Welcome

Teleperformance USA believes that “happy employees make happy customers, which makes happy clients and happy shareholders.” We pride ourselves on our relationships with our clients and their customers. We also recognize that our employees are our key asset and the foundation upon which our company is built.

The comprehensive benefits package outlined in this enrollment guide is designed to support your health and financial security while allowing you to focus your energies on creating happy customers for our clients. You will see that the various plans provide different levels of coverage. Be sure to review them all carefully, keeping in mind that you can choose a combination of plans to get access to the type of care and protection you and your family need.

If you have questions or need a detailed explanation of any benefit, contact your local Human Resources Coordinator. These benefits are one of many ways that Teleperformance USA thanks you for choosing to share your talents and abilities with us. After all, it is your passion that drives the success of our company.

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Making Your Decisions is Easy and Convenient
As Open Enrollment approaches, TPUSA is pleased to announce that current benefit elections will carry over to 2017!*

*Please be aware that contribution elections for your HSA or FSA will not carry over and you will need to select new contributions for the 2017 plan year.

In order to confirm that all eligible employees have access to their benefits package, and to help ensure that TPUSA and its employees comply with certain requirements of the Affordable Care Act, we do still recommend that you review your current benefits to ensure you have your needs met and make necessary updates to your personal information.

If you wish to make any changes or enroll for the first time you can do so during Open Enrollment from November 1 - November 21, 2016. There are two ways to easily and conveniently accomplish this:

1) Log on to the TPUSA Benefits Portal: [https://my.adp.com](https://my.adp.com)
   (If a first time user please follow instructions provided in the ADP Experience user guide located on the benefits landing page at [www.tpusa-a1-benefits.com](http://www.tpusa-a1-benefits.com))

2) Call the TPUSA Benefits Enrollment Center: **1-877-TPUSA-03** M-F 8AM to 8PM EST. Be sure to have your User ID available when you call.
Here is a list of terms that will be helpful as you consider the options available to you:

**Coinsurance** – The percentages of the total medical bill that you and the plan pay; for example, if the plan pays 80% coinsurance for a covered service, you pay the remaining 20%.

**Copay** – A flat dollar amount that you pay for office and specialist visits.

**Deductible** – The amount you pay toward covered services each year before your medical plan begins to pay part of your medical bills. Generally, you will not have to pay a deductible for preventative care received from a network provider.

**Generic Drugs** – Generic drugs are approved by the U.S. Food and Drug Administration (FDA) as having the same effectiveness, quality, safety and strength as their brand-name counterparts. The one notable difference is that they cost less.

**Mail-Order Prescription Program** – A program that fills a 90-day prescription for long-term or maintenance medications. The mail-order program offers you a reduced out-of-pocket cost when compared to filling the same prescription at a retail pharmacy.

**Network** – A group of providers that offer services to participants in a health plan with negotiated rates.

**Out-of-Pocket Maximum** – The most you will pay each year (deductible and coinsurance) for covered medical expenses. However, reasonable and customary charges may still apply.

**Providers** – Providers in a network include doctors, hospitals or other health-care facilities.
Eligibility

Who is Eligible?
You are eligible to participate in the benefits program if you are a full-time employee of Teleperformance USA. Employees must work at least 30 hours a week to be eligible for insurance benefits.

Coverage Levels
You may choose from four coverage tiers for health benefits:

- Employee
- Employee + Spouse or Domestic Partner
- Employee + Child(ren)
- Family

Eligible Dependents
When you enroll yourself in the benefits program, you may also cover your eligible dependents. Eligible dependents include your:

- Legal spouse
- Domestic partner
- Dependent children up to age 26, regardless of student status, marital status, residence or financial dependence on you. For purposes of this plan, the term “child” is defined as:
  - Your natural child
  - A child for whom you are the legally-appointed guardian of with full financial responsibility
  - Your stepchild
  - Your legally adopted child or child placed with you for adoption
  - A child named in a Qualified Medical Child Support Order
  - Your child age 26 or older who is incapable of self-support because of a total physical or mental disability that occurred while covered under the plan.

New Hires
You become eligible on the first of the month following a 60 day waiting period, not to exceed 90 days of continuous employment.

Annual Enrollment
You may add, drop or make changes to your benefits each year during open enrollment, which takes place in November. You may also add or drop dependents. Elections you make during open enrollment remain in effect throughout 2017, unless you have a qualified change in status.

Changing Benefits During the Year
The benefit elections you make during open enrollment (or when you first enroll) remain in effect for the entire year. Some benefits, such as Allstate medical, dental, and voluntary products can be terminated at any point during the year. For others, you cannot change your elections unless you have a qualified change in status, including:

- Change in your marital status (marriage or divorce)
- Addition of a dependent (birth or adoption of a child)
- Death of a spouse or child
- Involuntary loss of your spouse’ eligibility for coverage under another benefit plan (as might result from termination of employment or a change in status, such as moving from full-time to part-time)
- You or your spouse goes on an unpaid leave of absence.

When you have a qualified event, you must notify Human Resources within 30 days of the date of your life event. Otherwise, you’ll have to wait until the next open enrollment period to change your benefits. You will be able to change your benefit elections as long as the change is consistent with your qualified life event. If adding new coverage or dependents, the change will be effective on the date of the qualified event. If canceling insurance due to a qualified event, the change will be effective the first of the month after the change occurs.
Making Your Choices

In reviewing your benefit plan options, you may want to consider the following:

- **Your family’s health care needs**: How often do you and your family see a doctor? What types of services do you typically require?

- **What medical expenses you incurred in the past**: Have you spent more on health care services than you anticipated? Which of the plans offered would give you the most value?

- **Other health care coverage available**: Are other family members enrolled in or eligible to enroll in another medical plan? If so, which plan offers the coverage that best meets your needs? How do the copayments, coinsurance, deductibles, out-of-pocket maximum and premium contributions compare? What amount of reimbursement would you receive from each plan if you were covered by more than one plan?

- **Your personal priorities**: Do you want the freedom to choose any provider? Are you willing to pay more out-of-pocket to visit your own doctor? Did you know that using in-network physicians generally means pre-negotiated costs and lower out-of-pocket expenses?

The Health Insurance Marketplace

While Teleperformance USA offers health insurance for the current plan year, there is also another way for you to purchase health insurance as part of Healthcare Reform Legislation. The Health Insurance Marketplace is available to help you find health insurance that meets your needs and fits your budget. The Marketplace, also known as an Exchange, offers “one-stop shopping” to find and compare private health insurance options.

While reviewing this guide, be sure to keep in mind that insurance options offered in the Marketplace rather than from Teleperformance USA might be a better fit for you; however, please note that if you do decide to waive Teleperformance USA’s medical offering and purchase coverage through the Marketplace, you will not be able to join the Teleperformance USA plan until next open enrollment for a January 1, 2018 effective date, unless you have a qualifying event such as birth, marriage, loss of other coverage, etc.

If you purchase a health plan through the Marketplace instead of accepting Teleperformance USA’s coverage, you will also lose Teleperformance USA’s contributions to your medical coverage. In addition, keep in mind that the amount you would pay for TPUSA’s coverage is paid for on a pre-tax basis, while your payments for coverage through the Marketplace would be made on an after-tax basis. Lastly, an individual is ineligible for a premium tax credit in the Marketplace if he / she is offered affordable, minimum value coverage through their employer.

