CARTER Lumber

EMPLOYEE BENEFITS GUIDE

2021

Important Contacts

BENEFIT CONSULTANT

HYLANT

Be prepared: When contacting any of the companies below, it is important to have the insurance card or ID card number(s) of the subscriber for the coverage you are calling about as well as any appropriate paperwork, such as an explanation of benefits, a denial letter, receipts, etc.

Questions About	Policy Number	Contact	Phone	Website
Medical	W41139	Anthem	1-866-755-2680	www.anthem.com
Prescription Drug	W41139	Anthem	1-888-809-6084	www.anthem.com
Telemedicine	W41139	Livehealth Online	1-888-548-3432	Livehealthonline.com
Health Savings Account	29093	Discovery Benefits	1-877-765-8810	www.discoverybenefits.com
Flexible Spending Account (PPO ONLY)	29093	Discovery Benefits	1-877-765-8810	www.discoverybenefits.com
Dental	015955	MetLife	1-800-942-0854	www.metlife.com
Vision	378553/0105955	MetLife	1-855-638-3931	www.metlife.com
Voluntary Life (Employee & Dependents)	0105955	MetLife	1-800-523-6381	www.metlife.com
Disability	0105955	MetLife	1-800-858-6506	www.metlife.com
Critical Illness	0105955	MetLife	1-800-638-5433	www.metlife.com
Accident	0105955	MetLife	1-800-638-5433	www.metlife.com
Group Home & Auto	0105955	MetLife	1-800-438-6381	www.metlife.com
Group Legal	0105955	MetLife	1-800-438-6388	www.metlife.com

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If you (and/or) your dependents have Medicare or will become eligible for Medicare In the next 12 months, a Federal law give you more choices about your prescription Drug coverage. Please see page 45 for more details.

HIGHLIGHTS FOR 2021

Your benefits are an important part of your total compensation at Carter-Jones Lumber. Please take the time to review this Benefits Guide to assist you in making informed enrollment decisions that are the best fit for the health, wellness and financial needs of you and your family.

The Anthem Medical and Prescription Drug benefits will remain the same for 2021 as will the majortiy of the Carter benefit package with a few new additional benefits and enhancements as shown below.

New Enhanced Buy-Up Dental Benefit Option With Orthodontia For Dependent Children to Age 26

Effective January 1, 2021, Carter is offering two new Dental options. Option I provides the same benefits as offered in the past to those employees with one or more years of service. Option 2 offers an enhanced buy-up dental plan with Orthodontia for dependent children to age 26. ***(See page 20 for further details)***

Voluntary Life Enhancements For You and New Voluntary Life Coverage For Your Dependents

Effective January 1, 2021, Carter is enhancing the current Voluntary Life coverage. The Employee benefit maximum will be increase to $500,000 and Voluntary Dependent coverage is being offered for your eligible spouse and children.
(See page 22 for further details)

Voluntary Legal For You and Your Family

Effective January 1, 2021 Carter is offering the option to purchase legal services through MetLife. Legal services would include advice & consultation, consumer protechtion, debt matters, civil lawsuit defensse, document preparation, family law, immigration, personal injury, real estate, traffic and criminal as well as wills and estate planning.
(See page 24 for further details)

2021 Open Enrollment (November 2, 2020 – November 20, 2020)

All benefit elections during Open Enrollment, for coverage effective January 1, 2021, must be made through the ADP enrollment portal. Also, if you experience a Qualifying Event that results in the right ot make a change in your benefit elections during the year, those changes will be made in ADP as well. (Please see page 5 for further details)

This year, we will have a passive enrollment for all benefits except Flexible Spending as well as the Enhanced Buy-Up Dental, Voluntary Life, Dependent Life and Legal Assistance plans which are all new or enhanced benefits for the 2021 plan year.

This means if you do not wish to make any changes in your existing benefis (Medical/Prescription Drug, current Dental, Critical Illness, Accident or Vision), there is nothing you need to do.

However, you MUST log into ADP and make your 2021 benefit elections for the Flexible Spending as well as the new Enhanced Buy-Up Dental, Voluntary Life, Dependent Life and Legal Assistance benefits. Any of these benefits not actively elected will be waived and you WILL NOT BE COVERED in 2021.

ENROLLING IN BENEFITS

OPEN ENROLLMENT
NOVEMBER 2, 2020 – NOVEMBER 20, 2020

This Benefits Guide provides an overview of your benefit options and additional information to help you make your enrollment decisions.

IMPORTANT: This year, we will have a passive enrollment for all benefits except Flexible Spending as well as the enhanced Buy-Up Dental, Voluntary Life, Dependent Life and Legal Assistance plans which are all new options for the 2021 plan year. This means if you do not wish to make any changes in your existing benefis (Medical/Prescription Drug, current Dental, Critical Illness, Accident or Vision, there is nothing you need to do.

However, you do need to log into ADP and make your 2021 benefit elections for Flexible Spending, the new Enhanced Buy-up Dental, Voluntary Life, Dependent Life and Legal Assistance benefits. Any of these benefits not actively elected will be waived and you WILL NOT BE COVERED in 2021.

ACTION ALERT:

Choose your benefits wisely! After the enrollment deadline, benefit elections cannot be changed or canceled until the next enrollment period unless a qualifying event occurs.

GETTING STARTED: EVALUATE

When reviewing your benefit options, you should consider your expected total annual healthcare cost, which includes your plan contributions plus your expected out-of-pocket costs, such as deductibles, coinsurance and copays. You should also consider healthcare plan features that are important to you and how you prefer to pay for coverage (i.e., less up front in contributions but more out-of-pocket should you need unexpected care vs. more upfront in contributions but less out-of-pocket should you need unexpected care).

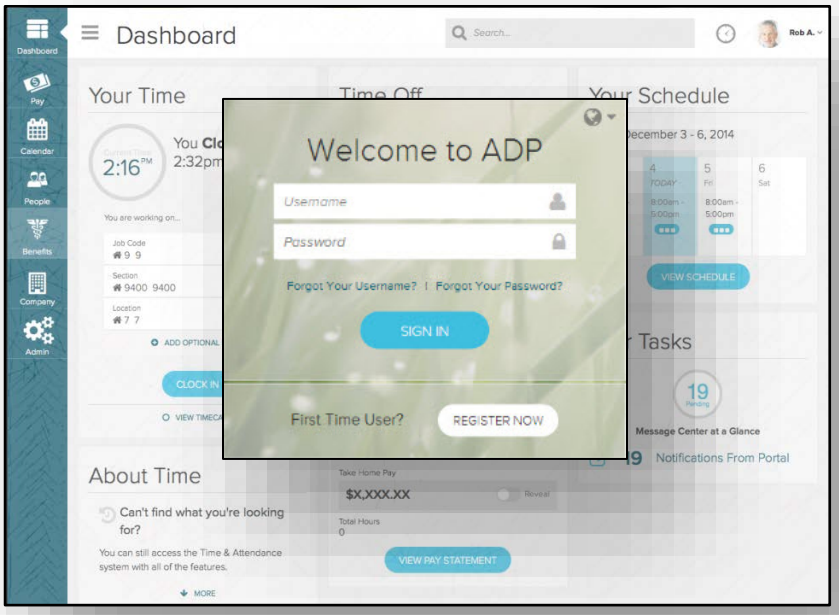
Use the websites and phone numbers in the *Important Contacts* section to see which doctors and other healthcare providers you can use under your plan choices. If you have dependents that live out of state, check on provisions for coverage of members away from home.

MAKING YOUR ELECTIONS

Enrollment for benefits will be conducted through ADP. Information on accessing the benefits portal is provided below.

MyADP – The ADP Experience

Getting Started with MyADP



Register, log in, and learn about key features

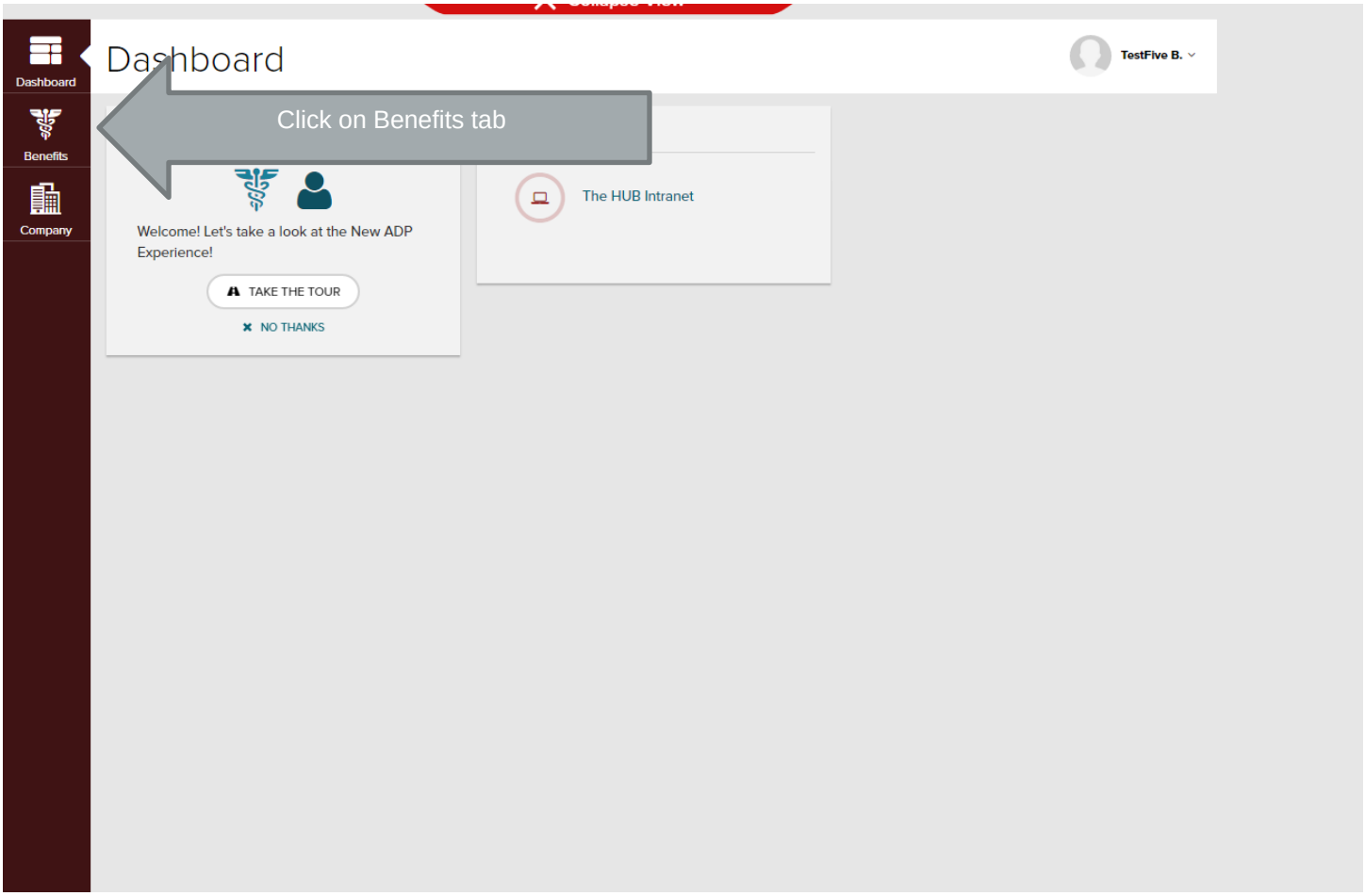
Self-Registration for First Time Users

If this is your first time using ADP services, follow the self-registration process below. Otherwise, use your existing credentials.

1. Go to **adpvantage.adp.com**.
2. Click **Register Now**.
3. Enter the registration code provided by your company and click **Go**.
4. Enter your name and other requested information and click **Confirm**.
    - If the prompt indicates that your record was found, click **Register Now**.
    - If the prompt indicates your record could not be found, contact your administrator or help desk.
5. On the Register for Services page, enter your contact information.
6. View or create (if permitted) a user ID.
7. Create a password.
8. Select and answer security questions.
9. If prompted, read the terms and conditions and select the **I Agree** check box.
10. Click **Register** (or **Register Now**).
11. Activate your contact devices by following the instructions in the two emails you will receive.
12. You can now log in to your ADP service.

Signing In

1. Go to **adpvantage.adp.com**.
2. Enter your **User Name**.
   Your user name is the user ID you received when you completed self-registration.
3. Enter your **Password**.
   Your password is the one you created during self-registration.
4. Click **Sign In**.



Managing Your Benefits

The Benefits landing page, which provides quick access to all your benefits information with easy-to-use navigation.

(1) Access an open event (New Hire, Annual Enrollment, incomplete Life Events, and so forth) at the top

of the page or the corresponding event tile below to begin or continue the enrollment process.

