mail your prescription along with your member identification number to one of our participating mail-order pharmacies.
- To find participating mail-order pharmacy information visit us online at www.ProvidenceHealthPlan.com.

If you use a non-participating pharmacy

- Urgent or emergency medical situations may require that you use a non-participating pharmacy.
- If this occurs, you will need to pay full price for your prescription at the time of purchase. Reimbursement forms are available online.
- Reimbursement is subject to your plan's limitations and exclusions.

Base

7.1.4

Your Benefit Summary

Option Advantage Premium (B)

PROVIDENCE Health Plan

Copay	What You Pay In-Network	What You Pay Out-of-Network	Calendar Year In-Network Out-of-Pocket Maximum	Calendar Year Out-of-Network Out-of-Pocket Maximum	Calendar Year In-Network Deductible	Calendar Year Out-of-Network Deductible
$15	20% coinsurance (after deductible)	40% coinsurance (after deductible; UCR applies)	$3,500 per person $7,000 per family (2 or more)	$7,000 per person $14,000 per family (2 or more)	$1,500 per person $3,000 per family (2 or more)	$3,000 per person $6,000 per family (2 or more)

Important information about your plan

This summary provides only highlights of your benefits. To view your plan details, register and log in at www.myProvidence.com.

- The individual deductible applies if there are no dependents enrolled. If two or more members are enrolled, the individual deductible applies for each member only until the family deductible is met.
- The individual out-of-pocket maximum applies if there are no dependents enrolled. If two or more members are enrolled, the individual out-of-pocket applies for each member only until the family out-of-pocket is met.
- Your deductible(s) are included in the out-of-pocket maximum amount(s) listed above.
- In-network and out-of-network services accumulate separately.
- Some services and penalties do not apply to out-of-pocket maximums.
- Prior authorization is required for some services.
- To get the most out of your benefits, use the providers within the Providence Signature network. View a list of network providers and pharmacies at http://phppd.providence.org.
- If you choose to go outside the network, you may be subject to billing for charges that are above Usual, Customary and Reasonable charges (UCR). Benefits for out-of-network services are based on these UCR charges.
- Limitations and exclusions apply to your benefits. See your Member Handbook for details.

Option Advantage Premium (B) Benefit Highlights

✓ No deductible needs to be met prior to receiving this benefit.	After you pay your calendar year deductible(s), then you pay the following for covered services: In-Network Copay or Coinsurance (after deductible, when you see an in-network provider)	Out-of-Network Copay or Coinsurance (after deductible, when you see a non-network provider)
On-Demand Provider Visits		
• Virtual visits to a Primary Care Provider by phone & video (ExpressCare Virtual) or by Web-direct Visits (where available)	Covered in full✓	Not covered
• Providence ExpressCare Retail Health Clinic	Covered in full✓	Not applicable
• Virtual visits to a Specialist by phone & video	$5 / visit✓	Not covered
Preventive Care		
• Periodic health exams and well-baby care	Covered in full✓	40%✓
• Colonoscopy (age 50 +)	Covered in full✓	40%
• Routine immunizations; shots	Covered in full✓	40%✓
• Gynecological exam (calendar year) and PAP test	Covered in full✓	40%✓
• Mammograms	Covered in full✓	40%
• Nutritional counseling	Covered in full✓	40%✓
• Tobacco cessation, counseling/classes and deterrent medications	Covered in full✓	Not covered
Physician / Provider Services		
• Office visits to Primary Care Provider	$15 / visit✓	40%✓
• Office visits to Alternative Care Provider (such as Naturopath) (Chiropractic manipulation & acupuncture services are covered only if a separate benefit has been purchased by your employer. Consult your member materials for these benefits.)	$15 / visit✓	40%✓
• Office visits to Specialists/Other Providers	$15 / visit✓	40%✓
• Allergy shots and serums	20%✓	40%
• Infusions and injectable medications	20%	40%
• Surgery; anesthesia in an office or facility	20%	40%
• Inpatient hospital visits	20%	40%
Diagnostic Services		
• X-ray, lab services, and testing services (includes ultrasound)	20%✓	40%
• High-tech imaging services (such as PET, CT or MRI)	20%✓	40%

Option Advantage Premium (B) Benefit Highlights (continued)	In-Network Copay or Coinsurance	Out-of-Network Copay or Coinsurance
Emergency and Urgent Services		
• Emergency services (For emergency medical conditions only. If admitted to hospital, copayment is not applied; all services subject to inpatient benefits.)	$250✓	$250✓
• Urgent care services (for non-life threatening illness/minor injury)	$15 / visit✓	40%✓
• Emergency medical transportation (air and/or ground) (Emergency medical transportation is covered under your in-network benefit, regardless of whether or not the provider is an in-network provider)	20%	20%
Hospital Services		
• Inpatient/Observation care	20%	40%
• Rehabilitative care (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services.)	20%	40%
• Habilitative care (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services.)	20%	40%
• Skilled nursing facility (Limited to 60 days per calendar year)	20%	40%
• Temporomandibular joint (TMJ) services (Inpatient and/or outpatient services combined limit of $1,000 per calendar year/$5,000 per lifetime)	50%	Not covered
Outpatient Services		
• Outpatient surgery, infusion, dialysis, chemotherapy, radiation therapy (Prior authorization required for outpatient hospital-based infusions)	20%	40%
• Outpatient Surgery at an Ambulatory Surgical Center (ASC)	10%	40%
• Temporomandibular joint (TMJ) service (Inpatient and/or outpatient services combined limit of $1,000 per calendar year/$5,000 per lifetime)	50%	Not covered
• Colonoscopy (Non-preventive) at a Hospital-based facility	20%	40%
• Colonoscopy (Non-preventive) at an Ambulatory Surgical Center (ASC)	10%	40%
• Outpatient rehabilitative services: physical, occupational, and speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services)	20%✓	40%
• Outpatient habilitative services: physical, occupational and speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.)	20%✓	40%
• Cardiac rehabilitation (In-network, first 16 visits covered in full, deductible waived, then deductible and coinsurance)	20%	40%
Maternity Services		
• Prenatal office visits	Covered in full✓	40%
• Delivery and postnatal services	$150 / delivery✓	40%
• Inpatient hospital/facility services	20%	40%
• Routine newborn nursery care	20%✓	40%
Medical Equipment, Supplies and Devices		
• Medical equipment, appliances, prosthetics/orthotics and supplies (Hearing aids limited to 1 per ear every 3 calendar years)	20%	40%
• Diabetes supplies (such as lancets, test strips and needles)	20%✓	40%
• Removable custom shoe orthotics (Limited to $200 per calendar year)	20%✓	40%✓
• Oral Sleep Apnea Appliance (Out-of-Network limited to $2,000 per calendar year)	20%	40%
Mental Health / Chemical Dependency (All services, except outpatient provider office visits, must be prior authorized. For information, please call 800-711-4577.)		
• Inpatient and residential services	20%	40%
• Day treatment, intensive outpatient and partial hospitalization services	20%	40%
• Applied behavior analysis	20%	40%
• Outpatient provider office visits	$15 / visit✓	40%✓
Home Health and Hospice		
• Home health care	20%	40%
• Hospice care	Covered in full✓	Covered in full✓
Routine Vision Exam Provided by VSP VSP Choice Network (for Customer Service call 800-877-7195) Your copays do not apply to your plan's medical out-of-pocket maximums		
• Pediatric WellVision Exam® (under age 19) - Every 12 months	Covered in full✓	Covered up to $45✓
• Adult WellVision Exam® - Every 12 months	$10✓	Covered up to $45✓

Your Benefit Summary

Prescription Drug Plan - Formulary B

PROVIDENCE Health Plan

Important information about your plan

This summary provides only highlights of your pharmacy benefits. Certain limitations and exclusions apply. To view all your plan details, register and log in at www.myProvidence.com.

- Medicare Part D creditable.
- To find out how a drug is covered under your plan, view the complete formulary and pharmacy information available online at www.ProvidenceHealthPlan.com or call us.
- You have broad access to our network of participating pharmacies and their services at discounted rates. Pharmacies are designated as participating retail, preferred retail, specialty or mail-order pharmacies.
- View a list of participating pharmacies, including specialty pharmacies, at www.ProvidenceHealthPlan.com or call us.
- Not sure what a word or phrase means? See the back for the definitions used in this summary.
- Copayments and coinsurance apply to your medical plan out-of-pocket maximum.

	Copay or Coinsurance		
Drug Coverage Category	All Participating and Preferred Retail Pharmacies (for up to a 30-day supply)	All Mail Order and Preferred Retail Pharmacies (for up to a 90-day supply of maintenance prescriptions)	All Participating Specialty Pharmacies (for up to a 30-day supply of specialty drugs)
1 - Preferred generic drug	$10	$20	N/A
2 - Non-preferred generic drug	$15	$30	
3 - Preferred brand-name drug	$30	$60	
4 - Non-preferred brand-name drug	$60	$120	
5 - Specialty drugs	N/A	N/A	50% up to $200

What you need to know about drug coverage categories

- Both generic and brand-name drugs are covered subject to the terms of your plan.
- FDA-approved women's contraceptives, as listed on your formulary, are covered at no cost for up to a 12-month supply, after a 3-month initial fill, at any participating pharmacy.
- ACA Preventive Drugs are covered in full for up to a 30-day supply purchased at a participating / preferred retail pharmacy. Covered in full for up to a 90-day supply of maintenance drugs at a preferred retail or mail order pharmacy.
- If the cost of your prescription is less than your copay, you will only be charged the cost of the prescription.
- If your brand-name benefit includes a copayment or a coinsurance and you or your provider request or prescribe a brand-name drug when a generic is available, regardless of reason, you will be responsible for the cost difference between the brand-name and generic drug in addition to the brand-name drug copayment or coinsurance indicated on the benefit summary. Your total cost, however, will never exceed the actual cost of the drug.
- Compounded medications are prescriptions that are custom prepared by your pharmacist. They may be obtained at your participating pharmacy and must contain at least one FDA-approved drug to be eligible for coverage under your plan. Compounded medications are covered for up to a 30-day supply at a 50% coinsurance. Claims are subject to clinical review for medical necessity and are not guaranteed for payment.
- Specialty drugs are prescriptions that require special delivery, handling, administration and monitoring by your pharmacist and are limited to 30 days. In rare circumstances, specialty medications may be filled for a great than 30-day supply; in these cases, additional specialty cost-share(s) may apply.
- Self-administered chemotherapy drugs are covered under your pharmacy benefits or your medical benefits, whichever allows for your lowest out-of-pocket cost.
- Approved non-formulary medications will be covered at the non-preferred brand-name drug tier. Approved non-formulary specialty drugs will be covered at the specialty cost sharing tier.

Using your prescription drug benefit

- Your prescription drug benefit requires that you fill your prescriptions at a participating pharmacy.
- Be sure you present your current Providence Health Plan member identification card, along with your copay or coinsurance when you use a participating pharmacy.
- You may be assessed multiple copayments for a multi-use or unit-of-use container or package depending on the medication and the number of days supplied.
- You may purchase up to a 90-day supply of maintenance drugs using preferred retail or mail order pharmacy after the initial 30-day supply purchase. Not all drugs are considered maintenance prescriptions, including compounded drugs and drugs obtained from specialty pharmacies.
- Most specialty and chemotherapy drugs are only available at our designated specialty pharmacies. For more information, visit us online at www.ProvidenceHealthPlan.com.
- Diabetes supplies may be obtained at your participating pharmacy, and are subject to your group's medical supplies and devices benefits, limitations, and coinsurance. See your Member Handbook for details.
- Certain drugs, devices and supplies obtained from your pharmacy may apply toward your medical benefit.
- Self-injectable medications are only covered when they are being self-administered and labeled by the FDA for self-administration; in some cases, a prior authorization may be required for the drug. Documentation of self-administration may also be required. Drugs labeled for self-administration that are being administered by a provider will fall to your medical benefit.

Using your prescription drug formulary

- The Providence formulary is a list of FDA-approved prescription brand-name and generic drugs developed by physicians and pharmacists. It is designed to offer drug treatment choices for covered medical conditions.
- The formulary can help you and your physician choose effective medications that are less costly and minimize your out-of-pocket expense.
- Some prescription drugs require prior authorization or a formulary exception in order to be covered; these may include select formulary agents, non-formulary agents, step therapy, and/or quantity limits as listed in our Prescription Drug Formulary available on our website.
- Effective generic drug choices are available to treat most medical conditions. Visit www.ProvidenceHealthPlan.com for answers to frequently asked questions about both generic drugs and the formulary.

Ordering prescriptions by mail

- To order prescriptions by mail, your provider may call in the prescription or you can mail your prescription along with your member identification number to one of our participating mail-order pharmacies.
- To find participating mail-order pharmacy information visit us online at www.ProvidenceHealthPlan.com.

If you use a non-participating pharmacy

- Urgent or emergency medical situations may require that you use a non-participating pharmacy.
- If this occurs, you will need to pay full price for your prescription at the time of purchase. Reimbursement forms are available online.
- Reimbursement is subject to your plan's limitations and exclusions.

Your Benefit Summary

HSA Qualified Plan – Embedded – Formulary F

PROVIDENCE Health Plan

What You Pay In-Network	What You Pay Out-of-Network	Calendar Year Common Out-of-Pocket Maximum	Calendar Year Common Deductible
20% coinsurance (after deductible)	40% coinsurance (after deductible; UCR applies)	$5,500 per person $11,000 per family (2 or more)	$2,800 per person $5,600 per family (2 or more)

Important information about your plan

This summary provides only highlights of your benefits. To view your plan details, register and log in at www.myProvidence.com.

- The embedded individual deductible applies if there are no dependents enrolled. If two or more members are enrolled, the individual deductible applies for each member only until the family deductible is met.
- The embedded individual out-of-pocket maximum applies if there are no dependents enrolled. If two or more members are enrolled, the individual out-of-pocket applies for each member only until the family out-of-pocket is met.
- Your deductible(s) are included in the out-of-pocket maximum amount(s) listed above.
- In-network and out-of-network services accumulate toward your common out-of-pocket maximum.
- Not Medicare Part D creditable
- To find if a drug is covered under your plan, check online at www.ProvidenceHealthPlan.com/pharmacy.
- If you or your provider request or prescribe a brand-name drug when a generic is available, regardless of reason, you will be responsible for the cost difference between the brand-name and generic drug in addition to the brand-name drug copayment or coinsurance indicated on the benefit summary. Your total cost, however, will never exceed the actual cost of the drug.
- Prior authorization is required for some services.
- To get the most out of your benefits, use the providers within the Providence Signature network. View a list of network providers and pharmacies at http://phppd.providence.org.
- If you choose to go outside the network, you may be subject to billing for charges that are above Usual, Customary and Reasonable charges (UCR). Benefits for out-of-network services are based on these UCR charges.
- Limitations and exclusions apply to your benefits. See your Member Handbook for details.

HSA Qualified Plan – Embedded Benefit Highlights	After you pay your calendar year common deductible, then you pay the following for covered services:	
✓ No deductible needs to be met prior to receiving this benefit.	In-Network Coinsurance (after deductible, when you see an in-network provider)	Out-of-Network Coinsurance (after deductible, when you see a non-network provider)
On-Demand Provider Visits		
• Virtual visits to a Primary Care Provider by phone & video (ExpressCare Virtual) or by Web-direct Visits (where available)	Covered in full	Not covered
• Providence ExpressCare Retail Health Clinic	Covered in full	Not applicable
• Virtual visits to a Specialist by phone & video	5%	Not covered
Preventive Care		
• Periodic health exams and well-baby care	Covered in full✓	40%
• Routine immunizations; shots	Covered in full✓	40%
• Colonoscopy (age 50 +)	Covered in full✓	40%
• Gynecological exam (calendar year) and PAP test	Covered in full✓	40%
• Mammograms	Covered in full✓	40%
• Nutritional counseling	Covered in full✓	40%
• Tobacco cessation, counseling/classes and deterrent medications	Covered in full✓	Not covered
Physician / Provider Services		
• Office visits to Primary Care Provider	20%	40%
• Office visits to Alternative Care Provider (such as Naturopath) (Chiropractic manipulation & acupuncture services are covered only if a separate benefit has been purchased by your employer. Consult your member materials for these benefits.)	20%	40%
• Office visits to Specialists/Other Providers	20%	40%
• Allergy shots and serums	20%	40%
• Infusions and injectable medications	20%	40%
• Surgery; anesthesia in an office or facility	20%	40%
• Inpatient hospital visits	20%	40%
Diagnostic Services		
• X-ray, lab services, and testing services (includes ultrasound)	20%	40%
• High-tech imaging services (such as PET, CT or MRI)	20%	40%

HSA Qualified Plan – Embedded Benefit Highlights (continued)	In-Network Coinsurance	Out-of-Network Coinsurance
Prescription Drugs (Up to a 30-day supply/retail and preferred retail pharmacies; 90-day supply/mail-order and preferred retail pharmacies)		
Safe Harbor drugs are exempt from the deductible, subject to the formulary and applicable tier cost share		
• ACA Preventive drugs	Covered in full✓	Not covered
• Preferred generic drugs	20%	Not covered
• Non-preferred generic drugs	20%	Not covered
• Preferred brand-name drugs	20%	Not covered
• Non-preferred brand-name drugs	20%	Not covered
• Specialty drugs (specialty drugs are limited to a 30-day supply and must be obtained through a contracted specialty pharmacy)	50% up to $200	Not covered
• Compounded drugs (compounded drugs are limited to 30-day supply and must be obtained at a retail/preferred retail pharmacy)	50%	Not covered
Emergency and Urgent Services		
• Emergency services (for emergency medical conditions only. If admitted to hospital, all services subject to inpatient benefits.)	20%	20%
• Urgent care services (for non-life threatening illness/minor injury)	20%	40%
• Emergency medical transportation (air and/or ground) (Emergency medical transportation is covered under your in-network benefit, regardless of whether or not the provider is an in-network provider)	20%	20%
Hospital Services		
• Inpatient/Observation care	20%	40%
• Rehabilitative care (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services.)	20%	40%
• Habilitative care (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services.)	20%	40%
• Skilled nursing facility (Limited to 60 days per calendar year)	20%	40%
• Temporomandibular joint (TMJ) services (Inpatient and/or outpatient services combined limit of $1,000 per calendar year/$5,000 per lifetime)	50%	Not covered
Outpatient Services		
• Outpatient surgery, infusion, dialysis, chemotherapy, radiation therapy (Prior authorization required for outpatient hospital-based infusions)	20%	40%
• Outpatient Surgery at an Ambulatory Surgical Center (ASC)	10%	40%
• Colonoscopy (Non-preventive) at a Hospital-based facility	20%	40%
• Colonoscopy (Non-preventive) at an Ambulatory Surgical Center (ASC)	10%	40%
• Temporomandibular joint (TMJ) services (Inpatient and/or outpatient services combined limit of $1,000 per calendar year/$5,000 per lifetime)	50%	Not covered
• Outpatient rehabilitative services: physical, occupational, and speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services)	20%	40%
• Outpatient habilitative services: physical, occupational and speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.)	20%	40%
• Cardiac rehabilitation	20%	40%
Maternity Services		
• Prenatal office visits	Covered in full✓	40%
• Delivery and postnatal services	20%	40%
• Inpatient hospital/facility services	20%	40%
• Routine newborn nursery care	20%	40%
Medical Equipment, Supplies and Devices		
• Medical equipment, appliances, prosthetics/orthotics and supplies (Hearing aids limited to 1 per ear every 3 calendar years)	20%	40%
• Diabetes supplies (such as lancets, test strips and needles)	20%✓	40%
• Removable custom shoe orthotics (Limited to $200 per calendar year)	20%	40%
• Oral Sleep Apnea Appliance (Out-of-Network limited to $2,000 per calendar year)	20%	40%
Mental Health / Chemical Dependency (All services, except outpatient provider office visits, must be prior authorized. For information, please call 800-711-4577.)		
• Inpatient and residential services	20%	40%
• Day treatment, intensive outpatient and partial hospitalization services	20%	40%
• Applied behavior analysis	20%	40%
• Outpatient provider office visits	20%	40%

HSA Qualified Plan – Embedded Benefit Highlights (continued)	In-Network Coinsurance	Out-of-Network Coinsurance
Home Health and Hospice		
• Home health care	20%	40%
• Hospice care	Covered in full	Covered in full
Routine Vision Exam		
Provided by VSP		
VSP Choice Network (for Customer Service call 800-877-7195)		
Your copays do not apply to your plan's medical out-of-pocket maximums		
• Pediatric WellVision Exam® (under age 19) - Every 12 months	Covered in full✓	Covered up to $45✓
• Adult WellVision Exam® - Every 12 months	$10✓	Covered up to $45✓

Your guide to the words or phrases used to explain your benefits

ACA Preventive drug
Affordable Care Act (ACA) preventive drugs are medications, including contraceptives, that are listed in our formulary as such, and are covered at no cost when received from Participating Pharmacies.
Over-the-counter preventive drugs received from Participating Pharmacies require a written prescription from your Qualified Provider to be covered in full under this benefit.

Coinsurance
The percentage of the cost that you may need to pay for a covered service.

Common deductible
The dollar amount that an individual or family pays for covered services before your plan pays any benefits within a calendar year. The deductible can be met by using in-network or out-of-network providers, or the combination of both. The following expenses do not apply to an individual or family deductible:

- Services not covered by your plan
- Fees that exceed usual, customary and reasonable (UCR) charges as established by your plan
- Penalties incurred if you do not follow your plan's prior authorization requirements
- Copays and coinsurance for services that do not apply to the deductible

Common out-of-pocket maximum
The limit on the dollar amount you will have to spend for specified covered health services (a combination of both in- and out-of-network services) in a calendar year. Some services and expenses do not apply to the common out-of-pocket maximum. See your Member Handbook for details.

Copay
The fixed dollar amount you pay to a health care provider for a covered service at the time care is provided.

Formulary
A formulary is a list of FDA-approved prescription drugs developed by physicians and pharmacists, designed to offer drug treatment choices for covered medical conditions. The Providence Health Plan formulary includes both brand-name and generic medications.

Maintenance drug
Medications that are typically prescribed to treat long-term or chronic conditions, such as diabetes, high blood pressure and high cholesterol. Maintenance drugs are those that you have received under our plan for at least 30 days and that you anticipate continuing to use in the future. Not all drugs are considered maintenance prescriptions, including compounded drugs and drugs obtained from specialty pharmacies.

Health Savings Account (HSA)
Employee-owned bank accounts where money is deposited – by employees, employers and even family members – to be used for employees' current and future health care expenses. Contributions can be deducted pre-tax from paychecks, and the money rolls over year to year and stays with the employee even with job changes and retirement.

In-Network
Refers to services received from an extensive network of highly qualified physicians, health care providers and facilities contracted by Providence Health Plan for your specific plan. Generally, your out-of-pocket costs will be less when you receive covered services from in-network providers. balance billing may apply. To find an in-network provider, go to www.ProvidenceHealthPlan.com/providerdirectory.

Limitations and Exclusions
All covered services are subject to the limitations and exclusions specified for your plan. Refer to your member handbook or contract for a complete list.

Out-of-network
Refers to services you receive from providers not in your plan's network. Your out-of-pocket costs are generally higher when you receive covered services outside of your plan's network. An out-of-network provider does not have contracted rates with Providence Health Plan and so balance billing may apply. To find an in-network provider, go to http://phppd.providence.org.

Preferred brand-name drug / Non-preferred brand-name drug
Brand name drugs are protected by U.S. patent laws and only a single manufacturer has the rights to produce and sell them. Generally your out-of-pocket costs will be less for preferred brand-name drugs.

Preferred generic drug / Non-preferred generic drug
Generic drugs have the same active-ingredient formula as the brand-name drug. Generic drugs are usually available after the brand-name patent expires. Generally your out-of-pocket costs will be less for Preferred generic drugs.

Prescription Drug Prior Authorization
The process used to request an exception to the Providence Health Plan drug formulary. This process can be initiated by the prescriber of the medication. Some drugs require prior authorization for medical necessity, place of therapy, length of therapy, step therapy or number of doses.

Primary Care Provider
A qualified physician or practitioner that can provide most of your care and, when necessary, will coordinate care with other providers in a convenient and cost-effective manner.

Prior authorization
Some services must be pre-approved. In-network, your provider will request prior authorization. Out-of-network, you are responsible for obtaining prior authorization.

Retail Health Clinic
A walk-in health clinic, other than an office, urgent care facility, pharmacy or independent clinic that is located within a retail operation. A Retail Health Clinic provides same-day visits for basic illness and injuries or preventive services.

Safe Harbor Preventive drugs
The Internal Revenue Code governing HSA-Qualified plans provides for a "safe harbor" for qualifying preventive medications, allowing these medications to be exempt from the deductible. Safe Harbor Preventive drugs do not include any medication used to treat an existing illness, injury or condition. Safe Harbor Preventive drugs are subject to formulary and tier status, as well as pharmacy management programs (i.e. prior authorization, step therapy, quantity limits).

Usual, Customary & Reasonable (UCR)
Describes your plan's allowed charges for services that you receive from an out-of-network provider. When the cost of out-of-network services exceeds UCR amounts, you are responsible for paying the provider any difference. These amounts do not apply to your out-of-pocket maximums.

Virtual visit
Visit with a Network Provider using secure internet technology such as Providence Express Care phone and video visits or Web-direct Visits.

Web-direct Visit
A consultation with Network Provider using an online questionnaire to collect information to diagnose and treat common conditions such as cold, flu, sore throat, allergies, earaches, sinus pain or UTI.

Contact us

Headquartered in Portland, our customer service professionals have been proudly serving our members since 1986.

Portland Metro Area: 503-574-7500
All other areas: 800-878-4445
TTY: 503-574-8702 or 888-244-6642

Have questions about your benefits and want to contact us via e-mail? Go to our Web site at:
www.ProvidenceHealthPlan.com/contactus

Non-discrimination Statement

Providence Health Plan and Providence Health Assurance comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Providence Health Plan and Providence Health Assurance do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Providence Health Plan and Providence Health Assurance:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you are a Medicare member who needs these services, call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. Hearing impaired members may call our TTY line at 711.

If you believe that Providence Health Plan or Providence Health Assurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Non-discrimination Coordinator by mail:

Providence Health Plan and Providence Health Assurance
Attn: Non-discrimination Coordinator
PO Box 4158
Portland, OR 97208-4158

If you need help filing a grievance, and you are a Medicare member call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. (TTY line at 711) for assistance. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW - Room 509F HHH Building
Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TTY)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

HSA
7.1.13

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.ProvidenceHealthPlan.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-878-4445 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**In-Network: $2,000**/per person **$4,000**/per family (**2** or more) **Out-of-Network: $4,000**/per person **$8,000**/per family (**2** or more).	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	**Yes.** Office visits, most preventive care, emergency and urgent care services.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	**No.**	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**In-Network: $5,000**/per person **$10,000**/per family (**2** or more) **Out-of-Network: $10,000**/per person **$20,000**/per family (**2** or more).	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, penalties, copays or coinsurance for Supplemental Benefits, services not covered, fees above UCR.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	**Yes.** For a list of participating providers see http://phppd.providence.org/ or call 1-800-878-4445.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your providers before you get services.
Do you need a referral to see a specialist?	**No.**	You can see the specialist you choose without a referral.

Base 4.1.17

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit	40% coinsurance	Deductible does not apply. Some services such as lab and x-ray will include additional member costs. Phone and video visits are covered in full in-network.
	Specialist visit	$25 copay/visit	40% coinsurance	Deductible does not apply. Some services such as lab and x-ray will include additional member costs.
	Preventive care/screening/ immunization	No charge	40% coinsurance	Deductible does not apply. Some preventive services will include additional member costs. For more information see: https://healthplans.providence.org/pdfs/members/documents/preventive-care-costs.pdf.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Deductible does not apply in-network.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Deductible does not apply in-network. Prior authorization required.

Boise 4.1.15

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.ProvidenceHealthPlan.com	Preferred generic drug	$10 copay retail $20 copay mail order	Not covered	ACA Preventive drugs are covered in full in-network. Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription). Prior authorization may apply. If a brand name drug is requested when a generic is available, you will pay the difference in cost, plus your copay. Specialty drugs can only be purchased at a participating specialty pharmacy.
	Non-preferred generic drug	$15 copay retail $30 copay mail order	Not covered	
	Preferred brand-name drug	$30 copay retail $60 copay mail order	Not covered	
	Non-preferred brand-name drug	$60 copay retail $120 copay mail order	Not covered	
	Specialty drug	50% coinsurance up to $200 retail	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory surgery center: 10% coinsurance Hospital-based facility: 20% coinsurance	40% coinsurance	Prior authorization required.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	$250 copay	$250 copay	Deductible does not apply. For emergency medical conditions only. If admitted to hospital, copayment is not applied; all services subject to inpatient benefits.
	Emergency medical transportation	20% coinsurance	20% coinsurance	——————none——————
	Urgent care	$25 copay/visit	40% coinsurance	Deductible does not apply. Some services will include additional member costs.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Prior authorization required.

Base 9.1.14

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/provider office visit 20% coinsurance all other services	40% coinsurance	All services except provider office visits must be prior authorized. Deductible does not apply to provider office visits. See your benefit summary for ABA services.
	Inpatient services	20% coinsurance	40% coinsurance	
If you are pregnant	Office visits	No charge	40% coinsurance	Deductible does not apply in-network.
	Childbirth/delivery professional services	$250 copay	40% coinsurance	Copay applies to provider delivery charges. Deductible does not apply in-network.
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	——————none——————
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	——————none——————
	Rehabilitation services	20% coinsurance	40% coinsurance	Inpatient services: coverage limited to 30 days per calendar year. Outpatient services: coverage limited to 30 visits per calendar year. Deductible does not apply in-network. Limits do not apply to Mental Health Services.
	Habilitation services	20% coinsurance	40% coinsurance	Inpatient services: coverage limited to 30 days per calendar year. Outpatient services: coverage limited to 30 visits per calendar year. Deductible does not apply in-network. Limits do not apply to Mental Health Services.
	Skilled nursing care	20% coinsurance	40% coinsurance	Prior authorization required. Coverage is limited to 60 days per calendar year.

Base 4.1.17

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Durable medical equipment	20% coinsurance	40% coinsurance	Deductible does not apply to diabetes supplies from in-network providers.
	Hospice services	No charge	No charge	Deductible does not apply.
If your child needs dental or eye care	Children's eye exam	No charge	Covered up to $45	Deductible does not apply. Limited to 1 exam every 12 months.
	Children's glasses	Not covered	Not covered	No coverage for glasses.
	Children's dental check-up	Not covered	Not covered	No coverage for dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Bariatric surgery
- Cosmetic surgery (with certain exceptions)
- Dental care (Adult)
- Dental check-up (Child)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine foot care (covered for diabetics)
- Voluntary termination of pregnancy
- Weight loss programs

Base 4.1.18

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (limits apply)
- Chiropractic care (limits apply)
- Hearing Aids (limits apply)
- Non-emergency care when traveling outside the U.S. See www.ProvidenceHealthPlan.com
- Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or http://www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or http://www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Providence Health Plan at 1-800-878-4445, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol.gov/ebsa/healthreform, or you can contact the Oregon Insurance Division by:

- Calling (503) 947-7984 or the toll free message line at (888) 877-4894
- Writing to the Oregon Insurance Division, Consumer Protection Unit, 350 Winter Street NE, Salem, OR 97301-3883
- Through the Internet at http://dfr.oregon.gov/gethelp/ins-help/health/Pages/index.aspx
- E-mail at: cp.ins@state.or.us

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

Base 1.1.19

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$2,000
Specialist *copayment*	$25
Hospital (facility) *coinsurance*	20%
Other *coinsurance*	20%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$340
Coinsurance	$2,001
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,401**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$2,000
Specialist *copayment*	$25
Hospital (facility) *coinsurance*	20%
Other *coinsurance*	20%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$950
Coinsurance	$372
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,378**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$2,000
Specialist *copayment*	$25
Hospital (facility) *coinsurance*	20%
Other *coinsurance*	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,960**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,109
Copayments	$75
Coinsurance	$326
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,510**

Base 4.1.20

The plan would be responsible for the other costs of these EXAMPLE covered services.

Non-Discrimination Statement:

Providence Health Plan and Providence Health Assurance comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Providence Health Plan and Providence Health Assurance do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Providence Health Plan and Providence Health Assurance:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you are a Medicare member who needs these services, call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. Hearing impaired members may call our TTY line at 711.

If you believe that Providence Health Plan or Providence Health Assurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Non-discrimination Coordinator by mail:

Providence Health Plan and Providence Health Assurance
Attn: Non-discrimination Coordinator
PO Box 4158
Portland, OR 97208-4158

If you need help filing a grievance, and you are a Medicare member call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. (TTY line at 711) for assistance. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW - Room 509F HHH Building
Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TTY)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.ProvidenceHealthPlan.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-878-4445 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$1,500**/per person **$3,000**/per family (2 or more) Out-of-Network: **$3,000**/per person **$6,000**/per family (2 or more).	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	**Yes.** Office visits, most preventive care, emergency and urgent care services.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	**No.**	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: **$3,500**/per person **$7,000**/per family (2 or more) Out-of-Network: **$7,000**/per person **$14,000**/per family (2 or more).	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, penalties, copays or coinsurance for Supplemental Benefits, services not covered, fees above UCR.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	**Yes.** For a list of participating providers see http://phppd.providence.org/ or call 1-800-878-4445.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your providers before you get services.
Do you need a referral to see a specialist?	**No.**	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay/visit	40% coinsurance	Deductible does not apply. Some services such as lab and x-ray will include additional member costs. Phone and video visits are covered in full in-network.
	Specialist visit	$15 copay/visit	40% coinsurance	Deductible does not apply. Some services such as lab and x-ray will include additional member costs.
	Preventive care/screening/ immunization	No charge	40% coinsurance	Deductible does not apply. Some preventive services will include additional member costs. For more information see: https://healthplans.providence.org/pdfs/members/documents/preventive-care-costs.pdf.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Deductible does not apply in-network.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Deductible does not apply in-network. Prior authorization required.

4.1.23 (buy-up)

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.ProvidenceHealthPlan.com	Preferred generic drug	$10 copay retail $20 copay mail order	Not covered	ACA Preventive drugs are covered in full in-network. Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription). Prior authorization may apply. If a brand name drug is requested when a generic is available, you will pay the difference in cost, plus your copay. Specialty drugs can only be purchased at a participating specialty pharmacy.
	Non-preferred generic drug	$15 copay retail $30 copay mail order	Not covered	
	Preferred brand-name drug	$30 copay retail $60 copay mail order	Not covered	
	Non-preferred brand-name drug	$60 copay retail $120 copay mail order	Not covered	
	Specialty drug	50% coinsurance up to $200 retail	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory surgery center: 10% coinsurance Hospital-based facility: 20% coinsurance	40% coinsurance	Prior authorization required.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	$250 copay	$250 copay	Deductible does not apply. For emergency medical conditions only. If admitted to hospital, copayment is not applied; all services subject to inpatient benefits.
	Emergency medical transportation	20% coinsurance	20% coinsurance	——————none——————
	Urgent care	$15 copay/visit	40% coinsurance	Deductible does not apply. Some services will include additional member costs.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Prior authorization required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay/provider office visit 20% coinsurance all other services	40% coinsurance	All services except provider office visits must be prior authorized. Deductible does not apply to provider office visits. See your benefit summary for ABA services.
	Inpatient services	20% coinsurance	40% coinsurance	
If you are pregnant	Office visits	No charge	40% coinsurance	Deductible does not apply in-network.
	Childbirth/delivery professional services	$150 copay	40% coinsurance	Copay applies to provider delivery charges. Deductible does not apply in-network.
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	——————none——————
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	——————none——————
	Rehabilitation services	20% coinsurance	40% coinsurance	Inpatient services: coverage limited to 30 days per calendar year. Outpatient services: coverage limited to 30 visits per calendar year. Deductible does not apply in-network. Limits do not apply to Mental Health Services.
	Habilitation services	20% coinsurance	40% coinsurance	Inpatient services: coverage limited to 30 days per calendar year. Outpatient services: coverage limited to 30 visits per calendar year. Deductible does not apply in-network. Limits do not apply to Mental Health Services.
	Skilled nursing care	20% coinsurance	40% coinsurance	Prior authorization required. Coverage is limited to 60 days per calendar year.

4.1.25 Beng. Dm

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Durable medical equipment	20% coinsurance	40% coinsurance	Deductible does not apply to diabetes supplies from in-network providers.
	Hospice services	No charge	No charge	Deductible does not apply.
If your child needs dental or eye care	Children's eye exam	No charge	Covered up to $45	Deductible does not apply. Limited to 1 exam every 12 months.
	Children's glasses	Not covered	Not covered	No coverage for glasses.
	Children's dental check-up	Not covered	Not covered	No coverage for dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Bariatric surgery
- Cosmetic surgery (with certain exceptions)
- Dental care (Adult)
- Dental check-up (Child)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine foot care (covered for diabetics)
- Voluntary termination of pregnancy
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (limits apply)
- Chiropractic care (limits apply)
- Hearing Aids (limits apply)
- Non-emergency care when traveling outside the U.S. See www.ProvidenceHealthPlan.com
- Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or http://www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or http://www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Providence Health Plan at 1-800-878-4445, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol.gov/ebsa/healthreform, or you can contact the Oregon Insurance Division by:

- Calling (503) 947-7984 or the toll free message line at (888) 877-4894
- Writing to the Oregon Insurance Division, Consumer Protection Unit, 350 Winter Street NE, Salem, OR 97301-3883
- Through the Internet at http://dfr.oregon.gov/gethelp/ins-help/health/Pages/index.aspx
- E-mail at: cp.ins@state.or.us

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

Buy-up 2.1.27

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,500
Specialist *copayment*	$15
Hospital (facility) *coinsurance*	20%
Other *coinsurance*	20%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$220
Coinsurance	$2,001
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,781**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,500
Specialist *copayment*	$15
Hospital (facility) *coinsurance*	20%
Other *coinsurance*	20%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$848
Coinsurance	$372
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,276**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,500
Specialist *copayment*	$15
Hospital (facility) *coinsurance*	20%
Other *coinsurance*	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,960**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,109
Copayments	$42
Coinsurance	$326
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,477**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Non-Discrimination Statement:

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Providence Health Plan and Providence Health Assurance:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you are a Medicare member who needs these services, call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. Hearing impaired members may call our TTY line at 711.

If you believe that Providence Health Plan or Providence Health Assurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Non-discrimination Coordinator by mail:

Providence Health Plan and Providence Health Assurance
Attn: Non-discrimination Coordinator
PO Box 4158
Portland, OR 97208-4158

Buy-up
4.1.24

If you need help filing a grievance, and you are a Medicare member call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. (TTY line at 711) for assistance. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW - Room 509F HHH Building
Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TTY)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.ProvidenceHealthPlan.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-878-4445 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$2,800** per person / **$5,600** per family (2 or more).	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	**Yes.** Most preventive care services in-network.	This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	**No**	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$5,500** per person / **$11,000** per family (2 or more).	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, penalties, copays or coinsurance for Supplemental Benefits, services not covered, fees above UCR.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	**Yes.** See http://phppd.providence.org/ or call 1-800-878-4445 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your providers before you get services.
Do you need a referral to see a specialist?	**No.**	You can see the specialist you choose without a referral.

HSA 4.1.3D

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	Some services will include additional member costs. Phone and video visits are covered in full in-network.
	Specialist visit	20%coinsurance	40% coinsurance	Some services will include additional member costs.
	Preventive care/screening/ immunization	No charge	40% coinsurance	Deductible does not apply in-network. Some preventive services will include additional member costs. For more information see: https://healthplans.providence.org/pdfs/members/documents/preventive-care-costs.pdf.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Prior authorization required.

