2024
Employee Benefits Guide

Plan Year: January 1–December 31, 2024

3Cloud

OUR COMMITMENT

3Cloud understands the importance of offering valuable benefits to our employees. Since the company's inception, we have strived planned and coverage options to employees and their families, understanding the needs of each family are different. Our comprehensive benefits program includes medical, dental, and vision plans; life insurance coverage for you and your eligible dependents; income protection in the event of a disability; and supplemental worksite plans.

This guide provides an overview of the coverages available. 3Cloud reserves the right to amend or change benefit offerings at any time. This guide is not a Summary Plan Description (SPD) nor a contract or guarantee of benefits coverage. Official plan and insurance documents that govern your rights and benefits, including covered benefits, exclusions and limitations, will be posted on Employee Navigator. If any discrepancy exists between this guide and the official documents, the official documents will prevail.

Benefits At-a-Glance

Coverage	Carrier
Medical	BlueCross BlueShield of Illinois
Dental	Guardian
Vision	Guardian
Health Savings Account (HSA)	Flex Benefits
Flexible Spending Account (FSA)	Flex Benefits
Health Reimbursement Account (HRA)	Flex Benefits
Commuter Benefit	Flex Benefits
Life and AD&D	Guardian
Disability	Guardian
Accident / Critical Illness	Guardian

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IMPORTANT CONTACTS

3Cloud: Benefits Contact

Kristin Gilligan
Tel: 331.300.3410
Email: kgilligan@3cloudsolutions.com

Medical: BlueCross BlueShield of Illinois

Policy #: 271488
Tel: 800.538.8833
Web: bcbsil.com

Medical Accounts (HRA, HSA, FSA) | Commuter Benefit: Flex Benefits

Tel: 888.345.7990
Web: myflexaccount.com

Employee Assistance Program: Uprise Health (Guardian)

Tel: 800.395.1616
Web: members.uprisehealth.com

Dental | Vision | Life Insurance | Disability | Supplemental Plans: Guardian

Policy #: 00029433
Tel: 888.482.7342
Web: guardianlife.com

Employee Care Center

The Employee Care Center (ECC), provided by BKS Partners, is a dedicated team of individuals that are here to assist you with your benefits-related questions. The ECC is focused on bringing clarity to the open enrollment and claims processes, along with providing education on how to use your benefits to maximize efficiency and cost savings. Available during open enrollment and throughout the year, hours of operation are Monday-Friday, 8 a.m.-5 p.m. EST.

Tel: 800.560.3605 | Email: 3cloud@bks-partners.com

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 33 for more details.

ELIGIBILITY

Employees

Employees with full time status, who work at least 30 hours a week, are eligible for insurance benefits effective the first day of the month following or coinciding with your hire date.

Dependents

You may also elect coverage for your dependents in some circumstances. Eligible dependents may include the following:

- Your Legal Spouse
- Domestic Partner
- Dependent Children

Domestic Partner is defined as:

- You are each other's sole domestic partner.
- You both are at least 18 years old and mentally competent to consent to contract.
- You reside together in at least one personal residence for at least 12 months.
- You are engaged in a committed relationship of mutual caring and support and are jointly responsible for each other's common welfare; and either:
  a. You are jointly responsible for your assets and debts as provided by applicable law; OR
  b. You have executed a written agreement or civil contract, which defines your domestic partnership and your liabilities with respect to your assets and debts.
- You are not related by blood closer than what would bar marriage under applicable law in effort where you reside;
- You are not legally married to anyone else and are not involved in any other domestic partnership.
- If previously married or in another domestic partner relationship, at least one year has elapsed since that date of the judgment terminating the prior marriage or end of the domestic partner relationship.
- You have not entered into this relationship for the primary purpose of obtaining insurance benefits.

IMPORTANT NOTES: The Domestic Partner portion of premium deductions are not eligible for pre-tax deductions. Domestic Partners are not eligible for COBRA benefits.

The term "child(ren)" includes:

- A natural or legally adopted child
- A foster child, if placed in your home with state statutes prior to their 18th birthday
- A spouse's or domestic partner's child(ren) residing with you and dependent upon you for support; or a child whom you or your spouse/domestic partner have a legal obligation to support, even though not living with you.

Type of Coverage	Coverage End Date	Coverage Exceptions
Medical* | Dental | Vision	End of the month of 26th birthday	
Life	On 26th birthday	
Universal Life	Child: Age 22 Grandchild: Age 18	Maximum age refers to the max age the child and/or grandchild can be in order to be enrolled in the policy

*The age limit does not apply to a child who becomes disabled, or became disabled, before reaching the age limit and who: cannot hold a self-supporting job due to a permanent physical handicap or intellectual disability; and depends on you for financial support.

CHANGING YOUR BENEFITS

Section 125 | Pre-tax Benefits

Several benefits offered by 3Cloud are covered under the IRS Section 125 plan. This plan allows your premium contributions to be taken out of your paycheck before taxes are applied. This results in a greater take home pay for you. Because your share of the cost of the plan is taken from your paycheck on a pre-tax basis, the IRS requires that you only change your elections when a family status change takes place or during open enrollment.

Examples of family status change include:

- Marriage, divorce, legal separation or annulment
- Birth or adoption of a child
- A qualified medical child support order
- Death of a spouse or child
- A change in your dependent's eligibility status
- Loss of coverage from another health plan
- Change in your residence or workplace (if your benefit options change)
- Loss of coverage through Medicaid or Children's Health Insurance Program (CHIP)
- Becoming eligible for a federal or state premium assistance program under Medicare, Medicaid, or CHIP

If you would like to make a benefit change due to a status change, you must notify HR within 30 days of the life event. Otherwise, no changes will be allowed until the next annual open enrollment. Remember, if you change your benefit elections, your premium contributions will change.

Key Terms To Know

Copay

A fixed dollar amount that you pay for certain covered services. Typically, your copay is due up front at the time of service.

Deductible

The amount that you must pay each year for certain covered health services before the insurance plan will begin to pay.

Coinsurance

After you meet your deductible, you may pay coinsurance, which is your share of the costs of a covered service.

Out-of-Pocket Maximum

Includes copays, deductibles, and coinsurance. Once you meet this amount, the plan will pay 100% of covered services the rest of the year.

Common Healthcare Terminology

Understanding healthcare–related terminology can be difficult. That's why BKS Partners has created a digital resource where you can find definitions for common medical terminology and phrases. You can access the PDF online at bit.ly/3sqA7gl or by scanning the QR code to the right with your mobile phone's camera.

Scan Me!

MEDICAL PLANS

The medical benefit is offered through BlueCross BlueShield of Illinois and the network is BluePrint PPO.

Plan Name	BluePrint PPO 2120	BluePrint PPO 2030
Health Benefits		
Plan Year Deductible		
Individual	$2,500	$500
Family (Individual / Family)	$2,500 / $7,500	$500 / $1,500
Out-of-Pocket Maximum Includes:	Deductible, Coinsurance, Copays & Rx	Deductible, Coinsurance, Copays & Rx
Individual	$4,500	$2,500
Family (Individual / Family)	$4,500 / $12,000	$2,500 / $7,500
Coinsurance (Amount member pays)	20%	20%
Office Visit Copay		
Preventative	$0	$0
Primary Care Physician	$30	$20
Specialist	$50	$40
In-Patient Hospital Visit	20% after deductible	20% after deductible
Outpatient Surgery—*Hospital*	20% after deductible	20% after deductible
Outpatient Surgery—*Ambulatory*	20% after deductible	20% after deductible
Emergency Room Visit	$150	$150
Urgent Care Visit	20% after deductible	20% after deductible
Lab (Independent Facility)	PCP: $30 / SPC: $50	PCP: $20 / SPC: $40
X-Ray (Diagnostic Facility)	PCP: $30 / SPC: $50	PCP: $20 / SPC: $40
Advanced Imaging (Diagnostic Facility)	20% after deductible	20% after deductible
Prescription Benefits		
Prescription Tier Structure		
Tier 1 (Generic – Preferred / Non-preferred)	$0 / $15	$0 / $10
Tier 2 (Preferred)	$30	$50
Tier 3 (Non-preferred)	$50	$100
Tier 4	Not covered	Not covered
Specialty	$150	PB: $150 / NPB: $250
Mail Order Rx (90-day supply)	NPG: $30 / PB: $50 / NPB: $100	P: $0 / NPG: $20 / PB: $100 / NPB: $200
Out-of-Network Benefits		
Deductible (Individual / Family)	$5,000 / $15,000	$1,000 / $3,000
Coinsurance (Amount member pays)	40%	40%
Out-of-Pocket Maximum (Individual / Family)	$13,500 / $36,000	$7,500 / $22,500

Medical Premiums / Payroll Deductions

Plan Name	BluePrint PPO 2120	BluePrint PPO 2030
	Semi-monthly	**Semi-monthly**
Employee Only	$106.53	$127.12
Employee + Spouse	$234.86	$280.24
Employee + Child(ren)	$232.71	$277.67
Employee + Family	$361.04	$430.79

MEDICAL PLANS

The medical benefit is offered through BlueCross BlueShield of Illinois and the network is BlueEdge HSA Network.

