MAPP

2021-2022 MAPP Benefits

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We all work together to make MAPP a success, and our teamwork extends to your benefits. Your health and well-being are important to us, so we provide benefit options to make your and your family's lives better. Together, let's invest in you. Read over this guide for details on your 2021-2022 benefits from A to Z. If you have questions, your Human Resources department is here to help.

Info on the Go!
Scan with Your Smartphone to Access Enrollment Materials Online Anytime.

See **page 31** for important information concerning Medicare Part D coverage.

In this Guide, we use the term company to refer to The MAPP Group, LLC. This Guide is intended to describe the eligibility requirements, enrollment procedures and coverage effective dates for the benefits offered by the company. It is not a legal plan document and does not imply a guarantee of employment or a continuation of benefits. While this Guide is a tool to answer most of your questions, full details of the plans are contained in the Summary Plan Descriptions (SPDs), which govern each plan's operation. Whenever an interpretation of a plan benefit is necessary, the actual plan documents will be used.

Eligibility & Enrollment

MAPP offers a variety of benefits to support your and your family's needs. Choose options that cover what's important to your unique lifestyle.

Eligibility

If you are a full-time employee who is regularly scheduled to work at least 30 hours per week, you are eligible to participate in the medical, dental, vision, life and disability plans and additional benefits.

When Does Coverage Begin?

Annual Enrollment: Elections made during our Annual Open enrollment will be effective on February 1, 2021. If you are still in your new hire waiting period, your effective date will be delayed until the waiting period has been satisfied.

New Hire: Your elections will be effective on the first of the month following your new hire waiting period. This waiting period is 60 days for hourly employees and 30 days for salary employees.

You won't be able to change your benefits until the next annual enrollment period unless you experience a qualifying life event.

Eligible Dependents

Dependents eligible for coverage in the MAPP benefits plans include:

- Your legal spouse (or common-law spouse where recognized).
- Children up to age 26 (includes birth children, stepchildren, legally adopted children, children placed for adoption, foster children and children for whom legal guardianship has been awarded to you or your spouse).
- Dependent children 26 or more years old, unmarried and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a dependent under this plan (periodic certification may be required).

Verification of dependent eligibility is required upon enrollment.

Thoughts & Tips: **You cannot change your benefit selections during the plan year unless you have a qualifying life event, such as marriage and/or the birth or adoption of a child.**

Enroll now. You've got one shot!

What are Qualifying Life Events?

Most people know you can change your benefits when you start a new job or during Open Enrollment. But did you know that changes in your life may permit you to update your coverage at other points in the year? Qualifying Life Events (QLEs) determined by the IRS could allow you to enroll in health insurance or change your elections outside of the annual time.

Common qualifying events include:

- A change in your employment status from full time to part time, or part time to full time, resulting in a gain or loss of eligibility
- A change in your legal marital status (marriage, divorce or legal separation)
- Entitlement to Medicare or Medicaid
- A change in the number of your dependents (for example, through birth or adoption, or if a child is no longer an eligible dependent)
- Eligibility for coverage through the Marketplace
- A change in your spouse's employment status (resulting in a loss or gain of coverage)
- Changes in your address or location that may affect the coverage for which you are eligible

Some lesser-known qualifying events are:

- Turning 26 and losing coverage through a parent's plan
- Changes that make you no longer eligible for Medicaid or the Children's Health Insurance Program (CHIP)
- Death in the family (leading to change in dependents or loss of coverage)

When a Qualifying Life Event occurs, you have 30 days to request changes to your coverage. Keep in mind your change in coverage must be consistent with your change in status.

Questions regarding specific life events and your ability to request changes should be directed to MAPP's Human Resources. Don't miss out on a chance to update your benefits!

Preparing For Open Enrollment

As a committed partner in your health, MAPP absorbs a significant amount of your benefit costs. Your contributions for medical, dental and vision benefits are deducted on a pre-tax basis, lessening your tax liability. Please note that employee contributions vary depending on level of coverage. Typically, the more coverage you have, the higher your portion.

You may select any combination of medical, dental and/or vision plan coverage. For example, you could select medical coverage for you and your entire family, but select dental and vision coverage only for yourself. The only requirement is that you, as an eligible employee, must elect coverage for yourself in order to elect any dependent coverage.

Open Enrollment To-Do

Update your personal information.

If you've experienced a qualifying life event in the last year, you may need to change your elections or update your details.

Review your options with your family.

Make sure you include any other individuals who will be affected by your elections in the decision making process. Also consider if your spouse has benefit coverage available through another employer or if any of your covered dependents will be turning 26 or getting married this year as they could they could lose their eligibility. Please review the eligibility section and contact Human Resources if you have any questions.

Double-check covered and restricted medications.

Each year your Medical plan updates the prescription drug list (PDL). Be sure to review to see if your prescription has changed tiers, requires step therapy or is no longer covered. Also, if you make any changes to your plan, consider how it affects your prescription drug coverage.

Review available plans' deductibles.

Take a look at your options – if you foresee a lot of medical needs this year, you might want a lower deductible. If not, you could switch to a higher deductible and enjoy lower premiums.

Consider your HSA or FSA.

An HSA or FSA can help cover healthcare costs including dental and vision services and prescriptions. Adding one of these accounts to your benefits can help with your long-term financial goals – and your employer may help contribute.

Check to see if your pharmacy is in-network.

Going in-network often saves you money. Check for any plan changes to make sure your favorite pharmacy is still your best bet and is covered in-network.

Medical Benefits

Medical benefits are provided through UnitedHealthcare. Choose the plan that works best for your life. Consider the physician networks, premiums and out-of-pocket costs for each plan. Keep in mind your choice is effective for the entire 2021-2022 plan year, unless you have a qualifying life event.

Medical Premiums

Premium contributions for medical are deducted from your paycheck on a pre-tax basis. Your level of coverage determines your weekly contributions.

	QHDHP3000 (4W5/BX-INT)	PPO1000 (BYWP/BX)
WEEKLY CONTRIBUTIONS		
EMPLOYEE ONLY	$35	$50
EMPLOYEE + SPOUSE	$128	$175
EMPLOYEE + CHILD(REN)	$119	$165
EMPLOYEE + FAMILY	$205	$250

How to Find a Provider

Visit www.myuhc.com or call Customer Care at 866-314-0335 for a current list of **UnitedHealthcare Choice Plus** network providers.

Thoughts & Tips:

Most preventive care offered by an in-network physician is covered at 100%.

Medical Benefits

Medical Plan Summary

This chart summarizes the 2021-2022 medical coverage provided by UnitedHealthcare. All covered services are subject to medical necessity as determined by the plan. Please be aware that all out-of-network services are subject to Reasonable and Customary (R&C) limitations.

	QHDHP3000 (4W5/BX-INT)		PPO1000 (BYWP/BX)	
CALENDAR YEAR DEDUCTIBLE				
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
INDIVIDUAL	$3,000	$6,000	$1,000	$2,000
FAMILY	$6,000	$12,000	$2,000	$4,000
COINSURANCE (PLAN PAYS)	80%*	60%*	80%*	60%*
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (INCLUDES DEDUCTIBLE)				
INDIVIDUAL	$4,000	$8,000	$4,000	$8,000
FAMILY	$8,000	$16,000	$8,000	$16,000
COPAYS/COINSURANCE				
VIRTUAL VISITS (DESIGNATED PROVIDER)	80%*	Not covered	No charge	Not covered
PRIMARY CARE	80%*	60%*	$25 copay	60%*
SPECIALIST SERVICES	80%*	60%*	$45 copay	60%*
URGENT CARE	80%*	60%*	$50 copay	60%*
DIAGNOSTIC CARE	80%*	60%*	80%*	60%*
EMERGENCY ROOM	80%*	60%*	80%*	60%*

*After Deductible

Deductible and out-of-pocket maximums are on a "Calendar Year" basis (Calendar Year = January to December). The deductible (and out-of-pocket max) will reset each January 1. The medical plans have an embedded deductible. This means all individual deductible and out-of-pocket maximums will count towards the family deductible and family out- of-pocket maximum, but an individual will not have to pay more than their individual amount.

