ATW

2019 Open Enrollment

The Road Ahead, Designed for You

2019 Benefits Overview

ATW is pleased to announce our benefits package for 2019. The same benefit plans will continue to be offered in 2019 as well as some new benefits including an Employee Assistance Program, Hospital Indemnity and Identity Theft Protection. There are no changes to employee contributions with the exception of age rated plans if moving into a new tier.

This Guide is an overview of the benefits available to you as well as the cost that will be deducted from your paycheck should you choose to enroll. Please read it carefully in order to make the best choices for you and your family in the 2019 Plan Year which will run January 1 to December 31, 2019.

This will be a passive enrollment, meaning that your current elections will rollover to 2019 (with the exception of HSA) unless you make a change. Open Enrollment is held annually and is the one-time opportunity to enroll or make changes to your current healthcare benefits without a qualifying life event.

ATW will continue to offer three medical plan options to select from. **There are no changes to the contributions or plan design.**

- Consumer Driven Health Plan (CDHP)
- Preferred Provider Organization (PPO)
- Minimum Essential Coverage (MEC)

If you elect the CDHP and open a Health Savings Account (HSA), this account will be funded by the company with $500 for individual coverage or $750 for family coverage.

The Pharmacy plan attached to the CDHP and PPO Medical Plans is administered by Express Scripts.

If you enroll in the Medical plan, you will also have access to a **telemedicine benefit program.** The Telemedicine benefit allows you 24/7 access to board certified physicians through the convenience of phone or video consults.

There are no changes to the following plans:

- Dental through MetLife
- Vision through Superior Vision
- Short Term Disability (STD) through MetLife*
- Basic Life/AD&D through MetLife
- Voluntary Life/AD&D through MetLife*
  - If you are currently enrolled, you may increase your elected benefit by 1 increment up to the guarantee issue without providing Evidence of Insurability.
- Accident through MetLife
- Critical Illness through MetLife

Hospital Indemnity is a new benefit offered through MetLife, which provides a cash benefit for hospital admission and daily confinement.

Identity Theft Protection is a new benefit offered through LifeLock, which monitors your personal information to help prevent fraud.

Employee Assistance Program (EAP) will now be available to all employees. There is no cost for this benefit, which provides access to certified counselors 24 hours a day, 7 days a week.

*These are age rated plans; therefore, your premium may adjust if moving into a new tier.

All changes need to be made via the Benefit Information Line at 833-532-6892 by October 26th.

For more information, call 833-532-6892 (toll-free) or visit atw.mybenefitslibrary.com.

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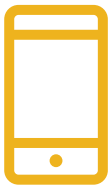


Go Mobile!

To Access Enrollment Materials Online, Go to atw.mybenefitslibrary.com

See **page 34** for important information concerning Medicare Part D coverage.

In this Guide, we use the term Company to refer to ATW. 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

You're a valued member of ATW, and your health and well-being are important to us. We are proud to provide you and your dependents with valuable and significant benefits. This guide is an overview of the benefits available to you. Please read it carefully in order to make the best choices for you and your family in the 2019 plan year and consult your HR representative with any questions.

You and your family have unique needs, which is why ATW offers a variety of benefit plans from which you may choose. If applicable, please make sure to consider your spouse's benefits through his or her place of employment and your dependents' eligibility when weighing each option.

Eligibility

If you are a full-time employee of ATW 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 other additional benefits.

When Does Coverage Begin?

The elections you make during Open Enrollment are effective on January 1, 2019. If you are a new hire or newly eligible for coverage, any elections you make are effective on the first day of the month following 60 days of service. Due to IRS regulations, once you have made your choices for the 2019 plan year, you won't be able to change your benefits until the next enrollment period unless you experience a Qualifying Life Event.

Eligible Dependents

Dependents eligible for coverage in the ATW benefits plans include:

- Your legal spouse
- 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, regardless of age, provided he or she is incapable of self-support due to a mental or physical disability, is fully dependent on you for support as indicated on your federal tax return, and is approved by your medical plan to continue coverage past age 26.

Qualifying Life Events

When one of the following events occurs, you have 30 days from the date of the event to notify Human Resources and/or request changes to your coverage.

- Change in your legal marital status (marriage, divorce or legal separation)
- Change in the number of your dependents (for example, through birth or adoption, or if a child is no longer an eligible dependent)
- Change in your spouse's employment status (resulting in a loss or gain of coverage)
- Entitlement to Medicare or Medicaid

Your change in coverage must be consistent with your change in status. Please direct questions regarding specific life events and your ability to request changes to Human Resources.

Preparing to Enroll

ATW provides its employees the best coverage possible. As a committed partner in your health, ATW will be absorbing a significant amount of the costs. Your share of the contributions for medical, dental and vision benefits is deducted on a pre-tax basis, which lessens your tax liability. Please note that employee contributions for medical, dental and vision coverage vary depending on the level of coverage you select. In general, the more coverage you have, the higher your contribution will be.

Keep in mind that you may select any combination of medical, dental and/or vision plan coverage categories. 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 of ATW, must elect coverage for yourself in order to elect any dependent coverage. Be sure to have the Social Security numbers and birthdates for any eligible dependent(s) that you plan to enroll. You cannot enroll your dependent(s) without this information.

Look!

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.

OPEN ENROLLMENT CHECKLIST

Important note: this is a passive enrollment, meaning that your current benefit elections will rollover to the new plan year unless you make a change. You will not have another opportunity to make changes to your benefit elections until the next Open Enrollment period, unless you experience a Qualifying Life Event.

1. Review Plan Options.

Review this Open Enrollment Guide, which includes plan details and premium amounts to determine the level of coverage needed for you and your family.

2. Review available plans' deductibles and plan design.

Changes to your deductible might trigger you to explore other plan options. If you're planning on having a baby or major surgery this year, think carefully about your out-of-pocket medical costs and deductible. Read on for more information about various plan deductibles later in the guide.

3. Consider your HSA.

Think about how much you plan to spend on healthcare in the coming year — this includes dental and vision services, prescriptions and more. If you enroll in the CDHP, consider contributing to an HSA to use for eligible healthcare expenses. As a reminder, HSA contributions must be re-elected each year; they do not roll-over.

4. Review & Verify current benefit.

Verify current benefit elections and determine if any changes/updates are needed, including your life insurance beneficiaries.

5. Call the Benefits Information Line to make changes and/or ask questions related to ATW benefits for 2019.

ALL CHANGES NEED TO BE MADE VIA THE BENEFIT INFORMATION LINE AT 833-532-6892. All benefit changes must be made by October 26th, 2018.

This is the only time you can make changes to your current benefits (new enrollments, plan changes, dependents covered) during the year without experiencing a qualifying life event.

Benefit counselors will also be on-site at select locations during the enrollment window to answer questions and assist with benefit changes. Speak to your HR Representative to find out if/when counselors will be visiting your location.

MEDICAL BENEFITS

Our medical coverage helps you maintain your well-being through preventive care and access to an extensive network of providers, as well as prescription medication. The CDHP and PPO Plan Options are offered through GPA utilizing the PHCS and HealthSmart networks. Choose the plan that best matches your needs and please keep in mind that the option you elect will be in place for all of the 2019 plan year, unless you have a Qualifying Life Event.

Medical Premiums

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

How to Find a Provider

To see a current list of PHCS network providers, visit www.multiplan.com (select Practitioner Only Network) or call 877-312-7427. If you live in the Dallas-Fort Worth Metroplex and enroll in the CDHP or PPO, your provider network will be the HealthSmart network. To find a HealthSmart provider, go to www.healthsmart.com (select the Physician/Ancillary Only network) or call 214-574-3546.

If you are unsure which network you have access to, refer to the back of your ID card.

Network Information

The PHCS or HealthSmart network are for physician services only. For Facility based services such as Hospitals (Inpatient/Outpatient), Inpatient Facilities (Rehab Facilities, Nursing Facilities etc,), Ambulatory Surgery Centers, Dialysis Clinics and other Inpatient or freestanding facilities you can access any facility at the same coverage level.

Benefit Information and Claims Status

For questions regarding the Medical Benefit coverage or relating to status of a claim, contact GPA at 800-827-7223 or www.gpatpa.com.