Plan Name	BlueEdge HSA 2080
Health Benefits	
Plan Year Deductible	Medical & Rx Combined
Individual	$6,000
Family (Individual / Family)	$6,000 / $12,000
Out-of-Pocket Maximum Includes:	All Covered Expenses
Individual	$6,000
Family (Individual / Family)	$6,000 / $12,000
Coinsurance (Amount member pays)	0%
Office Visit Copay	
Preventative	$0
Primary Care Physician	0% after deductible
Specialist	0% after deductible
In-Patient Hospital Visit	0% after deductible
Outpatient Surgery—*Hospital*	0% after deductible
Outpatient Surgery—*Ambulatory*	0% after deductible
Emergency Room Visit	0% after deductible
Urgent Care Visit	0% after deductible
Lab (Independent Facility)	0% after deductible
X-Ray (Diagnostic Facility)	0% after deductible
Advanced Imaging (Diagnostic Facility)	0% after deductible
Prescription Benefits	
Prescription Tier Structure	
Tier 1 (Generic)	0% after deductible
Tier 2 (Preferred)	0% after deductible
Tier 3 (Non-preferred)	0% after deductible
Tier 4	0% after deductible
Specialty	0% after deductible
Mail Order Rx (90-day supply)	0% after deductible
Out-of-Network Benefits	
Deductible (Individual / Family)	$12,000 / $24,000
Coinsurance (Amount member pays)	0%
Out-of-Pocket Maximum (Individual / Family)	$12,000 / $24,000

Health Reimbursement Account:

If you enroll in the BlueEdge HSA 2080 Plan, you are eligible to participate in the Health Reimbursement Account (HRA) provided by 3Cloud.

If you are enrolled in individual coverage:

Once you have paid $1,600 towards your deductible, the HRA will begin and 3Cloud will contribute $2,400 to your individual HRA to help offset the cost of medical expenses.

If you are enrolled in family coverage (including employee & spouse or employee & child(ren):

Once you have paid $3,200 towards your deductible, the HRA will begin and 3Cloud will contribute $4,800 to your family HRA to help offset the cost of medical expenses.

Once your portion of the deductible has been met, either $1,600 or $3,200, and your HRA starts, you cannot use your Health Savings Account (HSA) to pay for medical expenses and then submit those expenses to the HRA for reimbursement.

Medical Premiums / Payroll Deductions

Plan Name	BlueEdge HSA 2080
	Semi-monthly
Employee Only	$32.07
Employee + Spouse	$70.71
Employee + Child(ren)	$70.06
Employee + Family	$108.70

HEALTH REIMBURSEMENT ACCOUNT

If you elect the HDHP/HSA medical plan, BlueEdge HSA 2080, you will be enrolled in the employer-funded Health Reimbursement Account through Flex Benefits starting January 1, 2024. Unused funds will not rollover at the end of the calendar year. This is a "use it or lose it" account.

How It Works

The HRA will be available to you once you have met the IRS minimum deductible (for out-of-pocket medical and prescription expenses) of $1,600 for an individual only and $3,200 for individual and dependent(s). This is not considered taxable income and there are no claim forms. Reimbursement will be direct deposited into your registered bank account. HRA claims are processed semi-monthly.

If you enroll in the health savings account (more information on pages 10-11) you can use those funds toward your out-of-pocket expenses until you meet the minimum deductible, and then the HRA will begin. You are responsible for any additional out-of-pocket expenses up to the medial plans yearly out-of-pocket maximum.

	Employee Only	Employee + Dependent(s)
Annual Deductible	$6,000	$12,000
You Pay First	$1,600	$3,200
HRA Reimburses You	$2,400	$4,800
You Pay the Remaining Amount	$2,000	$4,000
Your Net Out-of-Pocket Maximum	**$3,600**	**$7,200**

What does an HRA cover?

There are many HRA-eligible items. A few examples are given below:

Services

Body scans

Diagnostic tests

Rehabilitation services

Specialist office visits

Prescriptions

Medications prescribed by a doctor

Medically necessary items (must be signed off by a doctor)

Tip!

Use your health savings account (HSA) dollars to pay for qualified healthcare expenses not covered by the HRA

HEALTH REIMBURSEMENT ACCOUNT

Real-world Claim Scenarios

Important Reminder: You must meet your portion of the deductible, either $1,600 or $3,200, before your HRA starts. If you have an HSA and your HRA has started, you **cannot** use your HSA to pay for medical expenses and then submit those expenses to the HRA for reimbursement. You may only use your HSA to pay for HSA-eligible items that are not covered under the HRA.

HOW AN **HRA** WORKS: Doctor Visit

STEP 1

You meet your minimum deductible limit:
- Individual: $1,600
- Individual + Dependent(s): $3,200

STEP 2

You visit your doctor for care. The doctor will submit their bill to your health insurance provider.

STEP 3

The insurance company will send you and your doctor an Explanation of Benefits (EOB), which details the amount your insurance will pay and your responsibility.

STEP 4

The insurance company forwards the claim information to Flex electronically. Flex then processes the claim.

STEP 5

You receive your reimbursement and pay your doctor.

HOW AN **HRA** WORKS: Rx Pick up

STEP 1

You meet your minimum deductible limit:
- Individual: $1,600
- Individual + Dependent(s): $3,200

STEP 2

You go to the pharmacy to pick up a prescription. The pharmacy processes the claim and adjusts the pricing to reflect the network discount.

STEP 3

You pay the discounted prescription cost to the pharmacy.

STEP 4

Flex receives the electronic claim from the pharmacy and processes it.

STEP 5

You receive your reimbursement.

HEALTH SAVINGS ACCOUNT

A health savings account (HSA) is a benefit that allows you to choose how much of your paycheck you'd like to set aside, before taxes are taken out, for healthcare expenses or use as a retirement savings tool. This plan offers more tax savings than a traditional 401(k) or Roth IRA, making it a powerful option for diversifying your retirement portfolio.

Your HSA is your personal account through Flex Benefits. You will be subject to normal banking fees, similar to those of a personal checking account.

How It Works

If you elect the HDHP/HSA medical plan, BlueEdge H.S.A 2080, you have the option to open an HSA.*

It's yours

Think of your HSA as a personal savings account. Any unspent money in your HSA remains yours, allowing you to grow your balance over time. When you reach age 65, you can withdraw money (without penalty) and use it for anything, including non-healthcare expenses.

Easy to use

Swipe your benefits debit card at the point of purchase. There is no requirement to verify any of your purchases. We recommend keeping any receipts in case of an IRS audit.

Smart savings

The HSA's unique, triple-tax savings means the money you contribute, earnings from investments and withdrawals for eligible expenses are all tax-free, making it a savvy savings and retirement tool.

WHAT DOES IT COVER?

There are thousands of HSA-eligible items. The list includes but is not limited to:

- Copays, coinsurance
- Doctor visits and surgeries
- Over-the-counter medications
- Dental and orthodontia
- Vision expenses, such as frames, contacts, prescription sunglasses, etc.

For a complete list of IRS qualified healthcare expenses, visit irs.gov/publications/p502, or scan the QR code below.

Scan Me!

*If you are enrolled in Medicare, Tricare, or another secondary health insurance plan that is not HSA-compatible, or if you are currently claimed as a dependent on someone else's taxes, you are not eligible to contribute to an HSA.

Contact HR immediately if any of the previously mentioned circumstances apply to you. Per the IRS, you are not eligible for your employer's contribution. Failure to notify HR and reverse this automatic contribution will have tax consequences for ineligible individuals.

HEALTH SAVINGS ACCOUNT

How To Contribute

You have the option to contribute pre-tax funds from your paycheck into the HSA. The IRS allows you to contribute the maximum annual contribution as long as you remain eligible through December 31 of the following year. If you are concerned that you may not remain eligible for the entire period, you may wish to prorate contributions based on the number of months you are HSA eligible.

	IRS Annual HSA Contribution Maximums
Individual	$4,150
Individual + 1 or more	$8,300
Catch up contribution (over age 55)	$1,000

Using Your Funds

You will receive a debit card from Flex Benefits. You can use this debit care (at qualified merchants) at the time of claim to pay for healthcare expenses, or submit expenses for reimbursement. HSA funds can be used for a wide range of healthcare services, including eligible dental and vision expenses.

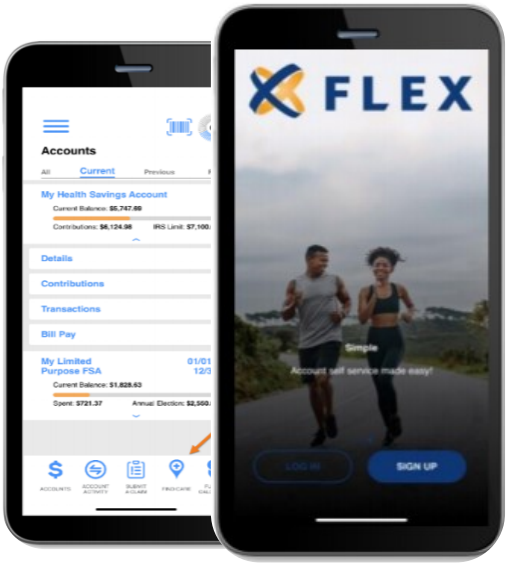
The account acts like a regular checking account with a debit card that accrues interest. All money in the account is owned by you and is fully vested as soon as it is deposited. Funds can accumulate over time and the account is portable. Any unused monies left in your HSA at the end of the calendar year will roll over to the next year for you to use.