Pharmacy Benefits

Prescription Drug Coverage for Medical Plans

Our Prescription Drug Program is coordinated through UnitedHealthcare. That means you will only have one ID card for both medical care and prescriptions. Information on your benefits coverage and a list of network pharmacies is available online at www.myuhc.com or by calling the Customer Care number on your ID Card. Your cost is determined by the tier assigned to the prescription drug product. Products are assigned as Tier 1, Tier 2, or Tier 3.

	QHDHP3000 (4W5/BX-INT)		PPO1000 (BYWP/BX)	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
RETAIL RX (30-DAY SUPPLY)				
TIER 1	$10 copay*	Applicable copay* + Balance Billing	$10 copay	$10 copay + Balance Billing
TIER 2	$35 copay*	Applicable copay* + Balance Billing	$35 copay	$35 copay + Balance Billing
TIER 3	$70 copay*	Applicable copay* + Balance Billing	$70 copay	$70 copay + Balance Billing
MAIL ORDER RX (90-DAY SUPPLY)				
TIER 1	$30 copay*	Not covered	$30 copay	Not covered
TIER 2	$105 copay*	Not covered	$105 copay	Not covered
TIER 3	$210 copay*	Not covered	$210 copay	Not covered

*After Deductible

Generic Drugs

Looking to save money on medication costs? You've most likely heard that generic prescription drugs are a more affordable option, so here's the skinny: Generic drugs are versions of brand-name drugs with the exact same dosage, intended use, side effects, route of administration, risks, safety and strength. Because they are the same medicine, generic drugs are just as effective as brand-name drugs and undergo the same rigid FDA standards. But on average, **a generic version costs 80% to 85% less than the brand-name equivalent.** To find out if there is a generic equivalent for your brand-name drug, visit www.fda.gov.

Online Benefits

Log into your myUHC account at www.myuhc.com and click on the Pharmacies & Prescriptions tab to go to OptumRx to:

- View your current drug prescriptions
- Check home delivery order status
- Refill home delivery prescriptions
- Compare drug pricing
- View your prescription benefits

Prescription Drug Coverage - Optum Rx

The prescription drug coverage included with your Medical plan provides different levels of coverage depending on the type of drug you receive. The plan allows you to receive up to a 90-day supply (mail order) or up to a 30-day supply of medication from a participating retail pharmacy. If you have any questions about your prescription drug benefits, call UHC/Optum Rx at 800-788-4863. UHC may require members to fill maintenance medication through the mail order program; however, you may opt out of the mail order if you call and request to do so. Prior authorization and step therapy may also be required. Specialty medications need to be filled at a designated specialty pharmacy.

Thoughts & Tips: When filling a new prescription, use the online tools to check pricing up front.

Out-of-Pocket Costs

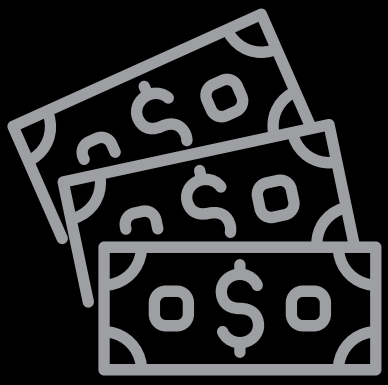
Know Before You Go: Paying for Services

Deductible

The amount you must pay for covered services before your insurance starts paying its portion.

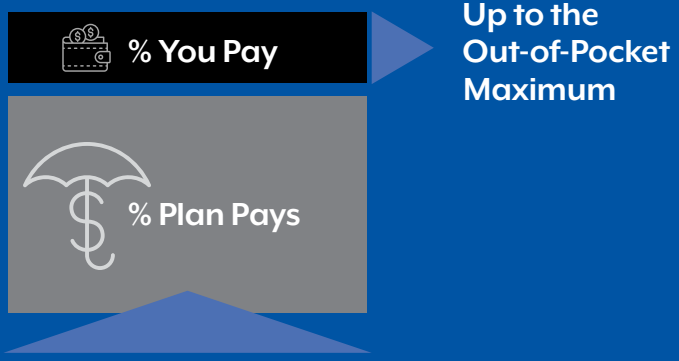
Copay

The fixed amount you pay for healthcare services at the time you receive them.



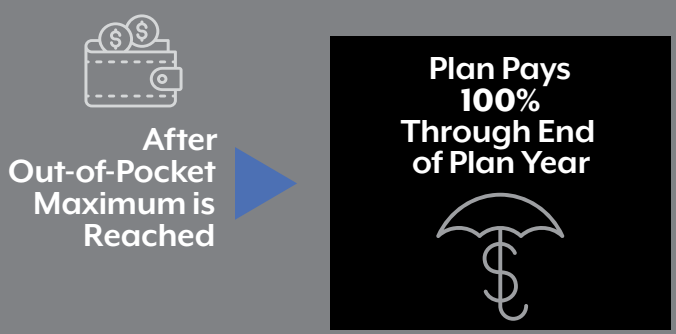
Coinsurance

Your percentage of the cost of a covered service. If your office visit is $100 and your coinsurance is 20% (and you've met your deductible but not your out-of-pocket maximum), your payment would be $20.



Out-of-Pocket Maximum

The most you will pay during the plan year before your insurance begins to pay 100% of the allowed amount.



Healthcare Cost Transparency

With options like Qualified High Deductible Health Plans, Health Savings Accounts and Flexible Spending Accounts, your healthcare spending is in your control. But with so many providers and varying costs for services, how do you decide where to go? Healthcare cost transparency tools are online services available through most health insurance carriers that allow consumers to compare costs for medical services, from prescriptions to major surgeries, to make choices easier. To learn more, visit www.myuhc.com.

Thoughts & Tips: **The cost of an MRI can vary between $300 and $3,000 — even within your area.**

Rising Costs of Healthcare

The cost of healthcare in the U.S. has been steadily growing each year. Why? Some of the factors include an aging population, increased demand for care (resulting in higher prices for premiums and prescription drugs) and an increase in chronic illnesses. **MAPP wants to help keep you healthy, so we do what we can to keep your healthcare costs reasonable.** Make sure you're informed about your options so you can make the best healthcare choices for you and your family. Placing an importance on preventive care, making healthy choices, and managing costs will help keep your health — and wallet — in control in the long run.

How to Pick a Plan

Which plan is right for you? When deciding, consider any medical needs you foresee for the upcoming plan year, your overall health, and any medications you currently take.

How does a PPO (Preferred Provider Organization) work?

You'll pay more in premiums out of your paycheck, but perhaps less at the time of service.

You're able to choose from a network of providers who offer a fixed copay for services.

If you expect to need more medical care this year or you have a chronic illness, the PPO may be the right choice for you to ensure your healthcare needs are covered.

How does a QHDHP (Qualified High Deductible Health Plan) work?

You'll pay less in premiums. (Think less money from your paycheck.)

You'll pay for the full cost of non-preventive medical services until you reach your deductible.

You can also use a Health Savings Account in conjunction, which provides a safety net for unexpected medical costs and tax advantages.

If you expect to mostly use preventive care (which is covered), this plan could be for you.