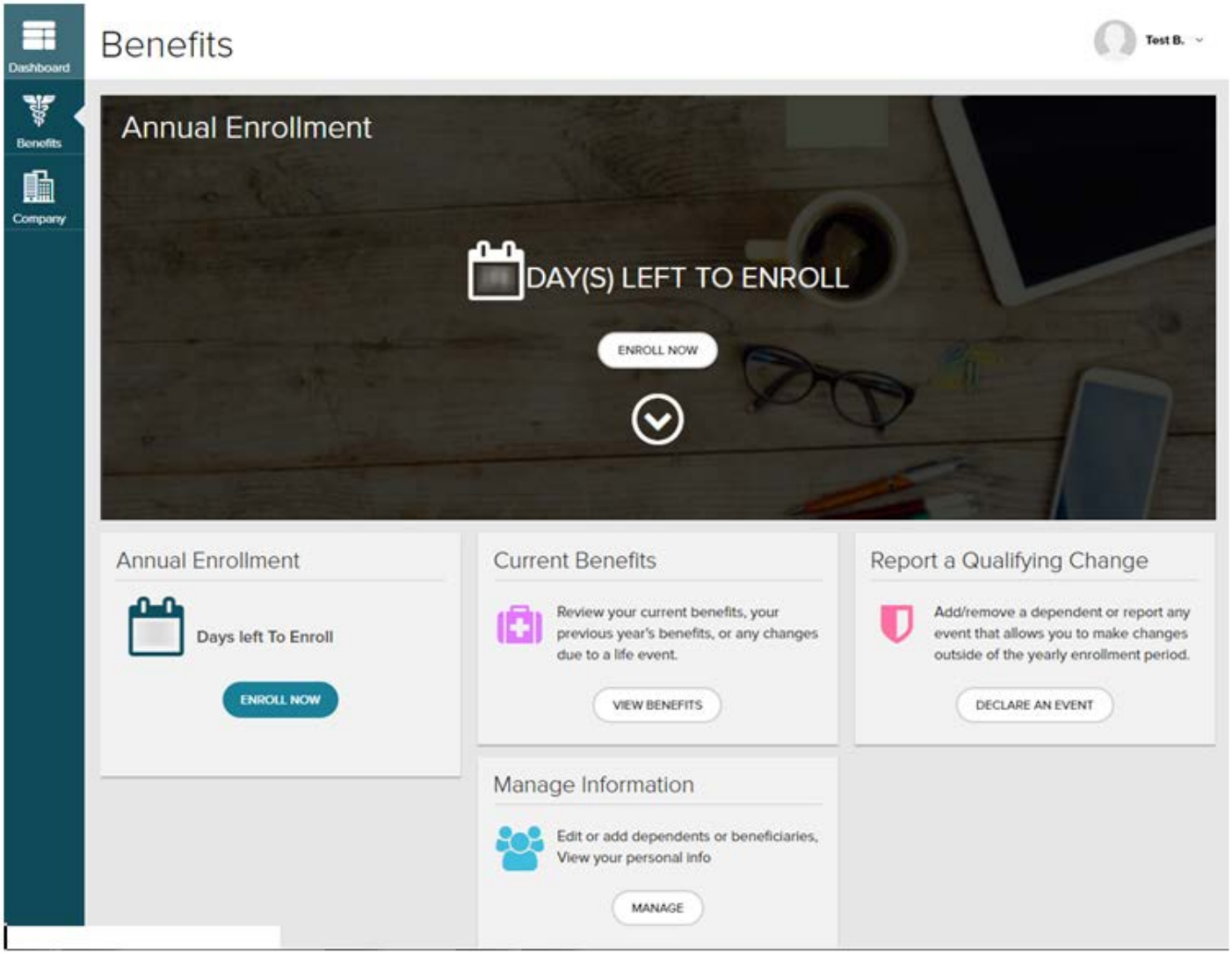
(2) View the benefits you are currently enrolled in and applicable paycheck deductions. Access benefits confirmation statements.

(3) Declare a Life Event, such as marriage, divorce, adoption, birth, and so forth.

(4) Manage Information.

(5) View or update dependent and beneficiary information, allocations or coverage (with a qualifying event).

(6) Access forms and documents related to your benefits.



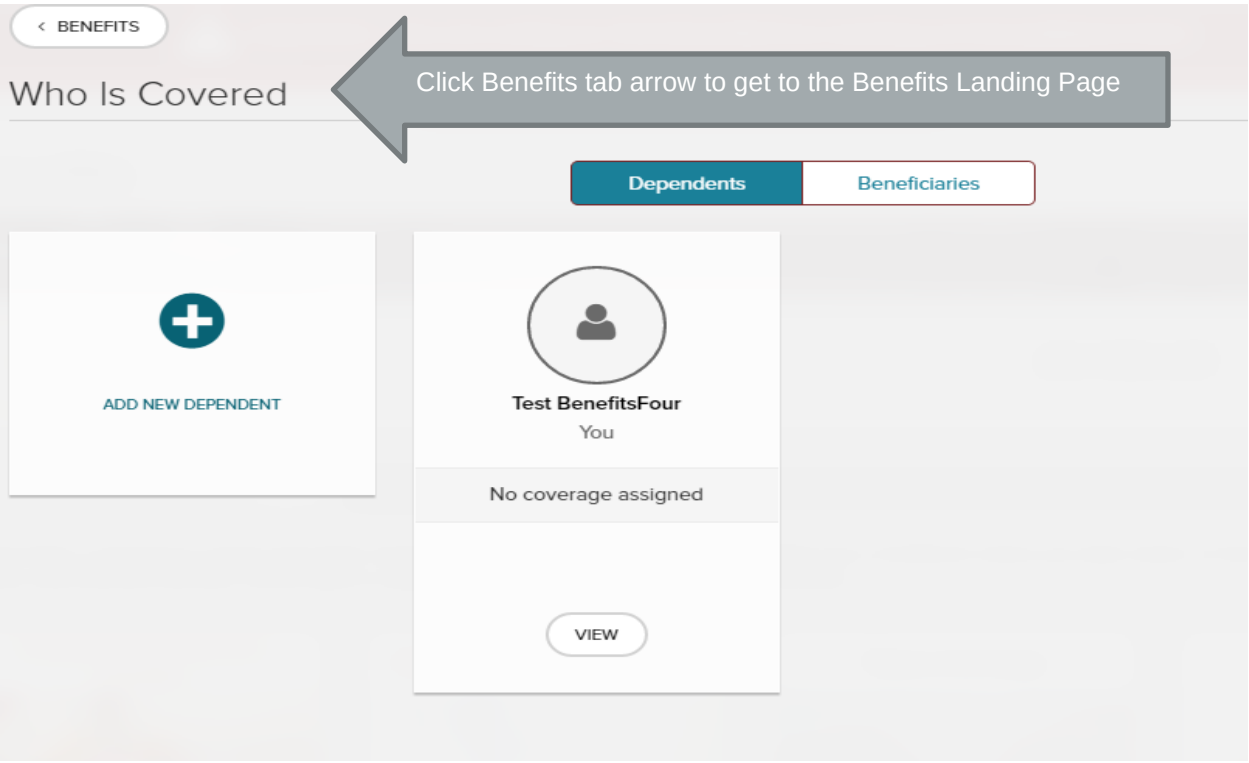
This plan year there will be an Active Enrollment for only the Flexible Spending as well as the new Enhanced Buy-Up Dental, Voluntary Life, Dependent Life and Legal Assistance benefits.

Employees must actively elect these benefits for the 2021 plan year

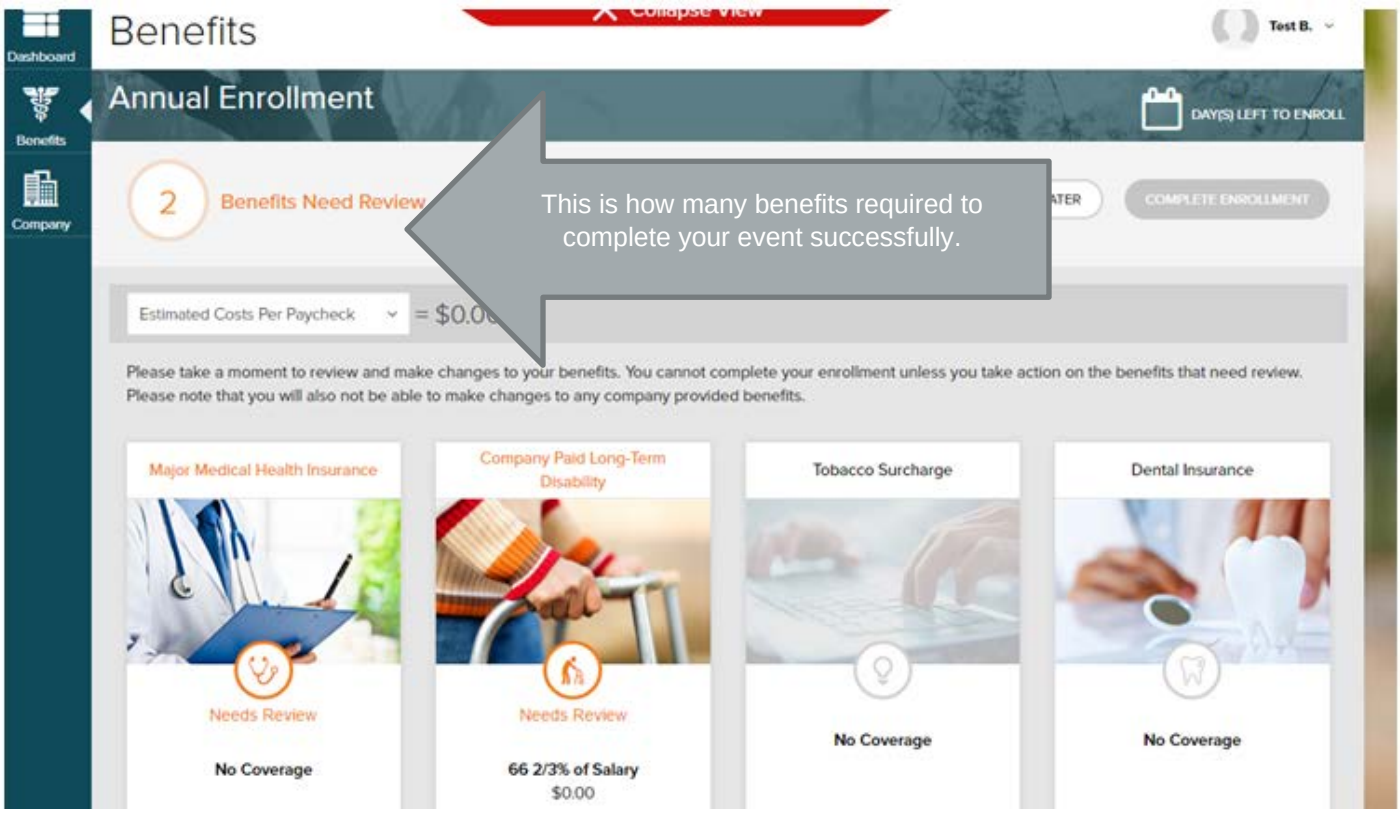
(01/01/2021- 12/31/2021) or they WILL NOT BE COVERED IN 2021 FOR THESE BENEFITS.

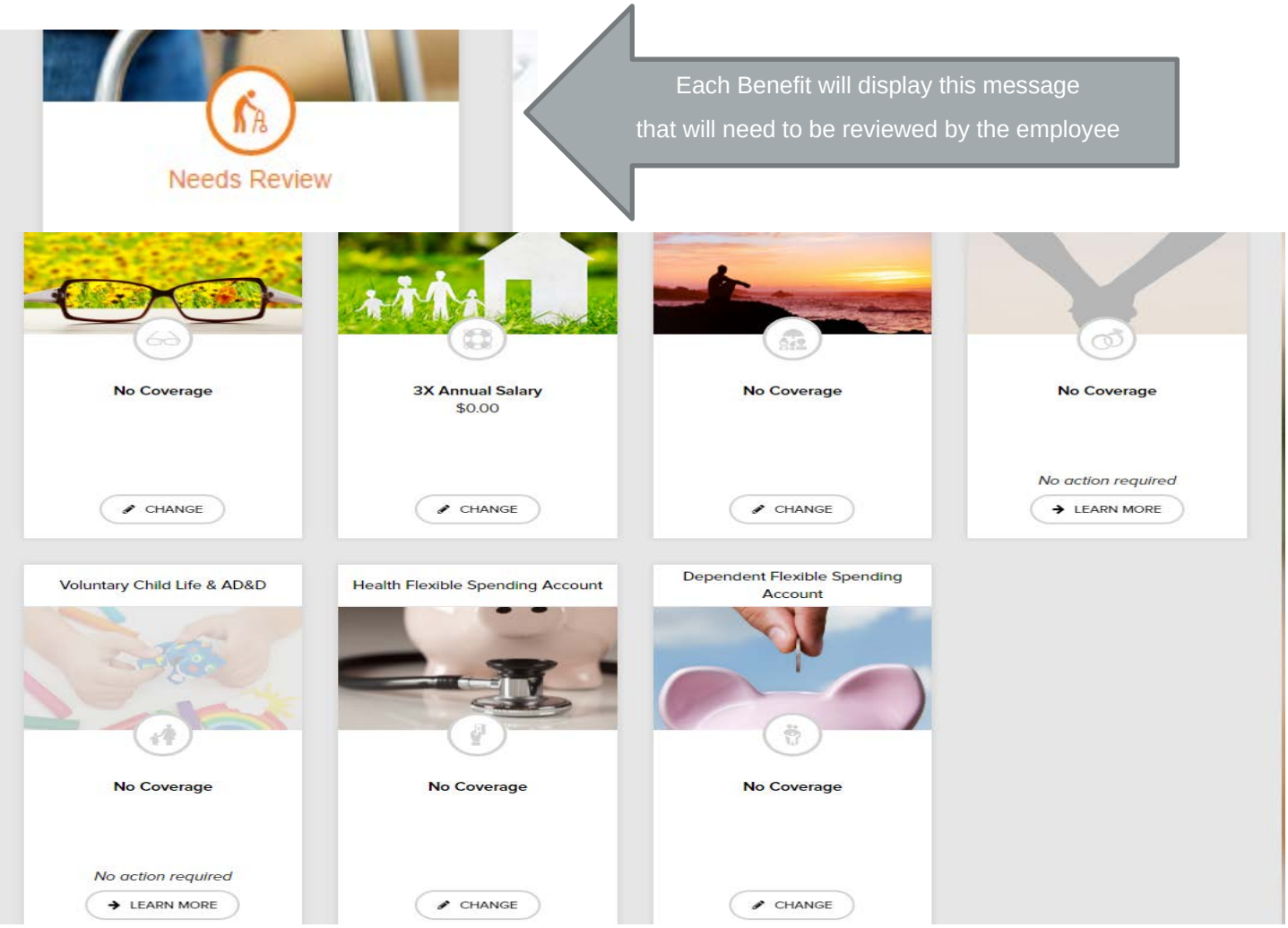
Employees have the opportunity once a year to make changes to their elections. The opportunity to enroll is called Annual Enrollment. **Carter-Jones Lumber- Annual Enrollment window is open from 11/02/2020 - 11/20/2020.** Changes made in the Annual Enrollment window are effective on the plan year start date 01/01/2021.

Once you click on the Annual Enrollment it will bring you to the Screen Below – Who is covered and Beneficiaries. The employee can add a new beneficiary or add a new dependent on this page.