When you use the funds for qualified health expenses, you will not pay taxes. If you use the money for other expenses, you'll pay a tax and a penalty fee.

Once your portion of the deductible has been met, either $1,600 or $3,200, and your HRA starts, you cannot use your HSA to pay for medical expenses and then submit those expenses to the HRA for reimbursement.

Access Your Flex Benefits Account Online and On-the-Go!

Visit myflexaccount.com or download the My Flex Account Mobile App (available on the App Store and Google Store) to view your account balance, find care, and more.



FLEXIBLE SPENDING ACCOUNT

Flexible Spending Accounts (FSAs) are special tax-advantaged accounts used to pay for eligible out-of-pocket healthcare and dependent care expenses. If elected, your account(s) will be funded with tax-free dollars using convenient payroll deductions. All funds are front loaded at the beginning of the year and only expenses for services incurred during the plan year are eligible for reimbursement from your accounts.

Any money that is left unspent at the end of the coverage period is forfeited back to the plan administer; this is commonly known as the "use it or lose it" rule.

Healthcare FSA | $3,200 Anticipated Maximum

This plan is used to pay for expenses not covered under your health plans, such as deductibles, coinsurance, copays and expenses that exceed plan limits. Eligible expenses include:

Coinsurance, Copays and Deductibles

Medical and Prescriptions

Dental and Orthodontia

Eye Exams, Eyeglasses and Lasik Eye Surgery

Limited Purpose FSA | $3,200 Anticipated Maximum

This plan is used to pay for eligible vision and dental expenses. Unlike a healthcare FSA, however, an LPFSA can be held at the same time as a Health Savings Account (HSA).

Dependent Care FSA | $5,000 Maximum

This plan is used to pay for eligible expenses you incur for child care, or for the care of a disabled dependent, while you work. Eligible expenses include:

Qualified childcare centers, after school programs, summer camps (under age 13), preschool

Adult daycare facilities

Important FSA Rules

Healthcare FSA

Don't forget to spend your FSA dollars! The IRS does not allow the return of unused account balances at the end of the year, and remaining balances cannot by carried forward to a future plan year.

3Cloud permits a Run-out Period. You have a 90-day period at the end of a plan year to claim reimbursement for eligible expenses that incurred 1/1/2024 to 12/31/2024. The Runout End date is 3/31/2025.

Dependent Care FSA

Unused funds will NOT be returned to you or carried over to the following year. You must incur claims by December 31st of each plan year.

Important Note for HSA Medical Participants:

If you enroll in the HSA Medical Plan and contribute to your HSA account, you may only participate in the Limited Purpose FSA to cover out-of-pocket dental and vision expenses.

What Does an FSA Cover?

There are thousands of FSA-eligible items. For a complete list of IRS qualified healthcare expenses, visit irs.gov/publications/p502 or scan the QR code to the right.

FSA Claim Filing

You will not receive a debit card for your FSA. The medical and prescription claims submission process will be handled with CrossTech. The portion of the claim you paid out-of-pocket will be automatically reimbursed to you from your Flex Account. Reimbursements are processed on all applicable approved claims and are processed semi-monthly. **You are responsible for keeping a copy of your paid itemized receipt for all transactions.**

Any dental and vision claims will have to be submitted via the My Flex Account mobile app or online at myflexaccount.com.

HRA vs. HSA vs. FSA

What's the Difference?

HRAs, HSAs, and FSAs all offer tax-free benefits. But what's the difference between them and which is more beneficial for yor needs? You can save money out-of-pocket with any of them, but they have many differences.

	HRA	HSA	FSA
Who owns it?	Employer-owned	Employee-owned	Employer-owned
Who is eligible?	Must be enrolled in the HDHP/HSA medical plan, BlueEdge HSA 2080	Must be enrolled in the HDHP/HSA medical plan, BlueEdge HSA 2080	Anyone is eligible, although you can't be enrolled in an HSA and a Healthcare FSA
Who contributes money into it?	Your employer	You do, but there are IRS regulated annual limits: Individual: $4,150 Individual + One or More: $8,300 Money is taken out of your paycheck on a pre-tax basis.	You do, but there are IRS regulated annual limits: Medical FSAs: $3,050 Dependent Care FSA: $5,000 Money is taken out of your paycheck on a pre-tax basis.
When is the money available?	HRA funds are paid out on a reimbursement basis. Once you have met the IRS minimum deductible, the HRA funds will be available. Minimum deductibles: Individual: $1,600 Individual + Dependents: $3,200	Money accumulates over time. You decide how much money to take out of your paychecks and put into the HSA account.	All money for Medical FSAs are frontloaded at the beginning of the year. Dependent Care FSAs are paid back as a reimbursement.
What happens to the money after the year is up?	Unused funds do not carry over from year to year	All funds can carry over from year to year	Unused funds do not carry over from year to year
What does it cover?	Medical expenses covered under the medical plan	All eligible healthcare expenses, including copays, dental and vision expenses, over-the-counter medications, plus more.	Healthcare FSA: Eligible medical, dental, vision and Rx expenses Limited Purpose FSA: Eligible dental and vision expenses Dependent Care FSA: Eligible dependent care costs
Click here the Flex Benefits Eligible Expenses Summary			

Check Your Flex Benefits Account Online and On-the-Go!

You can always visit myflexaccount.com or download the My Flex Account Mobile App (available on the App Store and Google Store) to view your account balance, find care, and more, for all of your healthcare accounts.

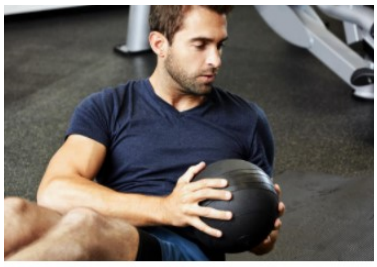
HEALTHY LIVING IS JUST A DEAL AWAY.

Join Blue365® and start saving today!

With Blue365, great deals are yours for every aspect of your life! You can receive discounts such as 20% off Reebok.com, discounted products through Jenny Craig, FitBit, and more!

To access deals such as these, register now at **blue365deals.com/bcbsofil** to take advantage of Blue365! It's an online destination featuring healthy deals and discounts exclusively for BlueCross BlueShield members. Just have your BlueCross BlueShield Member ID Card handy. In a couple minutes you'll be registered and ready to shop. Every week, Blue365 will send a special deal right to your email inbox!

Examples of current discounts are included below:



Gym Network 360

5%- 20% Off Gym Memberships

Heart Rate Monitors USA

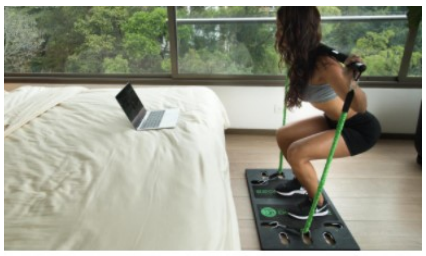
Up to 55% Off Select Garmin, Polar, and Fitbit Products

Croakies

Enjoy 25% Off Outdoor Retention Products, Including Belts and Eyewear Retainers

FitBoomBah - Dentisse

Up to 24% Off Teeth Whitening Toothpaste and Rinse



FitBoomBah-Body Boss

Save 37% On The BodyBoss 2.0 Home Gym

Petmate

Save 15% on Pet Supply Orders Over $49 Plus Free Shipping

TELEMEDICINE

As an enrolled member of BCBS of Illinois, you have access to virtual visits through MDLive. With MDLive you can have a consultation with a board-certified physician via the mobile app, online video or phone 24 hours a day, seven days a week.

Instead of going into your doctors office, you can speak with a doctor while you're at home, work, or many other places. A virtual visit can cost less than going to urgent care or the emergency room. Please see the copays listed below for the three BCBS of Illinois Plans.

BluePrint PPO 0120: $30 Copay General Provider

BluePrint PPO 2030: $20 Copay General Provider

BlueEdge HSA 2080: $44 Copay General Provider

You can speak with a provider by getting registered on your BCBS of Illinois member portal or by registering on the MDLive website or app (available on the Apple or Google Play store).

The right care when you need it most.

With MDLive, you can talk—by phone or video—to a doctor who can diagnose common medical conditions and even prescribe medications, if needed.

You can speak with a provider for a variety of general ailments such as:

- **Allergies**
- **Cold or Flu**
- **Cough**
- **Headaches**
- **Minor Insect Bites**
- **Pink Eye**
- **Rash**
- **Sinus Issues**
- **Sore Throats**
- **UTIs**
- **And much more!**

COST SAVING TIPS

Virtual Visit vs. Urgent Care vs. Emergency Room

When you need care, choosing the right treatment option can help you avoid needless worry, higher out-of-pocket costs and hours of unnecessary waiting. Your primary care physician is usually your first choice when seeking care, however sometimes you may need to utilize the urgent care or emergency room. Use the simple guide below to help you make the right decisions when it comes to your care!