Note: Apps such as GoodRx and RxSaver let you compare prices of prescription drugs and find possible discounts. If you use these tools, make sure to check the price against the cost through your insurance to get the best deal. Note that these discounts can't be combined with your benefit plan's coverage. As a result, if you choose to use a discount card from an app such as GoodRx or RxSaver, the amount you pay will not count toward your deductible or out-of-pocket maximum under the benefit plan.

Preventive Care

Most health plans are required to cover a set of preventive services — at no cost to you!

Screening tests and routine checkups are considered preventive, which means they're often paid at 100%. Keep up to date with your primary care physician to save time and money and keep yourself healthier in the long run. Under the U.S. Patient Protection and Affordable Care Act (PPACA), some common covered services include:

- Wellness visits, physicals and standard immunizations
- Screenings for blood pressure, cancer, cholesterol, depression, obesity and diabetes
- Pediatric screenings for hearing, vision, obesity and developmental disorders
- Anemia screenings, breastfeeding support and pumps for pregnant and nursing women
- Iron supplements (for children ages 6 to 12 months at risk for anemia)

Take advantage of these covered services. However, remember that diagnostic care to identify health risks is covered according to plan benefits, even if done during a preventive care visit. This means if your doctor finds a new condition or potential risk during your appointment, the services may be billed as diagnostic medicine and result in some out-of-pocket costs. Read over your benefit summary to see what specific preventive services are provided to you.

Where To Go For Care

You think you may be sick, but your primary care physician is booked through the end of the month. You have a question about the side effects of a new medication, but the pharmacy is closed. Instead of immediately choosing an expensive trip to the emergency room or relying on questionable information from the internet, take a look below at various care centers and resources and the types of care they provide.

PRIMARY CARE CENTER

When would I use this?
You need routine care or treatment for a current health issue. Your primary doctor knows you and your health history, can access your medical records, provide routine care, and manage your medications.

What type of care would they provide?*
- Routine checkups
- Immunizations
- Preventive services
- Manage your general health

What are the costs and time considerations?**
- Often requires a copay and/or coinsurance
- Normally requires an appointment
- Usually little wait time with scheduled appointment

TELEMEDICINE

When would I use this?
You need care for minor illnesses and ailments, but would prefer not to leave home. These services are available by phone and online (via webcam).

What type of care would they provide?*
- Cold & flu symptoms
- Allergies
- Bronchitis
- Urinary tract infection
- Sinus problems

What are the costs and time considerations?**
- There is usually a first-time consultation fee and a flat fee or copay for any visit thereafter.
- Access to care is usually immediate. Some states may not allow for prescriptions through telemedicine or virtual visits.

DO YOUR HOMEWORK

What may seem like an urgent care center could actually be a standalone ER. These newer facilities come with a higher price tag, so ask for clarification if the word "emergency" appears in the company name.

URGENT CARE CENTER

When would I use this?
You need care quickly, but it is not a true emergency. Urgent care centers offer treatment for non-life-threatening injuries or illnesses.

What type of care would they provide?*
- Strains, sprains
- Minor broken bones (e.g., finger)
- Minor infections
- Minor burns
  X-rays

What are the costs and time considerations?**
- Often requires a copay and/or coinsurance that is usually higher than an office visit
- Walk-in patients welcome, but waiting periods may be longer as patients with more urgent needs will be treated first

EMERGENCY ROOM

When would I use this?
You need immediate treatment for a serious life-threatening condition. If a situation seems life threatening, call 911 or your local emergency number right away.

What type of care would they provide?*
- Heavy bleeding
- Chest pain
- Major burns
- Spinal injuries
- Severe head injury
- Broken bones

What are the costs and time considerations?**
- Often requires a much higher copay and/or coinsurance
- Open 24/7, but waiting periods may be longer because patients with life-threatening emergencies will be treated first

*This is a sample list of services and may not be all-inclusive.

**Costs and time information represent averages only and are not tied to a specific condition or treatment.

Virtual Medicine

When you're sick, the last thing you want to do is leave the cozy comfort of your home. Or sometimes you're just too on the go to pop in for a visit. Virtual medicine is a convenient and easy way to talk to a doctor fast.

Virtual Visits

A virtual visit with UnitedHealthcare lets you see and talk to a doctor from your phone, tablet or computer without an appointment. Most visits take about 10-15 minutes, and doctors can write a prescription (in participating states). Try a virtual visit when your doctor is not available or you're traveling.

Doctors can diagnose and treat a wide range of non-emergency medical conditions, including:

- Bladder infection/ Urinary tract infection
- Bronchitis
- Cold/flu
- Pink eye
- Rash
- Sinus problems
- Sore throat
- Stomach ache

Access Virtual Visits

Visit www.myuhc.com to request a virtual visit. Once you register and request a consult, you will pay your portion of the service costs according to your medical plan, and then enter a virtual waiting room. During your visit you can talk to a doctor about your health concerns, symptoms and treatment options.

Virtual visits aren't good for conditions requiring an exam or test, complex or chronic problems, or emergencies, including sprains or broken bones.

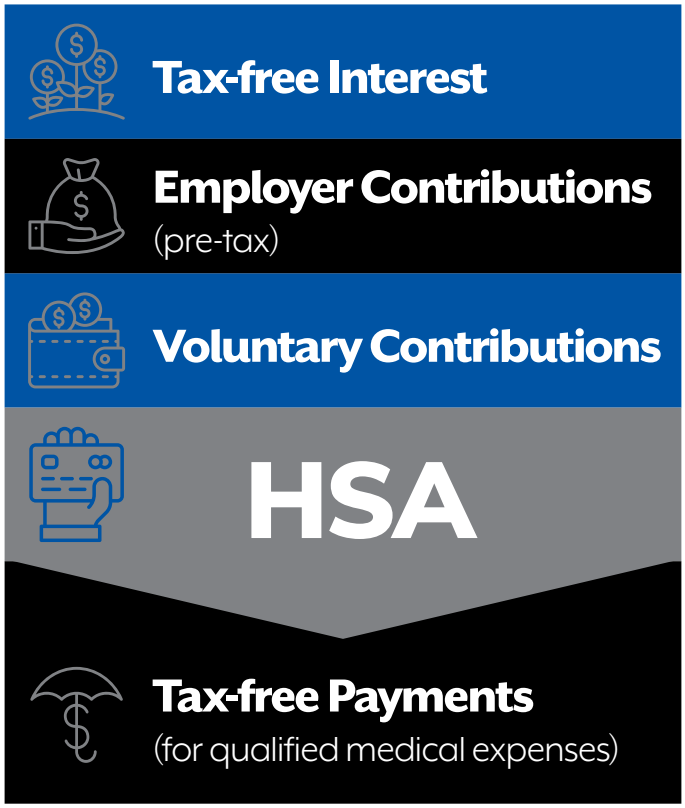
Health Savings Account

Need funds to help cover out-of-pocket healthcare expenses? Consider a Health Savings Account (HSA). An HSA is a personal healthcare bank account used to pay for qualified medical expenses and funded by you, and in some cases your employer too. HSA contributions and withdrawals for qualified healthcare expenses are tax free. You must be enrolled in a QHDHP to participate.

Your HSA can be used for qualified expenses for you, your spouse and/or tax dependent(s), even if they are not covered by your plan. If you are not currently enrolled in a QHDHP but you have unused HSA funds from a previous account, those funds can still be used for qualified expenses.

Optum Bank will issue you a debit card, giving you direct access to your account balance. Use your debit card to pay for qualified medical expenses, with no need to submit receipts for reimbursement. You must have a balance in your HSA account to use the card. There are no receipts to submit for reimbursement, but you should always retain a receipt for your records or use Optum Bank's receipt vault feature.