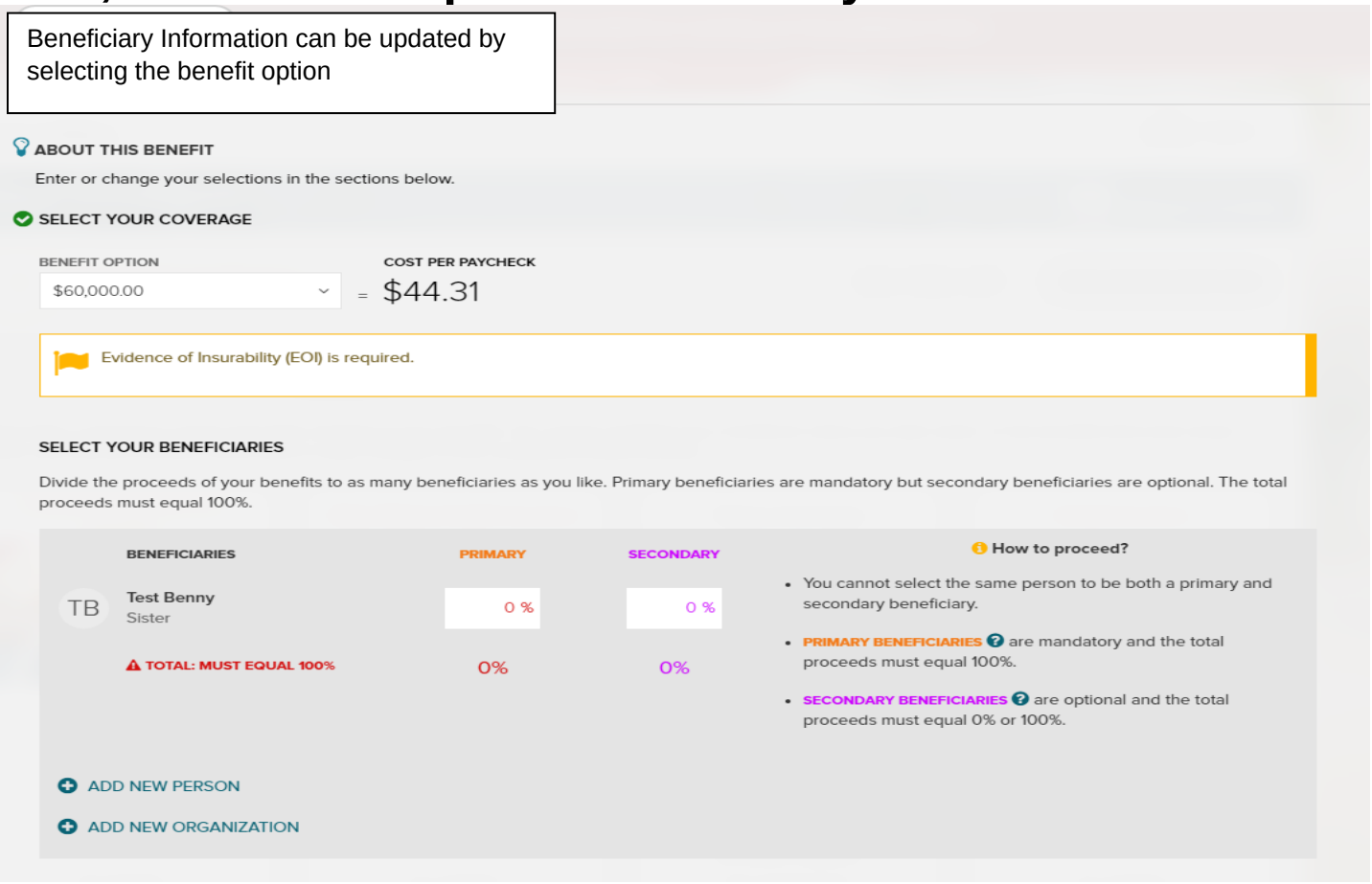
Click on the Benefits tab to take you the Benefits Landing Page.



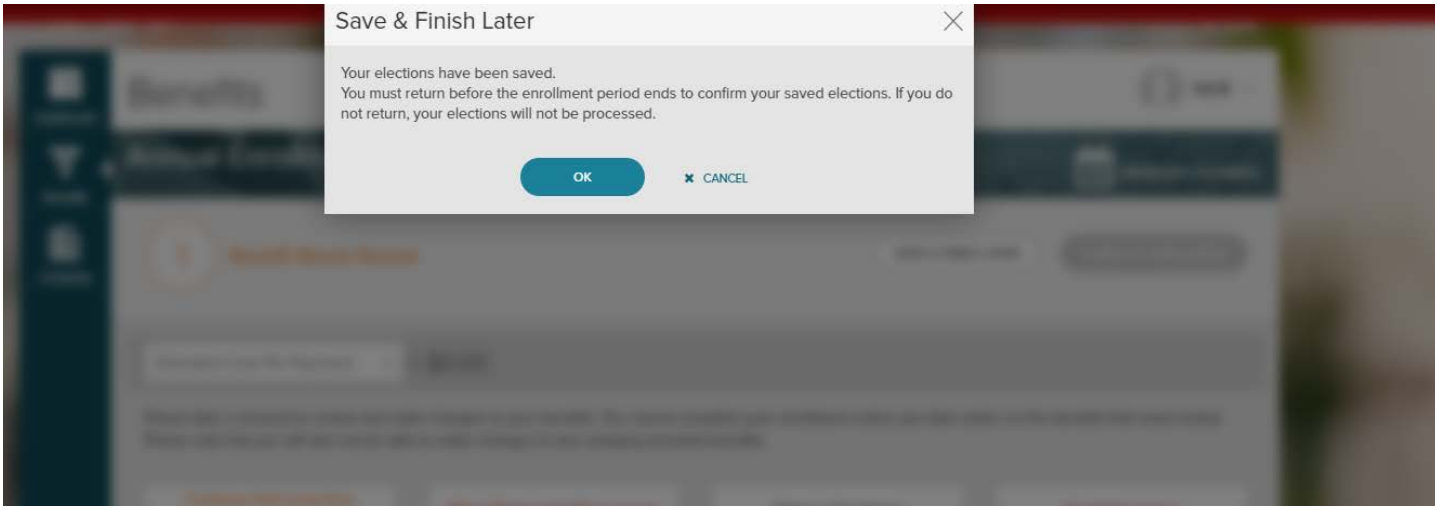

Needs Review
Each Benefit will display this message
that will need to be reviewed by the employee
No Coverage
CHANGE
3X Annual Salary
$0.00
CHANGE
No Coverage
CHANGE
No Coverage
No action required
LEARN MORE
Voluntary Child Life & AD&D
No Coverage
No action required
LEARN MORE
Health Flexible Spending Account
No Coverage
CHANGE
Dependent Flexible Spending Account
No Coverage
CHANGE

Add, Remove or Update Beneficiary Information

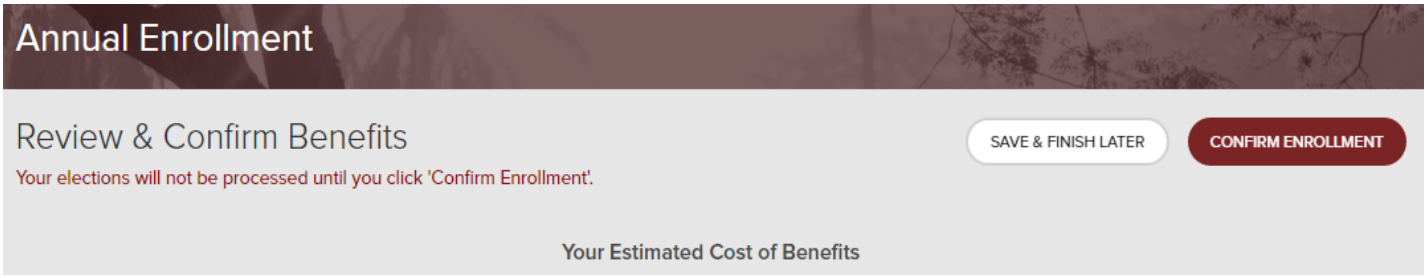
Beneficiary Information can be updated by selecting the benefit option



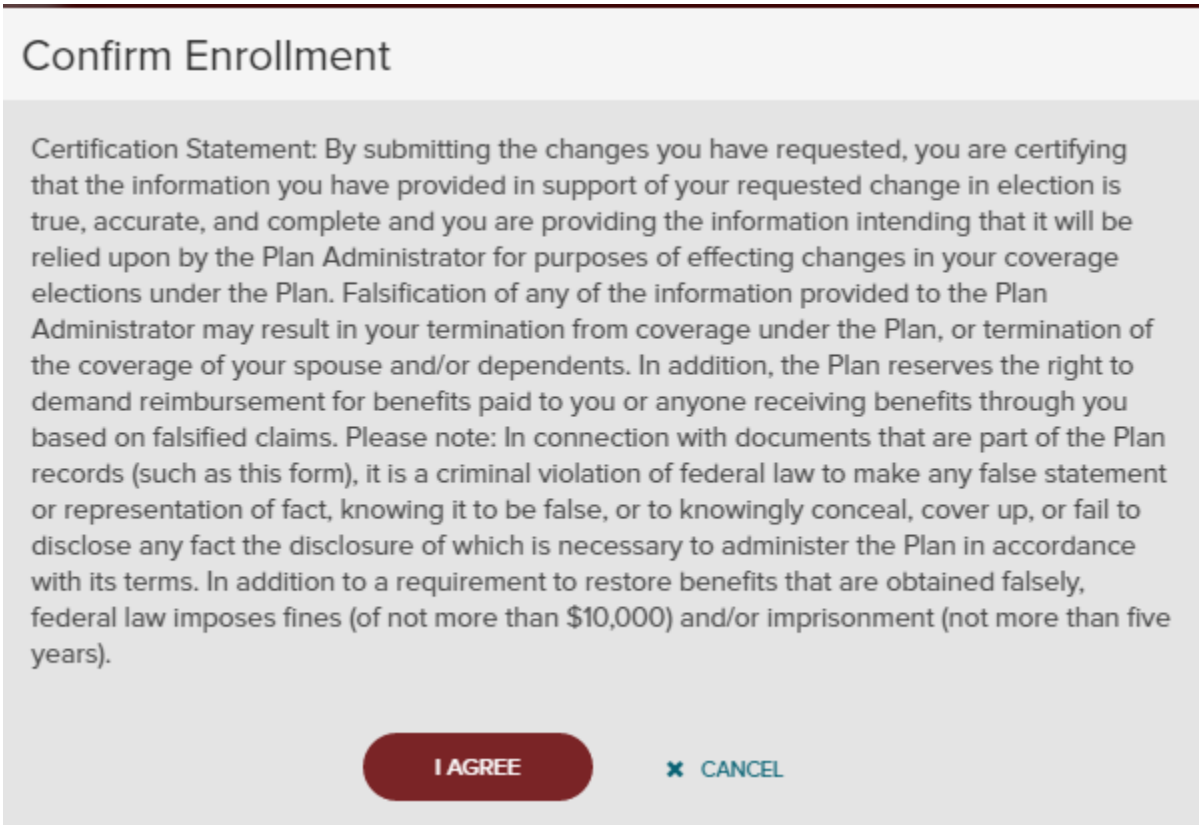
Save & Return Later / Confirming Elections



- At the Top and the bottom of the Benefits Landing page the options show Save & Return Later. Changes made will be saved until the event is accessed again. If these changes are not “Confirmed” by the end of the enrollment period changes will *not* be updated.
- Cancel option will take you back to the Benefits Landing Page.
- Confirm Elections option will secure all changes made and will be effective based upon the enrollment window effective date.

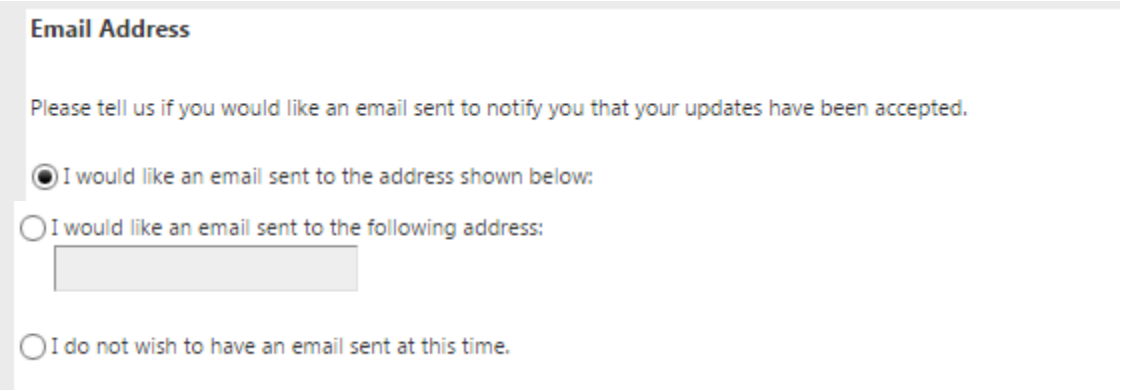


Certification Statement

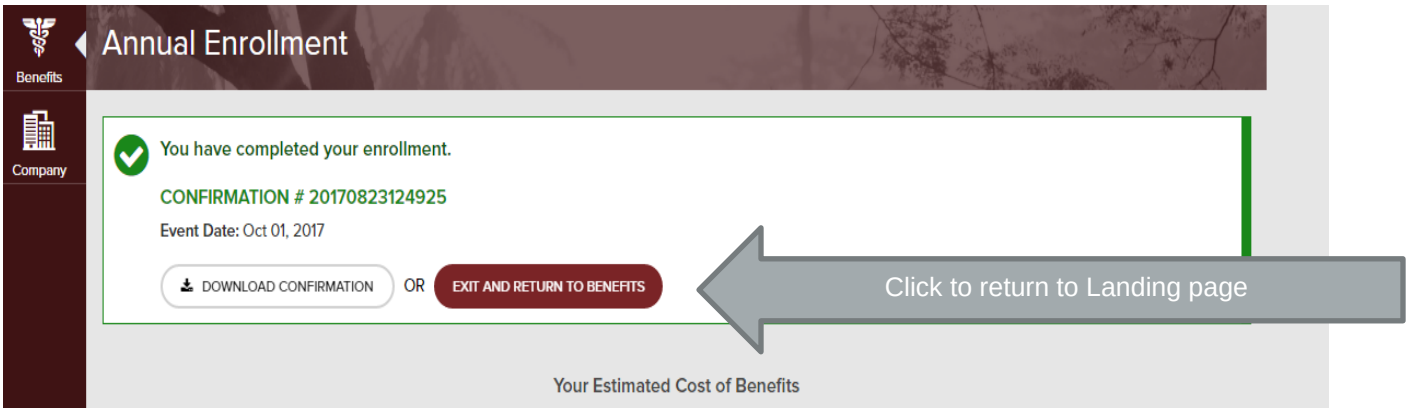


- After selecting Confirm Elections the Certification Statement will appear. I Agree will allow you to move forward with confirming your elections.
- I Disagree will take you back to the Benefits Landing Page
- After selecting Confirm Elections the Certification Statement will appear. I Agree will allow you to move forward with confirming your elections.