Virtual Visits

Virtual visits are available to you via phone or video 24/7/365 days a year. Use virtual visits for conditions like:

- **Upper respiratory infection**
- **Sinus infection**
- **Common cold or flu**
- **Cough**
- **Allergies**

Download the BCBS of IL app or create your member online portal to register.

Urgent Care

Urgent typically has shorter wait times and can treat for a variety of conditions including:

- **Strains and sprains**
- **Mild infections**
- **Mild burns**
- **Common cold or flu**

To find an urgent care close to you visit bcbsil.com and select Find a Doctor or Hospital.

Emergency Room

Going to the ER for an issue that is not life threatening often results in high medical bills. Examples of symptoms that require ER care:

- **Severe chest pain (possible heart attack)**
- **Signs of possible stroke**
- **Severe or sudden shortness of breath**
- **Broken bones**

If you have a life-threatening emergency, call 911 right away.

GoodRX (Prescription Savings Tool)

SAVE UP TO 80% ON MEDS

GoodRx gathers current prescription prices and discounts to help you find the lowest cost pharmacy for your prescriptions! It may be bale to help you find a lower price than your prescription copay.

It is simple to use. Simply go to goodrx.com and type your prescription name into the search, hit "Find the Lowest Price" and GoodRx will do the rest of the work! They will find local pharmacies with the lowest cost for your prescription. You can print your coupon and present it to the pharmacy when you go pick-up your prescription.

**Amounts paid using GoodRx's discount card do not apply towards your deductible or annual out-of-pocket maximum.

Pharmacy Discount Programs

Pharmacies such as Wal-Mart and Costco offer prescription discount programs that allow you to purchase medications for as low as $4 for a 30-day supply. If you aren't sure if your local pharmacy offers any discounts, please check with them to confirm.

COSTCO PHARMACY

Walmart Pharmacy

DENTAL

We offer dental coverage through Guardian. If you use an out-of-network provider, you may be subject to balance billing, see page 19 for more information. Your dental network is the DentalGuard Preferred PPO.

In addition to protecting your smile, dental insurance helps pay for dental care and usually includes regular checkups, cleanings and X-rays.

	Low Plan	High Plan
	In-Network	**In-Network**
Individual / Family Calendar Year Deductible *Waived for preventative and orthodontia services*	$50 / $150	$50 / $150
Calendar Year Maximum	$1,500	$2,000
Preventive Care		
Benefit Percentage	0%	0%
Other Services		
Basic Services	20% after deductible	10% after deductible
Major Services	50% after deductible	40% after deductible
Endodontics / Periodontics *(Covered under basic or major?)*	Non-Surgical Periodontics + Maintenance: Covered under basic Surgical Periodontics + Endodontics: Covered under major	Covered under basic
Orthodontia		
Benefit Percentage	50%	50%
Child Only or Child + Adult	Child(ren) & Adults	Child(ren) & Adults
Lifetime Maximum	$1,500	$2,000
Out-of-Network		
Preventive Services	0%	0%
Basic Services	20% after deductible	10% after deductible
Major Services	50% after deductible	40% after deductible
Orthodontia	50%	50%
Calendar Year Maximum (Preventive, Basic & Major)	$1,500	$2,000
Lifetime Maximum (Orthodontia)	$1,500	$2,000

Dental Premiums / Payroll Deductions

Carrier: Guardian	Low Plan	High Plan
	Semi-Monthly	**Semi-Monthly**
Employee Only	$13.39	$18.37
Employee + Spouse	$31.35	$42.51
Employee + Child(ren)	$41.53	$56.71
Employee + Family	$55.84	$75.55

VISION

Keep your vision clear and your eyes in good health with regular eye exams. We encourage you to visit your optometrist or ophthalmologist to maintain your vision health.

3Cloud offers vision coverage through Guardian, using the VSP Choice Network.

When you use in-network providers, you will be responsible for a copay for exams and lenses. The out-of-network benefits are paid as a reimbursement of the figures shown in the table below, less the copay.

	VSP Choice Network	
	In-Network	**Out-of-Network**
Eye Exam		
Exam Copay	$10	Up to $39
Frequency	Once every 12 months	
Lenses		
Single Vision	$10	Up to $23
Bi-focal	$10	Up to $37
Tri-focal	$10	Up to $49
Lenticular	$10	Up to $64
Frequency	Once every 12 months	
Frames		
Frame Benefit / Allowance	$130 allowance + 20% discount on remaining balance Costco, Wal-Mart, Sam's Club: $70 allowance	Up to $46
Frequency	Once every 12 months	
Contact Lenses		
Elective	$130 allowance	Up to $100
Medically Necessary	$10	Up to $210
Laser Vision Correction		
Benefit / Discount	10–20% off retail or 5% off promotional price	N/A

Vision Premiums / Payroll Deductions

Carrier: Guardian	
	Semi-Monthly
Employee Only	$3.48
Employee + Spouse	$6.27
Employee + Child(ren)	$5.28
Employee + Family	$9.99

LOCATING A PROVIDER

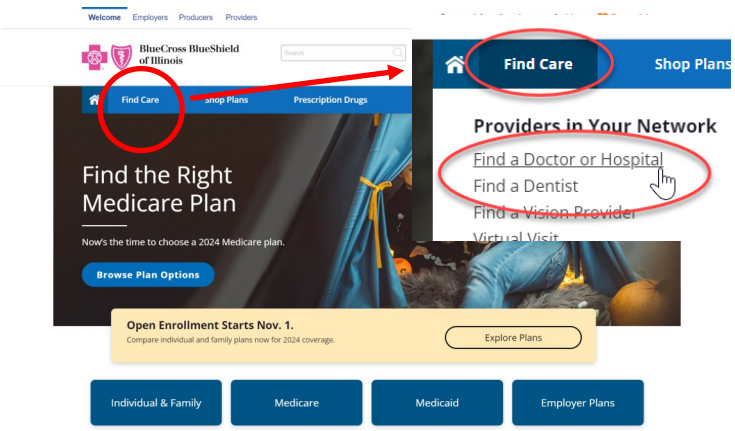
What is Balance Billing?

When you stay inside the network, you are protected by the Insurance Provider's contract and cannot be charged more than what is agreed to by the plan. This is called "Balance Billing" and it is not allowed by in-network providers. Out-of-network (non-participating) providers are not limited in the amount they may charge and can balance-bill the difference from what the Insurance paid and the billed charges. Many out-of-network providers do not bill insurance that they do not participate with and would require that you pay for the full cost of services and materials and submit for reimbursement.

Prior to your appointment, it is strongly recommended you confirm your provider is In-Network.

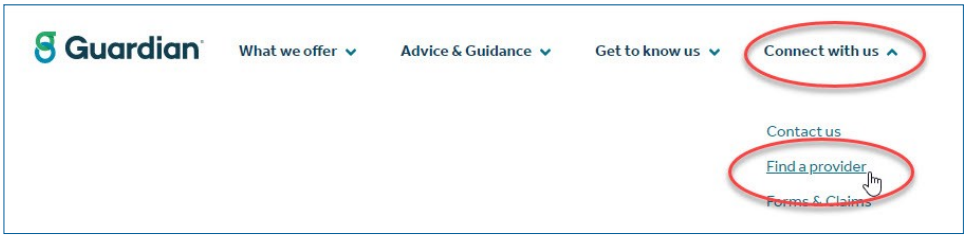
Medical: BlueCross BlueShield of Illinois

1. Visit **bcbsil.com**
2. Under "Find Care", select "Find a Doctor or Hospital"
3. You may log into your account, create a log in, or choose to search as a guest
4. Enter your location and the network provider name: BlueEdge HSA or BluePrint PPO
5. In the search bar enter your search criteria. You can search for a Primary Care Physician, specialty physician, type of facility, and more.



Dental and Vision: Guardian

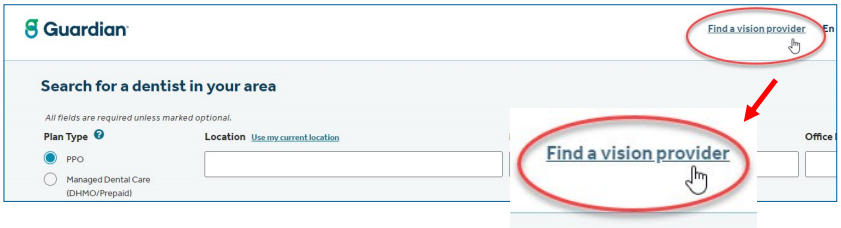
- Visit **guardianlife.com**
- Under the "Connect with us" dropdown menu, select "Find a provider".

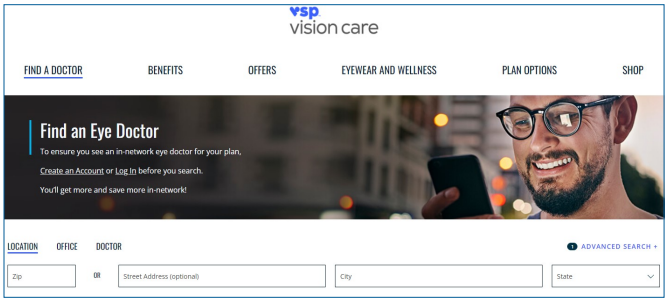


- On the next web page, select PPO as your plan type and enter in other search criteria to find an in-network dental provider near you.

