Wilkins Research Services LLC

2021 BENEFITS OVERVIEW

WHAT'S INSIDE

This guide is designed to provide a general overview of your benefits at Wilkins Research. It is not a contract or an official interpretation of the benefit plans. For more detailed information, please refer to your summary plan descriptions or the legal plan documents.

Should any questions or conflicts arise, the plan documents will be the final authority in determining your benefits. Wilkins Research reserves the right to modify or discontinue the plans at any time. This document was prepared exclusively for benefit eligible employees of Wilkins Research. Unauthorized reproduction is strictly prohibited.

Please contact Human Resources if you have any questions regarding your benefits plan.

ENROLLMENT CHANGES

Changes to your enrollment may be made annually during open enrollment each year. Mid-year changes may be made for the following qualifying events such as marriage/divorce, birth/adoption, death, change in job status of yourself or your spouse, and or change in Medicaid/CHIP eligibility.

However, all changes must be made within 30 days (with the exception of Medicaid/CHIP which gives you up to 60 days) of your qualifying event. You must notify Human Resources immediately when you experience a qualifying event.

SECTION 125 PLAN PREMIUM CONVERSION

Section 125 Premium Conversion Plan lets you exclude your Medical, Dental, Life and Vision premiums from your taxable income, meaning your premiums will come out of your income pre-tax. This lowers your taxable income. By default, your premiums will be deducted pre-tax, increasing your take-home pay anywhere from a couple hundred dollars to a thousand or more annually.

For Benefit Eligibility, Plan Documents, Important Annual Notices and other information, please review your Employee Benefit Center:

Employee Benefit Center

https://www.hrconnection.com/?u=WilkinsResearch

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 the Annual Notices for more details.

MEDICAL BENEFITS

BlueCross BlueShield of Tennessee (BCBST) | 800-565-9140 | www.bcbst.com

Wilkins Research's medical benefits are provided through BCBST.

BI-WEEKLY PREMIUMS	Option 1	Option 2	Option 3
Employee Only	$54.60	$54.74	$18.22
Employee + One	$275.35	$276.21	$209.15
Employee + Family	$475.61	$477.11	$382.36

Wilkins Research offers three plan options in the BCBST Networks. In these networks, you have the flexibility to go to any provider that you choose; however, anytime you select an in-network physician or facility, you will see significant discounts and savings.

If you select an out-of-network physician or facility, you will be subject to higher deductibles and out-of-pocket maximums. You are also responsible for the difference between billed charges and the maximum allowable charge. It definitely works to your advantage to go in-network whenever possible.

To find an in-network provider near you, go to www.bcbst.com and click on "Find A Doctor. Please be sure to consult either the online directory or the BCBST customer service department to confirm that your provider participates in the network.

GET STARTED.
SIGN UP FOR A USER ID AND PASSWORD.

Follow these simple steps to log in

- Go to **bcbst.com** and click on "Log In/Register to Blue Access."
- Click on the "Register Now" link and answer a few quick questions.
- You will need your BlueCross BlueShield of Tennessee member ID card.

HAVE QUESTIONS OR NEED HELP?

Call the Member Service number on your member ID card.

A **My Homepage**
View a snapshot of your benefit details, recent claims, tools and resources.

B **My Benefits & Coverage**
Get full details on what's covered, who's covered and what you pay for health care services.

C **My Claims & Balances**
View the status of your claims, get a copy of your EOB and check to see if your deductible has been met.

D **My Health & Wellness**
Make a personal health profile and look at facts designed to help you reach your health and wellness goals.

E **Member Tools**
Find a doctor or hospital in your network, get directions to their offices and print your personalized results. Get answers about health care costs – even compare fees.

F **My Account**
Set up your account profile, update your email and choose between paper or online statements, alerts and reminders.

MEDICAL BENEFITS CHART

Option 1 includes a Health Reimbursement Account (HRA). The full deductible amount is $5,500 for employee only coverage and $11,000 for family coverage. However Wilkins has set up an HRA account to cover the first $2,500 for employee only coverage and $5,000 for family coverage in deductible expenses. This means that when you go for doctor visits, receive emergency care, or have in or outpatient surgery the first $2,500 of the cost will be covered. If you have prescription drugs you will have to pay for those up front and then BlueCross BlueShield will reimburse you for covered drugs. Once you use all your $2,500 (or $5,000 for family) HRA funds you will be responsible for the next $3,000 ($6,000 for family) of deductible expenses. Once you meet your deductible you pay 50% of all costs until the Out of Pocket Maximum is met. The Out of Pocket Maximum is $4,100 for individual and $8,200 for family.

