PREMIUM LABEL & PACKAGING SOLUTIONS

2022

Premium Label & Packaging Solutions

Employee Benefits Guide

CONTENTS & CONTACT INFORMATION

Refer to this section when you need to contact one of your benefit vendors. For general information contact Human Resources.

HUMAN RESOURCES

Vanessa Frattaroli

T: (203) 536-8010

E: vanessa.frattaroli@plps.co

BROKER

United Benefits Partners, Inc.

Scott Clendaniel

T: 856-345-0355 x101

E: scott@ubpbenefits.com

UNITED
Benefits Partners

PAGE 6

Medical

Aetna

T: 1-800-802-3862

W: www.aetna.com

PAGE 10

HSA

OCA

T: 1-855-622-0777

W: www.oca125.com

PAGE 12

Dental

Aetna

T: 1-888-802-3862

W: www.aetna.com

PAGE 14

Vision

EyeMed

T: 1-844-225-3107

W: www.eyemed.com

PAGE 15-16

Group Life and Voluntary

Metlife & Colonial Life

T: 1-800-325-4368

W: www.coloniallife.com

PAGE 16

Service

UBP Service Team

T: 1-856-345-0355

W: www.ubpbenefits.com

ease

Benefits Enrollment

The days of filling out long confusing paperwork for benefits are finally over! With Ease, enrolling in benefits is easy and can be done from anywhere through a computer or mobile device!

Ease Login

Download on the App Store

GET IT ON Google Play

BENEFIT INFORMATION

YOUR BENEFITS PLAN

PLPS offers a variety of benefits allowing you the opportunity to choose a benefits package that meets your personal needs.

In the following pages, you'll learn more about the benefits being offered. You'll also see how choosing the right combination of benefits can help protect you and your family's health and finances – and your family's future.

Benefit	Carrier
Medical	aetna℠
Dental	aetna℠
Vision	eyemed
HSA	oca
Voluntary Benefits	Colonial Life
Life	MetLife

PRE-TAX BENEFITS

CHOOSING YOUR BENEFITS

The premium for elected coverages are taken from your paycheck automatically. There are two ways that the money can be taken out, pre-tax or post–tax.

WHY DO I PAY FOR BENEFITS WITH PRE-TAX MONEY?

There is a definite advantage to paying for some benefits with pre-tax money. Taking the money out before your taxes are calculated lowers the amount of your pay that is taxable. Therefore, you pay less in taxes.

WHICH BENEFIT PREMIUMS ARE TAKEN BEFORE TAX?

PRE tax

- Medical
- Dental
- Vision

POST tax

- None

ELIGIBILITY

All regular full-time employees working 25 hours or more are eligible to join the PLPS benefits once the waiting period has been satisfied. Coverage will begin on the 1st day of the month following 30 days from your date of hire. “Regular Full-Time Employees” must be regularly scheduled. You may also enroll your dependents in the Benefits Plan when you enroll.

WHO’S AN ELIGIBLE DEPENDENT?

- Your legal spouse
- Your married or unmarried natural child(ren), step-child(ren) living with you, legally adopted child(ren) and any other child(ren) for whom you have legal guardianship, up to age 30.

WHEN CAN YOU ENROLL?

You can sign up for Benefits at any of the following times:

- As a new hire, at your initial eligibility date.
- During the annual open enrollment period, effective November 1st of each year.
- Within 30 days of a qualified family-status change. Ex. Birth, Adoption, Etc.

If you do not enroll at one of the above times, you may enroll during the next annual open enrollment period.

MAKING CHANGES

Generally, you can only change your benefit elections during the annual benefits enrollment period. However, you may be able to change your benefit elections during the plan year if you have a change in status including:

- Your marriage or divorce
- Birth or adoption of an eligible child
- Death of your spouse or covered child
- Change in your spouse’s work status that affects your benefits
- Change in your work status that affects your benefits
- Change in residence that affects your eligibility for coverage
- Change in your child’s eligibility for benefits
- Receiving Qualified Medical Child Support Order (QMCSO)

You must notify and provide PLPS with the necessary documentation within 30 days from the life event by providing it to the HR Administrator. The IRS allows changes to be made within 60 days for those eligible for Medicaid or CHIP under HIPAA Special Enrollment Rights.

If you fail to do so you will be required to wait until the next annual enrollment period to make benefit changes unless you have another family status change.