**Please visit www.HealthCare.gov or www.getinsured.com/tpusa to learn more.**
As you may know, 2014 marked the first year where U.S. citizens could be charged with a penalty for not maintaining adequate medical insurance coverage. That penalty has continued to increase every year making it even more expensive to go without healthcare.

In 2017, Teleperformance is continuing to provide you with an opportunity to enroll in a Minimum Essential Coverage (MEC) plan through Ternian. This limited plan only covers the essential preventive requirements that are mandatory by law, and is not a comprehensive medical plan. However, it is very affordable and helps you satisfy the individual mandate. It also can be paired with one of the two Indemnity Medical plans offered through Allstate (see page 6) which together produce a more well-rounded yet still inexpensive benefit package.

There are 63 preventive services that must be covered at 100% without the individual having to pay a copayment or co-insurance. Please be aware this only applies when these services are delivered by a network provider.

The following are some examples of the most common of these preventive health services:

**Covered Services for Children/Adolescents**

**Well Child Exams**
- Physical Exam
- Vision Acuity Test
- Developmental & Behavioral Assessments

**Immunizations**
- Diptheria, Tetanus, Pertussis

**Screenings**
- Hearing Loss
- Lead Screening
- Depression Screening

**Covered Services for Adults**

**Annual Preventive Care Visit**
- Physical Exam

**Immunization**
- Hepatitis A & B
- Influenza (Flu)

**General Health Screenings**
- Blood Pressure
- Cholesterol Screening (based on age and other factors)
- Diabetes screening (only for adults with high blood pressure)

**Covered Services for Women Only**
- Prescription Contraceptives
- Osteoporosis Screening
- Breast Cancer Mammography

*Please note:* Please consult the plan documents for specific coverage and further plan details. The above statements to guarantee current or future coverage.

To find an in-network physician or facility, please call First Health PPO Network’s Customer Service at 800-226-5116 or search for a provider at: www.firsthealthlbp.com
The Allstate Indemity plans are low-cost options that cover some basic medical services and provide a defined benefit for other specific services. You can choose the low or high level of coverage. A benefit cost comparison of the two options is below.

**Special note regarding ACA:** The Allstate indemnity plans do not meet minimum essential coverage requirements by themselves, but can be paired with the Minimum Essential Coverage (MEC) plan offered by Ternian to create an affordable benefit package that meets the individual mandate of the Affordable Care Act while also giving you some first dollar coverage when you need it most (see page 24 for more details on ACA requirements).

<table>
<thead>
<tr>
<th>Medical Indemnity Coverage</th>
<th>Low</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospitalization</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Initial Hospitalization Confinement</td>
<td>$750</td>
<td>$1,000</td>
</tr>
<tr>
<td>• Daily Hospitalization Confinement</td>
<td>$300</td>
<td>$400</td>
</tr>
<tr>
<td>• Hospital Intensive Care</td>
<td>$300</td>
<td>$400</td>
</tr>
<tr>
<td><strong>Surgery and Related Benefits</strong></td>
<td>$60 to $1,500</td>
<td>$80 to $2,000</td>
</tr>
<tr>
<td>• Surgery</td>
<td>$25%</td>
<td>25%</td>
</tr>
<tr>
<td>• Anesthesia</td>
<td>$75</td>
<td>$100</td>
</tr>
<tr>
<td>• Inpatient Physician’s Treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient, Nursing, and Transportation</strong></td>
<td>$750</td>
<td>$1,000</td>
</tr>
<tr>
<td>• Outpatient Emergency Accident</td>
<td>$75</td>
<td>$100</td>
</tr>
<tr>
<td>• Outpatient Physician’s Treatment</td>
<td>$150</td>
<td>$200</td>
</tr>
<tr>
<td>• At Home Nursing</td>
<td>$450</td>
<td>$600</td>
</tr>
<tr>
<td>• Ambulance Services</td>
<td>$450</td>
<td>$600</td>
</tr>
<tr>
<td>• Non-local Transportation</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Wellness and Diagnostic</strong></td>
<td>$50</td>
<td>$100</td>
</tr>
<tr>
<td>• Outpatient Diagnostic X-ray and Laboratory</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Wellness and Preventative Test</td>
<td>$100</td>
<td>$200</td>
</tr>
<tr>
<td><strong>Prescription Drug</strong></td>
<td>$20 per day</td>
<td>$20 per day</td>
</tr>
</tbody>
</table>

This is a summary meant only for illustrative purposes and is not a guarantee of current or future benefits. Please consult the plan booklet for exact details.

Medical Indemnity coverage is provided by Limited Benefit Insurance. The coverage has limitations and exclusions. This information is incomplete without brochure ABJ19575X-4, which includes full details of the coverage. Allstate Benefits is the marketing name for American Heritage Life Insurance Company, a subsidiary of The Allstate Corporation.

**Allstate customer service:** 1-800-521-3535.

To learn more, watch this short video about the Group Indemnity Medical Plan.
Regence Medical / Cigna Dental

Teleperformance USA is continuing to offer the following medical plan options through Regence Blue Cross Blue Shield (BCBS):

- BluePoint 1000
- HSA Healthplan 3500
- HSA Healthplan 6250

All of these medical plans provide coverage for a wide range of health services, including preventative care, hospitalization, physician services and prescription drugs. On the following pages, you will find information about the plans so you can shop for the plan that is best suited to your needs. Your share of the cost for your medical plan coverage is paid on a pre-tax basis.

In addition, employees who elect the BluePoint 1000 or HSA Healthplan 3500 will automatically be enrolled in the bundled Cigna Dental Plan.

Use Network Providers to Lower Your Costs

Each of the plan options allows you to use out-of-network providers and receive benefits. It’s important to understand, however, that your costs will be lower and you’ll have fewer hassles when you use in-network providers. Here’s why:

- Network providers agree to charge lower rates for services.
- You do not need to file a claim when you see an in-network provider.

Comparing Your Medical Plan Options

While each of the Regence BCBS medical plans provides coverage for the same types of health care services, they differ in the deductibles and co-insurances you are responsible for. The higher the deductible the lower the amount the plan pays and the higher cost you pay for services. If you would like more detail, please refer to each plan’s Certificate of Coverage, which can be found on the TPUSA Benefits Portal.

How Benefits are Paid

**BluePoint 1000** – Preventive care is free. You pay health care costs up to the plan’s deductible. Once you meet the deductible, you pay co-insurance for health care costs. The plan pays the remaining balance. If the sum of your copays/ co-insurance reaches the out-of-pocket maximum the plan pays 100%.

The HSA Healthplans pay benefits in a different way than conventional medical plans, such as the BluePoint Plan. The following illustration is an example of cost-share with an HSA.

Preventive care is free. For all other covered services you pay 100% of health care costs until you reach your deductible. After that, you pay 20% co-insurance for in-network services until you reach the out-of-pocket maximum. Once you reach the out-of-pocket maximum the plan pays 100% of your in-network health care costs.

