Plan Year: 12/1/2017 - 11/30/2018

MOSAIC

Benefit Overview

Our employees are our most valuable asset

WELCOME

MOSAIC appreciates all of the hard work and effort that you put forth each and every day. It's the dedication of our employees that separates us from our competitors. That's why we offer a comprehensive employee benefits program at MOSAIC so that, in addition to your paycheck, you and your family may be relieved of the financial burdens of health care expenses, and loss of income.

We hope this employee benefit summary helps you to better understand the benefits offered at MOSAIC. It is important you take the time to review all of the plan options available to you prior to making your selections. Consider each benefit and the associated cost carefully and choose the benefits package that will best meet your needs as well as your family's needs throughout the year.

Options selected during open enrollment remain in place for the plan year. Options selected upon hire remain in place through the end of the plan year in which you are hired.

Once again, thank you for your commitment and dedication. If you need to contact any of your benefit providers, please refer to the Resource Directory on Page 21.

The Internal Revenue Service *(IRS)* states that the eligible employees may only make elections to the plan at time of hire and once a year at open enrollment. Your benefit choices are binding through November 30, 2018. The following circumstances are the ONLY reasons you may change your benefits during the year:

Marriage or divorce
Death of a spouse or child
Termination of a spouse's employment or significant change in health coverage (cost) attributable to the spouse's employment
Loss of dependent child status

These special circumstances, often referred to as life event changes, will allow you to make plan changes at any time during the year in which they occur. For any allowable changes, you must inform the Employee Benefits Center within 30 days of the event to avoid lapse in coverage. All other changes are deferred to open enrollment.

Exceptions are as follows:

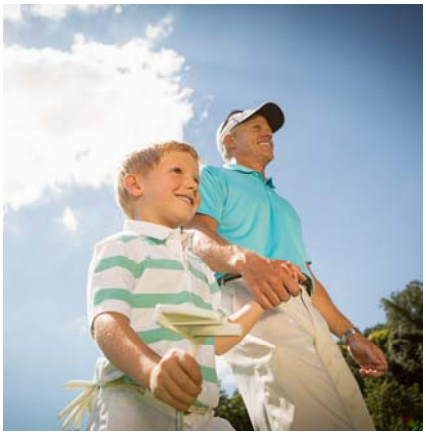
Newborn or adopted dependents and newly eligible grandchildren can be added with 31 days of birth, adoption, or legal custody (proper documentation sis required to support adoption or legal custody)
A newly married spouse can apply for coverage within thirty (30) days of the date of marriage
A dependent who loses coverage through a former employer

Inside this issue:

Who is Eligible?

All full-time employees (who work a minimum of 30 hours or more per week) and their dependents are eligible to enroll in the company benefits.

Employees or dependents who choose not to participate in the benefit program at the time of initial eligibility will be considered late applicants, subject to the subsequent open enrollment.



Dependents

Dependents are defined as your spouse; your adult children (until the first day of the month following their 26th birthday); your unmarried child who, before the age of 19, became disabled by a mental or physical handicap and is incapable of self-support.

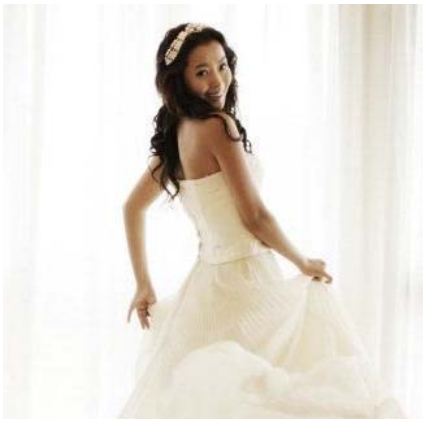
Benefits Effective Date

New employees will become eligible for coverage on the first day of the month after 30 days following their date of hire. All elections will remain in effect and cannot be changed until the subsequent open enrollment period (usually 12 months) unless a qualifying life event occurs, described on the cover page.

Opt-Out Cash Benefit Provision

MOSAIC will continue to offer Medical, Dental and Vision plans on an optional basis. Therefore, you can elect to receive a cash benefit in lieu of MOSAIC provided benefits, if you have medical coverage elsewhere (you will be required to provide verification of such coverage). If you choose to opt out and want to re-enter the plans at a later date, you may be subject to evidence of insurability, unless you experience a Qualifying Life Event (i.e., marriage, divorce, birth of a child, etc.). The Opt-Out Cash Benefit results in a savings to MOSAIC and we will share the savings with our employees as follows:

- $150/mo ($1,800/yr) for waiver of medical, dental and vision coverage
- $130/mo ($1,560/yr) for waiver of medical only or medical AND dental or vision coverage



How to Make Changes

If you have a qualified change in life status (birth, adoption, marriage, divorce, death) which creates the opportunity to change your benefit elections mid-year, you have 30 days from the date of the life event to request the change. Please see Human Resources to make any changes.

