It's Time To Talk
About Your Benefits

ENVIRO CLEAN SERVICES, LLC

2019 Benefit Enrollment

ENROLL FOR 2019 BENEFITS

TABLE OF CONTENTS

Enviro Clean Services, LLC is proud to offer a comprehensive benefits package to eligible employees who satisfy the plan requirements. The complete benefits package is briefly summarized in this booklet. More detailed information about each of these programs can be found within your contract documents.

BENEFITS OFFERED

- Medical — BlueCross BlueShield of Oklahoma
- Dental — Delta Dental of Oklahoma
- Vision — VSP
- Life and AD&D Insurance — MetLife
- Voluntary Life and AD&D — MetLife
- Short Term Disability—MetLife
- Long Term Disability—MetLife
- Flexible Benefit Plan—Discovery Benefits
- Health Savings Account—Optum Bank
- Hospital Indemnity Plan—Assurant

ELIGIBILITY

You and your dependents are eligible for benefits if you work the required number of hours per week, and have satisfied the waiting period.

Eligible dependents are your spouse, children under age 26, and disabled dependents of any age that satisfy the plan requirements.

Elections made now will remain until the next open enrollment unless you or your family members experience a qualifying event. If you experience a qualifying event, you must contact HR within 30 days. Please see the notice section within this guide for more information..

If you (and your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal Law gives you more choices about your prescription drug coverage. Please see pages 22 and 23 within this guide for further details.

MEDICAL & PHARMACY

MEDICAL

Administered by Blue Cross and Blue Shield of Oklahoma

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. A little prevention usually goes a long way—especially in healthcare. Routine exams and regular preventive care provide an inexpensive review of your health. Small problems can potentially develop into large expenses. By identifying the problems early, often they can be treated at little cost. To see a current list of network providers online, visit www.bcbsok.com.

	BLUE PREFERRED $1,000	HSA BLUE PREFERRED $3,500
DEDUCTIBLE INFORMATION	**In-Network**	**In-Network**
Annual Deductible	$1,000 Single / $2,000 Family	$3,500 Single / $7,000 Family
Annual Out-of-Pocket Max (includes deductible)	$4,000 Single / $8,000 Family	$6,350 Single / $12,700 Family
Coinsurance (Member Pays)	30%	20%
DOCTOR'S OFFICE		
Primary Care Office Visit	$25 Copay	Deductible, then 20%
Specialist Office Visit	$50 Copay	Deductible, then 20%
Preventive Care: routine exams, x-rays/tests, immunizations, well baby care and mammograms)	100% of Allowable	100% of Allowable
Emergency Room	$250 per Visit plus Deductible, then 30% Co-insurance	Deductible, then 20%
Urgent Care	$50 Copay	Deductible, then 20%
PRESCRIPTION BENEFITS		
Generic	$15 Copay Mail Order: $37.50 Copay	Deductible, then $10 Copay Mail Order: Deductible, then $25 Copay
Preferred Brand	$40 Copay Mail Order: $100 Copay	Deductible, then $35 Copay Mail Order: Deductible, then $87.50 Copay
Non-Preferred Brand	$75 Copay Mail Order: $187.50 Copay	Deductible, then $60 Copay Mail Order: Deductible, then $150 Copay

DENTAL BENEFITS

DENTAL

Administered by Delta Dental of Oklahoma

Good oral care enhances overall physical health, appearance and mental well-being. Problems with the teeth and gums are common and easily treated health problems. Keep your teeth healthy and your smile bright with the Enviro Clean Services, LLC dental benefit plan. Please keep in mind that Delta Dental does not mail out personalized ID cards. If you choose to enroll, your provider can contact Delta Dental and provide your social security number for verification. purposes

DENTAL BENEFITS		
ANNUAL DEDUCTIBLE	**In-Network**	**Out-of-Network**
Individual	$50	$50 *
Family	$150	$150 *
ANNUAL MAXIMUM		
Per Person	$2,000	$2,000 *
COVERED SERVICES		
Type A—Preventive	100%	100% *
Type B—Basic Restorative	Deductible, 80%	Deductible, 80% *
Type C—Major Restorative	Deductible, 60%	Deductible, 60% *
Orthodontics (Child to age 26)	50%	50% *
Orthodontic Lifetime Max	$1,500	$1,500 *

** If you obtain treatment from a dentist who has not signed a participating agreement with Delta Dental, any benefit payment will be paid directly to you, or to other participant or beneficiary if required by law, and will be based on the lesser of the dentist's submitted fee for his or her service or the prevailing fee. Prevailing Fee is an amount established by the Delta Dental Plan in the state in which the dental services are rendered. You are responsible for paying the dentist and filing your own claim.*

HELPFUL TIP: If the cost estimate of a dental treatment is $250 or more and is not emergency care, your dentist can determine the treatment needed and submit a treatment plan to Delta Dental of Oklahoma for a "Predetermination of Benefits". This procedure will enable you and the dentist to know in advance of treatment what services are covered, how much of the cost will be paid by your dental plan, and how much of the cost you will be responsible for paying.