Eligible expenses include doctors' visits, eye exams, prescription expenses, laser eye surgery, menstrual products, over-the-counter medications and more. Check out IRS Publication 502 on www.irs.gov for a complete list of eligible expenses.



Eligibility

You are eligible to contribute to an HSA if:

- You are enrolled in an HSA Qualified High Deductible Health Plan.
- You are not covered by your spouse's non-QHDHP.
- Your spouse does not have a healthcare Flexible Spending Account or Health Reimbursement Account.
- You are not eligible to be claimed as a dependent on someone else's tax return.
- You are not enrolled in Medicare or TRICARE.
- You have not received Department of Veterans Affairs medical benefits in the past 90 days for non-service-related care. (Service-related care will not be taken into consideration.)
- You participated in the MAPP Health FSA in the prior plan year and the grace period has ended. No contributions are permitted before the Health FSA grace period has ended.

Your Money. Your Account.

Your HSA is a personal bank account that you own and administer. It's up to you how much you contribute, when to use the money for medical services, and when to reimburse yourself. You can save and roll over HSA funds to the next year if you don't spend them all in the calendar year. You can even let funds accumulate year-over-year to use in retirement. HSA funds are also portable if you change plans. There are no vesting requirements or forfeiture provisions.

How to Enroll

To enroll in the company-sponsored HSA, you must elect the QHDHP with MAPP. Complete all HSA enrollment materials and designate the amount to contribute on a pre-tax basis. MAPP will establish an HSA account in your name and send in your contribution once bank account information has been provided and verified.

Plan. Spend. Save.

Contributions to an HSA can be made through payroll deduction on a pre-tax basis when you open an account with Optum Bank. **The money in this account (including interest and investment earnings) grows tax free.** When the funds are used for qualified medical expenses, they are spent tax free.

Per IRS regulations, if HSA funds are used for purposes other than qualified medical expenses and you are younger than age 65, you must pay federal income tax on the amount withdrawn, plus a 20% penalty tax.

Thoughts & Tips: It's up to you how much to contribute to your HSA. Buying a new house or sending a kid to college? You can contribute less this year. Paid off your student loans or got a new job? Stash the annual max in your account.

HSA Funding Limits

The IRS places an annual limit on the maximum amount that can be contributed to HSAs. For 2021-2022, contributions (which include any employer contribution) are limited to the following:

	HEALTH SAVINGS ACCOUNT
	2021 CONTRIBUTION LIMITS*
INDIVIDUAL	$3,600
FAMILY	$7,200
CATCH-UP CONTRIBUTION (ages 55 and older)	$1,000

	THE MAPP GROUP EMPLOYER CONTRIBUTION	
	PER PAYCHECK	ANNUALIZED
EMPLOYEE ONLY	$19.23	$1,000
EMPLOYEE + SPOUSE	$28.85	$1,500
EMPLOYEE + CHILD(REN)	$28.85	$1,500
EMPLOYEE + FAMILY	$38.46	$2,000

*2021 IRS maximum contributions include MAPP's contribution

MAPP provides an HSA employer contribution each pay period following your enrollment on the QHDHP medical plan and your HSA account activation is confirmed. Please note, if you previously participated in the MAPP Health FSA, due to IRS regulations, HSA contributions will be delayed until after the Health FSA grace period ends.

HSA contributions in excess of the IRS annual contribution limits ($3,600 for individual coverage and $7,200 for family coverage for 2021-2022) are not tax deductible and are generally subject to a 6% excise tax.

If you've contributed too much to your HSA this year, you have two options:

- Remove the excess contributions and the net income attributable to the excess contribution before you file your federal income tax return (including extensions). You'll pay income taxes on the excess removed from your HSA.
- Leave the excess contributions in your HSA and pay 6% excise tax on excess contributions. Next year consider contributing less than the annual limit to your HSA to make up for the excess contribution during the previous year.

The MAPP HSA is established with Optum Bank. You may be able to roll over funds from another HSA. For more enrollment information, contact Human Resources or visit www.optumbank.com.

Flexible Spending Accounts

Flex your spending power! A Flexible Spending Account (FSA) is a special tax-free account you put money into to pay for certain out-of-pocket expenses.

Healthcare Flexible Spending Account

You can contribute up to $2,750 annually for qualified medical expenses (deductibles, copays, coinsurance, menstrual products, over-the-counter medications, etc.) with pre-tax dollars, reducing your taxable income and increasing your take-home pay. You can even pay for eligible expenses with an FSA debit card at the same time you receive them without waiting for reimbursement.

Dependent Care Flexible Spending Account

In addition to the Healthcare FSA, you may opt to participate in the Dependent Care FSA — whether or not you elect any other benefits. You can set aside pre-tax funds into a Dependent Care FSA for expenses associated with caring for elderly or child dependents. Unlike the Healthcare FSA, reimbursement from your Dependent Care FSA is limited to the total amount that is deposited in your account at that time.

- With the Dependent Care FSA, you can set aside up to $5,000 ($2,500 if married and filing separately) to pay for child or elder care expenses on a pre-tax basis.
- Eligible dependents include children under 13 and a spouse or other individual who is physically or mentally incapable of self-care and has the principal place of residence as the employee for more than half the year may be a qualifying individual.
- Expenses are reimbursable if the provider is not your dependent.
- You must provide the tax identification number or Social Security number of the party providing care to be reimbursed.

This account covers dependent day care expenses that are necessary for you and your spouse to work or attend school full time. Examples of eligible dependent care expenses include:

- In-home babysitting services (not provided by a tax dependent)
- Care of a preschool child by a licensed nursery or day care provider
- Before- and after-school care
- Day camp
- In-house dependent day care

Due to federal regulations, expenses for your domestic partner and your domestic partner's children may not be reimbursed under the FSA programs. Check with your tax advisor to determine if any exceptions apply.

Thoughts & Tips: **Your FSA money can cover the cost of going to a chiropractor or acupuncturist, if your insurance doesn't already cover it.**

How to Use the Account

You can use your FSA debit card at doctor and dentist offices, pharmacies and vision service providers. It cannot be used at locations that do not offer services under the plan, unless the provider has also complied with IRS regulations. The transaction will be denied if you attempt to use the card at an ineligible location.

Once you incur an eligible expense, submit a claim form along with the required documentation. Contact UHC Benefit Services with reimbursement questions. If you need to submit a receipt, you will be notified by UHC Benefit Services. Always retain a receipt for your records.

While FSA debit cards allow you to pay for services at point of sale, they do not remove the IRS regulations for substantiation. Always keep receipts and Explanation of Benefits (EOBs) for any debit card charges. Without proof that an expense was valid, your card could be turned off and your expense deemed taxable.

General Rules and Restrictions

The IRS has the following rules and restrictions for Health Care and Dependent Care FSAs:

- Expenses must be incurred during the 2021-2022 plan year.
- Dollars cannot be transferred between FSAs.
- You cannot participate in a Dependent Care FSA and claim a dependent care tax deduction at the same time.
- You must "use it or lose it" — any unused funds will be forfeited.
- You cannot change your FSA election in the middle of the plan year unless you experience a qualifying life event.
- Terminated employees have fourty-five (45) days following the date of termination to submit their FSA claims for reimbursement.
- Those considered highly compensated employees (family gross earnings were $130,000 or more last year) may have different FSA contribution limits. Visit www.irs.gov for more information.

Grace Period

- FSA participants may have an additional 2½-month grace period to incur expenses after the plan year ends (1/31/2022).
- If an expense is incurred between 1/31/2022 and 4/17/2022, AND submitted for reimbursement on or before 5/31/2022, any remaining balance in the previous plan year that ended 5/31/2022 will be paid out from the claim, even though the service was provided in the NEW plan year.
- The grace period applies to both the Dependent Care and Health Care FSAs.