Medical Benefits

Each eligible employee will be able to elect to enroll in the MOSAIC medical program offered through Aetna. Please refer to the following pages for an overview of the medical program. To find a provider, go to www.aetna.com/docfind and utilize the "Find a Physician" feature, or call the Member Services number on your ID card for a list of providers nearest you. When searching online, elect **PPO "Managed Choice POS (Open Access)"** or **HMO "Aetna Health Network Only (Open Access)"**.

Benefit	Aetna Managed Choice POS (Open Access)		Aetna (HNOnly Open Access HMO)
	In-Network	Out-of-Network	In-Network
Annual Deductible			
Individual	$4,000	$8,000	$4,000
Family	$8,000	$16,000	$8,000
Coinsurance	80%	60%	80%
Annual Out-of-Pocket Maximum			
Individual	$6,350	$14,000	$6,350
Family	$12,700	$28,000	$12,700
Office Visits			
Primary Care Physician	Deductible, then 20%	Deductible, then 40%	Ded, then $30 copay
Specialist	Deductible, then 20%	Deductible, then 40%	Ded, then $30 copay
Hospitalization			
In-Patient	Deductible, then 20%	Deductible, then 40%	Deductible, then 20%
Out-Patient	Deductible, then 20%	Deductible, then 40%	Deductible, then 20%
Lab & X-Rays	Deductible, then 20%	Deductible, then 40%	Deductible, then 20%
Accident/Medical Emergency Room	Ded, then 20%		Deductible, then 20%
Urgent Care	Deductible, then 20%	Deductible, then 40%	Deductible, then 20%
Prescription Drugs			
Retail Co-Payment	Medical and RX Ded. Combined		Medical and RX Ded. Combined
Copays (Gen/Brand/Pref)	$20/$60/$100		$20/$60/$100
Provider Network	www.aetna.com		www.aetna.com

Employer HRA Contribution

Enrollment Tier	Contribution
Employee	$3,500.00
Employee/Spouse	$7,000.00
Employee/Child(ren)	$7,000.00
Family	$7,000.00

Employee Payroll Deductions (per pay)

Enrollment Tier	Deduction
Employee	$25.00
Employee/Spouse	$161.00
Employee/Child(ren)	$80.00
Family	$193.00

Employee Payroll Deductions (per pay)

Enrollment Tier	Deduction
Employee	$0.00
Employee/Spouse	$79.00
Employee/Child(ren)	$45.00
Family	$100.00

Health Reimbursement Arrangements (HRAs)

MOSAIC will continue to offer a Health Reimbursement Arrangement (HRA) to all employees that participate in the Aetna medical program. This is an added benefit to help offset employee deductible expenses.

The HRA is paid for solely by MOSAIC. Under the arrangement, the employer reimburses the employee for the pre-determined expenses (listed below up to a maximum dollar amount). Because this reimbursement is not taxable to you as an employee, it is important to save all receipts and Explanation of Benefits (EOBs) to submit for reimbursement. Without this proof of payment or submission to insurance, the expense is not qualified and, therefore, cannot be reimbursed.

Useful Information

1. The eligible expenses listed below are the ONLY eligible expenses.
2. The Date of Service must have occurred within the plan year (12/1/2017 - 11/30/2018).
3. There is a 90-day run-out period for any claims that were not submitted during the plan year.
4. Any unused funds in the HRA will be returned to the employer following the claim run-out period
5. If additional documentation is required, please respond to the request immediately.
6. To check your balance at any time, please visit www.wealthcareadmin.com. Please enter your Social Security Number and your MOSAIC Employer ID which is GBS9456.
7. Reimbursement submitted and approved by close of business on Tuesday, the check will be cut on Friday and mailed to the home address listed on file.

Some Other Reminders

1. Upon arriving at your doctor's office or pharmacy, first present your Aetna insurance card. If you do not show your card, you will pay the retail price and will NOT apply the charge to your deductible!
2. Ask the doctor to bill you for your services. At the pharmacy, you will pay the discounted price for your Rx.
3. Pharmacy: Email or fax to GBS Advantage HRA the register receipt along with the label from the pharmacy bag or the Explanation of Benefits from Aetna to receive your HRA reimbursement.
4. Medical: About two to four weeks after your service, you will receive your EOB from Aetna in the mail. You can also receive your EOB electronically by registering with www.aetna.com. Email or fax the EOB to GBS for your HRA reimbursement.

Email: HRAClaims@gbsio.net **Fax:** (410) 321-8053

Summary of Reimbursement of Benefits

Maximum Reimbursement Amount Allowed for Plan Year by Employee	
Coverage Level	**Maximum Amount Allowed**
Employee Only	$3,500
Employee & Spouse	$7,000
Employee & Child	$7,000
Employee & Children	$7,000
Family	$7,000
Benefits Covered	
Medical	Eligible
Prescription Drug	Eligible
Dental	Not Eligible
Vision	Not Eligible

Health Reimbursement Arrangements (HRAs)

How are HRA Funds Distributed To Pay Medical Expenses?