WHEN DOES COVERAGE END?

Coverage will end as of the date of termination/resignation.

MEDICAL INSURANCE

PLPS offers TWO medical plans through Aetna. The chart on the next page provides an overview and comparison of the plans, please refer to your benefit summary for further detail.

To find a provider visit www.aetna.com and click on “Find a Doctor”. From there, you can either login in with your member Id or search as a guest. Once you enter in your home zip code, select the network listed below as well as the type of service you are looking for. Once finished, you'll see a complete list of providers covered in network that are tailored to your search!

Aetna EPO Essentials	
National	Open Access Select

Aetna POS HSA	
National	Open Access Select

aetna℠	EPO Essentials	POS HSA***
IN-NETWORK	*** *All Benefits Begin After The Deductible Is Met*	
DEDUCTIBLE		
Individual / Family	$1,000 / $2,000	$2,250 / $4,500
COINSURANCE		
	20% (After Deductible)	0% (After Deductible)
MAXIMUM OUT-OF-POCKET		
Individual / Family	$6,000 / $12,000	$3,450 / $6,900
Maximum Out-of-Pocket Includes: Deductible, Coinsurance & Copayments (including prescription copays)		
PREVENTATIVE CARE		
Wellness, Immunizations, & Mammography/Colonoscopy	Covered 100% (NO DEDUCTIBLE APPLIES)	
FACILITY VISITS		
Telemedicine	$0	$0 After Ded
Primary Care	$15 Copay	$25 Copay After Ded
Specialist Visits	$75 Copay	$75 Copay After Ded
Inpatient Hospital	20% Coins. After Ded	$250 Copay + 0% Coins. After Ded
Outpatient Surgery	20% Coins. After Ded	$250 Copay + 0% Coins. After Ded
Emergency Room	$500 Copay + 20% Coins.	$500 Copay After Ded
Urgent Care	$50 Copay	$75 Copay After Ded
OUTPATIENT DIAGNOSTIC SERVICES (Freestanding)		
Lab Services	$25 Copay	0% Coins. After Ded
X-Ray Services	20% Coins. After Ded	0% Coins. After Ded
Complex Diagnostic	$250 Copay + 20% Coins After Ded.	0% Coins. After Ded
PRESCRIPTIONS		**Tier 1** **Tier 2**
Retail (30 day supply)	$2 / $15 / $85 / $125 / $275	$3 / $10 / $50 / $80 / 20% with $250 Max
Mail Order (90 day supply)	2.x retail (After Ded)	2.x retail (After Ded)

OUT-OF-NETWORK	POS Plan Only (Please see Plan Summary for Benefits	
	Per Pay Cost for Coverage	
Employee Only	**$32.55**	**$31.34**
Employee + Spouse	**$118.15**	**$113.38**
Employee + Child(ren)	**$89.32**	**$85.75**
Employee + Family	**$171.30**	**$164.31**

Telemedicine

TELADOC®

1-855-835-2362

Available 24/7

The Covid-19 pandemic has provided some with a reluctant feeling to leave the house even when it's absolutely necessary to. For a select few, regular visits to the doctor are unavoidable in order to keep up with any ongoing health condition. With Aetna's Teladoc Services, any potential fear of stepping into a doctor's office is wiped away with the ability to now see a doctor when YOU want from the comfort of your own home!

Endless Resources with Open Availability!

Many of Teladoc's competitors whom offer remote doctor's visits are great. However, they lack one thing.....their services are LIMITED! Teladoc not only offers the ability to see a doctor for general visit's (such as illness) but to also see a specialists as well!

General

- Allergies
- Bronchitis
- Flu
- Sinus Infections
- Much More!

Mental Health

- Addiction
- Anxiety
- Depression
- Stress
- Much More!

Dermatology

- Acne
- Psoriasis
- Eczema
- Rashes
- Much More!

*** All virtual visits are billed the same as if they were in person visits

Download the App or Call Today to Get Started!