HSA 4.1.3)

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.ProvidenceHealthPlan.com	Preferred generic drug	20% coinsurance retail and mail order	Not covered	Deductible does not apply to Safe Harbor drugs. ACA Preventive drugs are covered in full in-network. Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription). Prior authorization may apply. Specialty drug can only be purchased at a participating specialty pharmacy.
	Non-preferred generic drug	20% coinsurance retail and mail order	Not covered	
	Preferred brand-name drug	20% coinsurance retail and mail order	Not covered	
	Non-preferred brand drug	20% coinsurance retail and mail order	Not covered	
	Specialty drug	50% coinsurance up to $200 retail	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory surgery center: 10% coinsurance Hospital-based facility: 20% coinsurance	40% coinsurance	Prior authorization required.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	20%coinsurance	20% coinsurance	For emergency medical conditions only. If admitted to hospital, all services subject to inpatient benefits.
	Emergency medical transportation	20% coinsurance	20% coinsurance	——————none——————
	Urgent care	20% coinsurance	40% coinsurance	Some services will include additional member costs.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Prior authorization required.

HSA 4.1.3 V

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	All services except provider office visits must be prior authorized. See your benefit summary for ABA services.
	Inpatient services	20% coinsurance	40% coinsurance	
If you are pregnant	Office visits	No charge	40% coinsurance	Deductible does not apply in-network.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	Coinsurance applies to provider delivery charges.
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	——————none——————
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	——————none——————
	Rehabilitation services	20% coinsurance	40% coinsurance	Inpatient services: coverage limited to 30 days per calendar year. Outpatient services: coverage limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.
	Habilitation services	20% coinsurance	40% coinsurance	Inpatient services: coverage limited to 30 days per calendar year. Outpatient services: coverage limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.
	Skilled nursing care	20% coinsurance	40% coinsurance	Prior authorization required. Coverage is limited to 60 days per calendar year.
	Durable medical equipment	20% coinsurance	40% coinsurance	Deductible does not apply to diabetes supplies from in-network providers.

HSA 4.1.33

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Hospice services	No charge	No charge	——————none——————
If your child needs dental or eye care	Children's eye exam	No charge	Covered up to $45	Deductible does not apply. Limited to 1 exam every 12 months.
	Children's glasses			No coverage for glasses.
	Children's dental check-up	Not covered	Not covered	No coverage for dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Cosmetic surgery (with certain exceptions)
- Dental care (Adult)
- Dental check-up (Child)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine foot care (covered for diabetics)
- Voluntary termination of pregnancy
- Weight loss programs

HSA 4.1.34

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Hearing Aids (limits apply)
- Non-emergency care when traveling outside the U.S. See www.ProvidenceHealthPlan.com
- Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or http://www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or http://www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Providence Health Plan at 1-800-878-4445, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol.gov/ebsa/healthreform, or you can contact the Oregon Insurance Division by:

- Calling (503) 947-7984 or the toll free message line at (888) 877-4894
- Writing to the Oregon Insurance Division, Consumer Protection Unit, 350 Winter Street NE, Salem, OR 97301-3883
- Through the Internet at http://dfr.oregon.gov/gethelp/ins-help/health/Pages/index.aspx
- E-mail at: cp.ins@state.or.us

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

HSA 4,1.35

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$2,800
Specialist *coinsurance*	20%
Hospital (facility) *coinsurance*	20%
Other *coinsurance*	20%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$2,527
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,387**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$2,800
Specialist *coinsurance*	20%
Hospital (facility) *coinsurance*	20%
Other *coinsurance*	20%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$1,437
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$4,292**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$2,800
Specialist *coinsurance*	20%
Hospital (facility) *coinsurance*	20%
Other *coinsurance*	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,960**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,540
Copayments	$0
Coinsurance	$385
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,925**

The plan would be responsible for the other costs of these EXAMPLE covered services.

HSA 7.1.26

Non-Discrimination Statement:

Providence Health Plan and Providence Health Assurance comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Providence Health Plan and Providence Health Assurance do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Providence Health Plan and Providence Health Assurance:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you are a Medicare member who needs these services, call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. Hearing impaired members may call our TTY line at 711.

If you believe that Providence Health Plan or Providence Health Assurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Non-discrimination Coordinator by mail:

Providence Health Plan and Providence Health Assurance
Attn: Non-discrimination Coordinator
PO Box 4158
Portland, OR 97208-4158

If you need help filing a grievance, and you are a Medicare member call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. (TTY line at 711) for assistance. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW - Room 509F HHH Building
Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TTY)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

HS4
4.1.37

Dental

Metropolitan Life Insurance Company

Plan Design for: Rexius Forest By-Products, Inc.

Date Prepared: June 24, 2020

Choice, Service, Savings.

To help you enroll, this overview includes rate information and a Q&A so you can make the most informed decision possible.

Coverage Type:	**In-Network[1] Year #1** % of PDP Fee[2]	**Out-of-Network[1] Year #1** % of R&C Fee[4]	**In-Network[1] Year #2** % of PDP Fee[2]	**Out-of-Network[1] Year #2** % of R&C Fee[4]
Type A - Preventive	100%	100%	100%	100%
Type B - Basic Restorative	80%	80%	80%	80%
Type C - Major Restorative	25%	25%	50%	50%
Deductible[3]				
Individual	$50	$50	$50	$50
Family	$150	$150	$150	$150
Annual Maximum Benefit:				
Per Person	$1000	$1000	$1000	$1000

Deductible[3]			
Individual	$50 / $50	$50 / $50	$50 / $50
Family	$150 / $150	$150 / $150	$150 / $150
Annual Maximum Benefit:			
Per Person	$1000 / $1000	$1000 / $1000	$1000 / $1000

± Changes have been made to your Plan as of the Amendment Effective Date listed above. Please refer to your Certificate of Insurance/Certificate Rider for more details or contact your benefits administrator with any questions.

[1] "In-Network Benefits" means benefits provided under this plan for covered dental services that are provided by a Participating PDP Provider. "Out-of-Network Benefits" means benefits provided under this plan for covered dental services that are not provided by a Participating PDP Provider.

[2] PDP Fee refers to the fees that participating PDP dentists have agreed to accept as payment in full.

[3] Applies to Type B and C services only.

[4] Out-of-network benefits are payable for services rendered by a dentist who is not a participating provider. The Reasonable and Customary charge is based on the lowest of:

- the dentist's actual charge (the 'Actual Charge'),
- the dentist's usual charge for the same or similar services (the 'Usual Charge') or
- the usual charge of most dentists in the same geographic area for the same or similar services as determined by MetLife (the 'Customary Charge'). Services must be necessary in terms of generally accepted dental standards.

200 Park Ave., New York, NY 10166

Cancellation/Termination of Benefits:
Coverage is provided under a group insurance policy (Policy form GPN99) issued by Metropolitan Life Insurance Company. In Pennsylvania, coverage is provided under a group insurance policy (Policy form G.2130P-S) issued by Metropolitan Life Insurance Company. Subject to the terms of the group policy, rates are effective for one year from your plan's effective date. Once coverage is issued, the terms of the group policy permit Metropolitan Life Insurance Company to change rates during the year in certain circumstances. Coverage terminates when your full-time employment ceases, when your dental contributions cease or upon termination of the group policy by the Policyholder. The group policy may also terminate if participation requirements are not met, or on the date of the employee's death, if the Policyholder fails to perform any obligations under the policy, or at MetLife's option. The dependent's coverage terminates when a dependent ceases to be a dependent. There is a 30-day limit for the following services that are in progress: Completion of a prosthetic device, crown or root canal therapy after individual termination of coverage.

IMPORTANT ENROLLMENT INFORMATION

Benefits Plan Effective Date: Please see the enclosed cover sheet for specifics on your Plan's effective date.

Important Enrollment Provisions: If Timely Request Is Made - A timely request for Dental Expense Benefits is one that is made on or prior to the date thirty-one days after your Eligibility Date.

If Late Request Is Made - If a request is not a timely request, it is a late request. Dental Expense Benefits will become effective for late requests after you satisfy the waiting period(s) shown below. The waiting period begins on the date of your request.

Preventive Services..... No waiting period
Basic Restorative Services (Fillings).....6 month waiting period
Basic - All Other Services..... 12 month waiting period
Major Services..... 24 month waiting period
Orthodontia Services (if applicable)..... 24 month waiting period

Qualifying Event: Request to be covered, or to change your coverage, upon a Qualifying Event
If there is a Qualifying Event you may request to be covered, or to change your coverage only within 31 days of a Qualifying Event. Such a request will not be a late request. Except for marriage or the birth or adoption of a child, you must give us proof of prior dental coverage under your spouse's plan if you are requesting coverage under This Plan because of a loss of the prior dental coverage. If you make a request to be covered for Dental Expense Benefits or a request for change(s) in Dental Expense Benefits within thirty-one days of a Qualifying Event, your Dental Expense Benefits or the change(s) in Dental Expense Benefits will become effective on the first day of the month following the date of your request, subject to the Active Work Requirement, and provided that the change in coverage is consistent with your new family status.

List of Covered Services & Limitations*

Type A - Preventive	How Many/How Often:
Oral Examinations	• Oral exams but not more than once every 6 months.
X-rays	• Full mouth X-rays: once every 60 months.
Bitewing X-rays	• Not more than 1 set every 6 months for Dependent Children under 19 years of age, no more than 1 set every 12 months for all other Covered Persons.
Prophylaxis (cleanings)	• Cleaning of teeth (oral prophylaxis) but not more than once every 6 months.
Topical Fluoride Applications	• Topical fluoride treatment for a Dependent child under 19 years of age but not more than once in 12 months.
Sealants	• Sealants which are applied to non-restored, non-decayed, first and second permanent molars only, for dependents up to the age of 19, but not more than once per tooth every 60 months.
Space Maintainers	• Space Maintainers for dependent children to 19 years of age.
Emergency Palliative Treatment	

Type B - Basic Restorative	How Many/How Often:
Fillings	• Amalgam and Resin-based Fillings.
Prefabricated Crown	• Prefabricated stainless steel crowns but not more than once in any 60 month period.
Repairs of Dentures, Crowns, Inlays, and Onlays	• Simple Repairs of Cast Restorations.
Endodontics	• Root canal treatment, but not more than once in any 24 month period for the same tooth.
Periodontal Surgery	• Periodontal surgery but no more than one surgical procedure per quadrant in any 36 month period.
Periodontics	• Periodontal scaling and root planing, but not more than once per quadrant in any 24 month period.
Periodontal Maintenance	• Periodontal maintenance where periodontal treatment has been previously performed, but the total of covered periodontal maintenance treatments and the number of covered oral prophylaxes will not exceed four treatments in a calendar year.
Relining and Rebasing	• Relining and Rebasing of existing removable dentures but not more than once in 36 months.
Simple Extractions	
Oral Surgery	
General Anesthesia	• When dentally necessary in connection with oral surgery, extractions or other covered dental services.
Consultations	• Consultations, but not more than twice in a 12 month period.
Injections of Antibiotic Drugs	

Type C - Major Restorative	How Many/How Often:
Crowns/Inlays/Onlays	• Replacement of crowns, inlays or onlays but not more than once for the same tooth in a 60 month period.
Bridges and Dentures	• Replacing an existing removable denture or fixed bridgework if: it is needed because of the loss of one or more natural teeth after the existing denture or bridgework was installed and the denture or bridgework cannot be made serviceable; or it is needed because the existing denture or bridgework can no longer be used and was installed more than 60 months prior to its replacement.

Where two or more professionally acceptable dental treatments for a dental condition exist, reimbursement is based on the least costly treatment alternative. If you and your dentist have agreed on a treatment that is more costly than the treatment upon which the plan benefit is based, you will be responsible for any additional payment responsibility. To avoid any misunderstandings, we suggest you discuss treatment options with your dentist before services are rendered, and obtain a pretreatment estimate of benefits prior to receiving certain high cost services such as crowns, bridges or dentures. You and your dentist will each receive an Explanation of Benefits (EOB) outlining the services provided, your plans reimbursement for those services, and your out of pocket expense. Actual payments may vary from the pretreatment estimate depending upon annual maximums, plan frequency limits, deductibles and other limits applicable at time of payment.

* The service categories and plan limitations shown above represent an overview of your Plan of Benefits. This document presents many services within each category, but is not a complete description of the Plan. Please see your Plan description for complete details. In the event of a conflict with this summary, the terms of the certificate will govern.

Like most group dental insurance policies, MetLife group policies contain certain exclusions, exceptions, limitations, reductions and waiting periods and terms for keeping them in force. The certificate of insurance sets forth all plan terms and provisions, including all exclusions and limitations..

The MetLife® Preferred Dentist Program (PDP) Exclusions

The following expenses are not Covered Dental Expenses

x Services or Supplies…

— related to teeth lost before dental benefits began or for congenitally missing natural teeth;
— received by a covered person before the dental expense benefits start for that person;
— which are covered by any worker's compensation laws or occupational disease laws;
— which are covered by any employer's liability laws;
— which an employer is required by law to furnish in whole or in part;
— received through the medical department or similar facility which is maintained by the covered person's employer;
— received by a covered person for which no charge would have been made in the absence of dental expense benefits for that covered person;[2]
— for which a covered person is not required to pay;[1]
— which are not necessary, according to generally accepted dental standards, or which are not recommended or approved by a dentist;
— which do not meet generally accepted dental standards, including experimental treatment;
— received as a result of dental disease, defect, or injury due to an act of war, or warlike act in time of peace, which occurs while the dental expense benefits for the covered person are in effect;
— which are provided by any other plan which the employer (or an affiliate) contributes to or sponsors.[2]

x Services not performed by a dentist except for those of a licensed dental hygienist which are supervised and billed by a dentist and which are for cleaning and scaling of teeth or fluoride treatments.

x Cosmetic surgery or supplies. However, any such surgery or supply will be covered if it otherwise is a covered dental expense; it is required for reconstructive surgery that is incidental to or follows surgery that results from a trauma, an infection or other disease of the involved part; or is required for re-constructive surgery because of a congenital disease or anomaly of a dependent child that has resulted in a functional defect.

x Replacement of a lost, missing or stolen crown, bridge or denture.

x Repair or replacement of an orthodontic appliance.

x Adjustment of a denture or a bridgework which is made within six months after it is installed by the same dentist who installed it.

x Any duplicate appliance or prosthetic device.

x Use of materials or home health aids, to prevent decay, such as toothpaste or fluoride gels, other than the topical application of fluorides.

x Instruction for oral care such as hygiene or diet.

x Periodontal splinting.

x Charges by a dentist for completing dental forms.[2]

x Charges for broken appointments.[3]

x Temporary or provisional restorations.

x Temporary or provisional appliances.

x Sterilization supplies.[3]

x Services or supplies furnished by a family member.[3]

x Treatment of temporomandibular joint disorders.

x Implant Services.

x Orthodontia.

x Myofunctional therapy or correction of harmful habits.

x Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.

In Maryland:

x Services or supplies furnished as a result of a Referral prohibited by Section 1-302 of the Maryland Health Occupations Article. A prohibited Referral is one in which a Health Care Practitioner:

a. refers a covered person to; or
b. directs an employee or a person under contract with the Health Care Practitioner to refer a covered person to a Health Care Entity in which:
   a. the Health Care Practitioner; or
   b. the Health Care Practitioner's immediate family; or
   c. both own a Beneficial Interest or have a Compensation Agreement.

For the purposes of this provision, the terms "Referral," "Health Care Practitioner," "Health Care Entity," "Beneficial Interest," and "Compensation Agreement" have the same meaning as provided in Section 1-301 of the Maryland Health Occupations

[1] In policies sitused in **MD,** these exclusions do not apply to Medicaid.
[2] Not applicable in **MD**.
[3] Not applicable in **FL, MD, NJ** and **TN**.

Common Questions… Important Answers

Who is a participating Preferred Dentist Program (PDP) dentist? A participating dentist is a general dentist or specialist who has agreed to accept MetLife's negotiated fees as payment in-full for services provided to plan participants. PDP fees typically range from 15-45%* below the average fees charged in a dentist's community for the same or substantially similar services.

*Based on internal analysis by MetLife.

How do I find a participating PDP dentist? There are more than 150,000 participating PDP dentist locations nationwide, including over 37,000 specialist locations. You can receive a list of these participating PDP dentists online at www.metlife.com/mybenefits or call 1-800-275-4638 to have a list faxed or mailed to you.

What services are covered by my plan? All services defined under your group dental benefits plan are covered. Please review the enclosed plan benefits to learn more.

Does the Preferred Dentist Program (PDP) offer any discounts on non-covered services? MetLife's negotiated fees with PDP (in-network) dentists may extend to services not covered under your plan and services received after your plan maximum has been met, where permitted by applicable state law. If you receive services from a PDP dentist that are not covered under your plan or where the maximum has been met, in those states where permitted by law, you may only be responsible for the PDP (in-network) fee.

May I choose a non-participating dentist? Yes. You are always free to select the dentist of your choice. However, if you choose a dentist who does not participate in the MetLife PDP, your out-of-pocket expenses may be more, since you will be responsible to pay for any difference between the dentist's fee and your plan's payment for the approved service. If you receive services from a participating PDP dentist, you are only responsible for the difference between the PDP in-network fee for the service provided and your plan's payment for the approved service. Please note: any plan deductibles must be met before benefits are paid.

Can my dentist apply for PDP participation? Yes. If your current dentist does not participate in the PDP and you'd like to encourage him or her to apply, tell your dentist to visit www.metdental.com, or call 1-877-MET-DDS9 for an application. The website and phone number are designed for use by dental professionals only.

How are claims processed? Dentists may submit your claims for you which means you have little or no paperwork. You can track your claims online and even receive e-mail alerts when a claim has been processed. If you need a claim form, visit www.metlife.com/mybenefits or request one by calling 1-800-275-4638.

Can I find out what my out-of-pocket expenses will be before receiving a service? Yes. MetLife recommends that you request a pre-treatment estimate for services in excess of $300. Simply have your dentist submit a request online at www.metdental.com or call 1-877-MET-DDS9. You and your dentist will receive a benefit estimate for most procedures while you're still in the office. Actual payments may vary depending upon plan maximums, deductibles, frequency limits and other conditions at time of payment.

How can I learn about what dentists in my area charge for different procedures? If you have MyBenefits you can access the Dental Procedure Fee Tool provided by go2dental.com where you can learn more about approximate fees for services such as exams, cleanings, fillings, crowns and more. Simply visit www.metlife.com/mybenefits and use the Dental Procedure Fee Tool to help you estimate the in-network (PDP fees) and out-of-network fees* for dental services in your area.

* Out-of-network fee information is provided by go2dental.com, Inc., an industry source independent of MetLife. This site does not provide the benefit payment information used by MetLife when processing your claims. Prior to receiving services, we recommend that you obtain pre-treatment estimates through your dentist.

Can MetLife help me find a dentist outside of the U.S. if I am traveling? Yes. Through international dental travel assistance services* you can obtain a referral to a local dentist by calling +1-312-356-5970 (collect) when outside the U.S. to receive immediate care until you can see your dentist. Coverage will be considered under your out-of-network benefits.** Please remember to hold on to all receipts to submit a dental claim.

* International Dental Travel Assistance services are administered by AXA Assistance USA, Inc. AXA Assistance is not affiliated with MetLife and any of its affiliates, and the services they provide are separate and apart form the benefits provided by MetLife. Referral services are not available in all locations.

** Refer to your dental benefits plan summary for your out-of-network dental coverage.

How does MetLife coordinate benefits with other insurance plans? Coordination of benefits provision in dental benefits plans are a set of rules that are followed when a patient is covered by more than one dental benefits plan. These rules determine the order in which the plans will pay benefits. If the MetLife dental benefit plan is primary, MetLife will pay the full amount of benefits that would normally be available under the plan. If the MetLife dental benefit plan is secondary, most coordination of benefits provisions require MetLife to determine benefits after benefits have been determined under the primary plan. The amount of benefits payable by MetLife may be reduced due to the benefits paid under the primary plan.

Do I need an ID card? No, you do not need to present an ID card to confirm that you're eligible. You should notify your dentist that you participate in MetLife's PDP. Your dentist can easily verify information about your coverage through a toll-free automated Computer Voice Response system.

Do my dependents have to visit the same dentist that I select? No, you and your dependents each have the freedom to choose any dentist.

If I do not enroll during my initial enrollment period can I still purchase Dental Insurance at a later date?
Yes, employees who do not elect coverage during their 31-day application period may still elect coverage later. Dental coverage would be subject to the following waiting periods.

- No waiting period on Preventive Services
- 6 months on Basic Restorative (Fillings)
- 12 months on all other Basic Services
- 24 months on Major Services
- 24 months on Orthodontia Services (if applicable)

CALIFORNIA HEALTHCARE LANGUAGE ASSISTANCE PROGRAM
NOTICE TO INSUREDS

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card, if any, or 1-800-942-0854. For more help call the CA Dept. of Insurance at 1-800-927-4357.
To receive a copy of the attached MetLife document translated into Spanish or Chinese, please mark the box by the requested language statement below, and mail the document with this form to:
Metropolitan Life Insurance Company
PO Box 14587
Lexington, KY 40512
Please indicate to whom and where the translated document is to be sent.

☐ **Servicio de Idiomas Sin Costo.** Puede obtener la ayuda de un intérprete. Se le pueden leer documentos y enviar algunos en español. Para recibir ayuda, llámenos al número que aparece en su tarjeta de identificación, si tiene una, o al 1-800-942-0854. Para recibir ayuda adicional llame al Departamento de Seguros de California al 1-800-927-4357.
Para recibir una copia del documento adjunto de MetLife traducido al español, marque la casilla correspondiente a esta oración, y envíe por correo el documento junto con este formulario a:
Metropolitan Life Insurance Company
PO Box 14587
Lexington, KY 40512
Por favor, indique a quién y a dónde debe enviarse el documento traducido.
NOMBRE______________________________
DIRECCIÓN____________________________

☐ **免費語言服務。**您可獲得免費口譯服務。您可要求翻譯員向你口譯文件，或可要求向你發回文件的中文譯本。如需協助，請致電您的ID卡上所示號碼（如有），或 1-800-942-0854。如需更多協助，請致電加州保險部熱線1-800-927-4357。
爲收取隨附MetLife文件的中文譯本，請勾選此陳述前的方框，並將文件連同此表一併郵寄至：
Metropolitan Life Insurance Company
PO Box 14587
Lexington, KY 40512
請指明經翻譯文件收件人的姓名及地址。
姓名______________________________
地址______________________________

Անվճար թարգմանչական ծառայություններ: Ձեզ կտրամադրվի հայերենի թարգմանիչ, որի օգնությամբ կարող եք հայերենով կարդալ փաստաթղթերը: Հարցերի դեպքում զանգահարեք մեզ Ձեր ID քարտի վրա նշված հեռախոսահամարով կամ 1-800-942-0854: Առավել մանրամասն տեղեկատվության համար զանգահարեք Կալիֆորնիայի Ապահովագրական Դեպարտամենտ 1-800-927-4357 հեռախոսահամարով:

សេវាបកប្រែដោយឥតគិតថ្លៃ ។ អ្នកអាចទទួលបានអ្នកបកប្រែម្នាក់ និងឱ្យគេអានឯកសារនានាឱ្យអ្នកស្តាប់ជាភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើង តាមលេខដែល មានចុះនៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់អ្នកប្រសិនបើមាន ឬ តាមលេខ 1-800-942-0854 ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងនៃរដ្ឋកាលីហ្វ័រញ៉ា (CA Dept. of Insurance) តាមលេខ 1-800-927-4357 ។

Kev pab txhais lus tsis kom them nqi. Koj thov tau kom nrhiav neeg txhais lus thiab nyeem ntaub ntawv hais ua lus Hmoob rau koj mloog. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj sau hauv koj daim npav ID, yog muaj, lossis 1-800-942-0854. Yog xav kom pab lwm yam hu rau lub CA Hauv Paus lv-saws-las ntawm 1-800-927-4357.

無料の通訳サービス。通訳を通して日本語で文書を読み上げてもらうことができます。サービスの利用をご希望の方は、お手持ちの ID カードに記載されている番号、または 1-800-942-0854 へお電話ください。さらなる支援が必要な場合は、カリフォルニア州保険庁 1-800-927-4357 までお問い合わせください。

무료 통역 서비스. 통역자가 문서를 한국어로 읽어드릴 수 있습니다. 도움이 필요하시면, 귀하의 ID 카드에 있는 번호나 1-800-942-0854 로 전화하십시오. 다른 도움이 필요하시면, 전화번호 1-800-927-4357 로 캘리포니아 보험국에 연락하여 주십시오.

Бесплатные услуги устного перевода. Вы можете воспользоваться услугами переводчика, который прочитает вам документы на русском языке. Чтобы получить помощь, позвоните нам по номеру, указанному на вашей идентификационной карточке, если у вас она есть, либо по номеру 1-800-942-0854. Если вам нужна помощь в других вопросах, позвоните в горячую линию Департамента страхования (CA Dept. of Insurance) 1-800-927-4357.

Libreng serbisyo sa pagsasalin. Maaari kang kumuha ng tagasalin para basahin sa iyo ang mga dokumento sa wikang Tagalog. Para ikaw ay matulungan, tawagan kami sa numerong nakalista sa iyong ID card, kung mayroon man, o sa numerong 1-800-942-0854. Para sa karagdagang tulong tawagan ang CA Dept. of Insurance sa numerong 1-800-927-4357.

Dịch vụ thông dịch miễn phí. Quý vị có thể tìm một thông dịch viên và nhờ đọc các tài liệu này cho quý vị bằng tiếng Việt. Để được giúp đỡ, gọi cho chúng tôi tại số nêu trên thẻ ID của quý vị, nếu có, hoặc 1-800-942-0854. Để được giúp đỡ thêm gọi cho Ban Bảo Hiểm CA tại số 1-800-927-4357.

لا تتوفر خدمات ترجمة بتكلفة. يمكنك الاتصال بمترجم والحصول على خدمة قراءة المستندات باللغة العربية. للمساعدة، اتصل بنا على الرقم الموجود على بطاقة التعريف الخاصة بك، أو اتصل بالرقم 1-800-942-0854. ولمزيد من المساعدة، اتصل بقسم التأمينات التابع لـ CA على الرقم 1-800-927-4357.

سرویس های ترجمه رایگان. شما می توانید مترجم و اسنادی را به زبان فارسی برای مطالعه دریافت کنید. برای راهنمایی،از طریق شماره درج شده در کارت شناسایی خود (در صورت وجود) یا شماره 1-800-942-0854 با ما تماس بگیرید. برای راهنمایی بیشتر با بخش بیمه کالیفرنیا 1-800-927-4357 تماس بگیرید.

بلا معاوضہ مترجم دی خدمات مل سکدی اے۔ تُسی ایک مترجم دی خدمات حاصل کرسکدے او جو توڈے واسطے دستاویزات پنجابی وچ پڑ سکدا اوے۔ مدد واسطے اپڑیں آئی ڈی کارڈ، گرہوتو، دے وچ نمبر یا 1-800-942-0854 پہ کال کرو۔ آگے مزید مدد واسطے اے نمبر 1-800-927-4357 پہ سی اے ڈیپارٹمنٹ برائے انشورنس نال گال کرو۔

REXIUS FOREST BY-PRODUCTS INC

SUMMARY PLAN DESCRIPTION
Flexible Spending Account

Effective: 8/1/2020

With Third Party Administrative Services Provided By:

This document explains in detail the operation and rules that govern your Plan. Some features of a Flexible Spending Account described in this Summary Plan Description may not apply. Refer to Section II – Your Plan at a Glance to determine the specific features your Employer offers.

Table of Contents

REXIUS FOREST BY-PRODUCTS INC

SUMMARY PLAN DESCRIPTION
FLEXIBLE SPENDING ACCOUNT

I. Introduction

This Summary Plan Description (SPD) provides, in general terms, the main features of the REXIUS FOREST BY-PRODUCTS INC Flexible Spending Account Plan (the "Plan") and the related Premium Payment Component, Health FSA Component and DCAP Component, how it can work for you, and how it can benefit you. Such plans are also known as cafeteria plans, or Section 125 plans.

Under the Plan, you may choose to redirect a portion of your wages to pay for certain benefits for you, your spouse, and your dependents with pre-tax dollars instead of after-tax dollars. Participating in the Plan will reduce the amount of your taxable compensation. Accordingly, there could be a decrease in your Social Security benefits and/or other benefits (e.g., pension, disability, and life insurance), which are based on taxable compensation. However, the tax savings that you realize through Plan participation will often more than offset any reduction in other benefits. Alternatively, eligible Employees may choose to pay for any of the benefits with after-tax contributions on a payroll-reduction basis.

You should read this SPD carefully so that you understand the provisions of the Plan and the benefits you will receive. We want you to be fully informed of the benefits available to you under the Plan both before you enroll and while you are a Participant. You should direct any questions you have to the Employer. A copy of your Plan Document is on file at your Employer's office and may be read by you, your Beneficiaries, or your legal representatives at any reasonable time. **IF THERE IS A CONFLICT BETWEEN THIS SUMMARY PLAN DESCRIPTION AND THE PLAN DOCUMENT, THE PLAN DOCUMENT WILL TAKE PRECEDENCE.**

The provisions of the Plan, as initially adopted or subsequently amended and restated, as the case may be, are effective 8/1/2020, through 7/31/2021. Your Plan's records are maintained on a fiscal period known as the Plan Year.

This SPD does not describe the Group Sponsored Insurance. The provisions of this Plan are not intended to override any exclusions, eligibility requirements, or waiting periods specified in the Group Sponsored Insurance plan documents.

Assistance in Other Languages
Plan Participants who do not speak English may contact PacificSource Administrator's Customer Service Department for assistance. PacificSource Administrators can usually arrange for a multilingual staff member or interpreter to speak with them in their native language.

II. Your Plan at a Glance

PERIOD OF COVERAGE and **PLAN YEAR** of this Plan: 8/1/2020 through 7/31/2021

Cafeteria Plan Name:	REXIUS FOREST BY-PRODUCTS INC
Three Digit Plan Number:	501
Type of Legal Entity:	S Corp.
Employer/Plan Sponsor:	REXIUS FOREST BY-PRODUCTS INC PO BOX 22838 EUGENE, OR 97402
Benefits Coordinator:	Human Resources/Benefits Representative (541) 342-1835
Legal Representative:	REXIUS FOREST BY-PRODUCTS INC
Plan Administrator:	REXIUS FOREST BY-PRODUCTS INC
Third Party Administrator:	PacificSource Administrators, Inc. PO Box 70168 Springfield, OR 97475 Phone: (800) 422-7038 FAX: (866) 446-6090
Secure Web Portal (TPA):	https://hrbenefitsdirect.com/PSA
Claim Mailing Address (TPA):	PacificSource Administrators, Inc. PO Box 2797 Portland, OR 97208
Employer Representative or Named Fiduciary:	REXIUS FOREST BY-PRODUCTS INC
The HIPAA Effective date:	8/1/2020
HIPAA Privacy Officer:	REXIUS FOREST BY-PRODUCTS INC

BENEFIT PLANS: The administrative plan expenses are paid by the Employer.
The following components are offered under the Flexible Spending Account. You may elect:

- **Premium Payment Component:** Your salary reductions will be used to pay the premium for medical and hospitalization insurance, major medical insurance, dental insurance, vision insurance, and/or other qualified benefits under Section 125 for you and your eligible family members.

- **Health FSA Component:** Your salary reductions will be deposited into a Health FSA Account from which funds will be withdrawn to reimburse you for eligible medical care expenses incurred by you and your eligible family members.
    - The election may be for:
        - **General-Purpose Health FSA (HRE) Option**
            - **Maximum Salary Reduction:** $2,750
            - **Minimum Salary Reduction:** $0
        - **Limited-Scope Health FSA (LSFSA) Option (Vision/Dental Care)**
            - **Maximum Salary Reduction:** Not Available
            - **Minimum Salary Reduction:** Not Available
        - **Limited-Purpose Health FSA (LFSA) Option (Vision/Dental/Preventive Care)**
            - **Maximum Salary Reduction:** $2,750
            - **Minimum Salary Reduction:** $0
    - **Mid-year Elections:** Mid-year hires and election changes due to a qualifying event, as allowed under the component, will be pro-rated. The maximum pay period contribution cannot exceed the annual IRS limit divided by the number of pay periods in the Plan Year.
    - **Allows all applicable Change in Status options:** No Changes

- **DCAP Component:** Your salary reductions will be deposited into a Dependent Care Expense (DCE) Account from which funds will be withdrawn to reimburse you for eligible dependent care expenses.
    - **Maximum Salary Reduction:** $5,000 (legal maximum of $5,000; $2,500 for a married individual filing a separate return)
    - **Minimum Salary Reduction:** $0
    - **Mid-year Elections:** Mid-year hires and election changes due to a qualifying event, as allowed under the component, will be pro-rated. The maximum pay period contribution cannot exceed the annual IRS limit divided by the number of pay periods in the Plan Year.
    - **Allows all applicable Change in Status options:** All of the events constituting a change in status under the regulations shall be allowed.

Funding Medium and Type of Plan Administration: The Health FSA Component is a group health plan. The Health FSA and DCAP Components are self-funded by the Employer and are contract administration plans. A third-party administrator processes claims for these components, but the Employer pays the claims out of its general assets. A health insurance issuer is not responsible for the financing or administration (including payment of claims) of these components. There is no trust for the Plan or any component.

Eligibility Requirements:

- Class I: Minimum of 20 hours required during each week; Class II: Minimum of 30 hours required during each week

Entry Dates:

- Class I: First of the month after 30 days of continued employment; Class II: First of the month after 60 days of continued employment

Exclusions:

- Owners in a S Corporation with more-than-2% ownership, their spouses, children, parents and grandparents are not eligible to participate, including pre-tax insurance premiums

Deemed Elections: Under the Premium Payment Component you will be deemed to elect for each upcoming Plan Year whatever election is in effect in the current Plan Year, unless you expressly change your election by turning in a completed election form prescribed by the Employer.

For example, if you are enrolled in the Premium Payment Component in the current year and want to remain enrolled in the upcoming year, you need not do anything, but if you want to stop participating in that Plan, you must affirmatively elect not to participate during the open enrollment period for the upcoming Plan Year. Under all the other components, you must make an affirmative election to participate every year by turning in a completed Enrollment Form prescribed by the Employer or you will be deemed to have elected not to participate.

Election Changes: The election changes allowed under the Plan are those made effective by the IRS January 1, 2001. Any new election must be made and communicated in writing to the Employer within **30 days** of the change in status.

Carryover Provision: Carryover is not permitted and therefore unused balances are subject to the "Use-It-or-Lose-It" rule discussed in Section V. Administrative Provisions on the Health FSA Component.

Grace Period: Your Employer does offer a Grace Period on the Health FSA and DCAP Component(s).

Forfeitures: Unclaimed cash balances are forfeited to the Employer after the end of a Plan Year. All forfeitures under this Plan shall be used as follows: first, to offset any losses experienced by the Employer during the Plan Year as a result of making reimbursements with respect to all Participants in excess of the contributions paid by such Participants through salary reductions; second, to reduce the cost of administering the Plan during the Plan Year or may be retained by the Employer to be used in the subsequent Plan Year (all such administrative costs shall be documented by the Employer); and third, to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion that the Employer deems appropriate, consistent with applicable regulations. Cash balances forfeited to the Employer cannot be returned directly to the individual Participant(s) who forfeited those funds.

Claim Reimbursement Forms may be submitted the following ways:

- Electronically via our secure web portal: https://hrbenefitsdirect.com/PSA
- Faxed to (866) 446-6090
- Mailed to PO Box 2797, Portland, OR 97208

Claim Submission Period Ends: 90 days after the close of the Plan period of coverage (also known as a run-out period)

Debit Card Availability: Health FSA

Documentation needed for claim submission: Your claim for expense reimbursement must include a statement from your service provider that you have incurred the expense, the date of service, and the amount of your expense. Note: In some instances, a statement from the provider that a medical care expense is medically necessary may be required.

Participation Rules:

- Reimbursements of Health FSA expenses include the period of coverage if such expenses are otherwise eligible healthcare expenses under the Code.
    - If you terminate employment, your FSA participation ends on the date of termination or on the last day of the pay period in which the Participant has contributed, whichever gives the Participant the greater period of coverage.
    - If you experience a loss of eligibility, your FSA participation ends on the date the loss of eligibility occurs or on the last day of the pay period in which the Participant has contributed, whichever gives the Participant the greater period of coverage.
- Reimbursements of DCAP expenses include the period of coverage and/or following termination - that is, through the remainder of the Plan Year if such expenses are otherwise eligible expenses under the Code.

Coverage continuation (if applicable): If you lose coverage under the Health FSA Component as a result a qualifying event (i.e. termination of employment or cessation of eligibility because of a reduction in hours of employment) you may be entitled to elect coverage continuation under the Health FSA to the extent required by federal law. See Section IV Component Options – Health FSA Component for more information.

A Participant cannot be forced to repay or voluntarily repay the employer for any amounts exceeding his or her Health FSA account balance (under most circumstances, individuals who have overspent their accounts will not elect continued coverage). The plan cannot accept the additional contributions as such a practice would be a violation of the Uniform Coverage rule.

Treatment of Rehires and/or Treatment of Participants that regain eligibility: If you terminate employment and later are rehired or lose eligibility and later regain eligibility during the same Plan Year, you may be entitled to rejoin the plan based on your Employer's plan design.

See Section III Participation in the Plan for more information regarding the treatment of rehires and treatment of Participants that regain eligibility during the same Plan Year.

Continuing Plan Participation under FMLA: Per Federal Law, coverage may continue under the provisions of Family Medical Leave Act (FMLA). If applicable, the option for member payment of continuation is listed below:

- FMLA coverage is offered and paid by the Employee based on the following: Pay-as-you-go with after-tax dollars, Pre-pay with pre-tax dollars, or Catch-up method

III. Participation in the Plan

✓ ***Who can participate in the Plan?***

Employees who actually participate in the Plan are called "Participants". You are eligible to participate if you have met the following required eligibility standards and waiting period as indicated below:

- Class I: Minimum of 20 hours required during each week; Class II: Minimum of 30 hours required during each week

Your "entry date" is the date on which you become eligible to participate in the Plan as indicated below:

- Class I: First of the month after 30 days of continued employment; Class II: First of the month after 60 days of continued employment

Eligibility for the Health FSA Component is subject to the eligibility for the Medical Insurance Plan.

- Individuals eligible to enroll in the Medical Insurance may enroll in a General-Purpose Health FSA (regardless of whether coverage under the Medical Insurance Plan is elected), covering all healthcare expenses as defined in Code §213(d).
- Individuals not eligible to enroll in the Medical Insurance may enroll in a Limited-Scope Health FSA, limited to covering Vision and Dental Care.
- Individuals who elect to participate in an HSA Benefit, or a Spouse participating in their Employer's HSA Benefit, may only enroll in a Limited-Purpose Health FSA, limited to covering Vision, Dental and Preventive Care.

Eligibility for the Group Sponsored Insurance is also subject to the additional eligibility requirements, if any, specified in the insurance plan documents.

✓ ***Are there any Employees who are not eligible to participate in the Plan?***

An "Employee" is an individual that the Employer classifies as a common-law Employee and who receives Compensation from the Employer. Employees do not, however, include (a) individuals classified by the Employer as independent contractors, even if such an individual is later reclassified as a common-law employee; (b) individuals who perform services for the Employer but who are paid by a temporary or other employment or staffing agency; or (c) self-employed individuals, partners in a partnership, or more-than-2% shareholders in a Subchapter S corporation.