Scenario A

Doctor Visit

Member shows Insurance ID Card
Ask to be billed for all services

Submit Claim

Insurance Processes claim

Sends EOB to Employee's home address and also electronically on www.aetna.com

Receive an invoice from doctor's office, match to EOB and pay invoice

Send EOB to GBS at hraclaims@gbsio.net or 410-321-8053 to receive a check to your home address

Scenario B

Pharmacy Visit

Member Shows Insurance ID Card

Fill Prescription

Pay Pharmacy

Send Pharmacy label or receipt or EOB to GBS at hraclaims@gbsio.net or 410-321-8053 to receive a check to your home address

Medical Benefits

made available through aetna®

TELADOC.

Imagine this...

You wake up one morning with cold-like symptoms. You don't want to take time off from work, but you need care now. **What can you do?**

1. You consider urgent care, but don't want to spend the time and money.

2. **Then you call Teladoc®.**

3. The Teladoc doctor calls you back about your symptoms.

4. Turns out you have sinus problems.

5. You pick up an antibiotic at your local pharmacy on your way to work.

6. **Problem solved. Boss happy.**

What is Teladoc? Teladoc provides a national network of U.S. board-certified doctors available 24/7/365 to resolve many of your medical issues. It's quality care when you need it at a price you can afford.

Talk to a doctor anytime for $40 or less

Less than an urgent care or ER visit, Teladoc's never more than a doctor visit.

Teladoc.com/Aetna

Facebook.com/Teladoc

1-855-Teladoc (835-2362)

Teladoc.com/mobile

HealthAdvocate™
Always at your side

Your All-in-1 Health Advocate Benefit

Health Advocate is a service provided by MOSAIC at no cost to you. With Health Advocate you have confidential, unlimited access to a Personal Health Advocate who can help you and your eligible family members resolve healthcare and insurance-related issues, as well as estimate costs for medical procedures - all through a single toll-free number.

(866) 695-8622

Save time, money and worry

Personal Health Advocates, typically registered nurses, supported by medical directors and benefits and claims specialists, are industry experts who can help you get to the bottom of a wide variety of healthcare and insurance-related issues.

Help for the whole family

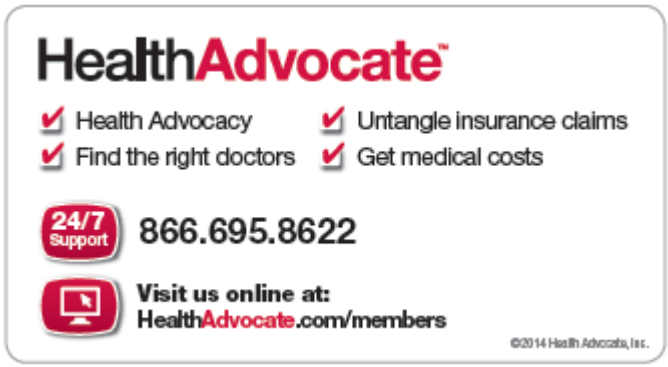
You, your spouse, dependent children, parents and parents-in-law can all use the service.

Member Website

Your password-protected customized Health Advocate member website makes it easy to access all your benefits and take advantage of your online tools.

How they can help

- ✓ Find the right doctors, hospitals and other providers
- ✓ Schedule appointments, transfer medical records
- ✓ Explain conditions and research latest treatments
- ✓ Resolve billing and insurance claims issues
- ✓ Secure second opinions
- ✓ Clarify benefits and get approvals for covered services
- ✓ Find options for non-covered services
- ✓ Estimate costs for medical procedures and negotiate payments
- ✓ Locate eldercare services



Dental Benefits

A comprehensive dental plan is offered through Aetna. Please note that you can save more money and you receive a greater benefit when you visit a dentist in the provider network. To find a dental provider, go to www.aetna.com/docfind or call the Member Services number on your ID card. When searching online, elect **Dental PPO/PDN with PPO III Network**.

Benefit	Aetna PPO	
	In-Network	Out-of-Network
Annual Deductible (Calendar Year)		
Individual Family	$50.00 $150.00	
Annual Benefit Maximum (Calendar Year)		
Applies to Class I - III	$2,000	$2,000
Class I - Diagnostic & Preventive Services	100%	100%
Class II - Basic Dental Services	90%	80%
Class III - Major Dental Services	60%	50%
Class III - Implants	60%	60%
Class IV - Orthodontic Services	50% (adult & child)	50% (adult & child)
Orthodontia Lifetime Maximum	$1,000	$1,000

Employee Payroll Deductions (per pay)

Enrollment Tier	Payroll Deduction
Employee Only	$0.00
Employee/Spouse	$10.00
Employee/Child	$9.00
Employee/Children	$9.00
Family	$15.00

Vision Benefits

NVA Vision Program

National Vision Administrators, L.L.C.

A comprehensive vision program including routine eye examinations, eyeglasses and contact lenses is available through NVA Vision. The vision plan offers a national network consisting of optometrists, ophthalmologists and opticians. To find a provider, go to www.e-nva.com and utilize the "Find a Doctor" feature or call (800) 672-7723 for a list of network providers near you.