Teladoc

If you enroll in the CDHP or PPO Medical plan, you will have access to a telemedicine benefit program through Teladoc. Teladoc allows you 24/7/365 access to U.S. board-certified doctors through the convenience of phone or video consults. Most visits take less than 10 minutes and doctors can write a prescription, if needed, that you can pick up at your local pharmacy.

You can be treated for a wide range of non-emergency medical conditions, including allergies, pink eye, cold/flu, sinus infections and ear infections. The cost per consultation is $45 and will apply to your calendar year out-of-pocket maximum. To access Teladoc, go to www.teladoc.com or call 800-835-2362.

Look!

Take advantage of preventive care offered by an in-network physician. This will save you time and money in the long run!

MEDICAL BENEFITS

Medical Plan Summary

The chart below gives a summary of the 2019 medical coverage provided by GPA. You have the option to choose between the Consumer-Driven Health Plan (CDHP) or the PPO Plan. 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.

	CDHP			PPO		
	WEEKLY (52)	BI-WEEKLY (26)	SEMI-MONTHLY (24)	WEEKLY (52)	BI-WEEKLY (26)	SEMI-MONTHLY (24)
EMPLOYEE CONTRIBUTIONS						
EMPLOYEE ONLY	$27.69	$55.38	$60.00	$36.92	$73.85	$80.00
EMPLOYEE + SPOUSE	$88.85	$177.69	$192.50	$133.27	$266.54	$288.75
EMPLOYEE + CHILD(REN)	$51.92	$103.85	$112.50	$73.85	$147.69	$160.00
EMPLOYEE + FAMILY	$115.38	$230.77	$250.00	$173.08	$346.15	$375.00
	IN-NETWORK		OUT-OF-NETWORK	IN-NETWORK		OUT-OF-NETWORK
HSA EMPLOYER CONTRIBUTION						
INDIVIDUAL	$500			N/A		
FAMILY	$750			N/A		
CALENDAR YEAR DEDUCTIBLE						
INDIVIDUAL	$2,700		$7,500	$3,000		$6,000
FAMILY	$5,400		$15,000	$6,000		$12,000
COINSURANCE						
COINSURANCE (YOU PAY)	20%*		40%*	0%*		40%*
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (INCLUDES DEDUCTIBLE)						
INDIVIDUAL	$4,000		$12,000	$6,350		$12,700
FAMILY	$8,000		$24,000	$12,700		$25,400
COPAYS/COINSURANCE (YOU PAY)						
PREVENTIVE CARE	0%		40%*	$0		40%*
PRIMARY CARE PHYSICIAN	20%*		40%*	$40 copay		40%*
SPECIALIST VISIT	20%*		40%*	$75 copay		40%*
URGENT CARE	20%*		40%*	$75 copay		40%*
EMERGENCY ROOM	20%*		20%*	$300 copay		$300 copay

*After Deductible

The PHCS or HealthSmart networks are for physician services only. For Facility based services such as Hospitals (Inpatient/Outpatient), Inpatient Facilities (Rehab Facilities, Nursing Facilities etc,), Ambulatory Surgery Centers, Dialysis Clinics and other Inpatient or freestanding facilities you can access any facility at the same coverage level.

Family Deductible/OOP Max:

When a family member meets his or her individual deductible, the coinsurance benefit will be available for that member. Once the family deductible is met by a combination of two or more family members, all family members will have medical expenses paid according to the plan's coverage, even if they have not met their own individual deductibles.

CDHP

The Consumer-Driven Health Plan (CDHP), coupled with a Health Savings Account (HSA), is an innovative health plan that helps to reduce health care costs. By actively engaging you in decisions about your health care, this type of plan provides you with more choice, flexibility and control over how you spend your health care dollars.

With the CDHP, you pay first-dollar costs for all covered Medical expenses (with the exception of preventive care) until you meet your annual deductible. Once you meet your annual deductible, you share the cost of covered services with the plan in a coinsurance arrangement until you meet your annual out-of-pocket maximum. If you enroll in the CDHP Plan you have the option of opening a Health Savings Account (HSA), contributing pre-tax dollars to be used on eligible health care expenses. See page 11 for more details.

Key Features

- 100% preventive and wellness care coverage with network providers.
- Certain preventive prescriptions at no cost, with a waived deductible.
- No copays for greater cost transparency.
- All qualified employee paid Medical expenses count toward the deductible and out-of-pocket maximum.

ELAP Process - Important

If you receive a balance bill from a provider, send it to ELAP via email, fax, or mail as soon as possible. Confirm you paid all out-of-pocket expenses including copays, deductibles, or coinsurance amounts due to the provider, as explained in the Explanation of Benefits you received from GPA when the claim was initially paid. Contact GPA at the number on your ID card with any questions regarding out-of-pocket expenses.

Urgent Care Centers vs. Freestanding Emergency Rooms

Freestanding emergency rooms may look a lot like urgent care centers, but the costs and services can be drastically different. In general, consider an urgent care center as an extension of your primary care physician, while freestanding emergency rooms should be used for health conditions that require a high level of care. Research the options in your area and determine which ones are covered by your insurance plan's network; note that balance billing may apply. Choosing an urgent care center for everyday health concerns rather than an ER could save you hundreds of dollars.

Look!

If you receive a bill from a medical provider or collection firm, contact ELAP Services immediately at balancebills@elapservices.com or 800-977-7381.

PHARMACY BENEFITS

Prescription Drug Coverage for Medical Plans

Our Prescription Drug Program is administered by RxBenefits utilizing the Express Scripts formulary and network.

You will have one ID card that includes information for both medical care and prescriptions. You may find information on your benefits coverage and search for network pharmacies by logging on to www.expressscripts.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. All products on the list are assigned as generic, preferred, non-preferred or specialty.

	CDHP		PPO	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
RX DEDUCTIBLE	Combined with Medical		Individual Ded: $100 Family Ded: $300 applies to brand name drugs	
RETAIL RX (UP TO 30-DAY SUPPLY)				
GENERIC	20%*	20%*	$5 copay	$5 copay
PREFERRED	20%*	20%*	$30 copay	$30 copay
NON-PREFERRED	20%*	20%*	$50 copay	$50 copay
MAIL ORDER RX (UP TO 90-DAY SUPPLY)				
GENERIC	20%*	20%*	$10 copay	$10
PREFERRED	20%*	20%*	$60 copay	$60
NON-PREFERRED	20%*	20%*	$100 copay	$100
SPECIALTY	20%*	20%*	20% copay to a max of $500	20% copay to a max of $500

*After Deductible

HEALTH SAVINGS ACCOUNT

Take charge of your health care spending with a Health Savings Account (HSA). Contributions to an HSA are tax free and withdrawals for qualified medical expenses are tax free.

