Full-time associates

2020 Benefits

HOLIDAY
RETIREMENT

At Holiday Retirement, we believe in helping our associates live well by doing good. Our benefits package is designed to help you optimize your strength, purpose and sense of belonging so you can enjoy life to the fullest.

Our Mission:

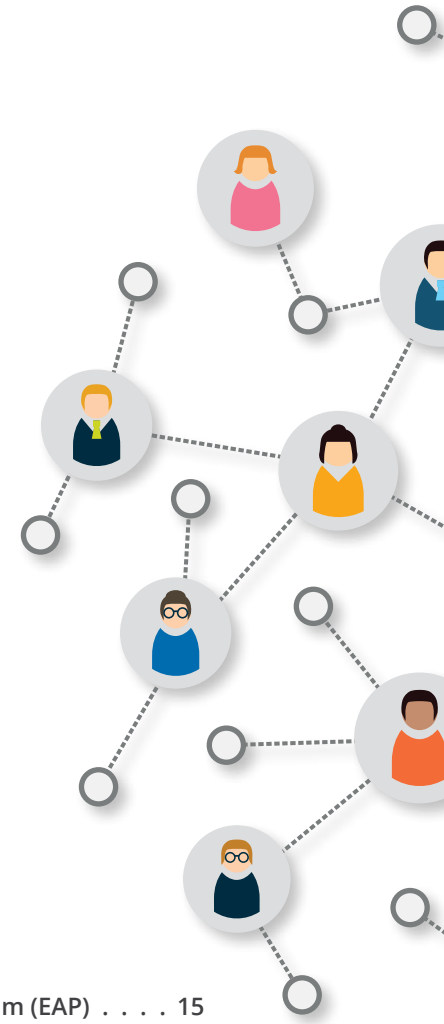
Holiday is in the business of helping older people live better.

Our Family of Brands

HOLIDAY RETIREMENT

beam Home Care Services
Live life your way

Contents



Contents:

These are only highlights of the Holiday Benefit offerings. The actual plan documents are the governing documents and, if discrepancies are found, the plan documents will govern. Holiday Retirement retains the right to amend or terminate its benefits at any time, and participation in the plans described does not guarantee your right to benefits, except as specifically provided in the plans.

How to Enroll

To make your benefit elections, log in to **my.adp.com/holiday**. If you do not intend to enroll, please log in to **my.adp.com/holiday,** waive the benefit plans that you do not want to elect and acknowledge that you have reviewed your benefit offerings. You will also need to document the beneficiary that you would like to receive your life insurance benefit. It is important you also log in to **my.adp.com/holiday** the first paycheck following your coverage effective date to check your paystub and make sure your benefit elections are correct.

Please contact My Holiday Service Center at **833-LINE4HR (833-546-3447)** with any questions regarding benefits or the enrollment process.

Eligibility

Full-time associates working an average of at least 30 hours per week are eligible to enroll in Holiday Retirement's health & welfare benefits on the first of the month following 60 days of employment. Premiums are deducted beginning the first pay date following your benefits start date. Retroactive deductions will be processed as required. When you enroll, you may also choose to cover your eligible dependents.

- Your legal spouse
- Domestic partner with completed affidavit
- Child(ren) up to age 26
- Disabled child(ren) physically or mentally incapable of self-support
- Adopted or foster child(ren) up to age 26
- Legal guardianship of child(ren) up to age 26

All enrollments must be completed within 30 days of your benefits start date. Otherwise, elections can't be made until the next Open Enrollment period unless you experience a Life Event.

Dependent Verification

Verification of dependent eligibility will be required to establish coverage. 48 hours after completing your enrollment a "button" will appear the benefits tab of your MyADP site. This is the best and fastest way to submit your verification. If documents are not submitted within 14 days of enrollment , dependents may be denied coverage. Examples of acceptable documentation:

- Copy of marriage certificate
- Domestic partner affidavit
- Copy of birth certificate
- Proof of disability from a treating physician
- Copy of papers showing placement of child in your home or copy of final adoption papers
- Copy of final legal guardianship papers

Life Events

If you experience a life event change during the plan-year – such as marriage, divorce, birth or adoption of a child, or a spouse losing or gaining other coverage – you could qualify to make changes to your benefit plans. You are required to log in to **my.adp.com/holiday** or call the My Holiday Service center at **833-LINE4HR (833-546-3447)** within **30 days** of the date of the event to make benefit plan changes. If changes are not made within 30 days, you will have to wait until the next Open Enrollment period to make any plan changes.

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2020 Benefit Plan Costs:

All deductions in this book are listed as biweekly. In the state of New York deductions will be made on a weekly basis. Simply divide the biweekly deduction in half to see what your weekly amount would be.

BLUECROSS/BLUESHIELD MEDICAL PLANS

	CDHP + HSA	70/30 PPO	80/20 PPO
Coverage Tier	**Biweekly**	**Biweekly**	**Biweekly**
Associate Only	$ 36.50	$55.85	$103.50
Associate/Spouse	$123.12	$187.85	$294.58
Associate/Child(ren)	$106.49	$162.46	$246.81
Family	$136.44	$208.15	$337.04

METLIFE DENTAL PLANS

	PREVENTIVE	SELECT
Coverage Tier	**Biweekly**	**Biweekly**
Associate Only	$2.60	$5.50
Associate/Spouse	$10.13	$21.44
Associate/Child(ren)	$11.00	$23.44
Family	$16.39	$34.53

METLIFE (VSP CHOICE NETWORK) VOLUNTARY VISION

Coverage Tier	Biweekly
Associate Only	$3.17
Associate/Spouse	$6.33
Associate/Child(ren)	$6.77
Family	$10.82

MUTUAL OF OMAHA VOLUNTARY SHORT-TERM DISABILITY PLAN

Example: Weekly Earnings	Multiply Weekly Earnings by 60% = Weekly Benefit	Divide Weekly Benefit by 10	Multiply by Rate	Biweekly Cost
$500	$500 x 60% = $300	$300 / 10 = 30	x $0.81	$11.22

MUTUAL OF OMAHA VOLUNTARY CORE LONG-TERM DISABILITY PLAN

Example: Monthly Earnings	Divide Monthly Earnings by 100	Multiply by Rate	Biweekly Cost
$2,000	$2,000/100 = $20	$20 x $0.50	$6.62

MUTUAL OF OMAHA VOLUNTARY BUY-UP LONG-TERM DISABILITY PLAN

Example: Monthly Earnings	Divide Monthly Earnings by 100	Multiply by Rate	Biweekly Cost
$3,500	$3,500/100 = $35	$35 x $0.85	$13.73

MUTUAL OF OMAHA SUPPLEMENTAL LIFE WITH AD&D*

RATES (Per $1,000)	Employee/ Spouse Biweekly
Under 24	$0.039
25-29	$0.039
30-34	$0.044
35-39	$0.049
40-44	$0.054
45-49	$0.080
50-54	$0.115
55-59	$0.210
60-64	$0.316
65-69	$0.517
70-74	$0.707
75 and over	$0.861
Child Life Rates	$0.12
Guaranteed Issue Amount	
Employee	$150,000
Maximum Coverage Amounts:	
Employee — $600,000;	
Spouse — $500,000;	
Child(ren) — $10,000	

**AD&D benefits match voluntary life benefit. Rate included in voluntary life rates.*

Consumer Driven Health Plan (CDHP) with HSA. This is a high-deductible plan with a built in tax free Health Savings Account (HSA). Holiday Retirement also makes an Employer contribution to your HSA if you elect this plan.

MEDICAL PLANS

We offer a choice between three medical plan options through Blue Cross/Blue Shield administered by Regence Group Administrators.

CVS Smart 90! Fill your 90-day Rx at your local CVS for the same cost as mail-order.