When you enroll in the HSA Healthplan, you have the option of opening a Health Savings Account (HSA) to help with deductible costs. If you elect to open an HSA with the HSA Healthplan 3500, TPUSA will contribute $50, $75, or $100 per month to your HSA depending on enrollment tier. You can also choose to contribute to your HSA. Any unused funds in your HSA will roll over to the next year.
2017 Regence Medical / Cigna Dental Benefit Plans Summary

The Medical Plan Summaries provide a brief overview of the benefits available in each of the medical plans. The amounts shown are the co-insurance that you would be responsible for, usually after the deductible (AD) is met. If you would like more detail, please refer to each plan’s Certificate of Coverage.

<table>
<thead>
<tr>
<th></th>
<th>BluePoint 1000</th>
<th>HSA Healthplan 3500</th>
<th>HSA Healthplan 6250</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductibles</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual: $1,000</td>
<td></td>
<td>Individual: $3,500</td>
<td>Individual: $6,250</td>
</tr>
<tr>
<td>Family: $3,000</td>
<td></td>
<td>Family: $7,000</td>
<td>Family: $12,500</td>
</tr>
<tr>
<td>Individual: $4,000</td>
<td></td>
<td>Individual: $6,250</td>
<td>Individual: $6,350</td>
</tr>
<tr>
<td>Family: $8,000</td>
<td></td>
<td>Family: $12,500</td>
<td>Family: $12,700</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximum</strong> (Includes deductible amount)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual: $2,000</td>
<td></td>
<td>Individual: $8,000</td>
<td>Individual: $6,250</td>
</tr>
<tr>
<td>Family: $6,000</td>
<td></td>
<td>Family: $16,000</td>
<td>Family: $12,500</td>
</tr>
<tr>
<td>Office Visits</td>
<td>$40 PCP / $40 Specialist*</td>
<td>45% AD</td>
<td>20% AD</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>30% AD</td>
<td>45% AD</td>
<td>20% AD</td>
</tr>
<tr>
<td>Ambulance Services</td>
<td>30% AD</td>
<td>30% AD</td>
<td>20% AD</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>30% AD</td>
<td>45% AD</td>
<td>20% AD</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>$200 Copay</td>
<td>$200 Copay</td>
<td>20% AD</td>
</tr>
<tr>
<td>Home Health (130 visits)</td>
<td>30% AD</td>
<td>45% AD</td>
<td>20% AD</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>30% AD</td>
<td>45% AD</td>
<td>20% AD</td>
</tr>
<tr>
<td>Hospital Services</td>
<td>30% AD</td>
<td>45% AD</td>
<td>20% AD</td>
</tr>
<tr>
<td>Maternity</td>
<td>30% AD</td>
<td>45% AD</td>
<td>20% AD</td>
</tr>
<tr>
<td>Mental Health/ Chemical Dependency</td>
<td>30% AD</td>
<td>45% AD</td>
<td>20% AD</td>
</tr>
<tr>
<td>• Inpatient</td>
<td>$40 Copay*</td>
<td>45% AD</td>
<td>20% AD</td>
</tr>
<tr>
<td>• Outpatient</td>
<td>30% AD</td>
<td>45% AD</td>
<td>20% AD</td>
</tr>
<tr>
<td>Neurodevelopmental Therapy (40 visits)</td>
<td>30% AD</td>
<td>45% AD</td>
<td>20% AD</td>
</tr>
<tr>
<td>Nutritional Counseling (3 visits)</td>
<td>30% AD</td>
<td>45% AD</td>
<td>20% AD</td>
</tr>
<tr>
<td>Diabetic, Anorexia, Bulimia Counseling</td>
<td>30% AD</td>
<td>45% AD</td>
<td>20% AD</td>
</tr>
<tr>
<td>Orthotics/Prosthesis</td>
<td>30% AD</td>
<td>45% AD</td>
<td>20% AD</td>
</tr>
<tr>
<td>Preventive Services/Immunizations</td>
<td>0%</td>
<td>45% AD</td>
<td>0%</td>
</tr>
<tr>
<td>Outpatient Radiology &amp; Laboratory ($600 Up Front Benefit**)</td>
<td>0%</td>
<td>0%</td>
<td>20% AD</td>
</tr>
<tr>
<td>Outpatient Radiology &amp; Laboratory (After the Up Front Benefit**)</td>
<td>30% AD</td>
<td>45% AD</td>
<td>20% AD</td>
</tr>
<tr>
<td>Rehabilitation - Inpatient (15 days)</td>
<td>30% AD</td>
<td>45% AD</td>
<td>20% AD</td>
</tr>
<tr>
<td>Rehabilitation - Outpatient (40 visits)</td>
<td>30% AD</td>
<td>45% AD</td>
<td>20% AD</td>
</tr>
<tr>
<td>Skilled Nursing Facility (60 days)</td>
<td>30% AD</td>
<td>45% AD</td>
<td>20% AD</td>
</tr>
<tr>
<td>Spinal Manipulations (limit of 20)</td>
<td>30% AD</td>
<td>45% AD</td>
<td>20% AD</td>
</tr>
<tr>
<td>TMJ</td>
<td>30% AD</td>
<td>45% AD</td>
<td>20% AD</td>
</tr>
<tr>
<td>Transplants</td>
<td>30% AD</td>
<td>45% AD</td>
<td>20% AD</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>$40 Copay*</td>
<td>45% AD</td>
<td>20% AD</td>
</tr>
<tr>
<td>Vision Exam</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Vision Hardware</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>
2017 Regence Medical / Cigna Dental Benefit Plans Summary (continued)

<table>
<thead>
<tr>
<th>Prescription</th>
<th>BluePoint 1000</th>
<th>HSA Healthplan 3500</th>
<th>HSA Healthplan 6250</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Retail</td>
<td>Mail Order</td>
<td>Retail</td>
</tr>
<tr>
<td>Deductible</td>
<td>$0</td>
<td>$0</td>
<td>Shared with Medical</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum</td>
<td>Shared with Medical</td>
<td>Shared with Medical</td>
<td>Shared with Medical</td>
</tr>
<tr>
<td>Generic</td>
<td>$15</td>
<td>$37.50</td>
<td>20%</td>
</tr>
<tr>
<td>Brand Name – Formulary</td>
<td>$40</td>
<td>$100</td>
<td>20%</td>
</tr>
<tr>
<td>Brand Name – Non-Formulary</td>
<td>$60</td>
<td>$150</td>
<td>20%</td>
</tr>
</tbody>
</table>

Please note: the prescription copay amounts shown above are for a 30-day supply.

<table>
<thead>
<tr>
<th>Dental</th>
<th>Cigna</th>
<th>Cigna</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Deductibles (applies to Type II and III Services)</td>
<td>$50 individual / $150 family</td>
<td>$50 individual / $150 family</td>
</tr>
<tr>
<td>Deductible waived for preventive</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Calendar Year Maximum</td>
<td>$1,500</td>
<td>$1,500</td>
</tr>
<tr>
<td>Type I Services: Preventative/Diagnostic (oral exams, cleanings, fluoride, sealants, x-rays)</td>
<td>100% coverage</td>
<td>100% coverage</td>
</tr>
<tr>
<td>Type II Services: Basic Restorative (fillings, extractions, anesthetics, oral surgery, root canals)</td>
<td>20% AD</td>
<td>20% AD</td>
</tr>
<tr>
<td>Type III Services: Major Restorative (crowns, bridges, dentures)</td>
<td>50% AD</td>
<td>50% AD</td>
</tr>
<tr>
<td>Type IV Services: Orthodontia (Children under the age of 19)</td>
<td>50% up to $1,500 Lifetime Maximum</td>
<td>50% up to $1,500 Lifetime Maximum</td>
</tr>
</tbody>
</table>

**Employees who enroll in the HSA Healthplan 6250 medical plan option may enroll in the Allstate dental plan explained on page 10.**

Please note: Out-of-network dental claims are reimbursed at 90% of reasonable and customary allowances.