EMPLOYEE AMOUNTS*	BCBST, Option 1 HRA
Annual Deductible Individual/Family = $5,500/$11,000 (Wilkins Pays $2,500/$5,000)	$3,000 / $6,000
Annual Out-of-Pocket Max Individual/Family = $6,600/$13,200 (Wilkins Pays $2,500/$5,000)	$4,100 / $8,200
Plan Maximum	Unlimited
Preventive Care	
Preventive Care Visits	100%*
Office Visits	
Primary Care Provider	After deductible, you pay 50%
Specialist	After deductible, you pay 50%
Physical, Occupational, Speech, Audiology and Cognitive Therapy	After deductible, you pay 50%
Outpatient and Group Therapy	After deductible, you pay 50%
Imaging Services	
Physician's Office (x-ray, ultrasound)	After deductible, you pay 50%
Non-Hospital, Independent Facility Advanced Imaging (MRI, CAT, PET)	After deductible, you pay 50%
Hospital Outpatient Advanced Imaging (MRI, CAT, PET)	After deductible, you pay 50%
Surgery	
Non-Hospital, Independent Facility Surgery	After deductible, you pay 50%
Outpatient or Inpatient Hospital Surgery	After deductible, you pay 50%
Urgent & Emergency Care	
Urgent Care	After deductible, you pay 50%
Emergency Care (Includes urgent care centers at a hospital. Copay waived for inpatient hospital admissions)	After deductible, you pay 50%
Other Services	
Home Health Care (60 visit max.), Durable Medical Equipment, Prosthesis, and Most Other Covered Services	After deductible, you pay 50%
Pharmacy	
Retail (Up to 30-day Supply)	After deductible, you pay 50%
Specialty	After deductible, you pay 50%

*Review plan documents for out-of-network rates, prior authorization requirements, limits on the number of visits per year and service restrictions.
** Amount you are charged can depend on where services are rendered.

MEDICAL BENEFITS CHART

Option 2 also includes a Health Reimbursement Account (HRA). The full deductible amount is $6,000 for employee only coverage and $12,000 for family coverage. However Wilkins has set up an HRA account to cover the first $1,200 for employee only coverage and $2,400 for family coverage for deductible expenses. This means that when you go for doctor visits, receive emergency care, or have in or outpatient surgery the first $2,400 of the cost will be covered. If you have prescription drugs you will only pay a copay of $10 for generic, $75 for Preferred Brand Name, and $150 for Non-Preferred Brand Name Drugs. Once you use all your $1,200 (or $2,400 for family) HRA funds you will be responsible for the next $4,800 ($9,600 for family) of deductible expenses. Once you meet your deductible you pay 50% of all costs until the Out of Pocket Maximum is met. The Out of Pocket Maximum is $6,700 for individual and $13,400 for family.

EMPLOYEE AMOUNTS*	BCBST, Option 2 HRA
Annual Deductible Individual/Family = $6,000/$12,000 (Wilkins Pays $1,200/$2,400)	$4,800 / $9,600
Annual Out-of-Pocket Max Individual/Family = $7,900/$15,800 (Wilkins Pays $1,200/$2,400)	$6,700 / $13,400
Plan Maximum	Unlimited
Preventive Care	
Preventive Care Visits	100%*
Office Visits	
Primary Care Provider	After deductible, you pay 50%
Specialist	After deductible, you pay 50%
Physical, Occupational, Speech, Audiology and Cognitive Therapy	After deductible, you pay 50%
Outpatient and Group Therapy	After deductible, you pay 50%
Imaging Services	
Physician's Office (x-ray, ultrasound)	After deductible, you pay 50%
Non-Hospital, Independent Facility Advanced Imaging (MRI, CAT, PET)	After deductible, you pay 50%
Hospital Outpatient Advanced Imaging (MRI, CAT, PET)	After deductible, you pay 50%
Surgery	
Non-Hospital, Independent Facility Surgery	After deductible, you pay 50%
Outpatient or Inpatient Hospital Surgery	After deductible, you pay 50%
Urgent & Emergency Care	
Urgent Care	After deductible, you pay 50%
Emergency Care (Includes urgent care centers at a hospital. Copay waived for inpatient hospital admissions)	After deductible, you pay 50%
Other Services	
Home Health Care (60 visit max.), Durable Medical Equipment, Prosthesis, and Most Other Covered Services	After deductible, you pay 50%
Pharmacy	
Retail (Up to 30-day Supply)	$10 / $75 /$150 copay
Specialty	$300 copay

*Review plan documents for out-of-network rates, prior authorization requirements, limits on the number of visits per year and service restrictions.
** Amount you are charged can depend on where services are rendered.