	CDHP with HSA *Pay less now, pay more later with some help*		70/30 PPO *Pay some now, pay some later*		80/20 PPO *Pay more now, pay less later*	
PLAN FEATURES	**Preferred Provider**	**Out-of-Network Provider**	**Preferred Provider**	**Out-of-Network Provider**	**Preferred Provider**	**Out-of-Network Provider**
Calendar-Year Deductible	$2,000 individual $4,000 family	$9,000 individual $18,000 family	$1,500 individual $3,000 family	$9,000 individual $18,000 family	$600 individual $1,800 family	$6,000 individual $10,000 family
Out-of-Pocket Max. *Includes deductible copays & coinsurance*	$6,000 individual $12,000 family	$22,500 individual $45,000 family *plus balance billing*	$6,000 individual $12,000 family	$22,500 individual $45,000 family *plus balance billing*	$4,000 individual $8,000 family	$12,600 individual $27,000 family *plus balance billing*
PHYSICIANS CHARGES:						
Routine Preventative Care	$0 no deductible	50% after deductible	$0 no deductible	50% after deductible	$0 no deductible	50% after deductible
Office Visit	20% after deductible	50% after deductible	$25 no deductible	50% after deductible	$25 no deductible	50% after deductible
Virtual Visit	MeMD	MeMD	MeMD	MeMD	MeMD	MeMD
Specialist Visit	20% after deductible	50% after deductible	$60 no deductible	50% after deductible	$60 no deductible	50% after deductible
FACILITIES CHARGES:						
Diagnostics: *Lab/X-ray/etc.*	20% after deductible	50% after deductible	30% after deductible	50% after deductible	20% after deductible	50% after deductible
Maternity Care	20% after deductible	50% after deductible	30% after deductible	50% after deductible	20% after deductible	50% after deductible
Hospital Services	20% after deductible	50% after deductible	30% after deductible	50% after deductible	20% after deductible	50% after deductible
Inpatient Admission	20% after deductible	50% after deductible	30% after deductible	50% after deductible	20% after deductible	50% after deductible
Outpatient Surgery & Emergency Svcs.	20% after deductible	50% after deductible	30% after deductible	50% after deductible	20% after deductible	50% after deductible
EMERGENCY CHARGES:						
Convenience Care	20% after deductible	50% after deductible	$25 no deductible	50% after deductible	$25 no deductible	50% after deductible
Urgent Care Facility	20% after deductible	50% after deductible	$75 no deductible	50% after deductible	$75 no deductible	50% after deductible
Emergency Room	20% after deductible	50% after deductible	$200 copay then 30%	50% after deductible	$200 copay then 20%	50% after deductible
PHARMACY BENEFIT:						
Deductible	Combined with medical deductible		$0		$0	
Out of Pocket Max.	Included in the medical OPM		Included in the medical OPM		Included in the medical OPM	
Generic	$10	not covered	$10	not covered	$10	not covered
Preferred Brand	$35	not covered	$35	not covered	$35	not covered
Non-Preferred	50% - $100 min., $150 max. per Rx.	not covered	50% - $100 min., $150 max. per Rx.	not covered	50% - $100 min., $150 max. per Rx.	not covered
Specialty Drug**	Applicable cost share	not covered	Applicable cost share	not covered	Applicable cost share	not covered
Mail-order	2x copay for 90-day; non-pref. min. $150, max. $375 per Rx.	not covered	2x copay for 90-day; non-pref. min. $150, max. $375 per Rx.	not covered	2x copay for 90-day; non-pref. min. $150, max. $375 per Rx.	not covered
PRE-TAX SPENDING ACCOUNTS						
	HSA: If you enroll in the CDHP with HSA plan Holiday will automatically enroll you in a Health Savings Account and contribute $500 towards associate only coverage or $1,000 towards any dependent tier. You may also contribute up to $3,050 in the associate only tier or $6,100 in any of the dependent tiers. Funds are deducted pretax and carry over year to year.		FSA: This is an **optional** plan and enrollment in a Flexible Spending Account (FSA) with either PPO plan is voluntary. You may elect up to $2,700 for employee only or $5,000 for employee plus family. Funds are pretax but do not carry over year to year. These are use-it-or-lose-it funds.			

Rx Benefits

Managed Retail Prescription Drug Benefits

Our plans offer a three-tier prescription drug program (generic, preferred brand and non-preferred brand) through a vast list of network pharmacies (participating pharmacies and preferred drug lists are available).

Please Note: If an equivalent generic medication is available and a brand-name medication is chosen, the member is responsible for paying the applicable brand-name copayment, plus the difference in price between the equivalent generic medication and the brand-name medication not to exceed the total retail cost.

Maintenance Drug Benefit

You are required to purchase prescriptions that you need on a long-term, maintenance basis by ordering from our mail-order program or by using CVS Smart 90 after filling scripts 2x at a retail pharmacy. If you do not, you will be required to pay 100% of the cost of the script. This is a convenience for members since you can get a 90-day supply of medication with each order.

**Specialty Pharmacy

Specialty pharmacy medications must be ordered through Accredo at **800-922-8279.**

CVS Smart 90

Are you taking a medication on a long-term, maintenance basis? If so you will want to read this page!

All three of our medical plans require you to switch to a 90-day prescription for all your maintenance medication after two fills at the retail pharmacy. In the past, you had to switch to the mail-order program as the only way to get your medication. **You can get the same 90-day prescription at one of more than 9,000 local CVS pharmacies!** If you are already getting your medication from the Express Scripts mail-order program, congratulations! You don't need to do anything.

How does it work?

1. Simply tell your doctor your plan requires you to fill all maintenance medication with 90-day prescriptions.
2. Choose one of two convenient options:
   • Express Scripts Mail-order Pharmacy - **www.express-scripts.com**, or
   • CVS – **www.cvs.com**
3. Save money! You will only pay for two months' worth of the supply, you get the third month at no cost!

What happens if I keep filling my maintenance medicine on a monthly basis at a participating local pharmacy?

Per our plans, if you keep filling a one-month supply instead of a three-month supply, or if you're using a non-CVS pharmacy to fill your long-term medicine, you'll pay 100% of the cost for your medicine.

What is the difference between maintenance medications and other medications?

Maintenance medications are those you take on an ongoing basis, such as to treat high blood pressure or high cholesterol. Short-term drugs include antibiotics and other medicines that you take for short periods of time. Under our plans, you can fill short-term prescriptions at any participating retail pharmacy in your network.

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HSAs & FSAs

HSA*

How an HSA works

A health savings account (HSA) paired with an HSA-qualified health plan allows you to make tax-free contributions to an FDIC-insured savings account. Balances earn tax-free interest and can be used to pay for qualified medical expenses. HSA-qualified health plans typically cost less than traditional plans, and the money saved can be put into your HSA.

HSAs empower savings:

- Lower monthly health insurance premiums
- Money put into your HSA is not taxed
- You earn tax-free interest on HSA balances
- HSA funds used for qualified medical expenses are not taxed
- You can invest your HSA funds for increased tax-free earning potential

HSA funds remain yours to grow

With an HSA, you own the account and all contributions. Unlike flexible spending accounts (FSAs), the entire HSA balance rolls over each year and remains yours even if you change health plans, retire, or leave your employer.

You can win with an HSA

Regardless of your personal medical situation, an HSA can empower you to maximize savings while building a reserve for the future. Contrary to what many may think, healthy individuals aren't the only users who benefit from an HSA.

*you cannot participate in an HSA and Holiday will not contribute to the HSA if you are enrolled elsewhere in a non-HSA compatible plan (i.e.: Medicare, TriCare, etc.).

FSA**

A simple way to save

Take advantage of significant tax savings by participating in a flexible spending account (FSA). You can elect to have a portion of your paycheck (up to $2,700) contributed pre-tax to pay for qualified medical expenses such as deductibles, copayments, dental and vision. A dependent-care FSA (DCRA) is also offered for similar tax savings on qualified dependent-care expenses.

Healthcare FSA

Funds from a healthcare FSA can be used for qualified expenses including medical, dental, vision, deductibles, copayments and co-insurance. For a full list of qualified expenses allowed by the IRS, see IRS Publication 502. With healthcare FSAs, the entire elected amount is available to you on the first day of the health plan year. You don't have to wait for your payroll contributions to accumulate before paying expenses with your FSA.

Dependent-care accounts

You may set aside up to $5,000 annually if single or married and filing your taxes jointly ($2,500 annually if married and filing taxes separately) on a pre-tax basis to pay for daycare expenses. Participants can save up to 30% on eligible child care expenses, such as daycare, in-home care, nursery school, preschool and other qualifying care for dependents under age 13. Participants can also cover a tax-dependent parent, spouse or child who lives with the associate and is incapable of caring for oneself. The care must be needed so that you and your spouse can go to work or attend school full-time.

Use-it-or-lose-it

Holiday's FSAs are use-it-or-lose-it plans. This means that amounts in the FSA at the end of the plan year cannot be carried over to the next year. However, the plan does provide for a grace period. Additionally, if an account holder leaves an employer or retires, unused funds are forfeited. For more details, see IRS publication 969 or consult a tax advisor.

**FSA is a Cobra eligible benefit. Please contact the COBRA administrator (please see back cover) if you have any questions.

MeMD

Welcome to healthcare virtually anywhere

MeMD

Member/Patient Services: (855) 636-3669

Group Name: Holiday Retirement

Plan Code: FNR49L6X

Visit Fee: $25 (medical) $65 (therapy)

What

What's telehealth? A service that helps you to reach a medical provider or therapist by phone or online when access to your regular doctor is not available.

What's a visit fee? A fixed amount that you owe at the time of your visit. Review your member card to see yours.

Who

Who can use the service? The program is available to you, your spouse or domestic partner, and children up to the age of 26. You must be 16+ to have a therapy session.

Who will I see? Medical care is provided by our US-licensed and board-certified physicians, physician assistants, and nurse practitioners. Licensed therapists provide talk therapy.

When

When should I use telehealth? When you need medical attention for a minor health concern anytime, day or night, at home or when traveling. Teletherapy can be a more convenient and private way to speak to someone.