This is a summary meant only for illustrative purposes and is not a guarantee of current or future benefits. Please consult the plan booklet for exact details.

**Prescription Drug Coverage:**

All Regence BCBS medical plans provide prescription drug coverage, including a mail-order program. When you fill your prescription at a participating retail pharmacy, you may purchase up to a 90-day supply of a covered drug. You will need to present your ID card at the pharmacy and make the required payment.

**Mail-order Program:**

If you use a maintenance drug, you may use the mail-order program to receive a 90-day supply of the drug at a reduced cost. To start, ask your doctor to provide a prescription for a 90-day supply of your medication, plus refills. Then order your prescription refills via the mail-order program.

**Access your CIGNA Dental ID card online at www.myCIGNA.com:**

- Log in
- Go to the main Dental page
- Click Print ID Card
Health Savings Account (HSA) / ADP

An HSA allows you to set aside tax-free payroll-deducted dollars that you can use to pay out-of-pocket medical expenses, now or in the future. For employees who participate in the HSA Healthplan 3500, TPUSA will help with these costs by contributing $50, $75, or $100 per month to your HSA depending on enrollment tier.

Please note: You must actively elect to participate in the HSA. You will not be automatically enrolled in the HSA if you select the HSA Healthplan 3500 or HSA Healthplan 6250.

Plan Eligibility

You must enroll in a High Deductible Health Plan (HSA Healthplan 3500 or HSA Healthplan 6250) to be eligible to participate in the HSA. In addition, in order to be eligible to participate in an HSA, you must not:

- Be claimed as a dependent on someone else’s tax return;
- Have other health plan coverage that provides benefits covered under the Choice Fund Plan (for example, a Health Care Flexible Spending Account, a separate prescription drug plan, or a spouse’s medical plan that covers you);
- Have a spouse with a Health Care Flexible Spending Account that could reimburse your medical expenses; nor
- Be enrolled in a government health plan, such as Medicare or Medicaid.

HSA Contributions

You do not need to make HSA contributions yourself to receive the TPUSA contribution. You may, however, choose to make pre-tax contributions to your HSA. The amount you are allowed to contribute is governed by federal law. For employees who elect individual coverage in 2017, the limit is $3,400; for family coverage, the limit is $6,750. If you are age 55 or older, you may make additional pre-tax catch-up contributions of up to $1,000 a year. Contribution amounts are generally indexed each year for inflation.

You can start, stop or change the amount of your HSA contributions prospectively anytime during the year. If you are married and your spouse is also enrolled in a separate high-deductible health plan, your combined HSA contributions cannot exceed the federal maximum for HSA contributions noted above.

<table>
<thead>
<tr>
<th>Health Savings Account</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2017 TPUSA Contribution</strong> (HSA Healthplan 3500 only)</td>
</tr>
<tr>
<td>Contribution Limit</td>
</tr>
<tr>
<td>Eligible Expenses</td>
</tr>
</tbody>
</table>

HSAs also have triple-tax favored status:

- Employee contributions are tax free reducing your taxable income.
- Distributions of HSA balances are tax free when used to cover qualified health care expenses.
- HSA balances grow tax free.

HSAs offer flexibility. You can:

- Carry forward the balances from year-to-year: no “use-it-or-lose-it” rule applies.
- Take HSA balances with you when you leave the company and continue to use the available balance to pay for qualified health care expenses.
- Use the HSA as a financial planning vehicle—invest a portion or all of your balance once you accumulate $2,000.

For HSA assistance, contact the ADP Participant Service Center: 888-557-3156; M-F 8am - 8pm ET

https://myspendingaccount.adp.com
Group PPO Dental* Benefits offered through Allstate Benefits

For employees who do not enroll in the BluePoint 1000 or HSA Healthplan 3500, we are pleased to offer Group PPO Dental through Allstate Benefits. This is available to all employees, regardless of whether you enroll in a medical plan or not.

Like the plan provided through Cigna, the Allstate plan provides coverage for exams, X-rays, cleanings, fillings and major dental work such as crowns and bridges as well as orthodontic services. You may use any dental provider under the plan, but your out-of-pocket costs will be less if you use an in-network provider.

Consider your dental needs for 2017, use the charts below to compare coverages and costs, and determine which option best suits your needs.

2017 Dental Care Plan Options Summary

<table>
<thead>
<tr>
<th>In-network and Out-of-network</th>
<th>Group PPO Dental Uses DentalGuard Preferred Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductibles</strong> (applies to Type II and III Services)</td>
<td>$50 individual / $100 family</td>
</tr>
<tr>
<td><strong>Deductible waived for preventive</strong></td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Calendar Year Maximum</strong></td>
<td>$1,000</td>
</tr>
<tr>
<td><strong>Type I Services:</strong> Preventative/Diagnostic (oral exams, cleanings, fluoride, sealants, x-rays)</td>
<td>100% coverage</td>
</tr>
<tr>
<td><strong>Type II Services:</strong> Basic Restorative (fillings, extractions, anesthetics, oral surgery, root canals)</td>
<td>80% after deductible</td>
</tr>
<tr>
<td><strong>Type III Services:</strong> Major Restorative (crowns, bridges, dentures)</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Type IV Services:</strong> Orthodontia (Children under the age of 19)</td>
<td>50%, to a lifetime maximum of $1,000 (children only)</td>
</tr>
</tbody>
</table>

This is a summary meant only for illustrative purposes and is not a guarantee of current or future benefits. Please consult the plan booklet for exact details. Please note: Type III (Major) and Type IV (Orthodontia) services in the chart shown above have a 12 month waiting period which may be partially or completely waived.

* Group PPO Dental (DentalGuard®) is underwritten by The Guardian Life Insurance Company of America and offered through Allstate Benefits. DentalGuard® is a registered servicemark of The Guardian Life Insurance Company of America (“Guardian”), used with permission. Guardian is not responsible for the statements in this material. Allstate Benefits is authorized to offer certain DentalGuard® policies underwritten by Guardian, however Allstate Benefits is not an affiliate or related entity of Guardian.

Access your dental ID card online at www.GuardianAnytime.com:
• Click ID Cards on the member landing page
• You will be directed to the Obtain Forms and Materials tab
• View or print your ID card
The vision care plan is a benefit that can help keep your eyes healthy and identify other health problems should they occur. The plan pays for both in-network and out-of-network services and is administered by Ameritas. When you visit an in-network vision care provider, benefits are greater and there are no claim forms to file. As a plan participant, you’ll also receive access to discounts on many vision care services and products. Please note that if you choose to use an out-of-network provider, you will be responsible for filing claims at the scheduled amounts listed on the charts below.