MEDICAL BENEFITS CHART

EMPLOYEE AMOUNTS*		BCBST, Option 3 HDHP
Plan Deductible	**Individual / Family**	$3,000 / $6,000
Plan Out-of-Pocket Max	**Individual / Family**	$5,000 / $10,000
Plan Coinsurance		50%
Plan Maximum		Unlimited
Preventive Care		
Preventive Care Visits		100%*
Office Visits		
Primary Care Provider		After deductible, you pay 50%
Specialist		After deductible, you pay 50%
Physical, Occupational, Speech, Audiology and Cognitive Therapy		After deductible, you pay 50%
Outpatient and Group Therapy		After deductible, you pay 50%
Imaging Services		
Physician's Office (x-ray, ultrasound)		After deductible, you pay 50%
Non-Hospital, Independent Facility Advanced Imaging (MRI, CAT, PET)		After deductible, you pay 50%
Hospital Outpatience Advanced Imaging (MRI, CAT, PET)		After deductible, you pay 50%
Surgery		
Non-Hospital, Independent Facility Surgery		After deductible, you pay 50%
Outpatient or Inpatient Hospital Surgery		After deductible, you pay 50%
Urgent & Emergency Care		
Urgent Care		After deductible, you pay 50%
Emergency Care (Includes urgent care centers at a hospital. Copay waived for inpatient hospital admissions)		After deductible, you pay 50%
Other Services		
Home Health Care, Durable Medical Equipment, Prosthesis, and Most Other Covered Services		After deductible, you pay 50%
Pharmacy		
Generic/ Preferred/ Non Preferred Brand		After deductible, you pay 50%
Specialty Medications		After deductible, you pay 50%
Preventive Drugs		$10 / $35 / $60

*Review plan documents for out-of-network rates, prior authorization requirements, limits on the number of visits per year and service restrictions.

GoodRx

GoodRx | 1-855-268-2822 | www.goodrx.com

Why do I need GoodRx?

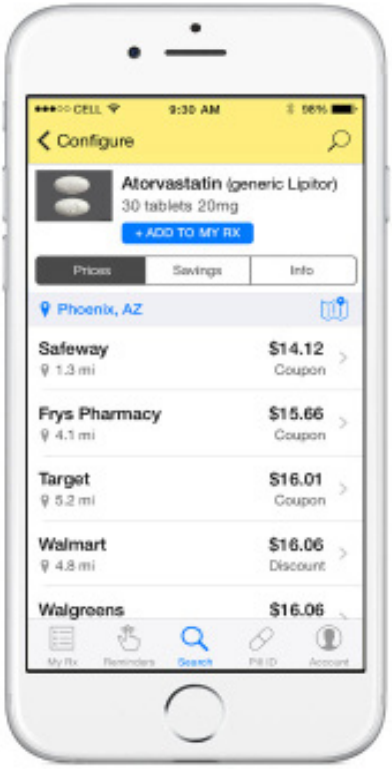
Prescription drug prices are not regulated. The cost of a prescription may differ by more than $100 between pharmacies across the street from each other!

How can GoodRx help me?

GoodRx gathers current prices and discounts to help you find the lowest cost pharmacy for your prescriptions. The average GoodRx customer saves $276 a year on their prescriptions. GoodRx is 100% free. No personal information is required.

How do I find discounts for my drug?

It's easy. Just go to www.goodrx.com, type in your drug's name in the search field, and click the "Find the Lowest Price" button. It will even help you spell the name of your prescription.



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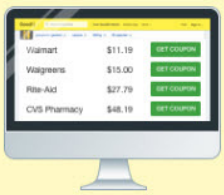


Compare prices

GoodRx collects prices & discounts from over 60,000 U.S. pharmacies

2

Print free coupons

Or send coupons to your phone by email or text message

3

Save up to 80%

Show the coupon to your pharmacist for massive savings on your meds

HEALTH SAVINGS ACCOUNT

HealthEquity | 1-866-346-5800 | www.healthequity.com

If you are enrolled in Medical Option 3, the High Deductible Health Plan, you are eligible to participate in a Health Savings Account (HSA) through HealthEquity.

An HSA is established to pay for future qualified medical, dental and vision expenses that are incurred by you or your dependents enrolled in the plan. This HSA allows you to make tax-free payroll contributions to the account to pay for subsequent future qualified medical expenses.

Your contributions to the HSA will be payroll deducted and the funds deposited into a selected financial institution custodial account. When a qualified expense is incurred, you simply use your Health Savings Account debit card or request reimbursement for the expense from the custodial account. Unused account dollars are yours to keep, even if you retire or leave the company.