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

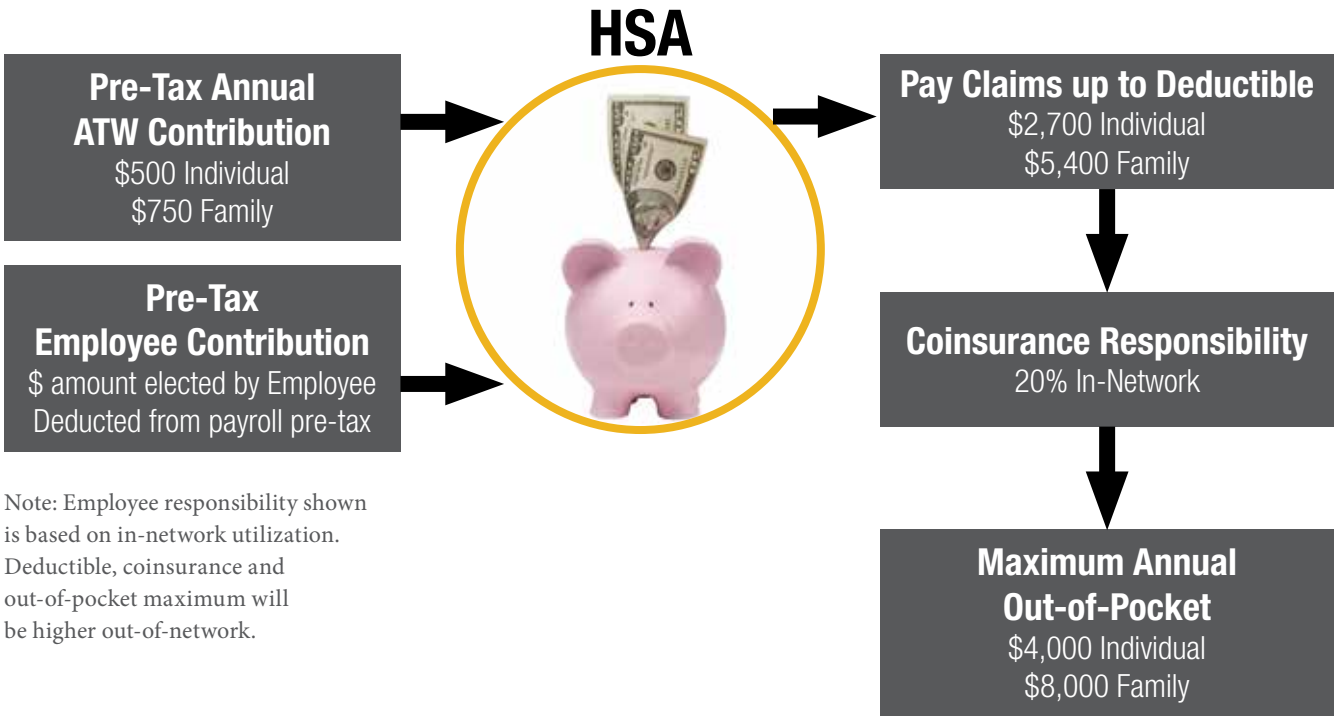
Eligible expenses include doctors' office visits, eye exams, prescription expenses, laser eye surgery and more. IRS Publication 502 provides a complete list of eligible expenses and can be found on www.irs.gov.

Eligibility

You are eligible to open and fund an HSA if:

- You are enrolled in an HSA-eligible Consumer-Driven Health Plan.
- You are not covered by your spouse's non-CDHP health plan.
- Your spouse does not have a health care 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.)

How It Works



Note: Employee responsibility shown is based on in-network utilization. Deductible, coinsurance and out-of-pocket maximum will be higher out-of-network.

Look!

An HSA is a great way to save for post-retirement healthcare needs. Aim to contribute the maximum amount allowed each year.

For more information, call 833-532-6892 (toll-free) or visit atw.mybenefitslibrary.com.

How to Enroll

You must elect the CDHP with ATW to be eligible to enroll. You will need to complete all HSA enrollment materials and designate the amount to contribute on a pre-tax basis. ATW will establish an HSA account in your name and send in your contribution once bank account information has been provided and verified.

Note: If you currently have an HSA through Optum Bank that was established under the company previously, you will not need to take action. Your current account will remain active.

Maximize Your Tax Savings

Contributions to an HSA are tax-free (they 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. As long as the funds are used to pay 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.

HSA Funding Limits

Each year, the IRS places a limit on the maximum amount that can be contributed to HSA accounts. For 2019, contributions (which include any employer contribution) are limited to the following:

HSA FUNDING LIMITS	
EMPLOYEE	$3,500
FAMILY	$7,000
CATCH -UP CONTRIBUTION (AGES 55+)	$1,000

ATW will provide an HSA employer contribution that will be deposited on a semi-annual basis.

EMPLOYER HSA CONTRIBUTION	
EMPLOYEE	$500
FAMILY	$750

HSA contributions in excess of the IRS annual contribution limits ($3,500 for individual coverage and $7,000 for family coverage for 2019) 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 can do one of two things:

- 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 you may want to consider contributing less than the annual limit to you HSA to make up for the excess contribution during the previous year.

The ATW HSA will be established with Optum Bank. You may be able to roll over funds from another HSA. For more enrollment information, contact Human Resources.

Look!

HSA contributions must be re-elected each year; they will not rollover. However, your account will remain open regardless of whether a new election is received.

PLAN OPTIONS: Which Is Best for You?

PPO Plan Higher Premium, Higher Deductible Highest Out-of-Pocket Costs

CDHP Lowest Premium, Lowest Deductible, Lowest Out-of-Pocket Costs

SCENARIO 1: DAVID
(LOW HEALTH CARE UTILIZER)

David is 26 years old and just starting out in his career. He has few health care needs aside from preventive exams and screenings (paid at 100% when he uses in-network providers). David is single, has no children, and earns $32,000 a year. He doesn't anticipate any major health care expenses in 2019 and wants to spend as little on health care as possible.

PLAN COST WITH NETWORK DISCOUNTS	CDHP	PPO
PREVENTIVE VISIT: 1	$0	$0
PRIMARY CARE OFFICE VISIT: 1	$85	$40
SPECIALIST OFFICE VISIT: 1	$125	$75
RXS: GENERIC EACH @ RETAIL: 3	$45	$15
DAVID'S TOTAL OUT-OF-POCKET COST FOR SERVICES	$255	$130
DAVID'S ANNUAL MEDICAL PLAN PAYROLL CONTRIBUTION	$1,440	$1,920
ATW'S 2019 CONTRIBUTION TO HSA	$500	—
DAVID'S TOTAL COST (SERVICES PLUS PREMIUM PAYROLL CONTRIBUTIONS) MINUS ATW HSA CONTRIBUTION	$1,195	$2,050

David's Choice

David's preferred option is the **CDHP with HSA** plan. The plan's lower premium fits his budget and he still gets regular preventive care at no additional cost. Though his deductible is higher, the HSA provides a safety net should he face unexpected medical issues. David likes the tax advantages of the Health Savings Account, knowing that he can use it to pay his out-of-pocket expenses in the near term and carry the balance forward to use toward future health care expenses.

David plans on contributing $480 to his HSA in 2019 which is the amount of money he saved in premiums compared to the PPO Plan. Although the contributions are deducted from his paycheck, they are tax-free, which lowers his taxable income. In addition, the earnings and interest on his HSA are tax-free, along with the withdrawals when he uses savings from the account for qualified health care expenses! If he doesn't use the money in 2019, it rolls over to the next year to use for future expenses.

DISCLAIMER:
Please be advised that these scenarios are only examples. Your actual experience may vary. All expenses assume the use of in-network providers and are eligible expenses under the plan.

SCENARIO 2: LISA
(MODERATE HEALTH CARE EXPENSES)

Lisa is 55 and single. She is healthy but has a few health care needs. She plans to have an outpatient orthopedic surgery this year. She suffers from allergies and annually goes to the Urgent Care for a sinus infection to get a prescription. She does take a generic maintenance prescription that she fills through mail order.

PLAN COST WITH NETWORK DISCOUNTS	CDHP	PPO
PREVENTIVE EXAMS: 1 TOTAL	$0	$0
SPECIALIST VISIT: 2 TOTAL	$250	$150
URGENT CARE VISIT	$150	$75
RX GENERIC @ RETAIL: 1 TOTAL	$15	$5
OUTPATIENT SURGERY DEDUCTIBLE & COINSURANCE	$3,560	$3,000
RX GENERIC MAINTENANCE @ MAIL ORDER (12 MONTHS)	$25 (Out-of-Pocket Max Satisfied)	$40
PRIMARY CARE PHYSICIAN: 1 TOTAL	$0 (Out-of-Pocket Max Satisfied)	$40
LISA'S TOTAL HEALTHCARE COST	$4,000	$3,310
LISA'S ANNUAL PAYROLL CONTRIBUTIONS	$1,440	$1,920
ATW'S 2019 CONTRIBUTION TO THE HSA	$500	—
LISA'S TOTAL COST (SERVICES PLUS PREMIUM PAYROLL CONTRIBUTIONS)	$4,940	$5,230

LISA's Choice

Although LISA will benefit from the fixed copay amounts with the PPO, she actually comes out ahead in the end due to the lower out-of-pocket maximum, lower premium contributions and the HSA employer contribution.

DISCLAIMER:
Please be advised that these scenarios are only examples. Your actual experience may vary. All expenses assume the use of in-network providers and are eligible expenses under the plan.

MEDICAL BENEFITS - MEC

Minimum Essential Coverage (MEC) Plans are offered through Century Healthcare and utilize the PHCS network. MEC Plans include 100% coverage for preventive care as well as Limited Fixed Indemnity coverage which offers first dollar benefits. The Limited Fixed Indemnity coverage is designed to help you manage medical expenses such as physician office visits, emergency room trips, hospitalization, diagnostic tests and even prescription drugs up to certain preset limited benefit levels. Please keep in mind that the option you elect will be in place for all of the 2019 Plan Year, unless you have a Qualifying Life Event.