- To find an in-network vision provider near you, click on "Find a vision provider" at the top of the page.
- On the next web page, select VSP as your vision network.
- The following web page should open in a new tab: **vsp.com/eye-doctor**.

  Here, you will be able to search for a vision provider by location, office, or doctor name/type.





LIFE and AD&D INSURANCE

100% Employer-paid Basic Life & AD&D Insurance	
All full-time employees are enrolled in Basic Life and AD&D at no charge.	
Employee Benefit Amount	$50,000

Voluntary Life and AD&D	
Employee	
Minimum Benefit Amount	$10,000
Increments of	$10,000
Maximum Benefit Amount	$750,000
Guarantee Issue	$250,000 (if under age 65)
Spouse	
Minimum Benefit Amount	$5,000
Increments of	$5,000
Maximum Benefit Amount	$250,000, not to exceed 50% of employee election
Guarantee Issue	$50,000 (if under age 65)
Dependent Child(ren)	
Minimum Benefit Amount	$10,000
Maximum Benefit Amount	$10,000
Guaranteed Issue	Birth to 14 days: $500 14 days to 26 years: $10,000

Exception: If a dependent, other than a newborn child, is confined to a *hospital or other health care facility; or is home-confined; or is unable to carry out the normal activities of someone of like age and sex on the date his dependent benefits would otherwise start, elected benefits will be postponed until the day after discharge from such facility; until home confinement ends; or until the dependent resumes the normal activities of someone of like age and sex.*

***Conversion:** If your employment ends, there are several circumstances where you and your covered dependents can convert to individual policies. You must contact your employer for the conversion forms and information on how you can apply. The purchase amount varies depending on the termination situation.

****Portability:** If your employment ends, you may be eligible to continue your life insurance without submitting Proof of Good Health. You must contact your employer for the portability forms and information on how you can apply.

Evidence of Insurability (EOI)

When electing Voluntary Life and AD&D coverage, you and your covered dependents are responsible for completing an Evidence of Insurability (EOI) form if:

You are electing more than the guaranteed issue.

To submit an Evidence of Insurability, visit Employee Navigator to locate the online evidence of insurability form.

Conversion and Portability

Voluntary Life and AD&D insurance offered through Guardian. It gives you the opportunity to purchase additional life insurance for you and your family.

You may be eligible to convert* or port** this benefit upon termination. Your cost per pay period is determined by your election. To view your cost please log in to Employee Navigator.

Keep in mind that you will have 31 days from the date of termination to submit the appropriate forms.

UNIVERSAL LIFE WITH LONG-TERM CARE

Universal Life offers permanent protection for you and your family, it's designed to last a lifetime.

Universal Life is a permanent form of life insurance. The Universal Life policy will not build cash value for approximately 4-5 years; once the policy is issued you will receive an illustration every year with this information because it is specific to each policy benefit amount and other factors. This policy has a Long-Term Care rider that is designed to protect you should you need it in the future. Detailed rates and more coverage details can be found on Employee Navigator.

Carrier: Trustmark	Benefits
Employee	
Benefit Amount	$5,000 increments up to $300,000
Guarantee Issue	$80,000
Spouse	
Benefit Amount	$5,000 increments up to $300,000
Guarantee Issue	All amounts subject to approval
Child and/or Grandchild	
Benefit Amount	Amounts of coverage can be purchased by $3.02 to $4.31 per week
Life Accelerated Death Benefit	Included; one time payment up to 75% of death benefit
Long-Term Care Rider	Provides 4% of base policy for up to 25 months for medically necessary activities of daily living provided by nursing home, adult day care, licensed home health provider, or assisted living facility. Triggered by two of six activities of daily living OR cogitative impairment
Long-Term Care Waiting Period	90 days
Long-Term Care Pre-Existing Condition	6 / 6

*Pre-Existing Condition: If you are treated for a condition 6 months prior to the effective date, that results in a critical illness in first 6 months, you will not receive benefits, unless the critical illness starts after you have been insured under this policy for 6 months

DISABILITY

Short-Term Disability

Short-Term Disability (STD) is insurance for your paycheck. This benefit is setup to help provide you with lost income in the event you become injured or ill for a period of time. **STD is 100% paid for by 3Cloud**.

Carrier: Guardian	Benefits
Benefit Percentage	66 and 2/3%
Maximum Weekly Benefit	Up to $2,500
Elimination Period	
Accident	7 calendar days
Illness	7 calendar days
Benefit Duration	Up to 12 weeks
Earnings Definition	Standard, including 24 month average of bonus and commissions

Long-Term Disability

Long-Term Disability (LTD) is another benefit available to provide income protection. It provides for long term income continuation if you become disabled from a qualified accidental bodily injury or illness. **LTD is 100% paid for by 3Cloud.**

Carrier: Guardian	Benefits
Benefit Percentage	66 and 2/3%
Maximum Monthly Benefit	Up to $12,000
Elimination Period	90 days
Own Occupation Period	2 years
Benefit Duration	Social Security Normal Retirement Age
Earnings Definition	Standard, including 24 month average of bonus and commissions
Pre-existing Limitation*	3 / 12

***Pre-Existing Condition:** if you are treated for a condition 3 months prior to the effective date that results in a disability in first 12 months of coverage, you will not receive benefits. Once you have been covered for 12 months, the pre-existing clause no longer applies.

VOLUNTARY BENEFITS

Critical Illness

Most health plans do not cover 100% of medical expenses. This plan offers added coverage for medical conditions like heart attack, stroke and cancer. Critical Illness insurance is a voluntary benefit offered through Guardian. Detailed coverage information and rates can be found on Employee Navigator.

Carrier: Guardian	Benefits
Employee	
Benefit Amount	$10,000 increments up to $40,000
Guarantee Issue Amount	$40,000
Spouse	
Benefit Amount	$10,000 increments up to $40,000 (Cannot exceed 100% of employee's benefit)
Guarantee Issue Amount	$40,000
Dependent Child(ren)	
Benefit Amount	25% of employee's benefit
Guarantee Issue Amount	All amounts are guaranteed
Wellness Benefit	$50
Pre-existing Limitation*	12 / 12

***Pre-existing condition:** If you are treated for a condition 12 months prior to the effective date, that results in a critical illness in first 12 months, you will not receive benefits, unless the critical illness starts after you have been insured under this policy for 12 months

Accident

Accidents can happen anywhere you and your family work, live and play. Be prepared to handle the medical expenses of these accidents with the help of this policy. Accident Insurance is a voluntary benefit offered through Guardian that pays a lump sum benefit for injuries you or your family may sustain in an accident. Detailed coverage information and rates can be found on Employee Navigator.

Carrier: Guardian	Benefits
Wellness Benefit	$50 (per insured)
Death Benefit	Employee: $25,000; Spouse: $25,000; Child: $12,500
Initial Care Reimbursement	
Initial Physician Office Visit	$125
Emergency Room	$150
Emergency Transportation Reimbursement	
Ambulance Ground	$300
Ambulance Air	$1,500
Hospital Services Reimbursement	
Hospital Admission	$1,500
Intensive Care Unit Admission	$3,000

COMMUTER BENEFIT

All benefits-eligible employees have the option to participate in the Commuter Benefit program. The program allows you to set aside a portion of your pre-tax earnings to pay for qualified transit and/or parking expenses related to your commute to/from the workplace. There are two types of commuter benefit plans, parking and mass transit—you may elect one or both. Flex is the administrator for our Commuter Benefits. Log on to Employee Navigator to elect.

When you enroll, you will receive a debit card* that can be used to pay for commuter expenses. You are responsible to keep a copy of your paid itemized receipt for all transactions. You may be asked to submit your itemized receipt to Flex to substantiate the transaction. If you fail to submit the requested information your debit card may be deactivated.

Important Reminder: Any money that is left unspent at the end of the coverage period is carried over to the following year. You may continue to incur expenses with your carried over funds even if you decide to not continue contribute for the next coverage period. You may submit expenses for reimbursement up to 180 days after incurring the expense.

***If you already have a current debit card for an existing spending account with Flex, you will not receive a new card. You will use the existing card for commuter benefit transactions.**

Account Options Available

Parking	Mass Transit
Maximum Contribution: up to $315 per month	**Maximum Contribution: up to $315 per month**
	
Common Eligible and Non-Eligible Expenses: **Eligible:** Parking at or near public transportation to get to work, parking at or near work, and parking meters (at or near work). **Non-Eligible:** Car Maintenance, gasoline, mileage, and transit expenses for spouses and dependents.	**Common Eligible and Non-Eligible Expenses:** **Eligible:** Bus fare, train, subway, ferry, street cars, subway, and vanpool. **Non-Eligible:** Tolls, airline flights, taxis, and transit expenses for spouses or dependents.