VISION BENEFITS

VISION

Administered by VSP

Regular eye examinations can not only determine your need for corrective eyewear but also may detect general health problems in their earliest stages. Protection for the eyes should be a major concern to everyone. Please keep in mind that VSP does not mail out personalized ID cards. If you choose to enroll, your provider can contact VSP and provide your social security number for verification purposes.

	IN-NETWORK—VSP CHOICE	OUT-OF-NETWORK
Eye Exam —Every 12 months	$20 Copay	Up to $45
LENSES — ONCE EVERY 12 MONTHS		
Single Vision Lenses	$20 Copay	Up to $30
Lined Bifocal Lenses	$20 Copay	Up to $50
Lined Trifocal Lenses	$20 Copay	Up to $65
Standard Progressive Lenses	$55 Copay	Up to $50
Premium Progressive Lenses	$95 - 105 Copay	Up to $50
FRAMES — ONCE EVERY 24 MONTHS		
Allowance	$20 Copay; $130 allowance; 20% savings on amount over allowance	Up to $70
CONTACT LENSES — ONCE EVERY 12 MONTHS		
Medically Necessary	$60 Copay, $130 allowance	Up to $105

Extra Savings

Get the most out of your benefits and greater savings with a VSP network doctor. Your coverage with out-of-network providers will be less or you'll receive a lower level of benefits. Visit vsp.com for plan details.

Glasses and Sunglasses

- Extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details.
- 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.

Retinal Screening

- No more than a $39 copy on routine retinal screening as an enhancement to a WellVision Exam

Laser Vision Correction

- Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities

LIFE INSURANCE

LIFE AND AD&D INSURANCE

Administered by MetLife

If you are an eligible full-time employee satisfying the plan requirements, Enviro Clean Services, LLC automatically enrolls you in their Basic Life and AD&D plan at no cost to you. This plan guarantees that loved ones, such as a spouse or other designated survivor(s), continue to receive part of an employee's benefits after a death.

Your Basic Life and AD&D insurance benefit is an amount equal to 1 times your basic annual earnings, rounded to the next higher $1,000 to a plan maximum of $250,000.

VOLUNTARY LIFE AND AD&D INSURANCE

Administered by MetLife

You may purchase Voluntary Life and AD&D insurance for yourself in increments of $10,000, up to a maximum of the lesser of 5x your basic annual earnings or $500,000. Evidence of Insurability (EOI) is required for $150,000 or more. You may purchase coverage for your spouse in increments of $5,000 up to $100,000 (not to exceed 50% of employee's approved amount). EOI is required for amounts over $25,000. You may purchase coverage for eligible child(ren) in the amounts of $1,000; $2,000; $4,000; $5,000 or $10,000.

VOLUNTARY LIFE INSURANCE	
RATES/$1,000 (MONTHLY)	
AGE (AS OF JANUARY 1, 2019)	EMPLOYEE/SPOUSE
<30	$0.028
30-34	$0.043
35-39	$0.059
40-44	$0.097
45-49	$0.158
50-54	$0.265
55-59	$0.418
60-64	$0.579
65-69	$0.954
70+	$1.604
Child Life Rate per $1,000	$0.24
VOLUNTARY ADD INSURANCE	
Employee & Spouse Rate per $1,000	$0.048
Child Rate per $1,000	$0.051

Due to rounding, your actual payroll deduction amount may vary.

INCOME PROTECTION

SHORT TERM DISABILITY

Administered by MetLife

If you are an eligible full-time employee satisfying the plan requirements, Enviro Clean Services, LLC automatically enrolls you in their Short Term Disability plan at no cost to you. This insurance can replace a portion of your income during the initial weeks of a disability. Certain exclusions, along with any pre-existing condition limitations, may apply. Please refer to your plan documents for details or contact Human Resources for specific benefits.