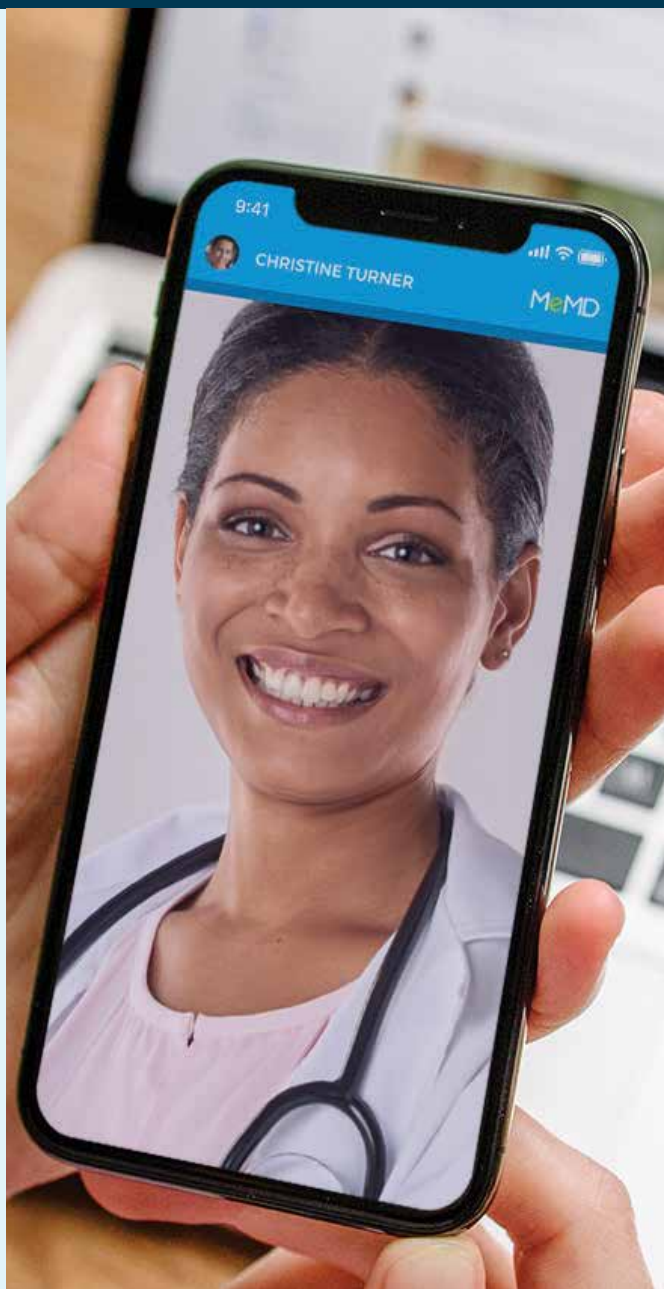
When can I use MeMD? Medical visits are available 24/7 - 365, and therapy sessions can be scheduled in as little as 24 hours.

How

How do I save more money? MeMD provides a convenient and less expensive alternative to costly ER and urgent care visits, as well as access to more affordable therapy sessions.

Where

Where can I use telehealth? Nationwide - from the privacy of your own home or office, online, over the phone, or by app.



Register online to start using your MeMD benefits:

- Request a visit with a medical provider 24/7/365, review past exams, schedule a therapy session, and, when medically necessary, have prescriptions sent to your local pharmacy.
- Download the MeMD App on your Apple or Android device to view your plan details and get care right when you need it: **go.memd.me/app**

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DID YOU KNOW YOU SHOULD ASK?

Patients often accept their doctors' advice without truly understanding what alternative treatments are available, and what – if any – differences there are in cost and effectiveness among those alternatives. Asking questions can help you decide what treatment plan is best for both your health and your wallet.

General questions to ask

- Why is this treatment necessary?
- How much will my treatment cost?
- Can I be treated another way that is equally effective but less costly?
- What is the current procedural terminology (CPT) code of this treatment so I can price shop this procedure?
- What can I do to improve my condition?

Questions to ask about prescriptions

- Why are you suggesting this specific dosage?
- Is my prescription in my insurance's approved list? Or, is this a specialty drug?
- Can you recommend a lower-cost generic or over-the-counter drug as an alternative?

Note: The questions listed above are designed to help you maximize your health care dollars. These questions should not be used as a substitute for your doctor's professional, medical advice.

DENTAL PLANS

Dental Benefits

There are two plans to choose from: the preventative plan and the select plan. You can receive care from any provider you choose on both plans. However, the plans will pay more toward services received from in-network providers. In-network providers are also called preferred dentist program (PDP) dentists. Please contact MetLife at **(800) GETMET-8** or visit **www.metlife.com/mybenefits** for a comprehensive listing of PDP dentists. **Please note: no ID card is required; group # 307739**, your name, and Social Security number are the identification used to access benefits.

	MetLife - Select Plan		MetLife - Preventative Plan	
Provider Network	**In Network (% of Negotiated Fee)***	**Out-of-Network (% of R&C Fee)****	**In Network (% of Negotiated Fee)***	**Out-of-Network (% of R&C Fee)****
Annual deductible	$50 per person / $100 per family		$50 per person/$100 per family	
Annual maximum	$1,500 per person		$1,000 per person	
Diagnostic/restorative services				
Exams, cleanings, X-rays	100% deductible waived	100% of R&C after deductible	100% deductible waived	100% of R&C after deductible
Basic/restorative services				
Fillings and simple oral surgery	80%, after deductible	80% of R&C after deductible	70% after deductible	70% of R&C after deductible
Major services				
Oral surgery, crowns, etc.	50% after deductible	50% of R&C after deductible	not covered	not covered
Orthodontia lifetime maximum				
Per person (up to age 26)	$1,500	$1,500	not covered	not covered

*Negotiated Fee refers to the fees that participating dentists have agreed to accept as payment in full for covered services, subject to any copayments, deductibles, cost sharing and benefitmaximums. Negotiated fees are subject to change.

**R&C fee refers to the Reasonable and Customary (R&C) charge, which is based on the lowest of (1) the dentist's actual charge, (2) the dentist's usual charge for the same or similar services, or (3) the charge of most dentists in the same geographic area for the same or similar services determined by MetLife.

Vision Benefits

We provide vision coverage through MetLife under the VSP Choice Network. You have the option to go to any provider you choose. However, if you choose a VSP network doctor, you will receive a discount. For a complete list of VSP providers, visit **metlife.com/vision or call (800) GET-MET8**. **Please note: no ID card is required**; **group# 307739**, your name and the last four digits of the associate's Social Security number are the identification used to access benefits.

COVERAGE	VSP Providers	Non-VSP Providers
Vision exam		
Once every 12 months	Covered in full	Up to $45 allowance
Lenses		
Every 12 months	Covered in full	Single vision: $30 allowance Bifocal: $50 allowance Trifocal: $65 allowance
Frames		
Every 12 months	Covered up to $130 allowance plus 20% off amount over the allowance	Up to $70 allowance
Contact lenses		
Contact lens exam (fitting & evaluation)	Up to $60 copay	$105 allowance
Contact lenses, in lieu of prescription glasses every 12 mo.	Covered up to $130 allowance	
All other materials		
Non-rx sunglasses, accessories, etc.	discounts available	not covered

VISION PLANS

LIFE & DISABILITY

Group Life and AD&D (GLI) — Mutual of Omaha

This plan pays your beneficiary 1x your annual base salary, up to a maximum of $600,000, in the event of your death.* We also cover 1x your annual base salary for Accidental Death & Dismemberment (AD&D) up to a maximum of $600,000. **Holiday Retirement pays 100% of the costs of this benefit.**

*Federal tax law requires Holiday Retirement to report the cost of company-paid life insurance in excess of $50,000 as imputed income.

Supplemental Life with AD&D — Mutual of Omaha

This plan allows you to elect coverage for yourself and your dependent family members. **These benefits are 100% associate-paid.**

- **Associate:** You may elect up to 7x your annual salary, a minimum of $10,000 up to a maximum of $600,000 in $10,000 increments. If you enroll during your initial enrollment period, no medical questions will be asked until your coverage exceeds $150,000. If you enroll outside of your initial enrollment period, you will need to complete a medical questionnaire known as an Evidence of Insurability (EOI) and receive approval for coverage requested.
- **Spouse:** You may elect in $10,000 increments up to $500,000. Coverage cannot exceed 100% of the associate supplemental life election. No medical questions are asked until coverage exceeds $30,000 if enrolling during the associate's initial eligibility period.
- **Children:** Dependent children 14 days up to age 26 are also eligible for coverage at $10,000. Coverage cannot exceed 100% of the associate supplemental life election.

Age reductions: Your group term life, supplemental life and AD&D insurance coverage amounts are reduced to 65% at age 70 and 50% at age 75. Benefits cease at retirement.