Benefit (12-month period)	NVA Vision Program	
	In-Network	Out-of-Network
Eye Examinations (once/year)		
Routine Eye Exam	Covered 100%	Reimbursed up to $31
Frames		
Contracted Frame Provider	Covered up to $5 Retail Allowance (35% discount on remaining balance)	Up to $4
Spectacle Lenses		
Basic Single Vision (Lenticular) Basic Bifocal Basic Trifocal	$35 $55 $70	Up to $29 Up to $39 Up to $47
Contact Lenses		
Medically Necessary Contacts	Covered up to $5 Retail Allowance	$250
Formulary Lenses Other Single Vision Contacts Other Bifocal Contacts	(15% discount off balance for conventional or 10% off balance for disposal)	Up to $3
Lens Options*		
Transition Lenses Scratch-Resistant Coating Ultraviolet Coating Tinting Oversize Lenses Polarized Lenses	$65 Single Vision, $70 Multi-Focal $10 $12 $12 Solid/Gradient Tint See Carrier Benefit Summary $75	See Carrier Benefit Summary
Laser Vision Correction		
15% off standard prices or 5% off promotional pricing		

*Lens Options list is not exhaustive; additional options may be available. Consult your carrier benefit summary for details.

Employee Payroll Deductions (per pay)

Enrollment Tier	Payroll Deduction
Employee Only	$0.00
Employee/Spouse	$2.00
Employee/Child	$1.50
Employee/Children	$1.50
Family	$2.50

Flexible Spending Accounts (FSA)

Section 125

BENEFITS YOU RECEIVE

A Flexible Spending Account (FSA) is a tax-advantaged financial account into which you can automatically deposit a portion of your paycheck pre tax. You can use funds in the account to pay for qualified medical expenses not covered by insurance, like dental and optometrist visits, certain "FSA-approved" over-the-counter medications and supplies for chronic conditions. FSAs can be beneficial to you and your employer. If used correctly, an FSA can help to offset your out-of-pocket medical expenses and pay for your monthly health insurance premiums. You can even use different types of FSAs to pay for your day-to-day expenses of caring for a dependent, or to cover adoption expenses.

HEALTH CARE REIMBURSEMENT FSA

This program allows our employees to pay for certain IRS-approved medical care expenses not covered by their insurance plan with pre-tax dollars, up to a max of $2,600 per year.

Some examples include:

- Health plan deductibles, copays or coinsurance out-of-pocket costs (after HRA)
- Hearing services, including hearing aids and batteries
- Vision services, including contact lenses, contact lens solution, eye examinations and eyeglasses
- Dental services and orthodontia
- Chiropractic services
- Acupuncture
- Prescription services

DEPENDENT CARE FSA

The dependent care FSA allows our employees to use pre-tax dollars to pay for qualified dependent care, such as caring for children under the age of 13, or caring for their elders. The annual maximum amount you may contribute to the Dependent Care FSA is $5,000 per calendar year.

Some examples include:

- The cost of child or adult dependent care
- The cost of an individual to provide care either in or out of your home
- Nursery schools and preschools (excluding kindergarten)

ADDITIONAL FSA NOTES

FSA funds are payroll deducted from your gross income before state, federal and social security taxes are computed. Special attention should be given when setting up an FSA. The amount that you elect to have allocated to your FSA cannot be changed throughout the year unless you experience an IRS qualified event. These qualifying events include marriage, divorce, adoption, change in employee status, and birth of a child.

Therefore, please be reasonable and conservative in your allocation so that your FSA funds can be spent by year end. Otherwise, you will be subject to the "use it or lose it" rules that apply to all Flexible Savings Accounts. These plans are extremely valuable and can bring tremendous tax savings in a time when medical plan deductibles, copays and out-of-pocket costs are increasing. Current employees may only enroll at the beginning of the FSA plan year, which begins in December, unless incurring a life changing event.

FSA ROLLOVER

MOSAIC employees may rollover up to $500 of unused funds from the previous year.

FSA Example & Helpful Hints

Geraldine and Ulysses Von Snitterton-Lewis earn $41,000 combined income per year. They are in a 32% tax bracket for Federal, State, FICA and Medicare taxes. The Von Snitterton-Lewis family spends $800 per year in medical care expenses for deductibles, eyeglasses and dental visits. The Von Snitterton-Lewis's also have a daughter in day care. They spend $75 per week or $3,900 per year on childcare expenses. By using FSAs, Geraldine and Ulysses's spendable income increases $1,504 per year because less tax is withheld.