STD BENEFITS	
Benefit	60% of Pre-disability earnings
Weekly Benefit Maximum	$2,000
Elimination Period—Injury	14 Days
Elimination Period—Sickness	14 Days
Benefit Duration	11 Weeks

LONG TERM DISABILITY

Administered by MetLife

If you are an eligible full-time employee satisfying the plan requirements, Enviro Clean Services, LLC automatically enrolls you in their Long Term Disability plan at no cost to you. This insurance can replace a portion of your income if you become partially or totally disabled for an extended period of time. Certain exclusions, along with any pre-existing condition limitations, may apply. Please refer to your plan documents for details or contact Human Resources for specific benefits.

LTD BENEFITS	
Monthly Benefit	60% of Pre-disability earnings
Monthly Benefit Maximum	$11,000
Elimination Period	180 Days

INCOME PROTECTION

EMPLOYEE ASSISTANCE PROGRAM

Administered by LifeWorks US, Inc. via MetLife

Difficult circumstances exist in every aspect of life. Sometimes individuals need assistance in dealing with such times. Therefore, included with your Long Term Disability plan through MetLife, your employer is providing an Employee Assistance Program at no additional cost to you.

The Employee Assistance Program can be used to address a broad range of issues, such as;

- Marriage, Relationship and Family Problems
- Problems at Work
- Legal and Financial Issues
- Stress and Anxiety
- Alcohol and Drug Dependency
- Identity Theft
- Health and Wellness Concerns

This program provides both you and the members of your household with up to 5 consultations with a licensed clinician per issue, per individual, per calendar year. You have telephonic consultations for maximum convenience and anonymity.

Please call 1.888.319.7819 anytime to speak with a clinician. You also have online member services available. Simply log on to www.metlifeeap.lifeworks.com and enter the user name of **metlifeeap** and the password of **eap** to begin.

FLEXIBLE BENEFIT PLAN

FLEXIBLE BENEFIT PLAN

Administered by Discovery Benefits

WHAT IS A FLEXIBLE BENEFIT PLAN, AND HOW DOES IT WORK?

A Flexible Benefit Plan, often known as a Cafeteria Plan, is an excellent way to set aside pre-tax dollars for various types of qualified eligible expenses.

Your company offers the following services:

- **Health Care Flexible Spending Account:** This allows you to set aside pre-tax dollars for eligible medical expenses not covered by your plan. Typical qualified expenses include items such as prescriptions, hearing aids, and orthopedic goods. This type of Flexible Spending Account is only available to those not covered on an HSA qualified plan.

- **Health Care Limited Purpose Flexible Spending Account:** Those enrolled in the HSA qualified plan, can choose to participate in the Limited Purpose Flexible Spending Account. The qualified expenses allowed under the Limited Purpose FSA encompass only certain qualified expenses for Dental and Vision.

- **Dependent Care Flexible Spending Account:** This account allows you to set aside pre-tax dollars to cover day care expense for qualified tax dependents (e.g., children younger than 13 and adult dependents incapable of caring for themselves).

The IRS governs the overall maximum allowed amounts for the Health Care FSA and Dependent Care FSA accounts. The IRS maximums are shown below. Please speak with your employer regarding your maximum amounts.

IRS 2019 MAXIMUMS	
Health Care Flexible Spending Account	$2,700
Dependent Care Flexible Spending Account *Account holder is married & files separate tax return	$2,500
Dependent Care Flexible Spending Account *Account holder is married & files joint tax return or files as single / head of household	$5,000

For a comprehensive list of qualified medical expenses, please visit the Discovery Benefits website at www.DiscoveryBenefits.com/eligibleexpenses.

Please see the Discovery Benefits flyers on the following pages for more detailed information about the Flexible Spending and Dependent Care Flexible Spending Accounts.

Please reach out to your Human Resources Department with any questions.

FLEXIBLE SPENDING ACCOUNT (FSA)

EMPLOYEE HANDOUT

AN FSA THAT SIMPLIFIES SAVINGS

- ONE PORTAL, ONE MOBILE APP AND ONE DEBIT CARD FOR ALL OF YOUR BENEFITS
- AVERAGE DEBIT CARD AUTO-SUBSTANTIATION RATE OF MORE THAN 85 PERCENT
- EASY DOCUMENTATION UPLOADING USING OUR MOBILE APP
- THOUSANDS OF ELIGIBLE EXPENSES FOR PURCHASE AT THE FSA STORE

Flexible Spending Account Overview

A Flexible Spending Account (FSA) allows you to budget and save for qualified medical expenses incurred over the course of your plan year. Dollars invested in an FSA are tax-free, and the entire election amount is available on the first day of the plan year. That makes an FSA a great tool for saving money, especially when big expenses are anticipated.