Medical Premiums

Premium contributions for Medical will be deducted from your paycheck on a pre-tax basis. Your level of coverage will determine your weekly premium.

	MEC		
	WEEKLY (52)	BI-WEEKLY (26)	SEMI-MONTHLY (24)
EMPLOYEE CONTRIBUTIONS			
EMPLOYEE ONLY	$16.66	$33.33	$36.11
EMPLOYEE + SPOUSE	$35.22	$70.44	$76.32
EMPLOYEE + CHILD(REN)	$29.43	$58.86	$63.77
EMPLOYEE + FAMILY	$46.28	$29.56	$100.27

How to Find a Provider

To see a current list of PHCS Limited Benefit Network providers go to www.multiplan.com or call 888-371-7427.

Preventive Services

All preventive services as specified by the Affordable Care Act such as annual physicals, mammograms, pap smears, preventive cancer screenings, routine lab and x-rays, and immunizations. These services are covered at 100% through in-network providers.

Telemedicine

If you enroll in the Century Healthcare Medical Plan, you will have access to a telemedicine benefit through Healthiest You. Reach a physician 24 hours a day 7 days a week who will provide a consultation, diagnosis and prescription (if needed). Healthiest You physicians treat non-emergency conditions such as allergies, bronchitis, earache, sinusitis, pink eye, strep throat and upper respiratory infection. The consultation is free and does not apply as a doctor's visit under your plan. To talk to a doctor, call 866-703-1259 or visit member.healthiestyou.com.

Look!

The MEC Medical plan satisfies the Government Individual Mandate for insurance coverage. Please note that each benefit category covered has a maximum benefit that will be paid during the plan year. Any visits/costs beyond that maximum are paid by the employee.

MEC Medical Plan Summary

The chart below illustrates the 2019 MEC Medical coverage provided by Century Healthcare. All covered services are subject to medical necessity as determined by the Plan.

	CENTURY HEALTHCARE VALUE PLAN PHCS PPO NETWORK
MEDICAL	
PREVENTIVE SERVICES	Covered 100%
DOCTOR'S OFFICE VISIT	$50/day (6 days)
TELEMEDICINE	Covered 100% via HealthiestYou app
OUTPATIENT X-RAY	$50/day (2 days)
OUTPATIENT LABS	$10/day (3 days)
ADVANCED STUDIES (CT SCAN, PET SCAN, MRI)	$200/day (1 day)
EMERGENCY ROOM (1 SICKNESS)	$100/day (1 day)
INPATIENT/OUTPATIENT SURGERY BENEFIT	IP $500 (1 Surgery) or OP $250 (1 Surgery)
INPATIENT/OUTPATIENT ANESTHESIA BENEFIT (1 IP OR 1 OP SURGERY)	IP $125 OP $62.50
FIRST HOSPITAL CONFINEMENT (1 TIME BENEFIT PAID IN ADDITION TO HOSPITAL CONFINEMENT)	$500/day (Day 1)
HOSPITAL CONFINEMENT	$100/day (30 days)
SUBSTANCE ABUSE CONFINEMENT	$100/day (30 days)
MENTAL ILLNESS CONFINEMENT	$100/day (30 days)
SKILLED NURSING FACILITY CONFINEMENT	$100/day (30 days)
ACCIDENT MEDICAL ($100 DEDUCTIBLE PER OCCURRENCE)	Up to $5,000 per occurrence
PHARMACY	
MONTHLY MAXIMUM	
EMPLOYEE	$100
FAMILY	$200
TIER 1	
MOST GENERICS	$10 copay
TIER 2	
SOME GENERICS, PREFERRED/FORMULARY BRAND NAME	$50 or 50%, whichever is greater
TIER 3	
NON-PREFERRED/NON-FORMULARY BRAND NAME	EE pays 100% after discounts
LIFE/AD&D	
EMPLOYEE TERM LIFE INSURANCE	$10,000
ACCIDENTAL DEATH & DISMEMBERMENT	
EMPLOYEE	$15,000
SPOUSE	$7,500
CHILD	$3,000

PREVENTIVE CARE

Did you know that most health plans must cover a set of preventive services — such as shots and screening tests — at no cost to you? Work with your Primary Care Physician to stay up to date on preventive services — identifying and treating illnesses early will save you time and money, and promote a healthy lifestyle in the long run!

Any screening test done in order to catch a disease early is considered a preventive service. Due to the U.S. Patient Protection and Affordable Care Act (ACA), many services, screenings and supplies are paid at 100% including, but not limited to, the following:

- Wellness visits, yearly physicals and standard immunizations
- Screenings for blood pressure, cancer, cholesterol, depression, obesity and Type 2 diabetes
- Pediatric screenings for hearing, vision, obesity, depression, autism and developmental disorders
- Anemia screenings, breastfeeding support and breastfeeding pumps for pregnant and nursing women
- Iron supplements (for children ages 6 to 12 months at risk for anemia)

Key Things to Remember:

- Many preventive care services and tests are covered at 100%. You can find a list of covered services in your plan documents.
- Think of preventive care visits as routine check-ups. Things that may occur during a preventive visit include immunizations, blood pressure and cholesterol measurement, diabetes screening, or counseling on healthy weight.
- Diagnostic care to identify potential health risks are covered according to plan benefits, even if recommended or done during a preventive care visit.
- If your physician finds a specific health risk or new medical condition during your appointment, your doctor may bill those services as diagnostic medicine. These types of diagnostic services may result in out-of-pocket costs for you (i.e., deductibles, coinsurance, or copayments) because they are no longer considered preventive care.

Check your benefit summary to see what preventive services are available to you at no cost.

Q&A: GENERIC DRUGS

What is a generic drug?

Generic drugs are copies of brand-name drugs that have exactly the same dosage, intended use, effects, side effects, route of administration, risks, safety and strength as the original drug. In other words, their pharmacological effects are exactly the same as those of their brand-name counterparts.

Are generic drugs as effective as brand-name drugs?

Yes. A generic drug is the same as a brand-name drug in dosage, safety, strength, quality, the way it works, the way it is taken and the way it should be used. FDA requires generic drugs have the same high quality, strength, purity and stability as brand-name drugs.

What standards do generic drugs have to meet?

Health professionals and consumers can be assured that FDA approved generic drugs have met the same rigid standards as the innovator drug. To gain FDA approval, a generic drug must:

- **Contain the same active ingredients as the innovator drug (inactive ingredients may vary)**
- **Be identical in strength, dosage form, and route of administration**
- **Have the same use indications**
- **Be bioequivalent**
- **Meet the same batch requirements for identity, strength, purity, and quality**
- **Be manufactured under the same strict standards of FDA's good manufacturing practice regulations required for innovator products**

Are generic drugs that much cheaper than brand-name medications?

Yes. On average, the cost of a generic drug is 80% to 85% lower than the brand-name equivalent.

Is there a generic equivalent for my brand-name drug?

To find out if there is a generic equivalent for your brand-name drug, visit www.fda.gov to view a catalog of FDA-approved drug products, as well as drug labeling information.

SUPPLEMENTAL HEALTH

ATW knows the value of well-rounded, balanced employees, which is why we offer a variety of supplemental health to help manage life's daily stresses. Voluntary Critical Illness, Accident and Hospital Indemnity are offered at group discounted rates through MetLife.

Critical Illness Coverage

Critical Illness coverage, available through MetLife, is designed to help you offset the financial effects of a catastrophic illness with a lump sum benefit if you or a loved one are diagnosed with a covered critical illness. The Critical Illness benefit is based on the amount of coverage in effect on the date of diagnosis of a critical illness or the date treatment is received according to the terms and provisions of the policy.

- Rates lock-in at your current age
- Pre-existing condition limitations apply; see plan document for details
- An annual $50 wellness benefit is payable for completion of certain wellness screenings

Rates shown below are based on a Non-Tobacco user. There are separate rates for a Tobacco user, which can be found on the Critical Illness Benefits Summary at atw.mybenefitslibrary.com.

Employee Rates

The below rates are based on a Weekly payroll deduction. If you are paid on a different payroll cycle, this will need to be converted.