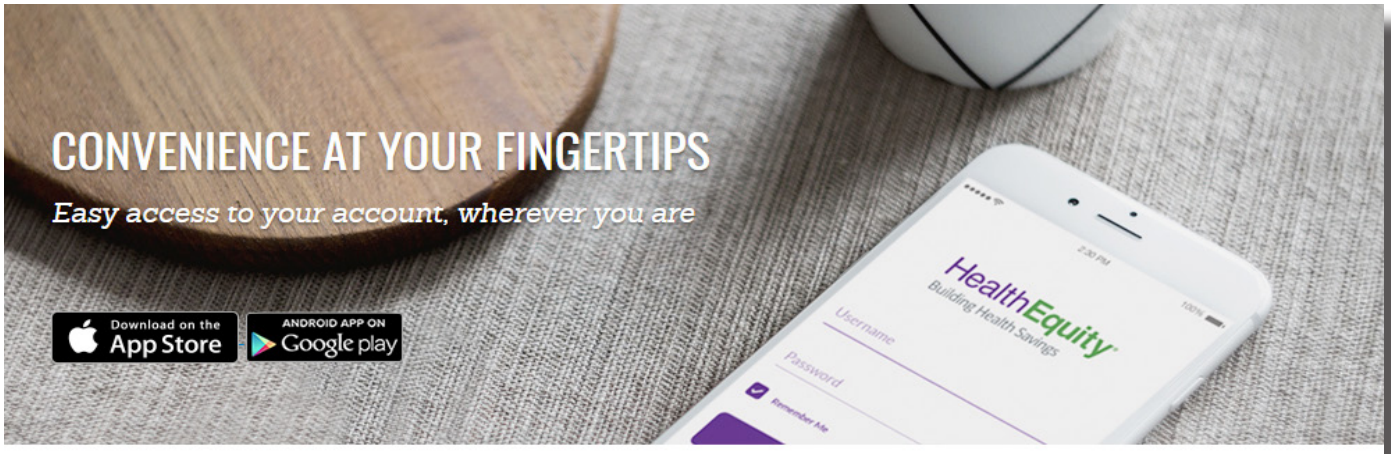
2021 Annual Maximum Contributions to your HSA

Employee:	$3,600
Family:	$7,200
Catch-Up Contribution: for those 55+	$1,000

To Complete Your Enrollment

Contact Human Resources for a HSA payroll deduction form.

Please note: Dependents over age 24, unless enrolled as a student, are not eligible to use the HSA benefit.



On-the-go access and history
Access all account types wherever you go

Photo documentation
Take a photo with your device to initiate claims and payments

Send payments & reimbursements
Send payments to providers or reimburse yourself for out-of-pocket expenses from your HSA

Manage debit card transactions
Link your debit card transactions to claims and documentation

Initiate claims and view their status
View the status of claims as well as link payments and documentation to claims

TELADOC

Teladoc | 1-800-835-2362 | www.teladoc.com

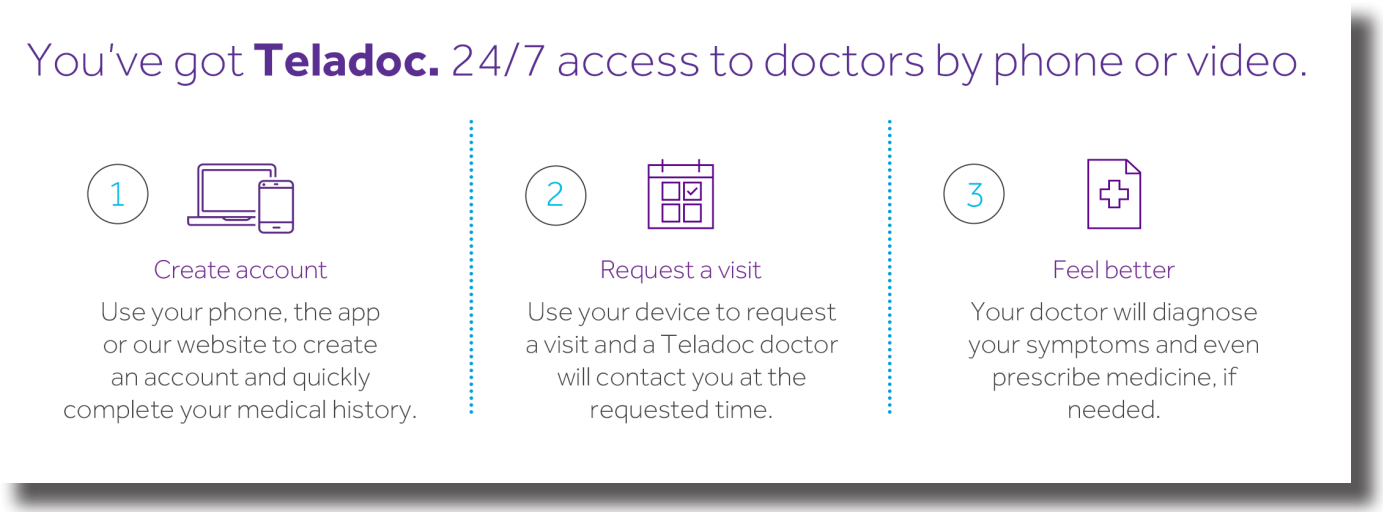
Wilkins Research is proud to offer Teladoc to all benefit eligible employees and their dependents. Teladoc is a national network of board certified physicians providing telephonic consultations 24/7 when your primary care physician is not available.

