EMPLOYEE BENEFITS GUIDE

Cherokee General Corporation

Doyon Project Services

Doyon Management Services

Doyon Technical Services

Doyon Logistics Services

Arctic IT
Tenacious Ingenuity™

2021

WELCOME TO YOUR BENEFITS!

We are proud to offer a robust benefits package to our employees and their families! Our benefits package is designed around choice, flexibility and value.

To learn about the available plans and choose which ones are right for your lifestyle and budget, take a look at this Benefits Guide. Highlights of all the plans and some additional decision-making tools are available online too. If you have general questions on your benefits or how to enroll, reach out to Human Resources or a Gallagher Benefit Advocate—their contact info is toward the back of this Guide under "Your Benefits Contacts."

In addition, a Summary of Benefits and Coverage (SBC) is available to help you make your healthcare coverage choices. The SBC summarizes information about your medical plan options and is in a standard format required by the Affordable Care Act.

The SBC is available on the PlanSource website. Your insurance plan booklets, Summary Plan Descriptions, and other benefit materials will be posted on the PlanSource website as well.

IMPORTANT:
If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, federal law gives you more choices about your prescription drug coverage. Please see page 23 for more details.

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NEW HIRE ENROLLMENT OVERVIEW

***For newly eligible employees*. Please follow the steps below to choose your benefits and enroll.**

BENEFIT PLANS

- A choice of two medical plans covering a broad network of doctors nationwide
  - Both plans have health spending accounts to help you pay for eligible health care expenses
    - Health Savings Account (HSA) for tax savings on healthcare expenses with company contribution
    - Health Reimbursement Account (HRA) funded by your company
- Prescription drug benefit with three levels of co-pays
- Voluntary dental benefit with $1,000 per year available for dental expenses and $1,000 lifetime orthodontia benefit for adults and children
- Vision benefit covering expenses for glasses, contacts and routine eye exams
- Short and Long Term Disability, Life & AD&D
- Voluntary Life & AD&D insurance option
- Employee Assistance Program
- Flexible Spending Account
- 401k

QUESTIONS

Contact DGG HR

DGGHR@doyongovgrp.com

1. PREPARE EVERYTHING YOU WILL NEED

- Social Security numbers for you and any family members whom you want to cover
- Dates of birth for your family members
- ID cards for any other medical plans under which you or your family members are covered

2. CHOOSE YOUR BENEFITS

Take the time to review the benefit outlines in this Guide and the Summary of Benefits and Coverage from the insurance company. This will help you understand the plans and how they will fit your lifestyle and budget. To make sure your family doctor and dentist are covered by the plans you have chosen, check the Provider Directory online or call customer service (see "Your Benefits Contacts" toward the back of this Guide).

During New Hire enrollment, you have the opportunity to enroll in Voluntary Life insurance with a guarantee issue. If offered Voluntary Life before and declined and you want to enroll during Open Enrollment, any all amounts require Evidence of Insurability/approval. Generally, all AD&D is guarantee issue since it is accident coverage. By nature of an accident, there are not pre-existing concerns.

3. DECIDE HOW MUCH TO CONTRIBUTE TO FLEXIBLE SPENDING ACCOUNTS (FSA) OR HEALTH SAVINGS ACCOUNT (HSA)

Calculate how much money you should put into these pre-tax accounts to save on taxes when paying for healthcare, dependent care prior to enrollment.

4. COMPLETE ONLINE ENROLLMENT

See Human Resources for details to access PlanSource at https://benefits.plansource.com/

Note: If you wish to waive coverage you must do so online with proof of insurance.

IMPORTANT

Enrollment timeline may vary in certain situations. See "Special Enrollment Rights" on pages 12 & 13.

5. YOU ARE DONE!

ELIGIBILITY

All regular full-time employees scheduled to work 30 or more hours each week are eligible for benefits. Coverage will begin on the first of the month following date of hire. You may enroll your eligible dependents for medical, dental, and vision. They are also eligible to receive Employee Assistance Program (EAP) services. Your eligible dependents include:

- Your legal spouse or domestic partner
- Your children up to age 26
- Any overage dependent adult child who is incapable of self-support because of a physical or mental disability and meets carrier requirements for coverage

MAKING CHANGES TO YOUR BENEFITS

You may make changes to your benefits once a year during Open Enrollment. All benefits you select will be effective for a full calendar plan year, unless you have a "qualified change in status" or are no longer eligible under the plan (e.g. leave employment). Because many of your benefits are available on a pre-tax basis, the IRS requires you to have a qualified change in status in order to make changes to your benefit elections during the year.

If you have a qualified change in status, you can make changes to your benefits by logging into PlanSource and electing a life event within 30 days of the change. The change to your benefits must be consistent with the qualified change in status. For example, if you have a new baby, you can enroll the child as a dependent under your current health plan, but you may not remove another dependent who is already covered. To determine if your situation allows you to make changes to your benefits, please contact Human Resources or a Gallagher Benefit Advocate.

QUALIFIED CHANGE IN STATUS EXAMPLES

- Birth or adoption of a child
- Loss of your or a dependent's coverage under another plan
- Change in marital status

MEDICAL BENEFITS

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. The company offers you a choice of two PPO medical plans through United Healthcare, supported by a very large network of medical care providers. These plans provide excellent coverage of preventive services, such as routine physical exams and immunizations, that are very important to your and your family's health. Prescription drug benefits are also included with the medical plan.

PPO WITH HRA

This PPO plan offers a wide choice of providers. You can choose to use a provider in the Choice Plus network or any other provider for your healthcare services. If you choose a network provider, your cost will be less. You do not need a referral for specialist care. You can find PPO providers online or by phone. See contact information in the back of this guide.

The HRA medical plan, excluding Alaska, must use in-network providers only. The network to search for providers is called Choice Plus. If a out-of-network provider is used then services will not be covered.

This plan has a Health Reimbursement Account (HRA) that is an employer owned account that can be used for eligible health care expenses. More information is on page 11.

HSA PLAN

The HSA Plan has the same network of providers as the PPO with HRA Plan explained above. The main difference is the deductible applies for most services (with the exception of preventive care and certain preventive medications).