FSA vs HSA

Flexible Spending Accounts (FSAs) and Health Savings Accounts (HSAs) are both ways to save pre-tax money to pay for your eligible healthcare costs. Which one is right for you?

	FSA	HSA
OWNERSHIP	Your employer owns your FSA. If you leave your employer, you lose access to the account unless you have a COBRA right.	You own your HSA. It is a savings account in your name and you always have access to the funds, even if you change jobs.
ELIGIBILITY & ENROLLMENT	You're eligible for an FSA if it's offered by your employer. You can elect a Health Care FSA even if you waive other coverage. You cannot make changes to your contribution during the Plan Year without a Qualifying Life Event. You cannot be enrolled in both a Health Care FSA and an HSA.	1. You must be enrolled in a Qualified High Deductible Health Plan to be eligible to contribute money to your HSA. You cannot be covered by a spouse's non-High Deductible plan or eligible for a spouse's FSA or enrolled in Medicare or TRICARE. 2. You can change your contribution at any time during the Plan Year.
TAXATION	Contributions are tax free via payroll deduction. However, the funds spent are not tax free.	For Federal tax purposes, the money in the account is "triple tax free," meaning: 1. Contributions are tax free. 2. The account grows tax free. 3. Funds are spent tax free (if used for qualified expenses).
CONTRIBUTIONS	Both you and your employer can contribute to the account according to IRS limits. The contribution limit for the Health Care FSA for 2021-2022 is $2,750.	Both you and your employer can contribute to the account according to IRS limits. The contribution limit for 2021-2022 is $3,600 for individuals and $7,200 for families. This amount includes the employer contribution. If you are 55 or older, you may make a "catch-up" contribution of $1,000 per year.
PAYMENT	Some plans include an FSA debit card to pay for eligible expenses. If not, you pay up front and submit your receipts for reimbursement.	Many HSAs include a debit card, ATM withdrawal or checkbook to pay for qualified expenses directly. You can also use online bill payment services from the HSA financial bank. You decide when to use the money in your HSA to pay for qualified expenses, or if you want to use another account to pay for services and save the money in your HSA for future expenses or retirement.
ROLL OVER OR GRACE PERIOD	You must use the money in the account by end of Plan Year; however, a Health Care FSA may allow up to $500 to roll over to the next year. A Health Care FSA or Dependent Care FSA may include a 2.5-month grace period after the end of the Plan Year for any extra expenses to be incurred and reimbursed. A plan can have either a rollover or a grace period, but not both. Any unclaimed funds at the end of the run out are lost and returned to your employer.	The money in the account rolls over from year to year. Funds are always yours and may be used for future qualified expenses — even in retirement years.
QUALIFIED EXPENSES	Physician services, hospital services, prescriptions, menstrual products, over-the-counter medications, dental care and vision care. A full listing of eligible expenses is available at www.irs.gov.	Physician services, hospital services, prescriptions, menstrual products, over-the-counter medications, dental care, vision care, Medicare Part D plans, COBRA premiums and long-term care premiums. A full listing of eligible expenses is available at www.irs.gov.
OTHER TYPES	Other types of FSAs include: • Dependent Care FSA - Allows you to set aside pre-tax dollars for elder or child dependent care and covers expenses such as day care and before- and after-school care. • Limited Use FSA (LUFSA)- Some employers offer a LUFSA that only covers eligible dental and vision expenses. LUFSAs are typically offered in conjunction with an HSA as the IRS does not allow someone to have a Healthcare FSA and an HSA.	There is only one type of HSA.

Please refer to your Summary Plan Description or plan certificate for your plan's specific FSA or HSA benefits.

Supplemental Health Benefits

MAPP offers several ways for you to supplement your medical plan coverage. This additional insurance can help cover unexpected expenses, regardless of any benefit you may receive from your medical plan. Coverage is available for yourself and your dependents and is offered at discounted group rates.

Accident Coverage

Accidents happen. You can't always prevent them, but you can take steps to reduce the financial impact. Accident coverage, available through Aflac, provides benefits for you and your covered family members if you have expenses related to an accident that occurs outside of work. Health insurance helps with medical expenses, but this coverage is an additional layer of protection that can help you pay deductibles, copays, and even typical day-to-day expenses such as a mortgage or car payment. Benefits under this plan are payable to you, to use as you wish.

	WEEKLY CONTRIBUTIONS
EMPLOYEE ONLY	$2.09
EMPLOYEE + SPOUSE	$3.51
EMPLOYEE + CHILD(REN)	$4.46
EMPLOYEE + FAMILY	$5.89

	BRIEF SUMMARY OF BENEFITS*
HOSPITAL CONFINEMENT	$1,000 + $250 per day ($300 per day for ICU)
DISLOCATIONS AND FRACTURES	Up to $8,000
AMBULANCE	Ground: $400 / Air: $1,200
EMERGENCY VISIT - PHYSICIAN, URGENT CARE OR EMERGENCY ROOM	$200
X-RAY	$50
FOLLOW-UP OFFICE VISIT	$35
BURNS	Up to $20,000
BRAIN INJURY DIAGNOSIS (CONCUSSION)	$500
CT OR MRI	$200
COMA	$10,000
OPEN ABDOMINAL OR THORACIC SURGERY	Up to $750
TENDON, LIGAMENT, ROTATOR CUFF OR KNEE CARTILAGE SURGERY WITH REPAIR	Up to $750
RUPTURED DISC SURGERY	Up to $750
BLOOD AND PLASMA	$200
PHYSICAL THERAPY	$35
APPLIANCE	Up to $100

*This list is a summary. Refer to plan documents for a comprehensive list of covered benefits.

Critical Illness Coverage

Critical Illness coverage through Aflac pays a lump-sum benefit if you are diagnosed with a covered disease or condition. You can use this money however you like; for example: to help pay for expenses not covered by your medical plan, lost wages, child care, travel, home health care costs or any of your regular household expenses.

Plan Highlights

- Guaranteed Issue Coverage (no medical questions)
- Children are covered at NO COST when you elect employee coverage
- Benefits are payable based on the date of the covered event occurring or the date of diagnosis.; Illnesses or occurrences prior to the effective date of coverage will not be payable events
- $50 annual Wellness Benefit is payable for each covered member for completing certain wellness screenings such as a pap test, cholesterol test, mammogram, colonoscopy or stress test (once per year per covered person)

Coverage Amounts:

- Employee: $15,000 or $30,000*
- Spouse: $15,000 or $30,0000*
- Children: 50% of employee benefit

BASE PLAN $15,000 COVERAGE (WEEKLY CONTRIBUTIONS)

EMPLOYEE AGE	$15,000 BENEFIT		$30,000 BENEFIT	
	EMPLOYEE ONLY AND EMPLOYEE +CHILDREN	EMPLOYEE + SPOUSE AND EMPLOYEE + FAMILY	EMPLOYEE ONLY AND EMPLOYEE +CHILDREN	EMPLOYEE + SPOUSE AND EMPLOYEE + FAMILY
18-25	$1.56	$2.93	$2.79	$5.19
26-30	$1.98	$3.77	$3.63	$6.89
31-35	$2.30	$4.40	$4.26	$8.14
36-40	$2.93	$5.67	$5.53	$10.68
41-45	$3.47	$6.80	$6.62	$12.86
46-50	$4.09	$8.00	$7.86	$15.34
51-55	$6.24	$12.29	$12.15	$23.91
56-60	$6.15	$12.11	$11.97	$23.57
61-65	$12.32	$24.45	$24.31	$48.23
66+	$21.44	$42.69	$42.55	$84.72

Premiums are based on the Employee's age on the effective date of coverage. Even if the Spouse is in a different age band, the rates are driven off of the employee's age. Children are covered at no additional cost, when you elect Employee coverage.
*$10,000, $20,000, $25,000 options also available

COVERED CONDITIONS AND BENEFIT AMOUNTS*

A covered employee and a covered spouse each have the full benefit amount illustrated below. Any covered child(ren) are covered at 50% of the benefit amount illustrated below.