Download on the App Store

GET IT ON Google Play

www.teladoc.com/aetna/

KNOW WHERE TO GO

TELADOC TELEMEDICINE	CONVENIENCE CARE	DOCTOR'S OFFICE	URGENT CARE	EMERGENCY ROOM
Access telehealth services to treat minor medical conditions. Connect with a board-certified doctor via video or phone when where and how it works best for you.	Treats minor medical concerns. Staffed by nurse practitioners and physician assistants. Located in retail stores and pharmacies. Often open nights and weekends.	The best place to go for routine or preventive care, to keep track of medications, or for a referral to see a specialist.	For conditions that aren't life threatening. Staffed by nurses and doctors and usually have extended hours.	For immediate treatment of critical injuries or illness. Open 24/7. If a situation seems life-threatening, call 911 or go to the nearest emergency room.
▪ Colds and flu ▪ Rashes ▪ Sore throats ▪ Headaches ▪ Stomachaches ▪ Fever ▪ Allergies ▪ UTIs and more	▪ Colds and flu ▪ Rashes or skin conditions ▪ Sore throats, earaches, sinus pain ▪ Minor cuts or burns ▪ Pregnancy testing ▪ Vaccines	▪ General health issues ▪ Preventive care ▪ Routine checkups ▪ Immunizations and screenings	▪ General health issues ▪ Preventive care ▪ Routine checkups ▪ Immunizations and screenings	▪ General health issues ▪ Preventive care ▪ Routine checkups ▪ Immunizations and screenings

PRESCRIPTIONS & WAYS TO SAVE

Ask your doctor or pharmacist if your brand medication has a generic or lower cost alternative.

SAVING ON PRESCRIPTIONS

A wide range of generic medications are offered at low cost at your local pharmacy.

Specific generic drugs are available at Target, Wal-Mart, and/or CVS for **$4 for a 30-day supply and $10 for a 90-day supply!**

Manufacturer Coupons

When name brands are necessary, manufacturer coupons are a great way to reduce your cost and the companies.

OCA
Health Savings Account (HSA)

1-855-622-0777
Mon - Fri 9am to 5pm

For 2022, we're happy to continue using OCA's Health Savings Account (HSA) as part of our lineup of great benefits being offered to you as employees. Just like previous HSA's we've had, these accounts are tax-advantaged personal savings accounts that can be used to pay for medical, dental, vision, and other qualified expenses now or later in life. Some qualified expenses include:

- Copays & Deductibles
- Prescriptions
- Dental Care
- Contacts & Eyeglasses
- Hearing Aids
- Laser Eye Surgery
- Orthodontia
- Chiropractic Care

Signing Up is as Easy as 1-2-3

1

Click the button below to create a username and password for your new OCA account

Click Here

2

After you create your login credentials, you will then be asked to select and answer 4 security questions for identity verification

3

Finally, you'll be asked to review all of the information you entered. Hit 'Submit' when finished and you're all ready to go!

Don't Forget to Download the App for Easier Access!

Download on the App Store

Download from Google Play

More Questions?...

Visit us on our website at
www.oca125.com

TERMS TO KNOW

Discounted Rate

When you enroll in coverage you become an Aetna member. A member of Aetna gets access to their network of providers (doctors and facilities) – these are in-network providers. Aetna members receive Discounted Rates with these in-network providers.

Copays

Copays are set dollar amounts you pay for specific services. These cost are typically collected at the time of service. Ex. you have a $50 copay for a visit to your primary care physician.

Deductible

Services not subject to a copay are subject to your deductible. You pay first dollar costs for claims subject to your deductible and you receive the Discounted Rate for all covered claims with an in-network provider.

Coinsurance

Coinsurance is a cost share. Once you meet the deductible Aetna will share in the cost of your claims. The percent of the cost for the claim you are responsible for. The amounts you pay in coinsurance apply to your out of pocket maximum.

Maximum Out-of-Pocket

This amount is the maximum amount you will pay towards covered services on the plan for the calendar year. This amount includes the amounts you pay in deductible, coinsurance, copays, and prescription copays.

DENTAL INSURANCE

PLPS offers both a DMO and PPO network under one single plan through Aetna named Freedom-of-Choice. The PPO plan allows you to use in-network or out-of-network benefits while the DMO only allows in-network care. If out-of-network dentists are used under the PPO plan, you will be responsible to pay the difference between Aetna's allowed amount and what the dentist may charge, also known as “balance billing”. The charts on the next page provides a brief overview of the plans as well as a side by side comparison.

