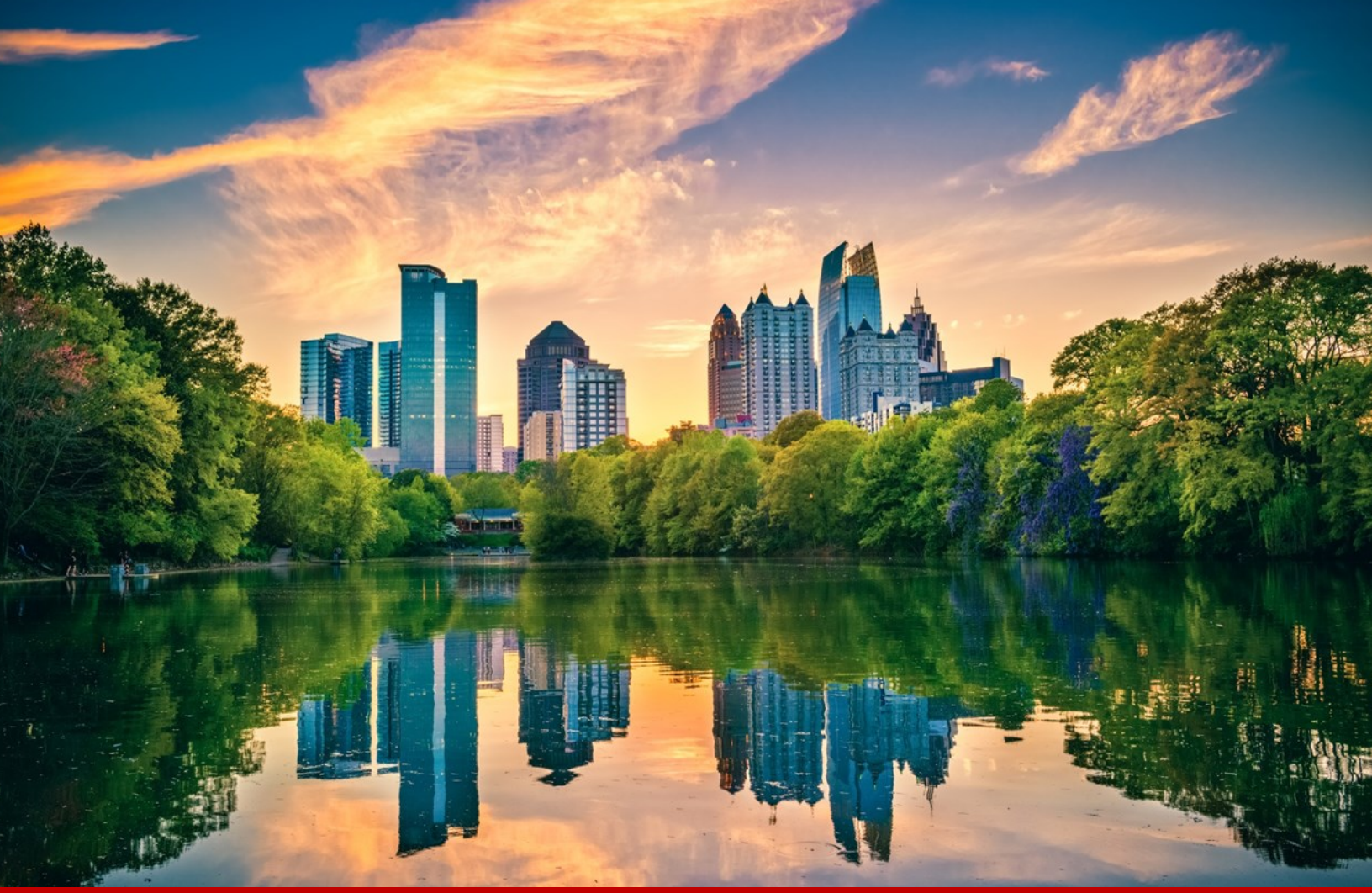


CLEVELAND

Guide to Employee Benefits

2017

WHAT'S INSIDE

WELCOME TO YOUR 2017 - 2018 BENEFITS

Cleveland Group owes much of our growth and success to YOU. We are fortunate to have a great team of people who are dedicated to our vision and are committed to keeping your overall health a high priority. We strive to keep our employee benefit package competitive and maintain initiative to help us all become healthier, live longer and have a better quality life.