The HSA medical plan, excluding Alaska, must use in-network providers only. The network to search for provides is called Choice Plus. If a out-of-network provider is used then services will not be covered.

A Health Savings Account (HSA) allows you to set aside money pre-tax to pay for healthcare expenses. Money in your HSA is yours and any unused amounts will roll-over every year. In addition, the company contributes $750 annually for individual coverage and $1500 for family coverage, to your HSA on your behalf for employees who enroll in the HSA Plan. More information on the Health Savings is on page 10.

WHAT IF I DON'T WANT COVERAGE?

If you already have other health insurance (i.e. through your spouse's employer), you may elect to opt out of health/vision coverage. Upon proof of other insurance coverage, you are eligible to receive $150 per month.

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COPAY & COINSURANCE

A copay is a flat dollar amount you pay for a medical service. Coinsurance is when you pay a percentage of the cost.

CALENDAR YEAR DEDUCTIBLE

This is the amount you pay before your plan begins covering expenses not subject to a copay. The family deductible applies if you have family members enrolled in your plan along with you. However, once the total family deductible is met, no one else in the family has to pay the balance of their deductible.

OUT-OF-POCKET (OOP) MAXIMUM

The OOP maximum is the most you pay in a calendar year for in-network covered medical services. Once the OOP maximum is met, the plan will pay 100% of the allowed amount for the remainder of the calendar year for in-network covered services. On a family plan, each person has their own OOP maximum.

OUT-OF-NETWORK

When you use out-of-network providers, your plan will pay for services based upon their allowed amount. You will be responsible for the remaining costs. When you use out-of-network services, your plan will only pay a percentage of the allowable amount. You may be responsible for the balance.

MEDICAL BENEFITS – PLAN HIGHLIGHTS
HRA

PCY = Per Calendar Year (January 1-December 31)	Non-Alaska HRA Medical Plan	Alaska HRA Medical Plan	
	In-Network Only	**In-Network**	**Out-of-Network**
Annual Deductible (individual/family)	$5,000/$10,000	$3,000/$6,000	$3,000/$6,000
HRA Funding (individual/family)	(Must satisfy a $1,500/$3,000 deductible before funds from the HRA are available) $3,500/$7,000	(Must satisfy a $1,500/$3,000 deductible before funds from the HRA are available) $1,500/$3,000	
Coinsurance (what you pay)	20%	20%	20% outpatient 50% inpatient
Annual Out-of-Pocket Maximum (individual/family)	$6,750/$13,000	$6,000/$12,000	$6,000/$12,000
Preventive Care	Covered in full	Covered in full	Covered in full
Primary Visits	$25 per visit	$30 per visit	$30 per visit
Specialist Visits	$50 per visit	$30 per visit	$30 per visit
Virtual Visits	$10 per visit	$10 per visit	20% after deductible
Mental Health	Covered in full	$30 per visit	$30 per visit
Diagnostic Lab & X-Ray	20%	20%	20%
Surgery	20% after deductible	20% after deductible	20% after deductible
Rehabilitation *Physical, Occupational, Massage, Speech, Pulmonary Rehab, Cardiac Rehab, Post-Cochlear Implant Aural, and Cognitive Rehab Therapies*	$25 per visit 20-36 visits combined PCY (depends on service)	$30 per visit 20-36 visits combined PCY (depends on service)	$30 per visit
Other Services			
Chiropractic Care	$25 per visit 20 visits combined PCY	$30 per visit 20 visits combined PCY	$30 per visit
Acupuncture	$25 per visit 12 visits combined PCY	$30 per visit 12 visits combined PCY	$30 per visit
Urgent Care	$25 per visit	$50 per visit	$50 per visit
Emergency Room	20% after deductible	20% after deductible	
Inpatient Hospitalization • Rehabilitation	20% after deductible Up to 60 days PCY	20% after deductible Up to 60 days PCY	50% after deductible

Important Note: Network benefits for virtual visits are available only when services are delivered through a Designated Virtual Visit Network Provider (except for the Alaska plan). Access to Virtual Visits and prescription services may not be available in all states or for all groups.

Limitations: This benefit outline is for illustrative purposes only. Actual claims paid are subject to maximum allowable charge, frequencies, age limitations, terms and conditions of the contract.

MEDICAL BENEFITS – PLAN HIGHLIGHTS HSA

PCY = Per Calendar Year (January 1-December 31)	Non-Alaska HSA Medical Plan	Alaska HSA Medical Plan	
	In-Network Only	**In-Network**	**Out-of-Network**
Annual Deductible (individual/family)	$1,500/$3,000*	$1,500/$3,000*	$1,500/$3,000*
HSA Funding by your employer (individual/family)	$750/$1,500	$750/$1,500	
Coinsurance (what you pay)	20%	20%	20%-50%
Annual Out-of-Pocket Maximum (individual/family)	$3,000/$6,000	$4,500/$9,000	Unlimited
Preventive Care	Covered in full	Covered in full	Covered in full
Primary Visits	20% after deductible	20% after deductible	20% after deductible
Specialist Visits	20% after deductible	20% after deductible	20% after deductible
Virtual Visits	20% after deductible	20% after deductible	20% after deductible
Mental Health	20% after deductible	20% after deductible	20% after deductible
Diagnostic Lab & X-Ray	20% after deductible	20% after deductible	20% after deductible
Surgery	20% after deductible	20% after deductible	20% after deductible
Rehabilitation *Physical, Occupational, Massage, Speech, Pulmonary Rehab, Cardiac Rehab, Post-Cochlear Implant Aural, and Cognitive Rehab Therapies*	20% after deductible 20-36 visits combined PCY (depends on service)	20% after deductible 20-36 visits combined PCY (depends on service)	20% after deductible
Other Services			
Chiropractic Care	20% after deductible 20 visits combined PCY	20% after deductible 20 visits combined PCY	20% after deductible
Acupuncture	20% after deductible 12 visits combined PCY	20% after deductible 12 visits combined PCY	20% after deductible
Urgent Care	20% after deductible	20% after deductible	20% after deductible
Emergency Room	20% after deductible	20% after deductible	
Inpatient Hospitalization • Rehabilitation	20% after deductible Up to 60 days PCY	20% after deductible Up to 60 days PCY	50% after deductible

*If more than one member is enrolled on your plan, the family deductible must be met before any member receives benefits.