The following Employees are excluded from participating in the Plan:

- Owners in a S Corporation with more-than-2% ownership, their spouses, children, parents and grandparents are not eligible to participate, including pre-tax insurance premiums

✓ ***What must I do to enroll?***

When you first meet the eligibility requirements of the Plan, you must complete and sign an enrollment form (or completing electronic enrollment materials) prior to your entry date. The signed enrollment form must be submitted to the Employer before the first day of the pay period in which participation will begin. After the initial period of coverage, you may renew your participation for the next Plan Year by filing your elections with your Employer during the next open enrollment period.

Failure to make an election will be treated as electing to not participate in the Plan unless an event occurs that would justify a mid-year election change, as described in Section V Administrative Provisions – Election Changes.

✓ ***When does participation end?***

The date your participation will cease under the Plan varies from component to component. Under the various components described in Section IV Component Options, your participation in each component will, unless otherwise expressly stated, cease on the date you terminate employment or otherwise cease to be eligible under the Plan or otherwise cease to be an eligible Employee.

- Upon termination, FSA participation ends on the date of termination or on the last day of the pay period in which the Participant has contributed, whichever gives the Participant the greater period of coverage.
- Upon loss of eligibility, FSA participation ends on the date the loss of eligibility occurs or on the last day of the pay period in which the Participant has contributed, whichever gives the Participant the greater period of coverage.

✓ ***What if I terminate and I am rehired during the Plan Year?***

If you enroll in the Health FSA Component, terminate employment, and are later rehired within 30 days, you are required to immediately rejoin the Plan and be reinstated with the same election as before termination of participation; resuming your per pay period contribution. If a period of non-coverage occurs due to missed contributions, services incurred during the period of non-coverage will not be eligible for reimbursement and missed contributions cannot be made up. If you are rehired more than 30 days after termination, you are treated as a new hire and must re-satisfy the Plan eligibility/entry requirements. The new election is subject to the IRS annual max and plan design if less. Services incurred during the period of non-coverage will not be eligible for reimbursement. Any unused reimbursement account balance prior to initial termination of participation will have a separate eligibility period.

If you enroll in the DCAP Component, terminate employment, and are later rehired within 30 days, you are required to immediately rejoin the Plan and be reinstated with the same election as before termination of participation less any missed contributions; resuming your per pay period contribution. Qualifying services incurred during the period of termination would be eligible for reimbursement through the end of the Plan Year but missed contributions cannot be made up. If you are rehired more than 30 days after termination, you will be treated as a new hire and must re-satisfy the Plan eligibility/entry requirements. The new election is subject to the IRS annual max and plan design if less. Qualifying services incurred during the period of termination would be eligible for reimbursement through the end of the Plan Year.

✓ ***What if I lose eligibility and then later regain eligibility during the Plan Year?***

If you enroll in the Health FSA Component, lose eligibility, and later regain eligibility within 30 days, you are required to immediately rejoin the Plan and be reinstated with the same election as before termination of participation; resuming your per pay period contribution. If a period of non-coverage occurs due to missed contributions, services incurred during the period of non-coverage will not be eligible for reimbursement and missed contributions cannot be made up. If you regain eligibility more than 30 days after the loss of eligibility date, you are treated as a new hire and must re-satisfy the Plan eligibility/entry requirements. The new election is subject to the IRS annual max and plan design if less. Services incurred during the period of non-coverage will not be eligible for reimbursement. Any unused reimbursement account balance prior to initial termination of participation will have a separate eligibility period.

If you enroll in the DCAP Component, lose eligibility, and later regain eligibility within 30 days, you are required to immediately rejoin the Plan and be reinstated with the same election as before termination of participation less any missed contributions; resuming your per pay period contribution. Qualifying services incurred during the loss of eligibility period would be eligible for reimbursement through the end of the Plan Year but missed contributions cannot be made up. If you regain eligibility more than 30 days after the loss of eligibility date, you will be treated as a new hire and must re-satisfy the Plan eligibility/entry requirements. The new election is subject to the IRS annual max or plan design if less. Qualifying services incurred during the loss of eligibility period would be eligible for reimbursement through the end of the Plan Year.

All Employees who terminate and are later rehired or lose eligibility and later regain eligibility during the same Plan Year must be treated the same based on when the event occurs.

- If you are rehired or regain eligibility within the same Plan Year as you termed or lost eligibility, but there is not enough time left in the Plan Year to meet the rehire or regain eligibility rules, you are still required to complete the remaining timeframe of the rehire or regain eligibility rules before entering the new FSA Plan Year.
- If you are rehired or regain eligibility and also experience an intervening event that would permit an election change (as permitted under the Plan), the rehire or regain eligibility rules would be applied first and the election change would follow.
- If you are not rehired or don't regain eligibility within the same Plan Year that you terminated or lost eligibility, you will be treated as a new hire and must meet the eligibility and entry requirements based on your Employer's FSA plan design.

If prior to termination or loss of eligibility, you were eligible and choose to waive FSA participation, your Employer's plan design for rehire and regain eligibility will still apply and will define whether you may make a new election or will be reinstated back to your previous enrollment status of no election. Refer to the above stated rules for guidance.

IV. Component Options

Premium Payment Component

✓ ***What is the Premium Payment Component?***

You will be able to pay for your share of contributions for Group Sponsored Insurance premiums or other qualified benefits with pre-tax dollars, provided you elect this coverage on the applicable enrollment form. Because the share of the contributions that you pay will be with pre-tax funds, you may save both federal income taxes and FICA (Social Security) taxes. In some situations your Employer may fund a portion of the premium.

Eligible Group Sponsored Insurance premiums include the premiums paid for medical and hospitalization insurance, major medical insurance, dental insurance, vision insurance, and/or other qualified benefits under Section 125 made available by the Employer. The insurance may cover you, your spouse, and/or any eligible dependent children. You may not enroll for this benefit if you can be reimbursed for the premium cost by any other source.

Your Employer offers a Health Savings Account (HSA) Benefit under the Plan, which permits eligible Employees to make pre-tax contributions to an HSA that Employees establish and maintain with an HSA trustee/custodian, outside the Plan. The HSA Benefits under the Plan consist solely of the ability to make pre-tax contributions under the Plan. Refer to Section VII Health Saving Accounts for applicable IRS regulations.

✓ ***How are my benefits paid for under the Premium Payment Component?***

If you select Group Sponsored Insurance described above, then you may be required to pay a portion of the contributions. When you complete the enrollment form, if you elect to pay for benefits on a pre-tax basis, you agree to a salary reduction to pay for your share of the cost of coverage (also known as contributions) with pre-tax funds instead of receiving a corresponding amount of your regular pay that would otherwise be subject to taxes. From then on, you must pay a contribution for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck, or an amount otherwise agreed to or as deemed appropriate by the Employer). The Employer may contribute all, some, or no portion of the benefits under the Premium Payment Component that you have selected, as described in documents furnished separately to you.

The Employer will then disburse the premium payment(s) to the applicable carrier(s). This method of payment is sometimes referred to as “Employer Disbursed Premium” (EDP) payments.

Note: This SPD does not describe the Group Sponsored Insurance. Consult the Group Sponsored Insurance plan documents and the separate SPD for the Group Sponsored Insurance.

Health FSA Component

✓ ***What is the Health FSA Component?***

You may use a Health FSA to pay for eligible medical care expenses incurred during the Plan Year with pre-tax dollars that have been reduced from your salary, provided you elect this coverage on the applicable enrollment form. Because the share of the contributions that you pay will be with pre-tax funds, you may save both federal income taxes and FICA (Social Security) taxes.

The Health FSA Component is intended to pay benefits solely for medical care expenses not reimbursed elsewhere. Accordingly, the Health FSA Component shall not be considered to be a group health plan for coordination of benefits purposes, and benefits under the Health FSA Component shall not be taken into account when determining benefits payable under any other plan. In the event that an expense is eligible for reimbursement under both the Health FSA Component and an HSA, you may seek reimbursement from either the Health FSA or the HSA, but not both.

✓ ***What are my Health FSA Component options?***

A Health FSA Component election may be for one of the following:

(a) General-Purpose Health FSA Option;
(b) Limited-Scope Health FSA Option (Vision/Dental Care, excluding Preventive Care); or
(c) Limited-Purpose Health FSA Option (Vision/Dental/Preventive Care).

Refer to Section II – Your Plan at a Glance to determine the options available to you under your Employers' Plan.

HSA Benefits cannot be elected with the Health FSA Component unless the Limited-Purpose Health FSA Option is available and selected.

✓ ***What are my Health FSA accounts?***

Once you elect to participate in one of the Health FSA Component options, then an account will be set up in your name to keep a record of the reimbursements that you are entitled to, as well as the contributions that you elected to have reduced from your salary or wages. Your Health FSA accounts are recordkeeping accounts and do not bear interest.

Your salary reductions will be deposited into a Health Related Expense (HRE) Account, a Limited-Scope Health FSA (LSFSA) Account or a Limited-Purpose Health FSA (LFSA) Account from which funds will be withdrawn to reimburse you for eligible medical care expenses incurred by you and your eligible family members under one of the Health FSA Component options.

✓ ***What are the benefits that I may elect under the Health FSA Component?***

The maximum salary reduction you can elect under the General-Purpose Health FSA Option is $2,750 with a minimum salary reduction of $0. The maximum salary reduction you can elect under the Limited-Scope Health FSA Option is Not Available with a minimum salary reduction of Not Available. The maximum salary reduction you can elect under the Limited-Purpose Health FSA Option is $2,750 with a minimum salary reduction of $0. Mid-year hires and election changes due to a qualifying event, as allowed under the component, will be pro-rated. The maximum pay period contribution cannot exceed the annual IRS limit divided by the number of pay periods in the Plan Year.

✓ ***How are my benefits paid for under the Health FSA Component?***

When you complete the enrollment form, you specify the amount of benefits that you wish to pay for with your salary reduction. From then on, you must pay a contribution for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck or an amount otherwise agreed to or as deemed appropriate by the Employer). For example, suppose you have elected a salary reduction of $1,300 for medical care expenses and that you have chosen no other benefits under the Plan. If you pay all of your contributions, then your Account would be credited with a total of $1,300 during the Plan Year. If you are paid bi-weekly, then your Account would reflect that you have paid $50.00 ($1,300 divided by 26) each pay period in contributions for the benefits that you have elected.

✓ ***What medical care expenses may be reimbursed?***

The Health FSA Component cannot reimburse you for any expenses that have been reimbursed by any other plan or source and you cannot claim a tax deduction for any expenses reimbursed under the Plan. The eligible medical care expenses vary according to the type of Health FSA Component option that is elected, as described below.

(a) **General-Purpose Health FSA Option.** For purposes of this Option, "Medical Care Expense" means expenses incurred by you, your Spouse, or your Dependents for "medical care" as defined in Code §213(d). Over-the-counter (OTC) medicines or drugs such as aspirin, antihistamines, and cough syrup qualify as medical care expenses. In addition, as described above, only reasonable quantities of OTC drugs will be reimbursed from your HRE Account in a single calendar month. Stockpiling is not permitted.

The following list specifies certain expenses that are not reimbursable, even if they meet the definition of medical care under Code §213(d) and may otherwise be reimbursable under regulations governing Health FSAs. Note that many expenses that are not on the list of exclusions below will still not be reimbursable if such expenses do not meet the definition of medical care under Code §213(d) and other requirements for reimbursement under the Health FSA.

EXCLUSIONS:

- Premiums for other health coverage, including but not limited to premiums for any other plan (whether or not sponsored by the Employer).
- Long-term care services.
- Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. “Cosmetic surgery” means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.
- The salary expense of a nurse to care for a healthy newborn at home.
- Funeral and burial expenses.
- Household and domestic help (even if recommended by a qualified physician due to an Employee's or Dependent's inability to perform physical housework).
- Custodial care.
- Costs for sending a child to a special school for benefits that the child may receive from the course of study and disciplinary methods.

- Social activities, such as dance lessons (even if recommended by a physician for general health improvement).
- Bottled water.
- Cosmetics, toiletries, toothpaste, etc.
- Uniforms or special clothing, such as maternity clothing.
- Automobile insurance premiums.
- Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician.
- Any item that does not constitute “medical care” as defined under Code §213(d).
- Any item that is not reimbursable due to the rules in Prop. Treas. Reg. §1.125-5(k)(4) or other applicable law or regulations.

For more information about what items are-and are not-medical care expenses, consult IRS Publication 502 (Medical and Dental Expenses) under the headings "What Medical Expenses Are Includible?" and "What Expenses Are Not Includible?" But use IRS Publication 502 with caution, because it was meant only to help taxpayers figure out what medical expenses can be deducted on the Form 1040 Schedule A (i.e., to figure out their tax deductions), not what is reimbursable under a Health FSA. In fact, some statements in IRS Publication 502 aren't correct when determining whether that same expense is reimbursable from a Health FSA. This is because there are several fundamental differences between what is deductible as medical care (under Code §§213(a) and 213(b)) and what is reimbursable as medical care under a Health FSA (under Code §213(d)). Not all expenses that are deductible are reimbursable under a Health FSA. For example, health insurance premiums, founders' fees, lifetime care, long-term contracts, and long-term care services are listed as deductible expenses in Publication 502, but generally they cannot be reimbursed from a Health FSA. And not all expenses that are reimbursable under a Health FSA are deductible. For example, Health FSAs may reimburse OTC drugs if they qualify as medical care under Code §213(d), but they are still not deductible under Code §§213(a) and 213(b).

Ask the Employer or PSA if you need further information about which expenses are-and are not-likely to be reimbursable, but remember that the Employer and PSA are not providing legal advice.

(b) **Limited-Scope Health FSA Option (Vision/Dental Care, excluding Preventive Care).** You may be eligible to make/receive tax-favored contributions to the Limited-Scope Health FSA Option and participate in a Health FSA Component if the Health FSA reimbursement is limited to the medical care expenses listed below:
- Services or treatments for dental care (excluding premiums); or
- Services or treatments for vision care (excluding premiums).

(c) **Limited-Purpose Health FSA Option (Vision/Dental/Preventive Care).** The Limited-Purpose Health FSA will not reimburse medical care expenses that would disqualify an individual from contributing to an HSA. According to rules in Code §223 (applicable to HSAs), you will not be able to make/receive tax-favored contributions to your HSA if you participate in a Health FSA that reimburses medical care expenses as described under the General-Purpose Health FSA Option (see subsection (a) above). You may, however, be eligible to make/receive tax-favored contributions to an HSA and participate in a Health FSA Component if the Health FSA reimbursement is limited to the medical care expenses listed below:

- Services or treatments for dental care (excluding premiums);
- Services or treatments for vision care (excluding premiums); or
- Services or treatments for "preventive care." Preventive care is defined in accordance with applicable rules and regulations under Code §223(c)(2)(C). This may include prescribed drugs to the extent that such drugs are taken by an eligible individual (1) to delay or prevent the onset of symptoms of a condition for which symptoms have not yet manifested themselves (i.e., the eligible individual is asymptomatic); (2) to prevent the recurrence of a condition from which the eligible individual has recovered; or (3) as part of a preventive care treatment program (e.g., a smoking-cessation or weight-loss program). Preventive care does not include services or treatments that treat an existing condition.

✓ ***What amounts will be available from the HRE, LSFSA, or LFSA Account at any particular time during the Plan Year?***

The full amount of Health FSA coverage that you have elected (reduced by prior reimbursements made during the same Plan Year) will be available to reimburse you for qualifying medical care expenses incurred during the Plan Year, regardless of the amount that you have contributed when you submitted the claim (so long as you have continued to pay the contributions). This is known as the “Uniform Coverage” rule.

✓ ***Is there any risk of losing or forfeiting the amounts that I elect?***

Yes. The difference between what you elected and the medical care expenses that were reimbursed will be forfeited at the end of the time limits. You should read the Plan in its entirety before electing to participate in the Plan.

✓ ***Does COBRA apply to my Health FSA?***

Health FSA COBRA continuation coverage will be available if the Employer normally employed 20 or more Employees on a typical business day during 50% or more of the preceding calendar year. The COBRA Administrator shall provide notice to the Participant of his or her right to continuation coverage and shall administer continuation coverage hereunder in accordance with applicable law and regulations.

Employers subject to COBRA must offer Health FSA COBRA coverage to qualified beneficiaries who lose their Health FSA coverage as the result of a qualifying event when the account is underspent (taking into account all claims submitted and deductions due before the date of the qualifying event). An Employer is not required to offer COBRA when accounts are overspent, but may choose to do so in a uniform manner.

The type of COBRA continuation obligation depends on whether the Health FSA is considered to be a qualifying Health FSA.

- If the Health FSA is a qualifying Health FSA, COBRA continuation coverage must be offered to all qualified beneficiaries but is subject to special limitations. This is called Special Limited COBRA continuation. If the Special Limited COBRA continuation is elected for the Health FSA, it will be available only for the Plan Year in which the qualifying event occurs, with coverage for the Health FSA ceasing at the end of the Plan Year, and no ability to re-enroll with a new election for the next Plan Year. In the event the qualified beneficiary experiences a secondary qualifying event, the COBRA continuation period may not be extended.
- If the Health FSA is not a qualifying Health FSA, COBRA continuation coverage must be offered to all qualified beneficiaries for the maximum COBRA period which includes the

rest of the Plan Year in which the qualifying event occurred, and, until the maximum COBRA period expires. Qualified beneficiaries may re-enroll for subsequent plan years during open enrollment with a new election. In addition, in the event the qualified beneficiary experiences a secondary qualifying event, the COBRA continuation period may be extended.

Regardless if the Health FSA is considered qualifying or not, if the Grace Period applies to the Health FSA, the Grace Period would also apply to Participants who are receiving coverage under the Health FSA at the end of the Plan Year.

A Participant who elects Health FSA COBRA continuation coverage will generally pay for coverage with after-tax dollars by writing a check to his or her Employer each month. However, an agreement can be made with the Employer to make payments with pre-tax dollars to his or her Employer, generally on a monthly basis but only through the end of the Plan Year in which the qualifying event occurred.

✓ ***Can I continue my Health FSA coverage without electing COBRA?***
Yes. You can elect to have a final pre-tax final paycheck salary reduction withheld. In the alternative, you may elect to pay on an after-tax basis any remaining contributions for the Plan Year. The Premium Completion Agreement extends eligibility to incur qualified health related expenses. This agreement is referred to as a Premium Completion Agreement. In the event the Employee terminates employment or otherwise ceases to be an eligible Employee, then the Employer can require the Employee to waive his or her COBRA rights with respect to the Health FSA as a condition to electing the voluntary Premium Completion Agreement to cover the Health FSA premium for the balance for the current Plan Year.

If the Grace Period applies to the Health FSA, the Grace Period would also apply to Participants who are receiving coverage under the Health FSA at the end of the Plan Year.

DCAP Component

✓ ***What is the DCAP Component?***

You may use the DCAP Component to pay for eligible dependent care expenses incurred during the Plan Year with pre-tax dollars that have been reduced from your salary, provided you elect this coverage on the applicable enrollment form. Because the share of the contributions that you pay will be with pre-tax funds, you may save both federal income taxes and FICA (Social Security) taxes.

The DCAP Component is intended to pay benefits solely for dependent care expenses not reimbursed elsewhere. Eligible dependent expenses might include: infant care, daycare, elder care etc. You may receive reimbursements under this component only if the dependent care is necessary to enable you and your spouse to work or seek employment, or if you work and your spouse is a student or is disabled. The dependent must reside with you more than half the year for the expenses with respect to that dependent to be eligible for reimbursement under this portion of the DCAP Component.

✓ ***What is my DCE Account?***

Once you elect to participate in the DCAP Component, then an account will be set up in your name to keep a record of the reimbursements that you are entitled to, as well as the contributions that you elected to have reduced from your salary or wages. The account is a recordkeeping account and does not bear interest.

Your salary reductions will be deposited into a Dependent Care Expense (DCE) Account from which funds will be withdrawn to reimburse you for eligible dependent care expenses incurred by you.

✓ ***What are the benefits that I may elect under the DCAP Component?***

The maximum salary reduction you can elect under the DCAP Component is $5,000 with a minimum salary reduction of $0. Mid-year hires and election changes due to a qualifying event, as allowed under the component, will be pro-rated. The maximum pay period contribution cannot exceed the annual IRS limit divided by the number of pay periods in the Plan Year.

The amount of dependent care expense reimbursement that you choose cannot exceed $5,000 for a calendar year or, if lower, the maximum amount that you have reason to believe will be excludable from your income under Code §129 when your election is made. The $5,000 maximum will apply to you if:

- you are married and file a joint federal income tax return;
- you are married and file a separate federal income tax return, and meet the following conditions: (1) you maintain as your home a household that constitutes (for more than half of the taxable year) the principal place of abode of a Qualifying Individual (i.e., the Dependent for whom you are eligible to receive reimbursements under the DCAP); (2) you furnish over half of the cost of maintaining the household during the taxable year; and (3) during the last six months of the taxable year, your Spouse is not a member of the household; or
- you are single or the head of the household for federal income tax purposes.

If you are married and file a separate federal income tax return under circumstances other than those described above, then the maximum DCAP benefit that you may exclude from your income under Code §129 is $2,500 for a calendar year.

These maximums ($5,000 or $2,500 for a calendar year, as applicable) are just the largest amount that is possible; the maximum amount that you are able to exclude from your income may be less because of other limitations (for example, note that you cannot exclude more than the amount of your or your Spouse's earned income for the calendar year).

✓ ***How are my benefits paid for under the DCAP Component?***

When you complete the enrollment form, you specify the amount of DCAP benefits that you wish to pay with your salary reduction. From then on, you must pay a contribution for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck or an amount otherwise agreed to or as deemed appropriate by the Employer). For example, suppose you have elected a salary reduction of $2,600 for dependent care expenses and that you have chosen no other benefits under the Plan. If you pay all of your contributions, then your DCE Account would be credited with a total of $2,600 during the Plan Year. If you are paid bi-weekly, then your DCE Account would reflect that you have paid $100.00 ($2,600 divided by 26) each pay period in contributions for the benefits that you have elected.

✓ ***What dependent care expenses may be reimbursed?***

Dependent care expenses means employment-related expenses incurred on behalf of a person who meets the requirements to be a qualifying individual, as defined below. All of the following conditions must be met for such expenses to qualify as dependent care expenses that are eligible for reimbursement:

- Each person for whom you incur the expenses must be a qualifying individual, that is, he or she must be:
    - a person under age 13 who is your "qualifying child" under the Code (in general, the person must: (1) have the same principal abode as you for more than half the year; (2) be your child or stepchild (by blood or adoption), foster child, sibling or stepsibling, or a descendant of one of them; and (3) not provide more than half of his or her own support for the year);
    - your spouse who is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as you for more than half of the year; or
    - a person who is physically or mentally incapable of caring for himself or herself, has the same principal place of abode as you for more than half of the year, and is your tax dependent under the Code (for this purpose, status as a tax dependent is determined without regard to the gross income limitation for a "qualifying relative" and certain other provisions of the Code's definition).

  NOTE: Under a special rule for children of divorced or separated parents, a child is a qualifying individual with respect to the custodial parent when the noncustodial parent is entitled to claim the dependency exemption for the child. See the Employer for more information on which individuals will qualify as your qualifying individuals.

- No reimbursement will be made to the extent that such reimbursement would exceed the balance in your DCE Account.
- The expenses are incurred for services rendered after the date of your election to receive DCAP benefits and during the Plan Year to which the election applies.
- The expenses are incurred in order to enable you (and your spouse, if you are married) to be gainfully employed, which generally means working or looking for work. There is an

exception: If your spouse is not working or looking for work when the expenses are incurred, he or she must be a full-time student or be physically or mentally incapable of self-care. The expenses can also be incurred while you are working and your Spouse is sleeping (or vice versa), if one of you works during the day and the other works at night and sleeps during the day.

- The expenses are incurred for the care of a qualifying individual or for household services attributable in part to the care of a qualifying individual.
- If the expenses are incurred for services outside of your household for the care of a qualifying individual other than a person under age 13 who is your qualifying child, then the qualifying individual must regularly spend at least eight hours per day in your household.
- If the expenses are incurred for services provided by a dependent care center (that is, a facility that provides care for more than six individuals not residing at the facility), the center complies with all applicable state and local laws and regulations.
- The person who provided care was not your spouse, a parent of your under-age-13 qualifying child (e.g., a former spouse who is the child's noncustodial parent), or a person for whom you (or your spouse) are entitled to a personal exemption under Code §151(c). If your child provided the care, then he or she must be age 19 or older at the end of the year in which the expenses are incurred.
- The expenses are not paid for services outside of your household at a camp where the qualifying individual stays overnight.
- The expenses can be for any of the following (assuming that the other requirements for reimbursement are met):
    - expenses for a day camp or a similar program to care for a Qualifying Individual, even if the camp specializes in a particular activity (e.g., soccer or computers), but excluding any separate equipment or similar charges (note that summer school and tutoring program expenses don't qualify because they are considered to be primarily for education rather than for care);
    - the cost of a Qualifying Individual's transportation to or from a place where care is provided, if furnished by a dependent care provider; and
    - expenses such as application fees, agency fees, and deposits that relate to but are not directly for a Qualifying Individual's care, if you must pay the expenses in order to obtain the related care (expenses of this type cannot be reimbursed unless and until the related care is provided-e.g., a deposit that is forfeited because you decide to send your child to a different dependent care provider is not eligible for reimbursement).

For more information about what items are-and are not-deductible dependent care expenses, consult IRS Publication 503 (Child and Dependent Care Expenses) under the heading "Tests to Claim the Credit." But use Publication 503 with caution, because it was meant only to help taxpayers figure out whether they can claim the household and dependent care services tax credit under Code §21 (the Dependent Care Tax Credit, discussed below), not to explain what is reimbursable under a DCAP. In fact, some of the statements in Publication 503 aren't correct when determining whether that same expense is reimbursable under your DCAP. This is because there are several fundamental differences between what expenses qualify for the Dependent Care Tax Credit and what expenses are reimbursable under a DCAP. Not all expenses that qualify for the Dependent Care Tax Credit are reimbursable under a DCAP. For example, for an expense to qualify for the Dependent Care Tax Credit in a given year, it must have been paid during that year, but to be reimbursed from the DCAP, the expense must have been incurred during the Plan Year for which reimbursement is sought.

Ask the Employer or PSA if you need further information about which expenses are-and are not-likely to be reimbursable, but remember that the Employer and PSA are not providing legal advice.

✓ ***What amounts will be available from the DCE Account at any particular time during the Plan Year?***

The amount of coverage that is available for reimbursement of qualifying dependent care expenses at any particular time during the Plan Year will be equal to the amount credited to your DCE Account at the time your claim is paid, reduced by the amount of any prior reimbursements paid to you during the Plan Year. For example, suppose that you incur $1,500 of dependent care expenses. At that time, your DCE Account would only have been credited with $700 ($100 times 7 pay periods), so only $700 would be available for reimbursement (assuming that you had not received any prior reimbursements). The remaining $800 in dependent care expenses would be held as a pending claim until additional contributions are credited to your DCE Account.

✓ ***Is there any risk of losing or forfeiting the amounts that I elect?***

Yes. The difference between what you elected and the dependent care expenses that were reimbursed will be forfeited at the end of the time limits. You should read the Plan in its entirety before electing to participate in the Plan.

✓ ***Can I continue DCAP coverage after terminating employment?***

When you cease to be a Participant under the DCAP Component, your salary reductions and election to participate will terminate. However, you will be able to receive reimbursements for qualifying dependent care expenses incurred during the period of coverage following termination through the end of the Plan Year.

V. Administrative Provisions

Funding and Type of Plan Administration

The Employer is the Plan Administrator for the Plan in accordance with ERISA §3(16)(a). The Plan is intended to qualify as a "cafeteria plan" under Code §125. The Employer's failure to enforce any provision of the Plan shall not affect its right to later enforce that provision or any other provision of the Plan.

The Employer has retained PacificSource Administrators, Inc. (PSA) to act as the Third Party Administrator and provide certain administrative services associated with the Plan. PSA is not a fiduciary of the Plan. PSA has **no** discretionary authority to interpret the Plan provisions or issues arising under the Plan, such as issues of eligibility, coverage, and benefits. PSA is not an "administrator" as defined in ERISA §3(16)(a).

Nothing herein will be construed to require the Employer or PSA to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account, or asset of the Employer from which any payment under this Plan may be made. There is no trust or other fund from which benefits are paid. While the Employer has complete responsibility for the payment of benefits out of its general assets (except for Premium Payment benefits paid as provided in the applicable insurance policy), it may hire an unrelated third-party paying agent to make benefit payments on its behalf.

You must make all elections about the use of the Plan before your entry date into the Plan. If you elect to pay for benefits on a pre-tax basis, you agree to a salary reduction to pay for your share of the cost of coverage (also known as contributions) with pre-tax funds instead of receiving a corresponding amount of your regular pay that would otherwise be subject to taxes. From then on, you must pay contributions for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck, or an amount otherwise agreed to or as deemed appropriate by the Employer). The amount reduced from your salary or wages cannot exceed the amount of your annual salary or wages.

Only expenses incurred on or after your entry date and prior to the end of the Plans period of coverage are eligible for payment. Your period of coverage is generally the same as the Plans period of coverage but if you begin or end eligibility in the middle of the Plan Year, your period of coverage is the portion of the Plan Year during which you were eligible in the Plan. An expense is incurred on the date a service is provided or rendered and not on the date that the service is billed or paid. You may submit claims incurred during your "period of coverage" for 90 days after the Plans period of coverage. Claims submitted beyond this run-out period are ineligible for reimbursement.

For purposes of the Group Sponsored Insurance, the terms Spouse and Dependent are defined as provided in the Group Sponsored Insurance. For purposes of the other benefits, Spouse means a person of the same or opposite sex who is treated as a spouse for federal tax purposes. For purposes of the Health FSA, Dependent means (a) your son, daughter, stepchild, legally adopted child, or eligible foster child who has not attained age 27 (e.g. end of the year in which the child turns 26) as of the end of the calendar year; and (b) your tax dependent under the Code except that an individual's status as a Dependent is determined without regard to the gross income limitation for a qualifying relative and certain other provisions of the Code's

definition. See the Employer for more information about which individuals will qualify as your Spouse or Dependents.

You and individuals who qualify as your dependents may receive benefits under the Plan. An individual may qualify as your dependent for purposes of this Plan even if that individual is not your tax dependent. An individual who would qualify as your tax dependent but has gross income in excess of the exemption amount, is a dependent of a dependent, or is married and files a joint tax return with his or her spouse, will be considered your dependent for purposes of this Plan. This may include the Participant's children, grandchildren, stepchildren, parents, in-laws, or any other person (other than the Participant's spouse) whose principal place of abode is the home of the Participant and who is a member of the Participant's household. For purposes of the DCAP Component, a dependent must reside with you for more than half of the year for expenses with respect to that dependent to be eligible for reimbursement under that portion of the Plan.

Election Changes

✓ ***Can I change my elections under the Plan during the Plan Year?***

As a general rule, your elections for the Plan Year are irrevocable for the balance of the year. However, certain exceptions apply which may allow you to revoke your election and make a new election. If you wish to change your election based on a change in status, you must establish that the revocation is on account of and corresponds with the change in status. The Employer, in its sole discretion and on a uniform and consistent basis, shall determine whether a requested change is on account of and corresponds with a change in status. As a general rule, a desired election change will be found to be consistent with a change in status event if the event affects coverage eligibility.

Accounts subject to the Uniform Coverage rule (Health FSA) can be excluded. Specific to your Plan design, benefit changes can be made as indicated below:

- Increases and Decreases to the Group Sponsored Insurance premiums (if permitted by insurance carrier) shall automatically result in a corresponding election change to the Premium Payment Component
- No Changes can be permitted to the HRE, LSFSA, or LFSA Account
- Both Increases and Decreases can be permitted to the DCE Account

If the Plan allows you to make reductions to your Health FSA coverage, your reduction cannot result in your contributions for the year being less than the amount for which you have already been reimbursed. For example, assume that you elected to contribute $100 per month to the Health FSA and in the second month you were reimbursed for expenses in the amount of $700. If a change in status event occurs in the third month that allows you to change coverage, your future contributions to the Health FSA cannot be reduced to a point where the total contributions for the Plan Year are less than the $700 already reimbursed for the Plan Year.

✓ ***When can I change my elections under the Plan during the Plan Year?***

If any change in election event occurs, you must inform the Employer and complete a Status Change Form within 30 days after the occurrence (or within 60 days after the occurrence in the case of a special enrollment right due to loss of eligibility for Medicaid or state children's health insurance program coverage, or eligibility for a state premium assistance subsidy from a Medicaid plan or through a state children's health insurance program with respect to coverage

under the Medical Insurance Plan). If the change involves a loss of your spouse's or dependent's eligibility for medical insurance benefits, then changes made to your Group Sponsored Insurance Plan will be deemed effective as of the date that eligibility is lost due to the occurrence of the Change in Election Event, even if you do not request it within 30 days.

- **Leaves of Absence (Applies to all Components of this Plan).** You may change an election under the Plan upon FMLA and non-FMLA leave only as described in Section V Administrative Provisions – Family and Medical Leave Act.

- **A Change in Status (Applies to all Components as Limited Below).** The Plan allows you to make a mid-year plan change or revocation of a benefit election if the change or revocation is consistent with a change in status. In this regard, a change in status is any of the following:
    - An event that changes your legal marital status, including marriage, death of a Spouse, legal separation, or annulment;

    - An event that changes the number of your Dependents, including by reason of birth, adoption, placement for adoption, or death of a Dependent;

    - Any of the following events that change the employment status of you, your Spouse, or your Dependent and that affect benefits eligibility under a cafeteria plan (including this Plan) or other employee benefit plan of you, your Spouse, or your Dependents. Such events include any of the following changes in employment status: termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; a change in worksite; switching from salaried to hourly-paid, union to non-union, or full-time to part-time (or vice versa); incurring a reduction or increase in hours of employment; or any other similar change that makes the individual become (or cease to be) eligible for a particular employee benefit;

    - An event that causes your Dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as attaining a specific age, ceasing to be a student, or a similar circumstance); or

    - A change in your, your Spouse's, or your Dependent's place of residence.

- **Change in Status-Other Requirements (Applies to Premium Payment, Health FSA (as limited below), and DCAP Components).** Generally, a revocation or change of your election is consistent with a change in status only if it is on account of and corresponds to a change in status that affects eligibility under an Employer's benefit plan. For example, if your Spouse terminates employment and loses healthcare coverage under the former Employer's benefit plan as a result, then that is a change in status affecting eligibility for healthcare coverage; if you then add your Spouse under the Employer's benefit plan, you could modify your election under the Premium Payment Component to pay for the increase in premiums under this Plan. An election change under the DCAP Component is consistent with a change in status if the election change is on account of and corresponds with a change in status that affects dependent care expenses.

  In addition, you must satisfy the following specific requirements in order to alter your election based on that change in status:

- **Loss of Spouse or Dependent Eligibility; Special COBRA Rules.** A special rule governs which types of election changes are consistent with the change in status. If you, your spouse, or dependent gains or loses coverage due to a COBRA qualifying event, you may change your election under the Premium Payment Component and Health FSA Component to pay for the continuation of coverage on a pre-tax basis or to reduce your election for the corresponding loss of coverage. See your Employer for more information.

  Example: Employee Mike is married to Sharon, and they have one child. The Employer offers a calendar-year cafeteria plan that allows Employees to elect any of the following: no medical coverage, employee-only coverage, employee-plus-one-dependent coverage, or family coverage. Before the plan year, Mike elects family coverage for himself, his wife Sharon, and their child. Mike and Sharon subsequently divorce during the plan year; Sharon loses eligibility for coverage under the plan, while the child is still eligible for coverage under the plan. Mike now wishes to revoke his previous election and elect no medical coverage. The divorce between Mike and Sharon constitutes a change in status. An election to cancel medical coverage for Sharon is consistent with this change in status. However, an election to cancel coverage for Mike and/or the child is not consistent with this change in status. In contrast, an election to change to employee-plus-one-dependent coverage would be consistent with this change in status.

- **Gain of Coverage Eligibility Under Another Employer's Plan.** For a change in status in which you, your Spouse, or your Dependent gains eligibility for coverage under another Employer's cafeteria plan (or qualified benefit plan) as a result of a change in your marital status or a change in your, your Spouse's, or your Dependent's employment status, your election to cease or decrease coverage for that individual under the Plan would correspond with that change in status only if coverage for that individual becomes effective or is increased under the other Employer's plan.

- **DCAP Component.** With respect to the DCAP Component, you may change or terminate your election with respect to a change in status event only if (a) such change or termination is made on account of and conforms with a change in status that affects eligibility for coverage under the DCAP; or (b) your election change is on account of and conforms with a change in status that affects the eligibility of dependent care expenses for the available tax exclusion.

  Example: Employee Mike is married to Sharon, and they have a 12-year-old daughter. The Employer's plan offers a DCAP as part of its cafeteria plan. Mike elects to reduce his salary by $2,000 during a plan year to fund dependent care coverage for his daughter. In the middle of the Plan Year when the daughter turns 13 years old, however, she is no longer eligible to participate in the DCAP. This event constitutes a change in status. Mike's election to cancel coverage under the DCAP would be consistent with this change in status.

- **Special Enrollment Rights (Applies Only to Premium Payment Component for the Medical Insurance Plan).** In certain circumstances, enrollment for Medical Insurance Benefits may occur outside the Open Enrollment Period. The Employer's Special Enrollment Notice also contains important information about your special enrollment rights. When a special enrollment right applies to your Medical Insurance Benefits, you may change your election under this Plan to correspond with the special enrollment right set forth in Section 9801(f) of the Internal Revenue Code. In brief, those rights provide that if you lose other healthcare plan coverage under certain circumstances, marry, or obtain an additional child through birth or adoption, you may be able to change your healthcare plan elections and make a corresponding change to your elections under this Plan. If you would like to do so, you should contact the Employer as soon as possible after the event occurs, within 30 days of that event.

- **Certain Judgments, Decrees, and Orders (Applies to Premium Payment, and Health FSA Components, but Not to DCAP Component).** If a judgment, decree, or order from a divorce, separation, annulment, or custody change requires your child (including a foster child who is your Dependent) to be covered under the Group Sponsored Insurance or Health FSA, you may change your election to provide coverage for the child. If the order requires that another individual (such as your former Spouse) cover the child, then you may change your election to revoke coverage for the child, provided that such coverage is, in fact, provided for the child.

- **Medicare and Medicaid (Applies to Premium Payment, and Health FSA Components as Limited Below, but Not to DCAP Component).** If you, your Spouse, or your Dependent becomes entitled to (i.e., becomes enrolled in) Medicare or Medicaid, then you may reduce or cancel that person's accident or health coverage under the Group Sponsored Insurance and/or your Health FSA may be canceled completely but not reduced. Similarly, if you, your Spouse, or your Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then you may elect to commence or increase that person's accident or health coverage (here, Group Sponsored Insurance and/or your Health FSA, as applicable).

- **Change in Cost (Applies to Premium Payment, and DCAP Components as Limited Below, but Not to Health FSA Component).** If the cost charged to you for your Group Sponsored Insurance or dependent care expenses significantly increases during the Plan Year, then you may choose to do any of the following:

    - make a corresponding increase in your contributions;

    - revoke your election and receive coverage under another benefit package option (if any) that provides similar coverage, or elect similar coverage under the plan of your Spouse's employer;

    - drop your coverage, but only if no other benefit package option provides similar coverage.