Types of FSAs

Medical FSA

Pair a traditional health plan with a Medical FSA, which covers eligible medical, dental and vision expenses.

Limited FSA

If you have a High-Deductible Health Plan and a Health Savings Account, you're eligible to enroll in a Limited FSA alongside your HSA to maximize savings. These funds can be used for qualifying dental and vision expenses.

Dependent Care Account (DCA)

A DCA allows you to put money aside for dependent care for children up to age 13, a disabled dependent of any age or a disabled spouse.

You may receive reimbursement up to the current balance in your account at the time the request is made. To be eligible for a DCA, you and your spouse (if applicable) must work, be looking for work or be full-time students.

Eligible Expenses

Common eligible expenses for a Medical FSA are prescriptions, hearing aids, orthopedic goods, doctor visits and dentist visits, while a Limited FSA is limited to dental and vision expenses. A DCA covers expenses such as work-related daycare and elderly care costs. To find out which specific expenses are eligible, view our searchable eligibility list at www.DiscoveryBenefits.com/eligibleexpenses.

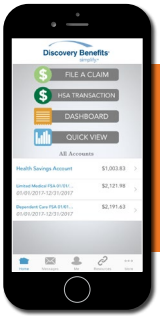
Using Funds

For easy access to your FSA funds, you can swipe your Discovery Benefits debit card and avoid out-of-pocket costs. If you use your card at a provider with an Inventory Information Approval System (IIAS), the expense will automatically be approved at the point of sale. If the card is swiped at a merchant that meets the IRS' 90% rule, you may need to provide documentation to show the expense is eligible.

Substantiation

The IRS requires FSA participants to provide documentation (e.g. an Explanation of Benefits) to show that an expense is FSA-eligible. You can easily upload documentation to a claim by logging in to your online account or taking a photo of your documentation with your phone's camera and uploading it through the Discovery Benefits mobile app.

Our Claims Sync tool helps automate the substantiation process by syncing insurance claims directly into your portal dashboard and instantly searching for matches within your debit card transactions. Or, if it's an expense that wasn't paid for with your benefits debit card, Claims Sync lets you pay and submit documentation for the claim directly from your portal dashboard.



DOWNLOAD THE APP FOR FREE ON APPLE AND ANDROID DEVICES

Download on the App Store | GET IT ON Google Play

RESOURCES

- **ELIGIBLE EXPENSE LIST** www.DiscoveryBenefits.com/eligibleexpenses
- **FSA CALCULATOR** www.DiscoveryBenefits.com/fsacalculator
- **MOBILE APP VIDEO** www.DiscoveryBenefits.com/mobileappvideo
- **FSA 101 VIDEO** www.DiscoveryBenefits.com/fsa101
- **FSA STORE** www.DiscoveryBenefits.com/fsastore

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Dependent Care Employee Handout

Who couldn't use a little more money? That's what you'll receive when you take advantage of the Dependent Care Flexible Spending Account (FSA). A Dependent Care FSA allows you to set aside a portion of your salary, before taxes, to pay for qualified dependent care expenses. Because that portion of your income is not taxed, you end up with more money in your pocket.

Dependent Care Flexible Spending Account (FSA)

A Dependent Care Account is a simple way to save money on care for your dependents. It allows you to set aside pre-tax dollars to pay for day care expenses. The annual IRS limit for this type of account is $5,000. If you are married and file separate returns, you can each elect $2,500 for the calendar year. When choosing how much to set aside for dependent care, please note that any unused funds remaining in your Dependent Care Account at the end of your plan year will be forfeited.

To be eligible for this type of account, both you and your spouse (if applicable) must work, be looking for work or be full-time students. You may receive reimbursement up to the current balance in your account at the time the request is made.

Eligible Dependents

- Children under age 13 who are claimed as a dependent for tax purposes
- Disabled spouse or disabled dependent of any age

Ineligible Expenses

- Costs claimed as a dependent care tax credit on your tax return
- Services provided by one of your dependents
- Expenses for nighttime babysitting
- Your own dependents, under age 19, babysitting
- Expenses paid for school (Kindergarten and above)

Recurring Dependent Care Reimbursement

You can eliminate the need to submit substantiation throughout the year for dependent care expenses by enrolling in Recurring Dependent Care. This process only requires you to submit one form per year for each day care provider used during the year. If your cost of dependent care per month is less than your monthly payroll deduction or you have currently contributed more to your plan than you have incurred in expenses, you do not qualify for Recurring Dependent Care and you'll need to file claims as services are incurred.