BASE BENEFITS	
HEART ATTACK (MYOCARDIAL INFARCTION)	100%
SUDDEN CARDIAC ARREST	100%
CORONARY ARTERY BYPASS SURGERY	25%
MAJOR ORGAN TRANSPLANT*	100%
BONE MARROW TRANSPLANT (STEM CELL TRANSPLANT)	100%
KIDNEY FAILURE (END-STAGE RENAL FAILURE)	100%
STROKE (ISCHEMIC OR HEMORRHAGIC)	100%
CANCER BENEFITS	
CANCER (INTERNAL OR INVASIVE)	100%
NON-INVASIVE CANCER	25%
SKIN CANCER	$250 per calendar year
ADDITIONAL BENEFITS	
COMA	100%
SEVERE BURNS	100%
PARALYSIS	100%
LOSS OF SIGHT	100%
LOSS OF SPEECH	100%
LOSS OF HEARING	100%
ADVANCED ALZHEIMER'S DISEASE	25%
ADVANCED PARKISON'S DISEASE	25%
BENIGN BRAIN TUMOR	100%
AMYOTRAPHIC LATERAL SCLEROSIS (ALS)	100%
MULTIPLE SCLEROSIS (MS)	100%
CHILDHOOD CONDITIONS	
CYSTIC FIBROSIS, CEREBRAL PALSY, CLEFT LIP OR CLEFT PALATE, DOWN SYNDROME, PHENYLALANINE HYDROXYLASE DEFICIENCY DISEASE (PKU), SPINA BIFIDA , TYPE I DIABETES	50% of employee benefit
AUTISM SPECTRUM DISORDER	$3,000

*This is a summary. Refer to plan document for details including definitions, plan exclusions and limitations.

Dental Benefits

Brushing your teeth and flossing are great, but don't forget to visit the dentist too! MAPP offers affordable plan options for routine care and beyond. Coverage is available from UNUM Dental (Alwayscare).

Network Dentists

If you use a dentist who doesn't participate in your plan's network, your out-of-pocket costs will be higher, and you are subject to any charges beyond the Reasonable and Customary (R&C). To find a network dentist, visit UNUM Dental (Alwayscare) at unumdentalcare.com or at alwaysassist.com

Dental Premiums

Premium contributions for dental are deducted from your paycheck on a pre-tax basis. Your tier of coverage determines your weekly premium.

Dental Plan Summary

This chart summarizes the 2021-2022 dental coverage provided by UNUM Dental (Alwayscare).

	PASSIVE PPO	
WEEKLY CONTRIBUTIONS		
EMPLOYEE ONLY	$6.18	
EMPLOYEE + SPOUSE	$12.37	
EMPLOYEE + CHILD(REN)	$15.28	
EMPLOYEE + FAMILY	$22.67	
	IN-NETWORK	**OUT-OF-NETWORK (90TH)**
CALENDAR YEAR DEDUCTIBLE		
INDIVIDUAL	$50	$50
FAMILY	$150	$150
CALENDAR YEAR MAXIMUM		
PER PERSON	$1,500	$1,500
COVERED SERVICES		
PREVENTIVE SERVICES	100%	100%
BASIC SERVICES	80%*	80%*
MAJOR SERVICES	50%*	50%*
ORTHODONTICS Dependent Child(ren) (to age 19) Only	50%	
ORTHODONTIC LIFETIME MAXIMUM	$1,000	

*After Deductible

Thoughts & Tips: **Only 60% of adults ages 20 to 64 have been to the dentist in the past year. Take advantage of your dental coverage to keep your smile healthy.**

Vision Benefits

Don't wear glasses? Even you shouldn't skip an annual eye exam! MAPP provides you and your family access to quality vision care with a comprehensive vision benefit through UNUM Vision (Alwayscare).

Vision Premiums

Premium contributions for vision are deducted from your paycheck on a pre-tax basis. Your tier of coverage determines your weekly premium.

Vision Plan Summary

This chart summarizes the 2021-2022 vision coverage provided by UNUM Vision (Alwayscare).

	VISION CARE SERVICES		
WEEKLY CONTRIBUTIONS			
EMPLOYEE ONLY	$1.29		
EMPLOYEE + SPOUSE	$2.45		
EMPLOYEE + CHILD(REN)	$2.87		
EMPLOYEE + FAMILY	$4.04		
	IN-NETWORK	**OUT-OF-NETWORK**	**FREQUENCY**
EXAMS			
COPAY	$10 copay	Up to $35 allowance	12 months
LENSES			
SINGLE VISION	$25 copay	Up to $25 allowance	12 months
BIFOCAL	$25 copay	Up to $40 allowance	
TRIFOCAL	$25 copay	Up to $50 allowance	
LENTICULAR	$80 allowance	Up to $50 allowance	
PROGRESSIVE	$70 allowance	Up to $40 allowance	
CONTACTS (IN LIEU OF LENSES AND FRAMES)			
FITTING AND EVALUATION*	Included in allowance	See allowances below	12 months
ELECTIVE	$25 copay; $130 allowance	Up to $100 allowance	
FRAMES			
COPAY	$25 copay	N/A	24 months
ALLOWANCE	$130 allowance	$50 allowance	

*Fitting and Evaluation fee applied to contact lens allowance.

Thoughts & Tips: More than 150 million Americans use corrective eye wear to compensate for refractive errors.

Survivor Benefits

It's difficult to think about what would happen if something ever happened to you, but it's important to have a plan in place to make sure your family is provided for. Survivor benefits provide financial protection and security in the event of an absence or unexpected event. Securing Life insurance now ensures your family will be protected for the future.

Basic Life and Accidental Death and Dismemberment (AD&D) Insurance

MAPP provides employees with Basic Life and AD&D insurance as part of your basic coverage through Hartford, which guarantees that loved ones, such as a spouse or other designated survivor(s), continue to receive part of an employee's benefits after death.

Your Basic Life and AD&D insurance benefit is $10,000. If you are a full-time employee, you automatically receive Life and AD&D insurance even if you elect to waive other coverage.

What's a beneficiary?

Your beneficiary is the person you designate to receive your Life insurance benefits in the event of your death. This includes any benefits payable under Basic Life offered by MAPP. You receive the benefit payment for a dependent's death under the Hartford insurance.

Name a primary and contingent beneficiary to make your intentions clear. Make sure to indicate their full name, address, Social Security number, relationship, date of birth and distribution percentage. Please note that in most states, benefit payments cannot be made to a minor. If you elect to designate a minor as beneficiary, all proceeds may be held under the beneficiary's name and will earn interest until the minor reaches majority age at 18. If you need assistance, contact Human Resources or your own legal counsel.

Voluntary Life and AD&D Insurance

Life and AD&D benefits are an important part of your family's financial security. The basic benefits provided to you by MAPP may not be enough to cover expenses in a time of need. Therefore, extra coverage is available to protect you and your family. Eligible employees may purchase additional Voluntary Life and AD&D insurance. Premiums are paid through payroll deductions.

