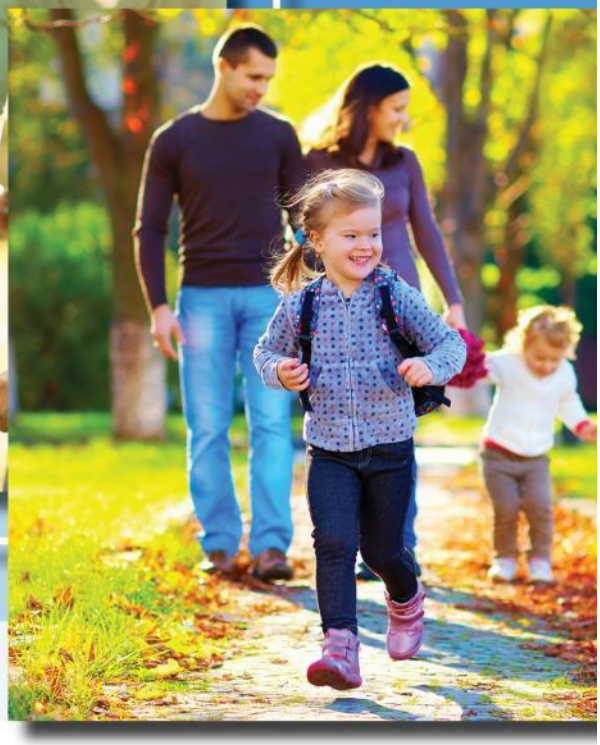
Benefit Presentation

A National Insurance Program



Simple
BENEFITS

Welcome to your Benefit Enrollment Guide

Please review this guide carefully before making benefit decisions for you and your family.

Dear Employee:

The company is proud to offer you a comprehensive benefits package. This enrollment guide will assist you in determining the coverage levels that will provide you and your family with the protection that gives you peace of mind.

This guide explains each type of coverage, gives suggestions about how to effectively use your benefits, and provides examples to help you determine your benefit and payroll deduction amounts.

We encourage you to take the time to review the enrollment guide prior to enrollment.

Participation in enrollment is mandatory this year.

Qualifying Life Events

No changes are allowed to your medical, dental, or vision account coverage during the plan year, except for a "qualifying life event." Qualifying life events that could result in changes to your coverage include:

- marriage or divorce,
- birth or adoption of a child,
- death of a dependent,
- medicare entitlement,
- termination of your spouse's employment that affects benefits, and/or
- loss of other group coverage

If you have a qualifying life event, you must notify Human Resources and provide necessary documentation within 30 days of the change. If you do not do so within 30 days, you must wait until the next open enrollment to make benefit plan changes.

Please note that this guide is a general summary of your benefits. For specific details, you may refer to each carrier's summary plan description. Every effort has been made to ensure that this booklet accurately represents the benefits. However, if there are any discrepancies between the terms in this booklet and the terms in the plan document, the plan document will prevail.

Eligibility

If you aren't currently enrolled, you and your eligible family members can participate in the company benefits package on the first of the month following 60 days from your date of full-time employment. If you do not enroll for your benefits during or after becoming eligible, you must wait until the next open enrollment to elect benefits and you will be subject to late entrant penalties, if applicable.

Who Can Enroll?

You are eligible to participate in our plans if you are a regular full-time associate, and are scheduled to work 30 hours or more per week. Certain dependents of eligible employees can enroll in the medical, dental, and vision. Eligible dependents are:

- Spouse (except in the case of divorce).
- Children under age 26.
- Children who are mentally or physically handicapped and totally dependent on the associate for support, regardless of age with the exception of incapacitated children age 19 or older. To be eligible for coverage as an incapacitated dependent, the dependent must have been covered under this plan or have creditable coverage prior to reaching age 19. Certification of the handicap is required within 30 days of attainment of age 19. You will be required to complete a Handicapped/Disabled member certification form.

About Your Payroll Deductions

Your premiums for Medical, Dental, and Vision plans will be deducted on a pre-tax basis because they are covered under your Cafeteria plan under Section 125 of the Internal Revenue Service code. This means that once you elect to enroll in any of these plans, you will not be allowed to drop or change your election until the Company's next Open Enrollment unless you have a qualifying event.

Special Enrollment Rights

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 and your dependents in the company's medical, dental, or vision plans within 30 days after your other coverage ends.