### 2017 Vision Care Plan Summary

<table>
<thead>
<tr>
<th></th>
<th><strong>In-Network</strong></th>
<th><strong>Out-of-Network</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductibles</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$25 Exam</td>
<td></td>
<td>$25 Exam</td>
</tr>
<tr>
<td>$25 Eye Glass Lenses or Frames</td>
<td></td>
<td>$25 Eye Glass Lenses or Frames</td>
</tr>
<tr>
<td><strong>Annual Eye Exam</strong> (once every 12 months)</td>
<td>Covered in full</td>
<td>Up to $45</td>
</tr>
<tr>
<td><strong>Frames</strong> (Once every 24 months)</td>
<td>$100</td>
<td>Up to $70</td>
</tr>
<tr>
<td><strong>Lenses</strong> – (Once every 12 months)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Single vision</td>
<td>Covered in full</td>
<td>Up to $30</td>
</tr>
<tr>
<td>• Bifocal</td>
<td>Covered in full</td>
<td>Up to $50</td>
</tr>
<tr>
<td>• Trifocal</td>
<td>Covered in full</td>
<td>Up to $65</td>
</tr>
<tr>
<td>• Lenticular</td>
<td>Covered in full</td>
<td>Up to $100</td>
</tr>
<tr>
<td><strong>Contacts</strong> – (Once every 12 months)</td>
<td>Member cost up to $60</td>
<td>No benefit</td>
</tr>
<tr>
<td>• Fit and Follow Up Exams</td>
<td>Up to $115</td>
<td>Up to $105</td>
</tr>
<tr>
<td>• Elective</td>
<td>Covered in full</td>
<td>Up to $210</td>
</tr>
<tr>
<td>• Medically Necessary</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Eye Care Plan Member Service**

**VSP Call Center:** 1-800-877-7195

*Service representative hours:*
5 a.m. to 7 p.m. PST Monday through Friday, 6 a.m. to 2:30 p.m. PST Saturday

*Interactive Voice Response available 24/7*

Locate a VSP provider at: [www.ameritasgroup.com/member](http://www.ameritasgroup.com/member)

View plan benefit information at: [www.vsp.com](http://www.vsp.com)
Accident Insurance can help your family cover unexpected out-of-pocket expenses and supplement lost income due to a covered off-job accident. Accident Insurance covers a wide range of injuries and accident-related expenses such as hospitalization, emergency room visits, physical, occupational and speech therapy, accidental death and catastrophic accidents.

**Please Note:** Coverage is portable - you may take the coverage with you if you leave the company or retire. This is a limited policy. Please refer to the limitations and exclusions for more details.

### Sample Coverage and Benefit

<table>
<thead>
<tr>
<th>Treatment, services, and covered injuries</th>
<th>Benefit Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Room Treatment</td>
<td>$400</td>
</tr>
<tr>
<td>Emergency treatment in physician office/urgent care facility</td>
<td>$200</td>
</tr>
<tr>
<td>Hospital admission</td>
<td>$1,500</td>
</tr>
<tr>
<td>Hospital confinement (up to 365 days per covered accident)</td>
<td>$300</td>
</tr>
<tr>
<td>Medical Imaging Test (X-Ray)</td>
<td>$400</td>
</tr>
<tr>
<td>Physician follow-up visit (Up to 2 visits)</td>
<td>$50</td>
</tr>
<tr>
<td>Chiropractic Visit (up to 6 visits per calendar year)</td>
<td>$60</td>
</tr>
<tr>
<td>Physical/Occupational/Speech Therapy (6 per accident)</td>
<td>$60</td>
</tr>
<tr>
<td>Major Fractures / Dislocations</td>
<td>Up to $8,000</td>
</tr>
<tr>
<td>Accidental Death</td>
<td></td>
</tr>
<tr>
<td>• Employee</td>
<td></td>
</tr>
<tr>
<td>• Spouse</td>
<td></td>
</tr>
<tr>
<td>• Child</td>
<td>$60,000 for all</td>
</tr>
</tbody>
</table>

This is a summary meant only for illustrative purposes and is not a guarantee of current or future benefits. Please consult the plan booklet for exact details.

### Accident Premiums

<table>
<thead>
<tr>
<th></th>
<th>Semimonthly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$5.23</td>
</tr>
<tr>
<td>Employee &amp; Spouse</td>
<td>$12.14</td>
</tr>
<tr>
<td>Employee &amp; Child(ren)</td>
<td>$19.13</td>
</tr>
<tr>
<td>Family</td>
<td>$24.49</td>
</tr>
</tbody>
</table>

To learn more, watch this short video on **Group Voluntary Accident Plan**
Critical Illness insurance can pay a $10,000, $20,000, or $30,000 lump sum benefit at the diagnosis of a specified disease. Benefits are paid directly to you to use any way you see fit.

- Includes a Recurrence Benefit which provides an additional payout for a second occurrence of an initial critical illness for which a benefit was previously paid. Initial and subsequent diagnoses must be separated by at least 12 months.
- Health Screening Benefit – Allstate will pay a health screening benefit of $50 upon submission of proof that a covered test was taken. This benefit can be paid out once per covered person per calendar year.
- Covered Spouses and Children are eligible for 50% of the insured employee benefit amount.
- Does not include a pre-existing condition limitation.
- Rates are calculated based on age, policy amount and smoker status.
- This is a limited policy. Please refer to the Summary Plan Description for more details, any exclusions and policy limitations.
- Rates are based on issue age and will not increase for as long as you are enrolled on the plan.

<table>
<thead>
<tr>
<th>Covered Conditions</th>
<th>Initial Benefit (First occurrence after effective date)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Invasive Cancer</td>
<td>100% of Benefit Amount</td>
</tr>
<tr>
<td>Carcinoma in Situ (non-invasive cancer)</td>
<td>25% of Benefit Amount</td>
</tr>
<tr>
<td>Heart Attack</td>
<td>100% of Benefit Amount</td>
</tr>
<tr>
<td>Stroke</td>
<td>100% of Benefit Amount</td>
</tr>
<tr>
<td>Coronary Artery Bypass Surgery</td>
<td>25% of Benefit Amount</td>
</tr>
<tr>
<td>Kidney Failure</td>
<td>100% of Benefit Amount</td>
</tr>
<tr>
<td>Major Organ Failure</td>
<td>100% of Benefit Amount</td>
</tr>
<tr>
<td>Permanent Paralysis as the result of a covered accident</td>
<td>100% of Benefit Amount</td>
</tr>
<tr>
<td>Coma as the result of Severe Traumatic Brain Injury</td>
<td>100% of Benefit Amount</td>
</tr>
<tr>
<td>Blindness</td>
<td>100% of Benefit Amount</td>
</tr>
<tr>
<td>Benign Brain Tumor</td>
<td>100% of Benefit Amount</td>
</tr>
</tbody>
</table>

This is a summary meant only for illustrative purposes and is not a guarantee of current or future benefits. Please consult the plan booklet for exact details.