- Weekly rate X 52 / 26 = **Bi-Weekly rate**
- Weekly rate X 52 / 24 = **Semi-Monthly rate**

THE BELOW BENEFITS ARE PAYABLE AT 100% OF YOUR COVERAGE AMOUNT:

- Alzheimer's Disease
- Coronary Artery Bypass Graft
- Full Benefit Cancer
- Stroke
- Heart Attack
- Kidney Failure
- Major Organ Transplant

THE BELOW BENEFITS ARE PAYABLE AT 25% OF YOUR COVERAGE AMOUNT:

- Partial Benefit Cancer
- Addison's disease
- Amyotrophic lateral sclerosis
- Cerebrospinal meningitis
- Cerebral palsy
- Cystic fibrosis
- Diphtheria
- Encephalitis
- Huntington's disease
- Legionnaire's disease
- Malaria
- Multiple sclerosis
- Muscular dystrophy
- Myasthenia gravis
- Necrotizing fasciitis
- Osteomyelitis
- Poliomyelitis
- Rabies
- Sickle cell anemia
- Systemic lupus erythematosus
- Systemic sclerosis
- Tetanus
- Tuberculosis

BASE PLAN (WEEKLY RATES)

EMPLOYEE = $15,000; SPOUSE = $7,500; CHILD(REN) = $7,500

EMPLOYEE'S AGE	EMPLOYEE ONLY	EMPLOYEE + SPOUSE	EMPLOYEE + CHILDREN	EMPLOYEE + FAMILY
<25	$1.77	$2.77	$2.39	$3.36
25–29	$1.77	$2.77	$2.39	$3.36
30–34	$2.60	$3.74	$3.18	$4.36
35–39	$3.70	$5.26	$4.29	$5.85
40–44	$5.88	$8.10	$6.51	$8.72
45–49	$8.38	$11.46	$8.97	$12.08
50–54	$11.53	$15.65	$12.15	$16.27
55–59	$14.82	$20.11	$15.44	$20.70
60–64	$18.21	$24.75	$18.83	$25.37
65–69	$20.25	$27.93	$20.84	$28.56
70+	$23.78	$33.02	$24.40	$33.61

PLUS PLAN (WEEKLY RATES)

EMPLOYEE = $30,000; SPOUSE = $15,000; CHILD(REN) = $15,000

EMPLOYEE'S AGE	EMPLOYEE ONLY	EMPLOYEE + SPOUSE	EMPLOYEE + CHILDREN	EMPLOYEE + FAMILY
<25	$3.53	$5.54	$4.78	$6.72
25–29	$3.53	$5.54	$4.78	$6.72
30–34	$5.19	$7.48	$6.37	$8.72
35–39	$7.41	$10.52	$8.58	$11.70
40–44	$11.77	$16.20	$13.02	$17.45
45–49	$16.75	$22.92	$17.93	$24.16
50–54	$23.05	$31.29	$24.30	$32.54
55–59	$29.63	$40.22	$30.88	$41.40
60–64	$36.42	$49.50	$37.66	$50.75
65–69	$40.50	$55.87	$41.68	$57.12
70+	$47.56	$66.05	$48.81	$67.22

Accident Coverage

Accident coverage by MetLife helps to protect you from the unexpected expenses related to an accident. We never expect an accident to occur, but if does, our medical expenses rise and our living expenses don't go away. The Accident plan helps to protect your pocketbook so you can maintain your way of life.

A brief summary of the benefits is included below. Benefits are payable directly to you, regardless of any portion of the cost that your medical plan may cover.

CORE BENEFITS	
FRACTURES	Up to $6,000
DISLOCATIONS	Up to $6,000
EMERGENCY CARE	$200 for emergency room $100 for physician office or urgent care
NON-EMERGENCY INITIAL CARE	$100
MEDICAL TESTING BENEFIT (X-RAY, MR/MRI, ULTRASOUND, NCV, CT/CAT, EEG)	$200
PHYSICIAN FOLLOW-UP VISIT	$75
THERAPY SERVICES	$25 for Cognitive Behavioral, Occupational, Physical, Respiratory, Speech and Vocational Therapy
HOSPITAL OR ICU BENEFIT	$1,000 for initial hospitalization plus $200 per day
ADDITIONAL BENEFITS	
BURNS (2ND AND 3RD DEGREE)	Up to $10,000
CONCUSSION	$200
COMA	$10,000
RUPTURED DISC (WITH SURGERY)	$1,000
TORN CARTILAGE IN KNEE (WITH SURGERY)	$750
LACERATION	$50 without stitches, up to $400 with stitches
TORN, RUPTURED OR SEVERED TENDON/ LIGAMENT/ROTATOR CUFF (WITH SURGERY)	$750
AMBULANCE	$1,000 for air/$300 for ground
PROSTHETIC DEVICE	$750
MEDICAL APPLIANCE	Up to $1,000
BLOOD BENEFIT	$400
INPATIENT SURGERY	Up to $2,000
OUTPATIENT SURGERY	$300

	ACCIDENT COVERAGE		
	WEEKLY (52)	BI-WEEKLY (26)	SEMI-MONTHLY (24)
EMPLOYEE CONTRIBUTIONS			
EMPLOYEE ONLY	$3.38	$6.77	$7.33
EMPLOYEE + SPOUSE	$6.00	$11.99	$12.99
EMPLOYEE + CHILD(REN)	$7.35	$14.69	$15.92
EMPLOYEE + FAMILY	$9.11	$18.22	$19.74

Hospital Indemnity Coverage

Hospital Indemnity Coverage through MetLife pays cash benefits directly to you if you have a covered stay in a hospital or critical care unit. The benefit amount is determined based on the type of facility and the number of days you stay. You can use the benefits from this policy to help pay for your medical expenses such as deductibles and copays, travel cost, food and lodging, or everyday expenses such as groceries and utilities.

		BASE PLAN	PLUS PLAN
HOSPITAL ADMISSION (PAYABLE 1X/ACCIDENT)	Non-ICU	$500	$1,000
	ICU	$1,000	$2,000
HOSPITAL CONFINEMENT (UP TO 31 DAYS PER COVERED PERSON, STARTING ON DAY 1)	Non-ICU	$100	$200
	ICU	$200	$400
INPATIENT REHABILITATION (UP TO 15 DAYS/PERSON/ ACCIDENT, MAX 30 DAYS/ CALENDAR YEAR)	Daily Benefit	$100	$200
PRE-EXISTING CONDITION EXCLUSION		Waived	Waived
BENEFIT REDUCTION DUE TO AGE		25% reduction at age 65; 50% reduction at age 70	25% reduction at age 65; 50% reduction at age 70
PORTABILITY		Included	Included

MONTHLY PREMIUM

	BASE PLAN			PLUS PLAN		
	WEEKLY (52)	BI-WEEKLY (26)	SEMI-MONTHLY (24)	WEEKLY (52)	BI-WEEKLY (26)	SEMI-MONTHLY (24)
EMPLOYEE ONLY	$2.59	$5.18	$5.62	$5.19	$10.38	$11.24
EMPLOYEE + SPOUSE	$7.35	$14.70	$15.93	$14.70	$29.40	$31.86
EMPLOYEE + CHILD(REN)	$4.61	$9.22	$9.99	$9.13	$18.27	$19.79
EMPLOYEE + FAMILY	$9.43	$18.86	$20.44	$18.74	$37.48	$40.61

Supplemental Health

Universal LifeEvents® with Long Term Care

The Trustmark Universal LifeEvents® coverage combines a permanent life insurance policy with living benefits in the form of Long Term Care (LTC).

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.

Check out the three main features of this plan alongside an example of how the plan works for a 35 year old, non-smoker, who is paying $8 per week for coverage.

1	**A death benefit**, payable to your beneficiaries if you pass away	$57,376 death benefit is payable to your beneficiaries when you pass away
2	**A living benefit**, to help pay for care in an assisted living, long term care facility, home health care and/or adult day care	Pays you 4% per month, up to 25 months. $2,295 per month x 25 months = $57,376
3	**A terminal illness benefit**, that pays you 75% of your death benefit if your life expectancy is less than 24-months	Pays you $43,032 with life expectancy declaration Pays remaining $14,344 to your beneficiaries when you pass away

Plan Highlights

- Your rates lock in at your current age and do not increase as you age
- Coverage is portable which means 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

	GUARANTEED ISSUE (NO MEDICAL QUESTIONS)	MAXIMUM BENEFIT AMOUNT
EMPLOYEE ONLY	up to $100,000	$300,000
SPOUSE	lesser of $3/week or $15,000	$300,000
CHILD(REN)	up to $4.32 per week	up to $4.32 per week

Rates are based on your age and coverage level.