The IHP Medical Summary

OPTION 1: MVP Basic LDM (PHCS/Multiplan)	In-Network & Out-of-Network
Co-Insurance	100%
Calendar Year Deductible	$0
Out of Pocket Maximum	$8,7,00 / $17,400
Physician Office Copay	Primary Care Physician: $25 copay / 8 visits per year Specialist: $50 copay / 8 visits per year
Telemedicine	$0 copay / Unlimited
Lab & X-Ray	$50 copay / 3 Visits Max/Plan Year INN: Network Rate/OON 85% UCR
Urgent Care Copay	$50 copay / 2 Visits Max/Plan Year INN: Network Rate/OON 85% UCR
Emergency Room* INN/OON	INN/OON: $350 copay / 1 Visit Max/Plan Year
In-Patient Hospital* INN/OON	INN/OON: $350 copay / 5 Days Max/Plan Year
Out-Patient Surgery/Diagnostic Testing* INN/OON	INN/OON: $350 copay 1/1 Visits Max/Plan Year
Prescription Copay	Tier 1: $0 copay Tier 2: $5 copay
*** In-Network and Out-of-Network Hospital bills, the plan pays 100% of 150% of Medicare (Reference-based Pricing) but there is *no patient liability for any balance billing for covered days/services.***	

OPTION 2: MVP Plus LDM (PHCS/Multiplan)	In-Network & Out-of-Network
Co-Insurance	100%
Calendar Year Deductible	$0
Out of Pocket Maximum	$5,000 / $10,000
Physician Office Copay	Primary Care Physician: $15 copay / 10 visits per year Specialist: $25 copay / 10 visits per year
Telemedicine	$0 copay / Unlimited
Lab & X-Ray	$50 copay / 3 Visits Max/Plan Year INN: Network Rate/OON 85% UCR
Urgent Care Copay	$35 copay / 3 Visits Max/Plan Year INN: Network Rate/OON 85% UCR
Emergency Room* INN/OON	INN/OON: $350 copay / 1 Visit Max/Plan Year
In-Patient Hospital* INN/OON	INN/OON: $350 copay / 7 Days Max/Plan Year
Out-Patient Surgery/Diagnostic Testing* INN/OON	INN/OON: $350 copay 2/2 Visits Max/Plan Year
Prescription Copay	Non-Preventive Generic: $10.00 Preferred Brand: $40 Non-Preferred: $80
*** In-Network and Out-of-Network Hospital bills, the plan pays 100% of 150% of Medicare (Reference-based Pricing) but there is *no patient liability for any balance billing for covered days/services.***	

The IHP Medical Summary

OPTION 4: MVP Premier (PHCS/Multiplan)	In-Network & Out-of-Network
Co-Insurance	100%
Calendar Year Deductible	$0 / $0
Out of Pocket Maximum	$7,000 / $14,000
Physician Office Copay	Primary Care: $15 copay /12 visits Specialist: $25 copay / 12 visits
Telemedicine	$0 copay / Unlimited
Lab & X-Ray	$50 copay (4 visits per year)
Urgent Care Copay	$35 copay (3 per year)
Emergency Room	$350 copay (2 visits per year)
In-Patient Hospital	$350 copay (10 days per year)
Out-Patient Surgery/Diagnostic Testing	$350 copay (2 / 3 visits per year)
Prescription Copay	Tier 1: $5 copay Tier 2: $40 copay Tier 3: 80 copay
*** In-Network and Out-of-Network Hospital bills, the plan pays 100% of 150% of Medicare (Reference-based Pricing) but there is *no patient liability for any balance billing for covered days/services.***	