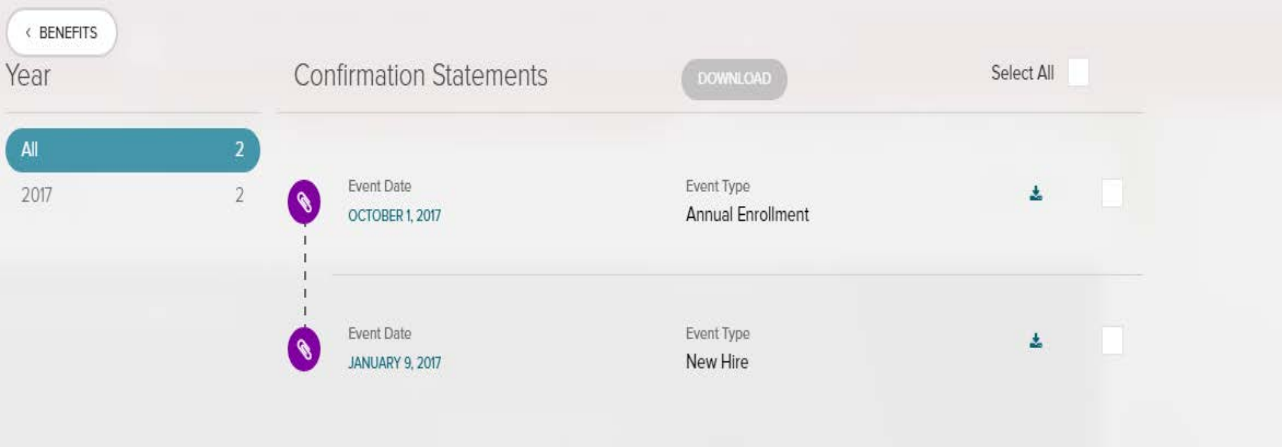
- The employee can choose/ elect to send to your email address



- The Email Notification page will offer the opportunity to have an email sent to your primary email address on file, the option to have the email sent to another email address, or no email to be sent.



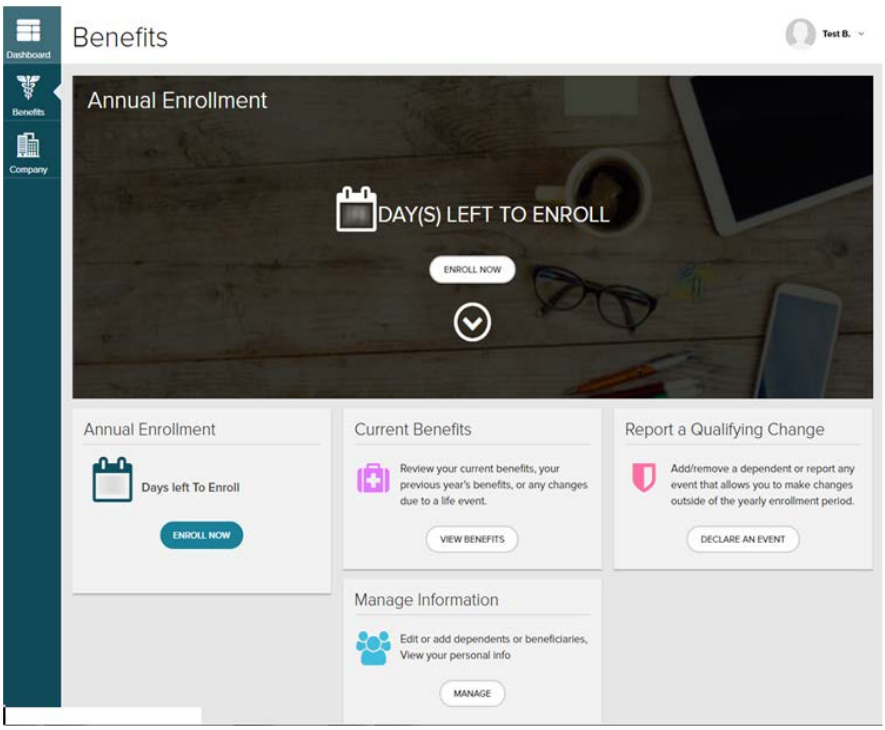
- The confirmation number is a time stamp yyyymmddhhmmss (year, month, day, hours, minutes, seconds)
- Download and print Confirmation:



The Confirmation Statement will show everything the employee is enrolled in for benefits.

- Employee Name and Address
- The day the confirmation statement was pulled up to be printed.
- Employee Date of Birth
- Event Date
- Event Type – for current elections no event or event date will be listed.
- Benefit Elections – will include benefit plan, plan option, coverage level, effective date of the change, employee price per pay period and employer contribution per pay period.
- Dependent Information
- Beneficiary Information

- Click Blue Arrow to Return to the Landing Page.



ELIGIBILITY

As a benefits-eligible employee, Carter-Jones Lumber Co. offers a health and welfare program that offers you and your family coverage that helps reduce your medical expense, improve your health and well-being, and protect you while you are an active employee. Employees must work 30+ hours per week.

DEPENDENT ELIGIBILITY

Your dependents may also be covered under the benefit plans described below.

Benefit	Legal Spouse	Dependent Child(ren)
Medical	√	Up to age 26
Dental	√	Up to age 26
Vision	√	Up to age 26
Life and AD&D	√	Up to age 19

DEPENDENT VERIFICATION

You may be asked to provide proof of dependent eligibility, which may include one or more of the following:

- Marriage Certificate
- Birth Certificate
- Affidavit of Qualifying Adult
- Adoption Certificate
- Placement Certificate
- Document of Guardianship
- Other as necessary

WORKING SPOUSE RULE

An employee's spouse who has medical coverage available from his or her employer's group health plan is not eligible for medical coverage under this plan. If your spouse is employed full-time and his or her employer offers medical coverage, your spouse must enroll in their employer's plan.

NEW HIRE COVERAGE

As a new employee you have 45 days to make your benefit elections. It is important you review the benefit information and enroll in benefits during your initial new hire eligibility period. If you do not enroll by that deadline, you will not be eligible for coverage until the following annual open enrollment period or if you experience a qualifying event. Following enrollment, your coverage is effective the first of the month following 60 days of service (1st of the month following 90 days of service for life, short term disability and long term disability insurance).

TERMINATION OF COVERAGE

If employment is terminated, all coverage will end on the last day of the month of termination.

COBRA CONTINUATION OF COVERAGE

When you or any of your dependents no longer meet the eligibility requirements under this plan, you may be eligible for continued coverage as required by the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986.

MAKING CHANGES DURING THE YEAR

Unless you experience a life-changing qualifying event, you cannot make changes to your benefits until the next open enrollment period. You must notify the Benefits Department of such change(s) within the noted days from the event as shown in the below table. Failure to notify the Benefits Department within the timeframe noted (and provide any necessary dependent documentation) will require you to wait until the next open enrollment period to make your change. Qualifying events may require documentation of the event such as marriage certificate, birth certificate, divorce decree, etc. to finalize the event change. For questions, please see your Benefits Department representative.

Qualifying Event	Timeframe to Notify Benefits Department*
Marriage, divorce or legal separation	30 days
Birth, adoption or placement for adoption	30 days
Death of a dependent	30 days
Change in your Spouse's employment status	30 days
Change in coverage status under your spouse's plan	30 days
A loss of eligibility for other health coverage	30 days
Change in dependent child's status, either newly satisfying the requirements for dependent child status or ceasing to satisfy them	30 days
Judgment, decree or court order allowing you to add or drop coverage for a dependent child	30 days
Change in eligibility for Medicare or Medicaid	60 days
Termination of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP)	60 days
Becoming eligible for a premium assistance subsidy under Medicaid or a state CHIP	60 days

** days from the qualifying event*

TURNING AGE 65 AND BECOMING MEDICARE ELIGIBLE

If you are an active employee and have reached the age of 65, you may be wondering about Medicare. If you are already receiving Social Security benefits, you should receive an advisory notice from Medicare about three (3) months before your 65th birthday for your initial enrollment period. Otherwise, you must actively enroll in Medicare yourself by contacting your local Social Security office as you will not receive a mailed notice of eligibility.

If you are turning age 65 during the plan year but will continue working in a benefits-eligible position, you have the option of enrolling in Medicare Part A (hospital) coverage, which is typically premium-free. You may also enroll in Part B (medical) coverage at your cost. If you do so, your Group Health medical plan remains your primary and Part B (Medical Insurance), which does have a fee involved, would coordinate as secondary coverage to your Group Health medical plan.

Medicare will allow you to delay your enrollment in Medicare Part B until you officially retire, without a late enrollment penalty (enrollment in Medicare Part A is optional). Employees more typically enroll in Part A and defer Part B until retirement. For additional information on Medicare eligibility and enrollment periods, please visit www.Medicare.gov.

BENEFICIARY DESIGNATION

In addition to electing or making benefit changes during open enrollment, it is important to designate a beneficiary for your life insurance and if electing the High Deductible Health Plan, your Health Savings Account (HSA). Your beneficiary is the person(s) who will receive your life insurance benefits and any remaining HSA balance when you die. If you have a beneficiary in place, or if your family situation has changed, now is the time to ensure all information on record is correct.

If you do not name a beneficiary, your benefits will automatically go to your estate. For additional information contact the Benefits Department.

COST OF COVERAGE SUMMARY

2021 PAYROLL DEDUCTIONS (MONTHLY)

	Single	Employee + 1	Family
MEDICAL			
Medical PPO Plan	$195.00	$315.00	$390.00
Medical High Deductible Plan	$75.00	$125.00	$160.00
DENTAL			
Base Dental PPO Plan ($1,000 maximum w/o orthodontia)	$28.07	$52.84	$80.83
Buy Up Dental PPO Plan ($1,500 maximum with orthodontia)	40.70	76.61	117.19
VISION			
Vision Plan	$6.58	$12.34	$18.00

UNDERSTANDING YOUR PRE-TAX BENEFIT PAYROLL DEDUCTIONS

The Section 125 Cafeteria Plan allows you to pay for many of the benefits we offer with “before-tax” dollars (e.g., medical, dental and vision coverage). By paying premiums with “before-tax” dollars, you may reduce the amount of income and Social Security taxes that you otherwise would be required to pay. The elections made during the Cafeteria Plan enrollment period are effective for the entire 12-month plan year. Unless you experience a life-changing qualifying event, you cannot make changes to your benefits until the next open enrollment period. Refer to the preceding page of this guide for information on what constitutes a qualifying event, and the associated timeframe you must notify the Benefits Department if you intend to make a change.

COST OF COVERAGE SUMMARY (Continued)

VOLUNTARY LIFE - Below is the cost for the Voluntary Life Insurance coverage.

NOTE: The rates are age banded based on the employee's age as of the first day of the plan year. Spousal rates are based on the employee's age.

EMPLOYEE MONTHLY PAYROLL DEDUCTIONS										
Age Bands	<29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
Rates per $1,000	$.070	$.090	$.120	$.140	$.210	$.360	$.630	$.890	$1.650	$2.670
CHILD (REN) MONTHLY PAYROLL DEDUCTIONS $10,000 each child / family unit $2.00										

VOLUNTARY STD - Below is the cost for the Voluntary STD Insurance coverage.

NOTE: The rates are age banded based on the employee's age as of the first day of the plan year.

EMPLOYEE MONTHLY PAYROLL DEDUCTIONS											
Age Bands	<29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70	75+
Rates per $10	$.315	$.315	$.326	$.389	$.420	$.504	$.586	$.735	$.935	1.103	$1.292

VOLUNTARY LTD - Below is the cost for the Voluntary LTD Insurance coverage.

NOTE: The rates are the same for all age bands.

EMPLOYEE MONTHLY PAYROLL DEDUCTIONS										
Age Bands	<29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
Rates per $100	$.788	$.788	$.788	$.788	$.788	$.788	$.788	$.788	$.788	$.788

VOLUNTARY LEGAL SERVICES - Below is the cost for the Voluntary Legal Services coverage.

EMPLOYEE MONTHLY PAYROLL DEDUCTIONS

NOTE: The rate per single or family unit is a flat $18 per month.

COST OF COVERAGE SUMMARY (Continued)

VOLUNTARY CRITICAL ILLNESS - Below is the cost for the Voluntary Critical Illness Insurance coverage options. You can elect either the $5,000 Low Level plan or the $10,000 High Level plan. The rates are age banded, based on the employee's age as of the first day of the plan year.

For High Deductible Health Plan Participants: The $5,000 Low Level benefit is already included with your High Deductible Health Plan election. You have the option to elect the $10,000 High Level plan by purchasing an additional $5,000 of coverage based on the age banded rates shown below.