Accessing Your Account

You can access your commuter benefits account through the Flex website at myflexaccount.com or using their mobile app, available for iPhone and Android devices.

On the Flex website and the mobile app you can:

- View eligible expenses lists
- View educational videos and FAQs to help educate you on your commuter account
- Submit new claims, add receipts for previous claims, and view your transaction history
- And more!

EMPLOYEE ASSISTANCE PROGRAM

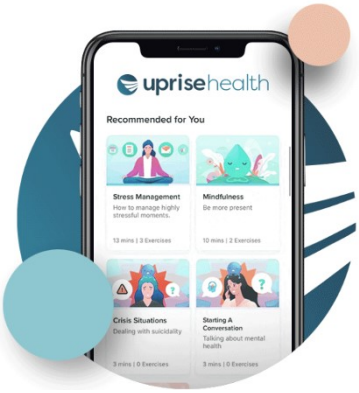
3Cloud has partnered with Guardian to provide you with an employee assistance program—Uprise Health—which offers you a confidential resource for resolving personal, family and work-related concerns before they become overwhelming crisis that affect your health, well-being and job performance. By offering an EAP, 3Cloud has acknowledged that you are valuable asset; they understand that personal concerns can affect all aspects of an individual's life, and an EAP counselor can provide you with assistance to explore and resolve issues at home and/or work.

Contact Uprise Health via phone 800.395.1616 or use the Member portal at members.uprisehealth.com.

The EAP can help with such issues as:

- Stress, Anxiety or Depression
- Relationship Issues
- Grief and Loss
- Legal Assistance
- Financial Services and Referrals
- Childcare Resources and Referrals
- Senior Care
- Pet Care
- Identity Theft
- and More!

How to Get Started



- You can access coaching online from your computer or from your mobile phone via a Google Play or Apple app.
- Go to app.uprisehealth.com or download the Uprise Health app on the Google Play Store or Apple App Store.
- Create an account with your email, personal password, and your assigned access code **worklife.**
- Complete the assessment and check your wellbeing score.
- Receive your own personalized recommendations.
- Get started on your mental health and skill building with videos, audio and interactive exercises based on your personal preferences.
- All information is confidential and will never be shared with your employer.

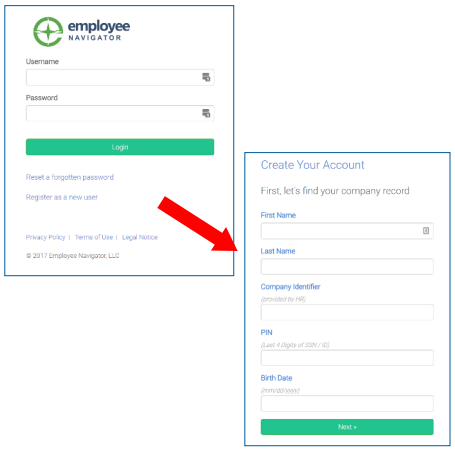
HOW TO ENROLL

All benefits eligible employees are required to register elections and waivers. To do so, 3Cloud uses Employee Navigator.

Employee Navigator allows you to access your account, manage your benefits online, view your plan descriptions, make changes to your benefit plans, and view and understand your total compensation statement and the value of your benefits.

LET'S GET STARTED!

- Go to employeenavigator.com/benefits/Account/Login on your web browser.
- If you are a new user, click "New User Registration" and that will take you to the Account Registration page and enter in the requested personal information for login access, along with the company identifier **3Cloud.**
- On your home page, click on the "Start Benefits" to begin making your enrollment elections.
- After you have completed your enrollment elections, you will have until the enrollment deadline to make changes to your elections. Do this by logging back into Employee Navigator.



ENROLLMENT PROCESS

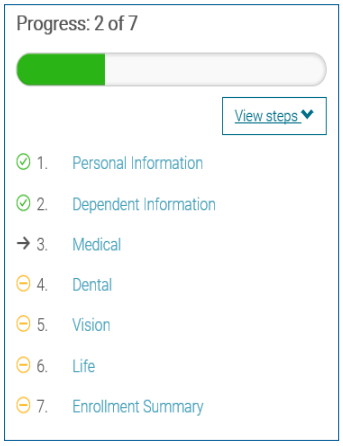
The **Start Enrollments** screen will walk you through confirming your account details and help you navigate through the list of benefits offered.

For each benefit, make your selection and then click **Save & Continue** at the bottom of the screen. To view your progress, click **View Steps**.

Once you've made your election, a checkmark will appear next to the benefit. You will automatically move forward to the next benefit screen. To CHANGE A BENEFIT, click on the benefit you'd like to modify, make the change and click **Save & Continue**.

Once all sections have been completed and show a checkmark, you are ready to review and submit your elections.

Sample List of Benefits

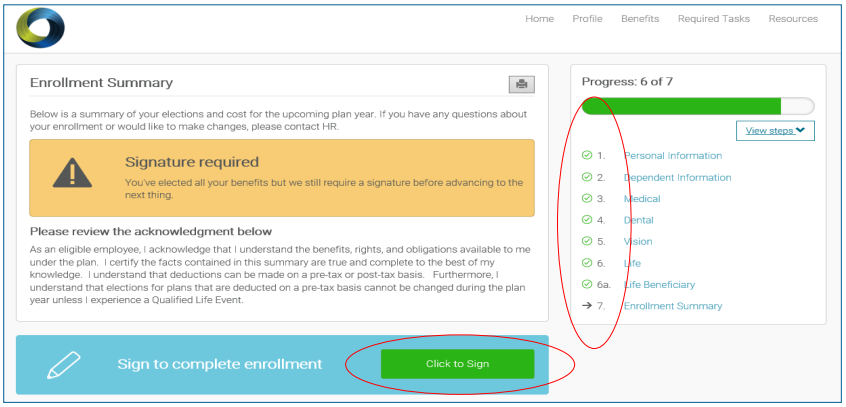


ENROLLMENT SUBMISSION

You MUST click on the green **Click to Sign** button in order to electronically sign your elections.

If this button is not green and you cannot click on it, it is because you have failed to make at least one of the benefit elections on your list.

Review your list to see which benefit does not have a green checkmark next to it, and complete the election(s).



AFFORDABLE CARE ACT (ACA)

ACA Eligibility Testing

3Cloud uses a 12-month standard measurement period to measure the hours of all ongoing part-time, and variable-hour employees hired on or before the start date of a standard measurement period. If an employee is determined to be eligible for health coverage during an initial or standard measurement period, the employee must be allowed to remain enrolled in health coverage for the entire associated stability period. (see below)

Change in Status

If you are full-time, and your status changes to part-time, or variable hours, during the stability period—you will continue to be covered on the insurance for a full 3 months, at which time your employer will be allowed to re-test your eligibility. If you continue to meet the hourly requirements, then you will be extended medical benefits through the remainder of the stability period. If you do not, then you will be removed from the benefits and will be retested at the next Measurement Period. However, if you remain qualified, but wish to terminate your coverage, this can be a Qualifying Event due to the change in compensation and hours worked. If you remain on the benefits, you will be responsible to pay your portion of the premiums regardless of the amount of pay on your checks. Based on your new status as a variable hour employee, you will be subject to your employer's Standard Measurement Period and may not be qualified to continue benefits upon testing for the next Stability Period.

If you are a part-time or variable hour employee and have a change in status to full-time then you may be eligible to come on to the plan, as long as you were not previously eligible (and declined) based on ACA standard testing during the previous measurement period.

Annual Testing Standards		New Hire Testing Standards	
Measurement Period	Dec 1 — Nov 30	**Measurement Period**	1st day of the month, following date of hire—continues for 12 months.
Administrative Period	Dec 1 — Dec 31	**Administrative Period**	1st day of the month following measurement period—continues for 1 month
Stability Period	Jan 1 — Dec 31	**Stability Period**	1st day of the month following administrative period—continues for 12 months.

ACA Definitions	
Full-Time	At time of hire or change in job classification, employee is reasonably expected to work, on average, 30 or more hours per week [1560 hours annually]
Part-Time	At time of hire or change in job classification, employee is reasonably expected to work less than 30 hours per week. [1560 hours annually]
Variable-Hour	At time of hire or change in job classification, Employer cannot reasonably determine whether employee will or will not average 30 or more hours per week. [1560 hours annually, or 130 hours in any single month]
Measurement Period	The defined time period chosen by your Employer (12 consecutive calendar months) used to determine eligibility for health benefits
Administrative Period	A period of time (one month) for Employer to measure eligibility, before the stability period begins.
Stability Period	The defined time period chosen by your Employer (12 Months) for which employees may elect and remain on the health benefits.

ACA MINIMUM VALUE AND AFFORDABILITY:

The medical benefit plans offered by 3Cloud meet affordability and minimum value standards under the Affordable Care Act (ACA). You will not be eligible to receive a premium tax credit or cost-sharing reduction subsidy if you choose to waive health benefits in order to enroll in an individual or family plan through the Health Insurance Marketplace.

If you were to enroll and claim a subsidy, you would have to repay that subsidy to the federal government at the end of the year.

FEDERAL GUIDELINES

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 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)**.