OPTION 3: MVP Ultimate (PHCS/Multiplan) *Removes the "Day Limits" And Other Exclusions*	In-Network PHCS/MultiPlan PPO Network	Non-Network
Co-Insurance	Covered in full. No patient cost	After Deductible, patient pays **60% coinsurance** *(subject to balance billing)*
Calendar Year Deductible	$0	Single $500 / Family $1,000
Out of Pocket Maximum	Single $2,000 / Family $13,000	No Maximum Out of Pocket
Physician Office Copay	$20 copay	After Deductible, patient pays **40% coinsurance** *(subject to balance billing)*
Telemedicine	$0 copay	Unlimited
Specialist Copay	$40 copay	After Deductible, patient pays **40% coinsurance** *(subject to balance billing)*
Urgent Care Copay	$50 Copay	After Deductible, patient pays **40% coinsurance** *(subject to balance billing)*
Emergency Room*	After $400 Copay, Plan pays 100% of 150% of Medicare Allowable Payment*	After $400 Copay, Plan pays 100% of 150% of Medicare Allowable Payment*
In-Patient Hospital*	After $400 Copay, Plan pays 100% of 150% of Medicare Allowable Payment*	After $400 Copay, Plan pays 100% of 150% of Medicare Allowable Payment*
Out-Patient Hospital*	After $400 Copay, Plan pays 100% of 150% of Medicare Allowable Payment*	After $400 Copay, Plan pays 100% of 150% of Medicare Allowable Payment*
Prescription Copay	Preventive Generic: $0.00 Copay Non-Preventive Generic: $10.00 Preferred Brand: $40 Non-Preferred Brand: $80	Not Covered Patient pays 100% of cost
*** In-Network and Out-of-Network Hospital bills, the plan pays 100% of 150% of Medicare (Reference-based Pricing) but there is *no patient liability for any balance billing for covered days/services.***		

The IHP Medical Summary

OPTION 5: HSA Medical (PHCS/Multiplan)	In-Network & Out-of-Network
Co-Insurance	100%
Calendar Year Deductible	$5,000 /$10,000
Out of Pocket Maximum	$7,000/$14,000
Physician Office Copay	Plan Pays 100% after Deductible INN: Network Rate/OON 85% UCR
Telemedicine	$0 copay / Unlimited
Specialist Copay	Plan Pays 100% after Deductible INN: Network Rate/OON 85% UCR
Urgent Care Copay	Pays 100% after Deductible INN: Network Rate/OON: 85% UCR
Emergency Room	Plan Pays 100% after Deductible INN: Network Rate/OON 85% UCR
In-Patient Hospital	Plan Pays 100% after Deductible INN: Network Rate/OON 85% UCR
Out-Patient Surgery/Diagnostic Testing* INN/OON	Plan Pays 100% after Deductible INN: Network Rate/OON 85% UCR
Prescription Copay	Tier 1: $5 copay Tier 2: $40 copay Tier 2: $80 copay
*** In-Network and Out-of-Network Hospital bills, the plan pays 100% of 150% of Medicare (Reference-based Pricing) but there is *no patient liability for any balance billing for covered days/services.***	

The IHP Medical Monthly Premium

The Health Benefit Alliance (HBA) Medical Monthly Premium	Base LDM	Plus LDM	Premier LDM	MVP Ultimate Medical	MVP $5k HSA Medical
Employee	$402.30	$446.87	$481.67	$595.09	$502.97
Employee + Spouse	$653.57	$751.63	$810.09	$1,058.01	$921.81
Employee + Child(ren)	$575.31	$655.55	$700.61	$929.87	$782.20
Family	$826.59	$960.30	$1,029.03	$1,285.29	$1,201.07

The HI "Hospital Indemnity" Voluntary Benefit

Hospital Indemnity Insurance from Zurich (an A-rated carrier)...**an excellent way for an employee to get financial support if hospitalized beyond the Base, Plus, or Premier Hospital Day Limits!**

Employees can choose either a **$2,000 daily benefit** payable directly to them starting on the day the IHP hospital covered days end (i.e. at day 11 on the Premier Plan).

There is no employee minimum participation requirement and no pre-existing condition exclusions.

Can be 100% employee-paid!

HI Bundle for MVP Options

Plan	Bundled with IHP Basic	Bundled with IHP Plus	Bundled with IHP Premier
Elimination Period	5 Day Elimination	7 Day Elimination	10 Day Elimination
In-Hospital Indemnity Benefit	Plan pays $2,000 per day (30 per year)	Plan pays $2,000 per day (30 per year)	Plan pays $2,000 per day (30 per year)
Rates			
Single	$23.29	$18.90	$12.32
EE + Spouse	$46.74	$37.93	$24.72
EE + Child(ren)	$45.10	$36.60	$23.85
Family	$74.29	$60.29	$39.29

**Pre-Ex Waived*

DISCLAIMER: HOSPITAL INDEMNITY BENEFITS LISTED ARE INTENDED TO BE A BRIEF SUMMARY. REFER TO POLICY FOR FULL DETAILS OF THE BENEFITS INCLUDING DESCRIPTION OF COVERAGE AND A LIST OF EXCLUSIONS.