EMPLOYEE MONTHLY PAYROLL DEDUCTIONS											
Coverage Amounts	<24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
$1,000 increments Employee Only	$.660	$.680	$.820	$.940	$1.060	$1.500	$2.180	$3.120	$4.220	$5.860	$8.280
$1,000 increments Employee + Spouse	$1.140	$1.180	$1.380	$1.550	$1.730	$2.290	$3.170	$4.380	$5.820	$7.920	$11.160
$1,000 increments Employee + Child(ren)	$1.080	$1.100	$1.250	$1.360	$1.490	$1.920	$2.600	$3.540	$4.650	$6.290	$8.700
$1,000 increments Family	$1.570	$1.610	$1.800	$1.980	$2.150	$2.710	$3.600	$4.800	$6.250	$8.350	$11.590

VOLUNTARY ACCIDENT - Below is the cost for the Accident Insurance coverage options. You can elect either the $25,000 Low Level plan or the $50,000 High Level plan. **These rates are based upon the tier level and plan elected.**

For High Deductible Health Plan Participants: The Low Level benefit is already included with your High Deductible Health Plan election. If you are interested in purchasing the $50,000 High Level plan, please see the rates below on the next page.

EMPLOYEE MONTHLY PAYROLL DEDUCTIONS		
Coverage Levels	**Low Option**	**High Option**
Employee Only	$7.96	$11.62
Employee + Spouse	$15.70	$22.81
Employee + Child(ren)	$17.70	$25.62
Family	$21.94	$31.78

COST OF COVERAGE SUMMARY (Continued)

VOLUNTARY ACCIDENT BUY UP PLAN FOR HIGH DEDUCTIBLE HEALTH PLAN PARTICIPANTS ONLY

The Low Level Accident plan is already included with your High Deductible Health Plan election. You have the option to purchase the $50,000 High Level Accident plan based on the rates below.

EMPLOYEE MONTHLY PAYROLL DEDUCTIONS		
Coverage Levels	**Low Option**	**High Option**
Employee Only	Included with your High Deductible Plan	$5.39
Employee + Spouse	Included with your High Deductible Plan	$10.51
Employee + Child(ren)	Included with your High Deductible Plan	$11.75
Family	Included with your High Deductible Plan	$14.59

MEDICAL COVERAGE

The following is a summary of your medical benefits. For a more detailed explanation of benefits, please refer to your Summary Plan Description (SPD), certificate of coverage or SBC. You may access a list of participating providers through the carrier's website.

www.anthem.com 1-866-755-2680

BENEFITS AT-A-GLANCE

Look for a participating provider in the following network:

	PPO Plan*		HSA Plan*	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
DEDUCTIBLES	Calendar Year		Calendar Year	
Individual	$850	$1,700	$6,350	$12,700
Family	$1,700	$3,400	$12,700	$25,400
COINSURANCE				
Plan Pays	80%	60%	100%	60%
You Pay	20%	40%	0%	40%
OUT-OF-POCKET MAXIMUM (Includes Deductibles, Coinsurance and Copays)				
Individual	$2,500	$5,000	$6,350	$12,700
Family	$5,000	$10,000	$12,700	$25,400
COMMONLY USED SERVICES				
Primary Physician Visit	$30 copay	60% after deductible	100% after deductible	60% after deductible
Specialist Visit	$40 copay	60% after deductible	100% after deductible	60% after deductible
Virtual Visit	$30 copay	Not Covered	$30 copay	Not Covered
Preventive Care Services	100% coverage	60% after deductible	100% coverage	60% after deductible
Urgent Care Visit	$60 copay	$60 copay	100% after deductible	100% after deductible
Emergency Room	$130 copay	$130 copay	100% after deductible	60% after deductible
Diagnostic Labs & X-Rays	Diagnostic: 100% coverage Imaging: 80% after deductible	60% after deductible	100% after deductible	60% after deductible
Hospitalization	80% after deductible	60% after deductible	100% after deductible	60% after deductible
Mental Health*	Inpatient & Outpatient: 80% after deductible Office Visit: $30 copay	60% after deductible	100% after deductible	60% after deductible
Substance Abuse*			100% after deductible	60% after deductible

PRESCRIPTION DRUGS – 30 DAY SUPPLY AT RETAIL PHARMACY**

	Retail (30-day)	Mail Order (90-day)	Retail (30-day)	Mail Order (90-day)
Tier 1 – Generic	$15 copay	$25 copay	100% after deductible	100% after deductible
Tier 2 – Preferred Brand	$30 copay	$60 copay	100% after deductible	100% after deductible
Tier 3 – Brand	$55 copay	$115 copay	100% after deductible	100% after deductible
Tier 4 – Specialty	Covered	Not Covered	100% after deductible	100% after deductible

**See Summary Plan Description for additional details. You may also contact the plan administrator regarding benefits.*
***90-day mail order available*

Rates for the Medical/Prescription Insurance can be found on page 15.

DENTAL COVERAGE

The following is a summary of your dental benefits. For a more detailed explanation of benefits, please refer to your Summary Plan Description (SPD), certificate of coverage or benefit summary. You may access a list of participating providers through the carrier's website.

www.metlife.com 1-800-942-0854

BENEFITS AT-A-GLANCE

	Dental – Base Plan $1,000 Maximum / Without Orthodontia		Dental – Buy Up Plan $1,500 Maximum / With Orthodontia	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Type I—Preventive Services: Oral Exams, Bitewing X-Rays, Full Mouth X-Rays, Cleanings, Fluoride Treatment for Children, Topical Sealants	100% coverage	100% coverage	100% coverage	100% coverage
Type II—Basic Services: Space Maintainers, Restorative, Periodontics, Fillings,	80% after deductible	80% after deductible	90% after deductible	90% after deductible
Type III—Major Services: Oral Surgery, Periodontics, Endodontics, Repairs, Crowns, Bridges, Dentures, Implants	50% after deductible	50% after deductible	60% after deductible	60% after deductible
Type IV—Orthodontics Up to age 26	Not Covered	Not Covered	60% coverage	60% coverage
DEDUCTIBLE *Waived for Preventive Services & Orthodontics*	2021 Year Deductible		2021 Year Deductible	
Individual	$50	$50	$50	$50
Family	$150	$150	$150	$150
MAXIMUM BENEFIT LIMITS				
Annual Limit: Preventative, Basic & Major Services	$1,000	$1,000	$1,500	$1,500
Lifetime Limit: Orthodontics	Not Covered	Not Covered	$1,500	$1,500

WHICH PLAN FITS: THINKING IT THROUGH…

- Do you visit a dentist for regular cleanings and maintenance?
- What kind of dental expenses will you have next year?
- Do you expect to have certain dental procedures performed?
- Do you have dependents who will require orthodontia services?
- Does your dentist participate in the network?

- **Rates for Dental can be found on page 15**.

VISION COVERAGE

The following is a summary of your vision benefits. The vision care network consists of private practicing optometrists, ophthalmologists, opticians and optical retailers. For a more detailed explanation of benefits, please refer to your Summary Plan Description (SPD), certificate of coverage or benefit summary. You may access a list of participating providers through the carrier's website.

www.metlife.com 1-855-638-3931

BENEFITS AT-A-GLANCE

	Vision Plan	
	In-Network	**Out-of-Network**
Eye Exams Covered Once Every 12 Months	$20 copay	Up to $45 reimbursement
Frames Covered Once Every 24 Months	$130 allowance	Up to $70 reimbursement
Lenses Covered Once Every 12 Months	$20 copay	Up to $30-$65 reimbursement
Contact Lenses (Medically Necessary) Covered Once Every 12 Months	$20 copay	Up to $210 reimbursement
Contact Lenses (Elective) Covered Once Every 12 Months	$130 allowance	Up to $105 reimbursement

Rates for Vision Insurance can be found on page 15.

VOLUNTARY LIFE INSURANCE

Employees AND Dependents have the opportunity to elect to purchase Voluntary Life Insurance that provides an additional life insurance benefit for you and your family. If you waived voluntary life coverage when you were initially eligible you will be required to provide **Evidence of Insurability (EOI)** when enrolling at a later date for both you and your family. EOI is the documentation of good health in order to be approved for coverage. The carrier will review and determine approval based on EOI documentation. Benefits may be limited and/or denied based on EOI results. Claims incurred prior to the approval of your coverage will not be covered.

www.metlife.com 1-800-523-6381

BENEFITS AT-A-GLANCE

	EMPLOYEE AND DEPENDENT VOLUNTARY LIFE COVERAGE		
	EMPLOYEE	**SPOUSE**	**CHILD (REN)**
Increments	$10,000 increments	$5,000 increments	$10,000 increments
Maximum	4 times annual earnings or $500,000 ($150,000 is Guaranteed Issue)	lesser of $250,000 or 50% of the employee elected and approved amount ($50,000 is Guaranteed Issue)	Single $10,000 election ($10,000 is Guarantee Issue)

ACTIVELY AT WORK REQUIREMENT - Employee Eligibility Requirements for Life Insurance:

- You must be actively at work on the day coverage is scheduled to begin. If you are not actively at work on that day, coverage for you will begin once you have returned to work.
- Dependent Eligibility Requirement for Life Insurance:
- A dependent confined to a hospital on the date on which insurance would normally begin will become insured upon discharge from the hospital.

Rates for Voluntary Life Insurance can be found on page 16.

VOLUNTARY SHORT TERM DISABILITY

Short Term Disability Insurance provides income protection in the event you become disabled and are unable to work due to sickness or non-occupational injury, including pregnancy, for a short period of time.

 www.metlife.com  1-800-858-6506

BENEFITS AT-A-GLANCE

Benefit Amount	60% of weekly earnings
Benefit Maximum	$500
Benefits Begin After	14 days for accident 14 days for illness
Maximum Benefit Period	13 weeks
Pre-Existing Waiting Period	6/12

VOLUNTARY LONG TERM DISABILITY

Long Term Disability Insurance provides income protection in the event you become disabled and are unable to work for an extended period of time.

 www.metlife.com  1-800-858-6506

BENEFITS AT-A-GLANCE

Benefit Amount	60% of monthly earnings
Benefit Maximum	Executives: $10,000 Hourly Employees: $3,000 Salaried Employees: $6,000
Definition of Disability	2-year own occupation
Benefits Begin After	90 days
Maximum Benefit Period	ADEA Schedule
Pre-Existing Waiting Period	3/12

ACTIVELY AT WORK PROVISION

Employee Eligibility Requirements for Disability Insurance

You must be actively at work on the day coverage is scheduled to begin. If you are not actively at work on that day, coverage for you will begin once you have returned to work.

Rates for Voluntary STD & LTD Insurance can be found on page 16.

VOLUNTARY LEGAL SERVICES

Reduce the out of pocket cost of legal services with MetLife Legal Plans

MetLife Legal Plans, formerly known as Hyatt Legal Plans, gives you access to the expert guidance and tools you need to handle the broad range of personal legal needs you might face throughout your life for you and your dependents. No deductibles and claim forms are needed when using a network attorney for covered items. For non-covered items, that are not otherwise excluded, this benefit provides four hours of network attorney time and services per year.

BENEFITS AT-A-GLANCE

Money Matters				
	Identity Theft Defense	Credit Negotiations	Tax Audits Representation	Debit Collection Defense
	Personal Bankruptcy	Promissory Notes	Tax Collection Defense	Identity Mgmt. Services
Home & Real Estate				
	Boundary & Title Disputes	Eviction Defense	Foreclosure	Home Equity Loans
	Sale/Purchase Home	Security Deposit	Tenant Negotiations	Zoning Applications
	Deeds	Mortgages	Property Tax Asses.	Refinancing of Home
Estate Planning				
	Codicils	Living Wills	Power of Attorney	Revocable and
	Complex Wills	Simple Wills	Healthcare, Financial	Irrevocable Trusts
	Healthcare Proxies		Child Care & Immigration	
Family and Personal				
	Affidavits	Conservatorship	Juvenile Court Defense Including Criminal Matters	Prenuptial Agreement
	Protection from Domestic Violence	Review of any Personal Legal Documents	Parental Responsibility Matters	Personal Property Protection
	School Hearings	Garnishment Defense	Name Change	Adoption
	Immigration Assistance	Guardianship	Demand Letters	Conservatorship
Civil Lawsuits				
	Administrative Hearings	Civil Litigation Defense	Incompetency Defense	Pet Liabilities
	Small Claims Assistance	Disputes Over Consumer Goods & Services		
Elder Care				
	Consultation & Document Review for your Parents: Deeds and Leases	Nursing Home Agreements	Power of Attorney Medicare/Medicaid	Prescription Plans Wills
Vehicle & Driving				
	Defense of Traffic Tickets	License Suspension Due DUI	Repossession	Driving Privileges Restoration

Rates for Legal Services can be found on page 16.

NOTE: You will be responsible to pay the difference, if any, between the plan's payment and the out-of-network attorney's charge for services.
No more than a combined maximum total of four hours of attorney time and service are provided for the member, spouse and qualified dependents, annually.
This benefit provides the Participant with access to LifeStages Identity Management Services provided by CyberScout, LLC. CyberScout is not a corporate affiliate of MetLife Legal Plans. Does not cover DUI.

VOLUNTARY AUTO AND HOME INSURANCE

Employees of Carter-Jones Lumber Co. are eligible for discounts on their home and auto coverage.
You are eligible right now and all you need to do is call to inquire about your discounts on auto insurance. You can switch at any time, no need to wait until your current policy expires. It only takes one quick and easy phone call to MetLife Auto & Home.

Savings and Options

- The option of having premium payments deducted straight from your paycheck.
- **A discount of up to 10%** for choosing this payment option.

Make sure you mention you work for The Carter-Jones Lumber Co. to get your discounts and your personal premium quotes.

Call For Your FREE
Employee Quote From
MetLife Auto & Home

1 800 GET-MET 8 (1-800-438-6388)

VOLUNTARY ACCIDENT INSURANCE

Low Level plan is included in the High Deductible Health Plan

www.metlife.com 1-800-638-5433

Accident insurance includes coverage for both on-the-job and off-the-job accidents. Since accidents can happen at any time, it's important to prepare for the unexpected. This policy can help you pay for out-of-pocket expenses associated with an accident by paying you a benefit depending on the injuries you receive. You can use the money as you wish - pay for healthcare-related expenses, childcare while you go to the doctor, or save it for another unfortunate incident.