There are certain benefit restrictions for anyone enrolling beyond age 64.

Ask a Benefit Counselor today for your coverage options and premium.

DENTAL BENEFITS

Regular dental checkups do more for your well-being than just preserve a healthy smile. ATW's dental coverage will provide you and your family affordable options for overall health. Coverage is available from MetLife.

Dental Premiums & Plan Summary

Premium contributions for dental will be deducted from your paycheck on a pre-tax basis. Your tier of coverage will determine your weekly premium. The chart below gives a summary of the 2019 dental coverage provided by MetLife.

	DENTAL PPO		
	WEEKLY (52)	BI-WEEKLY (26)	SEMI-MONTHLY (24)
EMPLOYEE CONTRIBUTIONS			
EMPLOYEE ONLY	$4.91	$9.82	$10.64
EMPLOYEE + SPOUSE	$10.19	$20.38	$22.08
EMPLOYEE + CHILD(REN)	$12.52	$25.04	$27.13
EMPLOYEE + FAMILY	$18.75	$37.50	$40.63

	IN-NETWORK	OUT-OF-NETWORK**
CALENDAR YEAR DEDUCTIBLE		
INDIVIDUAL	$50	
FAMILY	$150	
CALENDAR YEAR MAXIMUM		
PER PERSON	$1,250	
COVERED SERVICES (YOU PAY)		
PREVENTIVE SERVICES	0%	0%
BASIC SERVICES	20%*	20%*
MAJOR SERVICES	50%*	50%*
ORTHODONTICS (Children to age 19)	50%	50%
ORTHODONTIC LIFETIME MAXIMUM	$1,000	

*After deductible
**All out-of-network services are subject to Reasonable and Customary (R&C) limitations

You will not receive an ID card for Dental benefits. In order to access the Plan, you will need to provide either your social security number or group number at your provider's office so they can verify eligibility. If preferred, you can download and print an ID card at www.metlife.com/mybenefits.

Network Dentists

If you choose to 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 MetLife at www.metlife.com (select PDP Plus Network). You can also go to www.metlife.com/mybenefits and enter American Trailer World as the company name or call MetLife at 800-438-6383.

For more information, call 833-532-6892 (toll-free) or visit atw.mybenefitslibrary.com.

VISION BENEFITS

Even those with perfect eyesight should have their vision checked on a regular basis. To ensure that you and your family have access to quality vision care, ATW offers a comprehensive vision benefit provided by Superior Vision.

Vision Premiums & Plan Summary

Premium contributions for vision will be deducted from your paycheck on a pre-tax basis. Your tier of coverage will determine your weekly premium. The chart below gives a summary of the 2019 vision coverage provided by Superior Vision. All out-of-network services are subject to the fee schedule allowances.

	VISION		
	WEEKLY (52)	BI-WEEKLY (26)	SEMI-MONTHLY (24)
EMPLOYEE CONTRIBUTIONS			
EMPLOYEE ONLY	$1.75	$3.51	$3.80
EMPLOYEE + SPOUSE	$2.98	$5.96	$6.46
EMPLOYEE + CHILD(REN)	$3.16	$6.31	$6.84
EMPLOYEE + FAMILY	$4.74	$9.48	$10.27

	VISION	
	IN-NETWORK	OUT-OF-NETWORK
COVERED MATERIALS		
LENSES		
SINGLE VISION LENSES	$25 copay	Up to $26
BIFOCAL LENSES	$25 copay	Up to $34
TRIFOCAL LENSES	$25 copay	Up to $50
FRAMES		
RETAIL FRAME EQUIVALENT	$150 allowance	Up to $60
CONTACT LENSES		
ELECTIVE	$175 allowance	Up to $100
NECESSARY	Covered in full	Up to $210
EXAMS		
EXAM (Opthalmologist)	$10 copay	Up to $42
EXAM (Optometrist)	$10 copay	Up to $37
CONTACT LENS FITTING	$25 copay	Not covered
BENEFIT FREQUENCY		
EXAMINATION	Once every 12 months	
LENSES	Once every 12 months	
FRAMES	Once every 12 months	
CONTACTS (in lieu of Lenses and Frames)	Once every 12 months	

Look!

Eye doctors are often the first health care professionals to detect chronic systemic diseases such as high blood pressure and diabetes.

For more information, call 833-532-6892 (toll-free) or visit atw.mybenefitslibrary.com.

SURVIVOR BENEFITS

It's not always easy to talk with your family about how they'll be provided for if you weren't around, but it's an important conversation to have. Survivor benefits provide financial assistance in an absence, and can help you plan for the unexpected. If you secure Life insurance now, chances are you can take comfort in knowing that those who depend on you will be provided for.

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

Life and AD&D benefits are essential to your family's financial security. As such, it is important to understand how your plan works and what benefits you will receive. Basic Life and AD&D benefits are provided to you as a part of your basic coverage. ATW provides employees with Basic Life and AD&D insurance through MetLife, 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 $20,000. If you are a full-time employee, you automatically receive Life and AD&D insurance even if you elect to waive other coverage.

Beneficiary Designation

A 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 ATW. You receive the benefit payment for a dependent's death under the MetLife insurance.

Make sure your beneficiary designation is clear so there is no question as to your intentions, and remember to name a primary and contingent beneficiary. When naming your beneficiary(ies), please indicate their full name, address, Social Security number, relationship, date of birth and distribution percentage. If the beneficiary is not legally related, insert the words "Not Related" in the relationship field.

If you name more than one beneficiary with unequal shares, please show the amount of insurance to be paid to each beneficiary in percentages. If you need assistance, contact Human Resources or your own legal counsel.

Look!

Your beneficiary doesn't have to be a person. A trust, or a legal agreement that lets you place property under the control of a trust manager, can be named the beneficiary. The beneficiary can also be a charity or simply your estate.

For more information, call 833-532-6892 (toll-free) or visit atw.mybenefitslibrary.com.

Life and AD&D Insurance

Eligible employees may purchase Voluntary Life and AD&D insurance for themselves and their families. Voluntary Life and Voluntary AD&D are independent elections. You have the option to elect one or the other or both, with different election amounts. However, you must elect coverage for yourself in order to elect coverage for your family. Premiums are paid through payroll deductions. Both Basic Life and Voluntary Life policies are subject to a benefit reduction schedule beginning at age 65.

BASIC LIFE/AD&D	
COVERAGE AMOUNT	$20,000
WHO PAYS	ATW
BENEFITS PAYABLE	If you die, lose a limb or suffer paralysis in an accident
MAXIMUM BENEFIT	$20,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	N/A
VOLUNTARY EMPLOYEE LIFE	
COVERAGE AMOUNT	$10,000 increments
WHO PAYS	Employee
BENEFITS PAYABLE	In event of your death. This benefit is in addition to the Basic Life benefit.
MAXIMUM BENEFIT	5x salary or $500,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	Elections exceeding the guarantee issue amount of $150,000 when first eligible, any increase to current benefit or elections outside of initial eligibility period.
VOLUNTARY SPOUSE LIFE	
COVERAGE AMOUNT	$5,000 increments
WHO PAYS	Employee
BENEFITS PAYABLE	In the event of your spouse's death.
MAXIMUM BENEFIT	$100,000 not to exceed 50% of employee elected amount
EVIDENCE OF INSURABILITY (EOI) REQUIRED	Elections exceeding the guarantee issue amount of $50,000 when first eligible, any increase to current benefit or elections outside of initial eligibility period.
VOLUNTARY CHILD LIFE	
COVERAGE AMOUNT	$10,000
WHO PAYS	Employee
BENEFITS PAYABLE	In the event of your child's death
MAXIMUM BENEFIT	$10,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	N/A
VOLUNTARY AD&D	
COVERAGE AMOUNT	Same coverage options and Maximum Benefits as the Voluntary Life
WHO PAYS	Employee
BENEFITS PAYABLE	If you or your covered dependent die, lose a limb or suffer paralysis in an accident
MAXIMUM BENEFIT	100% of supplemental life benefit
EVIDENCE OF INSURABILITY (EOI) REQUIRED	N/A

Annual Enrollment

Employees and Spouses currently enrolled in the Voluntary Life plan may increase their benefit by one increment up to the guarantee issue without supplying Evidence of Insurability (EOI). EOI will be required for any increases above one increment (or if the increment increase exceeds the guarantee issue) as well as for all elections outside of initial eligibility period. The EOI must be approved by MetLife prior to the benefit becoming active.