Plans & Rates Available In: AL, AK, AZ, AR, CA, CO, DE, DC, FL, GA, HI, ID, IL, IN, IA, KS, KY, LA, ME, MA, MI, MS, MO, MT, NE, NV, NH, NC, OH, OK, PA, PR, RI, SC, SD, TN, TX, UT, VT, VA, WV, WI, WY

Plans Available (Needs Quoted): CT, MD, MN, NJ

Available in all states and Washington D.C. except New Mexico and Washington.

Pending approval: California, New York, Oregon.

Dental Coverage (Argus) – $1,000 Plan

Dental benefits are available to you and your eligible dependents to cover routine care such as exams, x-rays, and cleanings, as well as fillings, dentures, bridge work and periodontal care. In order to receive the highest level of benefits and pay the least amount out of your pocket, you need to access care from the providers who have elected to be part of the network.

This plan allows employees to select any dentist of their choice. When services are provided by an in-network provider, out-of-pocket costs (if any) will generally be less than if performed by an out-of-network provider. Services performed out-of-network will be paid based on the basis of Usual, Customary and Reasonable (UCR) services in the area where services are rendered.

To find an in-network provider, visit www.argusdentalvision.com.

Please Note: No changes are allowed to your dental coverage during the plan year, except for a "qualifying life event." If you do not participate in the Dental benefits when initially eligible and later elect to participate, you will receive limited benefits for 12 months.

Monthly Premiums – for all states except those below	
Employee	$25.16
Employee + Spouse	$49.26
Employee + Child(ren)	$67.58
Family	$103.78

Monthly Premiums – AK, CA, CT, DE, HI, ME, MA, NV, NH, VT, WA	
Employee	$31.70
Employee + Spouse	$62.06
Employee + Child(ren)	$85.15
Family	$130.76
No sales in the following states until Aflac filings approved: MD, MT, NJ, NM, and NY.	

Dental Summary of Benefits	
	In-Network
Annual Deductible Individual Family	 $50 $150
Preventive Care *Routine exams and cleanings (3x per year), Fluoride for children under 19, Bitewing X-rays, Sealants, and Space Maintainers*	Plan pays 100%, no deductible
Basic Services *Simple restorative services (fillings), Simple & Surgical Extractions, Emergency Palliative Care, Crown, Bridge & Denture Repair, X-Rays*	You pay 20% after deductible
Major Services *Inlays, Onlays, Crowns, Bridges and Dentures, Anesthesia, Implants, All Periodontics, All Endodontics, and Oral Surgery*	You pay 50% after deductible
Annual Maximum	$1,000 per person
Out-of-Network Reimbursement	90th Percentile
Orthodontia	Not Covered
This is a general outline of covered benefits and does not include all the benefits, limitations and exclusions of the policy. Please see your certificate for full details.	

Note: Predetermination of benefits is recommended for charges in excess of $300.

Dental Coverage (Argus) – $1,500 Plan

Dental benefits are available to you and your eligible dependents to cover routine care such as exams, x-rays, and cleanings, as well as fillings, dentures, bridge work and periodontal care. In order to receive the highest level of benefits and pay the least amount out of your pocket, you need to access care from the providers who have elected to be part of the network.

This plan allows employees to select any dentist of their choice. When services are provided by an in-network provider, out-of-pocket costs (if any) will generally be less than if performed by an out-of-network provider. Services performed out-of-network will be paid based on the basis of Usual, Customary and Reasonable (UCR) services in the area where services are rendered.

To find an in-network provider, visit www.argusdentalvision.com.

Please Note: No changes are allowed to your dental coverage during the plan year, except for a "qualifying life event." If you do not participate in the Dental benefits when initially eligible and later elect to participate, you will receive limited benefits for 12 months.