Teladoc doctors are U.S. board certified in Internal Medicine, Family Practice, or Pediatrics. They average 15 years practice experience, are licensed in your state, and incorporate Teladoc into their day-to-day practice as a way to provide people with convenient access to quality medical care.

Teladoc does not replace your primary care physician. Teladoc should be used when you need immediate care for non-emergent medical issues. It is an affordable, convenient alternative to urgent care and ER visits.

You can talk with a Teladoc doctor via a phone visit, video visit within the secure member portal, or video visit within the Teladoc mobile app. To request a visit, visit the Teladoc website or mobile app, log into your account and click “Request a Visit”. A doctor will call you back in 16 minutes, on average.

Prescriptions. Teladoc doctors can prescribe short term medication for a wide range of conditions when medically appropriate. Teladoc doctors do not prescribe substances controlled by the DEA, nontherapeutic and/or certain other drugs which may be harmful because of their potential abuse. When you go to your pharmacy of choice to pick up the prescription, you may use your health/prescription insurance card to help pay for the medication. You will be responsible for the co-pay based on the type of medication and your plan benefits.



TESTIMONIALS

I used Teledoc fairly extensively in the last year and overall was a fan of it. There were several times that I needed prescription medication for an acute condition and was able to get it quickly and cheaply. The doctors respond in a timely manner and for the most part are very friendly and helpful. I’d be disappointed if we lost this benefit.

I used Teledoc on more than one occasion and was pleased by the quick responses once I put the call in and I especially appreciated the convenience of using Teledoc when I was on vacation in Florida and was able to use Teledoc rather than having to go to the ER or use a walk-in clinic.

Using Teledoc was very easy. They were prompt with calling me back and the doctor asked me several questions about what was going on the call lasted like 15 minutes. I was also to get a prescription with no trouble and the medicine was one I had never heard about before and I had had this same issue before but was never told about this medicine. The pharmacy also had no issue with filling the script which I thought they might. I will continue to use when I need it, if we continue to use.

DENTAL BENEFITS

BlueCross BlueShield of TN | 1-800-565-9140 | www.bcbst.com

Your dental benefits at Wilkins Research are provided by BCBST. This dental plan is a PPO (similar to your medical plan), in that you may visit any provider that you choose, however, you will most likely see increased benefit levels if you go to a provider in network.

To find a provider in the network, visit www.bcbst.com and click on "Find a Dentist".

BI-WEEKLY PREMIUMS	
Employee Only	$12.31
Employee + One	$24.63
Employee + Family	$38.90

DENTAL BENEFITS	In-Network
Deductible: (Aggregate) Individual / Family	$50/$150
Benefits Paid by the Plan	
Plan Year Maximum	$1,500
Preventive - Includes exams, cleanings (2 per year), sealants, x-rays	100%
Basic - Fillings, periodontic services, minor oral surgery	80%
Major - Root Canals, periodontic surgery, crowns, dentures, bridges, anesthesia	50%
Orthodontia Coinsurance / Lifetime Maximum	N/A

VISION BENEFITS

BlueCross BlueShield of TN | 1-800-565-9140 | www.bcbst.com

Your vision plan is provided by BCBST. When using in-network providers, this plan covers most exams, eyeglass and medically necessary contacts in full. Discounts are available for upgrades on covered frames and lenses, as well.

Should you choose to see an out-of-network provider, BCBST will reimburse you up to a specified amount. Please see the plan document for the out-of-network reimbursement schedule.

BI-WEEKLY PREMIUMS	
Employee Only	$2.81
Employee + One	$5.61
Employee + Family	$8.98

VISION BENEFITS	In-Network		
	Frequency	Copay	Description
WellVision Exam	Every 12 months	$10	
Prescription Glasses		$20	
Frames	Every 24 months	$0	Up to $135
Lenses	Every 12 months		100% after copay
Contact Lenses Exam (instead of glasses)	Every 12 months		(Premium fit and follow-up: 10% off retail) Exam $40
Conventional		$0	Up to $135
Disposable		$0	Up to $135
Medically Necessary			$0

of Tennessee

A Healthy Mouth for a Healthy Life

Keeping your mouth healthy is important to your overall health. Most people should have a checkup every six months, but here are some other ways to keep your mouth healthy.

Oral Care

- Brush your teeth with a fluoride toothpaste for at least two minutes at a time, twice a day.
- Be gentle! Scrubbing too hard may hurt your teeth and gums.
- Brush all surfaces of your teeth.
- Brush your tongue to keep your breath smelling fresher.
- Floss at least once a day with about 18 inches of floss.
- Gently work the floss between each tooth.
- Curve the floss around each tooth and slide it between the tooth and the gum, rubbing gently.