  For these purposes, the Health FSA is not similar coverage with respect to the Group Sponsored Insurance; an HMO and a PPO are considered to be similar coverage; and coverage under another employer plan, such as the plan of a Spouse's or Dependent's employer, may be treated as similar coverage if it otherwise meets the requirements of

similar coverage. If the cost of Group Sponsored Insurance or dependent care expenses significantly decreases during the Plan Year, then the Employer may permit the following election changes:

- if you are enrolled in the benefit package option that has decreased in cost, you may make a corresponding decrease in your contributions;

- if you are enrolled in another benefit package option, you may change your election on a prospective basis to elect the benefit package option that has decreased in cost; or

- if you are otherwise eligible, you may elect the benefit package option that has decreased in cost on a prospective basis, subject to the terms and limitations of the benefit package option.

For insignificant increases or decreases in the cost of benefits, however, the Employer will automatically adjust your election contributions to reflect the minor change in cost.

The Employer generally will notify you of increases or decreases in the cost of Group Sponsored Insurance; you must notify the Employer of increases or decreases in the cost of dependent care expenses if you want to make changes. The change in cost provision applies to DCAP Component only if the cost change is imposed by a dependent care provider who is not your relative.

- **Change in Coverage (Applies to Premium Payment, and DCAP Components, but Not to Health FSA Component).**
  You may also change your election if one of the following events occurs:

  - **Significant Curtailment of Coverage.** If your Group Sponsored Insurance or DCAP coverage is significantly curtailed without a loss of coverage (for example, when there is an increase in the deductible under the Medical Insurance Benefits), then you may revoke your election for that coverage and elect coverage under another benefit package option that provides similar coverage. (Coverage under a plan is significantly curtailed only if there is an overall reduction of coverage under the plan generally-loss of one particular physician in a network does not constitute significant curtailment.) If your Group Sponsored Insurance or DCAP coverage is significantly curtailed with a loss of coverage (for example, if you lose all coverage under the option by reason of an overall lifetime or annual limitation), then you may either revoke your election and elect coverage under another benefit package option that provides similar coverage, elect similar coverage under the plan of your Spouse's employer, or drop coverage, but only if there is no option available under the plan that provides similar coverage. (The Employer generally will notify you of significant curtailments in Group Sponsored Insurance; you must notify the Employer of significant curtailments in DCAP coverage if you want to make changes.)

  - **Addition or Significant Improvement of Salary Reduction Plan Option.** If the Plan adds a new option or significantly improves an existing option, then the Employer may permit Participants who are enrolled in an option other than the new or improved option to elect the new or improved option. Also, the Employer may permit eligible Employees to elect the new or improved option on a

prospective basis, subject to limitations imposed by the applicable option.

- **Loss of Other Group Health Coverage.** You may change your election to add group health coverage for you, your Spouse, or your Dependent, if any of you loses coverage under any group health coverage sponsored by a governmental or educational institution (for example, a state children's health insurance program or certain Indian tribal programs).

- **Change in Election Under Another Employer Plan.** You may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or a plan of your Spouse's or Dependent's employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change permitted under the IRS regulations; or (b) the Salary Reduction Plan permits you to make an election for a period of coverage (for example, the Plan Year) that is different from the period of coverage under the other cafeteria plan or qualified benefits plan, which it does. For example, if an election to drop coverage is made by your Spouse during his or her employer's open enrollment, you may add coverage under this Plan to replace the dropped coverage.

- **DCAP Coverage Changes.** You may make a prospective election change that is on account of and corresponds with a change by your dependent care service provider. For example: (a) if you terminate one dependent care service provider and hire a new dependent care service provider, then you may change coverage to reflect the cost of the new service provider; and (b) if you terminate a dependent care service provider because a relative becomes available to take care of the child at no charge, then you may cancel coverage.

- **Mid-Year Election Changes for Health Coverage (Applies only to Premium Payment Component)**
  Employer will default to not allow Employees to revoke their election under their Premium Payment Component if they meet the conditions specified under "Reduction in hours in service" or "Enrollment in a Qualified Health Plan".

✓ **Other than the reasons above, when could my elections change?**

You may also change your election if one of the following events occurs:

- **Error at time of Enrollment.** If a mistake is made as to your eligibility or participation, the allocations made to your account, or the amount of benefits to be paid to you or another person, then the Employer shall, to the extent that it deems administratively possible and otherwise permissible under the Code and other applicable law, allocate, withhold, accelerate, or otherwise adjust such amounts as will in its judgment accord the credits to the account or distributions to which you are or such other person is properly entitled under the Plan. Such action by the Employer may include withholding of any amounts due from your compensation.

- **Highly Compensated and/or a Key Employee.** If you are a Highly Compensated Employee or a Key Employee as defined by the IRS, the amount of your contributions and benefits may be limited so that the Plan as a whole does not unfairly favor those who are highly paid. Congress has intended this Plan to be available to all classes of

Employees and not to be considered top-heavy in participation.

Plan experience will dictate whether contribution limitations on Highly Compensated or Key Employees will apply. Employees will be notified of these limitations if affected. Your Employer may also reduce your salary reductions (and increase your taxable regular pay) during the Plan Year if you are a Highly Compensated and/or Key Employee as defined by the Internal Revenue Code ("the Code"), if necessary to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law.

Family and Medical Leave Act
(if applicable)

✓ ***What is the Impact of the Family and Medical Leave Act (FMLA)?***

Notwithstanding any other provision in this Plan, the Employer may (a) permit you to revoke (and subsequently reinstate) your election of one or more benefit coverage's under the Plan, (b) adjust your compensation reduction as a result of a revocation or reinstatement and (c) permit payment of your share of the cost of benefit coverage during an unpaid leave with after-tax dollars (or pay for benefits under another arrangement such as pre-paying the benefits with pre-tax dollars prior to the leave or "catching up" by paying for the benefits with pre-tax dollars subsequent to the leave) to the extent the Employer deems necessary or appropriate to assure the Plan's compliance with the provisions of the FMLA and any regulation pertaining thereto. You should consult the Employer if you have any questions.

✓ ***How does a leave of absence (such as FMLA) affect my health benefits?***

***FMLA Leaves of Absence*.** If you go on a qualifying leave under the FMLA, then to the extent required by the FMLA your Employer will continue to maintain your Group Sponsored Insurance and Health FSA coverage on the same terms and conditions as if you were still active (that is, your Employer will continue to pay its share of the contributions to the extent that you opt to continue coverage). Your Employer may require you to continue all Group Sponsored Insurance and Health FSA coverage while you are on paid leave (so long as Participants on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the contributions by the method normally used during any paid leave (for example, on a pre-tax salary-reduction basis).

If you are going on unpaid FMLA leave (or paid FMLA leave where coverage is not required to be continued) and you opt to continue your Group Sponsored Insurance and Health FSA coverage, then you may pay your share of the contributions in one of the following ways:

- **Pay-as-you-go:** with after-tax dollars, by sending monthly payments to the Employer by the due date established by the Employer;

- **Pre-pay:** with pre-tax dollars, by having such amounts withheld from your ongoing Compensation, if any, including unused sick days and vacation days, or pre-paying all or a portion of the Contributions for the expected duration of the leave on a pre-tax salary reduction basis out of pre-leave Compensation. To pre-pay the Contributions, you must make a special election to that effect prior to the date that such Compensation would normally be made available (pre-tax dollars may not be used to fund coverage during the next Plan Year);

- **Catch-up:** under another arrangement agreed upon between you and the Employer (e.g., the Employer may fund coverage during the leave and withhold "catch-up" amounts from your Compensation on a pre-tax or after-tax basis) upon your return.

If your Employer requires all Participants to continue Group Sponsored Insurance and Health FSA coverage during the unpaid FMLA leave, then you may discontinue paying your share of the required contributions until you return from leave. Upon returning from leave, you must pay your share of any required contributions that you did not pay during the leave. Payment for your

share will be withheld from your compensation either on a pre-tax or after-tax basis, depending on what you and the Employer agree to. If your Group Sponsored Insurance and Health FSA coverage ceases while you are on FMLA leave (e.g., for non-payment of required contributions), you will be permitted to re-enter such Benefits, as applicable, upon return from such leave on the same basis as when you were participating in the Plan before the leave or as otherwise required by the FMLA. You may be required to have coverage for such Benefits reinstated so long as coverage for Employees on non-FMLA leave is required to be reinstated upon return from leave.

But, despite the preceding sentence, with regard to the Health FSA coverage, if your coverage ceased (e.g., you revoke coverage or choose the Pay-as-you-go option and then fail to pay a required contribution) then you are not entitled to reimbursement for claims incurred during the period when the coverage is not in effect and you may not retroactively elect Health FSA coverage for claims incurred during the period when coverage was not in effect. However, you will be permitted to elect whether to be reinstated in the Health FSA at the same coverage level as was in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at a coverage level that is reduced pro rata for the period of FMLA leave during which you did not pay contributions. If you elect the pro rata coverage, the amount withheld from your compensation on a payroll-by-payroll basis for the purpose of paying for reinstated Health FSA will equal the amount withheld before FMLA leave.

Non-FMLA Leaves of Absence. If you go on an unpaid leave of absence that does not affect eligibility, then you will continue to participate and the contributions due for you will be paid by pre-payment before going on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by your Employer.

If you go on an unpaid leave that affects eligibility, then the election change rules in Section V Administrative Provisions – Election Changes will apply.

✓ ***How does a leave of absence (such as FMLA) affect my non-health benefits?***
If you are commencing or returning from FMLA leave, then your election for non-health benefits (such as dependent care expenses, etc.) will be treated in the same way as under your Employer's policy for providing such Benefits for Participants on a non-FMLA leave (see above). If that policy permits you to discontinue contributions while on leave, then upon returning from leave you will be required to repay the contributions not paid by you during leave. Payment will be withheld from your compensation either on a pre-tax or after-tax basis, as agreed to by the Employer and you or as the Employer otherwise deems appropriate. You are not entitled to reimbursements for claims incurred during the period when coverage is not in force.

"Use-it-or-Lose-it" Rule

If the expenses that you incur during your period of coverage in this Plan Year are less than the annual amount that you elected, you will forfeit all rights with respect to such balance to the following Plan Year.

Therefore, it is important to consider reducing your salary only to pay expenses you are sure you will incur during the Plan Year. Examples of the types of expenses that you know you will incur are regular expenses for items such as braces, insulin or other recurring drug expenses, office visit co-pay charges and weekly or monthly dependent care expenses.

Contributions allocated to one account under a component can only be used to pay claims for that component and no other. For example, amounts credited to your DCE Account cannot be used to pay or reimburse you for an expense under the HRE Account, even if your DCE Account has money in it but your HRE Account has none. Similarly, amounts credited to your HRE Account cannot be used to pay or reimburse you for a dependent care expense under the DCE Account, even if your HRE Account has money in it but your DCE Account has none.

You will forfeit any amounts in your account(s) that are not applied to pay expenses submitted no later than the end of the run-out period following the component's period of coverage end date for which the election was effective. Forfeited amounts will be used as follows: first, to offset any losses experienced by the Employer as a result of making reimbursements in excess of contributions paid by all Participants; second, to reduce the cost of administering the account during the Plan Year and subsequent Plan Year; and third, to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion that the Employer deems appropriate, consistent with applicable regulations. In addition, any benefit payments that are unclaimed (e.g., uncashed benefit checks) shall be forfeited and applied as described above.

Grace Period

A Grace Period is an extension of the time to use your Plan benefits before they become subject to the "Use-it-or-Lose-it" rule and will begin immediately following the last day of the Plan Year. This extension gives you an additional 2.5 months "Grace Period" after the end of a Plan Year in which to incur expenses that can be reimbursed from your prior Plan Year account(s) under the Health FSA and DCAP Account(s). Thus, expenses incurred within 2.5 months after the close of the Plan Year can be reimbursed with funds from the prior Plan Year. In order to take advantage of the Grace Period, you must be a Participant in the Plan with FSA coverage that is in effect on the last day of the Plan Year to which the Grace Period relates.

Funds available during the Grace Period under the Health FSA and DCAP Account(s) may only be used to pay or reimburse expenses eligible under the Health FSA and DCAP Account(s) respectively. For example, if you have not used a portion of your HRE Account by the end of the Plan Year, funds in that account remain available to pay or reimburse expenses incurred during the Grace Period.

The following additional rules will apply to expenses that are incurred during a Grace Period or are submitted after the close of the Plan Year in which they were incurred:

- Expenses incurred during a Grace Period and approved for reimbursement will be paid first from available amounts that were remaining at the end of the preceding Plan Year and then from any amounts that are available to reimburse expenses incurred during the current Plan Year. For example, assume that $200 remains in your HRE Account at the end of the preceding Plan Year and that you have also elected $2,400 in an HRE Account for the current Plan Year. If you submit a $500 expense that was incurred in the current Plan Year, $200 of your claim will be paid out of the unused amounts remaining in your HRE Account from the preceding Plan Year and the remaining $300 will be paid out of the amounts that are available to reimburse you for expenses incurred in the current Plan Year.
- Once paid, a claim will not be reprocessed or otherwise re-characterized so as to change the Plan Year from which funds are taken to pay it. For example, using the same facts as in the example in the preceding paragraph, assume that a few days after being

reimbursed for the $500 Grace Period expense, you discover $200 of the preceding Plan Year expenses that have not been submitted for reimbursement. You cannot be reimbursed for the newly discovered expenses because no amounts remain to reimburse you for the preceding Plan Year expenses. The Plan will not reprocess the $500 Grace Period expense so as to pay it entirely from your new HRE amounts. For this reason, if you also have an HRE Account for the current year, you may want to wait to submit expenses you incur during the Grace Period until you are sure you have no remaining unreimbursed expenses from the preceding Plan Year.

- Expenses incurred during a Grace Period must be submitted by the 90th day following the Plan Year ending date to which the Grace Period relates in order to be reimbursed from amounts remaining at the end of that Plan Year.
- If the Employer implements an electronic payment card plan (debit card, credit card, or similar method) to pay expenses from the Health FSA, expenses would need to be submitted manually in order to be reimbursed from unused amounts in your account from the preceding Plan Year as the card is unavailable for such reimbursement.

Ask your Employer or PSA if you have further questions about the Grace Period or how the Grace period works.

How Benefits are Taxed

Generally, you may not be taxed for the amounts you elect under the Plan. However, the Employer cannot guarantee that specific tax consequences will flow from your participation in the Plan. **This information is not intended to provide legal or tax advice. You should consult your own personal tax advisor.**

The tax benefits that you receive depend on the validity of the claims that you submit. If you are reimbursed for a claim that is later determined to not be eligible under the Plan, then you will be required to repay the amount. Alternatively, PSA may offset the amount against any other eligible expense submitted for reimbursement or your Employer may withhold the amount from your pay.

Ultimately, it is your responsibility to determine whether any reimbursement under the Plan constitutes an eligible expense that qualifies for the federal income tax exclusion. Any reimbursement that the Employer has reason to believe will exceed your statutory limit will be subject to FICA and income tax withholding. Note that if you are married and your spouse also participates in a DCAP, the maximum amount that you and your spouse together can exclude from taxable income is $5,000.

✓ ***How does enrollment in a DCAP affect my taxes?***

Using a DCAP for reimbursement of dependent care expenses results in a reduction of your taxable salary; therefore, your tax payments are reduced. Depending on your income tax bracket, you may also be entitled to claim the Federal Income Tax Credit for dependent care expenses. It is important to remember that you may use either of these (or a combination of the two), but you may not take a tax deduction of those expenses reimbursed under this Plan, or vice versa. For most individuals, participating in a DCAP will produce the greater federal tax savings, but there are some for whom the opposite is true. And in some cases, the federal tax savings from participating in a DCAP will be only marginally better. Because the preferable method for treating benefits payments depends on certain factors such as a person's tax filing status (e.g., married, single, head of household), number of qualifying individuals, earned

income, etc., each Participant will have to determine his or her tax position individually in order to make the decision. Use IRS Form 2441 (Child and Dependent Care Expenses) to help you.

Ask your Employer if you need further information about the DCAP or the Dependent Care Tax Credit, but remember that your Employer is not providing legal advice. If you need an answer upon which you can rely, you should consult your own personal tax advisor.

✓ ***If I elect DCAP, do I still report dependent care expenses on my federal income tax return?***

You must file a 2441 Child Care Tax Credit form with your annual tax filing. Your Employer is required to report the amount you elect to withhold from your salary on your IRS W-2 form. You must list the names and taxpayer identification numbers (TINs) of any entities that provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement.

You may not claim any other tax benefit for the amount of your pre-tax salary reductions under the DCAP Component, although your dependent care expenses in excess of that amount may be eligible for the Dependent Care Tax Credit. For example, if you elect $3,000 in coverage under the DCE Account and are reimbursed $3,000, but you had dependent care expenses totaling $5,000, then you could count the excess $2,000 when calculating the Dependent Care Tax Credit if you have two or more qualifying individuals.

Ask your Employer or PSA if you need further information about which expenses are, and are not, likely to be reimbursable.

The Plan Can Be Changed

The Plan is intended to comply with all applicable sections of the Internal Revenue Code and specifically Section 125; therefore, the Plan and any Employer benefit plans offered under the Plan may be amended to comply with the Internal Revenue Code and the Treasury Regulations as they may be amended. In addition, the Plan and any Employer benefit plans offered under the Plan may be amended at any time for reasons other than compliance with new law. Although the Employer expects to maintain the Plan, it has the right to amend or terminate all or any part of the Plan at any time for any reason.

How to File a Reimbursement Request

✓ ***What is required to submit a claim for benefits?***

If you have a claim under an insurance plan or policy, you should follow the claims procedure applicable to that plan or policy, as described in the SPD or similar explanatory booklet available from the insurer.

For claims associated solely with this Plan, you should file your claim for reimbursement as soon as possible after you have incurred the expense. It is not necessary for you to have actually paid the amount due for an expense; only for you to have incurred the expense and that it is not being paid for or reimbursed from any other source. A signed Request for Reimbursement Form is required for all requests that you submit via mail or fax. Your claim for expense reimbursement must include a statement from your service provider that you have incurred the expense and the amount of your expense. Further details about what must be

provided are contained in the Request for Reimbursement Form. In some instances, a statement from the provider that a Health FSA expense is medically necessary may be required.

If the Employer implements an electronic payment card plan (debit card, credit card, or similar method) to pay expenses from the Health FSA, some expenses may be validated at the time the expense is incurred (like co-pays for medical care). For other expenses, the card payment is only conditional and you will still have to submit supporting documents.

✓ ***How do I submit a claim for benefits?***
Claims may be submitted the following ways:

- Electronically via our secure web portal: https://hrbenefitsdirect.com/PSA
- Faxed with a reimbursement form to (866) 446-6090
- Mailed with a reimbursement form to PO Box 2797, Portland, OR 97208

✓ ***Is there a filing deadline?***
Claims will be paid up to 90 days after the Plan's period of coverage end date. Those submitted after the allowable year-end run-out period may not be paid.

✓ ***What happens if I receive an overpayment?***
If you receive reimbursement and it is later determined that you received an overpayment or a payment was made in error (e.g., you were reimbursed for an expense that is later paid by an insurance plan), you will be required to refund the improper payment to the Plan. If you do not refund the improper payment, the Plan reserves the right to offset future reimbursement equal to the improper payment or, if that is not feasible, to withhold such funds from your pay. If all other attempts to recoup the improper payment are unsuccessful, the Employer may treat the overpayment as a bad debt, which may have income tax consequences for you.

Handling Denied Claims

✓ ***What happens if my claim for benefits is denied?***
If PSA denies a claim, in whole or in part, you will be notified in writing within 30 days of the date PSA receives your claim. The 30-day period may be extended for an additional 15 days for matters beyond PSA's control, such as situations where a claim is incomplete. PSA will provide written notice of any extension, describing the reasons for the extension and the date by which you can expect a decision. Where a claim is incomplete, the extension notice will describe the information still needed by PSA and allow you 45 days from receipt of the notice to provide the additional information. If this happens, it will have the effect of suspending any decision on your claim until you provide the specified information.

If PSA denies your claim, you will receive a notice that includes the following elements:

- The specific reason or reasons for the denial;
- The specific Plan provision or provisions that support the denial;
- A description of any items or information you would need to validate your claim and an explanation of why the added material is necessary; and
- A description of the steps to appeal the denial, including your right to submit written comments, your right to review (upon request and at no charge) relevant documents and other information, and your right to file suit under ERISA (where applicable) with respect to any adverse determination after appeal of your claim.

Appeals

✓ ***Can I appeal a denied claim of benefits?***

You may appeal a claim denial by submitting a Request for Review (or other written appeal request) to PSA, in writing, within 180 days of your claim denial. If you do not appeal on time, you will lose the right to appeal the denial and the right to file suit in court. Your written appeal should state the reasons that you feel your claim should not have been denied, and should include any additional items or information that you feel supports your claim. The appeal process will provide you with the opportunity to ask additional questions and make written comments, and you may review (upon request and at no charge) documents and other information relevant to your appeal.

To the extent a dispute arises under the terms of one of the insurance plans or policies, such as a group medical or dental insurance plan offered by your Employer, your ability to appeal decisions under the insurance plan will be outlined in the SPD or similar explanatory booklet available from the insurer.

PSA will review your appeal in a reasonable time, but within 60 days after receiving your request. PSA may, in its discretion, hold a hearing on the denied claim. If PSA consults with a medical expert to help analyze your appeal, the expert will be different from, and not subordinate to, any expert that was consulted in connection with the initial claim denial. If upon review a decision is reached to affirm the original denial of your claim, you will receive a notice of that determination, which will include the following elements:

- The specific reason or reasons for the decision on review;
- The specific Plan provision or provisions that motivated the decision;
- A statement of your right to review (upon request and at no charge) relevant documents and other information;
- If internal rules, guidelines, protocols, or other similar criteria (collectively referred to as "internal guidelines") are relied on in making the decision on review, a description of the specific internal guidelines, or a statement that such internal guidelines were relied on, and a copy of the internal guidelines will be provided free of charge to you upon request; and
- A statement of your right to bring suit under ERISA Section 502(a) (where applicable).

ERISA Rights

The Premium Payment, and the DCAP Components are not ERISA welfare benefit plans under the Employee Retirement Income Security Act of 1974 (ERISA). However, the Health FSA Component and the Group Sponsored Insurance are governed by ERISA. Note: This SPD does not describe the Group Sponsored Insurance. Consult the Group Sponsored Insurance Plan Documents and the separate SPDs for the Group Sponsored Insurance.

✓ ***Do I have ERISA Rights?***

As a Participant in this Plan**,** you may be entitled to certain rights and protections under ERISA. ERISA does not apply to Employee benefit plans sponsored by governmental entities or churches. **If your Employer is a church or governmental organization (such as a city or school district), ERISA will not apply and you will not have the rights described in this section.**

✓ ***If I have ERISA Rights, what does that mean to me?***

ERISA provides that Plan Participants are entitled to:

- Examine, without charge, at the Employer's office and at other specified locations, such as work-sites and union halls, all Plan Documents and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports.
- Obtain copies of all documents and other Plan information upon written request to the Employer. The Employer may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if any. The Employer is required by law to furnish each Participant with a copy of this SPD.

Fiduciary Obligations

In addition to creating rights for Plan Participants, ERISA imposes duties upon the Employer who is responsible for the operation of an Employee benefit plan. The Employer is called the "fiduciary" of the Plan, and has a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit from the Plan, or from exercising your rights under ERISA.

Right to Review

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, you must submit this request to PSA, in writing, 180 days of the date of notice of your claim denial. Requests should be submitted to PacificSource Administrators, Attn: Request for Review, PO Box 2797, Portland, OR 97208.

Enforcing your rights

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan Documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Employer to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Employer. If you have a claim for benefits which is denied or ignored, in whole or in part, and if you have exhausted the claims procedures available to you under the plan, you may file suit in a state or federal court.

In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

Contact your Employer if you have any questions about your Plan, this statement or about your rights under ERISA. If you need assistance in obtaining documents from the Employer, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200

Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

HIPAA Privacy Rights

A federal law, the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), requires that the Plan protect the confidentiality of your private health information. The Plan and your Employer, as sponsor of the Plan, will not use or further disclose information that is protected under HIPAA (Protected Health Information or PHI) except as necessary for treatment, payment, healthcare operations and Plan administration, or as permitted or required by law.

As required under HIPAA, the Plan has required all of its business associates to also observe HIPAA's privacy rules. In particular, the Plan will not, without a written authorization from you, use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employment benefit plan of the Employer.

Under HIPAA, you have certain rights with respect to your PHI, including the right to review and copy the information, receive an accounting of any disclosures of the information and, under certain circumstances, amend the information. You also have a right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

VI. Notices Required by Law

Qualified Medical Child Support Order
The Health FSA will provide benefits as required by any qualified medical child support order (QMCSO), as defined in ERISA § 609(a). The Health FSA has detailed procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Employer.

Newborns' and Mothers' Health Protection Act of 1996 (NMPHA)
Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or to 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).

Women's Health and Cancer Rights Act of 1998 (WHCRA)
The Women's Health and Cancer Rights Act of 1998 (WHCRA) is a federal law that provides protections to patients who choose to have breast reconstruction in connection with a mastectomy. This law applies generally both to persons covered under group health plans and persons with individual health insurance coverage. But WHCRA does NOT require health plans or issuers to pay for mastectomies. If a group health plan or health insurance issuer chooses to cover mastectomies, then the plan or issuer is generally subject to WHCRA requirements.

Michelle's Law
"Michelle's Law", enacted October 9, 2008, requires group and individual health plans to continue to cover otherwise eligible dependent children taking a medical leave of absence from a postsecondary educational institution (e.g., a college, university, or vocational school) due to a serious illness or injury. Dependent children on a leave of absence must be covered until the earlier of one year from the first day of the leave of absence or the date on which the coverage otherwise would terminate.

The Genetic Information Nondiscrimination Act of 2008 (GINA)
GINA prohibits discrimination by health insurers and Employers based on individuals' genetic information. Genetic information includes the results of genetic tests to determine whether someone is at increased risk of acquiring a condition in the future, as well as an individual's family medical history. GINA imposes the following restrictions: prohibits the use of genetic information in making employment decisions restricts the acquisition of genetic information by Employers and others imposes strict confidentiality requirements and prohibits retaliation against individuals who oppose actions made unlawful by GINA or who participate in proceedings to vindicate rights under the law or aid others in doing so.

Health Information Technology for Economic and Clinical Health Act (HITECH Act)
HITECH was passed as part of the American Recovery and Reinvestment Act of 2009 to strengthen the privacy and security protection of health information, and to improve the workability and effectiveness of HIPAA Rules.

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

This law amends ERISA, the Public Health Service Act (PHSA), and the Internal Revenue Code (IRC) and applies to all ERISA group health plans and to health insurers that provide insurance coverage to group health plans. In general, this new law requires group health plans that provide mental health or substance use disorder benefits to provide such benefits on par with medical-surgical benefits.

What is a Qualified Reservist Distribution?

A Qualified Reservist Distribution permits you to take a distribution of the amount you have contributed to the Plan (less reimbursements you have received or distributions previously taken) as of the date you request the distribution. If you are ordered or called to active military duty for 180 days or more you may request a Qualified Reservist Distribution by delivering a copy of such order or call to active duty to the Employer. You must request a Qualified Reservist Distribution on or after the date of the order or call to active duty, and before the last day of the Plan Year (or Grace Period, if applicable) during which the order or call to active duty occurred. A Qualified Reservist Distribution is included in your gross income and wages, and is subject to employment taxes. You may submit expenses incurred after the date a Qualified Reservist Distribution has occurred. The amount that may be reimbursed is the amount by which you have elected to reduce your Compensation, less the sum of the Qualified Reservist Distribution and the amount of the reimbursements you received as of the date of the Qualified Reservist Distribution.

USERRA

Continuation and reinstatement rights may also be available if you are absent from employment due to service in the uniformed services pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). More information about coverage under USERRA is available from the Employer.

VII. Health Savings Account

✓ ***What is the HSA Benefit?***

An HSA is not an Employer-Sponsored Employee benefit plan and neither the HSA nor the HSA Benefit of the Plan that allows Employees to contribute to an HSA on a pre-tax basis is subject to ERISA. An HSA is an individual trust or custodial account that an Employee opens with an HSA trustee/custodian of the Employee's choice to be used primarily to reimburse eligible medical expenses as set forth in Code §223. See the Employer to determine if they limit the number of HSA providers to whom they will forward pre-tax contributions and if so, to obtain a list of those providers. If the Employer does maintain a list of HSA trustees/custodians, it is not an endorsement of any particular HSA trustee/custodian. The chosen HSA trustee/custodian administers the HSA. The Employer's role is limited to allowing Employees to contribute to an HSA on a pre-tax basis and has no authority or control over the funds deposited in the HSA. The Employer will maintain records to keep track of HSA contributions Employees make on a pre-tax basis, but it will not create a separate fund or otherwise segregate assets for this purpose.

✓ ***What are the HSA Benefits I may elec*t?**

Your annual contribution for HSA Benefits is equal to the annual benefit amount that you elect. The amount elected must not exceed the statutory maximum amount, as published by the IRS, for HSA contributions applicable to your High Deductible Health Plan coverage option (i.e., single or family) for the calendar year in which the contribution is made. An additional catch-up contribution of $1,000 may be made if you are age 55 or older (you must certify your age to your Employer).

If your Employer provides Employer contributions in addition to any Employee pretax contributions (matching or other), the maximum annual contribution is reduced by the total amount of Employer contributions to the HSA.

If you are an HSA-Eligible Individual for only part of the Plan Year but meet all of the requirements under Code §223 to be eligible to contribute to an HSA on first day of the last month of the Plan Year (for example), you may be able to contribute up to the full statutory maximum amount for HSA contributions applicable to your coverage option (i.e., single or family). However, any contributions in excess of your annual contribution under the Plan for HSA benefits (as described above), but not in excess of the applicable full statutory maximum amount, must be made outside the Plan. In addition, if you do not remain eligible to contribute to an HSA under the requirements of Code §223 during the following year, the portion of HSA contributions attributable to months that you were not actually eligible to contribute to an HSA will be includible in your gross income and subject to a 20% penalty (exceptions apply in the event of death or disability).

✓ ***How are the HSA Benefits paid for under the Plan?***

Once you have established an HSA with an HSA trustee/custodian, to elect the HSA Benefits, you must complete an Enrollment Form with your Employer specifying the amount you choose to contribute to your HSA on a pretax basis. You must also provide sufficient identifying information about your HSA to facilitate the forwarding of the pre-tax contributions to the designated HSA trustee/custodian. From then on, you contribute to the HSA by having the specified amount deducted from each paycheck on a pre-tax basis (generally, an equal portion from each paycheck or an amount otherwise agreed to or as deemed appropriate by your

Employer). Such contributions are forwarded to the HSA trustee/custodian (or its designee) within a reasonable time after being withheld.

✓ ***Who can contribute to an HSA under the Plan?***
Only Employees who are HSA-Eligible Individuals can contribute to an HSA under the requirements of Code §223 and have elected to participate in a qualifying High Deductible Health Plan coverage offered by their Employer. A High Deductible Health Plan means the high deductible health plan option offered by the Employer that is intended to qualify as a high deductible health plan under Code 223(c)(2), as described in the Group Sponsored Insurance plan documents provided by the Employer.

Employees who elect the HSA Benefits must certify with their Employer that they meet the requirements under Code §223 to be eligible to contribute to an HSA (e.g. disqualifying coverage). IRS Publication 969 (Health Savings Accounts and Other Tax-Favored Health Plans) describes the HSA eligibility requirements and the consequences of contributing to an HSA when participants are not eligible.

✓ ***Can I change my HSA pre-tax contribution under the Plan?***
You may increase, decrease, or revoke your HSA contribution election at any time during the Plan Year for any reason by submitting an election change form to your Employer. Your election change will be prospectively effective on the first day of the month following the month in which you properly submitted your election change request. Your ability to make pre-tax contributions under the Plan to the HSA ends on the date you cease to meet the eligibility requirements.

✓ ***Where can I get more information on my HSA and its related tax consequences?***
For details regarding rights and responsibilities with respect to your HSA (including information regarding the terms of eligibility, what constitutes a qualifying High Deductible Health Plan, contributions to the HSA, and distributions from the HSA), you should refer to the HSA trust or custodial agreement and other documentation associated with your HSA and provided to you by the HSA trustee/custodian.

You may save both federal income taxes and FICA (Social Security) taxes by participating in the Plan. However, different rules apply with respect to taxability of HSA Benefits than for other benefits offered under the Plan. For more information regarding the tax ramifications of participating in an HSA as well as the terms and conditions of the HSA, you should refer to the communications materials provided by the HSA trustee/custodian and see IRS Publication 969 (Health Savings Accounts and Other Tax-Favored Health Plans).

Your Employer cannot guarantee that specific tax consequences will follow from your participation in the Plan. Ultimately, it is your responsibility to determine the tax treatment of HSA Benefits.

Consult the HSA trust or custodial documents provided by the applicable trustee/custodian for further HSA information (e.g., with respect to investments or distributions, claims and reimbursement under the HSA).

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Return document to:
PSAenrollment@PacificSource.com

Rexius Forest By-Products Inc - FSA Renewal Rates
Effective: 8/1/2020

	Current Fees	Renewal Fees
Annual Renewal Fee:	$300.00	$300.00
FSA PMPM Fee*:	$5.50	$5.50
HRA PMPM Fee*:	N/A	N/A
Transportation PMPM Fee*:	N/A	N/A
Maximum PMPM Fee: *Excludes Benefit Card and Grace Period fees*	$5.50	$5.50
Monthly Minimum Fee: *When the PMPM fees calculates to less than the minimum monthly fee, an adjustment will be invoiced for the difference.*	$80.00	$80.00
MasterCard® PMPM Fee: *Benefit fee is not included in the PMPM or Monthly Minimum Fee.*	$1.00	$1.00
Grace Period PMPM Fee: *Grace Period Fee is not included in the PMPM Fee. It does accumulate towards the Monthly Minimum Fee.*	$0.25	$0.25

**The Per Member Per Month (PMPM) fees will be assessed for the duration of the plan year in which the member/employee may incur claims; including members that exhaust their funds or do not have continuous payroll deductions. The PMPM fee will begin the month that the participant may begin utilizing their account (e.g. Fees for Carryover will begin when funds are rolled for the participant) and will cease at the end of the month in which the participant terminates or loses eligibility.*

☑ **Renew as is, with No Plan changes needed.** I have reviewed the Plan Summary and we are renewing our service agreement with PacificSource Administrators effective 8/1/2020 with the renewal rates stated in this document. Return of enrollment materials signifies acceptance of the renewal fees.

- ☐ "No Plan Change" Exception: Update our Health FSA plan maximum to $2,750.
- ☐ "No Plan Change" Exception: Update our Transit/Parking plan maximum to $3,240.

☐ **Renew, but with Plan Summary changes requested.** We are renewing our service agreement with PacificSource Administrators effective 8/1/2020 with the renewal rates stated in this document. We understand requested changes to the Plan are not binding for the upcoming plan until accepted by PacificSource Administrators and may result in increased fees. A revised renewal rate (page 3) will be provided for any rate changes.

☐ Please have my Client Service Representative contact me.

Employer Signature _____ Date 4/30/20

Jerry Cunningham _____ CFO

Print Name _____ Title

4.3.20

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PSAenrollment@PacificSource.com

Rexius Forest By-Products Inc - Plan Summary

The following plan summary table below shows what PSA currently has in our system, and is merely a tool to assist in indicating the most frequently requested changes. Please note any additional changes, and these will be updated and reflected comprehensively in the final 2020 Plan Documents*.

**To ensure PacificSource Administrators has the most up to date information, please take a moment to review the information on the following pages. Return changes and corrections to your Client Service Representative. If changes are made electronically, please use colored text or highlight your changes. We will not update and re-issue the below plan summary.*

General Information		
	Billing & Customer Service contact; Receives Invoices	Informational; tends to be CEO or HR Manager
Contact Name:	Leanne Clark	Leanne Clark
Contact Phone:	(541) 342-1835	(541) 342-1835 EXT
Contact Email:	leannec@rexius.com	leannec@rexius.com
Contact Fax:	(541) 343-4802	(541) 343-4802
Mailing Address:	Po Box 22838 Eugene, OR 97402	
	Group Administrative contact Receives Plan Documents, Rates, & Renewal Materials	**Administrative Broker contact** Receives copies of Plan Documents, Rates, & Renewal Materials
Admin Contact Name:	Jerry Cunningham	Star Henderson
Administrative Contact Phone:	541-335-8009	N/A
Administrative Contact Email:	jerryc@rexius.com	starh@kpdinsurance.com
Additional Authorized contacts:		
	Agent 1 – Primary Agent	**Agent 2 – Account Manager/Support Staff Member**
Agent:	Star Henderson	Jennifer Gibson
Agency Name:	K P D Insurance	K P D Insurance
Agent Phone:	(541) 741-0550	(541) 741-0550
Agent Email:	starh@kpdinsurance.com	jenniferg@kpdinsurance.com
Renewing Plan Type(s):	FSA	
Company Offers:	FSA	
Business Entity:	S Corp.	
# of Eligible Employees:	On file: 207	Indicate current # of eligible employees:

Group Sponsored Insurance Plans Offered:		Renewal Month:
Medical:	PROVIDENCE	August
Dental:		
Other:		
HSA Offered by Employer:	Employer offers a Health Savings Account (HSA).	

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Flexible Spending Account					
Plan Specifications					
Components:	**Health FSA Component**			**DCAP Component**	
Accounts:	**HRE** General Purpose Health FSA	**LFSA** Limited Purpose Health FSA	**LSFSA** Limited Scope Health FSA	**DCE** Dependent Care Expense Account	
Maximum:	$2,700.00	$2,700.00	Not currently	$5,000.00	
Minimum:	$0.00	$0.00	offered by employer.	$0.00	

Health FSA Carryover or Grace Period:	
Health FSA Carryover: If permitted, unused amounts in a Participants Health FSA Component will be carried forward and remain available to reimburse eligible healthcare expenses incurred in later years.	The Health FSA Carryover Provision is not permitted and therefore unused balances are subject to the FSA "Use It or Lose It" rule..
Grace Period: If permitted, Participants have an extended time to use Plan benefits before they become subject to the "use it or lose it" rule.	Employer does offer a Grace Period on the Health FSA and DCAP Plan(s).
Debit Cards:	
Debit Card Availability:	Employer allows participants to use the Debit Card for eligible healthcare expenses. Participants may opt to have a Debit Card; however, the employer must approve.
If a Debit Card is allowed, it may be used for the following accounts:	Health FSA

FSA Plan Participation	
Employee Eligibility:	Class I: Minimum of 20 hours required during each week; Class II: Minimum of 30 hours required during each week
Entry Dates:	Class I: First of the month after 30 days of continued employment; Class II: First of the month after 60 days of continued employment
Exclusions:	Owners in a S Corporation with more-than-2% ownership, their spouses, children, parents and grandparents are not eligible to participate, including pre-tax insurance premiums
Termination Rules:	FSA participation ends on the date of termination or on the last day of the pay period in which the Participant has contributed, whichever gives the Participant the greater period of coverage.
Loss of Eligibility Rules:	FSA participation ends on the date the loss of eligibility occurs or on the last day of the pay period in which the Participant has contributed, whichever gives the Participant the greater period of coverage.

Y.3.42

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PSAenrollment@PacificSource.com

Employer Funding (ERF) Funding provided by the employer towards employee's FSA accounts.	
Employer funding Maximum:	ERF is not currently offered by the employer.
If ERF is offered, it may be applied to the following Accounts:	
ERF Cashout Allowed: If permitted, Participant have the option to apply ERF funds to their FSA Account or receive the funds in their paycheck.	
ERF Funding Frequency: When ERF funds can be credited to the Participants account.	
ERF Funding Method:	
Carryover allowed on ERF Acct: If cashout of ERF is allowed, ERF funds applied to HRE or LFSA Account will be automatically carried over. If ERF cashout is not allowed, the Group may choose whether to carryover ERF funds in the HRE or LFSA Account.	
ERF funding pro-rated for mid-year hires:	
Employer Funding Eligibility:	ERF is not currently offered by the employer.
Employer Funding Exclusions:	ERF is not currently offered by the employer.