<table>
<thead>
<tr>
<th>Age Band</th>
<th>Non Tobacco User</th>
<th>Tobacco User</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>EE, EE &amp; Ch</td>
<td>EE &amp; Sp, Family</td>
</tr>
<tr>
<td>18-29</td>
<td>$2.67</td>
<td>$4.32</td>
</tr>
<tr>
<td>30-39</td>
<td>$4.68</td>
<td>$7.33</td>
</tr>
<tr>
<td>40-49</td>
<td>$8.54</td>
<td>$13.11</td>
</tr>
<tr>
<td>50-59</td>
<td>$15.04</td>
<td>$22.87</td>
</tr>
<tr>
<td>60-63</td>
<td>$24.36</td>
<td>$36.86</td>
</tr>
<tr>
<td>64+</td>
<td>$31.85</td>
<td>$48.08</td>
</tr>
</tbody>
</table>

$10,000 Benefit Semimonthly Premium
(With Cancer and Wellness Benefit)

To learn more, watch this short video on Group Voluntary Critical Illness Plan
**Allstate Disability Coverage**

**Disability Insurance (Agents Only)**

Many people live paycheck to paycheck. In the event of a covered injury or illness (including pregnancy*) occurring, Short-Term Disability Insurance (STD) replaces part of your income if the ailment causes you to temporarily be away from work. Disability benefits through Allstate begin after you have been disabled either due to an illness or injury for at least seven (days). Upon approval, you then may be eligible for up to a three (3) month benefit period for which you will be paid a portion of your income even though you are missing work. Rates may depend on variables such as state of age, salary, and benefit amount.

Please reference the TPUSA Benefits Portal for more information about the plan design and premiums.

* Must have prior coverage or have been covered by Allstate for 9 months or more before pregnancy will be covered.

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**Allstate Term Life Insurance**

Term life insurance provides consistent coverage with premiums and benefits that won’t change as you grow older. The Term to 100 Life Insurance pays a lump-sum cash benefit when you die before age 100.

Other features:

- No physical exam — During your initial enrollment, most individuals can get this insurance up to a specified amount without a health exam.* You may be asked a few health questions.
- The policy is yours — The payment is deducted from your paycheck and coverage becomes effective the first day of the month. You can keep the policy even if you leave or retire; Allstate will bill you directly for the same premium amount.
- You can purchase policies for your spouse and eligible children.
- Life-event riders can be added to provide additional coverage.
- Rates are based on your age, tobacco status and the policy amount you elect and should not change.
- Please refer to the plan documents for more details and any limitations and exclusion.

* An exam or other evidence of insurability requirements may be needed dependent on age and other factors.
Flexible Spending Accounts (FSAs) are voluntary accounts that allow you to set aside pre-tax money for certain health and dependent care expenses. These are two separate accounts for two separate purposes. The monies in one account cannot be used to satisfy expenses in the other account. You can choose to participate in neither one or both of these accounts, depending on what is best for you. ADP is the new claims administrator for the FSA’s beginning on 1/1/2017.

When you enroll in an FSA, you choose the annual amount you want to contribute, up to certain plan limits. This amount is deducted from your paycheck in equal installments before federal and Social Security taxes are withheld. It’s a great way to save, but keep in mind that these are “use-it or lose-it” accounts, which means you forfeit any unused balances in your FSAs in excess of $500 which can be rolled over to the following year, but you must remain enrolled in the FSA to keep rollover money. Be sure to budget on the conservative side to avoid losing money. Keep in mind that you cannot change your election unless you have a qualifying life event.

Health Care FSA

Plan Eligibility
Your Health Care FSA is used to pay for eligible medical, dental, vision and other health care expenses that you incur. In general, an eligible dependent under the Health Care FSA is anyone you list as a dependent on your federal income tax return. You can, however, use the funds for children who are not your tax dependents up through the month they turn age 26.

Using your FSA
You may pay for eligible health care expenses in one of two ways: using the FSA Debit Card or filing a manual claim. Use your debit card for copays and to purchase services and supplies from certified merchants. If you wish to file a claim for reimbursement, the FSA claim form is available by visiting the website or calling customer service. You will need to provide proof of your expenses to ADP.

<table>
<thead>
<tr>
<th>2017 FSA Annual Contribution Limit</th>
<th>Up to $2,600</th>
</tr>
</thead>
</table>
| Eligible Expenses                  | • Out-of-pocket medical, dental and vision costs, such as deductibles and co-payments  
• Prescription drug co-payments   
• Over-the-counter medicine (prescribed by a physician)  
• Non-covered medical, dental, vision and hearing care expenses  
• In certain cases, substantiation of claims may be required |
| Rollover                           | Up to $500 of unused funds to the following year  
Please note: you MUST remain enrolled in the FSA in order to keep rollover funds. If changing to an HSA, you will forfeit any unused funds. |
| Claims Deadline                    | Claims must be submitted by February 26, 2018 (60 days to submit) |

Please note: With the administrator change to ADP, you will receive new FSA debit cards after January 1, 2017.
Dependent Care FSA

Contributions
You may contribute up to $5,000 per year to the Dependent Care FSA. This annual maximum applies to all contributions made by you and your spouse to a dependent care account. If you are married and filing separately for federal income tax purposes, you may elect to contribute up to $2,500 per year.

Eligible dependents include:
- Your dependent child(ren) under age 13 who lives with you for more than half the year and for whom you can claim an exemption
- A child under age 13 for whom you have custody if you are divorced or legally separated
- Your spouse who is physically or mentally incapable of self-care
- A dependent of any age, such as an elderly parent or other adult dependent, who meets all of the following criteria:
  - Is physically or mentally incapable of caring for himself or herself,
  - Receives over half of his or her support from you,
  - Lives with you for more than half the year, and
  - Is your sibling, step-sibling or any of their descendants; a parent or step-parent or any of their ancestors; an aunt, uncle, niece, or nephew; children or parents-in-law; or an unrelated individual who shares your residence as a member of the household.

Eligible dependent care expenses
If your dependent care services are necessary to allow you and your spouse to work, you can be reimbursed for these expenses incurred in a plan year. Eligible expenses include:
- Before-and after-school programs
- Day care (child and adult)
- Nursery school or preschool
- Summer day camps

These services may be provided inside or outside your home by babysitters, companions or eligible day care centers. Services may not, however, be provided by someone you claim as a dependent on your tax return.

Paying your eligible expenses
You must pay your dependent care provider directly and then file a claim for reimbursement. Complete a Dependent Care FSA claim form and submit it to ADP along with your receipts. Make sure the receipts include service dates and your provider’s taxpayer identification number.

You have until March 1 of the following year to submit claims for eligible expenses incurred during the prior year.

Please note: If you separate from service with Teleperformance USA, you can only claim a monthly amount after each month you incur expenses. You have until the end of the calendar year to submit claims for reimbursement.

For FSA customer service, please contact ADP at 888-557-3156 or https://myspendingaccount.adp.com.
With Metlife’s Auto & Home group insurance, you will have access to value-added features and benefits, including special group discounts on auto and home insurance, as well as a variety of other insurance policies. And as part of your workforce benefits program, you could save hundreds of dollars:

- Save up to an additional 10% right away with a Welcome Discount for NEW customers
- Qualify for a group discount of up to 15% off your policy
- Earn an additional discount when you pay your premium through automatic bank account deduction
- Receive extra savings if you’ve been with your company for a long time
- Save more with our superior driver discount
- Choose from a variety of insurance policies to meet your coverage needs including personal excess liability, boat, condo, renter’s, motor home, recreational vehicle and motorcycle.