Additional note: Please remember to keep your beneficiary designations updated. If you have a family status change (marriage, birth, divorce or death), you may want to update your beneficiary information. Beneficiary information can be updated at any time online, via your MyADP account. Employees already enrolled may add $10,000 with no EOI required, up to the guarantee issue amount of $150,000.

Short-Term Disability (STD) — Mutual of Omaha

In the event an off-the-job injury or illness prevents you from working for a period of time, the STD plan would provide income benefits as long as your physician certifies you medically unable to work. You are eligible to receive benefits on the first day if you have an injury/accident or eighth day if you have an illness. The benefits are paid at 60% of your income to maximum of $1,500 per week for a maximum of 25 weeks for an injury/accident and 26 weeks for an illness. Associates who choose to enroll after their first opportunity in the STD plan are subject to 6 month pre-existing condition limitation and will experience a longer waiting period before STD benefits will begin.

This benefit is 100% associate-paid.

Long-Term Disability (LTD) — Mutual of Omaha

After 180 days if you are disabled by an injury or illness, our long-term disability (LTD) plan provides income benefits as long as you are physician-certified as disabled. Two LTD plan options are available to purchase, the Core Plan and the Buy-Up Plan. Associates who choose to enroll after their first opportunity in the LTD plan are subject to a12 month pre-existing condition limitation and will be required to complete an EOI form. **This benefit is 100% associate-paid.**

Plan Features	Core Plan	Buy-Up Plan
Monthly Benefit	50% of monthly salary up to $10,000 /monthly	60% of monthly salary up to $10,000 /monthly

Associates with five or more years of service receive the core plan at no charge, or may purchase the buy-up plan instead. Holiday will contribute the amount that would be paid for the Core LTD to this plan, and you pay the difference.

Please note: If you enroll outside of your initial enrollment period for long-term disability, you will need to complete an evidence of insurability form. Please refer to Mutual of Omaha summary of benefits, which will provide more detail on the exact definition of disability and requirements to be eligible to receive a benefit.

FINANCIAL WELLNESS

Employee Assistance Program — Mutual of Omaha (EAP)

All associates are enrolled in the Employee Assistance Program (EAP). This program is offered through Mutual of Omaha Insurance Co. You will have access to counselors with a master's or doctorate degree in counseling via a dedicated phone number 24 hours a day, 365 days a year and up to three face-to-face confidential consultation sessions with a counselor, financial planner and/or legal advisor.

Please visit www.mutualofomaha.com/eap or call **800-316-2796** for more information. **Holiday pays 100% of the cost of this benefit.**

401(k) — Fidelity

How to get a 4% Raise

All full-time and part-time associates at least 21 years of age are eligible to contribute the first of the month following three months of employment. Once eligible, associates can enroll at any time while changes can occur on a per-pay-period basis. Associates are eligible for a company match the first of the month following six months of employment. The company matches each pay period 100% on the first 3% of compensation deferred then 50% on the next 2% of compensation deferred. Associates are 100% vested in their own deferrals and fully vested in the company match.

Give yourself a raise by enrolling in these plans. Holiday Retirement offers two ways of saving for the future. There is the pre-tax 401(k) plan and an after-tax Roth option. While the 401(k) allows you to defer tax-free now, the Roth allows you to withdraw at retirement tax-free! Just for participating, after six months of employment, Holiday will contribute 100% on the first 3% of compensation contributed and 50% on the next 2% of compensation contributed.

Retirement savings examples: See how a 2% employee contribution can turn into 4%!

	Employee Deferral	Company Match	Total Contribution %
Example 1	2%	2%	4%
Example 2	5%	4%	9%
Example 3	35%	4%	39%

Enrollment: Enroll Online Today!
Go to **www.netbenefits.com** and click on "Register Now" when logging in for the first time. Follow the instructions to enroll today! Call the Retirement Benefits Line if you need assistance at **800-294-4015**.

Travel Assistance Program — Mutual of Omaha

Travel Assistance helps you cope with emergencies when you travel more than 100 miles from home or internationally for trips of up to 180 days. It can also help you with non-emergencies, such as planning your trip.

You do not have to enroll. As a Holiday Retirement associate, you and your family are automatically covered with Mutual of Omaha. All services are available 24 hours a day, every day. Services offered: pre-trip assistance, trip assistance, medical assistance, legal assistance, emergency transportation services and personal security services. For more information, please see the contact numbers on the back cover of this book.

To utilize this benefit, please call 1-800-856-9947. Holiday pays 100% of the cost of this benefit.

Auto Insurance — MetLife

In addition to MetLife's standard discounts and best-in-class features, employees are eligible for:

- Group discounts that could save you an additional 10%
- Auto insurance deductible savings benefit
- Glass repairs without a deductible
- Identity protection services at no additional cost
- Premium deductions through your paycheck

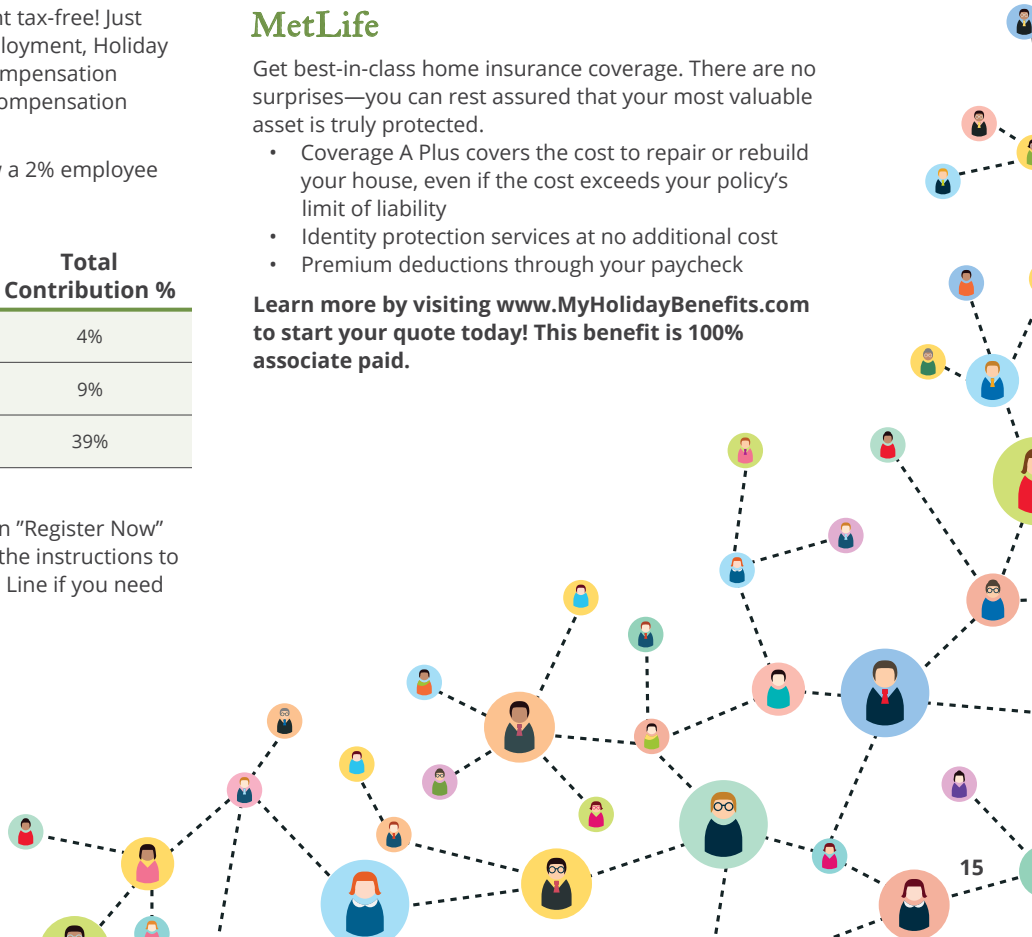
Learn more by visiting www.MyHolidayBenefits.com to start your quote today! This benefit is 100% associate paid.

Home Insurance — MetLife

Get best-in-class home insurance coverage. There are no surprises—you can rest assured that your most valuable asset is truly protected.

- Coverage A Plus covers the cost to repair or rebuild your house, even if the cost exceeds your policy's limit of liability
- Identity protection services at no additional cost
- Premium deductions through your paycheck

Learn more by visiting www.MyHolidayBenefits.com to start your quote today! This benefit is 100% associate paid.



LEGAL & ID THEFT

Introducing MetLaw with Credit Monitoring and ID Theft Protection — MetLaw*

MetLaw attorneys are here to help when you're:

- Getting married
- Buying or selling a home
- Starting a family
- Dealing with identity theft
- Sending kids off to college
- Care-giving for aging parents
- And more...

Legal experts on your side for less than a dollar a day

Quality legal assistance can be pricey. And it can be hard to know where to turn to find an attorney you trust. But for a low monthly fee, you can have a team of top attorneys ready to help you take care of life's planned and unplanned legal events.