The Recurring Dependent Care Request Form can be found in the consumer portal. This form must be completed by you as the participant and by your day care provider. A separate form must be completed for each day care provider if you use more than one.

Accessing Your Account

Access your online account from our website at www.DiscoveryBenefits.com. You can submit expenses online, through the toll-free fax, via email or by mail. Your money will be directly deposited into your checking or savings acccount, or you can receive a check in the mail.

HSA ADMINISTRATION

HSA ADMINISTRATION

Administered by Optum Bank

WHAT IS A HEALTH SAVINGS ACCOUNT, AND HOW DOES IT WORK?

A Health Savings Account (HSA) is a tax-advantaged benefit account available to eligible employees who are enrolled in a High Deductible Health Plan (HDHP). The funds contributed to an HSA are not subject to federal income tax at the time of deposit and automatically roll over year-to-year with no risk of forfeiture.

HSA's can provide real savings for employees with tax-free contributions made through payroll deductions. Withdrawals for eligible medical expenses are also tax-free and can be taken any time, any year.

Please see below for just a few of the advantages an HSA can provide:

- Web-based, fully integrated portals: 24/7 access to account information and reports.
- HSA Debit Card is a convenient way to access HSA funds.
- Many integrated resources to help you manage your HSA account.

For full details and a comprehensive list of qualified eligible expenses, please visit the Optum Bank website located at www.optumbank.com.

HOW MUCH CAN YOU PUT IN A HEALTH SAVINGS ACCOUNT?

The total overall contributions allowed annually into a Health Savings Account are governed by the IRS. The totals per the IRS guidelines are shown below.

IRS HSA MAXIMUMS 2019	
Individual Limit	$3,500
Family Limit	$7,000

As shown on the Payroll Deduction page, your employer contributes toward your HSA. The amounts contributed each month are shown below for both Individual and Family. If you are a new employee after 1.1.2019, your amounts will be pro-rated. Please speak with your Human Resources Department for more information.

HSA MONTHLY CONTRIBUTIONS—INDIVIDUAL	
Individual Contribution—January 2019	$250
Individual Contribution—Per Month over next 11 Months	$22.72
Individual Contribution—TOTAL for 2019	**$500**
HSA MONTHLY CONTRIBUTIONS—FAMILY	
Family Contribution—January 2019	$500
Family Contribution—Per Month over next 11 Months	$45.45
Family Contribution—TOTAL for 2019	**$1,000**

IMPORTANT NOTE: If you are a recipient of Medicare or Tricare, you are not eligible to participate in an HSA.plan.

HOSPITAL INDEMNITY

HOSPITAL INDEMNITY

Offered by Assurity

WHY HOSPITAL INDEMNITY PRO?

No one wants to end up in the hospital, but sometimes the unexpected happens. When it does, rest assured, Assurity will be there to help you with the medical costs not currently covered by your health insurance. Or use the money for any other purpose you see fit. Plus, there are no deductibles or co-payments.

ADVANTAGES OF HOSPITAL INDEMNITY PRO:

- Any approved medical doctor or hospital may be used
- Available for employees / spouses (ages 18 and over) and dependent children (0-25)
- It's portable—you may keep the policy in force even if you leave your current employer, as long as you continue to pay the premium

MONTHLY RATES FOR GROUP PLAN IN OKLAHOMA

Benefit Amounts					
Benefit Amount	**Issue Ages**	**Employee**	**Employee & Spouse**	**Employee & Child**	**Family**
$100.00	18-39	21.07	42.55	62.63	90.12
	40-49	24.18	47.78	37.01	63.19
	50-59	35.21	70.53	46.30	83.33
	60-64	51.44	104.23	62.57	115.62
	65-69	63.97	130.19	75.70	141.07
	70+	68.98	140.79	81.20	151.85

This coverage is being offered to you by Assurity, and if you are interested in applying for this coverage, please obtain an enrollment form and contact your Assurity representative, Jenny Elsasser at jelsasser@assurity.com, or call her at 800.869.0355, extension 4308. Her information is also present on the Contact page within this guide..