Since everyone’s insurance policies renew at different times during the year, you may apply for group auto and home insurance any time after January 1, 2017. And coverage is 100% portable, so even if you change jobs you can take your policy with you. Take advantage of ALL your company benefits and start saving. Call 1 800 GET-MET 8 today to get started!
Although not part of your annual benefits enrollment, while you’re on the subject of benefits, you might want to review your 401(k) plan account. Keep in mind the following features of the plan:

- TPUSA offers discretionary matching contributions when you save in the plan.
- You can invest in one or a combination of professionally managed investment funds; or you may select to direct your own investments via a brokerage account.
- You are immediately 100% vested in your own contributions to the account.
- The plan vests 25% per year for four years.
- You may change your investment elections or stop payroll contributions at any time.
- Contribution amounts can only be changed during the scheduled quarterly enrollment periods.

Who Can Participate?
Participation in the elective deferral portion of the Plan is open to employees who have met the following requirements:

- Attained age 21
- Completed 3 months of service, as defined by the Plan
- All current employees are eligible to participate in the employer match on elective deferrals portion of the Plan

How Do I Enroll?
Visit empower.com or contact human resources to learn more.

How Much Can I Contribute to the Plan?
As of 2017, you may contribute as much as $18,000, in total, to all 401(k) accounts. If you are over age 50, you may make additional catch-up contributions up $6,000.

When Can Money Be Withdrawn from My Plan Account?
Money may be withdrawn from your Plan account under the following circumstances:

- You are attaining age 59 ½ and are fully vested in your account
- Death
- Disability
- Hardship**
- Termination of Employment

* 401(k) Plan details do not apply to employees located in the Hobart, IN and Naperville, IL locations.

** See your Summary Plan Description for more information.
All contributions for TPUSA below are shown in semimonthly rates.

### Regence Blue Cross Medical Premiums (Employees based outside of Utah)

<table>
<thead>
<tr>
<th></th>
<th>BluePoint 1000*</th>
<th>HSA Healthplan 3500*</th>
<th>HSA Healthplan 6250</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$135.00</td>
<td>$100.00</td>
<td>$70.00</td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$367.50</td>
<td>$272.50</td>
<td>$362.50</td>
</tr>
<tr>
<td>Employee + Children</td>
<td>$235.00</td>
<td>$175.00</td>
<td>$187.50</td>
</tr>
<tr>
<td>Family</td>
<td>$495.00</td>
<td>$370.00</td>
<td>$515.00</td>
</tr>
</tbody>
</table>

*Contribution amount includes Cigna dental contribution.

### Regence Blue Cross Medical Premiums (Utah-based employees)

<table>
<thead>
<tr>
<th></th>
<th>BluePoint 1000*</th>
<th>HSA Healthplan 3500*</th>
<th>HSA Healthplan 6250</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$142.50</td>
<td>$105.00</td>
<td>$70.00</td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$390.00</td>
<td>$295.00</td>
<td>$362.50</td>
</tr>
<tr>
<td>Employee + Children</td>
<td>$250.00</td>
<td>$190.00</td>
<td>$187.50</td>
</tr>
<tr>
<td>Family</td>
<td>$525.00</td>
<td>$390.00</td>
<td>$515.00</td>
</tr>
</tbody>
</table>

*Contribution amount includes Cigna dental contribution.

### Allstate Medical Indemnity Plans

<table>
<thead>
<tr>
<th></th>
<th>Low</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$29.21</td>
<td>$45.34</td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$61.68</td>
<td>$85.74</td>
</tr>
<tr>
<td>Employee + Children</td>
<td>$57.47</td>
<td>$79.26</td>
</tr>
<tr>
<td>Family</td>
<td>$89.12</td>
<td>$118.44</td>
</tr>
</tbody>
</table>

### Minimum Essential Coverage (MEC) Plan

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$22.00</td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$31.00</td>
</tr>
<tr>
<td>Employee + Children</td>
<td>$31.00</td>
</tr>
<tr>
<td>Family</td>
<td>$43.00</td>
</tr>
</tbody>
</table>

### Group PPO Dental Plan*

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$9.45</td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$18.61</td>
</tr>
<tr>
<td>Employee + Children</td>
<td>$24.83</td>
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<tr>
<td>Family</td>
<td>$35.05</td>
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### Ameritas Vision Plan

<p>| | |</p>
<table>
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<tr>
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<tbody>
<tr>
<td>Employee Only</td>
<td>$2.55</td>
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<tr>
<td>Employee + 1 Dependent</td>
<td>$4.87</td>
</tr>
<tr>
<td>Employee + 2 or more Dependents</td>
<td>$6.87</td>
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* Group PPO Dental (DentalGuard®) is underwritten by The Guardian Life Insurance Company of America and offered through Allstate Benefits. DentalGuard® is a registered servicemark of The Guardian Life Insurance Company of America (“Guardian”), used with permission. Guardian is not responsible for the statements in this material. Allstate Benefits is authorized to offer certain DentalGuard® policies underwritten by Guardian, however Allstate Benefits is not an affiliate or related entity of Guardian.
<table>
<thead>
<tr>
<th>Benefit</th>
<th>Provider</th>
<th>Phone</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>For questions or to enroll</td>
<td></td>
<td>877-TPUSA-03</td>
<td><a href="https://my.adp.com">https://my.adp.com</a></td>
</tr>
<tr>
<td>Medical</td>
<td>Regence Blue Cross Blue Shield</td>
<td>877-508-7360</td>
<td><a href="http://www.regence.com">http://www.regence.com</a></td>
</tr>
<tr>
<td>HSA</td>
<td>ADP</td>
<td>800-678-6684</td>
<td><a href="https://myspendingaccount.adp.com">https://myspendingaccount.adp.com</a></td>
</tr>
<tr>
<td>Dental</td>
<td>Cigna</td>
<td>800-244-6224</td>
<td><a href="http://www.myCigna.com">www.myCigna.com</a></td>
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<tr>
<td>Dental (Allstate)</td>
<td>Guardian</td>
<td>800-541-7846</td>
<td><a href="http://www.guaridananytime.com">www.guaridananytime.com</a></td>
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<tr>
<td>Vision</td>
<td>Ameritas</td>
<td>800-877-7195</td>
<td>Locate a VSP provider at:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>View plan benefit information at:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><a href="http://www.vsp.com">www.vsp.com</a></td>
</tr>
<tr>
<td>FSA</td>
<td>ADP</td>
<td>800-678-6684</td>
<td><a href="https://myspendingaccount.adp.com">https://myspendingaccount.adp.com</a></td>
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<td>MEC Plan</td>
<td>Ternian</td>
<td>800-964-7096</td>
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<td>Indemnity Medical</td>
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<td><a href="http://www.allstatebenefits.com/mybenefits">www.allstatebenefits.com/mybenefits</a></td>
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<td>Critical Illness</td>
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<td>Short Term Disability</td>
<td>Allstate</td>
<td>800-521-3535</td>
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<td>Term Life</td>
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<td></td>
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<tr>
<td>Group Short Term Disability</td>
<td>Unum</td>
<td>800-858-6843</td>
<td><a href="http://www.unum.com">www.unum.com</a></td>
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<td>Long Term Disability</td>
<td>Unum</td>
<td>800-445-0402</td>
<td><a href="http://www.unum.com">www.unum.com</a></td>
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<tr>
<td>Supplemental Life Insurance</td>
<td>Unum</td>
<td>800-338-4015</td>
<td><a href="http://www.empower-retirement.com">www.empower-retirement.com</a></td>
</tr>
<tr>
<td>401(k)</td>
<td>Empower Retirement</td>
<td>800-338-4015</td>
<td></td>
</tr>
<tr>
<td>Auto and Home</td>
<td>MetLife</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

GetInsured
Considering purchasing healthcare through the Health Insurance Marketplace? GetInsured is a great resource to help you understand and shop for health insurance. Learn more today!