Call Your Dentist if You Notice

- Sores, bleeding, redness or swelling in your mouth and gums
- Bad odors or taste, pain when chewing
- Pain in your teeth when you eat something cold, hot or sweet
- Holes or dark spots in your teeth
- Loose teeth

Living a Healthy Lifestyle

- Avoid tobacco.
- Eat sugar and starches in moderation.
- Choose foods high in fiber like fruits and vegetables.
- Avoid sipping juices and sodas throughout the day.
- Drink water to wash away any acids in your diet.

What to Tell Your Dentist

Let your dentist know if you're pregnant or have any of these conditions, and what kind of treatment you're getting.

Pregnancy

Keeping your mouth healthy may help your delivery stay on schedule. Good oral health may help make sure your pregnancy goes to full term, keeping you and your baby healthy.

Source: Centers for Disease Control and Prevention, cdc.gov/oralhealth/publications/features/pregnancy-and-oral-health.html

Rheumatoid Arthritis

Gum bacteria can worsen rheumatoid arthritis, and that can cause inflammation that can worsen your oral health.

Source: Johns Hopkins University, hopkinsrheumatology.org/2017/01/gum-disease-linked-to-rheumatoid-arthritis/

Diabetes

If you have diabetes, a combination of higher blood sugar levels and dry mouth makes it difficult to fight gum infections. Good oral hygiene can help keep your mouth healthy and your blood sugar stable, regulating your diabetes and making you healthier.

Source: American Dental Association, mouthhealthy.org/en/az-topics/d/diabetes

Cancer

Certain head and neck cancers are treated with radiation and chemotherapy, which cause dry mouth, making it harder for saliva to remove harmful bacteria. Regular brushing and flossing can help remove what your body can't.

Source: National Institutes for Health, cancer.gov/about-cancer/treatment/side-effects/mouth-throat/oral-complications-pdq

Heart Health

Brushing twice a day can help keep your heart healthy. If you already have coronary artery disease, treating periodontal disease can lower your risk of hospital admissions by 28%.

Source: American Journal of Preventive Medicine's Impact of Periodontal Therapy on General Health Study, June 2014; heart.org/en/news/2018/11/07/bad-tooth-brushing-habits-tied-to-higher-heart-risk

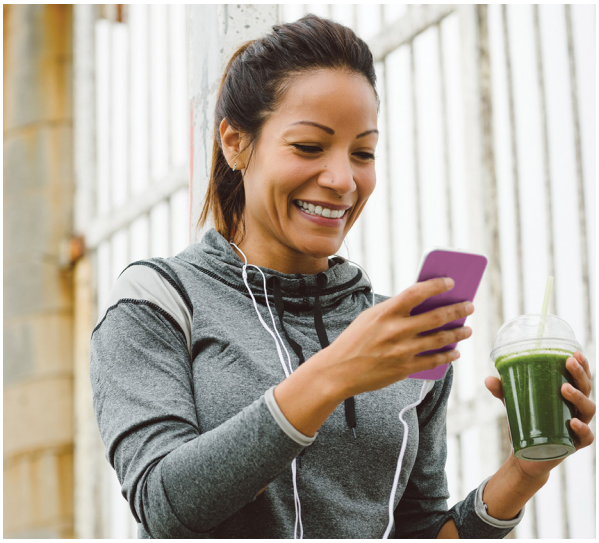
BASIC LIFE INSURANCE

USAble | 800-370-5856 | www.usablelife.com

BASIC LIFE/AD&D INSURANCE

At Wilkins Research, Basic Life/Accidental Death and Dismemberment (AD&D) Insurance is a provided benefit to you through USAble. The coverage amount is $25,000.

AD&D insurance pays an additional amount based on a specific list of losses such as loss of life, limb, or sight due to an accident. Please remember to contact Human Resources when you need to update your beneficiaries. Amounts are subject to age reductions beginning at age 65.



CONTACT INFORMATION

Plan	Carrier	Phone Number
Medical	BlueCross BlueShield of TN	1.800.565.9140
Health Savings Account (HSA)	Health Equity	1.866.346.5800
Dental	BlueCross BlueShield of TN	1.800.565.9140
Vision	BlueCross BlueShield of TN	1.800.565.9140
Basic Life	USAble	1.800.370.5856
Telemedicine	Teledoc	1.800.835.2362

ANNUAL NOTICES

IMPORTANT NOTICES FROM OUR COMPANY REGARDING THE PLAN

The following notices provide important information about the group health plan provided by your employer. Please read the attached notices carefully and keep a copy for your records.

If you have any questions regarding any of these notices, please contact:

Wilkins Research Services, LLC
Contact: Becky Keller, Plan Administrator
Phone: (423) 771-4011
Mailing Address: 1730 Gunbarrel Road
Chattanooga, TN 37421
Distribution Date: October 1, 2020

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

A Subscriber may continue his or her coverage and coverage for his or her Dependents during military leave of absence in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994. When the Subscriber returns to work from a military leave of absence, the Subscriber will be given credit for the time the Subscriber was covered under the Plan prior to the leave.