By working together, we will be able to keep costs under control and also continue to provide a meaningful and beneficial health benefit program for you and your family. We prove daily that a company is only as good as its employees, and we are fortunate enough to have the best and the brightest. We thank you for your continued partnership and your ongoing support of our corporate goals.

BENEFITS SNAPSHOT

ENROLLING FOR COVERAGE

July is our annual Enrollment Period and this is the time you may change your benefit elections effective August 1, 2017. Please review this benefit guide and your enrollment packet, and let us know your benefit decisions for the next 12 months.

2017 – 2018 Employee Contributions

With current medical and Rx trend at 8% and our particular claims running higher than in past years, it is necessary for us to make some adjustments to the health care premiums. However, we are extremely pleased to share that the company will be absorbing the entire increase and holding the employee's payroll deductions at their current level for the 12th year in a row, as well as making no plan design changes. While there will be no premium increase for the employees, premium increases are likely in the future due to the significant rise in the cost of insurance. Any health plan can be affected by uncontrollable factors, it is a credit to our employees that services offered, such as the biometric screening and the Medical Advocate Program are being utilized.

Employee payroll contributions are included in the benefit guide under each benefit section. Employees may continue to select either the POS or Health Saving Account (HSA) plan according to health care needs and ability to pay for expenses at the time of service.

NEW for 2017 – 2018

Will Preparation Services

Offered through Mutual of Omaha, Will Preparation Services provided by Willing allow you to create a free basic will by answering simple multiple choice questions on your computer or smartphone. You can create a free basic will at www.willing.com/MutualofOmaha. If you require an upgraded version, including Power of Attorney, Living Wills and Transfer of Death Deed, these are available for an additional discounted fee, using the code Mutual20 at checkout.

Hearing Aid Discount Program

Also offered through Mutual of Omaha, this program includes a discounted hearing test, risk-free 60-day trial for hearing aids and a hearing aid low price guarantee. Services offered through Amplifon.

Transamerica Universal Life / Long Term Care

In addition to the voluntary supplemental term life insurance offered through Mutual of Omaha, we are also introducing a Universal Life product through Transamerica. This product includes a Chronic Illness Rider, which pays a portion of your life insurance benefit on a monthly basis if you require long term care due to the inability to perform two of more activities of daily living.

ENROLLING FOR COVERAGE

Important to Remember!

Laboratory Services

Laboratory expenses can be a significant cost to employees as they are subject to co-insurance fees and deductibles. However, Cleveland provides a service to help reduce these costs called LabCard which is a service of Quest Diagnostics. Labcard/Quest is a voluntary program that allows you to obtain lab services free of charge. Simply ask your doctor to have all lab tests sent to Quest Diagnostics. If your doctor does not use Quest, you can request that the tests be completed on an outpatient basis. The tests must be ordered by your physician. There are numerous Labcard/Quest locations in your area that can be found at www.LabCard.com or www.questdiagnostics.com. Outpatient lab work includes: blood testing such as cholesterol or CBC, urine testing, cytology and pathology such as pap smears and biopsies and cultures such as a throat culture. Remember to show your health ID card to your physician and request to use the Labcard/Quest program.

Medical, Dental, Life and Disability Coverage

Aetna will continue as the network for the medical plan, utilizing the Aetna Choice POS II network. When searching for a provider on the website at www.aetna.com/docfind/custom/mymeritain, you will need to select the Aetna Choice POS II (open access) network. CVS Caremark will continue as the Pharmacy Benefit Manager (PBM). See inside for a brief outline of benefit details.