	Without FSAs	With FSAs
Combined Gross Annual Salary	**$40,000**	**$40,000**
Pre-Tax Medical Care Expenses		**- $800**
Pre-Tax Dependent Care Expenses		**- $3,900**
Taxable Income	**$40,000**	**$35,500**
Income Taxes @ 32%	**- $12,800**	**- $11,296**
After-Tax Medical Care Expenses	**- $800**	
After-Tax Dependent Care Expenses	**- $3,900**	
Spendable Income	**$22,500**	**$24,004**
Tax Savings with FSA	**$0**	**$1,504**

Getting the Most Out of Your FSA Plan

- FSA money can be used for the services listed on the previous page for anyone claimed on your tax return, even if they are not covered by your medical plan.
- Medical FSA accounts are "pre-funded" with your annual amount at the start of the plan year.
- You have 90 days from the end of the plan year to submit expenses that were incurred during the plan year for reimbursement.
- The rollover features allow you to carry over up to $500 of unused fund from the previous plan year.
- FSA dollars cannot be used to pay for expenses in advance, only for those incurred at the time of service.
- Any misuse of FSA money is tax fraud. GBS reserves the right to request a receipt for all expenses incurred during a plan year.
- Supporting documentation will be required **on all purchases**, as mandated by Federal regulation.
- **To check balance information**, please visit www.wealthcareadmin.com.

ELIGIBLE & INELIGIBLE HEALTH FSA EXPENSES

All submitted expenses are reviewed according to the regulations of Internal Revenue Code Section 125. All claims must be substantiated and appropriate documentation must be provided.

Some expenses may require documentation from your physician.

Drugs

Eligible

-Both prescription and over-the-counter drugs (with a Physician's prescription) that treats a medical condition.
-Birth control drugs.
-Insulin.

Ineligible

-Dietary supplements including vitamins, pre-natal vitamins (even if doctor prescribed) and herbs.
-Drugs for cosmetic purposes.

Vision Care

Eligible

-Optometrist or ophthalmologist fees
-Eyeglasses.
-Contact lenses and cleaning solutions.
-Prescription sunglasses.
-Corrective eye surgery (such as radial keratotomy).

Ineligible

-Lens replacement insurance.
-Warranties.
-Protection plans.
-Coating/tints that do not treat a medical condition

Dental/Orthodontic Care

Eligible

-Dental care.
-Artificial teeth/dentures.
-Cost of fluoridation of home water supply advised by dentist.
-Braces, orthodontic services (only those incurred within the active plan year).

Ineligible

-Teeth bleaching.
-Tooth bonding that is not medically necessary.

Treatments/Therapies

Eligible

-Weight loss programs prescribed to treat a medical condition.
-X-ray treatments.
-Smoking cessation programs.
-Treatment of alcoholism or drug dependency.
-Acupuncture.
-Vaccinations.
-Physical therapy (as a medical treatment).
-Speech therapy.
-Occupational therapy.
-Infertility treatment.

Ineligible

-Physical treatments unrelated to specific health problem (e.g., massage for general well-being).
-Any illegal treatment

Insurance

Eligible

-Deductibles and copayments for health care plans (medical, dental, vision).
-Coinsurance (the percentage of charges not paid by your health care plan).
-Amounts over usual and customary limits.

Ineligible

-All premiums/contributions for insurance coverage (including health insurance, long-term care, loss of income and loss of life).
-Expenses paid by your health care plan.

Fees/Services

Eligible

-Physician's fees.
-Routine/preventive physicals.
-Obstetrical expenses.
-Hospital services.
-Nursing services for care of a specific medical ailment.
-Cost of a nurse's room and board when nurse services qualify.
-The Social Security tax paid with respect to wages of a nurse when nurse's services qualify.
-Surgical or diagnostic services.
-Legal sterilization.
-Cosmetic surgery/procedures that treat deformity caused by an accident or trauma, disease, or an abnormality at birth.
-Services of chiropractors and osteopaths.
-Anesthesiologist fees.
-Dermatologist fees.
-Gynecologist fees.

Ineligible

-Cosmetic surgery/procedures that improve patient's appearance but do not meaningfully promote the proper function of a body or prevent/treat an illness/ disease.
-Payments to domestic help, companion, babysitter, chauffeur, etc. who primarily render services of a non- medical nature.
-Nursemaids or practical nurses who render general care for healthy infants.
-Payments for child care (eligible under the Dependent Care FSA).

Medical Equipment

Eligible

-Wheelchair or autoette (cost of operating/ maintaining).
-Crutches (purchased or rented).
-Oxygen equipment and oxygen used to relieve breathing problems that result from a medical condition.
-Artificial limbs.
-Support hose (if medically necessary).
-Wigs (where necessary for mental health of individual who loses hair because of disease).

Ineligible

-Wigs, when not medically necessary for mental health.
-Vacuum cleaner purchased by an individual with dust allergy.

Psychiatric Care

Eligible

-Services of psychotherapists, psychiatrists and psychologists.
-Legal fees directly related to commitment of a mentally ill person.

Ineligible

-Psychoanalysis undertaken to satisfy curriculum requirements of a student.
-Marriage counseling.

Assistance for the Disabled

Eligible

-Cost of guide for a blind person.
-cost of note-take for a deaf child in school.
-Cost of Braille books and magazines in excess of cost of regular editions.
-Seeing eye dog (cost of buying, training and maintaining).
-Hearing-trained cat or other animal to assist deaf person (cost of buying, training and maintaining).
-Household visual alert system for deaf person.
-Excess costs of specifically equipping automobile for a disabled person over the cost of ordinary automobile; device for lifting a disabled person into automobile

Miscellaneous Charges

Eligible

-Sales tax associated with an eligible expense.
-Hearing aids, batteries for operation of hearing aids, hearing aid repairs.
-Expenses connected with donating an organ.
-Cost of computer storage of medical records.
-Transportation expenses primarily for, and essential to, medical care including car mileage, bus, taxi, train, plane fares, ambulance services, parking fees and tolls.
-Lodging expenses (not provided in a hospital or similar institution) not to exceed $50 per night per individual while away from home if the lodging is primarily for an d essential to medical care provide by a doctor.