With MetLaw, a group legal plan available through Hyatt Legal Plans, you get access to experts who can assist you with a broad range of personal legal needs you might face throughout your life. This could be when you're buying or selling a home, starting a family, dealing with identity theft or caring for aging parents.

How it works

Our service is tailored to your needs. With network attorneys available in person or via phone or email, along with online tools to do it yourself or plan your next move, we make it easy to get legal help. And for certain legal matters, your attorney can represent you in court without you having to make an appearance.

Best of all, you have unlimited access to our attorneys for all legal matters covered under the plan. For a low monthly premium conveniently paid through payroll deduction, an expert is on your side for as long as you need.

Whatever you need to protect your family, MetLaw is here to make life a little easier.

For added peace of mind, your spouse and dependent children are also covered.

Plan cost:
$10.39 per biweekly paycheck

Getting Legal Help is as Easy as 1..2..3

1. Find an attorney nnline at **members.legalplans.com** or speak directly with a customer service representative who can help you find an attorney, **(800-821-6400)**.
2. Get a case number online or by calling and speaking with a customer service representative.
3. Make an appointment. Let them know you are a Hyatt Legal Plans member and provide your case number.

- Nationwide network of more than 14,000 vetted attorneys with an average of 25 years of experience.
- All billing is handled between MetLife and the attorney.

Identity Theft Defense — Included with MetLaw

With this service, attorneys in our network will help associates with potential ID theft and credit-related matters. They will contact creditors, credit bureaus and financial institutions on your behalf to help resolve issues. Associates can also access defense support for specific creditor actions over disputed accounts. The attorney defense services include limiting creditor harassment and representation in defense of any action that results from identity theft, such as foreclosure, repossession or garnishment, up to and including trial if necessary.

These benefits are 100% associate-paid

2020BEN-FT

PET INSURANCE

Discover the greatest pet insurance plans ever offered, exclusively for Holiday Retirement associates and only from Nationwide.*

Choose a plan that's as unique as your pet. Get back 90% of the vet bill for these items and more.

Visit any vet, anywhere.

It's easy to enroll at MyHolidayBenefits.com or 800-872-7387

	My Pet Protection w/ Wellness	My Pet Protection
Accidents, including poisonings and allergic reactions	✓	✓
Injuries, including cuts, sprains and broken bones	✓	✓
Common illnesses, including ear infections, vomiting and diarrhea	✓	✓
Serious/chronic illnesses, including cancer and diabetes	✓	✓
Hereditary and congenital conditions	✓	✓
Surgeries and hospitalization	✓	✓
X-rays, MRIs and CT scans	✓	✓
Prescription medications and therapeutic diets	✓	✓
Wellness exams	✓	
Dental cleaning	✓	
Vaccinations	✓	
Spay/neuter	✓	
Flea and tick prevention	✓	
Heartworm testing and prevention	✓	
Routine blood tests	✓	
BIWEEKLY RATES		
Cats	**$15.57 – $30.77**	**$9.31 – $18.41**
Dogs	**$25.95 – $51.29**	**$15.52 – $30.68**

These benefits are 100% associate-paid

To enroll your bird, rabbit, reptile or other exotic pet, please call. Disclaimer: Rates vary based on state. All rates are valid at the time of publication. Rates are guaranteed for one year from the policy effective date. Rates are subject to change

AFLAC VOLUNTARY INSURANCE BENEFITS

Aflac is different from major medical insurance. It's insurance for daily living. If you're sick or injured, Aflac pays cash benefits directly to you (unless otherwise assigned) to help address out-of-pocket medical costs, everyday expenses — whatever you choose. More than 50 million people worldwide have chosen Aflac voluntary insurance products for the added comfort of being better prepared for whatever life may bring.

Why Aflac?

- Most claims processed in about four business days
- Cash benefits paid directly to you, unless otherwise assigned
- Benefits paid regardless of any other insurance you may have
- No deductibles or copayments
- Freedom to choose any provider
- Plan stays with you if you leave your job (with certain stipulations)

The following insurance plans are available during your enrollment:

Group Accident Insurance*

After an accident, you may have expenses you've never thought about. Can your finances handle them? It's reassuring to know that an accident insurance plan can be there for you through the many stages of care, from the initial emergency treatment or hospitalization, to follow-up treatments or physical therapy. Group Accident insurance from Aflac helps with out-of-pocket costs that arise when you have a covered accident such as a fracture, dislocation or laceration.

Benefits:

- More than 50 events that trigger benefits payments, including fractures, dislocations, ambulance, and physical therapy, among others
- Hospital admission benefit
- Hospital confinement benefit
- Guaranteed-issue coverage (which means you may qualify for coverage without having to answer health questions)
- Portable coverage that allows you to retain coverage at the same rate if your employment status changes (with certain stipulations)

Group Critical Illness Insurance*

The Aflac group Critical Illness insurance plan can help with the treatment costs of covered critical illnesses, such as cancer, heart attack or stroke. More important, the plan helps you focus on recuperation instead of the distraction and stress over the costs of medical and personal bills. With group Critical Illness insurance from Aflac, you receive cash benefits directly (unless otherwise assigned) – giving you the flexibility to help pay bills related to treatment or to cover with everyday living expenses.

Benefits:

- Lump-sum benefit for a covered critical illness such as cancer, heart attack, stroke, major organ transplant and end-stage renal failure
- Health screening benefit

Group Hospital Indemnity Insurance*

Does your major medical insurance cover all of your bills? Even a minor trip to the hospital can present with unexpected expenses and medical bills. Aflac's group Hospital Indemnity insurance pays cash benefits that can be used to help with those out-of-pocket hospital expenses that may not be fully covered by major medical insurance.

Benefits:

- Hospital Admission
- Hospital Confinement
- Hospital Intensive Care

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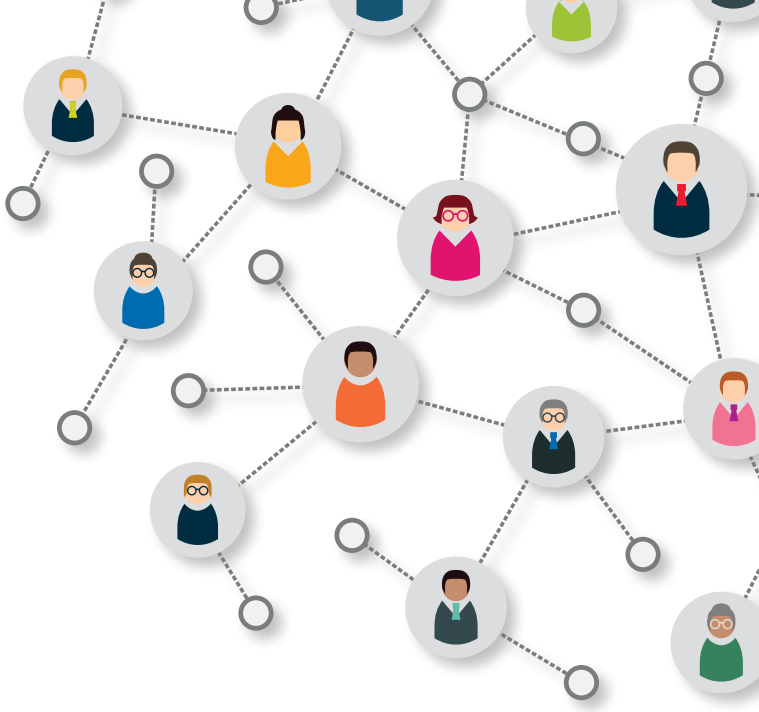


Group Hospital Indemnity Premiums (Biweekly)

COVERAGE	PREMIUM
Associate	$13.05
Associate and Spouse	$26.28
Associate and Child(ren)	$20.60
Family	$33.83

Group Accident Premiums (Biweekly)

COVERAGE	PREMIUM
Associate	$8.26
Associate and Spouse	$13.53
Associate and Child(ren)	$15.66
Family	$20.93

Group Critical Illness Premium (Uni-Tobacco) (Biweekly)

AGE	$10,000	$20,000	$30,000
18-25	$2.02	$3.39	$4.75
26-30	$2.58	$4.51	$6.43
31-35	$3.00	$5.34	$7.68
36-40	$3.84	$7.02	$10.20
41-45	$4.56	$8.46	$12.36
46-50	$5.38	$10.11	$14.83
51-55	$8.22	$15.79	$23.36
56-60	$8.11	$15.56	$23.01
61-65	$16.28	$31.91	$47.53
66+	$28.37	$56.09	$83.80

Rates are per individual adult, for two individual adults 2x rate.