Important Note: Network benefits for virtual visits are available only when services are delivered through a Designated Virtual Visit Network Provider (except for the Alaska plan). Access to Virtual Visits and prescription services may not be available in all states or for all groups.

Limitations: This benefit outline is for illustrative purposes only. Actual claims paid are subject to maximum allowable charge, frequencies, age limitations, terms and conditions of the contract.

MEDICAL BENEFITS – RESOURCES

CARE24 SERVICE

Care24 is a health and well-being concierge service in which members are connected with a single point who guides them to clinical, wellness, financial, legal or counseling resources through NurseLineSM – 24 hours a day, seven days a week.

Available services:

- Help finding a doctor
- Speak directly with Registered Nurses or master's level specialists or Nurse Chat online
- Health coaching
- Other assistance programs

Care24 Services call 1.888.887.4114 or www.myuhc.com

VIRTUAL VISITS

When you don't feel well, or your child is sick, the last thing you want to do is leave the comfort of home to sit in a waiting room. A virtual visit lets you see and talk to a doctor from your mobile device or computer without an appointment.

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

- Cold/flu
- Sinus problems
- Sore throat
- Stomach ache

Access virtual visits:

Log in to myuhc.com® and choose from provider sites where you can register for a virtual visit. After registering and requesting a visit you will pay your portion of the service costs according to your medical plan, and then you will enter a virtual waiting room. During your visit you will be able to talk to a doctor about your health concerns, symptoms and treatment option.

PRESCRIPTION DRUG BENEFITS

Your plan includes a comprehensive prescription drug program. The level of coverage depends on whether the drug is generic or brand, and whether it is on the United Healthcare formulary or preferred drug list. Your out-of-pocket cost is lowest when you buy Tier 1 drugs and highest when you buy Tier 3 drugs that are not on the formulary. The cost is illustrated below.

United Healthcare covers a broad formulary of drugs. To determine whether your drug is on the formulary, please check the online list at www.myuhc.com. There you can also find a list of in-network pharmacies. The drug list is updated periodically to ensure that newer, more effective drugs are listed. Brand name drugs are automatically removed from the formulary when generic alternatives become available.

When filling a prescription, present your United Healthcare member ID card to any participating pharmacy. If using an out-of-network pharmacy, you will need to pay the drug cost out-of-pocket and then submit a claim form to United Healthcare to be reimbursed for the covered amount.

MAIL ORDER PRESCRIPTION DRUGS- OPTUM RX

If you take prescription drugs on an ongoing, maintenance basis, you can save money by using the mail order program and ordering a 90-day supply at a time.

To take advantage of this money-saving program, download all required Mail-order forms online at: www.myuhc.com or call OptumRx.

For a personal consultation to find out if you can save, call OptumRx at the number on your member ID Card. You will receive your prescriptions by mail in about 7-10 days, delivered in sealed, insulated (when necessary) and tamper-evident packaging.

Prescription Drugs	Non-Alaska HRA Plan	Alaska HRA Plan
Retail Pharmacy (31-day supply)	*At Preferred Pharmacies*	*At Preferred Pharmacies*
• Tier 1	$15	$10
• Tier 2	$30	$30
• Tier 3	$50	$50
Mail Order (90-day supply)	2.5 x the applicable retail copay	2.5 x the applicable retail copay

Prescription Drugs	Non-Alaska HSA Plan	Alaska HSA Plan
Retail Pharmacy (31-day supply)	*At Preferred Pharmacies*	*At Preferred Pharmacies*
• Tier 1	20% after deductible	20% after deductible
• Tier 2	20% after deductible	20% after deductible
• Tier 3	20% after deductible	20% after deductible
• Tier 4	20% after deductible	20% after deductible
Mail Order (90-day supply)	20% after deductible	20% after deductible

IMPORTANT

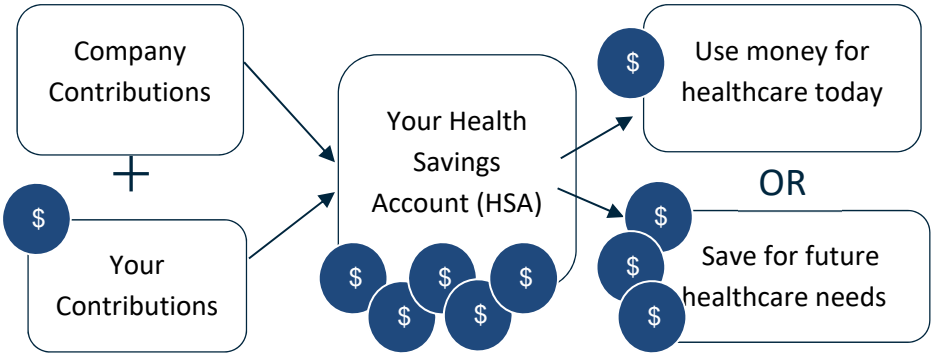
If you are prescribed a brand name drug when a generic equivalent is available, you will be charged the brand name copay, plus the difference in cost between the brand name and generic drug.

Specialty drugs are only available through a specialty pharmacy. You will be notified of the refill procedure if you are taking one of these drugs.

HEALTH SAVINGS ACCOUNT (HSA)

WHAT IS AN HSA?

If you enroll in the HDHP Medical Plan, then you may be eligible to open an Health Savings Account (HSA). An HSA is a bank account where you can set aside money to pay for expenses that your health plan does not cover. The money in your HSA is not considered income, so it is not subject to taxes.



HOW DOES AN HSA WORK?

You can use the money in your HSA at any time to pay for eligible medical expenses. When you visit a provider, no copay is required at the time of service. The provider will submit a claim to your health plan for the services you received.

Your health plan will then send you an Explanation of Benefits (EOB) outlining the negotiated/allowed charges. The provider will then send you an invoice reflecting the allowed charges. Make sure the amount matches the EOB sent to you by your health plan.