We continue to pay the majority (75%) of the cost of the employee Life, Accidental Death & Dismemberment (AD&D) and Long Term Disability (LTD) coverage. Coverage continues with Mutual of Omaha and premiums for the coverage have not changed. Please see the Life and LTD Sections for more information and payroll deductions.

Supplemental life insurance is available for employees and their families who need higher amounts of life insurance coverage. Premiums remain the same and are based on your age. If you cross over from one age bracket to another, you incur premium increases.

We continue to offer a choice of two different style dental plans designed to help cover the cost of dental care and treatment. The Prepaid Dental Program through Humana CompBenefits and the PPO plan with Always Care. Rates for the Humana CompBenefits plan will remain the same. The Always Care PPO plan received an 8% premium increase. See inside for a brief outline of benefit details.

Wellness Services

For the eleventh year, we are pleased to offer individualized health assessments for employees and their spouses which includes onsite medical history, evaluation and a comprehensive blood test. The testing will be held in August. Our goal is to have 100% of our employees participate and receive important confidential, individualized biometric information on how to measure, compare and monitor your own health improvements from year to year. This is an excellent tool to provide your primary care physician. And to encourage participation, Cleveland provides a $100 bonus incentive to all employees and dependents who complete the evaluation.

Age appropriate preventive health care services are also provided to all health plan members free of charge. There are no deductibles or co-pays applicable to these benefits to encourage physical exams and cancer screenings. We encourage all health plan members to utilize these important preventive health care benefits.

ENROLLING FOR COVERAGE

Medical Advocate Program

The Medical Advocate Program (MAP) assists employees by showing how they can get more value out of their healthcare benefits, while at the same time helping them to become more educated purchasers of healthcare. With just a single phone call, MAP offers one-on-one personal assistance with qualified healthcare professionals with your medical questions, help with finding the highest quality doctors and facilities in the area, and understanding treatment options.

We encourage our employees to be savvy health care shoppers. You can save money for yourself and Cleveland Group in claims dollars by choosing facilities that are lower cost when you have planned surgeries, outpatient services or diagnostic screenings such as Mammograms and Colonoscopies. For example, an MRI at an outpatient center would be of lower cost than having one done at a hospital. MAP is able to assist you in selecting high quality, economically priced facilities and procedures.

Prescriptions (Rx)

There are also ways to save money on prescription drugs. Many pharmacies have lower cost generics and some, like Publix, have free drug programs for certain maintenance drugs used to treat diabetes and high blood pressure. You can also check drug pricing with websites and apps, like OneRX.com and GoodRX.com. These sites will provide pricing at various pharmacies in your geographic area. And for maintenance prescriptions, you can obtain a 3 month supply for the cost of a 2 month supply when you request a 90 day prescription from your doctor.

For Current Employees

If you do not wish to change your medical or dental plan election, no further action is needed. Your current plan elections will remain the same. If you wish to change your medical or dental election(s) or election for any other coverage please contact Mrs. Brenda Lee 404-505-4576 or mail election information to Mrs. Lee at 1281 Fulton Industrial Blvd, Atlanta, GA 30336.

In order to receive an ID card by August 1st, 2017, **ALL CHANGES MUST BE RECEIVED BY July 21st.** Benefit elections made after July 31st cannot be honored unless you are a new employee.

For New Employees

Please contact Mrs. Brenda Lee at 404-505-4576 in the Risk Management Department for further assistance with your benefit elections.