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). If you have had or are going to have a mastectomy, you may be entitled to certain benefits. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

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

If you would like more information on WHCRA benefits, contact your Health Insurance issuer.

MASTECTOMY NOTICE

Patients who undergo a mastectomy and who elect breast reconstruction in connection with the mastectomy are entitled to coverage for:

• Reconstruction of the breast on which the mastectomy was performed;

• Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

• Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas

In a manner determined in consultation with the attending physician and the patient. The coverage may be subject to coinsurance and deductibles consistent with those established for other benefits.

Please contact Human Resources for more information.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Newborns' and Mothers' Health Protection Act requires that group health plans and health insurance issuers who offer childbirth coverage 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). In any case, plans and issuers 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). Refer to your plan document for specific information about childbirth coverage or contact your plan administrator.

For additional information about NMHPA provisions and how Self-funded non Federal governmental plans may opt-out of the NMHPA requirements, visit http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/nmhpa_factsheet.html.

HIPAA NOTICE OF PRIVACY PRACTICES

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.

If not attached to this document, you may request a copy of the current Privacy Practices, 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, 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.

NOTICE OF SPECIAL ENROLLMENT RIGHTS TO NEW ENROLLEES

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing

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

If you are decline enrollment for yourself or your dependents (including your spouse) while coverage under Medicaid or a state Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' Medicaid or CHIP coverage ends. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or a CHIP program with respect to coverage under this plan, you may be able to enroll yourself and your dependents (including your spouse) in this plan. However, you must request enrollment within 60 days after you or your dependents become eligible for the premium assistance.

To request special enrollment or obtain more information, contact the plan's General Contact.

PLEASE REVIEW IT CAREFULLY.

Our Company's Pledge to You

This notice is intended to inform you of the privacy practices followed by the Our Company Health and Welfare Plan (the Plan) and the Plan's legal obligations regarding your protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The notice also explains the privacy rights you and your family members have as participants of the Plan. It is effective in April. [Note: the effective date may not be earlier than the date on which the privacy notice is printed or otherwise published].

The Plan often needs access to your protected health information in order to provide payment for health services and perform plan administrative functions. We want to assure the plan participants covered under the Plan that we comply with federal privacy laws and respect your right to privacy. Our Company requires all members of our workforce and third parties that are provided access to protected health information to comply with the privacy practices outlined below.

Protected Health Information

Your protected health information is protected by the HIPAA Privacy Rule. Generally, protected health information is information that identifies an individual created or received by a health care provider, health plan or an employer on behalf of a group health plan that relates to physical or mental health conditions, provision of health care, or payment for health care, whether past, present or future.

How We May Use Your Protected Health Information

Under the HIPAA Privacy Rule, we may use or disclose your protected health information for certain purposes without your permission. This section describes the ways we can use and disclose your protected health information.

Payment. We use or disclose your protected health information without your written authorization in order to determine eligibility for benefits, seek reimbursement from a third party, or coordinate benefits with another health plan under which you are covered. For example, a health care provider that provided treatment to you will provide us with your health information. We use that information in order to determine whether those services are eligible for payment under our group health plan.

Health Care Operations. We use and disclose your protected health information in order to perform plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order to understand participant utilization and to make plan design changes that are intended to control health care costs.

Treatment. Although the law allows use and disclosure of your protected health information for purposes of treatment, as a health plan we generally do not need to disclose your information for treatment purposes. Your physician or health care provider is required to provide you with an explanation of how they use and share your health information for purposes of treatment, payment, and health care operations.

As permitted or required by law. We may also use or disclose your protected health information without your written authorization for other reasons as permitted by law. We are permitted by law to share information, subject to certain requirements, in order to communicate information on health-related benefits or services that may be of interest to you, respond to a court order, or provide information to further public health activities (e.g., preventing the spread of disease) without your written authorization. We are also permitted to share protected health information during a corporate restructuring such as a merger, sale, or acquisition. We will also disclose health information about you when required by law, for example, in order to prevent serious harm to you or others.

Pursuant to your Authorization. When required by law, we will ask for your written authorization before using or disclosing your protected health information. If you choose to sign an authorization to disclose information, you can later revoke that authorization to prevent any future uses or disclosures.

To Business Associates. We may enter into contracts with entities known as Business Associates that provide services to or perform functions on behalf of the Plan. We may disclose protected health information to Business Associates once they have agreed in writing to safeguard the protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims. Business Associates are also required by law to protect protected health information. To the Plan Sponsor. We may disclose protected health information to certain employees of Our Company for the purpose of administering the Plan. These employees will use or disclose the protected health information only as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have

authorized additional disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Your Rights

Right to Inspect and Copy. In most cases, you have the right to inspect and copy the protected health information we maintain about you. If you request copies, we will charge you a reasonable fee to cover the costs of copying, mailing, or other expenses associated with your request. Your request to inspect or review your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to inspect and copy your health information. To the extent your information is held in an electronic health record, you may be able to receive the information in an electronic format.