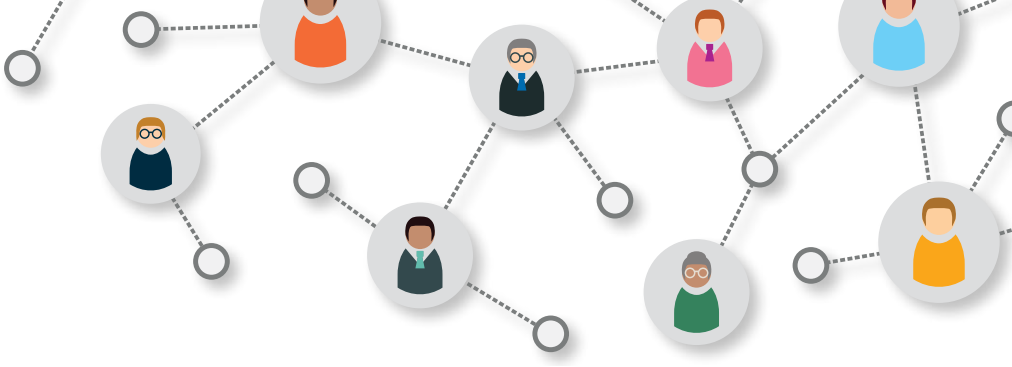
**These benefits are 100% associate-paid*

Rates are to be used in conjunction with the following product brochures that disclose all applicable benefit descriptions, limitations, and exclusions: CAI117560LRS R1, AG500751FL R1, AGC1802904, AG210751 R2, AG210841 R2, AG210844 R1, AG210845 R1, AG80075H R3, and AG80075HSB R1.

The Aflac coverage described in this booklet is subject to plan limitations, exclusions, definitions and provisions. For detailed information, please see the plan brochure, as this booklet is intended to provide a general summary of the coverage. This overview is subject to the terms, conditions and limitations of the plan.

Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated and underwrites group coverage. CAIC is not licensed to solicit business in New York, Guam, Puerto Rico, or the Virgin Islands. Continental American Insurance Company • Columbia, South Carolina • 1-800-433-3036 toll-free • 1-866-849-2970 fax AGC1802699FT IV (8/18)

PERKS & DISCOUNTS



Your Perks & Discounts – your personal online shopping mall!

This is your one-stop shop for associate pricing. We leverage the purchasing power of <u>all associates</u> to help you save money on all your large purchases, as well as all your everyday purchases (food, utilities and more).

Perks at Work

Once you activate your account, you will have access to exclusive offers and deep discounts from popular merchants at the places you already shop.

Absolute best pricing:

- Discounted shopping at top retailers like Macy's, Best Buy, The Home Depot, Overstock.com, etc.
- Computers – associate pricing for all major brands
- Eating in/out – up to 90% off at 18,000 locations
- Cell phones – discounts off monthly rates
- Personal vacations – air, hotel and car rental corporate rates
- Electronics – best prices at retailers and manufacturers
- And 20+ other categories

How to activate your account upon hire.

1. Go to www.perksatwork.com
2. Log in/register at Perks at Work
3. Start saving! It's that easy

WOWPoints

WOWPoints are as valuable as cash, and you can earn multiple WOWPoints for every dollar you spend.

100 WOWPoints equals $1

How do you earn WOWPoints?

- Managers can award associates for doing outstanding and inspiring work
- Browse and make a purchase at any of the 26+ categories and 30,000 merchants
- In addition to any discount listed, you will receive up to 15 WOWPoints per dollar spent
- After your purchase, upon merchant confirmation, we will reward you the WOWPoints you have earned

What can I do with WOWPoints?

- Get items at any merchant in the program
- Get a deeper discount at any merchant in the program
- Instantly spend WOWPoints on select items
- Get gift cards to top retailers like Amazon, iTunes, and Bass Pro Shops

How do I redeem WOWPoints?

- Go to www.perksatwork.com
- Browse any category or search for a merchant
- Select the option to use WOWPoints and shop through Perks at Work
- Complete your purchase using your linked credit/debit card if applicable
- Upon purchase confirmation, you will receive a rebate in the form of a cash credit on your linked card.

Benefit Glossary

The following definitions should help you understand your benefit plans. Remember, you have access to in-network and out-of-network providers. Our medical, dental and vision network providers have contracted rates that can be much lower than out-of-network providers. Your out-of-pocket expense may be lower by using in-network providers.

Copay: A copay is a fixed amount you pay for a health care service, usually when you receive the service. The amount can vary by the type of service. You may also have a copay when you get a prescription filled. For example, a doctor's office visit might have a copay of $30. The copay for an emergency room visit will usually cost more, such as $250. And you might pay some of the deductible if, for example, your doctor orders an X-ray or lab tests.

Deductible: A deductible is the amount you pay for health care services such as X-rays, lab work, inpatient hospital stays or outpatient surgeries. Let's say your plan's deductible is $1,500. That means for most services, except seeing your doctor or getting your prescription filled, you'll pay 100 percent of your medical and pharmacy bills until the amount you pay reaches $1,500. After that, you share the cost with your plan by paying co-insurance and copays.

Co-insurance: Co-insurance is your share of the costs of a healthcare service. It's usually figured as a percentage of the amount the insurance plan says is to be charged for services. You start paying co-insurance after you've paid your plan's deductible. Here's how it works: Lisa has allergies, so she sees a doctor regularly and pays an office visit copay. She had an MRI done recently and paid her $1,500 deductible. Now her plan will cover 70 percent of the cost of her allergy shots. Lisa pays the other 30 percent. That's her co-insurance.

Convenience care: A retail walk-in clinic that offers fast, convenient and affordable treatment. Staffed by nurse practitioners and physician assistants, these clinics are typically set up inside or adjacent to a large retailer or pharmacy for maximum patient convenience. The healthcare providers at walk-in medical clinics diagnose and prescribe medications to treat a range of common conditions such as allergies, colds, flu, earache and strep throat. Some walk-in clinics administer vaccinations and provide preventive care such as school physicals, health screenings and medical tests.

Imputed income: Imputed income is the value of a service or benefit provided by employers to employees, which must be treated as income.

Network: A network is the group of providers who are approved for services and available for treatment under the insurance company's contract.

Outpatient: Refers to receiving treatment at a hospital or outpatient facility without being admitted overnight.

Out-of-pocket maximum cost: The out of pocket maximum is the most you will pay in a calendar year for health care services. Once you have paid the maximum allowed under the health plan, the insurance company will cover 100% of costs for services as long as the service is provided by a contracted health care provider. As an example: Sue is admitted to the hospital on March 15 and stays four days. The total hospital bill is $30,000. Her insurance plan has a $1,500 deductible and a maximum out-of-pocket cost of $4,000. She will pay her deductible of $1,500, which is counted toward her out-of-pocket maximum. That leaves a remaining balance of $2,500. She will pay her co-insurance of 20% of the remainder of her hospital bill until she has paid the $2,500. Her total out-of-pocket cost is $4,000. Insurance company pays the remaining $26,000. For the rest of the calendar year, the insurance company will pay 100% of her costs for all services covered under her health plan, including doctor visits, prescriptions and any other healthcare services she needs.

Primary care physician (PCP): Your point person for a health tune-up. These doctors or nurse practitioners help take care of the basics of healthcare, focusing on wellness and prevention. The PCP is your primary partner for your health. You should see them at least once a year for your physical (annual physicals are covered at no cost to you).

Provider: A provider is any facility, person or entity recognized for payment by the insurance company.

Reasonable and Customary (R&C): The determined going rate for like services in the same area. The insurance company's co-insurance percentage that they pay is taken from the R&C amount for that service. You are responsible for your co-insurance percentage plus all of the amount that exceeds R&C. R&C is used only when services are provided by an out-of-network provider.

Urgent care: a walk-in clinic to treat patients whose illnesses or injuries are not life-threatening but require immediate medical care, such as broken bones and burns. Most urgent care locations have onsite X-ray equipment and at least one medical doctor available. However, it is common to be seen by a nurse practitioner or physician assistant at an urgent care center.

REQUIRED NOTICES

Required Notices

Health Insurance Marketplace Coverage Options

In 2014 a new option to buy health insurance began: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment based health coverage offered by your employer.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins November 1, 2019 and ends on December 15, 2019. You can get coverage through the Marketplace for 2020 if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP). Here are some important dates:

- November 1, 2019: Open Enrollment starts
- December 15, 2019: Last day to enroll or change 2020 health plan
- January 1, 2020: 2020 Insurance coverage begins

CAN I SAVE MONEY ON MY HEALTH INSURANCE PREMIUMS IN THE MARKETPLACE?

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

DOES EMPLOYER HEALTH COVERAGE AFFECT ELIGIBILITY FOR PREMIUM SAVINGS THROUGH THE MARKETPLACE?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.86% (2019) of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

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

HOW CAN I GET MORE INFORMATION?

For more information about your coverage offered by your employer, please check your summary plan description or contact your Human Resources department.

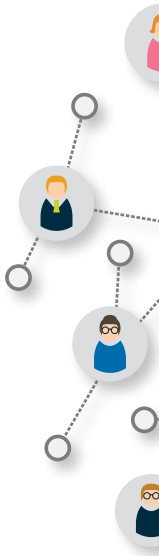
The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents due to other coverage, you may be able to enroll later if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward it) if you request enrollment within 30 days. If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may also be able to enroll later if you request enrollment within 30 days of the event. To request special enrollment or obtain more information about your special enrollment rights, contact the My Holiday Service Center. If you do not have a certificate, but do have prior health coverage, we will help you obtain one from your prior plan. There are also other ways of proving you have creditable coverage. Please contact the My Holiday Service Center if you need help demonstrating creditable coverage.