Ineligible

-Expenses of divorce when doctor or psychiatrist recommends divorce.
-Cost of toiletries, cosmetics and sundry items (e.g. soap, toothbrushes).
-Maternity clothes.
-Diaper service.
-Distilled water purchased to avoid drinking fluoridated city water supply.
-Installation of power steering in an automobile.
-Pajamas purchased to wear in a hospital.
-Mobile telephone used for personal phone calls as well as calls to a physician.

Life Insurance/Accidental Death & Dismemberment

In the event you decease or become seriously injured from a non-work related injury or sickness, life insurance and AD&D benefits are provided as a source of income for your surviving family members.

	Employee Cost
Life Insurance	$0.00
AD&D Insurance	$0.00

Benefit	Highlights
Life Benefit Amount	2x Annual Salary, up to $50,000
AD&D Benefit Amount	2x Annual Salary, up to $50,000
Guaranteed Issue Level	$50,000
Maximum Benefit	$50,000
Benefit Reduction	At age 65, reduces by 65%; at age 70, reduces by 50%
Portability	Included

Group Short-Term & Long-Term Disability

In the event you become disabled from a non-work related injury or sickness, disability income benefits are provided as a source of income.

	Employee Cost
Short-Term Disability	$0.00
Long-Term Disability	$0.00

Benefit	Short-Term Disability	Long-Term Disability
Benefit Percentage	60% of Weekly Earnings	60% of Monthly Earnings
Benefit Maximum	$1,000 Per Week	$5,000 Per Month
Benefit Minimum	None	$100
Elimination Period	30 Days	90 Calendar Days
Max Benefit Period	9 Weeks	To age 65; SSNRA
Definition of Disability	Residual Disability	2 Year Regular Occupations
Benefit Duration	9 Weeks	To age 65; SSNRA

Voluntary Life/Accidental Death & Dismemberment

EMPLOYEE LIFE INSURANCE

All full-time employees are eligible to purchase additional supplemental life insurance at their own expense through payroll deductions. This valuable optional benefit is available for you, your spouse and your children. You may purchase insurance in $2,000 increments up to a max of $10,000 for your children. You may also purchase insurance in $5,000 increments up to a max of $50,000 for your spouse. However, you have the ability to purchase up to the lesser of $500,000 or five times your annual salary for yourself. If you purchase an amount above $80,000 up to $500,000, the additional amount is not guaranteed. Therefore, you will be required to submit an Evidence of Insurability form and medical underwriting review will apply for the additional elected amount above $80,000. **Please Note: Guarantee Issue is available to new hires. Amounts over the Guarantee Issue will require a health application/evidence of insurability. For late entrants, all amounts will require a health application/evidence of insurability.**

SPOUSAL LIFE INSURANCE

You also have the option of purchasing supplemental life insurance for your spouse. Spouses are eligible to purchase coverage in increments of $5,000 to a maximum of 100% of the employee elected benefit up to $500,000. You can only purchase coverage for your spouse if you elect to purchase coverage for yourself. Amounts over $15,000 for your spouse are not guaranteed. Therefore, your spouse will need to complete an Evidence of Insurability form and will be subject to medical underwriting approval for elected amounts exceeding the guaranteed issue amount of $25,000.

DEPENDENT LIFE INSURANCE

You also have the option of purchasing supplemental life insurance for your children. You may purchase a minimum of $2,000 of coverage up to a maximum of $10,000 in $2,000 increments. This one amount will apply to each child in your family. Eligible children are covered up to age 21 and to age 25 if they are a full-time student. One total cost will apply and includes all eligible children in your family.

SUPPLEMENTAL AD&D

Provided you have elected some Life Insurance, Accidental Death & Dismemberment coverage for yourself, spouse or dependent is equal to the benefit amount for supplemental life insurance.

Employee Age Bracket	Term Life Employee/Spouse Cost (Monthly / $10,000)	Term Life Child Cost (Monthly / $2,000)	Voluntary AD&D Employee/Spouse Cost Monthly	Voluntary AD&D Child Cost Monthly
<24	$0.80	$0.40	$0.30	$0.060
25-29	$0.80	N/A		
30-34	$1.00	N/A		
35-39	$1.20	N/A		
40-44	$1.50	N/A		
45-49	$2.30	N/A		
50-54	$3.50	N/A		
55-59	$6.50	N/A		
60-64	$10.50	N/A		
65-69	$20.70	N/A		
70-74	$38.40	N/A		
75+	$106.60	N/A		

Basic Employee Assistance Program

Life's not always easy. Sometimes a personal or professional issue can get in the way of maintaining a healthy, productive life. Your Employee Assistance Program (EAP) can be the answer for you and your family.