Monthly Premiums – for all states except those below	
Employee	$30.58
Employee + Spouse	$59.88
Employee + Child(ren)	$82.15
Family	$126.16

Monthly Premiums – AK, CA, CT, DE, HI, ME, MA, NV, NH, VT, WA	
Employee	$38.53
Employee + Spouse	$75.45
Employee + Child(ren)	$103.51
Family	$158.96
***No sales in the following states until Aflac filings approved: MD, MT, NJ, NM, and NY.**	

Dental Summary of Benefits	
	In-Network
Annual Deductible Individual Family	 $50 $150
Preventive Care *Routine exams and cleanings (3x per year), Fluoride for children under 19, Bitewing X-rays, Sealants, and Space Maintainers*	Plan pays 100%, no deductible
Basic Services *Simple restorative services (fillings), Simple & Surgical Extractions, Emergency Palliative Care, Crown, Bridge & Denture Repair, X-Rays, All Periodontics and Endodontics, Oral Surgery*	You pay 20% after deductible
Major Services *Inlays, Onlays, Crowns, Bridges and Dentures, Anesthesia, Implants*	You pay 50% after deductible
Annual Maximum	$1,500 per person
Out-of-Network Reimbursement	90th Percentile
Orthodontia	Not Covered
This is a general outline of covered benefits and does not include all the benefits, limitations and exclusions of the policy. Please see your certificate for full details.	

Note: Predetermination of benefits is recommended for charges in excess of $300.

Dental Coverage (Argus) – $2,000 Plan

Dental benefits are available to you and your eligible dependents to cover routine care such as exams, x-rays, and cleanings, as well as fillings, dentures, bridge work and periodontal care. In order to receive the highest level of benefits and pay the least amount out of your pocket, you need to access care from the providers who have elected to be part of the network.

This plan allows employees to select any dentist of their choice. When services are provided by an in-network provider, out-of-pocket costs (if any) will generally be less than if performed by an out-of-network provider. Services performed out-of-network will be paid based on the basis of Usual, Customary and Reasonable (UCR) services in the area where services are rendered.

To find an in-network provider, visit www.argusdentalvision.com.

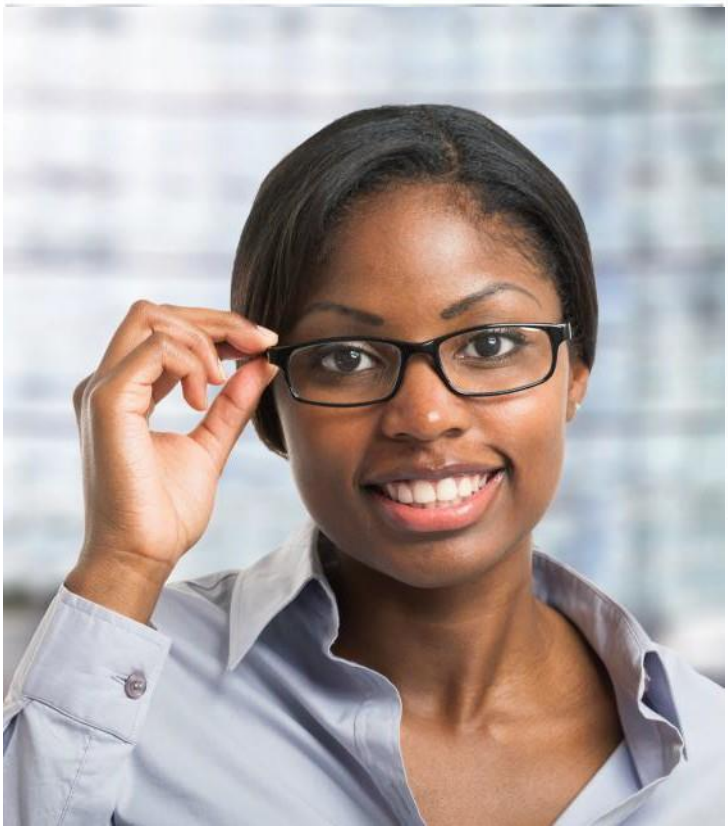
Please Note: No changes are allowed to your dental coverage during the plan year, except for a "qualifying life event." If you do not participate in the Dental benefits when initially eligible and later elect to participate, you will receive limited benefits for 12 months.

Monthly Premiums – for all states except those below	
Employee	$36.07
Employee + Spouse	$71.06
Employee + Child(ren)	$104.07
Family	$154.73

Monthly Premiums – AK, CA, CT, DE, HI, ME, MA, NV, NH, VT, WA	
Employee	$45.45
Employee + Spouse	$89.53
Employee + Child(ren)	$131.13
Family	$194.96
No sales in the following states until Aflac filings approved: MD, MT, NJ, NM, and NY.	