MEDICAL PLAN

Meritain Health - Policy Number 12217		
Type of Plan	**PPO**	
	In-Network	**Out-of-Network**
Overview	You may use both In-Network and Out-of-Network providers. Receive the highest level of benefits with use of the In-Network providers.	
Annual Deductible		
Single	$600	$1,200
Family	$1,800	$3,600
Annual Out-of-Pocket Maximum		
Single	$3,000	$6,000
Family	$6,000	$12,000
Maximum Annual Benefit	Unlimited	
PCP/Specialist Care (Outpatient)	$30 copay per office visit	60% covered after deductible
Hospital Inpatient Care	80% covered after deductible	60% covered after deductible
Hospital Outpatient Surgery	80% covered after deductible	60% covered after deductible
Emergency Services *(copay waived if admitted)*	80% covered after deductible	60% covered after deductible
Preventive Health Care Benefit	100% deductible waived, based on age appropriate recommendations*	100% deductible waived, based on age appropriate recommendations*
Chiropractic Care	80% covered after deductible, up to 30 visits annually	60% covered after deductible, up to 30 visits annually
Mental Health		
Inpatient	80% covered after deductible	60% covered after deductible
Outpatient	80% covered after deductible	60% covered after deductible
Long Term Care Services		
Skilled Nursing Facility, Hospice Care, Home Health Care, DME/Prosthetics, Speech and Occupational Therapy	80% covered after deductible, up to plan limits	60% covered after deductible, up to plan limits
Prescription Drugs		
Retail Pharmacy (30 days) *Generic/Brand*	$10/$30	Not covered
Mail Order Delivery (90 days) *Generic/Brand*	$20/$60	Not covered
Bi-Weekly Contribution		
Employee	$57.94	
Employee & Spouse	$127.57	
Employee & Child/ren	$104.36	
Employee & Family	$185.50	
Eligibility Date	Date of Hire - All full-time employees who work at least 30 hours per week.	
Contact Information	Meritain Health 1.800.925.2272 www.mymeritain.com www.meritain.com	
Provider Finder	www.aetna.com/docfind/custom/mymeritain Select Aetna Choice POS II (Open Access) Network	
Quest Diagnostics (LabCard)		
Quest Diagnostics LabCard Program is a voluntary program and allows you to avoid co-pays and/or deductibles. The testing must be covered and ordered by your physician. Outpatient lab work includes: blood testing such as cholesterol or CBC, urine testing such as urinalysis, cytology and pathology such as pap smears and biopsies, and cultures such as a throat culture. Simply show your Health ID card and verbally request to use the LabCard program offered by Quest Diagnostics.		
Contact Information	1.800.646.7788 www.LabCard.com	

MEDICAL PLAN

Meritain Health - Policy Number 12217		
Type of Plan	**HDHP**	
	In-Network	**Out-of-Network**
Overview	You may use both In-Network and Out-of-Network providers. Receive the highest level of benefits with use of the In-Network providers.	
Annual Deductible		
Single	$2,600	$5,000
Family	$5,000	$10,000
Annual Out-of-Pocket Maximum		
Single	$5,000	$10,000
Family	$10,000	$20,000
Maximum Annual Benefit	Unlimited	
PCP/Specialist Care (Outpatient)	70% covered after deductible	50% covered after deductible
Hospital Inpatient Care	70% covered after deductible	50% covered after deductible
Hospital Outpatient Surgery	70% covered after deductible	50% covered after deductible
Emergency Services *(copay waived if admitted)*	70% covered after deductible	50% covered after deductible
Preventive Health Care Benefit	100% deductible waived, based on age appropriate recommendations*	100% deductible waived, based on age appropriate recommendations*
Chiropractic Care	70% covered after deductible, up to 30 visits annually	50% covered after deductible, up to 30 visits annually
Mental Health		
Inpatient	70% covered after deductible	50% covered after deductible
Outpatient	70% covered after deductible	50% covered after deductible
Long Term Care Services		
Skilled Nursing Facility, Hospice Care, Home Health Care, DME/Prosthetics, Speech and Occupational Therapy	70% covered after deductible, up to plan limits	50% covered after deductible, up to plan limits
Prescription Drugs		
Retail Pharmacy (30 days)	70% covered after deductible	Not covered
Generic/Brand		
Mail Order Delivery (90 days)	70% covered after deductible	Not covered
Generic/Brand		
Bi-Weekly Contribution		
Employee	$24.98	
Employee & Spouse	$55.01	
Employee & Child/ren	$44.97	
Employee & Family	$79.99	
Eligibility Date	Date of Hire - All full-time employees who work at least 30 hours per week.	
Contact Information	Meritain Health 1.800.925.2272 www.mymeritain.com www.meritain.com	
Provider Finder	www.aetna.com/docfind/custom/mymeritain Select Aetna Choice POS II (Open Access) Network	