WE'RE HERE TO HELP

Mutual of Omaha's EAP assists employees and their eligible dependents with personal or job-related concerns, including:

- Emotional well-being
- Family and relationships
- Legal and financial
- Healthy lifestyles
- Work and life transitions

EAP BENEFITS

- Unlimited telephone access to EAP professionals 24 hours a day, seven days a week
- Telephone assistance and referral
- Service for employees and eligible dependents
- Legal assistance and financial services
  - Online will preparation
  - Legal library & online forms
  - Telephonic financial consultation
- Resources for:
  - Financial tools and resources
  - Substance abuse and other addictions
  - Dependent and elder care assistance & referral services
- Access to a library of educational articles, handouts and resources via *mutualofomaha.com/eap*

WHAT TO EXPECT

You can trust your EAP professional to assess your needs and handle your concerns in a confidential, respectful manner. Our goal is to collaborate with you and find solutions that are responsive to your needs.

Your EAP benefits are provided through your employer. If additional services are needed, your EAP will help locate appropriate resources in your area.

Don't delay if you need help. Visit *mutualofomaha.com/eap* or call 800-316-2796 for confidential consultation and resource services.

Benefits that work℠

10088

COMPLIANCE NOTICES

HIPAA Special Enrollment Notice

If you are declining enrollment for yourself and/or your eligible dependent(s)) because of other health/dental/vision insurance coverage and if you lose that coverage, you may in the future be able to enroll yourself and/or your eligible dependent(s) in this plan, provided that you request enrollment with 30 days after your other coverage ends. If you are declining coverage for yourself and/or your eligible dependent(s) for any other reason, you cannot join the plan later unless you have a new dependent as a result of marriage, birth, adoption, placement for adoption, loss of Medicaid or SCHIP coverage, eligibility for Medicaid or SCHIP coverage, or during an open enrollment period, if applicable. You may then be able to enroll yourself and your eligible dependent(s), provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption, or within 60 days of Medicaid and SCHIP.

If you decline coverage for yourself and/or your eligible dependent(s) because of other health/dental/vision coverage or if you fail to request plan enrollment within 30 days after your (and/or your eligible dependent's) other coverage ends, you will not be eligible to enroll yourself, or your eligible dependent(s) during the special enrollment period discussed above and you will need to wait until the next open enrollment period to enroll in the plan's health/dental/vision coverage.

Newborns' and Mothers' Health Protection Act Notice

Group health plans and health insurance issuers 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 vaginal delivery or less than 96 hours following a cesarean section.

However, federal law generally does not prohibit the mother's or the 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 insurers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours/96 hours.

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). 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, call your plan administrator .

IMPORTANT NOTICE 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 MOSAIC 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. MOSAIC has determined that the prescription drug coverage offered by Aetna 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 Aetna coverage may be affected. You may keep this coverage if you elect Part D and this plan will coordinate with Part D coverage. See pages 7-9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/) which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current Aetna 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 MOSAIC 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 November 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 MOSAIC 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).

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 August 10, 2017. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**KANSAS – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512
ALASKA – Medicaid	**KENTUCKY – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570
ARKANSAS – Medicaid	**LOUISIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**MAINE – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711
FLORIDA – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268	Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840
GEORGIA – Medicaid	**MINNESOTA – Medicaid**
Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507	Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739
INDIANA – Medicaid	**MISSOURI – Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
IOWA – Medicaid	**MONTANA – Medicaid**
Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084

NEBRASKA – Medicaid	SOUTH CAROLINA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 1-402-473-7000 Omaha: 1-402-595-1178	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
NEVADA – Medicaid	**SOUTH DAKOTA - Medicaid**
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW HAMPSHIRE – Medicaid	**TEXAS – Medicaid**
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NEW JERSEY – Medicaid and CHIP	**UTAH – Medicaid and CHIP**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NEW YORK – Medicaid	**VERMONT– Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
NORTH CAROLINA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
NORTH DAKOTA – Medicaid	**WASHINGTON – Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
OKLAHOMA – Medicaid and CHIP	**WEST VIRGINIA – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://mywvhipp.com/ Phone: 1-855-MyWVHIPP (1-855-699-8447)
OREGON – Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
PENNSYLVANIA – Medicaid	**WYOMING – Medicaid**
Website:http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
RHODE ISLAND – Medicaid	
Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347	

To see if any other states have added a premium assistance program since August 10, 2017, 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.

Your Rights Under COBRA

Under Federal law known as COBRA (continuation of coverage), as a covered employee, you have the right to obtain a temporary extension of your group health insurance.

INDIVIDUAL ELECTION RIGHTS

Each individual covered under your plan on the day before coverage was terminated is a "qualified beneficiary" and has independent election rights to continue coverage. This means that each dependent can elect independently to continue coverage, even if the covered employee chooses not to elect coverage.

ELECTING COVERAGE

During your COBRA election period, benefits are not available to you. Therefore, any access to care or claims submitted would be denied. Following receipt of your election form and any applicable premium due, your benefits will be reinstated retroactive to the termination date, and claims may be submitted for payment in accordance with your benefit plan.