IMPORTANT:

HOSPITAL INDEMNITY PRO PROVIDES LIMITED BENEFIT COVERAGE. This insurance does not provide major medical coverage and does not satisfy the requirement for minimum essential coverage under the Affordable Care Act (ACA).

This product is subject to limitations and exclusions. Please speak with the Assurity representative for more information regarding the full scope of coverage, and the limitations and exclusions that apply.

PAYROLL DEDUCTIONS

BLUE PREFERRED HSA
$3,500 Deductible Plan

EE Cost Per Month	Single	Emp/Spou	Emp/Child	Family
	$0.00	$107.36	$84.11	$209.17
EE Cost Per Pay Period	**Single**	**Emp/Spou**	**Emp/Child**	**Family**
	$0.00	$49.55	$38.82	$96.54

HSA Contribution Information

Did you know that your employer will contribute funds toward your HSA Account if you elect the HSA qualified Blue Cross plan? Please see below for the amounts your employer will contribute.

EE Contribution	$500.00

Family Contribution	$1,000.00

BLUE PREFERRED PPO
$1,000 Deductible Plan

EE Cost Per Month	Single	Emp/Spou	Emp/Child	Family
	$77.35	$271.48	$190.69	$469.02
EE Cost Per Pay Period	**Single**	**Emp/Spou**	**Emp/Child**	**Family**
	$35.70	$125.30	$88.01	$216.47

DENTAL PLAN

EE Cost Per Pay Period	Single	Emp/Spou	Emp/Child	Family
	$5.04	$23.30	$31.50	$40.37

VISION PLAN

EE Cost Per Pay Period	Single	Emp/Spou	Emp/Child	Family
	$3.31	$5.29	$5.40	$8.71

CONTACT INFORMATION

If you should have any questions during the plan year, there are many resources at your disposal. The carrier contacts listed below can assist you with many types of issues, including understanding your benefits, assisting with claim problems and helping you locate network providers. If the carrier contacts listed are unable to assist you, please feel free to reach out to the broker resource indicated.

BENEFIT	ADMINISTRATOR	PHONE	WEBSITE/EMAIL
Medical	BCBS of Oklahoma	800.942.5837	www.bcbsok.com
Dental	Delta Dental of Oklahoma	800.522.0188	www.deltadentalok.org
Vision	Vision Service Plans (VSP)	800.877.7195	www.vsp.com
Basic Life AD&D	MetLife	800.275.4638	www.metlife.com
Voluntary Life AD&D	MetLife	800.275.4638	www.metlife.com
Short Term Disability	MetLife	800.275.4638	www.metlife.com
Long Term Disability	MetLife	800.275.4638	www.metlife.com
Employee Assistance Program	MetLife-Life Works US, Inc.	888.319.7819	www.metlifeeap.lifeworks.com
Flexible Spending Account	Discovery Benefits	866.451.3399	www.discoverybenefits.com
HSA Administration	Optum Bank	866.234.8913	www.optumbank.com
Hospital Indemnity PRO	Assurity	800.869.0355 x. 4308	jelsasser@assurity.com
BROKER CONTACTS			
Dillingham Insurance	210 Park Avenue	405.236.1991	www.dillinghaminsurance.com
	OKC, OK 73102		

NOTICES

WOMEN'S HEALTH AND CANCER RIGHTS ACT

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

►All states of reconstruction of the breast on which the mastectomy was performed;

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

►Prostheses, and

►Treatment of physical complications of the mastectomy, including lymphedema.

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

If you would like more information on WHCRA benefits, call Human Resources.

INITIAL NOTICE OF YOUR HIPAA SPECIAL ENROLLMENT RIGHTS

Our records show you are eligible to participate in the Enviro Clean Services, LLC Group Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction). A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its' "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a State Children's Health Insurance Program.

New Dependent by Marriage, Birth Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Medicaid or a State Children's Health Insurance Program. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a State Children's Health Insurance Program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact the Human Resources Department.

If you decline enrollment for yourself or for an eligible dependent, you must select a declination reason on your enrollment. You are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a State Children's Health Insurance Program) is the reason for declining enrollment. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above.

MICHELLE'S LAW

Michelle's Law requires group health plans to provide continued coverage for a dependent child covered under the plan if the child loses eligibility under the Group Health Medical Plan because of the loss of student status resulting from a medically necessary leave of absence from a post-secondary educational institution. If your child is covered under the Group Health Medical Plan, but will lose eligibility because of a loss of student status caused by a medically necessary leave of absence, your child may be able to continue coverage under our plan for up to one year during the medically necessary leave of absence. This coverage continuation may be available if on the day before the medically necessary leave of absence begins your child is covered under the Group Health Medical Plan and was enrolled as a student at a post-secondary educational institution.