You can then pay the invoice with money from your HSA (either your HSA debit card or as a reimbursement to you). Remember to keep your receipts, in case the IRS requests them.

WHO CAN OPEN AN HSA?

You are eligible to open and contribute to an HSA if you meet the following requirements:

- You must be covered by a qualified high-deductible health plan.
- You must **not** be enrolled in or covered by Medicare or Tricare.
- You must **not** be covered by your own or a spouse's general Flexible Spending Account (FSA), Health Reimbursement Arrangement (HRA) or any other non-HSA-qualified health plan.
- You must **not** be claimed as a tax dependent on another person's taxes.
- You have **not** received any Veteran's Administration health benefits for a non-service connected disability in the last three months.
- You have **not** used Indian Health Services coverage in the last three months.

CONTRIBUTIONS

Your company contributes $750/year (employee only) or $1,500/year (family) into your HSA. You can also add your own tax-free contributions.

Together, your contributions and your company contributions cannot exceed $3,600 (individual) or $7,200 (family) in 2021.

For individuals age 55 or older, an additional $1,000 in "catch-up" contributions are allowed for 2021.

Your money rolls over every year. There is no "use it or lose it" rule.

You may change your HSA contribution anytime throughout the year.

HSA and Domestic Partners

Domestic partners are eligible to be enrolled in the HSA Medical Plan, however distributions from the HSA are only allowed if your domestic partner is an IRS qualified tax dependent. Consult your tax advisor for details.

NOTE

If you enroll in Medicare anytime in the year, you are no longer eligible to contribute to the HSA.

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

WHAT IS AN HRA?

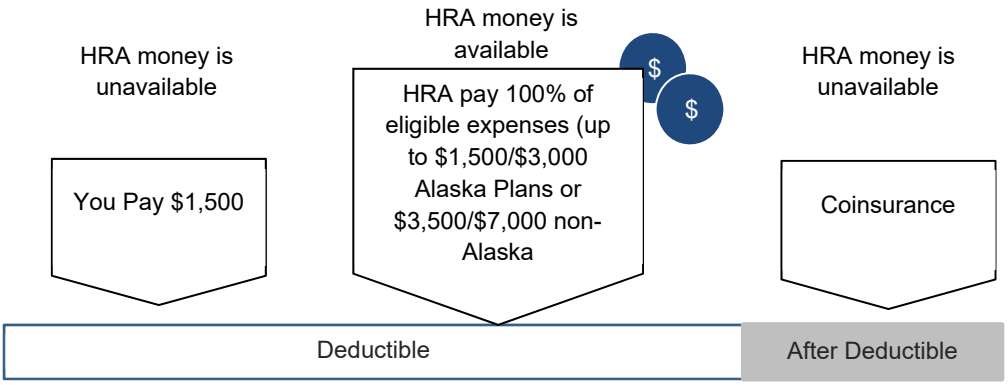
A health reimbursement arrangement (HRA) is an account funded only by your company to help pay for qualified healthcare expenses. The money in your HRA is not considered income, so it is not subject to taxes.

HOW DOES AN HRA WORK?

Each individual enrolled in the medical plan must meet a $1,500 deductible before money from the HRA is available.

Once the $1,500 deductible has been met, the HRA will pay claims subject to the deductible up to $3,500 per individual (or $1,500 on the Alaska Plan Only), but no more than $7,000 per family (or $3,000 per family on the Alaska Plan Only). Once all of the HRA money is used, any remaining claims subject to the deductible will be your responsibility.

Individual In-Network example:



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CONTRIBUTIONS

Your company contributes $3,500/year (employee only) or $7,000/year (family) into your HRA or $1,500/year (employee only) or $3,000/year (family) Alaska Plan only into your HRA

When you visit your provider, in most cases, your provider will submit a claim to your health plan for you. If your provider does not submit a claim, you'll need to do so to make sure your expenses are properly paid through your medical plan.

Your health plan will process your claim and apply any network discounts. Money from your HRA will automatically pay for eligible expenses to your provider. You will receive an Explanation of Benefits (EOB) showing what the HRA paid, any amounts you may owe and any remaining balance available in your HRA. If you owe money for the services provided, you will receive a bill from the provider.

WHAT IF I DON'T USE ALL THE MONEY IN THE HRA?

If you have any money you have not used in the HRA at the end of the year, those dollars will be forfeited.

Also, HRAs are not portable. If you leave your company, any unused money in the HRA (after all claims have been paid) will stay with your company unless you elect COBRA coverage.

HOW DO THE HSA AND HRA COMPARE

You have the choice between two medical plans. Although deductibles seem high, both have a healthcare spending accounts to help you pay for eligible expenses.

	HEALTH SAVINGS ACCOUNT (HSA)	HEALTH REIMBURSEMENT ACCOUNT (HRA)
Who owns it?	You	Company
Who Controls it?	You choose when to use it	Must satisfy first part of your deductible, then automatically used when deductible claims are incurred
Who Funds it?	Company and you (optional)	Company
Funds Available	Upon deposit into your account	January 1st or the effective date of your medical plan
Is it portable?	Yes, you own it	No
Annual Employee Contribution Limit	Including employer contribution: • Individual: $3,600 • Family: $7,200	You cannot contribute
What happens if you don't use it?	Unused balances carry over from year to year	No roll over
Does it earn interest?	Yes	No
FSA Permitted	Only Dependent Care	Yes
Debit Card?	Yes	No

IMPORTANT INFORMATION REGARDING YOUR MEDICAL BENEFITS

NON-NETWORK COSTS

The amount the plan pays for covered services provided by non-network providers is based on a maximum allowable amount for the specific service rendered. Although your plan stipulates an out-of-pocket maximum for out-of-network services, please note the maximum allowed amount for an eligible procedure may not be equal to the amount charged by your out-of-network provider. Your out-of-network provider may bill you for the difference between the amount charged and the maximum allowed amount. This is called balance billing and the amount billed to you can be substantial. The out-of-pocket maximum outlined in your policy will not include amounts in excess of the allowable charge and other non-covered expenses as defined by your plan. The maximum reimbursable amount for non-network providers can be based on a number of schedules such as a percentage of reasonable and customary or a percentage of Medicare. Contact your claims payer or insurer for more information. The plan document or carrier's master policy is the controlling document, and this Benefit Highlight does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual plan language.