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PacificSource ADMINISTRATORS

Using Your Flexible Spending Account

REXIUS FOREST BY-PRODUCTS INC

August 1, 2020 – July 31, 2021

A Flexible Spending Account (FSA) is a tax-free, account managed by PacificSource Administrators. By utilizing the Flexible Spending Account you could save 22 percent or more on your election depending on your combined tax bracket. The Expense Allocation Worksheet can help you estimate what your election should be and how much you could save each year.

The Plans: The following FSA plans are available through your employer. You may request reimbursement for expenses incurred for yourself and any taxable dependents for the Health FSA Component(s) and DCAP Component.

Contributing to Your FSA

Component	Maximum Annual Election
Health FSA	$2,750
Dependent Care Assistance Plan	$5,000 if married and filing a joint return or a single parent $2,500 if married but filing separately

Premium Component

- Your employer will deduct your portion of the group-sponsored insurance plans, including premiums for medical, dental, vision, hospitalization, accident insurance, and/or other qualified benefits from your gross salary on a pre-tax basis. This reduces income taxes and results in an increase in take home pay and lower taxable salary.

Health FSA Component – includes the following account(s)

Health Related Expense Account (HRE) - the General Purpose FSA

- If you're eligible for your employer's health plan, you can set up an HRE account. With an HRE account, you can save pre-tax money for healthcare expenses, including medical, dental, and vision expenses that are either not covered or only partially covered by your insurance plan.
- These expenses are for your tax dependents. Examples include: you, your spouse, or child(ren), whether or not they are covered on your employer's group insurance plan.
- No changes in election amounts will be allowed during the Plan Year.

Limited-purpose Flexible Spending Account (LFSA)

- This plan is available for employees, who they themselves or their family contribute to a health savings account (HSA) and are enrolled in the group sponsored health plan. You can use this plan for eligible expenses including dental, vision and preventive medical care expenses.
- These expenses can be for your or your spouse or child(ren), regardless if they are covered on your employer's group insurance plan.
- No changes in election amounts will be allowed during the Plan Year.

Dependent Care Assistance Plan (DCAP) Component

Dependent Care Expense Account (DCE)

- Our Dependent Care Expense Account (DCE) allows you to save pre-tax dollars to pay for dependent care. This is specifically for expenses for a child up to age 13 or disabled taxable dependent who is unable to care for themselves, including elder care expenses.
- When you have a qualified change in status—such as if your spouse's employment changes—you can increase or decrease how much you put into your account.

Questions?

Our Customer Service Team is happy to help.

Phone

Direct: (541) 485-7488
Toll-free: (800) 422-7038

Email

psacustomerservice@pacificsource.com

Forms and Materials

https://psa.pacificsource.com/Forms_Flex.aspx

PacificSource.com/PSA

PacificSource ADMINISTRATORS

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- In many cases, this account will be more beneficial to you than the federal tax credit.

How to Get Reimbursed

Reimbursement Time Frame

Reimbursements may be requested during the plan year or after it ends. Your claim submission period ends 90 days after the plan year ends. This is known as a run-out period.

All eligible reimbursement claims for services you received between **August 1, 2020** and **July 31, 2021** must be submitted by **January 15, 2022** for reimbursement.

Submitting Manual Claims

We offer several ways you can submit your claims for reimbursement:

1. Submit your claim online using our PSAConsumer portal: https://psa.consumer.pacificsource.com
2. Submit your claim via our Mobile App: myPacificSource Admin (PSA)
3. Mail or fax a Request for Reimbursement Form. You'll find the form at PSA.PacificSource.com/ Forms_Flex.aspx

Prepaid Benefits Debit Card

A Prepaid Benefits Debit Card gives you an easy, automatic way to pay for qualified healthcare expenses. Simply swipe your benefits card as you would a credit/debit card (and select "credit" rather than "debit"). When you use the card to make a purchase or payment, it deducts funds directly from your FSA. Be sure to save the documentation from your card swipe as it may be requested at a later date. When you opt to receive the card, you will receive two benefits cards.

Replacements or additional cards can be purchased for $10 per set of two cards.

Funds Remaining After the Plan Ends

Grace Period: There is a 2 ½ month extension to incur expenses, ending October 15, 2021. Any used balance is forfeited at the end of the plan year.

PSA Consumer Portal: Online Account Access for Participants

Manage your FSA from the convenience of your home or office by utilizing our website: www.psa.pacificsource.com/PSA or https://psa.consumer.pacificsource.com

- File a claim online.
- Access information on the most recent reimbursement payments.
- View payment details.
- Check your account balances, annual election, and year-to-date deposits.
- Change your address and other personal information.
- View FAQs and fliers.
- Download claim forms, direct deposit forms, and more.

What Happens if I Terminate Employment during the Plan Year?

If you terminate employment or lose eligibility, your participation in the plan will end with your final contribution. You may be eligible to continue the Health FSA under COBRA or by making an additional pre-tax contribution out of your last paycheck.

SUMMARY OF MATERIAL MODIFICATION

REXIUS FOREST BY-PRODUCTS INC

FLEXIBLE SPENDING ACCOUNT

This is a Summary of Material Modification (SMM) regarding the REXIUS FOREST BY-PRODUCTS INC Flexible Spending Account (FSA). This Summary of Material Modification supplements and amends the Summary Plan Description (SPD) previously provided to you. You should retain this document with your copy of the SPD.

Description of Modification

Effective for Plan Year 8/1/2019 through 7/31/2020, the following terms of the FSA offered by your Employer shall be amended as follows:

The declaration of National Emergency concerning the COVID-19 outbreak on 3/13/2020 prompted concern that Participants impacted by the outbreak could lose benefits due to pre-established timelines. To address these concerns, the following final ruling was released to provide relief and guidance to Participants of the FSA.

The final ruling applies from 3/1/2020 until 60 days after the announced end of the National Emergency, which is currently 6/29/2020. This time period is considered the "Outbreak Period". Specific to the Premium Payment and Health FSA Components under the FSA your Employer offers, the "Outbreak Period" should be disregarded in the following key area:

- **HIPAA Special Enrollment Period** These rights provide that if an individual or their dependent(s) lose other healthcare plan coverage under certain circumstances, marry, or obtain an additional child through birth or adoption, the individual may be able to change their health care plan election and make a corresponding change to their elections under the Plan. Generally in these cases, individuals, who are otherwise eligible, must be allowed to enroll in the healthcare plan coverage if enrollment is requested within 30 days of the event. Under new guidance, if the event occurs anytime during the "Outbreak Period", the request for enrollment must be submitted within 30 days of the end of the National Emergency *instead of* the date of the event.

Should the end of the National Emergency be extended, this amendment will continue to be in effect based on the revised National Emergency end date.

If you have questions, please contact the Human Resources/Benefits Representative with REXIUS FOREST BY-PRODUCTS INC at (541) 342-1835.

SUMMARY OF MATERIAL MODIFICATION

REXIUS FOREST BY-PRODUCTS INC

Flexible Spending Account

This is a Summary of Material Modification (SMM) regarding the REXIUS FOREST BY-PRODUCTS INC Flexible Spending Account (FSA). This Summary of Material Modification supplements and amends the Summary Plan Description (SPD) previously provided to you. You should retain this document with your copy of the SPD.

Description of Modification

The 2020 CARES ACT expanded items that are eligible for reimbursement under the REXIUS FOREST BY-PRODUCTS INC FSA. Effective 1/1/2020, the following items are classified as eligible for reimbursement under your employer's plan:

- Over-the-counter (OTC) drugs or medicines, such as aspirin, antihistamines, and cough syrup, are reimbursable from the FSA without a prescription.
- Menstrual care products qualify as an eligible expenses. Menstrual care products include items such as tampons, pads, liners, cups, sponges, or similar products.

Reminder: A receipt indicating the OTC item purchased, the date of purchase, and amount of the expense is still required for reimbursement. Items purchased to support general health, such as vitamins and supplements, continue to require documentation that the item was prescribed. In addition, only reasonable quantities of OTC drugs will be reimbursed in a single calendar month. Stockpiling is not permitted.

If you have questions, please contact the Human Resources/Benefits Representative with REXIUS FOREST BY-PRODUCTS INC at (541) 342-1835.

AMERICAN FAMILY LIFE ASSURANCE COMPANY

Since October 1975, REXIUS FOREST BY-PRODUCTS, INC. has offered Supplemental Cancer, Intensive Care, Life Care and Accident Expense Programs which are available to all full-time and part-time employees through the convenience of payroll deduction. These programs are offered by AFLAC, American Family Life Assurance Company. Most all of Rexius employees already have this valuable protection, part of the employee's program is provided by Rexius.

Although most Medical cost are covered by a person's health insurance, the American Cancer Society states there are more Non-medical costs which are not addressed at all. These are your responsibility and are the reason for AFLAC's programs.

BRIEF SUMMARY OF BENEFITS

- Return of premium benefit if Cancer-free.
- All benefits are paid directly to you.
- All benefits are paid in addition to all other overages you have.
- Your programs are guaranteed renewable for your lifetime. You can never be cancelled.
- You save 10% - 50% through payroll deduction.
- You maintain the same payroll rate even when you leave or retire from Rexius.
- In the event you or a covered family member incurs a claim, a local representative will personally handle your claim for you.

Our representative for the AFLAC program is Larri Wheeler. He will be contacting you to explain benefits available to you and your family. Although participation is voluntary, we encourage all of you to find out about the benefits that are available so that you can make an informed decision for you and your family.

Infinisource

General Notification of Your Rights and Responsibilities

Date: Monday, April 19, 2010

General Notice-PC HMO

To:

From:

Introduction to COBRA: This notice is intended to provide information about your rights and responsibilities under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). This notice does not change your status on the group health plan in any way. Rather, this notice explains rights and responsibilities you may have in the future under the following group health plan(s):

Group Health Plan
Group Health Plan(s) sponsored by SAMPLE CLIENT

If a COBRA qualifying event, which would terminate your group health plan coverage, occurs in the future, you would have the option to continue your coverage at your own expense. COBRA continuation coverage is the same group health plan coverage you had before your qualifying event. It is the same coverage provided to similarly situated active employees who have not experienced a qualifying event, but it does not include life insurance or disability coverage. Once you and your spouse or dependents (if any) become covered by the group health plan, there are specific qualifying events that may occur that cause you to lose coverage. Those events, and the length of continuation coverage you could be allowed are:

Event	Duration of Coverage
Termination of Employment (either voluntary or involuntary, other than for Gross Misconduct)	18 months
Reduction in Hours (such as layoff, leave of absence, reduced work hours, etc.)	18 months
Death of the Covered Employee	36 months
Divorce or Legal Separation	36 months
Covered Employee's Entitlement to Medicare	36 months
Dependent Child Ceasing to be Dependent	36 months
Bankruptcy (Title XI) of the Employer	Possible lifetime coverage for covered Retirees and their spouses and dependents only

Health Flexible Spending Account (FSA): An exception applies to the length of continuation coverage related to a Health Flexible Spending Account (FSA). In general, continuation coverage would be offered only for the remainder of the plan year in which the qualifying event occurred. Special rules govern FSA eligibility under COBRA. For additional information, please refer to the summary plan description for your FSA.

You may also experience a loss of coverage "in anticipation" of a qualifying event, such as a divorce or legal separation. If that happens, continuation coverage will be offered once the qualifying event has occurred (and has

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been reported within the proper time frames). In that case, coverage does not have to be provided from the date of your loss of coverage to the date of the qualifying event.

Who can elect COBRA: Each employee, spouse and dependent child covered by the group health plan the day before the qualifying event and who would lose coverage due to the qualifying event would be a COBRA Qualified Beneficiary. A child born to, or placed for adoption with, the covered employee during the period of COBRA continuation would also be a qualified beneficiary, if the employer/plan administrator is notified within 30 days of the birth or placement for adoption. Each qualified beneficiary would have an independent right to elect continuation coverage under COBRA. COBRA qualified beneficiaries will have the same rights, options and requirements as similarly situated active employees. You would not have to show evidence of insurability in order to elect. Certain timeframes listed in this notice may be extended if a qualified beneficiary is incapacitated. The word "you" throughout this notice refers to any qualified beneficiary, as described above.

How to elect COBRA: Infinisource, Inc. mails COBRA notices on behalf of SAMPLE CLIENT, and is also the party responsible for all other COBRA administration, including COBRA elections and payments. Infinisource is not an insurance company or the provider of benefits. Once a qualifying event occurs and is reported properly, SAMPLE CLIENT will instruct Infinisource to notify you, in writing, with specific information about your qualifying event. The notice will contain instructions for electing continuation coverage, as well as the last date on which you can elect. You will be allowed at least 60 days to elect continuation coverage. Verbal elections will not be accepted. If you elect continuation coverage, SAMPLE CLIENT has the right to verify your eligibility for coverage. If you are not eligible, continuation coverage may be denied or retroactively terminated. The covered employee or spouse may elect on behalf of all other qualified beneficiaries; a parent or legal guardian may elect on behalf of dependent children. If you fail to timely elect, you will lose your right to continue coverage. Proof of timely election is your responsibility (the United States Postal Service offers several proof of mailing services). A COBRA election is deemed made on the date it is postmarked. If you waive continuation coverage in writing, you have 60 days from the later of the loss of coverage date or the date the notification was mailed to you to revoke your waiver and elect continuation coverage. Any claims you incur during the waiver period may not be covered. Infinisource does not administer waivers of continuation coverage. Instead of waiving your COBRA rights if you do not want COBRA, you simply do not need to send in your COBRA Continuation Coverage Election Form. During your election period, you may find that you have been removed from the group health plan. Once you make a timely election and payment, your coverage will be reinstated retroactive to your Loss of Coverage date. If you do not elect, any expenses you incur will become your financial responsibility. You are not required to make a payment with your COBRA election, but coverage may not be reinstated until a timely payment is made. Reinstatement of coverage often depends upon the insurance company, and typically takes 7-10 business days or more after your payment is received. To confirm your coverage status, please call the insurance company directly.

If you participate in an HMO or walk-in clinic and use the provider's services during the election period, the plan may allow the employer, at the employer's option, to treat such use as a constructive election of COBRA coverage. You would be obligated to pay any applicable charge for the coverage within 45 days of the constructive election. HMOs may provide region-specific coverage. If you are outside the region, coverage may be reduced similarly to that of active employees outside the region. In certain instances, coverage may be eliminated or provided for emergency service only. If the employer has another plan that provides coverage outside the HMO region, that plan must be made available to you at the later of the date of your relocation, or the date you request the coverage. Please contact the employer/plan administrator or refer to your benefits booklet for specific information.

Paying for Continuation Coverage: Once you elect, continuation coverage must be paid for from the loss of coverage date forward, in consecutive monthly increments. You may be charged up to 102% of the applicable premium (including the employer's cost). Partial months of coverage (your first and last months of continuation coverage) will be prorated. Gaps in continuation coverage are not generally permitted. All retroactive payments for coverage are due in full within 45 days of the election date. For monthly payments following your date of election, the premium is due, in full, on the first day of each monthly coverage period. Each monthly coverage period has a grace period of at least 30 days. Payments postmarked after any grace period ends (either the 45-day grace period, or a monthly 30-day grace period) are considered late, and will not be accepted. Infinisource and SAMPLE

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CLIENT are not required to make exceptions based upon individual circumstances, and if you make a late payment, coverage will be terminated permanently, with no possibility of reinstatement. Invoices are not required, and you must postmark your payments by the monthly grace date even if you do not get an invoice. Returned checks (for instance, closed accounts, non-sufficient funds, or stop payments) are the same as no payment at all. Proof of timely payment is your responsibility (the United States Postal Service offers several proof of mailing services). A COBRA payment is deemed made on the date it is postmarked.

Extending Continuation Coverage: If, in the future, your qualifying event is the employee's Termination or Reduction of Hours (or by any other name, a qualifying event that allows for 18 months of continuation), there are two types of extensions that may allow for a longer continuation coverage period.

Social Security Disability Determination: If any qualified beneficiary is deemed disabled by the Social Security Administration, all qualified beneficiaries may receive an additional 11 months of continuation coverage (29 months from the original qualifying event). To qualify, all three of these requirements must be met:

1. The Social Security Administration must determine that the disability existed or began prior to, or within the first 60 days of continuation coverage.
2. You must provide the Social Security disability award letter before your 18-month continuation coverage period ends.
3. You must provide the Social Security disability award letter within 60 days from the later of your Event Date, Loss of Coverage date, or the date of the award notice.

You must also follow the reporting instructions found in the section "Event Reporting Procedure." During a disability extension, you may be charged up to 150% of the applicable premium (including the employer's cost) for the coverage. If the Social Security Administration later determines that the disabled qualified beneficiary is no longer disabled, the disability extension will end. Continuation coverage will terminate for all qualified beneficiaries at the end of the month that is 30 days after the date of the Social Security Determination (but not before the end of the original 18 months). If you are deemed no longer disabled, you must report this change within 30 days, following the instructions under the section "Event Reporting Procedure."

Second Qualifying Events: If a second qualifying event that would normally cause a loss of coverage as a first qualifying event (death of the covered employee, divorce or legal separation, the covered employee's Medicare Entitlement, or a dependent child ceasing to be a dependent child) occurs during the 18-month continuation coverage period, the spouse and/or dependent children who are qualified beneficiaries and who would have lost coverage may receive an additional 18 months of continuation coverage (36 months from the original qualifying event). In order to be eligible for this extension, you must follow the instructions under the section "Event Reporting Procedure", and report the second qualifying event within 60 days. Please note that an employee's entitlement to Medicare typically does not constitute a second qualifying event. You must follow the "Event Reporting Procedure" below to qualify for any extension described above. Once you report one of these events, Infinisource and SAMPLE CLIENT will review your eligibility. If you are not eligible, you will receive a Notice of Unavailability that will explain why.

Conversion Coverage: After continuation coverage expires, you may be eligible to elect an individual conversion policy, if your group health plan has such an option. Conversion coverage is not the same as group health plan coverage, and it is not the same as continuation coverage. Rates and benefits may be different. For more information, refer to your plan booklet, summary plan description, or contact the insurance company directly. Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely.

Event Reporting Procedure: As described above, you may experience events that affect your continuation coverage. Those events include:

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- Death of the Covered Employee
- Divorce or Legal Separation
- Dependent Child Ceasing to be Dependent
- Social Security Disability Award
- Social Security No Longer Disabled Determination

When you experience one of these events, you must report the event using the following procedure. Failure to report one of these events in a timely manner may make you ineligible for continuation coverage. Infinisource has a form, "COBRA Event Notice," available at no charge. You may call Infinisource at (800) 594-6957 to request a form.

You must report the events above in writing, but use of the form is not required if you include the following information:

1. Name, address and phone number of the covered employee.
2. Name, address and phone number of qualified beneficiaries experiencing the event.
3. Group health plan coverage.
4. The event experienced.
5. The date of the event.
6. For Social Security Disability Awards, you must include a copy of the award letter.
7. If deemed No Longer Disabled, you must also include a copy of that letter, and
8. For all other events, you must include your signature and a statement that the event occurred as represented.

Send the "COBRA Event Notice" or other written format to **Infinisource, Attention: COBRA Event Notice, PO Box 949, Coldwater, MI 49036**, or fax to (517) 278-0764.

Your notice must be made within 60 days of the qualifying event, and in the case of a Social Security Disability, also within 60 days of the Award Letter and before the end of the 18-month continuation coverage period. If you are deemed no longer disabled, you must report that within 30 days of the determination.

Reasons COBRA will Terminate: If you elect coverage under COBRA, you may continue coverage until the first of the following occurs:

1. The Coverage Expires date.
2. You first become, after the date you elect continuation coverage, covered by another group health plan that does not apply any pre-existing condition limitation or exclusion to you.
3. You first become, after the date you elect continuation coverage, entitled to Medicare.
4. Your payment is not postmarked by the end of any grace period.
5. SAMPLE CLIENT ceases to provide any group health plan.
6. During the 11-month disability extension, a disabled qualified beneficiary is deemed no longer disabled by the Social Security Administration.
7. Your coverage is terminated for cause, such as fraud, on the same basis that coverage can be terminated for active employees.

After electing continuation coverage, you or any qualified beneficiary must notify Infinisource or SAMPLE CLIENT, in writing, within 30 days of:

1. Becoming entitled to Medicare Part A and/or Part B.
2. Becoming covered under another group health plan that does not apply a pre-existing condition limitation or exclusion to you.
3. Satisfying or exhausting any pre-existing condition exclusion period under another group health plan that applied to you.

Failure to provide this notice as required may result in retroactive termination of continuation coverage. Any expenses incurred during a period for which coverage is later terminated will become your financial responsibility, and may require repayment to the providers.

HIPAA and COBRA: The Health Insurance Portability and Accountability Act (HIPAA) created the concept of Creditable Coverage, which is coverage under a health plan used to reduce the pre-existing condition exclusion period imposed by another group health plan. Continuation coverage under COBRA counts as creditable coverage. Creditable coverage counts toward fulfillment of a pre-existing condition exclusion or limitation period, thus reducing the time a pre-existing condition is not covered, as long as any gap in coverage is less than 63 days. If and when you have a qualifying event, you may reduce the possibility of a gap in coverage and the pre-existing condition exclusion period under another group health plan by electing continuation coverage. If you do not timely elect and pay for continuation coverage, you may experience a gap in coverage and may not be able to use your previous group health plan coverage as a credit toward reducing any pre-existing condition limitation or exclusion. In addition, if you do not exhaust your continuation coverage, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you keep continuation coverage for the maximum time available to you.

More Information: This notice does not fully describe your continuation coverage or other plan rights. You can find more complete information in your summary plan description, plan booklet or certificate. If you have questions about your COBRA rights or this notice, please contact CONTACT PERSON at PHONE NUMBER. It is important to keep SAMPLE CLIENT informed of address changes for all qualified beneficiaries. This notice contains important information about your rights and responsibilities under the COBRA law. Please keep this notice for future reference.

Women's Health and Cancer Rights Act of 1998 (WHCRA): WHCRA requires a group health plan to notify you, as a participant or a beneficiary, of your potential rights related to coverage in connection with a mastectomy. Your plan may provide medical and surgical benefits in connection with a mastectomy and reconstructive surgery. If it does, coverage will be provided in a manner determined in consultation with your attending physician and the patient for a) all stages of reconstruction on the breast on which the mastectomy was performed; b) surgery and reconstruction of the other breast to produce a symmetrical appearance; c) prostheses; and d) treatment of physical complications of the mastectomy, including lymphedema. The coverage, if available under your group health plan, is subject to the same deductible and coinsurance applicable to other medical and surgical benefits provided under the plan. For specific information, please refer to your summary plan description or benefits booklet, or contact SAMPLE CLIENT.

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ARRA Subsidy Provisions

(For qualifying events on or after February 17, 2009, and on or before May 31, 2010.)

Under the American Recovery and Reinvestment Act of 2009 (ARRA) you may be eligible to pay only 35% of your COBRA premium. The other 65% would be government paid for up to 15 months, but only if: (1) You are, and continue to be, eligible for the premium subsidy; and (2) You elect to continue COBRA coverage. In addition, as indicated below, ARRA has been further changed by the Department of Defense Appropriations Act, 2010 (2010 DOD Act), the Temporary Extension Act of 2010, and the Continuing Extension Act of 2010.

Who is Eligible for the 65% COBRA Premium Subsidy?

Assistance eligible individuals (AEIs) are entitled to elect COBRA coverage and pay only 35% of the applicable premium.

An AEI must meet all of the following requirements:

1. You lost group health plan coverage due to a covered employee being ***involuntarily terminated from employment*** during the period from September 1, 2008 through May 31, 2010.
2. You elect COBRA continuation coverage.
3. You are not eligible for other group health plan coverage or Medicare.

AEIs include spouses and dependent children of the covered employee whose coverage was lost due to an ***involuntary termination of employment***. Eligibility for the premium subsidy under ARRA does not allow eligibility for the HCTC under the Trade Act.

Subsidy Reduction: Subsidy Reduction: For modified adjusted gross income (MAGI) between $125,000 and $145,000 (or between $250,000 and $290,000 for married, filing jointly), the subsidy available would be reduced proportionately. An AEI may irrevocably opt out of receiving the subsidy. An AEI who fails to opt out and whose MAGI exceeds these limits (i.e., $145,000 for single individuals and $290,000 for married, filing jointly) would owe an additional tax on the federal tax return equal to the amount of the subsidy.

How Long Does the Premium Subsidy Last?

The subsidy would start as of the first period of COBRA continuation coverage under the Plan and would continue until the earliest of the following:

1. 15 months from the first date of the first month in which you receive the subsidy.
2. When you would become ELIGIBLE for coverage under any other group health plan (other than certain permitted coverage described below) or Medicare.
3. The date on which you would cease to be eligible for COBRA coverage (e.g., failure to pay the premium timely).

Caution: You must notify the plan if you or any related AEI are eligible for any other group health plan coverage or Medicare and NO longer eligible to receive the premium subsidy. A COBRA premium subsidy ineligibility notice is included for this purpose. Failure to notify the plan may result in a penalty in the amount of 110% of the subsidy received for periods during which you were not eligible for the subsidy.

The following types of permitted coverage will not disqualify an AEI from receiving the premium subsidy:

1. Coverage that is only dental, vision, counseling or referral services (or a combination of those services).
2. Coverage under a Health FSA under Section 106(c) (2) of the Code.
3. Coverage through an on-site medical facility maintained by the employer, consisting primarily of first-aid services, prevention and wellness care, or similar care (or a combination thereof).

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How Does an AEI Elect the Premium Subsidy?

An AEI must elect COBRA by completing the required forms.

Does this Election Extend the Period that COBRA Continuation Coverage is Available?

No. The premium subsidy under ARRA does not extend the period of COBRA coverage. Instead, ARRA provides a reduced COBRA premium for a limited period of time to make COBRA continuation coverage more affordable.

What if I Receive a Health Coverage Tax Credit (HCTC)?

You may decide whether you wish to receive the COBRA subsidy or the HCTC. You may not receive both. ARRA made several changes to the provisions of the Trade Act of 2002, which created the HCTC. These changes include:

1. An increase in the amount of the HCTC from 65% to 80% of premiums for coverage from May 1, 2009, through December 31, 2010.
2. Temporary extensions of the maximum period of COBRA continuation coverage for covered employees with a nonforfeitable right to a benefit from the Pension Benefit Guaranty Corporation and for those individuals who are eligible for Trade Adjustment Assistance.

If you have questions about the HCTC, please call the HCTC Customer Contact Center toll-free at 866-628-4282. TTD/TTY callers may call toll-free at 866-626-4282. More information about the Trade Act is also available at **www.doleta.gov/tradeact**.

How Did the 2010 DOD Act, the Temporary Extension Act of 2010, and the Continuing Extension Act of 2010 Change ARRA?

Under these laws, the ARRA subsidy program was changed on December 19, 2009, (2010 DOD Act Enactment Date), March 2, 2010 (Temporary Extension Act of 2010 Enactment Date) and April 15, 2010 (Continuing Extension Act of 2010 Enactment Date). The changes took immediate effect and include:

- **Extended Eligibility Period.** The eligibility period for becoming an assistance eligible individual (AEI) now ends May 31, 2010, instead of December 31, 2009. Your continuation coverage can start after May 31, 2010, as long as the qualifying event occurs no later than May 31, 2010.
- **Extended Subsidy Period.** The maximum ARRA subsidy period is now 15 months for all AEIs. This would include any AEIs whose subsidy previously expired on or after November 16, 2009.
- **Reduction in Hours Followed by Involuntary Termination.** The ARRA subsidy is now available to individuals who experience a reduction in hours followed by an involuntary termination of employment if that termination occurs on or after March 2, 2010, and on or before May 31, 2010. The subsidy begins with the first period of coverage after the termination. In this limited circumstance, those Qualified Beneficiaries who never elected COBRA or discontinued COBRA have a new special election right for electing COBRA. The special election period ends 60 days after notice is sent. Qualified Beneficiaries making this special election do not have to pay for any gap in coverage between the original loss of coverage date and the first period of coverage after the involuntary termination of employment date. For pre-existing conditions, any gap in coverage is not treated as a "break in coverage" under relevant HIPAA rules. This does not change the length of the COBRA maximum coverage period. It is still based on the original reduction in hours Qualifying Event date.

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

** Continuation Coverage Rights Under COBRA**

Introduction

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

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

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

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

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

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

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

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

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

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

When is COBRA continuation coverage available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Rexius Forest By-Products[.

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

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Are there other coverage options besides COBRA Continuation Coverage?

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

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

Providence Health Plans
Rexius Forest By-Products
P.O. Box 22838, Eugene, Or 97402
541-342-1835

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Lincoln Financial Group®

Group Term Life Insurance
Life and AD&D

SUMMARY OF BENEFITS

Sponsored by: **Rexius Forest By-Products, Inc.**

All Full-Time Salaried Employees
All Full-Time Hourly Employees

Coverage	Benefit Amount Employee	Benefit Amount Spouse/Domestic Partner and Dependents
Life	$20,000	Spouse/Domestic Partner: $1,000 Child: 14 days to 6 months: $1,000 Child: 6 months to age 19 (to age 23 if full-time student): $1,000
Guarantee Issue	$20,000	
AD&D	Will Equal the Life Benefit	N/A
Benefit Reduction	**Employee**	**Spouse/Domestic Partner**
Benefits will reduce:	35% at age 65; An additional 25% of original amount at age 70; An additional 15% of original amount at age 75; Benefits terminate at retirement	Benefits terminate at Spouse age 70
Additional Benefits		
See Understanding Your Benefits Page:	Accelerated Death Benefit Seatbelt Benefit – Air Bag Benefit - Common Carrier Benefit Conversion	
Enrolling for Coverage	**Employee**	**Spouse/Domestic Partner or Dependent**
Eligibility:	All employees in an eligible class.	Effective date of coverage will be delayed if Spouse/Domestic Partner or dependent is in a period of limited activity on policy issue date.

(Please see other side)

Understanding Your Benefits

Accelerated Death Benefit	Accelerated Death Benefit provides an option to be paid a portion of your life insurance benefit when diagnosed as terminally ill (as defined in the policy). The death benefit will be reduced by the amount withdrawn. To qualify, you must be covered under this policy for the amount of time defined by the policy.
AD&D	Accidental Death and Dismemberment (AD&D) insurance provides specified benefits for a covered accidental bodily injury that directly causes death or dismemberment (e.g., the loss of a hand, foot, or eye), subject to policy limitations.
Conversion	If you terminate your employment or become ineligible for this coverage, you have the option to convert all or part of the amount of coverage in force to an individual life policy on the date of termination without Evidence of Insurability. Conversion election normally must be made within 31 days of your date of termination.
Guarantee Issue	For timely entrants enrolled within 31 days of becoming eligible, the Guarantee Issue amount is available without providing Evidence of Insurability. Evidence of Insurability will be required for any amounts above this, for late enrollees or increases in insurance, and it will be provided at your own expense.
Seatbelt Benefit – Air Bag Benefit - Common Carrier Benefit	If you die as a result of a covered auto accident while wearing a seat belt or in a vehicle equipped with an airbag, additional benefits are payable up to $10,000 or 10% of the principal sum, whichever is less. If loss occurs due to an accident while riding as a passenger in a common carrier, benefits will be double the amount that would otherwise apply as outlined in the certificate.
Limited Activity	A period when a Spouse/Domestic Partner or dependent is confined in a health care facility; or, whether confined or not, is unable to perform the regular and usual activities of a healthy person of the same age and sex.
Term Life	A death benefit is paid to the designated beneficiary upon the death of the insured. Coverage is provided for the time period that you are eligible and premium is paid. There is no cash value associated with this product.

Additional Benefits

***LifeKeys*SM**	Online will & testament preparation service, identity theft resources and beneficiary assistance support for all employees and eligible dependents covered under the Group Term Life and/or AD&D policy.
***TravelConnect*SM**	Travel assistance services for employees and eligible dependents traveling more than 100 miles from home.

For assistance or additional information Contact Lincoln Financial Group at	
(800) 423-2765; reference ID: **REXIUSFBP**	www.LincolnFinancial.com

NOTE: This is not intended as a complete description of the insurance coverage offered. Controlling provisions are provided in the policy, and this summary does not modify those provisions or the insurance in any way. This is not a binding contract. A certificate of coverage will be made available to you that describes the benefits in greater detail. Should there be a difference between this summary and the policy, the policy will govern.

Group Insurance products are issued by The Lincoln National Life Insurance Company (Ft. Wayne, IN), **which is not licensed and does not solicit business in New York.** In New York, group insurance products are issued by Lincoln Life & Annuity Company of New York (Syracuse, NY). Both are Lincoln Financial Group companies. Product availability and/or features may vary by state. Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates. **Each affiliate is solely responsible for its own financial and contractual obligations.**

Lincoln Financial Group®

Group Short-Term Disability Insurance

SUMMARY OF BENEFITS

Sponsored by: **Rexius Forest By-Products, Inc.**

All Full-Time Hourly Employees

Short-term disability is intended to protect your income for a short duration in case you become ill or injured.

STD Benefit

Weekly Benefit	Elimination Period	Maximum Duration
70% of weekly salary up to $350 per week	Benefits begin on: Accident: 1st day Illness: 4th day	26 weeks

Integration of Benefits The benefits from this policy will be reduced by benefits you receive from state disability or worker's compensation programs.

Additional Benefits

See your Schedule of Benefits on your Certificate for more information

Enrolling for Coverage

Eligibility: All employees in an eligible class.

Understanding Your Benefits

Total Disability	Due to an injury or illness, you are unable to perform each of the main duties of your regular occupation.
Partial Disability	Due to an injury or illness, you are unable to perform one or more of the main duties of your regular occupation on a full-time basis. Partial Disability benefits may be payable if you are earning at least 20% of the income you earned prior to becoming disabled, but not more than 99%. Partial disability benefits allow you to work and earn income from your employer as well as continue to receive benefits, which may enable you to receive 100% of your income during your time of disability.
Continuation of Disability	If you return to work full-time but become disabled from the same disability within 2 weeks of returning to work, you will begin receiving benefits again immediately.
Benefit Exclusions	You will not receive benefits in the following circumstances: • Your disability is the result of a self-inflicted injury. • You are not under the regular care of a doctor when requesting disability benefits. • Your disability is the result of war, declared or undeclared, or any act of war. • Your disability is covered under a worker's compensation plan and/or is due to a job-related sickness or injury.
Benefit Reductions	Your benefits may be reduced if you are receiving benefits from any of the following sources: • Any governmental retirement system earned as a result of working for the current policyholder; • Any disability or retirement benefit received under a retirement plan; • Any Social Security, or similar plan or act, benefits; • Earnings the insured earns or receives from any form of employment; • Disability income benefits received under state disability benefit laws.
Coverage Termination	This coverage will terminate when you terminate employment with this policyholder, or at your retirement.

For assistance or additional information Contact Lincoln Financial Group at	
(800) 423-2765; reference ID: **REXIUSFBP**	www.LincolnFinancial.com

Lincoln Financial Group®

Group Long-Term Disability Insurance

SUMMARY OF BENEFITS

Sponsored by: **Rexius Forest By-Products, Inc.**

All Full-Time Salaried Employees

Long-term disability is intended to protect your income for a long duration after you have depleted short-term disability or any sick leave your company may offer.

LTD Benefit

	Monthly Benefit	Maximum Benefit Duration	Own Occupation Period	Elimination Period
Employer Paid Plan	60% of monthly salary up to $5,000 per month	Later of Age 65 or Social Security Normal Retirement Age	24 Months	90 Days

Pre-Existing Condition You may not be eligible for benefits if you have received treatment for a condition within 3 months prior to your effective date under this policy until you have been covered under the policy for 12 months.

Waiver of Premium You will not be required to pay premium during any time of approved total or partial disability.

Benefit Limitations

Mental Illness: 24 Months
Substance Abuse: 24 Months
Specified Illness: No Limit

Enrolling for Coverage

Eligibility: All employees in an eligible class

Additional Benefits

Progressive Income Benefit, Survivor Income Benefit, EmployeeConnect - Employee Assistance Plan and Waiver of Premium

See your Schedule of Benefits on your Certificate for more information

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Understanding Your Benefits

Elimination Period	The number of days you must be disabled prior to collecting disability benefits.
Own Occupation	The occupation, trade, or profession you were employed in prior to your disability as defined by the US DOL Dictionary of Occupational Titles.
Total Disability	Due to an injury or illness, you are unable to perform each of the main duties of your own occupation on a full-time basis. Your "own" occupation is covered for a specific period of time. Following this, the definition of total disability becomes the inability to perform any occupation for which you are reasonably suited based on your experience, education, or training. See Certificate of Coverage for details.
Partial Disability	Due to an injury or illness, you are unable to perform one or more of the main duties of your regular occupation on a full-time basis. Partial Disability benefits may be payable if you are earning at least 20% of the income you earned prior to becoming disabled, but not more than 99%. Partial disability benefits allow you to work and earn income from your employer and continue to receive benefits, which may enable you to receive 100% of your income during your time of disability. See Certificate of Coverage for details.
Continuation of Disability	If you return to work full-time but become disabled from the same disability within 6 months of returning to work, you will begin receiving benefits again immediately with no new Elimination Period.
Benefit Duration Reduction	Your benefit duration may be reduced if you become disabled after age 65.
Pre-Existing Condition	Any sickness or injury for which you received medical treatment, consultation, care, or services (including diagnostic measures or the taking of prescribed medications) during the specified months prior to your coverage effective date. A disability arising from any such sickness or injury will be covered only if it begins after you have performed your regular occupation on a full-time basis for the specified months following the coverage effective date.
Benefit Exclusions	You will not receive benefits in the following circumstances: • Your disability is the result of a self-inflicted injury. • You are not under the regular care of a doctor when requesting disability benefits. • You were involved in a felony commission, act of war, or participation in a riot. • You were residing outside of the United States or Canada for more than 12 consecutive months for purposes other than employment with your Employer.
Benefit Reductions	Your benefits may be reduced if you are receiving benefits from any of the following sources: • Any compulsory benefit act or law (such as state disability plans); • Any governmental retirement system earned as a result of working for the current policyholder; • Any disability or retirement benefit received under a retirement plan; • Any Social Security, or similar plan or act, benefits; • Earnings from any form of employment; • Workers compensation; • Salary continuance or employer contributions to an employer sponsored retirement plan.
Coverage Termination	Coverage will terminate when you terminate employment with this policyholder, or at your retirement.

For assistance or additional information Contact Lincoln Financial Group at	
(800) 423-2765; reference ID: **REXIUSFBP**	www.LincolnFinancial.com

NOTE: This is not intended as a complete description of the insurance coverage offered. Controlling provisions are provided in the policy, and this summary does not modify those provisions or the insurance in any way. This is not a binding contract. A certificate of coverage will be made available to you that describes the benefits in greater detail. Should there be a difference between this summary and the policy, the policy will govern.

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Health Insurance Marketplace Coverage Options and Your Health Coverage

General Information

With the key parts of the health care law that took effect in 2014, there is 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 Rexius Forest By-Products, Inc..

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.

The Open Enrollment period is November 1st through December 15th of the year preceding the benefit plan year. Individuals may also qualify for Special Enrollment Periods outside of Open Enrollment if they experience certain events. (See Special Enrollment Period and Qualifying Life Event)

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 may not be eligible for a tax credit through the Marketplace depending on the below factors and your household income. You may want 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 9.86% 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. *Note: For plan years beginning in 2020 the income rate will change to 9.78%.*

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 your employer.