A "medically necessary leave of absence" means a leave of absence from a post-secondary educational institution (or change in enrollment status in that institution) that (1) begins while the child is suffering from a serious illness or injury, (2) is medically necessary, and (3) causes the child to lose student status as defined under our plan.

The coverage continuation is available for up to one year after the first day of the medically necessary leave of absence and is the same coverage your child would have had if your child had continued to be a covered student and not needed to take a medical leave of absence. Coverage continuation may end before the end of one year if your child would otherwise lose eligibility under the plan.

If your child is eligible for this coverage continuation and loses coverage under the plan at the end of the continuation period, COBRA continuation may be available at the end of the Michelle's Law coverage continuation period.

If you have any questions concerning this notice or your child's right to continued coverage under Michelle's Law, please contact Human Resources.

NEWBORNS' AND MOTHERS HEALTH PROTECTION ACT (NMHPA)

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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or

www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2018. Contact your State for more information on eligibility.

ALABAMA – Medicaid	Website: http://myalhipp.com/	Phone: 1-855-692-5447
ALASKA – Medicaid The AK Health Insurance Premium Payment Program Email: CustomerService@myakhipp.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://myakhipp.com/	Phone: 1-866-251-4861
ARKANSAS – Medicaid	Website: http://myarhipp.com/	Phone: 1-855-MyARHIPP (855-692-7447)
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)		
Health First Colorado Health First Colorado Member Contact Center	Website: https://www.healthfirstcolorado.com/	Phone: 1-800-221-3943 State Relay 711
Child Health Plan Plus (CHP +) Customer Service	Website: Colorado.gov/HCPF/Child-Health-Plan-Plus	Phone: 1-800-359-1991 State Relay 711
FLORIDA – Medicaid	Website: http://flmedicaidtplrecovery.com/hipp/	Phone: 1-877-357-3268
GEORGIA – Medicaid	Website: http://dch.georgia.gov/medicaid Click on Health Insurance Premium Payment (HIPP)	Phone: 1-404-656-4507
INDIANA – Medicaid	Healthy Indiana Plan for low-income adults 19-64: Website: http://www.in.gov/fssa/hip/ All Other Medicaid: Website: http://www.indianamedicaid.com	 Phone: 1-877-438-4479 Phone: 1-800-403-0864
IOWA – Medicaid	Website: http://dhs.iowa.gov/hawk-i	Phone: 1-800-257-8563
KANSAS – Medicaid	Website: http://www/kdheks.gov/hcf/	Phone: 1-785-296-3512
KENTUCKY – Medicaid	Website: http://chfs.ky.gov/dms/default.htm	Phone: 1-800-635-2570
LOUISIANA – Medicaid	Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331	Phone: 1-888-695-2447
MAINE – Medicaid	Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html	Phone: 1-800-442-6003 TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP	Website: http://www.mass.gov/eohhs/gov/departments/masshealth/	Phone: 1-800-862-4840
MINNESOTA – Medicaid	Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-servies/medical-assistance.jsp	Phone: 1-800-657-3739
MISSOURI – Medicaid	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm	Phone: 1-573-751-2005