Privacy Policy

You are entitled to receive an explanation of how your personally identifiable health information will be used and disclosed. For example, a physician or hospital is required to provide you a Notice of Privacy Practices at your first visit. You will be required to sign an acknowledgment indicating that you received the Notice of Privacy Practices. If you have health insurance coverage, the insurance company or health plan will also provide you a Notice of Privacy Practices immediately after you are enrolled in the plan. It is important that you read the Notice of Privacy Practices in order to understand your rights and know who to contact if you feel your privacy rights have been violated. Contact the My Holiday Service Center for a copy of our health plans' Notice of Privacy Practices.



Addendum B - Medicare Part D Notice of Creditable Coverage

Remember: Keep this 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).

IMPORTANT NOTICE FROM HOLIDAY RETIREMENT 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 Nautique 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. Holiday Retirement has determined that the prescription drug coverage offered through Cigna is or are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is

[1]An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. The information in this benefit guide is presented for illustrative purposes only. Please refer to the plan document for complete details.

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 coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents will be able to reenroll in our program during the next open enrollment period.

WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

You should also know that if you drop or lose your current coverage with Nautique 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 Nautique 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).

CMS Form 10182-CC	**Updated April 1, 2011**
Date:	January 1, 2020
Name of Entity/Sender:	Holiday Retirement
Contact--Position/Office:	Nicole Hayric – Benefits Manager
Address:	631 W Morse Blvd Winter Park, FL
Phone Number:	407-855-4141

Medicare Part D Creditability

Our health plan's prescription drug benefit is creditable with Medicare Part D drug benefits. "Creditable" means our prescription drug benefits are as good or better than Medicare Part D benefits. This is important information that will help Medicare-eligible individuals decide whether to enroll in Medicare Part D benefits. Not enrolling in Medicare Part D when initially eligible will result in a significant premium penalty unless the individual can show he/she had credible group prescription drug benefits.

General Reminders

Health and welfare benefits are not vested benefits and are subject to change at the sole discretion of Holiday Retirement. Holiday Retirement reserves the sole and exclusive right to alter, reduce or eliminate any pay practice, policy or benefit at any time and without advance notice, except as required by law.

Please do not enroll dependents that are not eligible for our benefit plans. To knowingly do so will result in their termination from the benefit plans, your repayment of benefits paid and possible disciplinary actions.

Every effort has been made to ensure that the information provided in this benefit summary is accurate. In all cases, however, the benefit plans will be administered in accordance with the governing plan documents, insurance contracts, or company policies. These documents are available to plan participants upon your request.

General Notification of Your COBRA Rights and Responsibilities

Introduction to COBRA: This notice is intended to provide information about your rights and responsibilities under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). This notice does not change your status on the group health plan in any way. Rather, this notice explains rights and responsibilities you may have in the future under the following group health plan(s):

Group Health Plan
Group Health Plan(s) sponsored by Holiday Retirement

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 a COBRA qualifying event, which would terminate your group health plan coverage, occurs in the future, you would have the option to continue your coverage at your own expense. COBRA continuation coverage is the same group health plan coverage you had before your qualifying event. It is the same coverage provided to similarly situated active employees who have not experienced a qualifying event, but it does not include life insurance or disability coverage. Once you and your spouse or dependents (if any) become covered by the group health plan, there are specific

qualifying events that may occur that cause you to lose coverage. Those events and the length of continuation coverage you could be allowed are:

Event	Duration of Coverage
Termination of Employment (either voluntary or involuntary, other than for Gross Misconduct)	18 months
Reduction in Hours (such as layoff, leave of absence, reduced work hours, etc.)	18 months
Death of the Covered Employee	36 months
Divorce or Legal Separation	36 months
Covered Employee's Entitlement to Medicare	36 months
Dependent Child Ceasing to be Dependent	36 months
Bankruptcy (Title 11) of the Employer	Possible lifetime coverage for covered retirees and their spouses and dependents only

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

Health Flexible Spending Account (FSA): Generally, continuation coverage would be available only for the remainder of the plan year in which the qualifying event occurred. Special rules govern FSA eligibility under COBRA. For additional information, please refer to the summary plan description for your FSA.

You may also experience a loss of coverage "in anticipation" of a qualifying event, such as a divorce or legal separation. If that happens, continuation coverage will be offered once the qualifying event has occurred (and has been reported within the proper time frames). In that case, coverage does not have to be provided from the date of your loss of coverage to the date of the qualifying event.

Who can elect COBRA: Each employee, spouse and dependent child who was covered by the group health plan the day before the qualifying event and who loses coverage due to the qualifying event is a COBRA Qualified Beneficiary. A child born to, or placed for adoption with, the covered employee during the period of COBRA continuation is also a qualified beneficiary, if the employer/plan administrator is notified within 30 days of the birth or placement for adoption.

Each qualified beneficiary has an independent right to elect continuation coverage under COBRA. This means all qualified beneficiaries, including a spouse and/or a dependent child, may elect single coverage. However, if two or more family members elect the same coverage, you will be required to pay the applicable premium for the closest level of coverage that a similarly situated active employee would have, such as "two-person" or "family." The covered employee or spouse may elect on behalf of all other qualified beneficiaries. A parent or legal guardian may elect on behalf of dependent children.

How to elect COBRA: RGA mails COBRA notices on behalf of Holiday Retirement and is also the party responsible for all other COBRA administration, including COBRA elections and payments. RGA is not an insurance company or the provider of benefits. Once a qualifying event occurs and is reported properly, Holiday Retirement will instruct RGA to notify you, in writing, with specific information about your qualifying event. The notice will contain instructions for electing continuation coverage, as well as the last date on which you can elect. You will be allowed at least 60 days to elect continuation coverage. Verbal elections will not be accepted. If you elect continuation coverage, Holiday Retirement has the right to verify your eligibility for coverage. If you are not eligible, continuation coverage may be denied or retroactively terminated.

The covered employee or spouse may elect on behalf of all other qualified beneficiaries. A parent or legal guardian may elect on behalf of dependent children. If you fail to timely elect, you will lose your right to continue coverage. Proof of timely election is your responsibility (the United States Postal Service offers several proof-of-mailing services). A COBRA election is deemed made on the date it is postmarked. If you waive continuation coverage in writing, you have 60 days from the later of the loss of coverage date or the date the notification was mailed to you to revoke your waiver and elect continuation coverage.

Any claims you incur during the waiver period may not be covered. RGA does not administer waivers of continuation coverage. Instead of waiving your COBRA rights if you do not want COBRA, you simply do not need to send in your COBRA Continuation Coverage Election Form. During your election period, you may find that you have been removed from the group health plan. Once you make a timely election and payment, your coverage will be reinstated retroactive to your loss of coverage date. If you do not elect, any expenses you incur will become your financial responsibility. You are not required to make a payment with your COBRA election, but coverage may not be reinstated until a timely payment is made. The time frame for reinstatement of coverage often depends upon the insurance company. To confirm your coverage status, please call the insurance company directly.

Paying for Continuation Coverage: Once you elect COBRA continuation coverage, it must be **paid for from the "loss of coverage" date forward in consecutive monthly payments.** Gaps in continuation coverage are not permitted. The first payment for coverage (including coverage retroactive to the loss of coverage) is due in full within 45 days of your election date. For monthly payments following your date of election, the premium is due in full on the "day due" each month. Each monthly coverage period has a grace period of at least 30 days. If your first and last month's premiums are partial months, they will be prorated.

A COBRA payment is deemed made on the date it is postmarked (or when it is submitted online at RGA's website). Payments made after any grace period ends (either the 45-day grace period or a monthly 30-day grace period) are considered late and will not be accepted. Holiday Retirement and RGA are not required to make exceptions based upon individual circumstances, and if you make a late payment, coverage will be terminated permanently, with no possibility of reinstatement. Invoices are not required, and you must postmark your payments by the monthly grace date even if you do not get an invoice. Returned checks (for instance, closed accounts, non-sufficient funds or stop payments) are the same as no payment at all. Proof of timely payment is your responsibility (the United States Postal Service offers several proof-of-mailing services).

Certain states and certain plans may suspend coverage each month until payment is confirmed. Therefore, if you pay during your grace period, your coverage and your claims may be temporarily suspended each month. (This action is allowable under applicable federal COBRA law and regulations and may be required by certain state laws.).