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

Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

1. Employer Name: Rexius Forest By-Products, Inc.
2. Employer Identification Number (EIN): 93-0925466
3. Employer Address: PO Box 22838
4. Employer phone number: (541) 342-1835
5. City: Eugene
6. State: OR
7. ZIP code: 97402
8. Who can we contact about employee health coverage at this job: Jerry Cunningham
9. Phone number for contact: (541) 342-1835
10. Email address: jerryc@rexius.com

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to: Eligible Employees.

Eligible employees are: Hourly employees working 30 or more hours per week and Salaried employees working 20 or more hours per week.

- With respect to dependents: We do offer coverage to all eligible dependents.

Eligible dependents are: Legal spouse, same gender domestic partners and eligible dependent children as described in the medical carrier's employee booklet.

This coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.*Even ifyour employer intends your

coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), ifyou are newly employed mid-year, or ifyou have other income losses, you may still qualify for a premium discount. ifyou decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process.

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

REXIUS FOREST BY-PRODUCTS, INC. 401(K) PROFIT SHARING PLAN
SUMMARY PLAN DESCRIPTION

Amended & Restated Eff.: January 1, 2016

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REXIUS FOREST BY-PRODUCTS, INC. 401(K) PROFIT SHARING PLAN

SUMMARY PLAN DESCRIPTION

INTRODUCTION TO YOUR PLAN

What kind of Plan is this?

Rexius Forest By-Products, Inc. 401(k) Profit Sharing Plan ("Plan") has been adopted to provide you with the opportunity to save for retirement on a tax-advantaged basis. This Plan is a type of qualified retirement plan commonly referred to as a 401(k) Plan. As a participant under the Plan, you may elect to contribute a portion of your compensation to the Plan.

What information does this Summary provide?

This Summary Plan Description ("SPD") contains information regarding when you may become eligible to participate in the Plan, your Plan benefits, your distribution options, and many other features of the Plan. You should take the time to read this SPD to get a better understanding of your rights and obligations under the Plan.

In this SPD, the Employer has addressed the most common questions you may have regarding the Plan. If this SPD does not answer all of your questions, please contact the Plan Administrator or other plan representative. The Plan Administrator is responsible for responding to questions and making determinations related to the administration, interpretation, and application of the Plan. The name of the Plan Administrator can be found at the end of this SPD in the Article entitled "General Information about the Plan."

This SPD describes the Plan's benefits and obligations as contained in the legal Plan document, which governs the operation of the Plan. The Plan document is written in much more technical and precise language and is designed to comply with applicable legal requirements. If the non-technical language in this SPD and the technical, legal language of the Plan document conflict, the Plan document always governs. If you wish to receive a copy of the legal Plan document, please contact the Plan Administrator.

The Plan and your rights under the Plan are subject to federal laws, such as the Employee Retirement Income Security Act (ERISA) and the Internal Revenue Code, as well as some state laws. The provisions of the Plan are subject to revision due to a change in laws or due to pronouncements by the Internal Revenue Service (IRS) or Department of Labor (DOL). The Employer may also amend or terminate this Plan. If the provisions of the Plan that are described in this SPD change, the Employer will notify you.

ARTICLE I
PARTICIPATION IN THE PLAN

How do I participate in the Plan?

You may begin participating under the Plan once you have satisfied the eligibility requirements and reached your Entry Date, except as indicated above. The following describes Excluded Employees, if any, the eligibility requirements and Entry Dates that apply. You should contact the Plan Administrator if you have questions about the timing of your Plan participation.

Eligibility Conditions. You will be eligible to participate when you have completed one (1) Year of Service and have attained age 21. However, you will actually participate once you reach the Entry Date as described below.

Entry Date. Your Entry Date will be the first day of the Plan Year or the first day of the seventh month of the Plan Year coinciding with or next following the date you satisfy the eligibility requirements.

Excluded Employees. If you are a member of a class of employees identified below, you are an Excluded Employee and you are not entitled to participate in the Plan. The Excluded Employees are:

- union employees whose employment is governed by a collective bargaining agreement under which retirement benefits were the subject of good faith bargaining
- certain nonresident aliens who have no earned income from sources within the United States

Year of Service. You will have completed a Year of Service if, at the end of your first twelve months of employment with the Employer, you have been credited with at least 1,000 Hours of Service. If you have not been credited with 1,000 Hours of Service by the end of your first twelve months of employment, you will have completed a Year of Service at the end of any following Plan Year during which you were credited with 1,000 Hours of Service.

Hour of Service. You will be credited with your actual Hours of Service for:

(a) each hour for which you are directly or indirectly compensated by the Employer for the performance of duties during the Plan Year;

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(b) each hour for which you are directly or indirectly compensated by the Employer for reasons other than the performance of duties (such as vacation, holidays, sickness, disability, lay-off, military duty, jury duty or leave of absence during the Plan Year) but credit will not exceed 501 hours of service for any single continuous period during which you perform no duties; and

(c) each hour for back pay awarded or agreed to by the Employer.

You will not be credited for the same Hours of Service both under (a) or (b), as the case may be, and under (c).

What service is counted for purposes of Plan eligibility?

Service with the Employer. In determining whether you satisfy the minimum service requirements to participate under the Plan, all service you perform for the Employer will be counted.

Service with another Employer. For eligibility purposes, your Years of Service with [redacted] will be counted. See the Plan Administrator for details if you think you may be affected by this provision.

Military Service. If you are a veteran and are reemployed under the Uniformed Services Employment and Reemployment Rights Act of 1994, your qualified military service may be considered service with the Employer. If you may be affected by this law, ask the Plan Administrator for further details.

What happens if I'm a participant, terminate employment and then I'm rehired?

If you are no longer a participant because of a termination of employment, and you are rehired, then you will be able to participate in the Plan on the date on which you are rehired if you are otherwise eligible to participate in the Plan.

ARTICLE II
EMPLOYEE CONTRIBUTIONS

What are elective deferrals and how do I contribute them to the Plan?

Elective Deferrals. As a participant under the Plan, you may elect to reduce your compensation by a specific percentage or dollar amount and have that amount contributed to the Plan as an elective deferral. There are two types of elective deferrals: pre-tax deferrals and Roth deferrals. For purposes of this SPD, "elective deferrals" generally means both pre-tax deferrals and Roth deferrals. Regardless of the type of deferral you make, the amount you defer is counted as compensation for purposes of Social Security taxes.

Pre-Tax Deferrals. If you elect to make pre-tax deferrals, then your taxable income is reduced by the deferral contributions so you pay less in federal income taxes. Later, when the Plan distributes the deferrals and earnings, you will pay the taxes on those deferrals and the earnings. Therefore, with a pre-tax deferral, federal income taxes on the deferral contributions and on the earnings are only postponed. Eventually, you will have to pay taxes on these amounts.

Roth Deferrals. If you elect to make Roth deferrals, the deferrals are subject to federal income taxes in the year of deferral. However, the deferrals and, in certain cases, the earnings on the deferrals are not subject to federal income taxes when distributed to you. In order for the earnings to be tax free, you must meet certain conditions. See "What are my tax consequences when I receive a distribution from the Plan?" below.

Deferral procedure. The amount you elect to defer will be deducted from your pay in accordance with a procedure established by the Plan Administrator. If you wish to defer, the procedure will require that you enter into a salary reduction agreement. You may elect to defer a portion of your compensation payable on or after your Entry Date. Such election will become effective as soon as administratively feasible after it is received by the Plan Administrator. Your election will remain in effect until you modify or terminate it.

Deferral modifications. You may revoke or make modifications to your salary deferral election in accordance with procedures that the Employer provides. See the Plan Administrator for further information.

Annual dollar limit. Your total deferrals in any taxable year may not exceed a dollar limit which is set by law. The limit for 2015 is $18,000. After 2015, the dollar limit may increase for cost-of-living adjustments.

Catch-up contributions. If you are at least age 50 or will attain age 50 before the end of a calendar year, then you may elect to defer additional amounts (called "catch-up contributions") to the plan for that year. The additional amounts may be deferred regardless of any other limitations on the amount that you may defer to the plan. The maximum "catch-up contribution" that you can make in 2015 is $6,000. After 2015, the maximum may increase for cost-of-living adjustments. Any "catch-up contributions" that you make will be taken into account in determining any Employer matching contribution made to the Plan.

You should be aware that each separately stated annual dollar limit on the amount you may defer (the annual deferral limit and the "catch-up contribution" limit) is a separate aggregate limit that applies to all such similar elective deferral amounts and "catch-up

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contributions" you may make under this Plan and any other cash or deferred arrangements (including tax-sheltered 403(b) annuity contracts, simplified employee pensions or other 401(k) plans) in which you may be participating. Generally, if an annual dollar limit is exceeded, then the excess must be returned to you in order to avoid adverse tax consequences. For this reason, it is desirable to request in writing that any such excess elective deferral amounts be returned to you.

If you are in more than one plan, you must decide which plan or arrangement you would like to return the excess. If you decide that the excess should be distributed from this Plan, you must communicate this in writing to the Administrator no later than the March 1st following the close of the calendar year in which such excess deferrals were made. However, if the entire dollar limit is exceeded in this Plan or any other plan the Employer maintains, then you will be deemed to have notified the Administrator of the excess. The Plan Administrator will then return the excess deferral and any earnings to you by April 15th.

What are rollover contributions?

Rollover contributions. At the discretion of the Plan Administrator, if you are an eligible employee, you may be permitted to deposit into the Plan distributions you have received from other plans and certain IRAs. Such a deposit is called a "rollover" and may result in tax savings to you. You may ask the Plan Administrator or Trustee of the other plan or IRA to directly transfer (a "direct rollover") to this Plan all or a portion of any amount that you are entitled to receive as a distribution from such plan. Alternatively, you may elect to deposit any amount eligible to be rolled over within 60 days of your receipt of the distribution. You should consult qualified counsel to determine if a rollover is in your best interest.

Rollover account. Your rollover will be accounted for in a "rollover account." You will always be 100% vested in your "rollover account" (see the Article in this SPD entitled "Vesting"). This means that you will always be entitled to all amounts in your rollover account. Rollover contributions will be affected by any investment gains or losses. In addition, any Roth 401(k) Deferrals that are accepted as rollovers in this Plan will be accounted for separately.

Withdrawal of rollover contributions. You may withdraw the amounts in your "rollover account" at any time. You should see the Articles in this SPD entitled "Distributions Prior to Termination of Employment," "Distributions upon Termination of Employment," and "Distributions upon Death" for an explanation of how benefits (including your "rollover account") are paid from the Plan.

ARTICLE III
EMPLOYER CONTRIBUTIONS

In addition to any deferrals you elect to make, the Employer will make additional contributions to the Plan. This Article describes Employer contributions that will be made to the Plan and how your share of the contributions is determined.

What is the safe harbor contribution?

Safe harbor 401(k) plan. This Plan is referred to as a "safe harbor 401(k) plan." Before the beginning of each Plan Year, you will be provided with a comprehensive notice of your rights and obligations under the Plan. However, if you become eligible to participate in the Plan after the beginning of the Plan Year, then the notice will be provided to you on or before the date you are eligible. A safe harbor 401(k) plan is a plan design where the Employer commits to making certain contributions described below. This commitment to make contributions enables the Employer to simplify the administration of the Plan by ensuring that nondiscrimination regulations are met, which is why it is called a "safe harbor" plan. Alternatively, the Employer may reserve the right to enter safe harbor plan status during the Plan Year. The Employer will provide you with a notice explaining this possibility if it may apply. If the Employer decides to enter safe harbor plan status during a Plan Year, the Employer will provide you with an additional notice and will make safe harbor nonelective contribution described below.

Additional Discretionary Matching Contribution. The Employer may make a discretionary matching contribution. If the Employer makes an additional discretionary matching contribution, the additional discretionary matching contribution will not apply as to elective deferrals exceeding 6% of your compensation.

Safe Harbor Nonelective Contribution. In order to maintain "safe harbor" status, the Employer may make a safe harbor nonelective contribution. If the Employer decides to make this contribution, then you will receive a notice informing you of its decision. If this safe harbor contribution is made, it will be equal to 3% of your compensation. This contribution is 100% vested (see the Article in this SPD entitled "Vesting").

What is the Employer matching contribution and how is it allocated?

Matching Contribution. The Employer may make a discretionary matching contribution equal to a uniform percentage or dollar amount of your elective deferrals. Each year, the Employer will determine the formula for the discretionary matching contribution.

The Plan will match catch-up deferrals in the same manner as such matching applies to elective deferrals.

What is the Employer nonelective contribution and how is it allocated?

Nonelective contribution. Each year, the Employer may make a discretionary nonelective contribution to the Plan. Your share of any contribution is determined below.

Allocation conditions. In order to share in the nonelective contribution you must satisfy the following conditions:

- With limited exceptions, you must be employed on the last day of the plan year in order to share in the allocation of the Employer's nonelective and matching contributions and participant forfeitures for that plan year. You do not have to complete any service requirement to make a deferral contribution. However, in the year you terminate employment with the Employer, with limited exceptions, you must complete at least 501 hours of service to be entitled to an allocation.

Your share of the contribution. The nonelective contribution will be "allocated" or divided among participants eligible to share in the contribution for the Plan Year.

The contribution will be allocated to your account in the same proportion that your compensation plus your compensation in excess of 100% of the Social Security Taxable Wage Base (also called "excess compensation") bears to the total compensation plus "excess compensation" of all eligible participants. The maximum amount that can be allocated to you in this first step varies and is dependent upon the integration level. If you have any questions about the maximum that can be allocated in this first step, you should consult your Administrator.

If after the first step of the allocation process there still remains a portion of the contribution which has not yet been allocated, then the remainder will be allocated to you in the same proportion that your compensation bears to the total compensation of all participants.

Waiver of allocation conditions

You will share in the nonelective contribution for the year you terminate employment regardless of the amount of service you complete during the Plan Year if you terminate on or following your death, disability or attainment of Normal Retirement Age.

What are forfeitures and how are they allocated?

Definition of forfeitures. In order to reward employees who remain employed with the Employer for a long period of time, the law permits a "vesting schedule" to be applied to certain contributions that the Employer makes to the Plan. This means that you will not be entitled to ("vested" in) all of the contributions until you have been employed with the Employer for a specified period of time (see the Article in this SPD entitled "Vesting"). If a participant terminates employment before being fully vested, then the non-vested portion of the terminated participant's account balance remains in the Plan and is called a forfeiture. Forfeitures may be used by the Plan for several purposes.

Allocation of forfeitures. Forfeitures will be allocated as follows:

- Forfeitures attributable to nonelective contributions will be used to reduce any nonelective contributions; forfeitures attributable to matching contributions will be used to reduce any matching contributions for the plan year in which the forfeiture occurs.

ARTICLE IV
COMPENSATION AND ACCOUNT BALANCE

What compensation is used to determine my Plan benefits?

Definition of compensation. Compensation is defined as your total compensation that is subject to income tax and paid to you by the Employer. Amounts paid to you after you terminate employment may or may not be included as compensation for plan allocations as described below. If you are a self-employed individual, your compensation will be equal to your earned income. The following describes the adjustments to compensation that may apply for the contribution(s) noted above.

Adjustments to compensation. The following adjustments to compensation will be made:

- elective deferrals to this Plan and to any other plan or arrangement (such as a cafeteria plan) will be included.
- compensation paid while not a participant in the Plan will be excluded.
- compensation paid after you terminate is generally excluded for Plan purposes. However, the following amounts will be included in compensation even though they are paid after you terminate employment, provided these amounts would otherwise have been considered compensation as described above and provided they are paid within 2½ months after you terminate employment, or if later, the last day of the Plan Year in which you terminate employment:
  - compensation paid for services performed during your regular working hours, or for services outside your regular working hours (such as overtime or shift differential), or other similar payments that would have been made to you had you continued

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employment.

- compensation paid for unused accrued bona fide sick, vacation or other leave, if such amounts would have been included in compensation if paid prior to your termination of employment and you would have been able to use the leave if employment had continued.

- nonqualified unfunded deferred compensation if the payment is includible in gross income and would have been paid to you had you continued employment.

Is there a limit on the amount of compensation which can be considered?

The Plan, by law, cannot recognize annual compensation in excess of a certain dollar limit. The limit for the Plan Year beginning in 2015 is $265,000. For plan years beginning after 2015, the dollar limit may increase for cost-of-living adjustments.

Is there a limit on how much can be contributed to my account each year?

Generally, the law imposes a maximum limit on the amount of contributions including elective deferrals that may be made to your account and any other amounts allocated to any of your accounts during the Plan Year, excluding earnings. Beginning in 2015, this total cannot exceed the lesser of $53,000 or 100% of your annual compensation (as limited under the previous question). After 2015, the dollar limit may increase for cost-of-living adjustments.

How is the money in the Plan invested?

The Trustee of the Plan has been designated to hold the assets of the Plan for the benefit of Plan participants and their beneficiaries in accordance with the terms of this Plan. The trust fund established by the Plan's Trustee will be the funding medium used for the accumulation of assets from which Plan benefits will be distributed.

Participant direction of investments. You will be able to direct the investment of your entire interest in the Plan. The Plan Administrator will provide you with information on the investment choices available to you, the procedures for making investment elections, the frequency with which you can change your investment choices and other important information. You need to follow the procedures for making investment elections and you should carefully review the information provided to you before you give investment directions. If you do not direct the investment of your applicable Plan accounts, then your accounts will be invested in accordance with the default investment alternatives established under the Plan. These default investments will be made in accordance with specific rules under which the fiduciaries of the Plan, including the Employer, the Trustee and the Plan Administrator, will be relieved of any legal liability for any losses resulting from the default investments. The Plan Administrator has or will provide you with a separate notice which details these default investments and your right to switch out of the default investment if you so desire.

The Plan is intended to comply with Section 404(c) of ERISA (the Employee Retirement Income Security Act). If the Plan complies with this Section, then the fiduciaries of the Plan, including the Employer, the Trustee and the Plan Administrator, will be relieved of any legal liability for any losses which are the direct and necessary result of the investment directions that you give. Procedures must be followed in giving investment directions. If you fail to do so, then your investment directions need not be followed. If you do not direct the investment of your applicable Plan accounts, your accounts will be invested in accordance with the default investment alternatives established under the Plan.

Earnings or losses. When you direct investments, your accounts are segregated for purposes of determining the earnings or losses on these investments. Your Participant-directed Account does not share in the investment performance of other participants who have directed their own investments. You should remember that the amount of your benefits under the Plan will depend in part upon your choice of investments. Gains as well as losses can occur and the Employer, the Plan Administrator, and the Trustee will not provide investment advice or guarantee the performance of any investment you choose.

Will Plan expenses be deducted from my account balance?

The Employer has elected to pay all plan related expenses except for certain expenses which are intrinsic to the value of the Trust assets such as brokerage commissions.

The above is only a general statement about the possible treatment of Plan expenses. See the Appendix for Plan Expense Allocations for details.

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ARTICLE V
VESTING

What is my vested interest in my account?

In order to reward employees who remain employed with the Employer for a long period of time, the law permits a "vesting schedule" to be applied to certain contributions that the Employer makes to the Plan. This means that you will not be entitled to ("vested in") all of the contributions until you have been employed with the Employer for a specified period of time.

100% vested contributions. You are always 100% vested (which means that you are entitled to all of the amounts) in your accounts attributable to the following contributions:

- elective deferrals including Roth 401(k) deferrals and catch-up contributions
- rollover contributions
- safe harbor contributions

Vesting schedules. Your "vested percentage" for certain Employer contributions is based on vesting Years of Service. This means at the time you stop working, your account balance attributable to contributions subject to a vesting schedule is multiplied by your vested percentage. The result, when added to the amounts that are always 100% vested as shown above, is your vested interest in the Plan, which is what you will actually receive from the Plan. You will always, however, be 100% vested if you are employed on or after your Normal Retirement Age or if you terminate employment on account of your death, or if you terminate employment as a result of becoming disabled.

Nonelective Contributions and Additional Matching Contributions

Your "vested percentage" in your account attributable to nonelective contributions and discretionary matching contributions is determined under the following schedule.

Vesting Schedule
Nonelective and Discretionary Matching Contributions

Years of Service	Percentage
Less than 2	0%
2	20%
3	40%
4	60%
5	80%
6	100%

How is my service determined for vesting purposes?

Year of Service. To earn a Year of Service, you must be credited with at least 1,000 Hours of Service during a Plan Year. The Plan contains specific rules for crediting Hours of Service for vesting purposes. The Plan Administrator will track your service and will credit you with a Year of Service for each Plan Year in which you are credited with the required Hours of Service, in accordance with the terms of the Plan. If you have any questions regarding your vesting service, you should contact the Plan Administrator.

Hour of Service. You will be credited with your actual Hours of Service for:

(a) each hour for which you are directly or indirectly compensated by the Employer for the performance of duties during the Plan Year;

(b) each hour for which you are directly or indirectly compensated by the Employer for reasons other than the performance of duties (such as vacation, holidays, sickness, disability, lay-off, military duty, jury duty or leave of absence during the Plan Year) but credit will not exceed 501 hours of service for any single continuous period during which you perform no duties; and

(c) each hour for back pay awarded or agreed to by the Employer.

You will not be credited for the same Hours of Service both under (a) or (b), as the case may be, and under (c).

What service is counted for vesting purposes?

Service with the Employer. In calculating your vested percentage, all service you perform for the Employer will generally be counted.

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Military Service. If you are a veteran and are reemployed under the Uniformed Services Employment and Reemployment Rights Act of 1994, your qualified military service may be considered service with the Employer. If you may be affected by this law, ask the Plan Administrator for further details.

What happens to my non-vested account balance if I'm rehired?

If you have no vested interest in the Plan when you leave, your account balance will be forfeited. However, if you are rehired before incurring five consecutive Breaks in Service, your account balance as of the date of your termination of employment will be restored, unadjusted for any gains or losses.

If you are partially vested in your account balance when you leave, the non-vested portion of your account balance will be forfeited on the earlier of the date:

(a) of the distribution of your vested account balance, or

(b) when you incur five consecutive Breaks in Service.

If you received a distribution of your vested account balance and are rehired, you may have the right to repay this distribution. If you repay the entire amount of the distribution, the Employer will restore your account balance with your forfeited amount. You must repay this distribution within five years from your date of rehire, or, if earlier, before you incur five consecutive Breaks in Service. If you were 100% vested when you left, you do not have the opportunity to repay your distribution.

What happens if the Plan becomes a "top-heavy plan"?

Top-heavy plan. A retirement plan that primarily benefits "key employees" is called a "top-heavy plan." Key employees are certain owners or officers of the Employer. A plan is generally a "top-heavy plan" when more than 60% of the plan assets are attributable to key employees. Each year, the Plan Administrator is responsible for determining whether the Plan is a "top-heavy plan."

Top-heavy rules. If the Plan becomes top-heavy in any Plan Year, then non-key employees may be entitled to certain "top-heavy minimum benefits," and other special rules will apply. These top-heavy rules include the following:

- The Employer may be required to make a contribution on your behalf in order to provide you with at least "top-heavy minimum benefits."
- If you are a participant in more than one Plan, you may not be entitled to "top-heavy minimum benefits" under both Plans.

ARTICLE VI
DISTRIBUTIONS PRIOR TO TERMINATION OF EMPLOYMENT

Can I withdraw money from my account while working?

You are not entitled to any distribution from the Plan while you are still working for the Employer, other than distributions from accounts for rollover contributions.

Post-termination hardship distribution. If you have terminated employment and incur an event which would have entitled you to a hardship distribution if you had still been working (as described above), you may still receive a hardship distribution even though your account is not yet distributable to you based on your termination of employment. See "When can I get my money out of the Plan?" in the Article in this SPD entitled "Distributions upon Termination of Employment."

ARTICLE VII
DISTRIBUTIONS UPON TERMINATION OF EMPLOYMENT

When can I get money out of the Plan?

You may receive a distribution of the vested portion of some or all of your accounts in the Plan when you terminate employment with the Employer. The rules regarding the payment of death benefits to your beneficiary are described in the Article in this SPD entitled "Distributions upon Death."

As to the possibility of receiving a distribution while you are still employed with the Employer, see the Article in this SPD entitled "Distributions Prior to Termination of Employment."

Military Service. If you are a veteran and are reemployed under the Uniformed Services Employment and Reemployment Rights Act of 1994, your qualified military service may be considered service with the Employer. There may also be benefits for employees who die or become disabled while on active duty. Employees who receive wage continuation payments while in the military may benefit from various changes in the law. If you think you may be affected by these rules, ask the Plan Administrator for further details.

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Termination and distribution before Normal Retirement Age (or age 62 if later)

If your vested account balance exceeds $1,000, your consent is required to distribute your account before you reach Normal Retirement Age (or age 62 if later). You may elect to have your vested account balance distributed to you as soon as administratively feasible in the next Plan Year following your termination of employment. (See the question entitled "In what method and form will my benefits be paid to me?" below for an explanation of the method of payment.)

If you terminate employment with a vested account balance exceeding $1,000, you may not elect to postpone distribution of your account beyond the later of age 62 or Normal Retirement Age.

If your vested account balance does not exceed $1,000, a distribution of your vested account balance will be made to you, regardless of whether you consent to receive it, as soon as administratively feasible in the next Plan Year following your termination of employment. (See the question entitled "In what method and form will my benefits be paid to me?" below for an explanation of the method of payment.)

Amounts in your rollover account will be considered as part of your benefit in determining whether the $1,000 threshold for timing of payments described above has been exceeded as well as for determining if the value of your vested account balance exceeds the $1,000 threshold used to determine whether you must consent to a distribution.

Distribution on or after Normal Retirement Age (or age 62 if later)

If you terminate employment with the Employer and will receive distribution on or after the later of age 62 or your Normal Retirement Age, the Plan will distribute your account without your consent. The distribution will occur as soon as administratively feasible but in any event distribution will be made no later than 60 days after the end of the Plan Year in which you terminate employment.

What is Normal Retirement Age and what is the significance of reaching Normal Retirement Age?

You will attain your Normal Retirement Age when you reach age 65.

What happens if I terminate employment due to disability?

Definition of disability. Under the Plan, disability is defined as the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months. The permanence and degree of such impairment must be supported by medical evidence. The Plan Administrator may require that your disability be determined by a licensed physician.

Payment of benefits. If you terminate employment because you become disabled, you will be entitled to your vested account balance under the Plan and the Plan will distribute your account balance in the same manner as for any other non-death related termination.

In what method and form will my benefits be paid to me?

Your benefit will be paid in either one lump sum or partial distributions necessary to satisfy required minimum distributions described in the following paragraph.

Required beginning date. There are rules that require that certain minimum distributions be made from the Plan. If you are a 5% owner, distributions are required to begin not later than the April 1st following the end of the year in which you reach age 70½. If you are not a 5% owner, distributions are required to begin not later than the April 1st following the end of the year in which you terminate employment. You should see the Plan Administrator if you think you may be affected by these rules.

ARTICLE VIII
DISTRIBUTIONS UPON DEATH

What happens if I die while working for the Employer?

If you die while still employed by the Employer, then your vested account balance will be used to provide your beneficiary with a death benefit.

Who is the beneficiary of my death benefit?

You may designate a beneficiary of your Plan account on a form provided to you for this purpose by the Plan Administrator. If you do not designate a beneficiary, your account will be distributed as described below under "No beneficiary designation." If you are married, your spouse has certain rights to the death benefit. You should immediately report any change in your marital status to the Plan Administrator.

Married Participant. If you have been married at least one year at the time of your death, your spouse will be the beneficiary of the entire death benefit unless you designate in writing a different beneficiary. IF YOU WISH TO DESIGNATE A BENEFICIARY OTHER THAN YOUR SPOUSE, YOUR SPOUSE OF AT LEAST ONE YEAR MUST IRREVOCABLY CONSENT TO WAIVE ANY RIGHT TO THE DEATH BENEFIT. YOUR SPOUSE'S CONSENT MUST BE IN WRITING, BE WITNESSED BY A NOTARY OR A PLAN REPRESENTATIVE AND ACKNOWLEDGE THE SPECIFIC NON-SPOUSE BENEFICIARY.

Changes to designation.

If, with spousal consent as required, you have designated someone other than your spouse as beneficiary and now wish to change your designation, see the Plan Administrator for details. In addition, you may elect a beneficiary other than your spouse without your spouse's consent if your spouse cannot be located.

Divorce. A divorce decree automatically revokes your designation of your spouse or former spouse as your beneficiary under the Plan unless a Qualified Domestic Relations Order provides otherwise. You should complete a form to make a new beneficiary designation if a divorce decree is issued. See the Plan Administrator for details if you think you may be affected by this provision.

Unmarried Participant. If you are not married or have not been married at least one year, you may designate a beneficiary of your choosing.

No beneficiary designation. At the time of your death, if you have not designated a beneficiary or your beneficiary is not alive, the death benefit will be paid in the following order of priority to:

(a) your surviving spouse

(b) your children, including adopted children in equal shares (and if a child is not living, that child's share will be distributed to that child's living descendants)

(c) your surviving parents, in equal shares

(d) your estate

How will the death benefit be paid to my beneficiary?

Method/form of distribution. The form of payment of the death benefit will be in cash. If the death benefit payable to a beneficiary does not exceed $5,000, then the benefit may only be paid as a lump-sum. If the death benefit exceeds $5,000, your beneficiary may elect to have the death benefit paid in:

- a single lump-sum payment in cash
- annual installments at least equal to the required minimum distribution amount

Timing of distribution. Payment of the death benefit must begin by the end of the calendar year which follows the year of your death if your designated beneficiary is a person, unless you die before your required beginning date and your designated beneficiary elects to have the entire death benefit paid by the end of the fifth year following the year of your death as indicated below. If your designated beneficiary is not a person, then your entire death benefit must generally be paid within five years after your death. If your spouse is the sole beneficiary, your spouse may delay the start of payments until the year in which you would have attained age 70½.

When must the last payment be made to my beneficiary (required minimum distributions)?

The law generally restricts the ability of a retirement plan to be used as a method of deferring taxation for an unlimited period beyond the participant's life. Thus, there are rules that are designed to ensure that death benefits are distributable to beneficiaries within certain time periods. The application of these rules depends upon whether you die before or after your "required beginning date" as described above under "Required beginning date."

Death before required beginning date.

Regardless of the method of distribution a beneficiary might otherwise be able to elect, if your designated beneficiary is a person (other than your estate or certain trusts), then minimum distributions of your death benefit must begin by the end of the calendar year which follows the year of your death and must be paid over a period not extending beyond your beneficiary's life expectancy. If your spouse is the sole beneficiary, your spouse may delay the start of payments until the year in which you would have attained age 70½. However, instead of a life expectancy based distribution, your designated beneficiary may elect to have the entire death benefit paid by the end of the fifth year following the year of your death. Generally, if your beneficiary is not a person, then your entire death benefit must be paid within five years after your death.

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Death after required beginning date.

If you die on or after your required beginning date, regardless of the method of distribution a beneficiary might otherwise be able to elect, payment must be made over a period which does not exceed the greater of the beneficiary's life expectancy or your remaining life expectancy (determined in accordance with applicable life expectancy tables and without regard to your actual death). If your beneficiary is not a person, your entire death benefit must be paid over a period not exceeding your remaining life expectancy (determined in accordance with applicable life expectancy tables and without regard to your actual death).

What happens if I terminate employment, commence payments and then die before receiving all of my benefits?

Your beneficiary will be entitled to your remaining vested interest in the Plan at the time of your death. See the Plan Administrator for more information regarding the timing and method of payments that apply to your beneficiary.

Does the Plan provide life insurance?

The Employer may elect to purchase life insurance on your behalf. The amount of life insurance that may be purchased is limited by law. Any life insurance purchased will be used to provide a death benefit for your beneficiaries. If a life insurance policy is purchased on your behalf, your account will be reduced by the amount of the premiums and credited with any policy dividends.

ARTICLE IX
TAX TREATMENT OF DISTRIBUTIONS

What are my tax consequences when I receive a distribution from the Plan?

Generally, you must include any Plan distribution in your taxable income in the year in which you receive the distribution. The tax treatment may also depend on your age when you receive the distribution. Certain distributions made to you when you are under age 59½ could be subject to an additional 10% tax.

You will not be taxed on distributions of your Roth 401(k) deferrals. In addition, a distribution of the earnings on the Roth 401(k) deferrals will not be subject to tax if the distribution is a "qualified" distribution. A "qualified" distribution is one that is made after you have attained age 59½ or is made on account of your death or disability. In addition, in order to be a "qualified" distribution, the distribution cannot be made prior to the expiration of a 5-year participation period. The 5-year participation period is the 5-year period beginning on the calendar year in which you first make a Roth 401(k) deferral to our Plan (or to another 401(k) plan or 403(b) plan if such amount was rolled over into this Plan) and ending on the last day of the calendar year that is 5 years later. For example, if you make your first Roth 401(k) deferral under this Plan on November 30, 2015, your participation period will end after December 31, 2019. It is not necessary that you make a Roth 401(k) deferral in each of the five years.

Can I elect a rollover to reduce or defer tax on my distribution?

Rollover or Direct Transfer. You may reduce, or defer entirely, the tax due on your distribution through use of one of the following methods:

(a) **60-day rollover.** You may roll over all or a portion of the distribution to an Individual Retirement Account or Annuity (IRA) or another employer retirement plan willing to accept the rollover. This will result in no tax being due until you begin withdrawing funds from the IRA or other qualified employer plan. The rollover of the distribution, however, MUST be made within strict time frames (normally, within 60 days after you receive your distribution). Under certain circumstances, all or a portion of a distribution (such as a hardship distribution) may not qualify for this rollover treatment. In addition, most distributions will be subject to mandatory federal income tax withholding at a rate of 20%. This will reduce the amount you actually receive. For this reason, if you wish to roll over all or a portion of your distribution amount, then the direct rollover option described in paragraph (b) below would be the better choice.

(b) **Direct rollover.** For most distributions, you may request that a direct transfer (sometimes referred to as a direct rollover) of all or a portion of a distribution be made to either an Individual Retirement Account or Annuity (IRA) or another employer retirement plan willing to accept the transfer. A direct transfer will result in no tax being due until you withdraw funds from the IRA or other employer plan. Like the rollover, under certain circumstances all or a portion of the amount to be distributed may not qualify for this direct transfer. If you elect to actually receive the distribution rather than request a direct transfer, then in most cases 20% of the distribution amount will be withheld for federal income tax purposes.

Tax Notice. WHENEVER YOU RECEIVE A DISTRIBUTION THAT IS AN ELIGIBLE ROLLOVER DISTRIBUTION, THE PLAN ADMINISTRATOR WILL DELIVER TO YOU A MORE DETAILED EXPLANATION OF THESE OPTIONS. HOWEVER, THE RULES WHICH DETERMINE WHETHER YOU QUALIFY FOR FAVORABLE TAX TREATMENT ARE VERY COMPLEX. YOU SHOULD CONSULT WITH QUALIFIED TAX COUNSEL BEFORE MAKING A CHOICE.

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ARTICLE X
LOANS

Is it possible to borrow money from the Plan?

No. Loans are not permitted from the Plan.

ARTICLE XI
PROTECTED BENEFITS AND CLAIMS PROCEDURES

Are my benefits protected?

As a general rule, your interest in your account, including your "vested interest," may not be alienated. This means that your interest may not be sold, used as collateral for a loan, given away or otherwise transferred (except at death to your beneficiary). In addition, generally your creditors (other than the IRS) may not attach, garnish or otherwise interfere with your benefits under the Plan.

Are there any exceptions to the general rule?

There are two exceptions to this general rule. The Plan Administrator must honor a qualified domestic relations order (QDRO). A QDRO is defined as a decree or order issued by a court that obligates you to pay child support or alimony, or otherwise allocates a portion of your assets in the Plan to your spouse, former spouse, child or other dependent. If a QDRO is received by the Plan Administrator, all or a portion of your benefits may be used to satisfy that obligation. The Plan Administrator will determine the validity of any domestic relations order received. You and your beneficiaries can obtain from the Plan Administrator, without charge, a copy of the procedures used by the Plan Administrator to determine whether a qualified domestic relations order is valid.

The second exception applies if you are involved with the Plan's operation. If you are found liable for any action that adversely affects the Plan, the Plan Administrator can offset your benefits by the amount that you are ordered or required by a court to pay the Plan. All or a portion of your benefits may be used to satisfy any such obligation to the Plan.

Can the Employer amend the Plan?

The Employer has the right to amend the Plan at any time. In no event, however, will any amendment authorize or permit any part of the Plan assets to be used for purposes other than the exclusive benefit of participants or their beneficiaries. Additionally, no amendment will cause any reduction in the amount credited to your account.

What happens if the Plan is discontinued or terminated?

Although the Employer intends to maintain the Plan indefinitely, the Employer reserves the right to terminate the Plan at any time. Upon termination, no further contributions will be made to the Plan and all amounts credited to your accounts will become 100% vested. The Employer will direct the distribution of your accounts in a manner permitted by the Plan as soon as practicable. You will be notified if the Plan is terminated.

How do I submit a claim for Plan benefits?

Benefits will generally be paid to you and your beneficiaries without the necessity for formal claims. Contact the Plan Administrator if you are entitled to benefits or if you think an error has been made in determining your benefits. Any such request should be in writing.

If the Plan Administrator determines the claim is valid, then you will receive a statement describing the amount of benefit, the method or methods of payment, the timing of distributions and other information relevant to the payment of the benefit.

What if my benefits are denied?

Your request for Plan benefits will be considered a claim for Plan benefits, and it will be subject to a full and fair review. If your claim is wholly or partially denied, the Plan Administrator will provide you with a written or electronic notification of the Plan's adverse determination. This written or electronic notification must be provided to you within a reasonable period of time, but not later than 90 days after the receipt of your claim by the Plan Administrator, unless the Plan Administrator determines that special circumstances require an extension of time for processing your claim. If the Plan Administrator determines that an extension of time for processing is required, written notice of the extension will be furnished to you prior to the termination of the initial 90-day period. In no event will such extension exceed a period of 90 days from the end of such initial period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the benefit determination.

In the case of a claim for disability benefits, if disability is determined by a physician (rather than relying upon a determination of disability for Social Security purposes), then instead of the above, the Plan Administrator will provide you with written or electronic notification of the Plan's adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the Plan. This period may be extended by the Plan for up to 30 days, provided that the Plan Administrator both determines that such an extension is

necessary due to matters beyond the control of the Plan and notifies you, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If, prior to the end of the first 30-day extension period, the Plan Administrator determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the Plan Administrator notifies you, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the plan expects to render a decision. In the case of any such extension, the notice of extension will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and you will be afforded at least 45 days within which to provide the specified information.

The Plan Administrator's written or electronic notification of any adverse benefit determination must contain the following information:

(a) The specific reason or reasons for the adverse determination.

(b) Reference to the specific Plan provisions on which the determination is based.

(c) A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary.

(d) Appropriate information as to the steps to be taken if you or your beneficiary wants to submit your claim for review.

(e) In the case of disability benefits where disability is determined by a physician:

(i) If an internal rule, guideline, protocol, or other similar criterion (collectively "rule") was relied upon in making the adverse determination, either the specific rule or a statement that such rule was relied upon in making the adverse determination and that a copy of that rule will be provided to you free of charge upon request.

(ii) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided to you free of charge upon request.

If your claim has been denied, and you want to submit your claim for review, you must follow the claims review procedure in the next question.

What is the claims review procedure?

Upon the denial of your claim for benefits, you may file your claim for review, in writing, with the Plan Administrator.

(a) YOU MUST FILE THE CLAIM FOR REVIEW NO LATER THAN 60 DAYS AFTER YOU HAVE RECEIVED WRITTEN NOTIFICATION OF THE DENIAL OF YOUR CLAIM FOR BENEFITS.