Dental Summary of Benefits	
	In-Network
Annual Deductible Individual Family	 $50 $150
Preventive Care *Routine exams and cleanings (3x per year), Fluoride for children under 19, Bitewing X-rays, Sealants, and Space Maintainers*	Plan pays 100%, no deductible
Basic Services *Simple restorative services (fillings), Simple & Surgical Extractions, Emergency Palliative Care, Crown, Bridge & Denture Repair, X-Rays, All Periodontics and Endodontics, Oral Surgery*	You pay 10% after deductible
Major Services *Inlays, Onlays, Crowns, Bridges and Dentures, Anesthesia, Implants*	You pay 40% after deductible
Annual Maximum	$2,000 per person
Out-of-Network Reimbursement	90th Percentile
Orthodontia	You pay 50%
Orthodontia Lifetime Maximum	$1,500 with an annual max of $750
Orthodontic Age Limit	19
This is a general outline of covered benefits and does not include all the benefits, limitations and exclusions of the policy. Please see your certificate for full details.	

Note: Predetermination of benefits is recommended for charges in excess of $300.



Vision Coverage (Argus)

Vision coverage is offered through Argus Dental & Vision, Inc. (Davis Vision Network). You and/or your eligible spouse/dependents may elect vision coverage whether or not covered by the company medical plan. Below is a brief summary of the coverages. For additional information, please refer to the Plan Summary.

To find an in-network provider, visit www.davisvision.com.

Vision Monthly Premiums – all states except those below	
Employee	$6.25
Employee + Spouse	$12.25
Employee + Child(ren)	$13.00
Family	$18.00

Vision Monthly Premiums – AK, CA, NH, NM, VT and WV	
Employee	$6.75
Employee + Spouse	$13.23
Employee + Child(ren)	$14.04
Family	$19.44
No sales in the following states until Aflac filings approved: CO, MA, MD, MT, NJ, NM, NY, PA, RI & VA	

Davis Vision Summary of Benefits		
Your Coverage with Davis Vision Doctors and Affiliate Providers	**Copay**	**Frequency**
Vision Exam Focuses on your eyes and overall wellness	$10	Every 12 months
Materials	$10	See frame and lenses
Frame $130 allowance for a wide selection of frames *(receive an extra $50 toward frame allowance if purchased at VisionWorks)* 20% savings on the amount over your allowance	Included in material copay	Every 24 months
Lenses Single vision, bifocal, trifocal, lenticular lenses Polycarbonate lenses for dependent children	Included in material copay	Every 12 months
Contacts (instead of glasses) $130 allowance for elective contacts Contact evaluation and fitting	Included in material copay $0	Every 12 months

LIFE INSURANCE

Basic Life and AD&D (One America)

If you are eligible for benefits, we offer Basic Term Life Insurance and Accidental Death and Dismemberment coverages equal to $15,000 at no cost to you.

Voluntary Life (One America)

We have partnered with One America to make additional life insurance available to employees and their families. The cost is paid by the employee, and the premiums may be payroll deducted.

Voluntary Life Insurance provides the opportunity to supplement benefits already provided by our company. If you are a new hire, you are eligible to receive up to the guarantee issue amount with no health questions. This means you will be approved for the guarantee issue amount regardless of any health issues you may have.

However, if you do not elect this amount of coverage when you first become eligible, you will be required to provide evidence of insurability and answer health questions for approval by the insurance company if you wish to enroll at a later date.

Voluntary Life Monthly Rates per $1,000 of Coverage*		
Age	**Employee**	Spouse**
Under 30	$0.12	$0.12
30-34	$0.14	$0.14
35-39	$0.17	$0.17
40-44	$0.27	$0.27
45-49	$0.43	$0.43
50-54	$0.62	$0.62
55-59	$1.05	$1.05
60-64	$1.29	$1.29
65-69	$1.80	$1.80
70 and Over	$4.23	$4.23
**Benefits reduce by 45% at age 70, 30% at age 75, 20% at age 80, and 15% at age 85.*		
***Spouse's rate is based on the employee's age*		

Chid(ren) Rate	$2.18 for $5,000 of coverage

If you leave the Company, you may be able to keep your life insurance in force by paying premiums directly to One America.