BASIC EMPLOYEE LIFE/AD&D	
COVERAGE AMOUNT	$10,000
WHO PAYS	MAPP
BENEFITS PAYABLE	Upon employee's death
MAXIMUM BENEFIT	$10,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	No
VOLUNTARY EMPLOYEE LIFE	
COVERAGE AMOUNT	In increments of $10,000
WHO PAYS	Employee
BENEFITS PAYABLE	Upon employee's death
MAXIMUM BENEFIT	The lesser of $500,000 or 5x AE
EVIDENCE OF INSURABILITY (EOI) REQUIRED	For amounts over $150,000 at initial eligibility (new hires) or any amount thereafter
VOLUNTARY EMPLOYEE AD&D	
COVERAGE AMOUNT	Same as Employee Life
WHO PAYS	Employee
BENEFITS PAYABLE	In the event of accidental death or dismemberment
MAXIMUM BENEFIT	Same as Employee Life
EVIDENCE OF INSURABILITY (EOI) REQUIRED	No
VOLUNTARY SPOUSE LIFE AND AD&D	
COVERAGE AMOUNT	In increments of $5,000
WHO PAYS	Employee
BENEFITS PAYABLE	Upon dependent's death
MAXIMUM BENEFIT	The lesser of 100% of Employee Amount or $250,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	For amounts over $25,000 at initial eligibility (new hires) or any amount thereafter
VOLUNTARY CHILD LIFE AND AD&D	
COVERAGE AMOUNT	$10,000
WHO PAYS	Employee
BENEFITS PAYABLE	Upon dependent's death
MAXIMUM BENEFIT	$10,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	No

Life and AD&D benefits subject to age reduction schedule

Please note: You must be actively at work with your employer on the day your coverage takes effect. Your spouse and child(ren) must be performing normal activities and not be confined (at home or in a hospital/care facility).

Survivor Benefits

VOLUNTARY LIFE INSURANCE			
PREMIUM RATES/$1,000 (WEEKLY)			
AGE (AS OF FEBRUARY 1, 2021)	EMPLOYEE	AGE (AS OF FEBRUARY 1, 2021)	SPOUSE
Under 25	$0.059	Under 25	$0.062
25-29	$0.059	25-29	$0.071
30-34	$0.084	30-34	$0.090
35-39	$0.118	35-39	$0.131
40-44	$0.169	40-44	$0.188
45-49	$0.270	45-49	$0.294
50-54	$0.430	50-54	$0.481
55-59	$0.661	55-59	$0.703
60-64	$1.032	60-64	$1.202
65-69	$1.79	65-69	$2.054
70-74	$3.193	70-74	$3.659
75+	$6.258	75+	$7.329

*Spouse rates based on Employee's age

VOLUNTARY AD&D INSURANCE	
PREMIUM RATES – $1,000 MONTHLY	
Employee/Spouse	$0.050

VOLUNTARY CHILD LIFE AND AD&D INSURANCE	
PREMIUM RATES – $10,000 MONTHLY	
Life and AD&D	$1.39

TO CALCULATE HOW MUCH YOUR VOLUNTARY LIFE COVERAGE WILL COST:

$	÷ 1,000 =	$	x Age Based Rate =	$
Benefit Elected				Monthly Premium

Whole Life Insurance

Employees are eligible for the Whole Life insurance by Aflac, which offers you a permanent life insurance option with guaranteed premiums based on your current age.

Aflac coverage helps you prepare for LIFE and is a smart investment for you to protect your family's financial freedom.

You can enroll in this plan without medical questions when you are first eligible. If you wait to enroll at a later date, evidence of insurability will apply and coverage may be declined.

ACCELERATED DEATH BENEFIT (pays you a death benefit for qualified terminal conditions)	50% of the eligible death benefit up to $225,000
CHILD TERM RIDER	$10,000 benefit Insurance can be converted to an individual policy without evidence of insurability, up to $50,000

Plan Highlights

- Your rates are based on age at the time of application and do not individually increase due to a change in age, health or individual claim
- Coverage is portable which mean you can take this plan with you if you no longer work for the company
- You choose the level of Coverage that is right for you

	GUARANTEE ISSUE (NO MEDICAL QUESTIONS)	MAXIMUM BENEFIT AMOUNT
EMPLOYEE ONLY	$40,000	$300,000
SPOUSE	$5,000	$100,000
CHILD(REN)	$10,000 (child term rider)	$25,000

- Rate are based on your age and coverage level
- There are certain benefit restrictions for anyone enrolling beyond age 64

Income Protection

Maintaining your quality of life counts on your income. MAPP offers disability coverage to protect you financially in the event you cannot work as a result of a debilitating injury. A portion of your income is protected until you can return to work or until you reach retirement age.

MAPP offers both Short Term and Long Term Disability (STD & LTD) coverage to protect you financially in the event you cannot work because of a debilitating injury. A portion of your income can be protected until you can return to work or you reach retirement age. This coverage is offered through Hartford insurance on a voluntary basis. No medical questions are required for the 2/1/21 annual enrollment or when you are first eligible as a new hire. **Medical questions (Evidence of Insurability form) will be required if coverage is waived and enrollment is requested in the future.**

The chart below summarizes the STD & LTD benefits. Rates and additional information can be obtained or by contacting the Benefits Enrollment Help Line.

	STD	LTD
BENEFIT PERCENTAGE	60%	60%
MAXIMUM BENEFIT	$1,500/week	$8,000/month
ELIMINATION (waiting period)	7 days	90 days
MAXIMUM BENEFIT DURATION	12 weeks*	Later of Age 65 or SSNRA**
PRE-EXISTING WAITING PERIOD	None	12 months for conditions treated 6 months prior to effective date of coverage

*Maximum benefit period for pregnancy follows AMA guidelines, and may be limited to 6 weeks (normal delivery) or 8 weeks (C-section).
**Social Security Normal Retirement Age

VOLUNTARY STD	
AGE (AS OF 02/01/2021)	
AGE RANGE	STD
Under 40	$0.39
40-49	$0.46
50-54	$0.60
55-59	$0.76
60-64	$0.94
65+	$1.00
Rate Basis	Per $10 of Weekly Covered Benefit

TO CALCULATE HOW MUCH YOUR STD COVERAGE WILL COST:

$	÷ 52 =	$	x 60%	$	x Rate	$	÷ $10	$
Annual Salary		Weekly Income		Weekly Benefit		Amount		Monthly Premium

Thoughts & Tips: **Nearly 6% of working Americans will experience a short term disability due to illness, injury or pregnancy on average every year.**

Additional Benefits

MAPP cares about you and wants you to succeed in all aspects of life, so we offer a variety of additional benefits to help make your day-to-day easier.

Employee Assistance Program

We know life is complicated, and sometimes we all just need a little help. Our Employee Assistance Program (EAP) helps manage your and your family's total health, including mental, emotional and physical. And it comes at no cost to you — whether you're enrolled in a company-sponsored medical plan or not.

Through this program, you have access to mental health assistance and legal and financial help from a number of professionals. You and your dependents have 24-hour access to helpful resources by phone, and the EAP benefit includes five face-to-face visits per issue with a licensed professional. **All services provided are confidential** and will not be shared with MAPP. You may access information, benefits, educational materials and more either by phone at 800-327-1850 or online at www.guidanceresources.com (Web ID: HLF902).

The Program provides referrals to help with:

- Emotional health and well-being
- Alcohol or drug dependency
- Marriage or family relationship problems
- Job pressures
- Stress, anxiety, depression
- Grief and loss
- Financial or legal advice

Glossary

Balance Billing – When you are billed by a provider for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $60, you may be billed by the provider for the remaining $40.

Coinsurance – Your share of the cost of a covered healthcare service, calculated as a percent of the allowed amount for the service, typically after you meet your deductible.

Copay – The fixed amount, as determined by your insurance plan, you pay for healthcare services received.