HOWEVER, IF YOUR CLAIM IS FOR DISABILITY BENEFITS AND DISABILITY IS DETERMINED BY A PHYSICIAN, THEN INSTEAD OF THE ABOVE, YOU MUST FILE THE CLAIM FOR REVIEW NO LATER THAN 180 DAYS FOLLOWING RECEIPT OF NOTIFICATION OF AN ADVERSE BENEFIT DETERMINATION.

(b) You may submit written comments, documents, records, and other information relating to your claim for benefits.

(c) You may review all pertinent documents relating to the denial of your claim and submit any issues and comments, in writing, to the Plan Administrator.

(d) You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

(e) Your claim for review must be given a full and fair review. This review will take into account all comments, documents, records, and other information submitted by you relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In addition to the claims review procedure above, if your claim is for disability benefits and disability is determined by a physician, then:

(a) Your claim will be reviewed without deference to the initial adverse benefit determination and the review will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual.

4.8.13

(b) In deciding an appeal of any adverse benefit determination that is based in whole or part on medical judgment, the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

(c) Any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination will be identified, without regard to whether the advice was relied upon in making the benefit determination.

(d) The health care professional engaged for purposes of a consultation under (b) above will be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

The Plan Administrator will provide you with written or electronic notification of the Plan's benefit determination on review. The Plan Administrator must provide you with notification of this denial within 60 days after the Plan Administrator's receipt of your written claim for review, unless the Plan Administrator determines that special circumstances require an extension of time for processing your claim. If the Plan Administrator determines that an extension of time for processing is required, written notice of the extension will be furnished to you prior to the termination of the initial 60-day period. In no event will such extension exceed a period of 60 days from the end of the initial period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the determination on review. However, if the claim relates to disability benefits and disability is determined by a physician, then 45 days will apply instead of 60 days in the preceding sentences. In the case of an adverse benefit determination, the notification will set forth:

(a) The specific reason or reasons for the adverse determination.

(b) Reference to the specific Plan provisions on which the benefit determination is based.

(c) A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

(d) In the case of disability benefits where disability is determined by a physician:

(i) If an internal rule, guideline, protocol, or other similar criterion (collectively "rule") was relied upon in making the adverse determination, either the specific rule or a statement that such rule was relied upon in making the adverse determination and that a copy of that rule will be provided to you free of charge upon request.

(ii) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided to you free of charge upon request.

If you have a claim for benefits which is denied, then you may file suit in a state or Federal court. However, in order to do so, you must file the suit no later than 180 days after the date of the Plan Administrator's final determination denying your claim.

What are my rights as a Plan participant?

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to:

(a) Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including collective bargaining agreements and insurance contracts, if any, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

(b) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including collective bargaining agreements and insurance contracts, if any, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

(c) Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including the Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension benefit or exercising your rights under ERISA.

If your claim for a pension benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

4.5.14

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110.00 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. You and your beneficiaries can obtain, without charge, a copy of the Plan's QDRO procedures from the Plan Administrator.

If it should happen that the Plan's fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, it finds your claim is frivolous.

What can I do if I have questions or my rights are violated?

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

ARTICLE XII
GENERAL INFORMATION ABOUT THE PLAN

There is certain general information which you may need to know about the Plan. This information has been summarized for you in this Article.

Plan Name

The full name of the Plan is Rexius Forest By-Products, Inc. 401(k) Profit Sharing Plan

Plan Number

The Employer has assigned Plan Number 001 to your Plan.

Plan Trustee(s)

Jerry Cunningham
Rusty Rexius

Plan Trustee Information and Plan Funding Medium

All money that is contributed to the Plan is held in a trust fund. The Trustee is responsible for the safekeeping of the trust fund and must hold and invest Plan assets (unless the investment of assets is subject to Participant or other direction) in a prudent manner and in the best interest of you and your beneficiaries. The trust fund established by the Plan's Trustee(s) will be the funding medium used for the accumulation of assets from which benefits will be distributed. While all the Plan assets are held in a trust fund, the Administrator separately accounts for each Participant's interest in the Plan. If there is more than one Trustee, they will collectively be referred to as Trustee throughout this Summary Plan Description.

Other Plan Information

Valuations of the Plan assets are made annually on the last day of the Plan Year. The Plan Administrator also may require more frequent valuations.

The Plan's records are maintained on a twelve-month period of time. This is known as the Plan Year. The Plan Year ends on December 31.

The Plan and Trust will be governed by the laws of the state of the Employer's principal place of business to the extent not governed by federal law.

Benefits provided by the Plan are NOT insured by the Pension Benefit Guaranty Corporation (PBGC) under Title IV of the Employee Retirement Income Security Act of 1974 because the insurance provisions under ERISA are not applicable to this type of Plan.

4.8.15

Service of legal process may be made upon the Employer. Service of legal process may also be made upon the Trustee or Plan Administrator.

Employer Information

The Employer's name, address, business telephone number and identification number are:

Rexius Forest By-Products, Inc.
PO Box 22838
Eugene, OR 97402
(541) 342-1835
93-0925466

Plan Administrator Information

The Plan Administrator is responsible for the day-to-day administration and operation of the Plan. For example, the Plan Administrator maintains the Plan records, including your account information, provides you with the forms you need to complete for Plan participation, and directs the payment of your account at the appropriate time. The Plan Administrator will also allow you to review the formal Plan document and certain other materials related to the Plan. If you have any questions about the Plan or your participation, you should contact the Plan Administrator. The Plan Administrator may designate other parties to perform some duties of the Plan Administrator.

The Plan Administrator has the complete power, in its sole discretion, to determine all questions arising in connection with the administration, interpretation, and application of the Plan (and any related documents and underlying policies). Any such determination by the Plan Administrator is conclusive and binding upon all persons.

4.8.1L

APPENDIX
PLAN EXPENSE ALLOCATIONS

The Plan ☐will ☒ will not assess against an individual participant's account the following Plan expenses which are incurred by or are attributable to a particular participant based on use of a particular plan feature, listed by type and the amount charged (check all applicable expenses and fill in the charge or method of determining the charge):

[ ] Distributions (unless total account balance is less than $1,500): $_____

[n/a] Participant Loan Fee:
Annual maintenance fee: $_____
Application fee: $_____

[ ] QDRO Processing Fee: $_____

[ ] Other: $_____

Effective: 1/1/12

7.8.17

PLAN SPECIFICATION SHEET

The information provided in this specification sheet is for your convenience only and is substantially abbreviated. For more complete information about the Plan, refer to the summary plan description. For information on which you may rely, you must refer to the plan document itself.

1. **Employer**: Rexius Forest By-Products, Inc.

2. **Plan Name**: Rexius Forest By-Products, Inc. 401(k) Profit Sharing Plan

3. **Trustee(s)**: Jerry Cunningham; Rusty Rexius

4. **Plan Year**: January 1 to December 31

5. **Eligibility Conditions**: One year/1,000 hours; age 21

6. **Plan Entry Date(s)**: The January 1 or July 1 immediately after or coincident with satisfying Eligibility Conditions

7. **Participant Direction of Investment**: Permitted

8. **Annual Contributions**:

   8.1. Optional employee deferrals (pre-tax or Roth (after-tax))
   8.2. Employer may, during a plan year, elect to make a fully vested safe harbor contribution equal to 3% of participants' compensation (and, if so, you will be notified prior to year end); Employer also may, at its discretion, contribute amounts to be shared based on compensation, subject to integration at 100% of the social security wage base, or to be allocated as additional matching contributions

9. **Service/Employment Conditions**: After entering the Plan and becoming a Participant, you must be employed on the last day of the Plan Year to receive annual Employer discretionary profit sharing and matching contributions; deferrals and the 3% safe harbor contribution are not subject to the service/employment conditions (note, participants who terminate service with fewer than 501 hours of service in their year of termination also will not be eligible for Employer contributions for the year)

10. **Normal Retirement Age**: 65

11. **Vesting**:

    11.1. Deferrals and the safe harbor contribution: 100% vested at all times
    11.2. All other contributions:

Less than 2 years	0% vested
2 yrs but less than 3	20% vested
3 yrs but less than 4	40% vested
4 yrs but less than 5	60% vested
5 yrs but less than 6	80% vested
6 yrs or more	100% vested

12. **Distributions of Vested Accrued Benefits**: Generally, the first administratively practicable distribution date of the Plan Year after your employment terminates

13. **Form of Benefit Payment**: Lump sum and installments for required minimum distributions

PARTICIPANT NOTICE REGARDING
PARTICIPANT DIRECTED INVESTMENTS

To each Participant and Beneficiary of the Rexius Forest By-Products, Inc. 401(k) Profit Sharing Plan (Plan):

The Plan permits you to direct the investment of your account balance.

As a general rule, the Plan's Trustee is personally responsible for investing the Plan's assets. However, if the Plan qualifies as a "404(c) plan," the law relieves the Trustee and other Plan "fiduciaries" of at least part of this responsibility. A 404(c) plan permits participants to direct the investment of plan assets consistent with statutory and regulatory guidelines.

The Plan intends to qualify as a 404(c) plan. As a result, the Plan's fiduciaries will not be liable for losses which are the direct and necessary result of investment instructions received from you. As a 404(c) plan, the Plan must give you the information contained in this notice.

The Plan Administrator of the Plan is responsible for providing you this information and carrying out the Plan's procedures for investment direction. See the last page of this notice for the name of the person you may contact as the Plan Administrator's representative.

1. The Investment Options Available To You

Attached as an exhibit to this notice is an outline of the various investment funds available for investments through Rexius Forest By-Products, Inc. with a brief description of investment objectives and risk/return characteristics of each portfolio.

2. When, How, and to Whom You May Give Investment Directions

2.1. You may give investment instructions to the Plan Trustee or to Sapient (acting as the Plan Trustee's designee) at any time in the manner and on plan forms or the forms designated by Sapient, subject to the Plan and Sapient's applicable rules and trading restrictions. Note, applicable trading restrictions may limit the timing or frequency of trades. Your acceptable investment instructions become effective as of the earliest administratively feasible time after they are given. **If you do not provide any instructions, the Trustee will invest your contributions in the Plan's Qualified Default Investment Alternative (QDIA). See the attached QDIA notice.**

2.2. The Plan will pass-through to you all voting, tender, or other similar rights (if any) attendant on your ownership of an interest in any investment option. The Plan Administrator will provide you a copy of any materials received by the Plan which relate to your exercise of these rights.

2.3. Some brokers, custodians, and funds restrict the timing and frequency of transactions. Attempted exchanges beyond the set limit are voided. Additional information regarding Sapient's current restrictions is attached. Participants are subject to all such restrictions in addition to the Plan's own limits and restrictions.

3. Fees Associated With Your Purchase or Sale of an Interest in any Investment Alternative

Fees and costs associated with your investments will depend on the particular investments you choose, some of which are described in the attached information. Contact Sapient for detailed information on fees charged by particular funds.

4. Disclosures to You

When you initially invest in an alternative subject to the Securities Act of 1933, the Plan Administrator will give you a copy of the most recently received prospectus. However, if you received a copy from the Plan Administrator immediately before you invested, the Plan Administrator is not required to give you a second copy.

5. Review of Investments

The Plan Administrator has designated Sapient representatives to assist in overseeing the selection and performance of certain investment alternatives.

6. Additional Information You May Request

Upon request, the Trustee shall provide to any participant information that the Trustee has immediately available regarding investment vehicles. However, the Trustee shall not be obligated to provide investment advice.

4.8.14

The Plan Administrator will monitor the effectiveness of these procedures. The Plan Administrator must establish any new procedures that become necessary, and will advise you regarding those procedures in writing as soon as possible.

Please address any question you have regarding this notice to the following Plan representative:

Jerry Cunningham
Rexius Forest By-Products, Inc.
PO Box 22838
Eugene, OR 97402
(541) 342-1835

4.8.20

QUALIFIED DEFAULT INVESTMENT ALTERNATIVE NOTICE

To: Plan Participants/Beneficiaries

From: Plan Administrator, Rexius Forest By-Products, Inc. 401(k) Profit Sharing Plan (Plan)

Employer Sponsor: Rexius Forest By-Products, Inc. (Employer)

Re: Notice of Qualified Default Investment Alternative

Right to direct investment. This notice advises you that as a Participant (including a Beneficiary of a deceased Participant) in the Plan, you have the right to direct the investment of some or all of your Plan account assets. Specifically, under the Plan, you may direct the investment of:

[x] All of your Plan accounts

[ ] Your elective deferral contributions account

[ ] Your matching contributions account

[ ] Your nonelective (profit sharing) contributions account

Default investment. You may invest your account(s) specified above (your "directed account(s)") in any of the investment choices explained in the attached investment election form. If you do *not* make an election as to how the Plan should invest your directed account(s) by returning the election form to the Plan Administrator, the Plan Trustee will invest your directed account(s) in the "default" investment that the Plan officials have selected. The default investment is [here, describe the default investment], and is more fully explained below.

Description of default investment. The description of the default investment is as follows: "Fund B"

Investment objectives: long term growth of capital and income, current income and conservation of capital.

Risk and return characteristics (if applicable): See plan website

Fees and expenses: See plan website

Right to alternative investment. Even if the Plan Trustee invests some or all of your directed account(s) in the default investment, you have the continuing right to direct the investment of your directed account(s) in one or more of the other investment choices available to you as explained above. You may change your investments [at least once within any three month period]. You are entitled to invest in any of the alternative investment choices without incurring a financial penalty.

Where to go for further investment information. You can obtain further investment information about the Plan's investment alternatives other than the default investment by contacting the Plan Administrator at:

Rexius Forest By-Products, Inc.
PO Box 22838
Eugene, OR 97402
(541) 342-1835

Summary of Material Modification for the
Rexius Forest By-Products, Inc. 401(k) Profit Sharing Plan

This is a Summary of Material Modification (SMM) regarding the Plan. This SMM supplements the summary plan description (SPD) previously provided to you. You should retain this document with your copy of the SPD.

Summary Description of Modification. The Plan is amended, effective April 1, 2018, to permit participants who have reached age 65 to elect to receive a distribution from their accounts. Accordingly, Article VI of the SPD is amended in its entirety to read:

"ARTICLE VI

DISTRIBUTIONS PRIOR TO TERMINATION OF EMPLOYMENT

Can I withdraw money from my account while working?

In-service distributions. You may be entitled to receive an in-service distribution. However, this distribution is not in addition to your other benefits and will therefore reduce the value of the benefits you will receive at retirement. This distribution is made at your election subject to possible administrative limitations on the frequency and actual timing of such distributions.

Conditions and Limitations. Generally you may receive a distribution from certain accounts prior to termination of employment provided you satisfy any of the following conditions:

- you have attained age 65. Satisfying these conditions allows you to receive distributions from all contribution accounts."

AMENDMENT TO
REXIUS FOREST BY-PRODUCTS, INC. 401(K) PROFIT SHARING PLAN
(the Plan)

RECITALS

Employer amends the Plan according to the following terms and conditions.

AGREEMENT

1. **Addition of In-Service Distributions**. Section 47 is amended from (a) to (b)(2)(a.) and section 48 is amended to add (b) to permit participants who have reached age 65 to elect to receive a distribution from their accounts.

2. **Effective Date**. This amendment is effective April 1, 2018.

3. **Effect on Other Provisions**. All other terms and provisions of the Plan shall remain in full force and effect.

Rexius Forest By-Products, Inc.

By _____
Jerry Cunningham, ~~President~~ CFO

PLAN SPECIFICATION SHEET

The information provided in this specification sheet is for your convenience only and is substantially abbreviated. For more complete information about the Plan, refer to the summary plan description. For information on which you may rely, you must refer to the plan document itself.

1. **Employer**: Rexius Forest By-Products, Inc.

2. **Plan Name**: Rexius Forest By-Products, Inc. 401(k) Profit Sharing Plan

3. **Trustee(s)**: Jerry Cunningham; Rusty Rexius

4. **Plan Year**: January 1 to December 31

5. **Eligibility Conditions**: One year/1,000 hours; age 21

6. **Plan Entry Date(s)**: The January 1 or July 1 immediately after or coincident with satisfying Eligibility Conditions

7. **Participant Direction of Investment**: Permitted

8. **Annual Contributions**:

8.1. Optional employee deferrals (pre-tax or Roth (after-tax))
8.2. Employer may, during a plan year, elect to make a fully vested safe harbor contribution equal to 3% of participants' compensation (and, if so, you will be notified prior to year end); Employer also may, at its discretion, contribute amounts to be shared based on compensation, subject to integration at 100% of the social security wage base, or to be allocated as additional matching contributions

9. **Service/Employment Conditions**: After entering the Plan and becoming a Participant, you must be employed on the last day of the Plan Year to receive annual Employer discretionary profit sharing and matching contributions; deferrals and the 3% safe harbor contribution are not subject to the service/employment conditions (note, participants who terminate service with fewer than 501 hours of service in their year of termination also will not be eligible for Employer contributions for the year)

10. **Normal Retirement Age**: 65

11. **Vesting**:

11.1. Deferrals and the safe harbor contribution: 100% vested at all times
11.2. All other contributions:

Less than 2 years	0% vested
2 yrs but less than 3	20% vested
3 yrs but less than 4	40% vested
4 yrs but less than 5	60% vested
5 yrs but less than 6	80% vested
6 yrs or more	100% vested

12. **Distributions of Vested Accrued Benefits**: Generally, the first administratively practicable distribution date of the Plan Year after your employment terminates; Participants who are at least 65 may request distributions while still employed (subject to administrative policies)

13. **Form of Benefit Payment**: Lump sum and installments for required minimum distributions

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.

Background: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires health plans to notify plan participants and beneficiaries about its policies and practices to protect the confidentiality of their health information. This document is intended to satisfy HIPAA's notice requirement with respect to any health information created, received, or maintained by the Rexius Forest By-Products, Inc. Employee Benefit Plan (the "Plan"), as sponsored by Rexius Forest By-Products, Inc. (the "Company").

The Plan may need to create, receive, and maintain records that contain health information about you to administer the Plan and provide you with health care benefits. This notice describes the Plan's health information privacy policy with respect to your health insurance benefit. The notice tells you the ways the Plan may use and disclose health information about you, describes your rights, and the obligations the Plan has regarding the use and disclosure of your health information. However, it does not address the health information policies or practices of your health care providers.

Practices Pledge Regarding Health Information Privacy

The privacy policy and practices of the Plan protects any confidential health information that identifies you or could be used to identify you and relates to a physical or mental health condition or the payment of your health care expenses. This individually identifiable health information is known as "protected health information" (PHI). The Company generally does not receive PHI unless received or authorized by the employee. Your PHI will not be used or disclosed without a written authorization from you, except as described in this notice or as otherwise permitted by federal and state health information privacy laws.

Privacy Obligations of the Plan

The Plan is required by law to:

- make sure that health information that identifies you is kept private;
- give you this notice of the Plan's legal duties and privacy practices with respect to health information about you; and
- follow the terms of the notice that is currently in effect.

How the Plan May Use and Disclose Health Information About You

The following are the different ways the Plan may use and disclose your PHI:

- **For Treatment.** The Plan may disclose your PHI to a health care provider who renders treatment on your behalf. For example, if you are unable to provide your medical history as the result of an accident, the Plan may advise an emergency room physician about the types of prescription drugs you currently take.

- **For Payment.** The Plan may use and disclose your PHI so claims for health care treatment, services, and supplies you receive from health care providers may be paid according to the Plan's terms. For example, the Plan may receive and maintain information about surgery you received to enable the Plan to process a hospital's claim for reimbursement of surgical expenses incurred on your behalf.

- **For Health Care Operations.** The Plan may use and disclose your PHI to enable it to operate, or operate more efficiently, or make certain all of the Plan's participants receive their health benefits. For example, the Plan may combine health information about many Plan participants and disclose it to the Company in summary fashion so it can decide what overages the Plan should provide. The Plan may remove information that identifies you from health information disclosed to the Company so it may be used without the Company learning who the specific participants are.

- **To the Company.** The Plan may disclose your PHI to designated Company personnel so they can carry out their Plan-related administrative functions, including the uses and disclosures described in this notice. Such disclosures will be made only to the Company's designated claims payor and/or the designated members of the Company's benefits or human resources personnel (the "Plan Administrator"). These individuals will protect the privacy of your health information and ensure it is used only as described in this notice or as permitted by law. Unless authorized by you in writing, your health information: (1) may not be disclosed by the Plan to any other Company employee or department and (2) will not be used by the Company for any employment-related actions and decisions or in connection with any other employee benefit plan sponsored by the Company.

- **To a Business Associate.** Certain services are provided to the Plan by third party administrators known as "business associates." For example, the Plan may input information about your health care treatment into an electronic claims processing system maintained by the Plan's business associate so your claim may be paid. In so doing, the Plan will disclose your PHI to its business associate so it can perform its claims payment function. However, the Plan will require its business associates, through contract, to appropriately safeguard your health information.

- **As Required by Law**. The Plan will disclose your PHI when required to do so by federal, state, or local law, including those that require the reporting of certain types of wounds or physical injuries.

Special Use and Disclosure Situations

The Plan may also use or disclose your PHI under the following circumstances:

- **Lawsuits and Disputes.** If you become involved in a lawsuit or other legal action, the Plan may disclose your PHI in response to a court or administrative order, a subpoena, warrant, discovery request, or other lawful due process.

- **Law Enforcement.** The Plan may release your PHI if asked to do so by a law enforcement official, for example, to identify or locate a suspect, material witness, or missing person or to report a crime, the crime's location or victims, or the identity, description, or location of the person who committed the crime.

- **Workers' Compensation.** The Plan may disclose your PHI to the extent authorized by and to the extent necessary to comply with workers' compensation laws other similar programs.

- **Military and Veterans.** If you are or become a member of the U.S. armed forces, the Plan may release medical information about you as deemed necessary by military command authorities.

- **To Avert Serious Threat to Health or Safety**. The Plan may use and disclose your PHI when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person.

- **Public Health Risks.** The Plan may disclose health information about you for public heath activities. These activities include preventing or controlling disease, injury or disability; reporting births and deaths; reporting child abuse or neglect; or reporting reactions to medication or problems with medical products or to notify people of recalls of products they have been using.

- **Health Oversight Activities.** The Plan may disclose your PHI to a health oversight agency for audits, investigations, inspections, and licensure necessary for the government to monitor the health care system and government programs.

- **Research.** Under certain circumstances, the Plan may use and disclose your PHI for medical research purposes.

- **National Security, Intelligence Activities, and Protective Services**. The Plan may release your PHI to authorized federal officials: (1) for intelligence, counterintelligence, and other national security activities authorized by law and (2) to enable them to provide protection to the members of the U.S. government or foreign heads of state, or to conduct special investigations.

- **Organ and Tissue Donation.** If you are an organ donor, the Plan may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank to facilitate organ or tissue donation and transplantation.

- **Coroners, Medical Examiners, and Funerals Directors**. The Plan may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. The Plan may also release your PHI to a funeral director, as necessary, to carry out his/her duty.

- **Authorizations**. Other than described above, your PHI will only be disclosed in accordance with your written authorization. You may revoke an authorization at any time, so long as the revocation is in writing. Once we receive your revocation, it will be effective only for future uses and disclosures; it will not be effective for any information that may have been used and disclosed in reliance upon the written authorization prior to receiving your written revocation.

Your Rights Regarding Health Information About You

Your rights regarding the health information the Plan maintains about you are as follows:

- **Right to Inspect and Copy.** You have the right to inspect and copy your PHI. This includes information about your plan eligibility, claim and appeal records, and billing records, but does not include psychotherapy notes.

  To inspect and copy health information maintained by the Plan, submit your request in writing to the Plan Administrator. The Plan may charge a fee for the cost of copying and/or mailing your request. In limited circumstances, the Plan may deny your request to inspect and copy your PHI. Generally, if you are denied access to health information, you may request a review of the denial.

- **Right to Amend.** If you feel that health information the Plan has about you is incorrect or incomplete, you may ask the Plan to amend it. You have the right to request an amendment for as long as the information is kept by or for the Plan.

  To request an amendment, send a detailed request in writing to the Plan Administrator. You must provide the reason(s) to support your request. The Plan may deny your request if you ask the Plan to amend health information that was: accurate and complete; not created by the Plan; not part of the health information kept by or for the Plan; or not information that you would be permitted to inspect and copy.

- **Right to An Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of disclosures of your PHI that the Plan has made to others, except for those necessary to carry out health care treatment, payment, or operations; disclosures made to you; or in certain other situations.

  To request an accounting of disclosures, submit your request in writing to the Plan Administrator. Your request must state a time period, which may not be longer than six years prior to the date the accounting was requested.

- **Right to Request Restrictions.** You have the right to request a restriction on the health information the Plan uses or disclosures about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information the Plan discloses about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that the Plan not use or disclose information about a surgery you had.

  To request restrictions, make your request in writing to the Plan Administrator. You must advise: (1) what information you want to limit; (2) whether you want to limit the Plan's use, disclosure, or both; and (3) to whom you want the limit(s) to apply.

  Note: ***The Plan is not required to agree to your request.***
- **Right to Request Confidential Communications**. You have the right to request that the Plan communicate with you about health matters in a certain way or at a certain location. For example, you can ask that the Plan send you explanation of benefits (EOB) forms about your benefit claims to a specified address.

  To request confidential communications, make your request in writing to the Plan Administrator. The Plan will make every attempt to accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to a Paper Copy of this Notice.** You have the right to a paper copy of this notice. You may write to the Plan Administrator to request a written copy of this notice at any time.

Changes to this Notice

The Plan reserves the right to change this notice at any time and to make the revised or changed notice effective for health information the Plan already has about you, as well as any information the Plan receives in the future. The Plan will post a copy of the current notice in the Company's benefits or human resources office at all times.

Complaints

If you believe your privacy rights under this policy have been violated, you may file a written complaint with the Plan Administrator at the address listed below. Alternatively, you may complain to the Secretary of the U.S. Department of Health and Human Services, generally, within 180 days of when the act or omission complained of occurred.

Note: ***You will not be penalized or retaliated against for filing a complaint.***

Other Uses and Disclosures of Health Information

Other uses and disclosures of health information not covered by this notice or by the laws that apply to the Plan will be made only with your written authorization. If you authorize the Plan to use or disclose your PHI, you may revoke the authorization, in writing, at any time. If you revoke your authorization, the Plan will no longer use or disclosure your PHI for the reasons covered by your written authorization; however, the Plan will not reverse any uses or disclosures already made in reliance on your prior authorization.

Contact Information

If you have any questions about this notice, please contact the Plan's Company representative or third party administrators of the health insurance carriers for the Plan:

Jerry Cunningham
Rexius Forest By-Products, Inc
P.O. Box 22838
Eugene, OR 97402
(541) 342-1835 Ext. 109

Providence Health Plan (medical, prescription drugs)
Attn: Privacy Officer
PO Box 4327
Portland, OR 97208

Metropolitan Life Insurance Co (dental)
Attn: Privacy Officer
PO Box 14593,
Lexington, Ky 40512

Lincoln Financial Group (Group Life, STD, LTD)
Attn: Privacy Officer
PO Box 2616
Omaha, NE 68103

Pacific Source Administrators (Flexible Spending Accounts)
Attn: Privacy Officer
PO Box 70168
Eugene, OR 97401

AFLAC (cancer, intensive care)
Attn: Privacy Officer
1932 Wynnton Rd
Columbus, GA 31999

Notice Effective Date: August 1, 2020

REXIUS FOREST BY-PRODUCTS, INC.
§401(k) PROFIT SHARING PLAN

Contribution Election Form (Salary Deferral Agreement)

Name of Participant: _____

[ ] New enrollment [ ] Change to previous election

To the Plan Administrator of Rexius Forest By-Products, Inc. §401(k) Profit Sharing Plan:

In accordance with the Plan, I enter into this Salary Deferral Agreement (Agreement) with Rexius Forest By-Products, Inc. (Employer).

Reduction Amount. Effective _____, 20___ Employer will reduce my compensation, for each payroll period:

		Regular (Pre-Tax)	ROTH (After-Tax)
[ ]	Percent per pay period	_____	_____
	OR		
[ ]	Dollars per pay period	_____	_____

(Note: Salary deferral contributions for any Plan Year may not exceed the §402(g) limitation. The §402(g) limitation is a dollar limitation adjusted by the Internal Revenue Service as of each January 1. Upon your request, the Plan Administrator will provide you the §402(g) limitation in effect for a particular calendar year.)

[ ] I do not wish to participate in the §401(k) Plan

Investment Election. The amounts by which my pay is reduced should be invested in the following investment options, in the percentages indicated, available under the §401(k) Plan:

	Regular (Pre-Tax)	ROTH (After-Tax)
Fund A (Aggressive - 85% equity, 15% fixed)	_____	_____
Fund B (Balanced – 65% equity, 35% fixed)	_____	_____
Fund C (Conservative – 45% equity, 55% fixed)	_____	_____
Total (must equal 100%)	_____	_____

Bonus Reduction Option. Unless I request otherwise, the Plan Administrator will contribute the amount I have elected, for any regular pay period in accordance with these instructions. I understand that I can make a special election, applicable to the bonus pay, by requesting the appropriate form from the Plan Administrator.

In executing this agreement, I understand:

1. Employer will contribute to the plan on my behalf the amount I have elected to contribute under this agreement (my "deferral contributions"). "Compensation" means: my wages (including bonuses) received for my services rendered to Employer. My deferral contributions are not subject to federal or state income tax until distributed from the Plan, but my deferral contributions are subject to Social Security taxes. Employer will deduct from my remaining Compensation my Social Security tax liability on my deferral contributions.

2. This agreement remains in effect until I revoke the Agreement. I may revoke my Salary Deferral Agreement at any time. To revoke this Agreement, I must provide the Plan Administrator at least 15 days advanced written notice of my revocation, specifying the effective date of the revocation. Once I revoke my Agreement, I may file a new Agreement with an effective date no earlier than the first day of the next plan entry date.

3. I may modify my salary deferral percentage or dollar amount as of the January 1 or July 1 of each year. I must provide the Plan Administrator at least 15 days advanced written notice of my modification, specifying the effective date of the Modification.

4. I am 100 percent vested in my deferral contributions. The Plan Administrator will credit my deferral contributions to a Deferral Contributions Account established under the Trust for my benefit. I understand my deferral contributions are subject to gain or loss in the manner described in the Plan.

Date: _____, 20___

PARTICIPANT

_____

Participant's Signature

REXIUS FOREST BY-PRODUCTS, INC.
§401(k) PROFIT SHARING PLAN

Special Bonus Salary Deferral Agreement

Name of Participant: _____

To the Plan Administrator of Rexius Forest By-Products, Inc. §401(k) Profit Sharing Plan:

In accordance with the Plan, I enter into this Special Bonus Salary Deferral Agreement (Agreement) with Rexius Forest By-Products, Inc. (Employer).

Reduction Amount. For the special bonus pay period of _____, 20___ Employer will contribute the following amounts to the Plan from my bonus:

		Regular (Pre-Tax)	ROTH (After-Tax)
[ ]	Percent of bonus	_____	_____
	OR		
[ ]	Dollars from bonus	_____	_____

(Note: Contributions from your salary for any Plan Year may not exceed the §402(g) limitation. The §402(g) limitation is a dollar limitation adjusted by the Internal Revenue Service as of each January 1. Upon your request, the Plan Administrator will provide you the §402(g) limitation in effect for a particular calendar year.)

[ ] My regular Salary Deferral Agreement should apply to my bonus, without modification.

[ ] I do not wish to contribute any portion of my bonus to the §401(k) Plan

Investment Election. The amounts by which my bonus is reduced should be invested in the following investment options, in the percentages indicated, available under the §401(k) Plan:

	Regular (Pre-Tax)	ROTH (After-Tax)
Fund A (Aggressive - 85% equity, 15% fixed)	_____	_____
Fund B (Balanced – 65% equity, 35% fixed)	_____	_____
Fund C (Conservative – 45% equity, 55% fixed)	_____	_____
Total (must equal 100%)	_____	_____

In executing this agreement, I understand:

1. Employer will contribute to the plan on my behalf the amount which I have elected to contribute from my bonus under this agreement ("deferral contributions"). My deferral contributions are not subject to federal or state income tax until distributed from the Plan, but my deferral contributions are subject to Social Security taxes. Employer will deduct from my remaining Compensation my Social Security tax liability on my deferral contributions.

2. This agreement is a one-time agreement, applicable to the bonus payroll identified on page 1.

3. I must complete a separate bonus salary deferral agreement for each bonus I receive.

4. I am 100 percent vested in my deferral contributions. The Plan Administrator will credit my deferral contributions to a Deferral Contributions Account established under the Trust for my benefit. I understand my deferral contributions are subject to gain or loss in the manner described in the Plan.

Date: _____, 20___

PARTICIPANT

_____

Participant's Signature

BENEFICIARY DESIGNATION FORM (PLANS WITHOUT ANNUITIES) FOR THE REXIUS FOREST BY-PRODUCTS, INC. 401(k) PROFIT SHARING PLAN (the "Plan")

I. PARTICIPANT INFORMATION

Participant Name: _____

Social Security Number: _____

Mailing Address: _____

_____

Date of Birth: _____

Date of Hire: _____

Date of Participation: _____

Spouse's Name: _____ ☐ No Spouse

Spouse's Social Security Number: _____

Spouse's Mailing Address (if different from above):

_____

_____

Spouse's Date of Birth: _____

II. BENEFICIARY DESIGNATION

I hereby designate the following primary Beneficiary(ies) and alternate Beneficiary(ies) in the event of my death before I begin to receive payments under the Plan. The alternate Beneficiary(ies) shall be treated as my Beneficiary(ies) only if all my primary Beneficiary(ies) fail to survive me or otherwise cannot be treated as my Beneficiary(ies) under the Plan.

A. Primary Beneficiary Designation

If multiple Beneficiaries are designated, such Beneficiaries shall share equally unless otherwise indicated.

☐ Multiple Beneficiaries are designated and reflected on a separate attachment.

Name: _____

Address: _____

Date of Birth: _____

Social Security Number: _____

B. Alternate Beneficiary Designation

If multiple Beneficiaries are designated, such Beneficiaries shall share equally unless otherwise indicated.

☐ Multiple alternate Beneficiaries are designated and reflected on a separate attachment.

Name: _____

Address: _____

Date of Birth: _____

Social Security Number: _____

III. PARTICIPANT SIGNATURE

I hereby certify that the information on this form is true and correct to the best of my knowledge. I understand that federal law requires that my surviving spouse, if any, be my sole Beneficiary if he or she fails to consent in writing to the designations made by me on this form. I also understand that the designations made by me on this form revoke any prior Beneficiary designations made under this Plan. Finally, I understand that the designations made on this form will be void when I begin to receive benefits under the Plan.

_____ _____

DATE PARTICIPANT'S SIGNATURE

IV. SPOUSAL CONSENT

Your spouse must complete this part only if you indicate anyone else (other than your spouse) in Section IIA as a primary beneficiary. Please contact your Employer for more information if spousal consent cannot be obtained.

I hereby voluntarily and irrevocably consent before a Notary Public to the specific Beneficiary designations made by my spouse in Part II of this form. I understand that (as a result of my consent and waiver) no benefit may be payable to me under the Plan upon my spouse's death.

_____ _____

DATE SPOUSE'S SIGNATURE

Signed, sealed and delivered in the presence of:

_____

NOTARY PUBLIC

My Commission Expires:_____

V. ACKNOWLEDGMENT OF RECEIPT

Received by the Employer this _____ day of _____, 20___.

By: _____

Title: _____

PacificSource ADMINISTRATORS

Employee Flexible Spending Account (FSA) Enrollment Form

Please print responses. * = required field

1. Employment Information

Employer* _____ Division/Class _____

Hire Date (required for mid-yr. enrollment) _____ FSA Effective Date* _____ First Deduction Date _____

PSA Member ID (if applicable) _____ Employee ID _____ No. of Hrs. Worked per Wk. ____

2. Employee Information

Employee Last Name* _____ First Name, MI* _____

Birth Date* _____ Social Security No. _____

Mailing Address* _____

City* _____ State* _____ ZIP* _____

Primary Phone _____ Secondary Phone _____

Email _____

Beneficiary Name and Relationship _____

3. Premium Payment Component

☐ I agree to have my salary reduced on a pretax basis to pay the premiums offered by my employer for medical and hospitalization insurance, major medical insurance, dental insurance, vision insurance, and/or other qualified benefits under Section 125 for myself and my eligible family members. *If my employer uses the evergreen method of enrollment, I will remain enrolled in the Premium Payment Component until I notify my employer in writing that I do not wish to have my share of the premium(s) deducted on a pretax basis.*

4. Flexible Spending Account Election

	Account (as offered)	Employee Pay Period Election		No. of Pay Dates		Employee Annual Election	Account Information
DCAP Component	Dependent Care Expenses (DCE)	$	x		= $		Childcare expenses (for dependents younger than 13) and elder care expenses you incur while at work or school.
Health FSA Component	General-Purpose Health FSA (HRE)	$	x		= $		Eligible medical, dental, vision, and preventive expenses for yourself and your dependents.
	Limited-Purpose Health FSA (LFSA)	$	x		= $		Eligible dental, vision, and preventive expenses for yourself and your dependents. Employees contributing to a health savings account may elect this plan.
	Limited-Scope Health FSA (LSFSA)	$	x		= $		Eligible dental and vision for yourself and your dependents. Employees ineligible for the group-sponsored medical plan may elect this plan.

☐ Check here if you or your dependents are enrolled (or plan to enroll) in a health savings account.
☐ Check here if you are not eligible (or won't be eligible) in your employer's group sponsored medical plan.

Continued on reverse >

5. Member Information

Employer _____

Employee _____

6. Optional Features

Optional features may not be available for all plans. See your plan summary or ask your employer for additional information. If available, you may elect the Benny™ Debit Card. If you are enrolled in your employer's PacificSource plan, you may be eligible for the EasyPay program. FSA claims may still be submitted via fax, mail, or electronically through our MyFlex website. **Select one from the following choices:**

Benny Debit Card	A Benny™ Prepaid Benefits Card deducts directly from your health FSA at the point of sale. Itemized receipts are required for all transactions that are not auto-substantiated at the point of sale. There is no additional cost for acquiring your initial Benny™ Prepaid Benefits Cards. Upon expiration (5 years) a new set will be automatically mailed for no additional fee. *Select if you would like to enroll and/or remain enrolled, or disenroll.*	☐ Enroll and/ or Remain Enrolled ☐ Disenroll
Replacement Benny Debit Card	A set of two replacement/additional Benny™ Prepaid Benefits Cards are available for a fee of $10. This fee is deducted from your health FSA account. Please indicate if your cards have been lost or stolen (and you would like to replace your cards with new numbers). Or indicate if you would like to order additional cards with the same card number.	☐ Lost/Stolen ☐ Additional
EasyPay	EasyPay is the automatic reimbursement of eligible claims processed by PacificSource Health Plans. Employees must be enrolled in their employer's PacificSource plan to be eligible for EasyPay. Employees or their family members with secondary coverage are not eligible for EasyPay. In order to be enrolled, an EasyPay enrollment form must be signed and returned. The EasyPay form is available at PSA.PacificSource.com/Forms_Flex.aspx.	

7. Participant Authorization or Waiver

☐ **Participant Authorization**

I hereby certify the information provided on this form is correct and true to the best of my knowledge, and that the children for whom I will be claiming dependent or childcare expenses either reside with me in a parent-child relationship or are legally dependent on me for their support. I understand that any amount remaining in my account(s) not used for eligible expenses incurred during the plan year may be forfeited in accordance with current Plan provisions and tax laws. I further understand that the flexible compensation reductions will be in effect for the plan year and cannot be revoked unless I experience a qualified change in status. I also understand that the reductions may correspondingly reduce my future Social Security benefits.