ORGAN TRANSPLANT

Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational or Unproven Service. Benefits under this section include services, supplies and treatment on an inpatient or outpatient basis at a Hospital or Alternate Facility or in a Physician's office. Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Policy. Please see your plan contract booklet for further details.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

The Women's Health and Cancer Rights Act of 1998 requires group health plans that provide medical and surgical coverage for mastectomies also provide coverage for reconstructive surgery following such mastectomies in a manner determined in consultation with the attending physician and the patient.

Coverage must include:

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

Benefits for the above coverage are payable on the same basis as any other physical condition covered under the plan, including any applicable deductible and/or copays and co-insurance amounts.

SPECIAL ENROLLMENT RIGHTS – (NON-ALASKA PLANS)

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

You may also be able to enroll yourself or your dependents in the future if you or your dependents lose health coverage under Medicaid or your state Children's Health Insurance Program, or become eligible for state premium assistance for purchasing coverage under a group health plan, provided that you request enrollment within 30 days after that coverage ends or after you become eligible for premium assistance.

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 your Human Resources Department. Refer to your benefit booklet for details.

IMPORTANT INFORMATION REGARDING YOUR MEDICAL BENEFITS *(CONTINUED)*

SPECIAL ENROLLMENT RIGHTS – (ALASKA PLANS)

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

You may also be able to enroll yourself or your dependents in the future if you or your dependents lose health coverage under Medicaid or your state Children's Health Insurance Program, or become eligible for state premium assistance for purchasing coverage under a group health plan, provided that you request enrollment within 30 days after that coverage ends or after you become eligible for premium assistance.

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 your Human Resources Department. Refer to your benefit booklet for details.

HIPAA NOTICE OF PRIVACY PRACTICES REMINDER

HIPAA requires Doyon to notify its employees that a privacy notice is available from the Human Resources Department. To request a copy of Doyon's Privacy Notice or for additional information, please contact Human Resources.

HEALTHCARE REFORM & YOUR BENEFITS

Your company offers a medical plan option that provide valuable comprehensive coverage that meets the requirements of the healthcare reform law and is intended to be affordable as defined by the law. Also note, it's unlikely that you are eligible for financial help from the government to help you pay for insurance purchased through a Marketplace because you have access to an employer plan that complies with the affordability standard.

PREVENTIVE CARE

Certain preventive care services must be provided by non-grandfathered group health plans without member cost-sharing (such as deductibles or copays) when these services are provided by a network provider. Please refer to your insurance company for more information. Contact information is listed under "Your Benefits Contacts" in the back of this Guide.

COBRA

Federal COBRA is a U.S. law that applies to employers who employ 20 or more individuals and sponsor a group health plan. Under Federal COBRA you may be eligible to continue your same group health insurance for up to 18 months if your job ends or your hours are reduced. You are responsible for COBRA premium payments.

VOLUNTARY DENTAL BENEFITS

Going to the dentist isn't on anyone's list of favorite things to do, but the company dental benefits make it as painless as possible with comprehensive coverage through The Standard. You can access services from any licensed dentist you wish. However, your costs will typically be lower if you choose a Standard dentist. You can find Standard providers online. Please see the information in "Your Benefits Contacts" toward the back of this Guide.

BEFORE TREATMENT BEGINS

You should have your dentist's office contact Standard if you expect the charges to be more than $300. Your dentist's office will coordinate with Standard to determine how much of the cost will be covered under the plan, and how much will be your responsibility.

MAX BUILDER BENEFIT

The Max Builder gives employees and their dependents the opportunity to build their annual benefit maximums from year to year (up to $1,000) – as long as they see a dentist at least once a year and do not exceed the $500 annual benefit threshold.

USUAL, CUSTOMARY & REASONABLE

Benefits are paid at the negotiated fee level for in-network providers. Benefits for services from out-of-network providers will be paid at the 90th percentile of the amount charged by the majority of dentists in the area.

	In-Network	Out-of-Network
Annual Deductible (waived for Preventive & Diagnostic)	$50 per person $150 per family	
Annual Benefit Maximum	$1,000 per person	
Services		
Preventive & Diagnostic	Covered in full	Covered in full
Basic	20% after deductible	20% after deductible
Major	50% after deductible	50% after deductible
Periodontics	Non-Surgical covered under Basic Surgical covered under Major	
Endodontics	Covered under Major	
Implants	Covered under Major	
Orthodontia (child and adult)		
Services	Covered in full	Covered in full
Lifetime Benefit Maximum	$1,000 per person	

Late Enrollment Penalty: If you or your dependent does not enroll on the dental plan within 30 days of initially becoming eligible for coverage, no benefits will be payable for expenses occurred except for evaluations, prophylaxis (cleanings), and fluoride application for the first 12 months.

Limitations: This benefit outline is for illustrative purposes only. Actual claims paid are subject to maximum allowable charge, frequencies, age limitations, terms and conditions of the contract.

VISION BENEFITS

To help you take care of your eyesight, your company provides vision care coverage through Vision Service Plan (VSP). You can access vision care services from any provider you wish. However, your costs will typically be lower if you choose a VSP network provider. You will not receive a VSP identification card – simply let your provider know you are a VSP member when you make your appointment. You can find VSP providers online. Please see the information in "Your Benefits Contacts" toward the back of this Guide.

	In-Network	Out-of-Network Reimbursed
Routine Exam	$20 per visit	Up to $50*
Materials Copay (does not apply for elective contact lenses)	$20 copay	$20 copay
Lenses		
Single Vision	Covered in full*	Up to $50*
Lined Bifocals	Covered in full*	Up to $75*
Lined Trifocals	Covered in full*	Up to $100*
Standard Progressive	Covered in full*	Up to &75*
Frames	$130 then 20% discount*	Up to $70*
Contact Lenses (in lieu of eyeglasses)		
Fitting and Evaluation	15% discount, but no more than $60	Up to $105 for services and materials
Elective Contacts	$130 allowance	
Frequency (Exam/Lenses/Frames/Contacts)	12/12/24/12 Months	

*Less any applicable copay

If you purchase oversize lenses or have anything "special" done to your lenses (i.e., tinting, scratch guard, etc.), you will be responsible for this cost.