Deductible – The amount you owe for healthcare services before your health insurance begins to pay its portion. For example, if your deductible is $1,000, your plan does not pay anything until you've paid $1,000 for covered services. This deductible may not apply to all services, including preventive care.

Explanation of Benefits (EOB) – A statement from your insurance carrier that explains which services were provided, their cost, what portion of the claim was paid by the plan, and what portion is your liability, in addition to how you can appeal the insurer's decision.

Flexible Spending Accounts (FSAs) – A special tax-free account you put money into that you use to pay for certain out-of-pocket healthcare costs. You'll save an amount equal to the taxes you would have paid on the money you set aside. FSAs are "use it or lose it," meaning that funds not used by the end of the plan year will be lost. Some Health Care FSAs do allow for a grace period or a rollover into the next plan year.

- **Health Care FSA** – A pre-tax benefit account used to pay for eligible medical, dental, and vision care expenses that aren't covered by your insurance plan. All expenses must be qualified as defined in Section 213(d) of the Internal Revenue Code.
- **Dependent Care FSA** – A pre-tax benefit account used to pay for dependent care services. For additional information on eligible expenses, refer to Publication 503 on the IRS website.

Healthcare Cost Transparency – Also known as market transparency or medical transparency. Online cost transparency tools, available through health insurance carriers, allow you to search an extensive national database to compare varying costs for services.

Health Savings Account (HSA) – A personal healthcare bank account funded by your or your employer's tax-free dollars to pay for qualified medical expenses. You must be enrolled in a QHDHP to open an HSA. Funds contributed to an HSA roll over from year to year and the account is portable, so if you change jobs your account goes with you.

High Deductible Health Plan (HDHP) – A plan option that provides choice, flexibility and control when it comes to healthcare spending. Most preventive care is covered at 100% with in-network providers, there are no copays and all qualified employee-paid medical expenses count toward your deductible and your out-of-pocket maximum.

Network – A group of physicians, hospitals and other healthcare providers that have agreed to provide medical services to a health insurance plan's members at discounted costs.

- **In-Network** – Providers that contract with your insurance company to provide healthcare services at the negotiated carrier discounted rates.
- **Out-of-Network** – Providers that are not contracted with your insurance company. If you choose an out-of-network provider, services will not be covered at the in-network negotiated carrier discounted rates.
- **Non-Participating** – Providers that have declined entering into a contract with your insurance provider. They may not accept any insurance and you could pay for all costs out of pocket.

Open Enrollment – The period set by the employer during which employees and dependents may enroll for coverage, make changes or decline coverage.

Out-of-Pocket Maximum – The most you pay during a policy period (usually a 12-month period) before your health insurance begins to pay 100% of the allowed amount. This does not include your premium, charges beyond the Reasonable & Customary, or healthcare your plan doesn't cover. Check with your carrier to confirm what applies to the maximum.

Over-the-Counter (OTC) Medications – Medications available without a prescription.

Prescription Medications – Medications prescribed by a doctor. Cost of these medications is determined by their assigned type: generic, preferred, non-preferred or specialty. UnitedHealthcare groups medications into tiers by type and cost. Lower cost medications in Tier 1, midrange in Tier 2 and higher costing medications in Tier 3.

- **Generic Drugs** – Drugs approved by the U.S. Food and Drug Administration (FDA) to be chemically identical to corresponding preferred or non-preferred versions. Usually the most cost-effective version of any medication.
- **Preferred Drugs** – Brand-name drugs on your provider's approved list (available online).
- **Non-Preferred Drugs** – Brand-name drugs not on your provider's list of approved drugs. These drugs are typically newer and have higher copayments.
- **Prior Authorization** – A requirement that your physician obtain approval from your health insurance plan to prescribe a specific medication for you.
- **Step Therapy** – The goal of a Step Therapy Program is to steer employees to less expensive, yet equally effective, medications while keeping member and physician disruption to a minimum. You must typically try a generic or preferred-brand medication before "stepping up" to a non-preferred brand.

Reasonable and Customary Allowance (R&C) – Also known as the UCR (Usual, Customary, and Reasonable) amount. The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The R&C amount is sometimes used to determine the allowed amount.

Summary of Benefits and Coverage (SBC) – Mandated by healthcare reform, your insurance carrier provides you with a summary of your benefits and plan coverage.

Summary Plan Description (SPD) - The document(s) that outline the rights, obligations, and material provisions of the plan(s) to all participants and their beneficiaries.

Required Notices

Important Notice from The MAPP Group, LLC About Your Prescription Drug Coverage and Medicare under the UnitedHealthcare and Plan(s)

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The MAPP Group, LLC has determined that the prescription drug coverage offered by the UnitedHealthcare and plan(s) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. You may also enroll each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current The MAPP Group, LLC coverage will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed herein.

If you do decide to join a Medicare drug plan and drop your current The MAPP Group, LLC coverage, be aware that you and your dependents will not be able to get this coverage back.

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

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

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

For More Information about This Notice or Your Current Prescription Drug Coverage…

Contact the person listed at the end of these notices for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through The MAPP Group, LLC changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	February 1, 2021
Name of Entity/Sender:	The MAPP Group, LLC
Contact—Position/Office:	Human Resources
Address:	344 Third Street Baton Rouge, LA 70801
Phone Number:	225-408-7754

Women's Health and Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. For deductibles and coinsurance information applicable to the plan in which you enroll, please refer to the summary plan description. If you would like more information on WHCRA benefits, please contact Human Resources at 225-408-7754.

HIPAA Privacy and Security

The Health Insurance Portability and Accountability Act of 1996 deals with how an employer can enforce eligibility and enrollment for healthcare benefits, as well as ensuring that protected health information which identifies you is kept private. You have the right to inspect and copy protected health information that is maintained by and for the plan for enrollment, payment, claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask your benefits administrator to amend the information. For a full copy of the Notice of Privacy Practices, describing how protected health information about you may be used and disclosed and how you can get access to the information, contact Human Resources at 225-408-7754.

HIPAA Special Enrollment Rights

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 later 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 towards your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (i.e. legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment within 30 days after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or the CHIP, you may request enrollment under this plan within 60 days of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy towards this plan, you may request enrollment under this plan within 60 days after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact Human Resources at 225-408-7754.

Important Contacts

MEDICAL & VIRTUAL VISITS
UnitedHealthcare
866-314-0335
www.myuhc.com
Policy #: PPO: 01L5738
QHDHP: 01X6969

SUPPLEMENTAL HEALTH
(Accident, Critical Illness)
Aflac
800-433-3036
www.aflacgroupinsurance.com

DENTAL
UNUM Dental (Alwayscare)
888-400-9304
unumdentalcare.com
alwaysassist.com
Policy #: 699927

VISION
UNUM Vision (Alwayscare)
888-400-9304
unumvisioncare.com
alwaysassist.com
Policy #: 699927

HEALTH SAVINGS ACCOUNT
Optum Bank
866-234-8913
www.optumbank.com

FLEXIBLE SPENDING ACCOUNTS
UHC Benefit Services
877-797-7475
member.uhcbs.com

LIFE AND AD&D
Hartford
800-523-2233
www.thehartford.com
Policy #: 892843

DISABILITY
Hartford
800-523-2233
www.thehartford.com
Policy #: 892843

WHOLE LIFE INSURANCE
Aflac
800-433-3036
www.aflacgroupinsurance.com

EMPLOYEE ASSISTANCE PROGRAM
ComPsych - Guidance Resources
800-327-1850
www.guidanceresources.com
Web ID#: HLF902

MAPP HUMAN RESOURCES
344 Third Street
Baton Rouge, LA 70801
225-408-7754

MAPP BENEFITS ENROLLMENT HELP LINE
844-880-6774

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