MONTANA – Medicaid	Website: http://dphhs.mt.gov/MontanaHealthPrograms/HIPP	Phone: 1-800-694-3084
NEBRASKA – Medicaid	Website: http://www.ACCESSNebraska.ne.gov	Phone: 1-855-632-7633 Lincoln: 1-402-473-7000 Omaha: 1-402-595-1178
NEVADA – Medicaid	Website: http://dwss.nv.gov/	Medicaid Phone 1-800-992-0900
NEW HAMPSHIRE – Medicaid	Website: http://www.dhhs.nh.gov/ombp/nhhpp/ Hotline: NH Medicaid Service Center	Phone: 1-603-271-5218 Phone: 1-888-901-4999
NEW JERSEY – Medicaid and CHIP	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ CHIP Website: http://www.njfamilycare.org/index.html	Medicaid Phone 1-609-631-2392 CHIP Phone 1-800-701-0710
NEW YORK – Medicaid	Website: http://www.health.ny.gov/health_care/medicaid/	Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	Website: https://dma.ncdhhs.gov/	Phone: 1-919-855-4100
NORTH DAKOTA – Medicaid	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/	Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	Website: http://www.insureoklahoma.org	Phone: 1-888-365-3742
OREGON – Medicaid	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html	Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm	Phone: 1-800-692-7462
RHODE ISLAND – Medicaid	Website: http://www.eohhs.ri.gov/	Phone: 1-855-697-4347
SOUTH CAROLINA – Medicaid	Website: http://www.scdhhs.gov	Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid	Website: http://dss.sd.gov	Phone: 1-888-828-0059
TEXAS – Medicaid	Website: http://gethipptexas.com/	Phone: 1-800-440-0493
UTAH – Medicaid and CHIP	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip	Phone: 1-877-543-7669
VERMONT – Medicaid	Website: http://www.greenmountaincare.org/	Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm	Medicaid Phone 1-800-432-5924 CHIP Phone 1-855-242-8282
WASHINGTON – Medicaid	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program	Phone: 1-800-562-3022 x.15473
WEST VIRGINIA – Medicaid	Website: http://mywvhipp.com/	Phone: 1-855-699-8447 (1-855-MyWVHIPP)

WISCONSIN – Medicaid and CHIP	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf	Phone: 1-800-362-3002
WYOMING – Medicaid	Website: https://wyequalitycare.acs-inc.com/	Phone: 1-307-777-7531

To see if any other states have added a premium assistance program since July 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
1-866-444-EBSA (3272)

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

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

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

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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 Human Resources.

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

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

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

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

Plan contact information:
Enviro Clean Services, LLC
Rosie Dominic, HR Director
525 Central Park Drive, Suite 402
Oklahoma City, Oklahoma 73105
405.842.1066

MEDICARE PART D NOTICE
Important Notice from Enviro Clean Services, LLC 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 Enviro Clean Services, LLC 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. **Enviro Clean Services, LLC** has determined that the prescription drug coverage offered by the Enviro Clean Services, LLC Blue Cross and Blue Shield of Oklahoma Medical Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.
However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current Enviro Clean Services, LLC coverage will not be affected. You can keep this coverage if you elect Part D, but the group health plan will not coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current Enviro Clean Services, LLC coverage, be aware that you and your dependents will be able to get this coverage back only during open enrollment or a special enrollment event.

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 Enviro Clean Services, LLC 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 Enviro Clean Services, LLC changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

►Visit www.medicare.gov

►Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help

►Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	**1.1.2019**
Name of Entity/Sender:	**Enviro Clean Services, LLC**
Contact-Position/Office:	**Rosie Dominic, HR Director**
Address:	**525 Central Park Drive, Suite 500**
	Oklahoma City, Oklahoma 73105
Phone:	**405.604.3339**

Disclaimers:

The amount the plan pays for covered services provided by non-network providers is based on a maximum allowable amount for the specific service rendered. Although your plan stipulates an out-of-pocket maximum for out-of-network services, please note the maximum allowed amount for an eligible procedure may not be equal to amount charged by your out-of-network provider. Your out of-network provider may bill you for the difference between the amount charged and the maximum allowed amount. This is called balance billing and the amount billed to you can be substantial. The out -of-pocket maximum outlined in your policy will not include amounts in excess of the allowable charge and other non-covered expenses as defined by your plan. The maximum reimbursable amount for non-network providers can be based on a number of schedules such as a percentage of reasonable and customary or a percentage of Medicare. The plan document or carrier's master policy is the controlling document, and this Benefit Highlight does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual plan language. Contact your claims payer or insurer for more information.

This booklet gives you an overview of the main features of your benefit plans. The plans are administered according to legal plan documents and insurance contracts. Although we have tried to summarize the provisions of these legal documents clearly and accurately, if any information contained herein conflicts with the legal documents, the legal documents will govern. For more detailed information on the plans and your legal rights under the plans, be sure to read the summary plan descriptions or request a copy of the plan documents. All benefits are subject to change from time to time and Enviro Clean Services, LLC reserves the right to amend or cancel any benefits described in this booklet, with or without notice.

IMPORTANT: This benefit guide is an outline of the coverages proposed by the carrier(s) based upon the information provided by your company. It does not include all the terms, coverages, exclusions, limitations, and conditions of the actual contract language. See the policies and contracts for actual language. This benefit guide is not a contract and offers no contractual obligation on behalf of GBS. Policy forms for your reference will be made available upon request.

This benefit summary prepared by

Gallagher

Insurance | Risk Management | Consulting