IMPORTANT

Members receive a 35-40% discount off non-covered lens options when services are received from a VSP network provider.

Discuss your lens options with your provider to determine whether or not you want to continue with their recommendations for lens options based on your out-of-pocket cost.

BENEFIT COSTS

Your company pays a portion of your healthcare costs. Your basic life insurance coverage, basic short and long term disability benefits, and Employee Assistance Plan (EAP) are fully paid by your company. To view benefit costs, please log into Plansource https://benefits.plansource.com/.

Costs for coverage of domestic partners and their children might not be deducted on a pre-tax basis. If your domestic partner is not an eligible tax dependent as defined in Section 152 of the Internal Revenue Code, then a portion of your contribution will be deducted after-tax and the company's contribution for domestic partner coverage will be taxable income to you and reported as imputed income on your paycheck. For more information, please contact Human Resources.

LIFE & DISABILITY BENEFITS

BASIC LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE

To help you protect your family, your company offers basic life and accident insurance that is fully paid for by your company.

	Life/AD&D
Benefit Amount	
• Life Insurance	$25,000
• Accidental Death & Dismemberment	$25,000
Benefits Begin to Reduce at Age:	65

WHEN YOU FIRST ENROLL

When you first enroll in life insurance benefits, you will need to designate a beneficiary who would receive the benefits in the event of your death. You may change or update your beneficiary at any time.

SHORT-TERM DISABILITY (STD) COVERAGE

For an approved, non-work related illness or injury, STD coverage replaces a portion of your income on a short-term basis if you are unable to work for a limited period of time. This benefit is fully paid for by the company.

	Short-Term Disability
Weekly Benefit Amount	60% of base weekly earnings
Maximum Weekly Benefit	$1,500
Elimination Period	
• Injury	7 days
• Sickness	7 days
Benefit Duration	90 days

LONG-TERM DISABILITY (LTD) COVERAGE

When you cannot work for an extended period of time, an LTD plan can help cover a portion of your pre-disability earnings. For an approved, non-work related illness or injury, LTD benefits usually begin after the STD plan has ended. This benefit is fully paid for by the company.

	Long-Term Disability
Monthly Benefit Amount	60% of base monthly earnings (including commissions)
Maximum Monthly Benefit	$7,500
Elimination Period	90 days
Benefit Duration	To age 65

IMPORTANT

Restrictions and limitations apply to these benefits. Please review the insurance booklet or certificate for complete details.

VOLUNTARY LIFE/AD&D BENEFITS

Voluntary Life – Benefit Outline	
Benefit Options • Employee • Spouse • Children	1x, 2x, 3x, 4x, 5x annual earnings 0.5x, 1x, 1.5x, 2x, 2.5x employee earnings $1,000 increments
Benefit Maximums • Employee • Spouse • Children	Lesser of 5x annual earnings or $500,000 Lesser of 2.5x employee annual earnings or $500,000 $10,000
Guarantee Issue • Employee • Spouse • Children	$150,000 $75,000 $10,000
Benefits Begin to Reduce at Age:	70
Waiver of Premium	Included
Portability/Conversion	Included

IMPORTANT! GUARANTEE AMOUNT NOTE

Guarantee Issue amounts that don't need an EOI are for New Hires Only.

Voluntary AD&D – Benefit Outline	
Benefit Options • Employee • Spouse • Children	$100,000 increments up to $500,000 $50,000 increments up to $250,000, not to exceed 100% of employee amount $10,000

Voluntary Life – Monthly Cost Outline		
Age	**Employee & Spouse Rates** (per $1,000)	
	Tobacco	**Non-Tobacco**
< 25	$0.116	$0.096
25 - 29	$0.116	$0.096
30 - 34	$0.146	$0.100
35 - 39	$0.210	$0.132
40 - 44	$0.330	$0.183
45 - 49	$0.530	$0.290
50 - 54	$0.892	$0.446
55 - 59	$1.396	$0.735
60 - 64	$1.898	$1.110
65 - 69	$2.838	$1.929
70 - 74	$4.848	$3.440
75 +	$8.364	$6.924
Child(ren) Rate (per $1,000)	$0.250	

Voluntary AD&D – Monthly Cost Outline	
Employee (per $1,000)	$0.040
Spouse (per $1,000)	$0.040
Child(ren) (per $1,000)	$0.040

FLEXIBLE SPENDING ACCOUNTS (FSA)

Looking for a way to save money on healthcare and/or dependent day care? Flexible Spending Accounts (FSAs) save you money by reducing the taxes you pay. Your FSA contributions are deducted from each paycheck before federal, FICA and, in most cases, state taxes are calculated. So in effect, you do not pay taxes on your eligible FSA expenses.

HOW DOES AN FSA WORK?

FSA contributions are taken from your paycheck on a pre-tax basis according to your annual elections. Once you have elected your annual deductions, you cannot change your elections under most circumstances.

When you have an eligible healthcare or dependent day care expense, you can pay for it with tax-free money. The accounts are not connected: you pay for healthcare expenses and dependent day care expenses with separate accounts.

You may use money in your FSA to pay for eligible expenses incurred by you, your spouse and your dependents. You and/or your dependents do not have to be enrolled in the medical plan to participate in the healthcare FSA.

REIMBURSEMENTS

You can use your FSA debit card pay for healthcare expenses at the point of purchase at pharmacies and many other authorized retailers and providers. The debit card lets you to pay for eligible expenses directly from your healthcare FSA so you do not have to wait for reimbursement.

Keep your receipts! In the event PlanSource requires documentation for a purchase made with the benefits debit card, it is your responsibility to provide the detailed copy of your store receipt (not just a credit slip stating dollar amount).

If you do not use the debit card, you will need to submit a claim form and proper documentation. A claim form may be found at www.plansource.com.

PLANSOURCE

MAXIMUM CONTRIBUTIONS

Healthcare FSA: $2,750

Dependent Care FSA: $5,000 for single employees or married employee filing jointly. $2,500 for married employees filing separately.