To find a provider visit www.aetna.com and click on “Find a Doctor”. From there, you can either login in with your member Id or search as a guest. Once you enter in your home zip code, select the Open Access Select Network as well as the type of service you are looking for. Once finished, you'll see a complete list of providers covered in network that are tailored to your search!

aetna℠	DMO Plan	PPO Plan
DEDUCTIBLE		
Individual	$0	$75
Family	$0	$225
Annual Maximum		
Per covered person	$0	$1,000
Preventative Care		
Oral Exams (once/6 months), Cleanings, X-Rays (full mouth every 36 months & bitewing once/year)	Covered at 100%	Covered at 100%
Basic Procedures		
Fillings, Emergency Exams, Simple Extractions, Endodontics, Periodontics	Covered at 90%	Covered at 70% after deductible
Major Procedures		
Complex Oral Surgery, Crowns, Bridges, Dentures, General Anesthesia.	Covered at 60%	Covered at 40% after deductible
Orthodontia		
	$2,400 Copay	No Coverage
Out-of-Network		
Deductible	N/A	$75 / $225
Annual Maximum	N/A	$1,000
Preventive Care	N/A	100%
Basic Services	N/A	70%
Major Services	N/A	40%
Ortho	N/A	No Coverage

	Per Pay Cost for Coverage
Employee Only	**$7.71**
Employee + Spouse	**$15.21**
Employee + Child(ren)	**$19.68**
Family	**$26.56**

VISION INSURANCE

PLPS offers vision coverage through EyeMed. which uses the VSP Vision network. The Vision PPO Plan allows you to use in-network or out-of-network benefits. If out-of-network vision providers are used, you will be responsible for paying the difference between EyeMed's allowed amount and what the provider may charge, also known as "balance billing".

For a complete list of in-network providers near you, hit the button below or call **1-866-804-0982**

Find Provider

Vision - VSP Vision Network

	In-Network	Out-of-Network
Eye Exam	**Every 12 months**	
	$10 Copay	Up to $40
Lenses**	**Every 12 months**	
Single Vision	$20 Copay	Up to $30
Bifocal Lenses	$20 Copay	Up to $50
Trifocal Lenses	$20 Copay	Up to $70
Lenticular Lenses	$20 Copay	Up to $70
Progressive Lenses	$85 Copay	Up to $50
Frames	**Every 24 months**	
	Up to $130 + 80% off overage	Up to $91
Contact Lenses	**Every 12 months**	
Elective	Up to $110 + 15% off overage	Up to $110
Medically Necessary	Covered 100%	Up to $210
	Per Pay Cost for Coverage	
Employee Only	**$1.40**	
Employee + Spouse	**$2.66**	
Employee + Child(ren)	**$2.79**	
Family	**$4.11**	

** **Lenses, Frames & Contacts are limited to either one pair of contacts or frames/lenses per calendar year.**

Group Life & Accidental Death and Dismemberment

Group Term Life Benefits $15,000

As a valuable member of our team, you are receiving 1 and $15,000 in term life insurance coverage!

This benefit is paid for by the PLPS.

Voluntary Supplemental Life

You have the opportunity to purchase an additional 100k of term life insurance, at very competitive rates, with NO Medical and No Medical Questions.

Voluntary Benefits

Colonial Life

1-800-325-4368

Mon - Fri 8am to 8pm

For 2022, all of us at PLPS are happy to offer our Voluntary Benefits package through Colonial Life. Colonial Life continues to be ranked among the top carriers for voluntary benefits in the entire country with more to offer it's clients then anybody! To the right, you'll see the benefits available to choose from for this year. If you have any questions or wish to request additional information, please reach out to Vanessa Frattaroli accordingly!

Benefits to Choose From:

- Accident
- Cancer
- Critical Illness
- Hospital Confinement
- Short Term Disability
- Term Life
- Whole Life

Features of Colonial Life Benefits

- Coverage is available for your spouse and children for most products
- Benefits are paid directly to you, unless you specify otherwise
- You can keep your coverage if you retire or change jobs, at the same cost
- Coverage is available for your spouse and children for most products

www.coloniallife.com

The UBP Service Team

Customer Service Team

UNITED
Benefits Partners

1-856-345-0355
Mon - Fri 8:30am to 5:30 pm EST

As a PLPS employee, you have access to the best service team in the business, They're there to help answer any and all of your healthcare and benefit questions. Below are just a few examples of what the UBP Team can do to help (at NO cost to you):