AFFORDABLE CARE ACT (ACA) HEALTHCARE REFORM EXCHANGE NOTICE
Under ACA, large employers are responsible to provide eligible employees with coverage that meets the affordability and actuarial value rules set by our government. The plans offered by your employer meet these standards. You will receive a separate notice with specific information. As a result, you and/or your dependents may not be eligible for a federal or state subsidy when applying for coverage in the Healthcare Marketplace.

HIPAA– PRIVACY ACT LEGISLATION The Health Plan and your health care carrier(s) are obligated to protect confidential health information that identifies you or could be used to identify you as it relates to a physical or mental health condition or payment of your health care expenses. If you elect new coverage, you and your beneficiaries will be notified of the policies and practices to protect the confidentiality of your health information.

WOMEN'S HEALTH AND CANCER RIGHTS ACT The Women's Health and Cancer Rights Act (WHCRA) includes protections for individuals who elect breast reconstruction in connection with a mastectomy. WHCRA provides that group health plans provide coverage for medical and surgical benefits with respect to mastectomies. It must also cover certain post-mastectomy benefits, including reconstructive surgery and the treatment of complications (such as lymphedema). Coverage for mastectomy-related services or benefits required under the WHCRA are subject to the same deductible and coinsurance or copayment provisions that apply to other medical or surgical benefits your group contract providers.

GENETIC INFORMATION NONDISCRIMINATION ACT (GINA) OF 2008 Title II of the Genetic Information Nondiscrimination Act of 2008 protects applicants and employees from discrimination based on genetic information in hiring, promotion, discharge, pay, fringe benefits, job training, classification, referral, and other aspects of employment. GINA also restricts employers' acquisition of genetic information and strictly limits disclosure of genetic information. Genetic information includes information about genetic tests of applicants, employees, or their family members; the manifestation of diseases or disorders in family members (family medical history); and requests for or receipt of genetic services by applicants, employees, or their family members.

SECTION 111 OF JANUARY 1, 2009 Group Health Plans (GHP) are required to comply with the Federal Medicare Secondary Payer Mandatory Reporting provisions in Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007. It requires employers to report specified information regarding their GHP coverage (including Social Security numbers) in order for CMS to determine primary versus secondary payment responsibility. In essence, it helps determine if the Employer plan or Medicare/Medicaid/SCHIP is primary for those employees covered under a government plan and an employer sponsored plan.

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996 The Newborns' and Mothers' Health Protection Act of 1996 provides that group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). An attending provider is defined as an individual who is licensed under applicable state law to provide maternal or pediatric care and who is directly responsible for providing such care to a mother or newborn child. The definition of attending provider does not include a plan, hospital, managed care organization or other issuer. In any case, plans may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Please contact us if you would like any additional information on The Newborns' and Mothers' Health Protection Act or WHCRA.

MICHELLE'S LAW An amendment to the Employee Retirement Income Security Act (ERISA), the Public Health Service Act (PHSA), and the Internal Revenue Code (IRC), this law ensures that dependent students who take a medically necessary leave of absence do not lose health insurance coverage. Michelle's Law allows seriously ill college students, who are covered dependents under health plans, to continue coverage for up to one year while on medically necessary leaves of absence. The leave must be medically necessary as certified by a physician, and the change in enrollment must commence while the dependent is suffering from a serious illness or injury and must cause the dependent to lose student status. Under the law, a dependent child is entitled to the same level of benefits during a medically necessary leave of absence as the child had before taking the leave. If any changes are made to the health plan during the leave, the child remains eligible for the changed coverage in the same manner as would have applied if the changed coverage had been the previous coverage, so long as the changed coverage remains available to other dependent children under the plan.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA) The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) was signed into law on October 13, 1994. USERRA clarifies and strengthens the Veterans' Reemployment Rights (VRR) Statute. The Act itself can be found in the United States Code at Chapter 43, Part III, Title 38. The Department of Labor has issued regulations that clarify its position on the rights of returning service members to family and medical leave under the USERRA. See 20 CFR Part 1002.210. USERRA is intended to minimize the disadvantages to an individual that occur when that person needs to be absent from his or her civilian employment to serve in this country's uniformed services. USERRA makes major improvements in protecting service member rights and benefits by clarifying the law and improving enforcement mechanisms. It also provides employees with Department of Labor assistance in processing claims. USERRA covers virtually every individual in the country who serves in or has served in the uniformed services and applies to all employers in the public and private sectors, including Federal employers. The law seeks to ensure that those who serve their country can retain their civilian employment and benefits, and can seek employment free from discrimination because of their service. USERRA provides protection for disabled veterans, requiring employers to make reasonable efforts to accommodate the disability. USERRA is administered by the United States Department of Labor, through the Veterans' Employment and Training Service (VETS). VETS provides assistance to those persons experiencing service connected problems with their civilian employment and provides information about the Act to employers. VETS also assists veterans who have questions regarding Veterans' Preference.

FEDERAL GUIDELINES

HIPAA SPECIAL ENROLLMENT

SPECIAL ENROLLMENT NOTICE This notice is being provided to make certain that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive health insurance coverage at this time.

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

Example: You waived coverage under this plan because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this health plan.

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

Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this group health plan. However, you must apply within 30 days from the date of your marriage.

Medicaid or CHIP If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this health plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this group health plan if you apply within 60 days of the date of their loss of CHIP coverage. **For More Information or Assistance** To request special enrollment or obtain more information, please contact:

Payroll and Benefits Manager
3025 Highland Parkway, Suite 525
Downers Grove, Illinois 60515
253.219.9112

Note: If you or your dependents enroll during a **special enrollment period**, as described above, you will not be considered a late enrollee. Therefore, your group health plan may not impose a preexisting condition exclusion period of more than 12 months. Any preexisting condition exclusion period will be reduced by the amount of your prior creditable health coverage. **Effective for plan years beginning on or after Jan. 1, 2014, health plans may not impose pre-existing condition exclusions on any enrollees.**

HITECH (FROM WWW.CDC.GOV) The American Reinvestment & Recovery Act (ARRA) was enacted on February 17, 2009. ARRA includes many measures to modernize our nation's infrastructure, one of which is the "Health Information Technology for Economic and Clinical Health (HITECH) Act." The HITECH Act supports the concept of meaningful use (MU) of electronic health records (EHR), an effort led by the Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator for Health IT (ONC). HITECH proposes the meaningful use of interoperable electronic health records throughout the United States health care delivery system as a critical national goal. Meaningful Use is defined by the use of certified EHR technology in a meaningful manner (for example electronic prescribing); ensuring that the certified EHR technology is connected in a manner that provides for the electronic exchange of health information to improve the quality of care; and that in using certified EHR technology the provider must submit to the Secretary of Health & Human Services (HHS) information on quality of care and other measures.

RESCISSIONS The Affordable Care Act prohibits the rescission of health plan coverage except for fraud or intentional misrepresentation of a material fact. A rescission of a person's health plan coverage means that we would treat that person as never having had the coverage. The prohibition on rescissions applies to group health plans, including grandfathered plans, effective for plan years beginning on or after September 23, 2010.

Regulations provide that a rescission includes any retroactive terminations or retroactive cancellations of coverage except to the extent that the termination or cancellation is due to the failure to timely pay premiums. Rescissions are prohibited except in the case of fraud or intentional misrepresentation of a material fact. For example, if an employee is enrolled in the plan and makes the required contributions, then the employee's coverage may not be rescinded if it is later discovered that the employee was mistakenly enrolled and was not eligible to participate. If a mistake was made, and there was no fraud or intentional misrepresentation of a material fact, then the employee's coverage may be cancelled prospectively but not retroactively.

Should a member's coverage be rescinded, then the member must be provided 30 days advance written notice of the rescission. The notice must also include the member's appeal rights as required by law and as provided in the member's plan benefit documents.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA) MHPAEA generally applies to group health plans and health insurance issuers that provide coverage for both mental health or substance use disorder benefits and medical/surgical benefits. MHPAEA provides with respect to parity in coverage of mental health and substance use disorder benefits and medical/surgical benefits provided by employment-based group health plans. MHPA '96 required parity with respect to aggregate lifetime and annual dollar limits for mental health benefits. MHPAEA expands those provisions to include substance use disorder benefits. Thus, under MHPAEA group health plans and issuers may not impose a lifetime or annual dollar limit on mental health or substance use disorder benefits that is lower than the lifetime or annual dollar limit imposed on medical/surgical benefits. MHPAEA also requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles), and quantitative treatment limitations (such as visit limits), applicable to mental health or substance use disorder benefits are generally no more restrictive than the requirements or limitations applied to medical/surgical benefits. The MHPAEA regulations also require plans and issuers to ensure parity with respect to no quantitative treatment limitations (such as medical management standards).

PREVENTIVE CARE Health plans will provide in-network, first-dollar coverage, without cost-sharing, for preventative services and immunizations as determined under health care reform regulations. These include, but are not limited to, cancer screenings, well-baby visits and influenza vaccines. For a complete list of covered services, please visit: https://www.healthcare.gov/coverage/preventive-care-benefits/

WELLNESS PROGRAM Our company's Wellness Program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

The above Wellness Program notice is only applicable if your plan administrator or medical plan provides a wellness program.