Life and AD&D Insurance Premium Rates

VOLUNTARY LIFE INSURANCE		
RATES/$1,000 (MONTHLY)		
EMPLOYEE AGE (AS OF JANUARY 1, 2019)	EMPLOYEE	SPOUSE
Less than 30	$0.06	$0.06
30–34	$0.08	$0.08
35–39	$0.11	$0.11
40–44	$0.14	$0.14
45–49	$0.24	$0.24
50–54	$0.36	$0.36
55–59	$0.61	$0.61
60–64	$1.01	$1.01
65–69*	$1.27	$1.27
70+*	$2.06	$2.06

*Benefits subject to age reduction schedule.

VOLUNTARY AD&D INSURANCE	
PREMIUM RATES – $1,000 (MONTHLY)	
Employee	$0.033
Spouse/Child(ren)	$0.030

VOLUNTARY CHILD LIFE INSURANCE	
PREMIUM RATES – $1,000 (MONTHLY)	
Child(ren)	$0.180

The above rates are based on a Monthly basis. If you are paid on a different payroll cycle, this will need to be converted.

- Monthly rate X 12 / 52 = **Weekly rate**
- Monthly rate X 12 / 26 = **Bi-Weekly rate**
- Weekly rate X 52 / 24 = **Semi-Monthly rate**

TO CALCULATE HOW MUCH YOUR VOLUNTARY LIFE/AD&D COVERAGE WILL COST:

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

GRIEF COUNSELING

All benefits eligible employees and their dependents have access to five confidential counseling sessions per event — either face-to-face or by telephone. Counselors are available nationwide and are highly credentialed licensed professionals with extensive experience working with people who have suffered a loss. To schedule a call with a grief counselor call 888-319-7819 or log on to metlifegc.lifeworks.com (Username: metlifeassist; Password: support).

FUNERAL DISCOUNTS AND PLANNING SERVICES

Benefit eligible employees and their spouses/extended family will have also access to discounted Funeral Planning services through MetLife Advantages℠ and provided by Dignity Memorial as part of the basic benefits package. For detailed information call 866-853-0954 or visit www.finalwishesplanning.com.

INCOME PROTECTION

ATW offers disability coverage to protect you against any debilitating injury. This insurance protects a portion of your income until you can return to work, or until you reach retirement age.

Short Term Disability (STD) Insurance

Short Term Disability (STD) benefits are available to you through MetLife on a voluntary basis. STD insurance replaces a portion of your income if you become partially or totally disabled for a short period of time. You have the option to select between $50 to $1,000 a week in $25 increments up to 60% of your pre-disability earnings. Certain exclusions, along with any pre-existing condition limitations, may apply. Please refer to your plan documents for details or contact Human Resources for specific benefits.

WEEKLY MAXIMUM BENEFIT	$1,000
ELIMINATION PERIOD	14 days
MAXIMUM BENEFIT PERIOD	26 weeks

You are eligible to elect this plan without medical questions (guaranteed issue). If your income increases from year-to-year, you must re-elect coverage in order to receive a higher benefit.

VOLUNTARY STD INSURANCE	
AGE (AS OF JANUARY 1, 2019)	
AGE RANGE	MONTHLY RATE PER $10 OF WEEKLY BENEFIT
Less than 30	$0.52
30–34	$0.67
35–39	$0.68
40–44	$0.57
45–49	$0.73
50–54	$1.46
55–59	$1.78
60–64	$2.31
65–69	$2.50
70+	$2.91

The above rates are based on a Monthly basis. If you are paid on a different payroll cycle, this will need to be converted.

- Monthly rate X 12 / 52 = **Weekly rate**
- Monthly rate X 12 / 26 = **Bi-Weekly rate**
- Weekly rate X 52 / 24 = **Semi-Monthly rate**

TO CALCULATE HOW MUCH YOUR STD COVERAGE WILL COST:									
$	÷ 52 =	$	x 60%	$	x Rate	$	÷ $10	$	
Annual Salary		Weekly Income		Weekly Benefit		Amount		Monthly Premium	

ADDITIONAL BENEFITS

Identity Theft Protection

Access to identity theft protection is available on a voluntary basis. In an always-on, ever-connected world, the risk of identity theft is real. There is a new identity fraud victim every two seconds. You can help protect yourself with LifeLock. LifeLock's identity theft coverage monitors millions of transactions every second, alerting you to suspicious activity by text, phone or email. This protection is different than free credit monitoring and offers a full set of features to help proactively protect you and your covered family members against identity theft.

	BENEFIT ELITE			ULTIMATE PLUS		
LIFELOCK IDENTITY ALERT® SYSTEM	✔			✔		
LOST WALLET PROTECTION	✔			✔		
ADDRESS CHANGE VERIFICATION	✔			✔		
BLACK MARKET WEBSITE SURVEILLANCE	✔			✔		
REDUCED PRE-APPROVED CREDIT CARD OFFERS	✔			✔		
LIVE MEMBER SERVICE SUPPORT	✔			✔		
IDENTITY RESTORATION SUPPORT	✔			✔		
$1 MILLION TOTAL SERVICE GUARANTEE	✔			✔		
FICTITIOUS IDENTITY MONITORING	✔			✔		
COURT RECORDS SCANNING	✔			✔		
DATA BREACH NOTIFICATION	✔			✔		
INVESTMENT ACCOUNT ACTIVITY ALERTS	✔			✔		
CREDIT CARD, CHECKING & SAVINGS ACCOUNT ACTIVITY ALERTS				✔		
ONLINE TRI-BUREAU ANNUAL CREDIT REPORTS				✔		
ONLINE TRI-BUREAU ANNUAL CREDIT SCORE				✔		
CHECKING & SAVINGS ACCOUNT APPLICATION ALERTS				✔		
BANK ACCOUNT TAKEOVER ALERTS				✔		
CREDIT INQUIRY ALERTS				✔		
MONTHLY CREDIT TRACKING				✔		
FILE-SHARING NETWORK SEARCHES				✔		
SEX OFFENDER REGISTRY REPORTS				✔		
PRIORITY MEMBER SERVICE SUPPORT				✔		
	WEEKLY (52)	BI-WEEKLY (26)	SEMI-MONTHLY (24)	WEEKLY (52)	BI-WEEKLY (26)	SEMI-MONTHLY (24)
EMPLOYEE ONLY	$1.84	$3.69	$4.00	$5.54	$11.07	$12.00
EMPLOYEE + FAMILY	$3.69	$7.38	$7.99	$11.07	$22.14	$23.99

This plan is available via payroll deduction and is yours to keep if you retire or no longer work for ATW.

Employee Assistance Program

American Trailer World cares about you and your family's total health management — mental, emotional and physical. For that reason, we provide an Employee Assistance Program (EAP) at no cost to you.

Whether you are interested in work/life resources, mental health assistance, or legal and financial advice, the EAP service can connect you and members of your household with a variety of professionals. With just one phone call, at any hour of the day or night, you can have access to helpful resources. The EAP benefit includes three face-to-face visits per issue with a licensed professional. All services provided are confidential and will not be shared with American Trailer World. You may also access information, benefits, educational materials and more either by phone at 888-319-7819 or online at metlifeeap.lifeworks.com, user name: metlifeeap and password: eap.

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
- Identity Theft Recovery Services

RETIREMENT PLANNING

It's never too early — or too late — to start planning for your retirement. Making contributions to a 401(k) account is the first step toward achieving financial security later in life. The ATW 401(k) plan provides you with the tools and flexibility you need to retire comfortably and securely.