Extending Continuation Coverage: If the qualifying event leading to your election of COBRA continuation coverage was your termination or reduction of hours (or by any other name, a qualifying event that allowed for 18 months of continuation), you may be able to extend your COBRA continuation coverage period for two reasons:

Social Security Disability Determination: If any qualified beneficiary is determined to be disabled by the Social Security Administration, all qualified beneficiaries may receive an additional 11 months of COBRA continuation coverage (29 months total from the original qualifying event). To qualify for this extension, all requirements must be met:

1. The qualified beneficiary must be disabled at any time during the first 60 days of continuation coverage.
2. The qualified beneficiary must provide the Social Security disability award letter to RGA within 60 days from the later of his or her "event date", "loss of coverage" date or the date of the award letter.
3. The qualified beneficiary must provide the Social Security disability award letter to RGA before his or her 18-month continuation coverage period ends (refer to the "coverage expires" date above).

You must also follow the reporting instructions described at the end of this notice. During a disability extension, you may be charged up to 150% of the applicable premium (including the employer's cost) for the coverage. The increased cost begins in the 19th month.

If the Social Security Administration later determines that the disabled qualified beneficiary is no longer disabled, the disability extension will end. Continuation coverage will terminate for all qualified beneficiaries at the end of the month that is 30 days after the date of the Social Security determination (but not before the end of the original 18 months). If you are determined to be no longer disabled, you must report this change within 30 days, following the instructions at the end of this notice.

Second Qualifying Events: If a second qualifying event that would normally cause a loss of coverage as a first qualifying event (death of the covered employee, divorce or legal separation, or a dependent child ceasing to be a dependent child) occurs during the 18-month continuation coverage period, the spouse and/or dependent children who are qualified beneficiaries and who would have lost coverage may receive an additional 18 months of continuation coverage (36 months total from the original qualifying event). You may be eligible for this extension even if you have already been granted an extension of continuation coverage for Social Security Disability. You must report a second qualifying event within 60 days of the qualifying event.

You can report these events by mailing in the notice or a description of the event. Please see the instructions at the end of this notice for more details. Once you report one of these events, RGA and Holiday Retirement will review your eligibility. If you are not eligible, you will receive a Notice of Unavailability that will explain why.

Conversion Coverage: After continuation coverage expires, you may be eligible to elect an individual conversion policy, if your group health plan has such an option. Conversion coverage is not the same as group health plan coverage, and it is not the same as continuation coverage. Rates and benefits may be different. For more information, refer to your plan booklet or summary plan description, or contact the insurance company directly. Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely.

ADDITIONAL ELECTION, EVENT REPORTING AND PAYMENT INSTRUCTIONS

Once you have a qualifying event, copies of important documents relating to your COBRA rights are available by contacting RGA at Email: COBRARequests@accesstpa.com or phone: 877-462-1414.

PAPER REPORTING OF DISABILITY DETERMINATION OR ADDITIONAL QUALIFYING EVENTS

You may call RGA at 877-462-1414 to request a "COBRA Event Notice" form.

You must report these events in writing, but use of the form is not required if you include the following information:

- Name, address and phone number of the covered employee.
- Name, address and phone number of qualified beneficiaries experiencing the event.
- Group health plan coverage.
- The event experienced.
- The date of the event.
- For Social Security disability awards, you must include a copy of the award letter.
- If deemed no longer disabled, you must also include a copy of that letter.
- For all other events, you must include your signature and a statement that the event occurred as represented.

Send the "COBRA Event Notice" or other written format to:

Forms can be mailed to:
COBRA Department
Healthcare Management Administrators
P.O. Box 53168
Bellevue, WA 98015
Email option: COBRARequests@accesstpa.com
Fax option: 425-285-3662

How long does COBRA continuation coverage last: If you elect COBRA continuation coverage, your coverage will begin and end on the dates per the table above. COBRA continuation coverage may terminate earlier than the end date noted above for the following reasons:

- You first become, after the date you elect continuation coverage, covered by another group health plan.
- You first become, after the date you elect continuation coverage, entitled to Medicare Part A, Part B or both.
- Your payment is not timely as described below.
- Holiday Retirement ceases to provide any group health plan.
- During any 11-month disability extension, a disabled qualified beneficiary is deemed no longer disabled by the Social Security Administration.
- Your coverage is terminated for cause, such as fraud, on the same basis that coverage can be terminated under the Holiday Retirement Plan for active employees.

After electing COBRA continuation coverage, you or any qualified beneficiary must notify RGA or Holiday Retirement in writing within 30 days of: becoming entitled to Medicare Part A, Part B or both; or becoming covered under another group health plan.

Failure to provide this notice as required may result in retroactive termination of COBRA continuation coverage. Any expenses incurred during a period for which coverage is later terminated will become your financial responsibility and may require repayment to the providers.

HIPAA SPECIAL ENROLLMENT and COBRA: You should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event

listed above. You will also have the same special enrollment right at the end of continuation coverage if you keep continuation coverage for the maximum time available to you.

More Information: This notice does not fully describe your continuation coverage or other plan rights. You can find more complete information in your summary plan description, plan booklet or certificate. If you have questions about your COBRA rights, please contact RGA at 877-462-1414. For more information about your rights under ERISA, including COBRA, HIPAA and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 866-444-3272. For more information about health insurance options available through the Health Insurance Marketplace and to locate an assister in your area who you can talk to about the different options, visit www.healthcare.gov. It is important to keep Holiday Retirement and RGA informed of address changes for all qualified beneficiaries. This notice contains important information about your rights and responsibilities under the COBRA law. Please keep this notice for future reference.

Please make a copy for your records of any information you submit to RGA.

Holiday Retirement contact: Nicole Hayric, 800-322-0999.

Women's Health & Cancer Rights Act of 1998

Did you know that your medical 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, prostheses, and complications resulting from a mastectomy (including lymph edema)? For more information regarding this benefit, contact customer service at the number listed on the back of your medical ID card.

The Newborns' and Mothers' Health Protection Act (the Newborns' 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).

Your Right to Receive a Notice of Privacy Practices

Holiday Retirement is subject to the HIPAA privacy rules. In compliance with these rules, it maintains a Notice of Privacy Practices. You have the right to request a copy of its Notice of Privacy Practices by contacting the medical insurance company. (See telephone number on your medical ID card).

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 12/31/2019)

Addendum A – 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).

— Continued—

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, 2018. Contact your State for more information on eligibility:

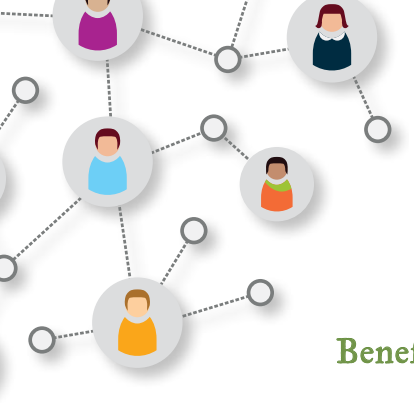
ALABAMA – Medicaid	**FLORIDA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – 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://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/ombp/nhhpp/ Phone: 603-271-5218 Hotline: NH Medicaid Service Center at 1-888-901-4999
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	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
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
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	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742

MISSOURI – Medicaid	OREGON – Medicaid
Website: https://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website:http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633, Lincoln: (402) 473-7000, Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
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	

To see if any other states have added a premium assistance program since January 31, 2018, or for more information on special enrollment rights, contact either:

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

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



Benefits Contact Information

Benefit	Provider/Contact	Phone	Email/Website
Human Resources	My Holiday Service Center	833-LINE4HR (833-546-3447)	my.adp.com/holiday
Health	BlueCross/BlueShield Administered by RGA Group #020290	877-462-1414	Website: accessrga.com Select Oregon, then log in to myRGA Provider Website: bcbs.com (enter prefix RHQ)
Prescription Drug	Express Scripts Group #35242RX Rx Bin #003858	800-334-8134	express-scripts.com
Vision	MetLife Group #307739	800-GET-MET8	metlife.com/vision
Dental	MetLife Group #307739	800-GET-MET8	metlife.com
Life and Disability	Mutual of Omaha Group #G000BGK9	Life Claims 800-775-8805 Disability Claims 800 877-5176	Complete and submit EOI forms on-line at mutualofomaha.com/forms
Employee Assistance Program	Mutual of Omaha	800-316-2796	mutualofomaha.com/eap
Flexible Spending Account (FSA)	HealthEquity	866-346-5800	accessrga.com Select Oregon, then log in to myRGA
Health Savings Account (HSA)	HealthEquity	866-346-5800	accessrga.com Select Oregon, then log in to myRGA
401(k) Plan	Fidelity Investments Group #00059	800-294-4015	netbenefits.com
Family Medical Leave	Holiday Leave of Absence	877-365-2666	leaveofabsense@ holidaytouch.com
Travel Assistance	Mutual of Omaha Administered by AXA Assistance USA	800-856-9947 within the U.S.	
Aflac Voluntary Insurance Benefits • Group Accident, • Group Critical Illness, • Group Hospital Indemnity	Aflac	1-800-433-3036	AflacGroup.com groupclaimfiling@aflac.com
COBRA Administrator	Healthcare Management Administrators	800-869-7093	COBRARequest@accesstpa.com