Please Note: For Individuals ages 65 to 69 benefits will be reduced by 25% and 50% at age 70.

MetLife Accident Benefit	Low Option Benefit MetLife Accident Pays YOU	High Option Benefit MetLife Accident Pays YOU
Accidental Death & Dismemberment	Employee receives 100% of the amount shown, spouse receives 50% and children receive 20% of the amount shown	Employee receives 100% of the amount shown, spouse receives 50% and children receive 20% of the amount shown
Accidental Death Benefit	$25,000 ($75,000 for common carrier)	$50,000 ($150,000 for common carrier)
Dismemberment/Functional Loss	$750 - $20,000	$1,000 - $40,000
Injuries		
Fractures	$100 - $8,000	$200 - $10,000
Dislocations	$100 – $8,000	$200 - $10,000
Second and Third-Degree Burns	$75 – $10,000	$100 - $15,000
Concussions	$250	$500
Cuts/Lacerations	$50 - $400	$75 - $700
Eye Injuries	$300	$400
Medical Services & Treatment		
Ambulance	$300	$400
Emergency Care	$75 – 150	$100 - $200
Non-Emergency Care	$75	$100
Therapy Services (including physical therapy)	$35	$50
Medical Testing Benefit	$150	$200
Medical Appliances	$75 - $750	$150 - $1,000
Inpatient & Outpatient Surgery	$150 – $1,500	$200 - $2,000
Hospital Coverage (Accident)		
Admission Benefit (for the day of admission)	$1,000	$1,500
Confinement Benefit	$200 a day (non ICU or ICU up to 15 days)	$200 a day (non-ICU or ICU up to 15 days)
Inpatient Rehabilitation Benefit	$150/day – up to 15 days	$200/day – up to 15 days

Please see page 17 for rate information

VOLUNTARY CRITICAL ILLNESS

www.metlife.com 1-800-638-5433

The Low Level plan is included in the High Deductible Health Plan

Critical Illness Insurance protects your family and your assets. Many people don't save money for healthcare expenses, which is why being diagnosed with a heath condition can be draining, both emotionally and financially. This policy provides you with a lump sum cash benefit in the event you or your loved one is diagnosed with a covered condition shown below.

Critical Illness Insurance		
Eligible Individual	**Initial Benefit**	**Requirements**
Employee	**$5,000 or $10,000**	Coverage is guaranteed provided you are actively at work.
Spouse	**50% of the employee's Initial Benefit**	Coverage is guaranteed provided the employee is actively at work and the spouse is not subject to a medical restriction as set forth on the enrollment form and in the Certificate.
Dependent Child(ren)	**50% of the employee's Initial Benefit**	Coverage is guaranteed provided the employee is actively at work and the dependent is not subject to a medical restriction as set forth on the enrollment form and in the Certificate.

Your **Initial Benefit** provides a lump-sum payment upon the first diagnosis of a Covered Condition. Your plan pays a Recurrence Benefit for the following Covered Conditions: Heart Attack, Stroke, Coronary Artery Bypass Graft, Full Benefit Cancer, Partial Benefit Cancer. A Recurrence Benefit is only available if an Initial Benefit has been paid for the Covered Condition. There is a Benefit Suspension Period between Recurrences. Initial Benefits and Recurrence Benefits will be paid until the Total Benefit Amount has been reached.

The maximum amount that you can receive through your Critical Illness Insurance plan is called the **Total Benefit** and is 3 times the amount of your Initial Benefit. This means that you can receive multiple Initial Benefit and Recurrence Benefit payments until you reach the maximum of 300%.

Please refer to the table below for the percentage benefit amount for each Covered Condition

Covered Conditions	Initial Benefit	Recurrence Benefit
Full Benefit Cancer	100% of Initial Benefit	50% of Initial Benefit
Partial Benefit Cancer	25% of Initial Benefit	12.5% of Initial Benefit
Heart Attack	100% of Initial Benefit	50% of Initial Benefit
Stroke	100% of Initial Benefit	50% of Initial Benefit
Coronary Artery Bypass Graft	100% of Initial Benefit	50% of Initial Benefit
Kidney Failure	100% of Initial Benefit	Not applicable
Alzheimer's Disease	100% of Initial Benefit	Not applicable
Major Organ Transplant Benefit	100% of Initial Benefit	Not applicable
22 Listed Conditions (Please see SPD for specific conditions)	25% of Initial Benefit	12.5% of Initial Benefit

Please see page 17 for rate information

TELEMEDICINE

ACCESS AND CONVENIENCE

We understand it may not always be convenient to go to the doctor, which is why we offer you the opportunity to video chat with a doctor for non-emergency situations with 24/7/365 access. It's an affordable and convenient option for quality medical care.

www.livehealthonline.com 1-888-548-3432

BENEFITS AT-A-GLANCE

Telemedicine services through Anthem LiveHealth Online provide you, your spouse and eligible dependents on-demand phone, video and email access to US based licensed physicians. You can connect with a network of physicians for information, advice and treatment including prescription medication when appropriate.

Talk to a doctor anytime, anywhere you happen to be	Receive quality care via phone or online video	Prompt treatment
A network of US based, licensed doctors that can treat children	No limit on consults, so take your time	Secure, personal electronic health record

Conditions Commonly Treated

- Cold and Flu
- Sinus Conditions
- Respiratory Conditions
- Sore Throat
- Allergies
- Upset Stomach
- Urinary Tract Infections
- Muscle or Joint Pain
- And More!

When Can I Use LiveHealth Online

- Your Primary Care Physician is unavailable
- Need treatment for a medical condition
- On a vacation or a business trip
- After business hours or on a weekend
- When you need non-emergent care now
- Any time at home or away
- Request prescription
- Need a short-term prescription refill
- Need assistance coping on your own and need support (video visits with a therapist in 4 days or less)

FLEXIBLE SPENDING ACCOUNT

Only available for those not enrolled in the High Deductible Meedical Plan

WHAT IS A FLEXIBLE SPENDING ACCOUNT?

A Flexible Spending Account (FSA) allows you to set aside money from your paycheck before income taxes (Federal, Social Security, Medicare, state and local taxes, if applicable) are withheld. This money is available to pay for eligible expenses, such as your medical deductibles and copayments, prescriptions, dental expenses, eyeglasses, contact lenses and other health-related expenses that are not reimbursed by your health plan.

HOW DOES IT WORK?

You decide how much to contribute to your FSA on a plan year basis, up to the maximum allowable amount. Your annual election will be divided by the number of pay periods and deducted evenly on a pre-tax basis from each paycheck throughout the plan year.

DEBIT CARD AND CLAIM FILING

You will be issued a debit card to access the Health FSA. Transactions are to be processed like a credit card; a PIN will not be issued. Simply swipe your card at the provider's office, pharmacy, etc. It is important when utilizing the debit card to still request and keep an itemized receipt. You may receive a letter asking for a copy of the receipt. If you fail to submit the information requested, your debit card may be deactivated. Please contact Discovery Benefits if this occurs.

If you do not use the debit card and you have an eligible expense that needs to be reimbursed, simply complete a claim form, include the name of the provider/merchant, name of the person receiving the services, the date of service, type of service and dollar amount. This can be submitted via mobile phone, online or via fax.

NOTE: The debit card issued is valid for three years or until the expiration date noted on the card.

Annual Health FSA Maximum Contribution 2021 Limits	
Health FSA	$2,750
Dependent Care FSA	$2,500 per person or $5,000 married couple

THINGS TO CONSIDER BEFORE YOU CONTRIBUTE TO A HEALTH FSA

- Be sure to fund the account wisely as Health FSAs are subject to a "use it or lose it" rule. Any unused funds at the end of the year will automatically be forfeited.
- You are permitted to carryover up to $550 of unused funds at the end of the year. Any amounts remaining in excess of $550 will be forfeited.
- You cannot take income tax deductions for expenses you pay with your Health FSA &/or Dependent Care FSA.
- You cannot stop or change contributions to your FSA during the year unless you have a change in family status consistent with your change in contributions.

EXAMPLES OF ELIGIBLE EXPENSES:

Unreimbursed medical expenses (deductibles, coinsurance, copays, etc.)

Dental services (excluding cosmetic services)

Orthodontia

Glasses, contacts, and eye exams

Lasik eye surgery

Note: Cosmetic services are not eligible for reimbursement

DEPENDENT FLEXIBLE SPENDING ACCOUNT

WHAT IS A DEPENDENT CARE FSA ACCOUNT?

This is a pre-tax benefit account used to pay for eligible expenses for dependents under age 13 or care for disabled spouse or dependent that allows you - or you and your spouse - to work.

DEPENDENT CARE FSA CONTRIBUTION LIMITS

Under the Dependent Care FSA, if you are married and file a joint return, or if you file a single or head of household return, the annual IRS limit is $5,000. If you are married and file separate returns, you can each elect $2,500 for the plan year. You and your spouse must be employed, or your spouse must be a full-time student to be eligible to participate in the Dependent Care FSA.

CLAIMS REIMBURSEMENT

You may fax, upload or submit your dependent care claim to the carrier for reimbursement online.

Note: You can only be reimbursed for the money you put into the account. For example: if you have contributed $200 into your Dependent Care FSA, but your after-school care was $300 for the month, you can only be reimbursed for $200.

THINGS TO CONSIDER BEFORE YOU CONTRIBUTE TO A DEPENDENT CARE FSA

- Be sure to fund the account wisely as funds are “use it or lose it.”
- You will have 2 ½ months after the end of the year to use FSA funds. Any unused funds after that point will be forfeited
- You must enroll in the dependent care FSA prior to the start of the plan year or during open enrollment (unless you experience certain qualifying life events).
- You may have a have a Health Savings Account and a Dependent Care FSA.
- Save your receipts for each eligible expense you submit for reimbursement. Receipts should include:
    - Name (who received service)
    - Provider name (provider that delivered service)
    - Date of service
    - Type of service
    - Cost of service

EXAMPLES OF ELIGIBLE EXPENSES:

In-Home Babysitting Fees*

Before and After School Care

Day Care Facility Fees

Nanny Expenses

Summer Day Camp

Adult Care Facility Fees

**In order to receive reimbursement for in-home babysitting fees, income must be recorded by the provider.*

For a full list of eligible expenses and requirements, visit www.irs.gov/publications and refer to Publication 503.

HEALTH SAVINGS ACCOUNT (Only available for those who have elected the High Deductible Health Plan)

WHAT IS A HEALTH SAVINGS ACCOUNT?

A Health Savings Account, commonly known as an "HSA," is an individual account you can open, add money to, and spend on eligible healthcare expenses. If you elected the high deductible health plan, you are eligible for an HSA.

SETTING UP YOUR HSA

Once you are covered by a qualified health plan you may set up your HSA.

Once you set up your HSA, any payroll deductions you have elected may begin. It is important to get your HSA set up as quickly as possible because you cannot turn in expenses incurred before the account was set up.

ADDING MONEY

The government sets the annual dollar maximum that can be contributed to an HSA depending on the level of coverage you have under your health insurance. Coverage of two or more people is considered family coverage. People who are age 55 or older can make additional catch-up contributions.

USING HSA MONEY

You decide when to spend money from your HSA. If you pay out of pocket for an eligible medical expense, you can choose to not reimburse yourself and let the money in your HSA build up or you can reimburse yourself for the expense from your HSA.

If you use your HSA money for expenses that are not eligible, you will pay a 20% penalty plus income tax on the amount. Once you turn age 65, you may use your HSA money for any expense, medical or not, but you will pay income taxes on those non-medical expenses. To view the full list of eligible expenses, visit **www.irs.gov/publications** and refer to Publication 969.

HSA Maximum 2021 Contribution Limits	
Employee Only	**$3,600**
Employee + Dependent(s)	**$7,200**
55+ Catch-up	**$1,000**

Note: It is your responsibility to familiarize yourself with IRS regulations on HSAS and maintain records of all transactions pertaining to your HSA for audit purposes.

ELIGIBLE EXPENSES

The money in your HSA must be used for eligible medical, dental, vision, and prescription drug expenses. In general, eligible expenses are those that qualify toward the deductibles, copays, and coinsurance with your health plan. If you use money for a dental, vision or medical expense that is not covered by the medical plan, it is important you understand your medical plan deductible still needs to be met if an expense is incurred.

PORTABILITY	FLEXIBILITY	TAX SAVINGS	PREMIUM SAVINGS
• You own 100% of the deposited funds, meaning if you change employers or retire, you do not lose the money in the accounts regardless of whether you contributed the money or if it was an employer contribution	• You can choose whether to spend the money on current medical expenses or you can save your money for future use • Any unused funds will automatically roll over to the following year as there is no "use it or lose it" provision	• Contributions are tax free (pre-tax through payroll deductions or tax deductible) • Earnings are tax free • Funds withdrawn for eligible medical expenses are tax free	• By choosing the HDHP available, your payroll premium cost is lower than the traditional PPO plan.

MEDICAL PLANS: UNDERSTANDING THE DIFFERENCE

HIGH DEDUCTIBLE HEALTH PLAN (HDHP) VS PPO

Having two health plans to choose from (or more if you have a spouse who also has access to health insurance) can create confusion when it comes time to decide which plan is best for you and your family.

	HDHP	PPO Plan
Annual Deductible	Applies to all expenses (medical and prescriptions)	Applies to hospital services, radiology and lab services performed outside of a doctor's office; does not include copays
Annual Out-of-pocket (OOP) Maximum	Includes all deductible expenses; once OOP reached, the plan pays all eligible expenses at 100% (medical and prescriptions)	Includes all medical deductible and copay expenses; once OOP reached, the plan pays all medical expenses at 100%
Rx Out-of-pocket (OOP) Maximum	Not Applicable	Includes all pharmacy copay expenses once OOP reached, the plan plays all eligible pharmacy expenses at 100%
Set Copayment Amount	No Copays	Copays apply for doctor's office visits and prescription drugs
Out-of-network Coverage	√	√
Preventive Care Coverage	Covered in full at network providers	Covered in full at network providers
Health Savings Account (HSA)	You can contribute up to $3,600 for self-only coverage and $7,200 for family coverage.	Not eligible per IRS guidelines
Flexible Spending Account (FSA)	Not offered with HDHP	No eligibility limitations
Premium Amount	Lower paycheck cost; higher out of pocket at the time of service	Higher paycheck cost; lower out of pocket

IMPORTANCE OF A PRIMARY CARE PHYSICIAN (PCP)

YOUR PARTNER IN HEALTH

Primary care doctors may provide you medical care over a long period of time, help you stay healthy, coordinate your care and recommend other providers, such as specialists, when needed.