Benefit Navigation

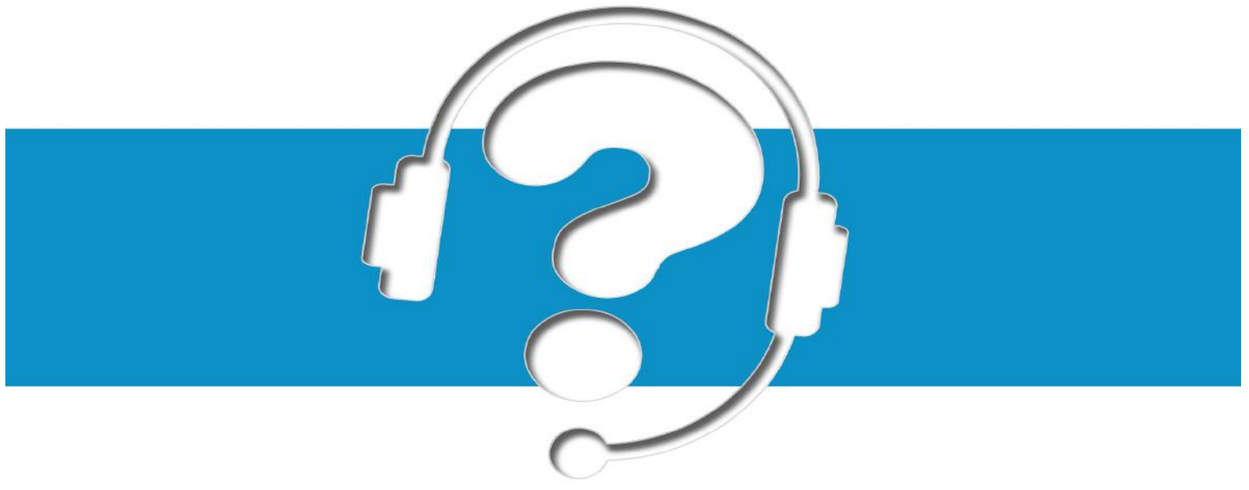
UBP assists with more than just medical insurance. They also support all your other benefits... Dental, Vision & HRA through Clarity.

Claims Help

Send UBP your bills, tell them what you think is wrong, and they work on your behalf to resolve them, including calling doctors and carriers.

Provider Search

Need a doctor who's in-network or need a second opinion? Let Touchcare run with it. They'll do it all so you don't have to.



Don't life a finger, let your Account Manager do it all! It's completely FREE.

dean@ubpbenefits.com

Continuation and ACA Information

HEALTHCARE REFORM AND YOU

The Patient Protection and Affordable Care Act & The Health Care and Education Affordability Reconciliation Act of 2010, together, create the most comprehensive health insurance reform ever under taken in recent history by our Country.

Many of the new laws required changes have already been incorporated into company health plans across the country since the effective date in September of 2010. However, there will be many more changes taking place in the months to come, as more guidance is issued by the government to employers, insurance carriers and individuals.

One of the key requirements of the new law beginning in 2014, is the mandate that all U.S. citizens & legal residents either carry health insurance or pay an income tax penalty. While the tax penalty is not too severe in the first year, it becomes progressively more costly each year thereafter.

Penalties for failing to buy coverage

Tax penalties for failing to buy coverage are phased in according to the following schedule:

In 2014, the greater of $95 or 1% of taxable income;
In 2015, the greater of $325 or 2% of taxable income;
In 2016, the greater of $695 or 2.5% of taxable income; and After 2016, the penalty is indexed for inflation.

However, there are two ways to avoid the tax penalty:

You can buy coverage for you and your family through your place of employment, if your employer offers such coverage. That coverage must meet certain standards set by the law in order for you and the employer to escape respective tax penalties. The coverage must meet certain minimum coverage standards (Generally pays at least 60% of your covered medical expenses) and must be considered “affordable” (Employer cannot charge you a premium for single or employee only coverage greater than 9.5% of your W-2 earnings for the year). The 9.5% would apply to annual salaries of up to about $45,000. Or, you can provide coverage for you and your family through a Federally run Insurance Exchange that is supposed to be up and running by 1/1/2014. Essentially, an Exchange is an interactive site where an individual can go to research, evaluate and buy health plans. The State of Florida chose not to set up a state run exchange, so the Federal government will take over that responsibility.