*** For more information on age appropriate recommendations, please see your Summary Plan Description.**

DENTAL PLAN

Always Care Dental PPO - DenteMax Network		
Type of Plan	**PPO**	
	In-Network	**Out-of-Network** Subject to Usual, Customary and Reasonable charges
Deductible *(Individual / Family)*	No Deductible	No Deductible
Office Visit Co-Pay	$0	$0
Annual Maximum Benefit Per Individual	$2,000	$2,000
Preventive Services *(Oral exam, cleaning, x-rays)*	100%	100%
Basic Services *(Fillings, root canal, oral surgery)*	80%	80%
Major Services *(Crowns, dentures)*	50%	50%
Bi-Weekly Contribution		
Employee	$22.24	
Employee & Spouse	$43.94	
Employee & Child/ren	$46.30	
Employee & Family	$72.48	
Eligibility Date	Date of Hire - All full-time employees working at least 30 hours per week.	
Waiting Periods	Waiting periods may apply for some services.	
Contact Information	Always Care Dental 1.888.729.5433 www.alwayscarebenefits.com	

Dental Coverage - Humana CompBenefits *Policy Number 15231*		
Type of Plan	**HMO**	
Diagnostic	Patient Pays $0 to $15	Patient fees determined by Schedule
Preventive	Patient Pays $0 to $95	Patient fees determined by Schedule
Fillings	Patient Pays $20 to $150	Patient fees determined by Schedule
Crowns, Bridges	Patient Pays $20 to $310	Patient fees determined by Schedule
Bi-Weekly Contribution		
Employee	$9.06	
Employee + 1	$16.14	
Family	$22.26	
Eligibility Date	Date of Hire - All full-time employees who work at least 30 hours per week.	
Contact Information	Humana CompBenefits 1.800.342.5209 www.mycompbenefits.com	

LIFE AND AD&D PLAN

Life and AD&D Coverage *Mutual of Omaha*	
Life and AD&D	1 times Base Annual Earnings (BAE) up to a maximum of $100,000
Monthly Contribution	$.12 per $1,000
Supplemental Coverage	
Employee	1 times to 5 times BAE, up to $500,000 whichever is lesser. Guarantee Issue of $100,000, available at initial enrollment only.
Spouse	Increments of $5,000 up to lesser of $100,000 or 50% of EE's amount. Guarantee Issue of $25,000, available at initial enrollment only.
Dependent	$5,000 for dependents age 15 days or older.

	Smoker	Non-Smoker	Spouse
< 25	.12	.08	.10
25 - 29	.12	.08	.10
30 - 34	.17	.09	.12
35 - 39	.22	.11	.15
40 - 44	.36	.16	.24
45 - 49	.67	.28	.42
50 - 54	1.10	.46	.65
55 - 59	1.75	.85	1.15
60 - 64	2.25	1.25	1.45
65 - 69	4.20	2.60	2.90
70 - 74	5.70	3.70	
75+	13.60	9.30	

Eligibility Date	Date of Hire - All full-time employees who work at least 30 hours per week.
Long -Term Disability *Mutual of Omaha*	
Basic Coverage	
Amount of Benefit	60% of Basic Monthly Earnings, reduced by other income, up to $3,000
When Benefits Begin	Benefits commence after 90 days of disability.
Monthly Contribution	$.118 per $100 covered salary.
Eligibility Date	Date of Hire - All full-time employees who work at least 30 hours per week.