FEDERAL GUIDELINES

HIPAA PRIVACY NOTICE The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that we maintain the privacy of protected health information, give notice of our legal duties and privacy practices regarding health information about you and follow the terms of our notice currently in effect.

You may request a copy of the current Privacy Practices from the Plan Administrator explaining how medical information about you may be used and disclosed, and how you can get access to this information. ***As Required by Law***. We will disclose Health Information when required to do so by international, federal, state or local law.

You have the right to inspect and copy, the right to an electronic copy of electronic medical records, right to get notice of a breach, right to amend, right to an accounting of disclosures, right to request restrictions, right to request confidential communications, right to a paper copy of this notice and the right to file a complaint if you believe your privacy rights have been violated.

Individual Rights You may obtain a copy of your health claims records and other health information from us typically within a 30 day period from your request. We may charge a reasonable, cost-based fee. You may ask us to correct your health/claims records if you think they are incorrect. We reserve the right to say "no" to your request, but will give you an explanation in writing within a 60 day period. Requesting a specific way to contact you for confidential reasons is permitted (home or office phone for example), specifically if you would be in danger from a certain form of communication.

If you would like us not to use or share certain health information for treatment, payment or our operations, you are permitted to do so. However, we are not required to agree to your request if it would affect your care. At your request, we will provide you with a list of the times we have shared your health information up to six years prior to your request date, who we shared it with, and why. This list will include all disclosures excluding treatment, payment, and health care operations, as well as other certain disclosures (such as any you ask us to make). We provide one list a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

You can ask for a paper copy of this notice at any time, which we will promptly provide, even if you have agreed to receive the notice electronically. If you have given someone medical power of attorney or if you have a legal guardian, that person can exercise your rights and make choices about your health information. We will make sure they have this authority and can act in your interests before we take any action.

If you feel that we have violated your rights, you may contact us using the information on the back page, or file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We can assure no retaliation from us against you for filing a complaint.

For certain health information, you can tell us your choices about what we share. You have the right and choice to tell us to share information with your family, close friends, or others involved in payment for your care, and in a disaster relief situation. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest and when needed to lessen a serious and imminent threat to health or safety. We never share your information for marketing purposes of sale of your information without your expressed written consent.

Our Uses and Disclosures We typically use or share your information in several different ways. We help manage the healthcare treatment you receive by sharing information with professionals who are treating you. We can use and disclose your information to run our organization and contact you when necessary. We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage (this does not apply to long term care plans). Our organization can use and disclose your health information as we pay for your health services, as well as disclose your health information to your health plan sponsor for plan administration.

Other Uses and Disclosures Typically in the matter of public health and safety issues, we can use and share your information. For instance, preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect or domestic violence, as well as preventing or reducing a serious threat to anyone's health or safety, and health research.

We may need to share your information if state or federal law requires it, including the Department of Health and Human Services if it wishes to see that we're complying with federal privacy law. Other organizations and professionals we may share your information with are organ procurement organizations, coroners, medical examiners, and funeral directors. We can share your information in special instances such as for worker's compensation claims, law enforcement purposes, health oversight agencies for activities authorized by law, and for special government functions such as military, national security, and presidential protective services. We can share information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

"We, Our, and Us" is defined as the insurance carrier for fully insured plans or the plan administrator or third party administrator for self insured plans.

COVERAGE CONTINUATION RIGHTS UNDER(COBRA)

Dear Employee, Spouse and Dependent Children:
We have been retained by your sponsoring employer to provide you with information concerning your rights under COBRA. You are receiving this notice because you have recently become covered or will become covered under your sponsoring employer's group health plan ("the Plan"). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. This notice only gives a summary of your continuation coverage rights under the Plan. For additional 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 or Admin America**.**

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as 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 a qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

· 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 any of the following qualifying events happens:

· The parent-employee dies;
· The parent-employee's hours of employment are reduced;
· The parent-employee's employment ends for any reason other than his or her gross misconduct;
· The parent-employee 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."

Qualified beneficiaries also include a child born to or placed for adoption with the covered employee who satisfies the plan eligibility requirements and becomes covered under the Plan during the period of COBRA coverage.

Retirees

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your sponsoring employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after Admin America has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the sponsoring employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify Admin America of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child) causing a loss of coverage, you must notify Admin America in writing within 60 days after the later of the date the qualifying event occurs or the date that you would lose benefits due to a qualifying event. The employee or family member can provide notice on behalf of themselves as well as other family members affected by the qualifying event. The written notice of the qualifying event should be sent to Admin America, at the address provided in this notice, and should include all of the following:

- Date (month/day/year)
- Spouse/Dependent's Name
- Social Security Number/ID#
- Spouse/Dependent's Address
- Spouse/Dependent's Telephone #
- Gender
- Date of Birth (month/day/year)
- Relationship to Employee
- Employer's Name
- Employee's Name
- Employee's SSN/ID#
- Reason for Loss of Coverage
- Loss of Coverage (month/day/year)

If you need help acting on behalf of an incompetent beneficiary, please contact Admin America for assistance.

How is COBRA Coverage Provided?

Once Admin America 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 employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. You will not have to show that you are insurable to choose continuation coverage. However, you will have to pay the group rate premium for your continuation coverage plus a 2% administration fee, if applicable.

How long does COBRA coverage last?

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. However, if the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). There are two ways in which an 18-month period of COBRA continuation coverage can be extended:

1) Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the COBRA vendor in writing in a timely fashion, you and your entire family may be entitled to receive an additional 11 months of COBRA continuation coverage for a total 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 continuation coverage. The qualified beneficiary must provide the written determination of disability from the Social Security Administration to Admin America within 60 days of the latest of the date of the disability determination by the Social Security Administration, the date of the qualifying event or the benefit termination date; and prior to the end of the 18-month COBRA continuation period. You will be required to pay up to 150% of the group rate during the 11- month extension.

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

If your family experiences another qualifying event while receiving 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 notice of the second qualifying event is properly given to Admin America. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning your Plan should be addressed to the Plan Administrator of the sponsoring employer identified at the top of the first page of this document. Questions concerning your COBRA continuation coverage rights should be addressed to Admin America at the address listed below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), 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 the EBSA website at **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Please Note

Some states offer financial aid to help certain individuals pay for COBRA coverage. Contact your appropriate state agency regarding availability and eligibility requirements. Additionally, under certain circumstances, COBRA coverage may be paid with pre-tax dollars from a cafeteria plan under Section 125.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator and Admin America informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to either the Plan Administrator or Admin America.

MEDICARE PART D NON-CREDITABLE COVERAGE DISCLOSURE NOTICE

NON-CREDITABLE COVERAGE DISCLOSURE NOTICE FOR BCBS OF IL

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with 3Cloud and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

- 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.
- 3Cloud has determined that the prescription drug coverage offered by **BlueEdge HSA** is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the HDHP OAP Plan. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.
- You can keep your current coverage from BCBS of IL. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you decide to drop your current coverage with 3Cloud since it is employer sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however you also may pay a higher premium (a penalty) because you did not have creditable coverage under **BCBS of IL BlueEdge HSA 2080.**

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

Since the coverage under BlueEdge HSA 2080, is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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 3Cloud coverage will [or will not] be affected. You can keep this coverage if you elect Part D and the **BCBS of IL BlueEdge HSA plan** will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current 3Cloud coverage, be aware that you and your dependents may not be able to get this coverage back.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through 3Cloud changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

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

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

CREDITABLE COVERAGE DISCLOSURE NOTICE

Important Notice from 3Cloud About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with 3Cloud and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

2. 3Cloud has determined that the prescription drug coverage offered by the BluePrint PPO 0120 and BluePrint PPO 2030 are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current employee coverage will not be affected. You can keep this coverage if you elect part D and the BlueCross BlueShield of Illinois plan will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current 3Cloud coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with 3Cloud and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

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

Remember: Keep this 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).

Date	January 1, 2024
Name of Entity	3Cloud, LLC
Contact	Kristin Gilligan
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SUMMARY PLAN DESCRIPTION

Please note this guide is designed to provide an overview of the coverages available. Your employer reserves the right to amend or change benefit offerings at any time. This guide is not a Summary Plan Description (SPD) nor a contract or guarantee of benefits coverage. Official plan and insurance documents govern your rights and benefits, including covered benefits, exclusions and limitations. If any discrepancy exists between this guide and the official documents, the official documents will prevail. If you would like a printed copy of the materials, please contact your employer or the Employee Care Center (ECC) and one will be provided to you.

SUMMARY OF BENEFIT COVERAGE

The Patient Protection and Affordable Care Act (Affordable Care Act or ACA) requires health plans and health insurance issuers to provide a Summary of Benefits and Coverage (SBC) to applicants and enrollees. The SBC is provided by your Medical carrier. Its purpose is to help health plan consumers better understand the coverage they have and to help them make easy comparisons of different options when shopping for new coverage. This information is available when you apply for coverage, by the first day of coverage (if there are any changes), when your dependents are enrolled off your annual open enrollment period, upon plan renewal and upon request at no charge to you.

Guide Prepared By:

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