CHOOSE THE RIGHT PCP

Choosing a doctor is a very important decision requiring care and consideration. Take advantage of the tools and resources through your medical plan such as provider directories for network providers, maps, and quality ratings to research your options. Asking friends, co-workers or relatives is also helpful when selecting a PCP. For information on specific physicians' training, specialties and board certification you can also visit the American Medical Association at www.ama-assn.org.

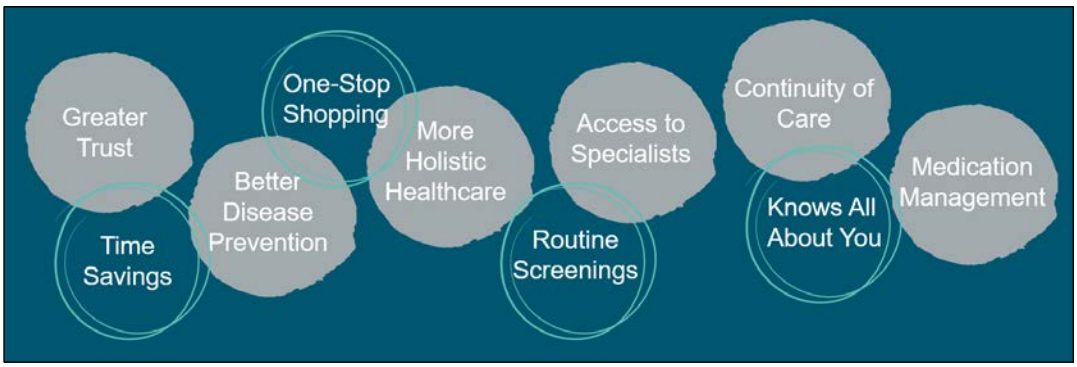
Once you have made your selection, it is important to call your primary care physician for an appointment to establish yourself as a patient. This is a valuable step that may prevent potential wait time in scheduling future appointments.

WHAT DOES A PCP DO?

A primary care provider is your main healthcare provider in nonemergency situations. Starting with preventive care, he or she coordinates the care you need and helps you address health issues before they become a more serious problem. PCPs conduct regular checkups, routine screenings and immunizations, provide patient education, offer advice on preventing disease, as well as overseeing specialty care, lab tests and hospitalization.

BENEFITS OF HAVING A PCP

In addition to the benefits and cost-savings of having an in-network provider, a PCP will help you navigate the healthcare system so you can concentrate on your health. Even if a plan doesn't require you to have a PCP, it's a good idea to choose one. Because of routine tests and regular visits, your PCP will know how to help you stay focused on self-care.



ESTABLISH A RELATIONSHIP WITH YOUR PCP

Having a well-established, trusting relationship with your doctor is crucial to your long-term health, and can also save you money in the long run. Research shows that patients who have a good relationship with their doctor receive better care and are happier with the care they receive.

Tell your doctor about your health history, your family's health history, symptoms, medications and any allergies you have. If you do not share relevant information, your doctor may not ask or may assume there is nothing important he or she needs to know. Withholding information may make it difficult for your doctor to determine the best care route for you to take. The more comfortable you are, the more you'll share — and that can be good for your health in the long run.

Your doctor works hard to keep you healthy, but quality healthcare is a team effort. Make sure to ask questions if you don't understand what your doctor is recommending. This is especially important to do before receiving health services. Not every plan is the same, so it's important to ask questions to avoid confusion and unexpected costs later. If you are confused about anything your doctor recommends, don't be afraid to ask questions.

EMERGENCY ROOM OR URGENT CARE

KNOW WHERE TO GO

If you're faced with a sudden illness or injury, making an informed choice on where to seek medical care is crucial to your personal and financial well-being. Making the wrong choice can result in delayed medical attention and may cost hundreds, if not thousands, of dollars. More than 10 percent of all emergency room visits could have been better addressed in either an urgent care facility or a doctor's office.

If you're suddenly faced with symptoms of an illness or injury, how can you determine which facility is most appropriate for your condition?

EMERGENCY ROOM

URGENT CARE

The **emergency room (ER)** is equipped to handle life- threatening injuries and illnesses and other serious medical conditions. Patients are seen according to the seriousness of their conditions in relation to the other patients.	**Urgent care centers** are not equipped to handle life-threatening injuries, illnesses or medical conditions. These centers are designed to address conditions where delaying treatment could cause serious problems or discomfort.
You should go to the nearest ER if you experience any of the following: • Compound fractures • Deep knife or gunshot wounds • Moderate to severe burns • Poisoning or suspected poisoning • Seizures or loss of consciousness • Serious head, neck or back issues • Severe abdominal pain • Severe chest pain or difficulty breathing • Signs of a heart attack or stroke • Suicidal or homicidal feelings • Uncontrollable bleeding	Some examples of conditions that require a visit to an urgent care center include: • Controlled bleeding or cuts that require stitches • Diagnostic services (x-rays, lab tests) • Ear infections • High fever or the flu • Minor broken bones (e.g., toes, fingers) • Severe sore throat or cough • Sprains or strains • Skin rashes and infections • Urinary tract infections • Vomiting, diarrhea or dehydration

REMEMBER: Unless it is a true emergency – a serious or life-threatening condition that requires immediate treatment that is only available in a hospital – consider your options for appropriate, quality care that is efficient and economical.

DON'T PAY MORE IF YOU DON'T HAVE TO:

Convenience Care Clinics are walk-in clinics typically located in a supermarket, pharmacy or retail store, where available. Services may be provided at a lower out-of-pocket cost compared to urgent or emergency care as they are subject to primary care office visit copays and/or coinsurance. Convenience care clinics are suitable for non-life threatening immediate care. *Examples include: common infections (ear, bladder, pink eye, strep throat); minor skin conditions, allergies, and more.*

PHARMACY RESOURCES

SAVE ON PRESCRIPTION COSTS

Many pharmacies now offer discount prescriptions – maybe even lower than your copay.

Pharmacies nationwide sell select generic drugs at a discounted rate. Generic drugs are distributed as the equivalent to the brand name; however, you should talk to your doctor if you have questions about your prescription. You can find the best deals on your medications by identifying the pharmacies that offer these programs. Here are just a few available:

Sam's Club	Plus members can receive hundreds of generic medications at $4 or $10 for a 30-day supply, and five select prescriptions for free
Walmart	$4 for a 30-day supply and $10 for a 90-day supply of some generic medications
Walgreens	Prescriptions Savings Club where members can get over 50 medications for as low as $5 for a 30-day supply and discounts on vitamins, birth control, diabetic supplies and lifestyle medications
Rite Aid	Rx Savings Program offers members a selection of generic medications at $9.99 for a 30-day supply and $15.99 for a 90-day supply
Costco	Member Prescription Program offers savings on brand and generic medications
Meijer	Offers a variety of oral antibiotics for free
Kroger	Rx Savings Club includes reduced prices on thousands of medications of which over 100 generic medications are priced between $3 and $12 and some select medications are free
Publix	Next Best Thing to Free Program offers a 90-day supply for select generic medications for only $7.50
Giant Eagle	Offers a wide range of generic drugs at $4 or $10 per prescription as well as a 90-day supply for qualified medications

NOTE: Be sure to check with the pharmacy for current discounts and offerings

HYLANT SCRIPT NAVIGATOR

Check out Hylant Script Navigator

The Hylant Script Navigator (**http://www.hylant.medtipster.com**) is the ultimate pharmacy search engine that will help you identify discounted generic prescriptions that are available at pharmacies throughout the USA. Just log on and enter the following:

HEALTH SAVINGS TIPS

STRETCHING YOUR HEALTHCARE DOLLAR

As healthcare costs continue to rise, it is increasingly important that you take an active role in decisions about your health, the care you receive and your benefits. Here are some tips to help get you the most for your money.

CHOOSE A PRIMARY CARE PHYSICIAN

Selecting a primary care physician is one of the best things you can do for your health. This person knows your health history and schedules routine screening tests that frequently help prevent and detect diseases, such as heart disease, cancer, and diabetes. Your PCP can provide necessary medical advice and identify health concerns before they become a major issue.

STAY IN-NETWORK

In-network providers have a contract with the health insurance company to provide services at reduced rates. In most cases, if you visit a physician or other provider within the network, the amount you will be responsible for paying will be less than if you go to an out-of-network provider.

DON'T SKIP PREVENTIVE CARE

Be sure your child gets routine checkups and vaccines as needed, both of which can prevent medical problems (and bills) down the road. Also, adults should get the preventive screenings recommended for their age in order to detect health conditions early.

PRICE COMPARE PRESCRIPTIONS

Ask your provider for the generic version of a prescription. If you order your maintenance medications in bulk (90-day supply) through mail order, search for the least expensive pharmacy option near you, or check to ensure prescribed medications are on the plan's formulary list.

LIVE A HEALTHY LIFESTYLE

Focus on eating nutritiously, cutting down on fast food and getting more physical exercise. Take advantage of tobacco cessation programs. Take a walk at lunch to manage stress. Striving toward a healthier lifestyle and maintaining a healthy weight can drastically reduce future medical conditions and diseases.

USE THE PLAN'S TOOLS & RESOURCES

Many health plans provide access to free disease management programs for chronic conditions like asthma, diabetes and heart disease. These programs can help you stay healthy and manage your condition and can possibly save you money in the long run. Look for other available resources or programs that are designed to prevent illness and lower health costs over the long run.

PRESCRIPTION OPIOID AWARENESS

BE INFORMED

You've no doubt heard that there's a national opioid epidemic, affecting people of all ages and income levels. Someone you know – a friend, a family member or even a coworker – might be misusing, abusing or addicted to prescription painkillers.

WHAT'S AN OPIOID

Prescription opioids can be used to help relieve moderate-to-severe pain and are often prescribed following a surgery or injury, or for certain health conditions. These medications can be an important part of treatment but also come with serious risks. It is important to work with your healthcare provider to make sure you are getting the safest, most effective care.

KNOW YOUR OPTIONS

Before accepting a prescription, talk to your doctor:

· Make the most informed decision.
· Work with your doctor to create a plan on how to manage your pain.
· Know your options and consider ways to manage your pain that do not include opioids.
· Talk to your doctor about any and all side effects and concerns.
· Follow up regularly with your doctor.

IF YOU ARE PRESCRIBED OPIOIDS

Make sure you know the name of your medication, how much and how often to take it, and its potential risks & side effects.

Never take opioids in greater amounts or more often than prescribed.

Avoid taking opioids with alcohol and other substances or medications you have not discussed with your doctor.

Store prescription opioids in a secure place and out of reach of others (this may include visitors, children, friends, and family).

Safely dispose of unused prescription opioids.

SIDE EFFECTS

Prescription opioids carry serious risks of addiction and overdose, especially with prolonged use. An opioid overdose, often marked by slowed breathing, can cause sudden death. The use of prescription opioids can have a number of side effects as well, even when taken as directed:

Tolerance	Sleepiness/dizziness
Physical dependence	Confusion
Increased sensitivity to pain	Depression
Constipation	Itching and sweating

Low levels of testosterone
Nausea, vomiting and dry mouth

ALTERNATIVES FOR PAIN MANAGEMENT

Talk with your doctor about the benefits of using one of the below methods if you suffer from chronic pain. Some of the options may even work more effectively than opioids, depending on the type of pain. Here are some of the alternative solutions proposed by the CDC:

- Acetaminophen (Tylenol) or ibuprofen (Advil)
- Cognitive behavioral therapy—a psychological, goal-directed approach in which patients learn how to modify physical, behavioral, and emotional triggers of pain and stress
- Exercise therapy, including physical therapy
- Medications for depression or for seizures
- Interventional therapies (injections)
- Exercise and weight loss
- Other therapies such as acupuncture and massage

HOW TO GET HELP

If you believe you or a loved one may be struggling with addiction, tell your health care provider and ask for guidance or call the Substance Abuse and Mental Health Services Administration (SAMHSA) National Helpline at 1-800-662-HELP (4357). Be Informed!

IMPORTANT TERMS

Brand A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine. You generally pay a higher copay for brand name drugs and your employer pays a higher amount when the claim is paid as well.

Coinsurance After you meet the deductible amount, you and the plan share the cost of covered expenses. Coinsurance is always a percentage totaling 100%. For example, if your plan pays 70% coinsurance, you pay the remaining coinsurance share, 30% of the cost.

Copayment or Copay A form of medical cost-sharing whereby a member pays at time of service (or purchase for prescription drugs) a fixed dollar amount, regardless of whether you have met your deductible for the year.

Deductible The fixed amount of cost-sharing you are responsible for during the benefit period before the plan will pay. The deductible typically does not apply to preventive care and certain other services. Plans may have both per individual and family deductibles. Deductibles may differ if services are received in-network versus out-of-network.

Evidence of Insurability (EOI) A medical questionnaire used to determine whether an applicant will be approved or declined for coverage. This may be required for certain types of insurance coverage.

Explanation of Benefits (EOB) The statement made available to a member by their carrier after services have been received and the claim has been processed, which lists the services received, amount paid by the plan, and the amount to be paid by the member.

Flexible Spending Accounts Health or Dependent Care (HCFSA or DCFSA): An account you put money into that you use to pay for certain out-of-pocket health or childcare costs with pre-tax dollars. This means you'll save an amount equal to the taxes you would have paid on the money you set aside. Funds deposited into a health FSA will be forfeited if you do not use them by the IRS deadline.

Formulary A list of prescription drugs covered by the plan that will be used to determine the coverage for the drug based on the tier the drug is listed.

Generic Medications that have the same active ingredients, dosage, and strength as their brand-name counterparts. Generic drugs generally have the same efficacy as their brand name counterparts at a much lower cost for you and your employer.