PROGRAMS AND CONTACTS

Worldwide Travel Assistance and Identity Theft Assistance *Mutual of Omaha*	
Comprehensive travel support for employees providing round the clock access to services for employees, spouses and dependent children on any single trip up to 90 days in length and more than 100 miles from home.	
Contact Information	Inside the U.S.: 1.800.856.9947 Outside of the U.S.: 1.312.935.3658 (Call Collect)
Emergency Travel Support Services	24/7 Access to Interpreter Services, coordination of emergency cash needs and payments, location of legal services, help with lost baggage, credit cards and airline tickets.
Medical Assistance while Traveling	Assistance with locating medical providers, help with medical and personal communications, and medical emergency lodging, medical insurance coordination assistance, coordination of transportaion during and after medical emergencies.
Pre-Trip Resources	Passport and other documentation needs, travel and health advisories, inoculation requirements, Embassy locations and currency rates.
Identity Theft Solutions	Education and prevention including comprehensive ID theft assistance guide, tips to defend against ID theft and signs of ID theft. Case managers are available 24 hours a day, seven days a week to counsel employees and help guide them. ID Theft Assistance does not provide credit monitoring, insurance benefits or direct recovery services.
Will Preparation Services *Mutual of Omaha*	
Creating a will is an investment in your future. It specifies how you want your possessions to be distributed after you die. Will Preparation Services, provided by Willing, uses bank-level security to keep your information safe and secure. In just 10 minutes, you can create a personalized will for free.	
How It Works	Log on to www.willing.com/mutualofomaha. Next, answer simple multiple choice questions on your computer or smartphone. Then download and print any document instantly.
Amplifon Hearing Discount Program *Mutual of Omaha*	
Amplifon provides customer hearing solutions that will fit your lifestyle and budget. The program provides a risk-free 60 day trial, two years of free batteries, and three year warranty.	
Contact Information	1.888.534.1747 or visit amplifonusa.com/mutualofomaha for more information
Health Services Contact Information	
Employee Advocate	1.770.858.4511 E-mail: Tblake@CBIZ.com
Medical Advocate Program (MAP)	Medical Advocate Program (MAP) is designed to assist you in making the best choices possible in accessing quality healthcare at the most competitive cost. Once you call MAP, you will receive one-on-one personal and confidential assistance by qualified healthcare professionals to answer your medical questions, help you find the highest quality doctors and facilities in your area, and help you understand your treatment options. MAP healthcare providers can even help prepare a personalized Care Plan specially for you. 1.888.289.0700 Group Number 15953-10 Internet: www.MAP-health.com