Voluntary Life Summary of Benefits			
	Employee	**Spouse**	**Child(ren)** *Dependents age 6 months to 19, or 26 if full-time student*
Benefit Amount	$50,000	$25,000	$5,000

Determining your Voluntary Life Monthly Premium	
Employee	Determine your rate based on your age. Multiply this rate by 50. A 30 year-old's monthly premium is $7.00 because $0.14 x 50 = $7.00
Spouse	Determine your spouse's rate based on your age. Multiply this rate by 25. A 30 year-old's spouse's monthly premium is $3.50 because $0.14 x 25 = $3.50

Short Term Disability (One America)

We offer Voluntary Short Term Disability to all benefit eligible employees. Short Term Disability provides a weekly benefit to replace a portion of your income for a relatively short period of time.

Please Note: A 3/12 pre-existing condition limitation applies for new enrollees. This means benefits will be excluded for 12 months for a disability for which you received treatment within three months prior to your effective date.

Short Term Disability (STD)	
Benefits Begin	After 14 days of your disability
Benefit Amount	60% of weekly earnings
Maximum Weekly Benefit	$1,000
Maximum Benefit Period	13 weeks

Short Term Disability Monthly Rates (*per $10 of weekly benefit*)	
Age	**Rate**
Under 30	$0.74
30-34	$0.74
35-39	$0.74
40-44	$0.59
45-49	$0.59
50-54	$0.74
55-59	$0.94
60-64	$1.08
65-69	$1.17
70 and Over	$1.25

Use the following steps to determine your monthly STD rate:

1. Benefit percentage: 0.60
2. Maximum weekly benefit: $1,000
3. Multiply your weekly salary by Step 1
4. Enter the lesser of Step 2 or Step 3
5. Divide Step 4 by 10
6. Multiply Step 5 by the rate based on your age as of the new plan year

If you do not elect disability coverage when you first become available, you will be required to provide evidence of insurability and answer health questions for approval by the insurance company if you wish to enroll at a later date.

Long Term Disability (One America)

We offer Voluntary Long Term Disability to all benefit eligible employees. Long Term Disability provides income protection if a serious illness or injury causes you to be unable to perform the duties of your occupation for a longer period of time.

Please Note: A 3/12 pre-existing condition limitation applies for new enrollees. This means benefits will be excluded for 12 months for a disability for which you received treatment within three months prior to your effective date.

Long Term Disability (LTD)	
Benefits Begin	After 90 days of your disablity
Benefit Amount	60% of monthly earnings
Maximum Monthly Benefit	$5,000
Maximum Benefit Period	5 years SSFRA

Long Term Disability Monthly Rates (*per $100 of monthly covered payroll*)	
Age	**Rate**
Under 30	$0.15
30-34	$0.28
35-39	$0.38
40-44	$0.56
45-49	$0.78
50-54	$1.16
55-59	$1.72
60-64	$2.10
65-69	$2.10
70 and Over	$2.10

Use the following steps to determine your monthly LTD rate:

1. Maximum covered monthly earnings: $8,333
2. Enter your monthly earnings
3. Enter the lesser of Step 1 or Step 2
4. Divide Step 3 by 100
5. Multiply Step 4 by the rate based on your age as of the new plan year

If you do not elect disability coverage when you first become available, you will be required to provide evidence of insurability and answer health questions for approval by the insurance company if you wish to enroll at a later date.

Carrier Contact Information

Medical

Health Benefit Alliance
S&S Health — TPA
Group Number:
Customer Service: 1-844-513-8866
Website: www.ss-health.com

Dental & Vision

Argus
Group Number:
Customer Service: 1-855-819-1873
Website: www.argusdentalvision.com

Life & Disability

OneAmerica
Group Number:
Customer Service: 1-800-553-5318
Website: www.oneamerica.com

Voluntary Products

Preferred Partners — Aflac, Sun Life and Allstate
Products: Accident and Critical Illness

Questions? Contact:

Patrick Thornton
Managing Director
Anderson Thornton Consultants
15429 N Florida Ave
Tampa, Florida 33613
Phone: 813-979-1588
Email: service@andersonthornton.com

Please note that this guide is a general summary of your benefits. For specific details, you may refer to each carrier's summary plan description. Every effort has been made to ensure that this booklet accurately represents the benefits. However, if there are any discrepancies between the terms in this booklet and the terms in the plan document, the plan document will prevail.