If I lose coverage under the health FSA component as a result of a qualifying event (for example, termination of employment or cessation of eligibility because of a reduction in hours of employment), I may be entitled to elect coverage continuation under the health FSA allowed by my employer's Plan. I understand that I cannot be forced to repay or voluntarily repay the employer for any amounts exceeding my health FSA account balance.

☐ **Participant Waiver**

I do not wish to participate in the Plan, and waive enrollment for the health FSA Component, DCAP Component, and Premium Payment Component. I understand that by refusing to participate, I will be unable to enroll this plan year unless my employer allows mid-year changes and I experience a qualifying event, in accordance to the IRS Code Section 125, and submit the change within 30 days of the qualifying event.

Any person who, with an intent to knowingly defraud, files this application with materially falsified information or conceals material information, may be subject to criminal and civil penalties and PacificSource Administrators may cancel such person's membership and refuse to pay their claims.

Employee Signature* _____ Date _____

Employee: *Please return the original to your employer and retain a copy for your records.*
Employer: *Please audit the form, retain a copy for your records, and forward a copy to PacificSource Administrators or submit a spreadsheet electronically.*

PacificSource Administrators PO Box 70168, Springfield, OR 97475-0110; (541) 485-7488, (800) 422-7038; fax (541) 225-3648, (800) 575-1109; PacificSource.com/PSA

The Lincoln National Life Insurance Company
P.O. Box 2616, Omaha, NE 68103-2616
Phone: 800-423-2765 Fax: 877-573-6177

Here is your Enrollment Form.

Follow these steps to complete the form.
Print clearly in ink.
Step 1: Fill in or confirm your personal information.
Step 2: Fill in dependent information, if any.
Step 3: Select your benefits.
Step 4: Assign beneficiaries.
Step 5: Confirm enrollment.
Step 6: Sign, date & return the form.

Group ID: REXIUSFBP

1. Your Personal Information

Group/Employer/Participating Organization Name: Rexius Forest By-Products, Inc.
County: _____ Zip: _____ State: _____

Your First Name: _____ Middle Name/MI: _____ Last Name: _____
Social Security No.: ___-___-____ Employee ID No.: _____ Date of Birth: ___/___/____

Street Address (Include Apt. or Suite No.): _____
City: _____ State: _____ Zip: _____

Home Phone: (___) ___-____ Cell Phone: (___) ___-____ Work Phone: (___) ___-____ Email Address: _____

Gender: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single

2. Personal Information on Dependents — Complete if you are enrolling dependents.

☐ **Spouse** ☐ **Domestic Partner**

First Name: _____ Middle Name/MI: _____ Last Name: _____
Social Security No.: ___-___-____ Date of Birth: ___/___/____

Provide contact information if different than Your information above.

Home Phone: (___) ___-____ Cell Phone: (___) ___-____ Work Phone: (___) ___-____ Email Address: _____

Dependent Children – List all children you are enrolling (attach a separate sheet, if needed).

First Name	Middle Name/MI	Last Name	SSN (Optional)	Gender	DOB	Full-time Student
			___-___-____	☐ Male ☐ Female	___/___/___	☐ Yes ☐ No
			___-___-____	☐ Male ☐ Female	___/___/___	☐ Yes ☐ No
			___-___-____	☐ Male ☐ Female	___/___/___	☐ Yes ☐ No

Employer Completes this Section.

Billing Division or Location: _____
Sort Group/Code: _____ Payroll Cycle: _____
Policy #(s): _____
Average Hours Worked Per Week: _____ ☐ Full-time ☐ Part-time Occupation: _____
Earnings: ☐ Hourly ☐ Weekly ☐ Monthly ☐ Yearly $_____ Date of Employment: ___/___/____
Actively at Work? ☐ Yes ☐ No Date of Rehire: ___/___/____

Continue on Next Page. . .

3. Benefit Selection — Choose your benefits.

Mark the box or boxes for each type of group insurance you are applying for. All insurance amounts are subject to the limitations and exclusions stated in the policy and certificate. (Spouse includes your Domestic Partner.)

Basic Group Insurance				
Employer Completes this section.		**Type of Insurance**	**Amount of Insurance**	**Total Premium (Weekly)**
Class	**Effective Date**			
_____	_____/_____/_____	Life & AD&D		Your Employer pays
_____	_____/_____/_____	Dependents (Spouse & Children) Life Only ☐ **Yes** ☐ **No*** *You must be enrolled for Life insurance to add your spouse & children.*		Your Employer pays
_____	_____/_____/_____	Long Term Disability (LTD)		Your Employer pays

*By selecting "No," enrolling for insurance at a later date may require further medical information and/or a physical exam, which will be at your own expense.

--Actual deductions may vary slightly from above illustrations due to rounding—

Continue on Next Page. . .

4. Select Your Beneficiaries — Choose who receives your insurance benefits.

Primary Beneficiary(ies)
The Primary Beneficiary is the person(s) you identify to receive insurance benefits upon your death.

If more than three Primary Beneficiaries, please attach a separate sheet of paper.
If multiple Primary Beneficiaries, total percentage of all combined must equal 100%.

First Name ____ Middle Initial ____ Last Name ____

Street Address ____ City ____ State ____ Zip ____

Social Security Number ____-____-____ Date of Birth ____/____/____ Relationship to You ____ Percentage ____% Phone Number (____) ____-____

First Name ____ Middle Initial ____ Last Name ____

Street Address ____ City ____ State ____ Zip ____

Social Security Number ____-____-____ Date of Birth ____/____/____ Relationship to You ____ Percentage ____% Phone Number (____) ____-____

First Name ____ Middle Initial ____ Last Name ____

Street Address ____ City ____ State ____ Zip ____

Social Security Number ____-____-____ Date of Birth ____/____/____ Relationship to You ____ Percentage ____% Phone Number (____) ____-____

Contingent Beneficiary(ies) and Other Beneficiary Designations

A Contingent Beneficiary will receive benefits only if the Primary Beneficiary(ies) does not survive you. Please attach a separate sheet to identify a Contingent Beneficiary. If multiple Contingent Beneficiaries, total percentage of all combined must equal 100%. To name a Beneficiary(ies) by product, attach a separate sheet identifying product and beneficiary.

Continue on Next Page. . .

5. Confirm Enrollment

This group insurance has been offered to me and after careful consideration of the benefits, I have decided to:

☐ **ENROLL FOR INSURANCE for which I am or may become eligible** under the group policies issued by The Lincoln National Life Insurance Company, or its insurance partners. If contributions are required, I authorize my Employer to deduct premium from my pay.

☐ **NOT ENROLL myself in the group insurance offered.** I understand if I enroll for insurance at a later date, and if a physical examination or further medical information is required, it will be at my own expense.

☐ **NOT ENROLL my dependents in the group insurance offered.** I understand if I enroll my dependents for insurance at a later date, and if a physical examination or further medical information is required, it will be at my own expense.

Fraud Warning/State Disclosure(s)

A PERSON MAY BE COMMITTING INSURANCE FRAUD, IF HE OR SHE SUBMITS AN APPLICATION OR CLAIM CONTAINING A MISSTATEMENT, MISREPRESENTATION, OMISSION OR CONCEALMENT WITH INTENT TO DEFRAUD (OR KNOWING THAT HE OR SHE IS HELPING TO DEFRAUD) AN INSURANCE COMPANY.

6. Sign and Return

I understand the group insurance requested will not be effective until approved by the Group Insurance Service Office of The Lincoln National Life Insurance Company, or its insurance partners. A delayed effective date will apply if you are not Actively at Work/an Active Member. A delayed effective date may apply to your dependent, if he or she is confined in a hospital or health care facility or is in a period of limited activity on the date insurance would otherwise take effect.

I understand the information provided is for enrollment in group insurance as offered by my Employer and will not be used for underwriting purposes.

The information provided is complete, true, and accurate to the best of my knowledge.

Your Full Name (Print): _____

Your Signature: X_____ **Date** _____/_____/_____

Complete and return this form.

(Be sure to sign and date the form to start your insurance.)

Questions? Call 800-423-2765

Enrollment/Change of Status/Waiver Form

PROVIDENCE Health Plan

P.O. Box 4327, Portland, OR 97208-4327, 800-878-4445, www.ProvidenceHealthPlan.com

Please complete all information on this form. This information is required to process your enrollment.

Group information

Employer group name: Rexius Forest By-Products, Inc. Group number: 100375 Date of hire: _____

Requested effective date: _____ Eligibility waiting period start date: _____ Class/subgroup: _____

❑ New enrollment ❑ Open enrollment ❑ Waiver of coverage *(see section 4)*

❑ Change in existing status Reason for status change:* _____ Date of event: _____

Subscriber ID number: _____ COBRA/state continuation: Start date: _____ End date: _____

Plan enrolling in: ☐ Open Advantage B $2000 Base ☐ Open Advantage B $1500 Buy-up _____

☐ HSA ❑ Deductible/Copay

Section 1 - Employee information

❑ Male ❑ Female Date of birth: _____ Social Security number: _____ ❑ Married ❑ Single

First name: _____ Last name: _____ Middle initial: _____

Street address: _____ City: _____ State: _____ Zip: _____

Mailing address (if different than above): _____ City: _____ State: _____ Zip: _____

Daytime phone: _____ Evening phone: _____ Email address: _____

Section 2 - Dependent enrollment information *(if waiving, see section 4)*

Add	Drop	First name	Last name	Middle initial	Relationship to employee	Social Security number	Date of birth	Gender

*Reasons include: rehired eligible employee, marriage, divorce, death, adoption, dependent change (add or drop), address or name change, involuntary loss of other coverage, COBRA, or state continuation. (Dependents of Personal Option subscribers moving out of or back into the service area must use the Out-of-Area Dependent Enrollment Form. Contact customer service at the number listed above to obtain one.)

(Continued on other side)

Section 3 - Additional and/or creditable coverage information *(This section is not a waiver of coverage. This information is required for payment of claims.)*

Do you or your family members have additional group health insurance and/or Medicare? ❑ YES ❑ NO

If YES, check the types of coverage, then complete the information below: ❑ Medical ❑ Prescription drug ❑ Vision

Name of policyholder:_____ Policyholder's date of birth: _____

Insurance carrier: _____ Policy number: _____ Effective date of policy: _____

Carrier phone number: _____ Full names of persons covered: _____

Is the insurance of any above dependents affected by a divorce decree / court order? ❑ YES ❑ NO
If YES, please include portion of decree that shows responsibility for medical expenses.

Have you had prior Providence Health Plan health coverage? ❑ YES ❑ NO If YES, please list previous member ID number: _____

Section 4 - Waiver of coverage information *(Please include the names of all eligible members who will **NOT** be enrolling with Providence Health Plan.)*

Person(s) waiving	Type of coverage (individual/employer group/Medicare)	Health plan name	Policy number	Employer group name

Notice: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may, in the future, be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. 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, provided that you request enrollment within 30 days after marriage, birth, adoption or placement for adoption.

Accuracy of enrollment information: Any person who, with an intent to knowingly defraud, files this application with materially false information or conceals material information, may be subject to criminal and civil penalties and Providence Health Plan may cancel such person's membership and refuse to pay their claims.

Subscriber acknowledgement: I acknowledge and understand that Providence Health Plan may request or disclose health information, other than psychotherapy notes, about me or my dependents (persons who are listed for benefits coverage on the enrollment form) for the purpose of: (a) performing the health plan business operations of Providence Health Plan; (b) facilitating health care treatment; (c) issuing or facilitating payment for health care services; or (d) as required by law. The use or disclosure of psychotherapy notes by Providence Health Plan is restricted to circumstances in which the patient has provided a signed authorization.

For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Notice of Privacy Practices. A copy is available at **www.ProvidenceHealthPlan.com** or by calling customer service.

Payroll deduction authorization: I authorize my employer to deduct the required contributions from my pay for the coverage requested in this enrollment form. This authorization applies to such coverage until I rescind it in writing. (Does not apply to COBRA, state continuation or waiver of coverage.)

Signature: _____ Date:_____

The Lincoln National Life Insurance Company
P.O. Box 2616, Omaha, NE 68103-2616
Phone: 800-423-2765 Fax: 877-573-6177

Here is your Enrollment Form.

Follow these steps to complete the form.
Print clearly in ink.
Step 1: Fill in or confirm your personal information.
Step 2: Fill in dependent information, if any.
Step 3: Select your benefits.
Step 4: Assign beneficiaries.
Step 5: Confirm enrollment.
Step 6: Sign, date & return the form.

Group ID: REXIUSFBP

1. Your Personal Information

Group/Employer/Participating Organization Name: Rexius Forest By-Products, Inc.
County: _____ Zip: _____ State: _____

Your First Name: _____ Middle Name/MI: _____ Last Name: _____
Social Security No.: ___-___-____ Employee ID No.: _____ Date of Birth: ___/___/____

Street Address (Include Apt. or Suite No.): _____
City: _____ State: _____ Zip: _____

Home Phone: (___) ___-____ Cell Phone: (___) ___-____ Work Phone: (___) ___-____ Email Address: _____

Gender: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single

2. Personal Information on Dependents — Complete if you are enrolling dependents.

☐ **Spouse** ☐ **Domestic Partner**

First Name: _____ Middle Name/MI: _____ Last Name: _____
Social Security No.: ___-___-____ Date of Birth: ___/___/____

Provide contact information if different than Your information above.

Home Phone: (___) ___-____ Cell Phone: (___) ___-____ Work Phone: (___) ___-____ Email Address: _____

Dependent Children – List all children you are enrolling (attach a separate sheet, if needed).

First Name	Middle Name/MI	Last Name	SSN (Optional)	Gender	DOB	Full-time Student
			___-___-____	☐ Male ☐ Female	___/___/___	☐ Yes ☐ No
			___-___-____	☐ Male ☐ Female	___/___/___	☐ Yes ☐ No
			___-___-____	☐ Male ☐ Female	___/___/___	☐ Yes ☐ No

Employer Completes this Section.

Billing Division or Location: _____
Sort Group/Code: _____ Payroll Cycle: _____
Policy #(s): _____
Average Hours Worked Per Week: _____ ☐ Full-time ☐ Part-time Occupation: _____
Earnings: ☐ Hourly ☐ Weekly ☐ Monthly ☐ Yearly $_____ Date of Employment: ___/___/____
Actively at Work? ☐ Yes ☐ No Date of Rehire: ___/___/____

Continue on Next Page. . .

3. Benefit Selection — Choose your benefits.

Mark the box or boxes for each type of group insurance you are applying for. All insurance amounts are subject to the limitations and exclusions stated in the policy and certificate. (Spouse includes your Domestic Partner.)

Basic Group Insurance				
Employer Completes this section.		**Type of Insurance**	**Amount of Insurance**	**Total Premium (Weekly)**
Class	**Effective Date**			
_____	_____/_____/_____	Life & AD&D		Your Employer pays
_____	_____/_____/_____	Dependents (Spouse & Children) Life Only ☐ **Yes** ☐ **No*** *You must be enrolled for Life insurance to add your spouse & children.*		Your Employer pays
_____	_____/_____/_____	Short Term Disability (STD)		Your Employer pays

*By selecting "No," enrolling for insurance at a later date may require further medical information and/or a physical exam, which will be at your own expense.

--Actual deductions may vary slightly from above illustrations due to rounding—

4. Select Your Beneficiaries — Choose who receives your insurance benefits.

Primary Beneficiary(ies)
The Primary Beneficiary is the person(s) you identify to receive insurance benefits upon your death.

If more than three Primary Beneficiaries, please attach a separate sheet of paper.
If multiple Primary Beneficiaries, total percentage of all combined must equal 100%.

First Name ______ Middle Initial ______ Last Name ______

Street Address ______ City ______ State ______ Zip ______

Social Security Number ______-______-______ | Date of Birth ______/______/______ | Relationship to You ______ | Percentage ______% | Phone Number (____) ____-______

First Name ______ Middle Initial ______ Last Name ______

Street Address ______ City ______ State ______ Zip ______

Social Security Number ______-______-______ | Date of Birth ______/______/______ | Relationship to You ______ | Percentage ______% | Phone Number (____) ____-______

First Name ______ Middle Initial ______ Last Name ______

Street Address ______ City ______ State ______ Zip ______

Social Security Number ______-______-______ | Date of Birth ______/______/______ | Relationship to You ______ | Percentage ______% | Phone Number (____) ____-______

Contingent Beneficiary(ies) and Other Beneficiary Designations

A Contingent Beneficiary will receive benefits only if the Primary Beneficiary(ies) does not survive you. Please attach a separate sheet to identify a Contingent Beneficiary. If multiple Contingent Beneficiaries, total percentage of all combined must equal 100%. To name a Beneficiary(ies) by product, attach a separate sheet identifying product and beneficiary.

Continue on Next Page. . .

5. Confirm Enrollment

This group insurance has been offered to me and after careful consideration of the benefits, I have decided to:

☐ **ENROLL FOR INSURANCE for which I am or may become eligible** under the group policies issued by The Lincoln National Life Insurance Company, or its insurance partners. If contributions are required, I authorize my Employer to deduct premium from my pay.

☐ **NOT ENROLL myself in the group insurance offered.** I understand if I enroll for insurance at a later date, and if a physical examination or further medical information is required, it will be at my own expense.

☐ **NOT ENROLL my dependents in the group insurance offered.** I understand if I enroll my dependents for insurance at a later date, and if a physical examination or further medical information is required, it will be at my own expense.

Fraud Warning/State Disclosure(s)

A PERSON MAY BE COMMITTING INSURANCE FRAUD, IF HE OR SHE SUBMITS AN APPLICATION OR CLAIM CONTAINING A MISSTATEMENT, MISREPRESENTATION, OMISSION OR CONCEALMENT WITH INTENT TO DEFRAUD (OR KNOWING THAT HE OR SHE IS HELPING TO DEFRAUD) AN INSURANCE COMPANY.

6. Sign and Return

I understand the group insurance requested will not be effective until approved by the Group Insurance Service Office of The Lincoln National Life Insurance Company, or its insurance partners. A delayed effective date will apply if you are not Actively at Work/an Active Member. A delayed effective date may apply to your dependent, if he or she is confined in a hospital or health care facility or is in a period of limited activity on the date insurance would otherwise take effect.

I understand the information provided is for enrollment in group insurance as offered by my Employer and will not be used for underwriting purposes.

The information provided is complete, true, and accurate to the best of my knowledge.

Your Full Name (Print): _____

Your Signature: X_____ **Date** _____/_____/_____

Complete and return this form.

(Be sure to sign and date the form to start your insurance.)

Questions? Call 800-423-2765

ENROLLMENT • CHANGE FORM

MetLife
Metropolitan Life Insurance Company, New York, NY 10166

SECTION 1: Group Customer Information *(To be Completed by the Recordkeeper)*

Name of Group Customer/Employer	Group Customer Number	Division	Class	Dept Code
REXIUS FOREST BY-PRODUCTS, INC.	5596137			

Date of hire *(mm/dd/yyyy)*	Coverage Effective Date *(mm/dd/yyyy)*

Original COBRA Effective Date *(if applicable, mm/dd/yyyy)*	COBRA Termination Date *(if applicable, mm/dd/yyyy)*

SECTION 2: Your Enrollment Information *(To be Completed by the Employee in blue or black ink)*

First Name	Middle Name	Last Name

SSN	Date of birth *(mm/dd/yyyy)*	Gender:	Marital status:
		☐ Male ☐ Female	☐ Single ☐ Married

Address	City	State	ZIP

Job title	Hours worked per week

☐ New Enrollment ☐ Change in Enrollment ☐ COBRA Continuation
If due to a Qualifying Event, enter date *(mm/dd/yyyy)*

- I have read my enrollment materials and I request coverage for the benefits for which I am or may become eligible. I understand that contributions are required for the benefits I select below.
- The following disclosure is required by New Mexico law: **This type of plan is NOT considered "minimum essential coverage" under the Affordable Care Act and therefore does NOT satisfy the individual mandate that you have health insurance coverage. If you do not have other health insurance coverage, you may be subject to a federal tax penalty.**
- If you are enrolling after the initial enrollment period, please refer to the Declarations and Signature section of this enrollment form to determine the evidence of insurability and late entrant requirements. If evidence of insurability is required for a coverage you are electing, you must complete a Statement of Health form for all amounts you are requesting.

GEF02-1 ADM
(The form number above applies to residents of all states except as follows: Form number **GEF09-1** *applies to residents of Montana;*
GEF02-1
ADM *applies to residents of North Dakota and Utah)*

Dental Insurance

☐ Dental Option

Select your level of coverage

☐ Employee Only

☐ Employee + Spouse/Domestic Partner[1]

☐ Employee + Child(ren)

☐ Employee + Spouse/Domestic Partner[1] + Child(ren)

[1] Domestic Partner includes your registered Domestic Partner if you and your Domestic Partner are registered as domestic partners, civil union partners or reciprocal beneficiaries with a government agency or office where such registration is available. It also includes your non-registered Domestic Partner in whom you have an insurable interest. By enrolling such Domestic Partner for coverage and signing this enrollment form, you are attesting to your insurable interest.

SECTION 3: Dependent Information

If you are applying for coverages for your Spouse/Domestic Partner and/or Child(ren), please provide the information requested below.

Name of your Spouse/Domestic Partner *(first, middle, last)*	Date of birth *(mm/dd/yyyy)*	
		☐ Male ☐ Female

Name(s) of your Child(ren) *(first, middle, last)*	Date of birth *(mm/dd/yyyy)*	
		☐ Male ☐ Female
		☐ Male ☐ Female
		☐ Male ☐ Female
		☐ Male ☐ Female

☐ Check here if you need more lines. Provide the additional information on a separate piece of paper and return it with your enrollment form.

GEF02-1 ADM
(The form number above applies to residents of all states except as follows: Form number **GEF09-1** *applies to residents of Montana;*
GEF02-1
ADM *applies to residents of North Dakota and Utah)*

SECTION 4: Fraud Warnings

Before signing this enrollment form, please read the warning for the state where you reside and for the state where the contract under which you are applying for coverage was issued.
Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, New Mexico, Ohio, Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

GEF09-1 FW
(The form number above applies to residents of all states except as follows: Form number **GEF09-1** *applies to residents of Montana;*
GEF09-1
FW *applies to residents of North Dakota and Utah)*

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies to the extent required by applicable law.
Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.
Kansas and Oregon: Any person who knowingly presents a materially false statement in an application for insurance may be guilty of a criminal offense and may be subject to penalties under state law.
Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.
Maine, Tennessee and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.
Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
New Jersey: Any person who files an application containing any false or misleading information is subject to criminal and civil penalties.
New York (only applies to Accident and Health Insurance): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.
Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.
Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.
Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.
Pennsylvania and all other states: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

GEF09-1 FW
(The form number above applies to residents of all states except as follows: Form number **GEF09-1** *applies to residents of Montana;*
GEF09-1
FW *applies to residents of North Dakota and Utah)*

SECTION 5: Declarations and Signature

By signing below, I acknowledge:

1. I have read this enrollment form and declare that all information I have given is true and complete to the best of my knowledge and belief.
2. I declare that I am actively at work on the date I am enrolling.
3. I understand that if I do not enroll for dental coverage during the initial enrollment period, a waiting period may be required before I can enroll for such coverage after the initial enrollment period has expired.
4. I authorize my employer to deduct the required contributions from my earnings for my coverage. This authorization applies to such coverage until I rescind it in writing.
5. I affirmatively decline coverage for any benefits for which I am eligible which I do not request on this enrollment form.
6. I have read the applicable Fraud Warning(s) provided in this enrollment form.

Sign Here	Signature of Employee	Date signed *(mm/dd/yyyy)*

Print First Name	Print Middle Name	Print Last Name

GEF09-1 DEC
(The form number above applies to residents of all states except as follows: Form number **GEF09-1** *applies to residents of Montana;*
GEF09-1
DEC *applies to residents of North Dakota and Utah)*

How to submit this form

After completion, make a copy for your records and return the original to your employer.

MetLife

Delaware American Life Insurance Company
Hyatt Legal Plans, Inc.
Hyatt Legal Plans of Florida, Inc.
MetLife Health Plans, Inc.
Metropolitan Life Insurance Company
Metropolitan Tower Life Insurance Company
SafeGuard Health Plans, Inc.
SafeHealth Life Insurance Company

Our Privacy Notice

We know that you buy our products and services because you trust us. This notice explains how we protect your privacy and treat your personal information. It applies to current and former customers. "Personal information" as used here means anything we know about you personally.

SECTION 1: Plan Sponsors and Group Insurance Contract Holders

This privacy notice is for individuals who apply for or obtain our products and services under an employee benefit plan, group insurance or annuity contract, or as an executive benefit. In this notice, "you" refers to these individuals.

SECTION 2: Protecting Your Information

We take important steps to protect your personal information. We treat it as confidential. We tell our employees to take care in handling it. We limit access to those who need it to perform their jobs. Our outside service providers must also protect it, and use it only to meet our business needs. We also take steps to protect our systems from unauthorized access. We comply with all laws that apply to us.

SECTION 3: Collecting Your Information

We typically collect your name, address, age, and other relevant information. We may also collect information about any business you have with us, our affiliates, or other companies. Our affiliates include life, car, and home insurers. They also include a legal plans company and a securities broker-dealer. In the future, we may also have affiliates in other businesses.

SECTION 4: How We Get Your Information

We get your personal information mostly from you. We may also use outside sources to help ensure our records are correct and complete. These sources may include consumer reporting agencies, employers, other financial institutions, adult relatives, and others. These sources may give us reports or share what they know with others. We don't control the accuracy of information outside sources give us. If you want to make any changes to information we receive from others about you, you must contact those sources.

We may ask for medical information. The Authorization that you sign when you request insurance permits these sources to tell us about you. We may also, at our expense:

- Ask for a medical exam
- Ask for blood and urine tests
- Ask health care providers to give us health data, including information about alcohol or drug abuse

We may also ask a consumer reporting agency for a "consumer report" about you (or anyone else to be insured). Consumer reports may tell us about a lot of things, including information about:

- Reputation
- Driving record
- Finances
- Work and work history
- Hobbies and dangerous activities

The information may be kept by the consumer reporting agency and later given to others as permitted by law. The agency will give you a copy of the report it provides to us, if you ask the agency and can provide adequate identification. If you write to us and we have asked for a consumer report about you, we will tell you so and give you the name, address and phone number of the consumer reporting agency.

Another source of information is MIB, Inc. ("MIB"). It is a not-for-profit membership organization of insurance companies which operates an information exchange on behalf of its Members. We, or our reinsurers, may make a brief report to MIB. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted, MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. You may do so by writing to MIB, Inc., 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734 or go to MIB website at www.mib.com.

SECTION 5: Using Your Information

We collect your personal information to help us decide if you're eligible for our products or services. We may also need it to verify identities to help deter fraud, money laundering, or other crimes. How we use this information depends on what products and services you have or want from us. It also depends on what laws apply to those products and services. For example, we may also use your information to:

- administer your products and services
- perform business research
- market new products to you
- comply with applicable laws
- process claims and other transactions
- confirm or correct your information
- help us run our business

SECTION 6: Sharing Your Information With Others

We may share your personal information with others with your consent, by agreement, or as permitted or required by law. We may share your personal information without your consent if permitted or required by law. For example, we may share your information with businesses hired to carry out services for us. We may also share it with our affiliated or unaffiliated business partners through joint marketing agreements. In those situations, we share your information to jointly offer you products and services or have others offer you products and services we endorse or sponsor. Before sharing your information with any affiliate or joint marketing partner for their own marketing purposes, however, we will first notify you and give you an opportunity to opt out.

Other reasons we may share your information include:

- doing what a court, law enforcement, or government agency requires us to do (for example, complying with search warrants or subpoenas)
- telling another company what we know about you if we are selling or merging any part of our business
- giving information to a governmental agency so it can decide if you are eligible for public benefits
- giving your information to someone with a legal interest in your assets (for example, a creditor with a lien on your account)
- giving your information to your health care provider
- having a peer review organization evaluate your information, if you have health coverage with us
- those listed in our "Using Your Information" section above

SECTION 7: HIPAA

We will not share your health information with any other company – even one of our affiliates – for their own marketing purposes. The Health Insurance Portability and Accountability Act ("HIPAA") protects your information if you request or purchase dental, vision, long-term care and/or medical insurance from us. HIPAA limits our ability to use and disclose the information that we obtain as a result of your request or purchase of insurance. Information about your rights under HIPAA will be provided to you with any dental, vision, long-term care or medical coverage issued to you.

You may obtain a copy of our HIPAA Privacy Notice by visiting our website at www.MetLife.com. For additional information about your rights under HIPAA; or to have a HIPAA Privacy Notice mailed to you, contact us at HIPAAprivacyAmericasUS@metlife.com, or call us at telephone number (212) 578-0299.

SECTION 8: Accessing and Correcting Your Information

You may ask us for a copy of the personal information we have about you. We will provide it as long as it is reasonably locatable and retrievable. You must make your request in writing listing the account or policy numbers with the information you want to access. For legal reasons, we may not show you privileged information relating to a claim or lawsuit, unless required by law.

If you tell us that what we know about you is incorrect, we will review it. If we agree, we will update our records. Otherwise, you may dispute our findings in writing, and we will include your statement whenever we give your disputed information to anyone outside MetLife.

SECTION 9: Questions

We want you to understand how we protect your privacy. If you have any questions or want more information about this notice, please contact us. A detailed notice shall be furnished to you upon request. When you write, include your name, address, and policy or account number.

Send privacy questions to:

MetLife Privacy Office
P. O. Box 489
Warwick, RI 02887-9954
privacy@metlife.com

We may revise this privacy notice. If we make any material changes, we will notify you as required by law. We provide this privacy notice to you on behalf of the MetLife companies listed at the top of the first page.

CALIFORNIA HEALTHCARE LANGUAGE ASSISTANCE PROGRAM
NOTICE TO INSUREDS

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card, if any, or 1-800-942-0854. For more help call the CA Dept. of Insurance at 1-800-927-4357.
To receive a copy of the attached MetLife document translated into Spanish or Chinese, please mark the box by the requested language statement below, and mail the document with this form to:
Metropolitan Life Insurance Company
PO Box 14587
Lexington, KY 40512
Please indicate to whom and where the translated document is to be sent.

☐ Servicio de Idiomas Sin Costo. Puede obtener la ayuda de un intérprete. Se le pueden leer documentos y enviar algunos en español. Para recibir ayuda, llámenos al número que aparece en su tarjeta de identificación, si tiene una, o al 1-800-942-0854. Para recibir ayuda adicional llame al Departamento de Seguros de California al 1-800-927-4357.
Para recibir una copia del documento adjunto de MetLife traducido al español, marque la casilla correspondiente a esta oración, y envíe por correo el documento junto con este formulario a:
Metropolitan Life Insurance Company
PO Box 14587
Lexington, KY 40512
Por favor, indique a quién y a dónde debe enviarse el documento traducido.
NOMBRE_____
DIRECCIÓN_____

☐ **免費語言服務。**您可獲得免費口譯服務。您可要求翻譯員向你口譯文件，或可要求向你發回文件的中文譯本。如需協助，請致電您的ID卡上所示號碼（如有），或 1-800-942-0854。如需更多協助，請致電加州保險部熱線1-800-927-4357。
為收取隨附MetLife文件的中文譯本，請勾選此陳述前的方框，並將文件連同此表一併郵寄至：
Metropolitan Life Insurance Company
PO Box 14587
Lexington, KY 40512
請指明經翻譯文件收件人的姓名及地址。
姓名_____
地址_____

Անվճար թարգմանչական ծառայություններ: Ձեզ կտրամադրվի հայերենի թարգմանիչ, որի օգնությամբ կարող եք հայերենով կարդալ փաստաթղթերը: Հարցերի դեպքում զանգահարեք մեզ Ձեր ID քարտի վրա նշված հեռախոսահամարով կամ 1-800-942-0854: Առավել մանրամասն տեղեկատվության համար զանգահարեք Կալիֆորնիայի Ապահովագրական Դեպարտամենտ 1-800-927-4357 հեռախոսահամարով:

សេវាបកប្រែដោយឥតគិតថ្លៃ ។ អ្នកអាចទទួលបានអ្នកបកប្រែម្នាក់ និងឱ្យគេអានឯកសារនានាឱ្យអ្នកស្តាប់ជាភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើង តាមលេខដែលមានចុះនៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់អ្នកប្រសិនបើមាន ឬ តាមលេខ 1-800-942-0854 ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងនៃរដ្ឋកាលីហ្វ័រញ៉ា (CA Dept. of Insurance) តាមលេខ 1-800-927-4357 ។

Kev pab txhais lus tsis kom them nqi. Koj thov tau kom nrhiav neeg txhais lus thiab nyeem ntaub ntawv hais ua lus Hmoob rau koj mloog. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj sau hauv koj daim npav ID, yog muaj, lossis 1-800-942-0854. Yog xav kom pab lwm yam hu rau lub CA Hauv Paus Iv-saws-las ntawm 1-800-927-4357.

無料の通訳サービス。通訳を通して日本語で文書を読み上げてもらうことができます。サービスの利用をご希望の方は、お手持ちの ID カードに記載されている番号、または 1-800-942-0854 へお電話ください。さらなる支援が必要な場合は、カリフォルニア州保険庁 1-800-927-4357 までお問い合わせください。

무료 통역 서비스. 통역자가 문서를 한국어로 읽어드릴 수 있습니다. 도움이 필요하시면, 귀하의 ID 카드에 있는 번호나 1-800-942-0854 로 전화하십시오. 다른 도움이 필요하시면, 전화번호 1-800-927-4357 로 캘리포니아 보험국에 연락하여 주십시오.

Бесплатные услуги устного перевода. Вы можете воспользоваться услугами переводчика, который прочитает вам документы на русском языке. Чтобы получить помощь, позвоните нам по номеру, указанному на вашей идентификационной карточке, если у вас она есть, либо по номеру 1-800-942-0854. Если вам нужна помощь в других вопросах, позвоните в горячую линию Департамента страхования (CA Dept. of Insurance) 1-800-927-4357.

Libreng serbisyo sa pagsasalin. Maaari kang kumuha ng tagasalin para basahin sa iyo ang mga dokumento sa wikang Tagalog. Para ikaw ay matulungan, tawagan kami sa numerong nakalista sa iyong ID card, kung mayroon man, o sa numerong 1-800-942-0854. Para sa karagdagang tulong tawagan ang CA Dept. of Insurance sa numerong 1-800-927-4357.

Dịch vụ thông dịch miễn phí. Quý vị có thể tìm một thông dịch viên và nhờ đọc các tài liệu này cho quý vị bằng tiếng Việt. Để được giúp đỡ, gọi cho chúng tôi tại số nêu trên thẻ ID của quý vị, nếu có, hoặc 1-800-942-0854. Để được giúp đỡ thêm gọi cho Ban Bảo Hiểm CA tại số 1-800-927-4357.

لا تتوفر خدمات ترجمة بتكلفة. يمكنك الاتصال بمترجم والحصول على خدمة قراءة المستندات باللغة العربية. للمساعدة، اتصل بنا على الرقم الموجود على بطاقة التعريف الخاصة بك، أو اتصل بالرقم 1-800-942-0854. ولمزيد من المساعدة، اتصل بقسم التأمينات التابع لـ CA على الرقم 1-800-927-4357.

سرویس های ترجمه رایگان. شما می توانید مترجم و اسنادی را به زبان فارسی برای مطالعه دریافت کنید. برای راهنمایی،از طریق شماره درج شده در کارت شناسایی خود (در صورت وجود) یا شماره 1-800-942-0854 با ما تماس بگیرید. برای راهنمایی بیشتر با بخش بیمه کالیفرنیا 1-800-927-4357 تماس بگیرید.

بلا معاوضہ مترجم دی خدمات مل سکدی اے۔ تُسی ایک مترجم دی خدمات حاصل کرسکدے او جو توڈے واسطے دستاویزات پنجابی وچ پڑھ سکدا اوے۔ مدد واسطے اپڑیں آئی ڈی کارڈ، گر ہووے، دے وچ نمبر یا 1-800-942-0854 تے کال کرو۔ آگے مزید مدد واسطے اے نمبر 1-800-927-4357 تے سی اے ڈیپارٹمنٹ برائے انشورنس نال گال کرو۔

PLAN DOCUMENT AMENDMENT

REXIUS FOREST BY-PRODUCTS INC

FLEXIBLE SPENDING ACCOUNT

Purpose:
As per the final ruling released by the Department of Labor and Department of Treasury to provide relief and guidance to assist Participants impacted by the outbreak. The following terms of the Flexible Spending Account (FSA) for REXIUS FOREST BY-PRODUCTS INC shall be amended.

The final ruling and this amendment shall be in effect from 3/1/2020 until 60 days after the announced end of the National Emergency, which is still to be determined (TBD). This time period is considered the "Outbreak Period". Specific to the Premium Payment and Health FSA Components under your FSA, and in respect to ERISA and the Code, the "Outbreak Period" should be disregarded (e.g. ignored) for plans subject to ERISA or the Internal Revenue Code in regards to:

- **HIPAA Special Enrollment Period** These rights provide that if an individual or their dependent(s) lose other healthcare plan coverage under certain circumstances, marry, or obtain an additional child through birth or adoption, the individual may be able to change their health care plan election and make a corresponding change to their elections under the Plan. Generally in these cases, individuals, who are otherwise eligible, must be allowed to enroll in the healthcare plan coverage if enrollment is requested within 30 days of the event. Under new guidance, if the event occurs anytime during the "Outbreak Period", the request for enrollment must be submitted within 30 days of the end of the "Outbreak Period" (TBD) *instead of* the date of the event.
- **Claim Filing Deadlines** Plans must establish and maintain claim filing procedures that allow for filing and payment of claims in a timely manner. Eligible claims will be paid during the run-out period following the end of the plan year which is generally 90 days unless it has been extended. Under new guidance, if the date of service occurred during the "Outbreak Period", eligible claims may be submitted up to 90 days from the end of the "Outbreak Period" (TBD) *instead of* the Plan's period of coverage end date. This is not a blanket statement extending the run-out for claims incurred outside the "Outbreak Period". Participants may resubmit any previously denied claims for reprocessing.
- **Claim Appeals** Participants must be provided a reasonable opportunity to appeal denied claims. Generally an appeal must be requested within 180 days following receipt of a denied claim. Under new guidance, appeals deadlines are based on the end of the "Outbreak Period" (TBD) *instead of* the date of denial; however, taking into account the number of days between the denial date and the first day of the National Emergency. For instance, if a claim is denied on 1/28/2020, the appeal deadline would be determined by subtracting the number of days between 1/28/2020 and 3/1/2020 (32 days) from 180 days; resulting in an appeal deadline of 148 days after the end of the "Outbreak Period" (TBD) *instead of* the claim denial date.
- **External Review Process Timeframes** Participants of a *non-excepted* Health FSA may request an external review within four months of the claim denial or internal appeal denial. Due to the nature of and simplicity of these types of claims (e.g. does the expense meet the definition of a medical expense and is there sufficient funds in the Participants account), an external review is generally not needed. In the rare case of an external review and under new guidance, an external appeals request deadline is based

on the end of the "Outbreak Period" (TBD). ***Note:*** PSA defines all of our Health FSAs as *excepted* benefits in which the external review process is not applicable.

Note: This amendment does not describe the group sponsored insurance plan rules. The provisions of the Premium Payment Component (pretax group sponsored insurance premiums) under the FSA are not intended to override any plan rules specified in the group sponsored insurance plan documents.

REXIUS FOREST BY-PRODUCTS INC formally adopts this Plan Document Amendment on 8/21/2020 and will administer the Plan in accordance with its terms. These are the only changes to the original FSA plan documents for the Plan Years that overlap with the "Outbreak Period" and the remainder of the plan documents continue in full force.

Signature of Authorized Representative

CFO 8/31/20

Title