VOLUNTARY PLAN

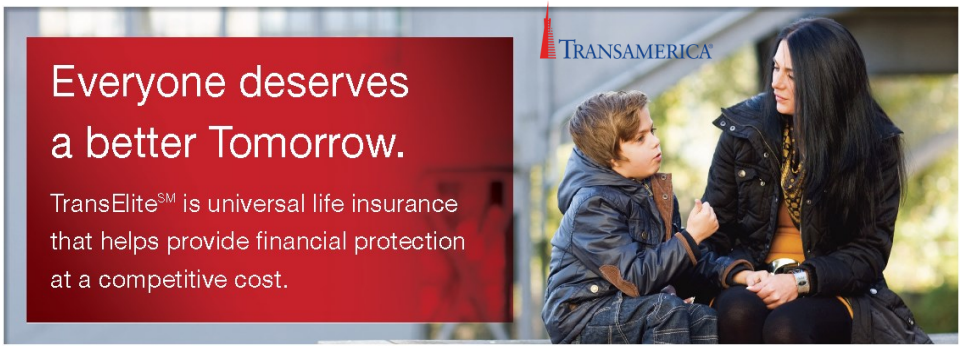
Voluntary Services by AFLAC		
Hospital Confinement Indemnity Insurance		
Overview	Whether you're in the hospital for a few days or a few weeks, cash benefits from AFLAC's hospital confinement indemnity insurance policy will help you pay for the associated expenses - either medical or unexpected out of pocket.	
Benefit	**Benefit Amount**	**Lifetime Maximum**
Annual Hospitalization Confinement Benefit (does not include emergency rooms)	Sickness: $400 per day Injury: $500 per day	None
Daily Hospital Confinement Benefit (does not include emergency rooms)	$100 per day	None
Rehabilitation Unit Benefit	$100 per day	None
Surgical Benefit	Up to $1,000	None
Outpatient Surgical Room Charge Benefit	With General Anesthesia $300 Without General Anesthesia $100	None
Invasive Diagnostic Exam Benefit	$100 for required arthroscopy, bronchoscopy, colonoscopy, cystoscopy, gastroscopy, larygnoscopy, sigmoidoscopy, esophagoscopy, or myringoscopy	None
Cancer Indemnity Insurance		
Overview	Benefits are paid only for Covered Persons who receive Physician-prescribed treatment approved by the National Cancer Institute (NCI) or the Food and Drug Administration for Cancer or an Associated Cancerous Condition, as applicable.	
Benefit	**Benefit Amount**	**Lifetime Maximum**
Initial Treatment	$3,000	$3,000
Injected Chemotherapy	$900 once per calendar week	None
Radiation Therapy	$500 once per calendar week	None
Surgical Benefit	Up to $1,000	None
Stem Cell Transplantation	$10,000	$10,000
Bone Marrow Transplantation		
Covered Person	$10,000	$10,000
Donor	$1,000	
Surgical/Anesthesia	Up to $5,000	None
Hospital Confinement 1- 30 days		
Named Insured/Spouse	$300 per day	None
Dependent Child	$375 per day	None
Outpatient Hospital	$300 per day	None
Hospice	Up to $5,000	None
Day 1	$1,000 (one time benefit)	None
Additional Days	$50 per day	None
Nursing Services	$150 per day	None
Additional Information	Both plans have limitations and exclusions	
Monthly Contribution	AFLAC Coverage is paid 100% by the Employee. Rates are based on plan selected and the participants age. Please see Brenda Lee for more information on pricing.	
Contact Information	General Information 1.800.992.3522 www.aflac.com	To Enroll for Coverage Micah Messer 1.678.787.9627

UNIVERSAL LIFE AND LONG TERM CARE

Universal Life and Long Term Care	
Get Guarnteed Issue Life and LTC Coverage for your most precious asset. You.	
Employee (up to age 80)	• Guarantee Issue up to $150,000 • Face Amount up to 5x salary or a maximum of $500,000
Spouse (up to age 65)	• Guarantee Issue (only if Employee signs up) of $15,000, if Evidence of Insurability (EOI) questions cannot be answered • Maximum Face Amount up to $100,000, if EOI questions can be answered
Children (up to age 26)	• $10,000/$20,000 of Term Life coverage available, as a rider attached to Employee policy • $25,000 of Individual Universal Life coverage available

Product Highlights

- Portable - an employee can take it with him/her at the same price if they leave the company.
- Policy earns guarantee interest rate of 3%, current interest rate is 5.25%.
- Chronic Illness Rider (Living Benefits) –This is the Long Term Care portion - It pays if you have severe memory or reasoning problems or if you can't perform at least two activities of daily living for yourself, such as dressing, bathing, eating, toileting, continence or moving from one activity to another. Pre-existing conditions and limitations do apply to this rider.
- 60 day waiting period/90 day elimination period for the Chronic Illness Rider.
- Chronic Illness rider is available to employees up to age of 75 years old at time of application.



- No Medical Questions
- $150K/$300K Life and LTC* majority of states
- Payroll Deduction
- Fully Portable
- Allows Home Health Care Options
- Coverage Available for Spouse, Children and Grandchildren
- Employee Funded Benefit

Product Highlights
No Physicals or Blood work
Accumulates Cash Value
Guaranteed 3% Interest Rate
Withdrawal and Loan Options
Convenient Payroll Deduction

MANDATED NOTICES

2017 Patient Protection and Affordable Care Act Notices

* Grandfathered Health Plan Notification

Cleveland Group, Inc. believes this medical plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the full coverage of clinical trials. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

2017 Health Plan Notices

* Women's Health and Cancer Rights Act of 1998

"Did you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy – related services, including reconstruction and surgery to achieve symmetry between the breasts, prosthesis, and complications resulting from a mastectomy (including lymphedema").