PREMIUM PAYMENT

If you elect to continue your health insurance, you are responsible for the full premium payment for the coverage elected. The COBRA premium includes the employer and employee's share of the premium. Following your COBRA election, you have a maximum of 45 calendar days from the date of your election to pay all past due premiums.

LENGTH OF CONTINUATION COVERAGE

Coverage will continue for all qualified beneficiaries for a period of 18 months if coverage loss was the result of a covered employee's termination (except for gross misconduct) or reduction of work hours.

Coverage will extend to qualified beneficiaries for a period of 36 months if the coverage loss was a result of any of the following circumstances:

- Death of a covered employee
- Divorce or legal separation from a covered employee
- Dependent ceasing to qualify as an eligible dependent
- Covered employee losing coverage as a result of Medicare

DISABILITY EXTENSION PROVISION

The initial 18-month extension privilege may be extended for an additional 11-month period for a total of 29 months to all qualified beneficiaries if the Social Security Administration (SSA) determines that a qualified beneficiary was disabled according to Title II or XVI of the Social Security Act on the date of the qualifying event or at the time during the firs 60 days of continuation coverage.

COBRA EMPLOYER REQUIREMENTS

Employers are only obligated to offer COBRA coverage if they offer an employer-sponsored health insurance plan and they have at least 20 employees.

YOUR RESPONSIBILITY

It is your responsibility to obtain the disability determination from SSA and to provide a copy to your employer within 60 days of the date of determination and before the original 18 months of COBRA expires. If you do not comply with these time frames, the additional 11 months of coverage will not be provided. It is also your responsibility to notify the HR Representative within 30 days if a final determination is made tha you are no longer disabled.

SECONDARY EVENTS (IF APPLICABLE)

Extension privileges may be extended beyond the original 18 months if, during the initial 18 months, a second event such as divorce, legal separation, death, Medicare entitlement or a dependent child ceasing to be an eligible dependent takes place. If a second event occurs, the original 18 months will be extended to 36 months from the date of the original qualifying event for the qualified beneficiary spouse and/or dependent child. The extension does not apply to the employee. If a second event occurs, it is your responsibility to notify the HR Representative within 60 days of the second event and before the end of the original 18 month COBRA expiration. In no event will continuation coverage last beyond three years from the date of the original qualifying event.

NEW DEPENDENT & OPEN ENROLLMENT

If you adopt a child or if a childis born to you withinyour COBRA extension period, your coveragemay be changed to include the new dependent. The change to add a new dependent must be done according to the rules of your plan. The new dependent will gain the rights of all other "qualified beneficiaries".

CANCELLATION OF CONTINUATION

COBRA continuation will end prior to the 18-, 29- or 36-month expiration period for any of the following reasons:

- Your former employer ceases to provide any group health plan to any of its employees
- Any required premium for continuation coverage is not paid within your grace period
- A qualified beneficiary becomes covered under another group health plan (provided the pre-existing condition limitation or exclusion does not apply to the qualified beneficiary)
- A qualified beneficiary becomes entitled to Medicare
- A qualified beneficiary covered under the disability extension provision receives SSA determination that he/she is no longer disabled
- A qualified beneficiary notifies the HR Representative of intention to cancel extended coverage

CONVERSION OPTIONS

When your extension period expires, qualified beneficiaries will be allowed to enroll in an individual conversion plan provided by the current carrier, if such an option is available. GBS will advise you in writing of your conversion option approximately 30 days prior to the expiration date of your continuation coverage. At that time, you must contact the carrier within 30 days to confirm applicable benefits and rates.

Resource Directory

Benefit	Phone Number	Additional Information
Aetna Medical & Prescription Drug	Refer to ID Card	www.aetna.com
Teladoc	(855) 835-2362	www.teladoc.com/aetna
Health Advocate	(866) 695-8622	www.healthadvocate.com
Aetna Dental	Refer to ID Card	www.aetna.com
NVA Vision Vision	(800) 672-7723	www.e-nva.com
GBS Advantage HRA HRA Administrator	(800) 337-4973	www.wealthcareadmin.com
GBS, Inc. FSA Administrator	(800) 337-4973	www.wealthcareadmin.com
Mutual of Omaha Life/AD&D, Disability, Vol Life/AD&D	(800) 769-7159	www.mutualofomaha.com
Mutual of Omaha Employee Assistance Program (EAP)	(800) 316-2796	www.mutualofomaha.com/eap
Human Resources Sarah Wilson Vicki Whetzel	 (301) 955-1361 (301) 955-1437	 swilson@mosaic.buzz vwhetzel@mosaic.buzz

Notes:

This benefits summary describes the highlights of our benefits in non-technical language. Your specific rights to benefits under the plan are governed solely, and in every respect, by the official documents and not the information in this summary. If there is any discrepancy between the descriptions of the programs as contained in the materials and the official plan documents, the language of the official plan documents shall prevail as accurate. Please refer to the plan-specific documents for detailed plan information.