HSA MEDICAL PLAN ENROLLEES

If you are enrolled in the HSA medical plan you are not eligible to participate in the healthcare FSA. You may participate in the dependent care FSA.

GRACE PERIOD

You have up to 2.5 months after the end of your plan year to use any remaining money in your healthcare or Dependent Care FSA plans. This means you can receive services and be reimbursed from the prior year's FSA accounts.

TRANSPORTATION ASSISTANCE

The transportation reimbursement plan allows you to claim pre-tax qualified transportation expenses that are necessary for you to get to work. Transportation accounts are separate and have much more lenient requirements than FSA. You can make changes to your pre-tax elections monthly and any remaining balance can be rolled over to the next year.

MAXIMUM CONTRIBUTIONS

You can contribute up to $3,240 annually (or $270 per month) for qualified parking, transit passes or vanpooling.

There are three allowable qualified transportation expenses:

- Qualified parking: Includes parking provided to you at or near your workplace.
- Transit passes: Include any pass, token, fare card, voucher, or similar item that entitles you to transportation on mass transit facilities.
- Vanpooling: Requires a highway vehicle with a seating capacity of six or more adults where at least 80% of the mileage use for a year can be reasonably expected to be for the purpose of transporting employees between their place of residence and their place of employment. In addition, the number of employees carried must be at least half of the seating capacity of the vehicle.

To participate in the transportation assistance plan, you will need to register for your online account at plansource.com.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Your company provides an Employee Assistance Program (EAP) through LifeWorks. The EAP offers free and confidential counseling and assistance in resolving situations that may impact your personal or professional life. All employees are automatically covered by the EAP.

The EAP provides free short-term counseling and referrals to help you deal with a variety of issues that can affect you at work or at home, such as:

- Managing stress and anxiety
- Depression
- Parenting
- Alcohol or drug problems
- Coping with grief and loss
- Legal assistance
- Debt management and budgeting
- Elder care options

EAP counselors are available to assist you 24 hours a day, seven days a week by calling 888.267.8126. All calls are confidential. When you or a family member contacts the EAP, your call will be answered by a trained professional who will discuss your personal concerns with you and make sure you have access to appropriate resources.

LifeWorks by Morneau Shepell

IF YOU VISIT A COUNSELOR

Up to 3 sessions are provided at no charge to you. If more sessions are needed, the EAP professionals can work with you to locate community resources in and out of your health plan.

FREE AND CONFIDENTIAL

Call 888.267.8126 or

www.login.lifeworks.com for assistance.
User Name: Sign up via email invite
Password: Create at sign up

401K RETIREMENT PLAN

Your company wants to help you reach your financial goals, and it is easy to get started. The 401(k) plan offers best in class features including an employer match, Roth contributions and an institutional investment lineup.

The Doyon 401(k) Plan offers the following features:

- This plan accepts rollovers from previous employers with a 401 (k) Plan and there is immediate vesting for employee and employer 401 (k) contributions.
- Eligibility to defer pre or post-tax contributions after 1 month of service
- There is a 3% automatic pre-tax deduction upon eligibility unless you opt-out online at http://www.schwab.com/workplace
- An Employer match of 100% up to 3% of eligible compensation and 50% for the next 2% of eligible compensation with 100% vesting for all current and future contributions
- Your contributions will automatically escalate 1% each year at until you reach 10%
- Bonus pay is eligible compensation
- Ability to invest through the brokerage window
- A catch-up provision is also available for employees age 50 and older
- In-service withdrawals available at 59 ½
- Early retirement age of 55 and a normal retirement age of 65
- Ability to save through Roth 401(k) contributions
- Ability to access your money through a hardship request

charles SCHWAB

PLEASE NOTE:

To access your 401(k) account at:
http://www.schwab.com/workplace

- You must have a social security number and default PIN #
- Default PIN# is month and day of birth date: (eg:0103)
- For assistance contact Charles Schwab at (800) 724.7526

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

I If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2020. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1.855.692.5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1.866.251.4861
Email: CustomerService@MyAKHIPP.com Medicaid Eligibility:
http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1.855.MyARHIPP (855.692.7447)

California – Medicaid
Website:
https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_co nt.aspx
Phone: 1-800-541-5555

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1.800.221.3943/ State Relay 711
CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus
CHP+ Customer Service: 1.800.359.1991/State Relay 711
Health Insurance Buy-up Program:
https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 1.855.692.6442

FLORIDA – Medicaid
Website: http://flmedicaidtplrecovery.com/hipp/
Phone: 1.877.357.3268

GEORGIA – Medicaid
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162 ext 2131

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1.877.438.4479
All other Medicaid
Website: http://www.indianamedicaid.com
Phone 1.800.257.8563

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/default.htm
Phone: 1-800-792-4884

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618.5488 (LaHIPP)

MAINE – Medicaid
Enrollment Website: http://www.maine.gov/dhhs/ofi/application-forms
Phone: 1.800.442.6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
http://www.maine.gov/dhhs/ofi/application-forms
Phone: 1.800.977.6740
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1.800.862.4840

CHIP *(CONTINUED)*

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-andfamilies/health-care/health-care-programs/programs-andservices/medical-assistance.jsp
Phone: 1.800.657.3739

MISSOURI – Medicaid
Website: https://www.mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 573.751.2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1.800.694.3084

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
Medicaid Website: https://dhcfp.nv.gov
Medicaid Phone: 1.800.992.0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 603.271.5218
Toll-Free: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609.631.2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1.800.701.0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1.800.541.2831

NORTH CAROLINA – Medicaid
Website: https://dma.ncdhhs.gov/
Phone: 919.855.4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1.844.854.4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1.888.365.3742

OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1.800.699.9075

PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 855.697.4347 , or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1.888.549.0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1.888.828.0059

TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 1.800.440.0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1.877.543.7669

VERMONT– Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1.800.250.8427

VIRGINIA – Medicaid and CHIP
Medicaid Website: http://www.coverva.org/hipp/
Medicaid Phone: 1.800.432.5924
CHIP Phone: 1.855.242.8282

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1.800.562.3022

WEST VIRGINIA – Medicaid
Website: https://mywvhipp.com
Phone: 1-855-MyWVHIPP (1.855.699.8447)

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1.800.362.3002

WYOMING – Medicaid
Website: https://healthy.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1.800.251.1269

To see if any other states have added a premium assistance program since July 31, 2020, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

Employee Benefits Security Administration
dol.gov/agencies/ebsa
866.444.EBSA (3272)

U.S. Department of Health & Human Services
Centers for Medicare & Medicaid Services
cms.hhs.gov
877.267.2323
(Menu Option 4, Ext. 61565)

CERTIFICATE OF CREDITABLE PRESCRIPTION DRUG COVERAGE

IMPORTANT NOTICE FROM DOYON ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Doyon 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:

Keep this Creditable Coverage 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).