Right to Amend. If you believe that information within your records is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. Your request to amend your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to amend your health information. If we deny your request, you may file a statement of disagreement with us for inclusion in any future disclosures of the disputed information.

Right to an Accounting of Disclosures. You have the right to receive an accounting of certain disclosures of your protected health information. The accounting will not include disclosures that were made (1) for purposes of treatment, payment or health care operations; (2) to you; (3) pursuant to your authorization; (4) to your friends or family in your presence or because of an emergency; (5) for national security purposes; or (6) incidental to otherwise permissible disclosures.

Your request to for an accounting must be submitted in writing to the person listed below. You may request an accounting of disclosures made within the last six years. You may request one accounting free of charge within a 12-month period.

Right to Request Restrictions. You have the right to request that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. You also have the right to request that we limit the protected health information that we disclose to someone involved in your care or the payment for your care, such as a family member or friend.

Your request for restrictions must be submitted in writing to the person listed below. We will consider your request, but in most cases are not legally obligated to agree to those restrictions. However, we will comply with any restriction request if the disclosure is to a health plan for purposes of payment or health care operations (not for treatment) and the protected health information pertains solely to a health care item or service that has been paid for out-of-pocket and in full.

Right to Request Confidential Communications. You have the right to receive confidential communications containing your health information. Your request for restrictions must be submitted in writing to the person listed below. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address.

Right to be Notified of a Breach. You have the right to be notified in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information. Notice of any such breach will be made in accordance with federal requirements.

Right to Receive a Paper Copy of this Notice. If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us upon request. To obtain a paper copy of this notice, please contact the person listed below.

Our Legal Responsibilities

We are required by law to protect the privacy of your protected health information, provide you with certain rights with respect to your protected health information, provide you with this notice about our privacy practices, and follow the information practices that are described in this notice.

We may change our policies at any time. In the event that we make a significant change in our policies, we will provide you with a revised copy of this notice. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below. If you have any questions or complaints, please contact: Human Resources.

PATIENT PROTECTION DISCLOSURE

Our Company generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact our medical provider, listed on the medical benefits page herein.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Our Company or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact our medical provider, listed on the medical benefits page herein.

Trinity Benefit Advisors
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Important Notice About Your Prescription Drug Coverage and Medicare

If you or any of your eligible dependents are eligible for Medicare, or will soon become eligible for Medicare, please read this notice. If not, you can disregard this notice.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage under the health plan 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. **We have determined that the prescription drug coverage offered by the health plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage.**

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 coverage will not be affected.

Prescription Drug Benefits for Options 1, 2 and 3	Option 1	Option 2	Option 3
Retail (Up to 30-day Supply)	After deductible, you pay 50%	$10 / $75 / $150	$10 / $35 / $60
Specialty	After deductible, you pay 50%	$300	After deductible, you pay 50%

Contact your plan administrator for an explanation of the prescription drug coverage plan provisions/ options under the plan available to Medicare eligible individuals when you become eligible for Medicare Part D. If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents [may or 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 health plan coverage and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 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.

For More Information About This Notice or Your Current Prescription Drug Coverage please contact the plan administrator indicated on the first page of this notice.

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 your current health plan provided by the current insurer changes. You also may request a copy of this notice at any time.

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

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

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

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

Remember: Keep this 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:	October 2020
Name of Entity/Sender	Wilkins Research Services, LLC
Contact -- Position / Office:	Becky Keller -- Plan Administrator
Address:	1730 Gunbarrel Road Chattanooga, TN 37421
Phone:	(423) 771-4011

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

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

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

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

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

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

ALABAMA – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 916-440-5676
ALASKA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS – Medicaid	**FLORIDA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Website: https://medicaid.georgia.gov/health-insurance- premium-payment-program-hipp Phone: 678-564-1162 ext 2131	Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840
INDIANA – Medicaid	**MINNESOTA – Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs- and-services/other-insurance.jsp Phone: 1-800-657-3739
IOWA – Medicaid and CHIP (Hawki)	**MISSOURI – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS – Medicaid	**MONTANA – Medicaid**
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KENTUCKY- Medicaid	**NEBRASKA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

MAINE – Medicaid	NEW HAMPSHIRE – Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740. TTY: Maine relay 711	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
NEW JERSEY – Medicaid and CHIP	**SOUTH DAKOTA - Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK – Medicaid	**TEXAS – Medicaid**
Website: https://www.health.ny.gov/health care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	**UTAH – Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA – Medicaid	**VERMONT– Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA – Medicaid and CHIP	**VIRGINIA – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
OREGON – Medicaid	**WASHINGTON – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND – Medicaid and CHIP	**WISCONSIN–Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	**WYOMING – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

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

Paperwork Reduction Act Statement

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

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