If you obtain coverage through an Exchange:

The Exchange will sell insurance policies at certain levels of coverage:

- **Bronze level** – a medical plan designed to pay 60% of covered medical benefits;
- **Silver level** – a medical plan designed to pay 70% of covered medical benefits;

- **Gold level** – a medical plan designed to pay 80% of covered medical benefits;
- **Platinum level** – a medical plan designed to pay 90% of covered medical benefits;
- **Catastrophic** – available to young adults up to age 30 or those exempt from the individual mandate (additional requirements may apply)

You may only obtain coverage through an Exchange if you are not participating in your employer's plan.

If you satisfy certain low income thresholds and do not have medical coverage through an employer, or have employer-provided coverage
that is considered "unaffordable" or pays benefits that are below the "Bronze" plan discussed above, there are tax credits available to help
you pay the premiums for coverage purchased through the Exchange. The credits also help pay for expenses like deductibles and co pays. 16 More information on these credits will be provided to you later. If you and your family are below 133% of the Federal Poverty Level in
2014, you may qualify for Medicaid.

Other changes that took effect in 2014 are:

- The health plan no longer excludes coverage of a pre-existing condition;
- The health plan may not impose more than a 90-day waiting period for coverage;
- Your plan no longer place s an annual limit on key benefits in the plan;
- Your health plan must allow dependent children up to age 26 to enroll in coverage, regardless of the availability of employer-sponsored coverage where they work.

GENERAL NOTICE OF COBRA RIGHTS

Continuations coverage rights under cobra*

Introduction

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

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the employer sponsoring the Plan.

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage:

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

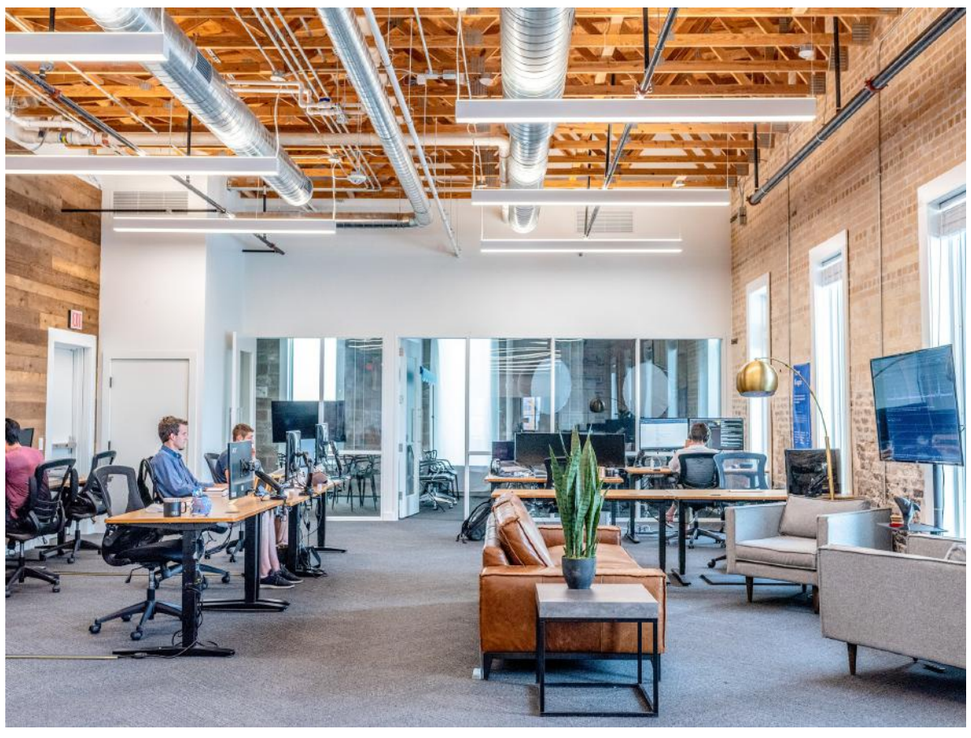
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of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

If you have questions

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

Keep your Plan informed of address changes

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



PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new 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 in October 2013 for coverage starting as early as January 1, 2014.

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 9.5% 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.

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

CONTACT

For general information
contact Human Resources.

Vanessa Frattaroli
(203) 536-8010
vanessa.frattaroli@plps.co