Please call your plan administrator for more information. These benefits may be subject to annual deductibles, co-insurance provisions or copays that are appropriate and consistent with other benefits under your plan.

MANDATED NOTICES

* The Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act of 2008, also referred to as GINA, is a new federal law that protects Americans from being treated unfairly because of differences in their DNA that may affect their health. The new law prevents discrimination from health insurers and employers. The President signed the act into federal law on May 21, 2008. The parts of the law relating to health insurers will take effect by May 2009, and those relating to employers will take effect by November 2009.

Who needs protection from genetic discrimination?

Everyone should care about the potential for genetic discrimination. Every person has dozens of DNA differences that could increase or decrease his or her chance of getting a disease such as diabetes, heart disease, cancer or Alzheimer's. It's important to remember that these DNA differences don't always mean someone will develop a disease, just that the risk to get the disease may be greater.

More and more tests are being developed to find DNA differences that affect our health. These tests (called genetic tests) will become a routine part of health care in the future. Health care providers will use information about each person's DNA to develop more individualized ways of detecting, treating and preventing disease. But unless this DNA information is protected, it could be used to discriminate against people.

Why was the law needed?

The law was needed to help ease concerns about discrimination that might keep some people from getting genetic tests that could benefit their health. The law also enables people to take part in research studies without fear that their DNA information might be used against them in health insurance or the workplace.

* Newborns' and Mothers' Health Protection Act of 1996 (Newborn's Act)

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). 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).

MANDATED NOTICES

Important Notice from Cleveland Group, Inc. 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 Cleveland Group, Inc. 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. **Cleveland Group, Inc. has determined that the prescription drug coverage offered by the Group Medical 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 through December 7th.

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Cleveland Group, Inc. coverage will be affected.

If you do decide to join a Medicare drug plan and drop your current Cleveland Group, Inc. 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 Cleveland Group, Inc. 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…

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 Cleveland Group, Inc. 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:

1. Visit www.medicare.gov
2. 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
3. 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:	August 1, 2017
Name of Entity/Sender:	Cleveland Group, Inc.
Contact--Position/Office:	Ms. Brenda Lee / Ms. Terri Hinson
Address:	1281 Fulton Industrial Blvd. NW, Atlanta GA 30336-1527
Phone Number:	(404) 505-4576 or (404) 505-4574

MANDATED NOTICES

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 January 31, 2017. Contact your State for more information on eligibility –

GEORGIA – Medicaid
Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507

To see if any more States have added a premium assistance program since July 31, 2015, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor

Employee Benefits Security Administration

www.dol.gov/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, Ext. 61565

MANDATED NOTICES

General Notice of COBRA Continuation Coverage Rights
** Continuation Coverage Rights Under COBRA**

Introduction

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

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

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

What is COBRA continuation coverage?

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

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

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

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

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

MANDATED NOTICES

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

- 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."

When is COBRA continuation coverage available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all 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), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to:
Brenda Lee / Terri Hinson
c/o Cleveland Group, Inc.
1281 Fulton Industrial Boulevard, NW
Atlanta, GA 30336

How is COBRA continuation coverage provided?

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

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

Brenda Lee / Terri Hinson
c/o Cleveland Group, Inc.
1281 Fulton Industrial Boulevard, NW
Atlanta, GA 30336
404-505-4576 / 404-505-4574
Fax: 404-505-4774

Disclaimer: This benefit summary highlights key features of The Cleveland Group, Inc. benefits program and does not include all plan rules and details. The terms of your benefit plans are governed by legal documents, including insurance contracts. Should there be any inconsistencies between this summary and the legal plan documents, the plan documents are the final authority. The Cleveland Group Inc. reserves the right to change or discontinue its benefit plans at any time without prior advance notice.

CBIZ Benefits & Insurance Services