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. Your company has determined that the prescription drug coverage offered by UnitedHealthcare 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 and 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 coverage may be affected. Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents may still be eligible to receive all of your current health and prescription drug benefits. If you do decide to join a Medicare drug plan and drop your current company coverage, be aware that you and your dependents may be able to get this coverage back by enrolling back into the company benefit plan during the Open Enrollment period under the company benefit plan.

WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

You should also know that if you drop or lose your current coverage with the company 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.

CERTIFICATE OF CREDITABLE PRESCRIPTION DRUG COVERAGE *(CONTINUED)*

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE…

Contact the person listed below for further information. **Note:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the company 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 800.MEDICARE (800.633.4227). TTY users should call 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 800.772.1213 (TTY 800.325.0778).

Date:	January 1, 2021
Name of Entity/Sender:	Doyon
Contact--Position/Office:	Human Resources
Address:	3450 South 344th Way, Federal Way, WA 98001
Phone Number:	253.344.5300
E-mail	DGGHR@doyongovgrp.com

STATEMENT OF ERISA RIGHTS

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the documents governing the plan, including the insurance contract and a copy of the latest annual report (Form 5500 Series) if any filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if any. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

You have a right to continue healthcare coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants and beneficiaries. Fiduciaries who violate ERISA may be removed and required to make good any losses they have caused the Plan.

No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan Administrator and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits, which is denied or ignored, in whole or in part, and you have exhausted the claims procedures available to you under the Plan (see your plan document or summary plan description for more detail), you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement, or your rights under ERISA, or if you need assistance or information regarding your rights under HIPAA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

YOUR BENEFITS CONTACTS

GALLAGHER BENEFIT ADVOCATES

If you do not receive satisfactory service from your insurance companies, a Benefit Advocate (a service provided by Gallagher), is available to help with issues pertaining to your benefits.

Please do not include any confidential or sensitive information, such as Social Security numbers or health information, via email. Once you are connected to a Benefit Advocate, more sensitive information can be shared.

You can reach a Benefit Advocate at:
BAC.Doyon@ajg.com or by phone:
425.201.9044,
Toll free: 800.542.3737
6:00 a.m. - 6:00 p.m. PT
Monday - Friday

Humane Resources
253.344.5300
dgghr@doyongovgrp.com

Benefit	Administrator	Group Number	Contact Information		Website
Medical	UnitedHealthcare	909650	Customer Service	866.633.2446	www.myUHC.com
Nursline	Care24		Care24 Services	888.887.4114	www.myUHC.com
Health Savings Account (HSA)	Optum Bank		Customer Service	800.791.9361	
Vision	Vision Service Plan	30018313	Customer Service	800.877.7195	www.vsp.com
Voluntary Dental, Life/AD&D, STD, LTD, Voluntary Life/AD&D	Standard Insurance	135137	Dental Life/AD&D STD LTD	800.547.9515 800.628.8600 800.368.2859 800.368.1135	www.standard.com
Flexible Spending Accounts & Transportation Assistance	PlanSource		Benefits Support	877.549.8549	www.plansource.com
Employee Assistance Program	LifeWorks		24/7	888.267.8126	www.login.lifeworks.com User Name: Sign up via email invite Password: Create at sign up
401k	Charles Schwab		Customer Service	800.724.7526	http://www.schwab.com/workplace

KEY TERMS

BRAND NAME PRESCRIPTION DRUG

A prescription drug that is sold under a trademarked name. An equivalent generic drug may or may not be available at lower cost, depending on whether the patent on the brand name drug has expired.

COPAY

A flat dollar amount you pay for a medical service.

COINSURANCE

The percentage of the charges you are responsible for paying. For example, the plan pays 80% and you pay 20%.

DEDUCTIBLE

This is the amount you pay before your plan begins covering expenses not subject to a copay.

EXPLANATION OF BENEFITS (EOB)

The statement you receive from your insurance company detailing how much the provider billed, how much (if any) the plan paid, and the amount that you owe the provider (if any).

GENERIC PRESCRIPTION DRUG

A prescription drug made and distributed after the brand name drug patent has expired, and available at a lower cost than brand name prescriptions.

OUT-OF-POCKET (OOP) MAXIMUM

The most you pay in a calendar year for covered medical services. Once the OOP maximum is met, the plan will pay 100% of the allowed amount for the remainder of the calendar year for covered services.

IN-NETWORK

Services from a provider or facility that is contracted with the insurance company. In-network providers agree to accept set fees for covered medical services and not bill you for any amounts over those fees. In-network providers also agree to bill the insurance company directly, so you will not have to pay up front and submit your own claims to the insurance company.

OUT-OF-NETWORK

Services from a provider or facility that is not contracted with the insurance company. If you receive services out-of-network, then you will typically have a higher coinsurance and you will be responsible for the difference between the provider's billed charge and the allowable charge.

PREVENTIVE CARE

Measures taken to prevent diseases. This includes routine cancer screenings, exams and certain drugs and immunizations. Most preventive care is covered-in-full by the plan, with no cost to you.

NOTES

NOTES

THIS BENEFIT SUMMARY PREPARED BY:

PLEASE NOTE:

This document is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all the terms, coverages, exclusions, limitations, and conditions of the actual contract language. The policies themselves must be read for those details. The intent of this document is to provide you with general information about your employee benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be directed to your Human Resources/Benefits Department.