Guaranteed Issue When an insurance policy is offered to any eligible applicant without regard to the health status of the individual that applies. Typically, no health questionnaires (EOI) or exams are required.

Health Savings Account (HSA) A tax-free, individually-owned savings account used to pay for you and your eligible dependents' insurance deductibles and qualified out-of-pocket medical, dental and vision expenses. Account owners must be enrolled in a high deductible health plan and have no access to first dollar coverage such as Medicare or Direct Primary Care. Money deposited in an HSA stays with you, regardless of employer or plan, and unused balances roll over year to year. The employer and the employee can contribute to the HSA up to the annual limit for an individual or a family as stated by IRS guidelines.

High Deductible Health Plan (HDHP) Also called a "Consumer Driven Health Plan" (CDHP), has lower premiums and higher deductibles than a traditional health plan. With the exception of preventive care, employees must meet the annual deductible before the plan pays benefits even for office visits and prescriptions.

In-network Doctors, clinics, hospitals and other providers with whom the plan has an agreement to care for its members. Plans cover a greater share of the cost for in-network providers than for providers who are out-of-network and the member pays a lower amount for those services.

Mandatory Generic When you request a brand name drug when there is a generic equivalent, you pay the generic copay plus the cost difference between the brand and generic drug.

Non-Preferred Brands These medications generally have generic alternative and/or one or more preferred brand options within the same drug class which causes these drugs to cost more. You and your employers usually pay more for non-preferred brand medications. Also known as non-formulary brands.

Out-of-Network A physician, healthcare professional, facility or pharmacy that doesn't participate in the plan's network and doesn't provide services at a discounted rate. Using an out-of-network healthcare professional or facility will cost you more.

Out-of-Pocket Maximum The maximum dollar amount a member is required to pay out of pocket for allowable covered expenses under a plan during a benefit period before the plan will pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or services your plan doesn't cover.

Preferred Drug A list of prescription medicines that are preferred based on an evaluation of effectiveness and cost. Another name for this list is a "formulary" or "formulary brand." The plan may charge more for non-preferred drugs or for brand name drugs that have generic versions. Drugs not on the preferred drug list may not be covered.

Payroll Deduction The amount you pay out of your paycheck in order to be enrolled in the medical, dental and/or vision insurance plans and possible other offered benefits.

Prior Authorization/Pre-Service Notification The decision by the plan that a service, treatment plan, prescription drug, medical equipment, or other services defined in the certificate of coverage and/or Summary Plan Description (SPD), is medically necessary. The plan may require preauthorization for certain services before receiving them, in order for the service to be covered.

Provider A physician (medical, dental or vision), healthcare professional or health care facility licensed, certified or accredited as required by state law recognized for payment by the plan.

Qualifying Event An occurrence defined by IRS Section 125 such as marriage/divorce, death, termination of employment, child birth/adoption, involuntary loss of coverage, etc. which triggers an employee's ability to make changes to their benefit elections at the time the qualifying event occurs outside of open enrollment.

Usual, Customary and Reasonable (UCR) The determined going rate for a service in a geographic area based on what providers in the area usually charge for the same or similar service. The UCR amount is sometimes used to determine the allowed amount and is used typically when services are provided by an out-of-network provider.

Note to All Employees

Certain Federal Regulations require employers to provide disclosures of these regulations to all employees. The remainder of this document provides you with the required disclosures related to our employee benefits plan. If you have any questions or need further assistance, please contact your Plan Administrator as follows:

October 1, 2020

Carter-Jones Lumber Co.
Benefits Department
601 Tallmadge Rd., #7331
Kent, OH 44240
330-673-6100 ext. 241

Notice Regarding Special Enrollment Rights

If you do not timely or properly complete the enrollment process, you and your Eligible Dependents generally will not be covered under the applicable Plan for the remainder of the Plan Year, except as described below. Also, if you fail to specifically enroll your Eligible Dependents on the enrollment form, your Eligible Dependents will not be covered under the applicable Plan for the remainder of the Plan Year, except as otherwise provided below.

(a.) If you decline enrollment for yourself or your dependents because you or your dependent had other health insurance or group health plan coverage, either through COBRA or otherwise, you may enroll yourself and Eligible Dependents in the Health Program within **30 days** of the loss of that coverage. For this purpose, “loss of coverage” will occur if the other group health plan coverage terminates as a result of: (i) termination of employer contributions for the other coverage; (ii) exhaustion of the maximum COBRA period; (iii) legal separation or divorce; (iv) death; (v) termination of employment; (vi) reduction in hours of employment; or (vii) failure to elect COBRA coverage.

However, a loss of coverage will not be deemed to occur if the other coverage terminates due to a failure to pay premiums or termination for cause. At the time you enroll in the Employer’s Plan, you must provide a written statement from the administrator of the other health plan that you no longer have that coverage.

(b.) You are eligible to enroll yourself and your Eligible Dependent in the Health Program within **30 days** of the date you acquire a new Eligible Dependent through marriage, birth, adoption or placement for adoption. Your enrollment will become effective on the date of marriage, birth, adoption or placement for adoption. (Note pre-tax payments may not be made for retroactive coverage due to marriage.)

(c.) You are eligible to enroll yourself and your Eligible Dependent in the Plan within **60 days** after either:

(1.) You or your Eligible Dependent’s Medicaid coverage under title XIX of the Social Security Act or CHIP coverage through a State child health plan under title XXI of the Social Security Act is terminated as a result of loss of eligibility for such coverage; or

(2.) You or your Eligible Dependent is determined to be eligible for employment assistance under Medicaid or CHIP to help pay for coverage under the Plan.

Notice Regarding Women’s Health and Cancer Rights Act (Janet’s Law)

On October 21, 1998, Congress passed a Federal Law known as the Women’s Health and Cancer Rights Act. The law includes important new protections for breast cancer patients who elect breast reconstruction in connection with a mastectomy. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and patient, for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymph edemas

These benefits will be provided subject to the same deductible and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, please call your plan administrator.

HIPAA Privacy

The Plan complies with the privacy requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These requirements are described in a Notice of Privacy Practices that was previously given to you. A copy of this notice is available upon request.

Health Insurance Marketplace Coverage Options and Your Health Coverage

There is an additional way to buy health insurance: the **Health Insurance Marketplace**. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

Each year, the open enrollment period for health insurance coverage through the Marketplace runs from Nov. 1 through Dec. 15 of the previous year. After Dec. 15, you can get coverage through the Marketplace only if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP).

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards.

If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.83 percent of your household income for 2021, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. (An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.)

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact the Benefits Department. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **www.HealthCare.gov** for more information, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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	**FLORIDA – Medicaid**
Website: **http://myalhipp.com/** Phone: 1-855-692-5447	Website: **http://flmedicaidtplrecovery.com/hipp/** Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – 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**	Website: **https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp** Phone: 678-564-1162 ext 2131
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: **http://myarhipp.com/** Phone: 1-855-MyARHIPP (855-692-7447)	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 1-800-457-4854
CALIFORNIA – Medicaid	**IOWA – Medicaid**
Website: **https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx** Phone: 916-440-5676	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
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**KANSAS – Medicaid**
Health First Colorado: **https://www.healthfirstcolorado.com/** Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: **www.colorado.gov/pacific/hcpf/child-health-plan-plus** CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): **https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program** HIBI Customer Service: 1-855-692-6442	Website: **http://www.kdheks.gov/hcf/default.htm** Phone: 1-800-792-4884

KENTUCKY – Medicaid	NEW HAMPSHIRE – 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: h**ttps://kidshealth.ky.gov/Pages/index.aspx** Phone: 1-877-524-4718 Kentucky Medicaid Website: **https://chfs.ky.gov**	Website: **https://www.dhhs.nh.gov/oii/hipp.htm** Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: **www.medicaid.la.gov** or **www.ldh.la.gov/lahipp** Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	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
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: **http://www.maine.gov/dhhs/ofi/public-assistance/index.html** Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: **https://www.maine.gov/dhhs/ofi/applications-forms** Phone: 1-800-977-6740 TTY: Maine relay 711	Website: **https://www.health.ny.gov/health_care/medicaid/** Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA - Medicaid**
Website: **http://www.mass.gov/eohhs/gov/departments/masshealth/** Phone: 1-800-862-4840	Website: **https://medicaid.ncdhhs.gov/** Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA - Medicaid**
Website: **https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp** Phone: 1-800-657-3739	Website: **http://www.nd.gov/dhs/services/medicalserv/medicaid/** Phone: 1-844-854-4825
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: **http://www.dss.mo.gov/mhd/participants/pages/hipp.htm** Phone: 573-751-2005	Website: **http://www.insureoklahoma.org** Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid**
Website: **http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP** Phone: 1-800-694-3084	Website: **http://healthcare.oregon.gov/Pages/index.aspx** **http://www.oregonhealthcare.gov/index-es.html** Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: **http://www.ACCESSNebraska.ne.gov** Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: **https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx** Phone: 1-800-692-7462
NEVADA – Medicaid	**RHODE ISLAND – Medicaid and CHIP**
Medicaid Website: **http://dhcfp.nv.gov**	Website: **http://www.eohhs.ri.gov/** Phone: 855-697-4347, or 401-462-0311 (Direct RIte Share Line)

Medicaid Phone: 1-800-992-0900	
SOUTH CAROLINA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: **https://www.scdhhs.gov** Phone: 1-888-549-0820	Website: **https://www.coverva.org/hipp/** Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
SOUTH DAKOTA - Medicaid	**WASHINGTON - Medicaid**
Website: **http://dss.sd.gov** Phone: 1-888-828-0059	Website: **http://www.hca.wa.gov/** Phone: 1-800-562-3022
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: **http://gethipptexas.com/** Phone: 1-800-440-0493	Website: **http://mywvhipp.com/** Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: **https://medicaid.utah.gov/** CHIP Website: **http://health.utah.gov/chip** Phone: 1-877-543-7669	Website: **https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf** Phone: 1-800-362-3002
VERMONT - Medicaid	**WYOMING – Medicaid**
Website: **http://www.greenmountaincare.org/** Phone: 1-800-250-8427	Website: **https://health.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
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email **ebsa.opr@dol.gov** and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)

Medicare Notice

You must notify Carter-Jones Lumber Co. when you or your dependents become Medicare eligible. Carter-Jones Lumber Co. is required to contact the insurer to inform them of your Medicare status. Federal law determines whether Medicare or the group health plan is the primary payer. You must also notify Medicare directly that you have group health insurance coverage. Privacy laws prohibit Medicare from discussing coverage with anyone other than the Medicare beneficiary or their legal guardian. The toll-free number to Medicare Coordination of Benefits is 1-855-797-2627.

If you have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices in your prescription drug plan. Please see the complete Medicare Part D Coverage Notice that follows.

Medicare Part D Coverage Notice – Important Information About Your Prescription Drug Coverage and Medicare

Please note that the following notice only applies to individuals who are or will become eligible for Medicare in the next 12 months.

Medicare eligible individuals may include employees, spouses or dependent children who are Medicare eligible for one of the following reasons.

- Due to the attainment of age 65
- Due to certain disabilities as determined by the Social Security Administration
- Due to end-stage renal disease (ESRD)

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

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.

Carter-Jones Lumber Co. has determined that the prescription drug coverage offered by your company plan 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. If 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 15 through December 7. 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 will not be affected. Your current coverage pays for other health expenses in addition to prescription drugs. The prescription drug coverage is part of the Group Health Plan and cannot be separated from the medical coverage. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits. You have the option to

waive the coverage provided under the Group Health Plan due to your eligibility for Medicare. If you decide to waive coverage under the Group Health Plan due to your Medicare eligibility, you will be entitled to re-enroll in the plan during the next open enrollment period.

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 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 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage

Contact your HR Representative. You will receive this notice each year and again, if this coverage through your 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 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, visit U.S. Social Security Administration's at **www.socialsecurity.gov** or call 1-800-772-1213 (TTY 1-800-325-0778).

Remember: 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).

COBRA NOTICE

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. If you're an associate, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

Your hours of employment are reduced, or
Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an associate, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

Your spouse dies;
Your spouse's hours of employment are reduced;
Your spouse's employment ends for any reason other than his or her gross misconduct;
Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

The parent-associate dies;
The parent-associate's hours of employment are reduced;
The parent-associates employment ends for any reason other than his or her gross misconduct;
The parent-associate becomes entitled to Medicare benefits (Part A, Part B, or both);
The parents become divorced or legally separated; or
The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

The end of employment or reduction of hours of employment;
Death of the associate;
Commencement of a proceeding in bankruptcy with respect to the employer; or
The associate's becoming entitled to Medicare benefits (under Part A, Part B, or both).

You Must Give Notice of Some Qualifying Events

For all other qualifying events (divorce or legal separation of the associate and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Benefits Department benefits@carterlumber.com.

Notification should be in writing and include official documentation of qualifying event

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered associates may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. Please provide Social Security disability determination confirmation to Discovery Benefits.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?
In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes
To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information
Carter-Jones Lumber Co.
Benefits Department
601 Tallmadge Rd., #7331
Kent, OH 44240
benefits@carterlumber.com
330-673-6100

NOTICE OF RESCISSION OF COVERAGE

Under Health Care Reform, your coverage may be rescinded (i.e., retroactively revoked) due to fraud or intentional misrepresentation regarding health benefits or due to failure to pay premiums. A 30-day advance notice will be provided before coverage can be rescinded.

Summary of Benefits & Coverage (SBC)

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

The Summary of Benefits & Coverage (SBC) is a document intended to help people understand their health coverage and compare health plans when shopping for coverage. The federal government requires all healthcare insurers and group healthcare sponsors to provide this document to plan participants. SBCs will be created for each medical plan offered. Group health plan sponsors must provide a copy of the SBC to each employee eligible for coverage under the plan. The SBC includes:

- A summary of the services covered by the plan
- A summary of the services not covered by the plan
- A glossary of terms commonly used in health insurance
- The copays and/or deductibles required by the plan, but not the premium
- Information about members' rights to continue coverage
- Information about members' appeal rights
- Examples of how the plan will pay for certain services

The SBCs are through the Benefits Department. Please contact benefits@carterlumber.com regarding questions.