Eligible employees can invest for retirement while receiving certain tax advantages. Effective January 1, 2019, ATW will match 100% on the first 3% and 50% on the next 2% of your salary you contribute. Administrative and record-keeping services for this plan are provided by Fidelity Investments.

Eligibility

You may start making pre-tax contributions into the plan on the first of the month following 90 days of hire. The company match will begin after 6 months of service.

Contributing to the Plan

Deferred contributions are based on a flat dollar amount not to exceed plan limits set by the IRS. The limit for 2019 is $18,500.

Catch-up Contributions

If you are or will be age 50 or older during this calendar year and you already contribute the maximum allowed to your 401(k) account, you may also make a "catch-up contribution." This additional deposit of funds accelerates your progress toward your retirement goals. The maximum catch-up contribution is $6,000 for 2019 — for a combined total contribution allowance of $24,500. See your plan administrator for more details.

Please note: The 401(k) enrollment will be a separate enrollment process from all other benefits.

Changing or Stopping Your Contributions

You may change the amount of your contributions any time. All changes will become effective as soon as administratively feasible and will remain in effect until you modify them. You may also discontinue your contributions any time. If you stop making contributions, you may start again at any time.

Investing in the Plan

You decide how to invest the assets in your account. The ATW 401(k) plan offers a selection of investment options for you to choose from. You may change your investment choices any time. For more details, refer to your 401(k) Enrollment Guide.

Look!

If you dip into your 401(k) account before age 59 1/2, you will pay a 10% early withdrawal penalty—in addition to income tax—on the amount.

For more information, call 833-532-6892 (toll-free) or visit atw.mybenefitslibrary.com.

GLOSSARY

Coinsurance – Your share of the cost of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service, typically after you meet your deductible. For instance, if your plan's allowed amount for an office visit is $100 and you've met your deductible (but haven't yet met your out-of-pocket maximum), your coinsurance payment of 20% would be $20. Your plan sponsor or employer would pay the rest of the allowed amount.

Consumer-Driven Health Plan (CDHP) – A plan option that provides choice, flexibility and control when it comes to spending money on health care. Preventive care is covered at 100% with in network providers, and all qualified employee-paid medical expenses count toward your deductible and your out-of-pocket maximum.

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

Deductible – The amount you owe for health care services before your health insurance or plan sponsor (employer) begins to pay its portion. For example, if your deductible is $2,700, your plan does not pay anything until you've met your $2,700 deductible for covered health care services. This deductible may not apply to all services, including preventive care.

Employee Contribution – The amount you pay for your insurance coverage.

Explanation of Benefits (EOB) – A statement sent by your insurance carrier that explains which procedures and services were provided, how much they 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. These statements are also posted on the carrier's website for your review.

Health Care Cost Transparency – Also known as Market Transparency or Medical Transparency. Healthcare provider costs can vary widely, even within the same geographic area. To make it easier for you to get the most cost-effective healthcare products and services, online cost transparency tools, which are typically available through health insurance carriers, allow you to search an extensive national database to compare costs for everything from prescription drugs and office visits to MRIs and major surgeries.

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

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

- **In-Network –** In-network providers are doctors that contract with your insurance company to provide healthcare services at discounted rates.
- **Out-of-Network –** Out-of-network providers are doctors that are not contracted with your insurance company. If you choose an out-of-network doctor, services will not be provided at a discounted rate.
- **Non-Participating –** Providers that have declined entering into a contract with your insurance company.

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

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

Prescription Medications – Medications prescribed to you by a doctor. Cost of these medications is determined by their assigned tier: generic, preferred, non-preferred or specialty.

- **Generic Drugs –** Drugs approved by the U.S. Food and Drug Administration (FDA) to be chemically identical to corresponding preferred or non-preferred versions. The color or flavor of a generic medicine may be different, but the active ingredient is the same. Generic drugs are usually the most cost-effective version of any medication.
- **Preferred Drugs –** Brand-name drugs on your provider's list of approved drugs. You can check online with your provider to see this list.
- **Non-Preferred Drugs –** Brand-name drugs not on your provider's list of approved drugs. These drugs are typically newer and have higher copayments.
- **Specialty Drugs –** Prescription medications used to treat complex, chronic and often costly conditions such as multiple sclerosis, rheumatoid arthritis, hepatitis C and hemophilia. Because of the high cost of these specialty drugs, many insurers require that specific criteria be met before a drug is covered. These requirements often include:
  - Performing a prior authorization to request coverage of the medication
  - Having a specific disease that the drug is FDA-approved to treat
  - Having a history of trying and failing cheaper medications
  - Creating high out-of-pocket costs when purchasing the medication
  - Restricting what pharmacy can dispense these medications
- **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) – 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 UCR amount sometimes is used to determine the allowed amount.

Summary of Benefits and Coverage (SBC) – Mandated by health care reform, your insurance carrier or plan sponsor will provide you with a clear and easy to follow summary of your benefits and plan coverage.

Required Notices

Important Notice from ATW About Your Prescription Drug Coverage and Medicare under the GPA 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 ATW 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. ATW has determined that the prescription drug coverage offered by the GPA 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 ATW 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 ATW 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 ATW 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.

Important Notice from ATW About Your Prescription Drug Coverage and Medicare under the Century Healthcare MEC 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 ATW 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three 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. ATW has determined that the prescription drug coverage offered by the Century Healthcare MEC plan is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the ATW plan. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.

3. You can keep your current coverage from ATW. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.

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 decide to drop your current coverage with ATW, since it is employer/union sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however you also may pay a higher premium (a penalty) because you did not have creditable coverage under the ATW 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 ATW 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 ATW 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?

Since the coverage under ATW is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, 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 (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 ATW 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:	January 1, 2019
Name of Entity/Sender:	ATW
Contact—Position/Office:	Human Resources
Address:	1701 N. Plano Road, Suite 120 Richardson, TX 75081
Phone Number:	903-575-0300

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act of 1998 was signed into law on October 21, 1998. The Act requires that all group health plans providing medical and surgical benefits with respect to a mastectomy must provide coverage for all of the following:

- Reconstruction of the breast on which a mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of all stages of mastectomy, including lymphedema

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions which apply for the mastectomy. For deductibles and coinsurance information applicable to the plan in which you enroll, please refer to the summary plan description or contact Human Resources at 903-575-0300.

HIPAA Privacy and Security

The Health Insurance Portability and Accountability Act of 1996 deals with how an employer can enforce eligibility and enrollment for health care 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. The Notice of Privacy Practices has been recently updated. 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 903-575-0300.

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 903-575-0300.

IMPORTANT CONTACTS

COVERAGE	CONTACT	
MEDICAL	GPA 800-827-7223 www.gpatpa.com Policy #: H870488	Telemedicine - Teladoc (Available to PPO and CDHP Medical Plan Participants) 800-835-2362 www.teladoc.com
MEDICAL – MEC	Century Healthcare 877-685-2432 www.centuryhealthcare.com	Telemedicine - Healthiest You (Available to MEC Plan participants). 866 -703-1259 member.healthiestyou.com
PHARMACY	Rx Benefits 800-334-8134 RxHelp@rxbenefits.com	
DENTAL	MetLife 800-942-0854 www.metlife.com/mybenefits Policy #: 210967	
VISION	Superior Vision 800-507-3800 www.superiorvision.com Policy #: 36534	
HEALTH SAVINGS ACCOUNT	Optum Bank 866-234-8913 www.optumbank.com	
LIFE AND AD&D	MetLife 800-638-6420 www.metlife.com/mybenefits Policy #: 210967	
DISABILITY	MetLife 800-858-6506 www.metlife.com/mybenefits Policy #: 210967	
SUPPLEMENTAL MEDICAL (ACCIDENT, CRITICAL ILLNESS, HOSPITAL INDEMNITY)	MetLife 866-626-3705 www.metlife.com/mybenefits	
LIFELOCK	Pre-enrollment: 866-917-2555 Enrolled employee: 800-607-9174 www.lifelock.com	
UNIVERSAL LIFE	Trustmark 800-396-2960 www.Trustmark.com	
EAP	888-319-7819 metlifeeap.lifeworks.com user name: metlifeeap and password: eap	
BENEFITS INFORMATION LINE	833-532-6892 atw.mybenefitslibrary.com	

For more information, call 833-532-6892 (toll-free) or visit atw.mybenefitslibrary.com.

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