Visit: www.getinsured.com/tpusa
**Affordable Care Act (ACA) – Frequently Asked Questions**

**Employees Eligible for the Company-Sponsored Medical Plan**

**Q. What is the Affordable Care Act?**

**A.** The Patient Protection and Affordable Care Act, commonly called the Affordable Care Act (ACA) is a United States federal statute signed into law by President Obama in March 2010.

The ACA includes subsidies, health insurance exchanges, and mandates, including an individual mandate that, with certain exceptions, requires all individuals as of January 1, 2014 to have health insurance or pay a penalty. The law includes subsidies to help individuals with low incomes comply with the mandate. Coverage through the health insurance exchange is guaranteed; even if you have a pre-existing medical condition, your cost for coverage will be the same as all other applicants of the same age living in the same geographic location.

**Q. Who is required to have health insurance?**

**A.** As of January 1, 2014, all Americans – with some exceptions – are required to have medical insurance coverage or incur a penalty. Qualified health insurance plans that meet the ACA requirements may include:
- Government-sponsored plans, such as:
  - Medicare or Medicaid
  - Children’s Health Insurance Program (CHIP)
  - TRICARE
- Veterans health care programs
- Employer-based or sponsored health care plans – the Transamerica Limited Benefit Hospital Indemnity Insurance is NOT considered qualified health insurance
- Individual private coverage

**Q. Will Teleperformance USA continue to offer medical coverage in 2017?**

**A.** Yes, we will continue to offer medical coverage to eligible employees and their eligible family members in 2017.

**Q. What is the health insurance exchange?**

**A.** The health insurance exchange, sometimes called the Exchange or Marketplace, is a resource where individuals can learn about private health coverage options, compare private health insurance plans, and enroll in private health insurance coverage. The health insurance exchange also provides information on programs that help individuals with low to moderate incomes, and resources to pay for private health insurance coverage.

You can get help online at www.healthcare.gov, or call 1-800-318-2596, 24 hours a day, 7 days a week.

**Newborns’ and Mothers’ Health Protection Act**

Under federal law, health care plans may not restrict any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal 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 and with the mother’s consent, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

**Continued Coverage Under COBRA**

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you and your covered dependents may be able to continue your medical and dental coverage if you lose your health care coverage as the result of certain qualifying events. Contact the Human Resources Department for more information.

**Women’s Health and Cancer Rights Act of 1998**

Under the Women’s Health and Cancer Rights Act, group health plans must make certain benefits available to participants of health plans who have undergone a mastectomy. In particular, a plan must offer mastectomy patients benefits for:
- Reconstruction of the breast on which the mastectomy was performed
- Any necessary surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical conditions related to the mastectomy, including lymphedema.

Our medical plans comply with these requirements. Benefits for these items are similar to those provided under the plan for similar types of medical services and supplies.
HIPAA Regulations Help to Protect Your Privacy
The privacy provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) help to ensure that your health care-related information stays private. New employees will receive a Privacy Practice Notice which outlines the ways in which the medical plan may use and disclose protected health information (PHI). The notice also describes your rights. For more information, contact the Human Resources Department.

Your Rights under Michelle’s Law
Effective January 1, 2010, full-time students covered under the group health plan, that would otherwise lose eligibility under the plan because of a reduction in their full-time class status due to a medically necessary leave of absence from school, may be eligible to extend their coverage under the plan for up to one year, or to age 26, whichever occurs first. The child must be a dependent child of a plan participant and be enrolled in the company group health plan on the basis of being a student at a postsecondary educational institution immediately before the first day of the leave.

Mental Health Parity
Effective January 1, 2010, the Company sponsored medical plans were modified to cover mental health and substance abuse expenses subject to the same treatment limits, deductibles, copayments, co-insurance and out-of-pocket requirements that apply to other medical and surgical expenses. This change applies to both inpatient and outpatient services.

Children’s Health Insurance Program Reauthorization Act of 2009 (CHIP)
Signed into expand state CHIP eligibility to more children and expectant mothers with an extended 60-day time frame to coordinate any changes to employer health elections in the event of gain or loss of eligibility and/or a subsidy under Medicaid or CHIP.

Uniformed Services Employment and Reemployment Rights Act (USERRA)
USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services. The Act also states that if an employee leaves their job to perform military service, they have the right to elect to continue existing employer-based health plan coverage for the employee and their eligible dependents for up to 24 months while in the military. Even if the employee doesn’t elect to continue coverage during their military service, they have the right to be reinstated in their employer’s health plan when they are reemployed, generally without any waiting periods or exclusions (e.g. pre-existing condition exclusions) except for service-connected illnesses or injuries.

Notice of HIPAA Special Enrollment Rights
If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, 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 towards 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).

In Addition, 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 dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact Human Resources at (508) 999-9920.

Termination of Health Coverage for Cause, Including Fraud or Intentional Misrepresentation
P.A.C.E. reserves the right to terminate health care coverage for you and/or your dependent prospectively without notice for cause (as determined by the Plan Administrator), or if you and/or your dependent are otherwise determined to be ineligible for coverage under the plan. In addition, if you or your covered dependent commits fraud or intentional misrepresentation in an application for health coverage under the plan, in connection with a benefit claim or appeal, or in response to any request for information by P.A.C.E. or its delegates (including the Plan Administrator or a claims administrator), the Plan Administrator may terminate your coverage retroactively upon 30-days’ notice.

Failure to inform any of such persons that you or your dependents are covered under another group health plan or knowingly providing false information in order to obtain or continue coverage for an eligible dependent are examples of actions that constitute fraud under the plan.
Important Notice from Teleperformance USA 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 Teleperformance USA 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. Teleperformance USA has determined that the prescription drug coverage offered by the Regence 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.

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 Teleperformance USA coverage will not be affected. If you or your dependents are Medicare Part D eligible, there are certain options available to you:

- Retain your existing coverage and choose not to enroll in a Part D plan; or
- Enroll in a Part D plan as a supplement to your existing coverage with Teleperformance USA. Note: Information about the prescription drug plan provisions/options available to Medicare Part D eligible individuals is available at http://www.cms.hhs.gov/CreditableCoverage/

If you do decide to join a Medicare drug plan and drop your current Teleperformance USA coverage, be aware that you and your dependents will be able to get this coverage back during the qualified life event or the annual open enrollment period for Teleperformance USA group plan.

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 Teleperformance USA 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.

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.

Additional Information
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 Teleperformance USA 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)

Name of Entity/Sender: Teleperformance USA
Contact–Position/Office: Chelsey Donis, Benefits Coordinator
Address: 4335 Equity Drive, Columbus OH 43228
Phone Number: 614-219-5657

Additional Information
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.

How Can I Get More Information?
For more information about your coverage offered by your employer, please check your summary plan description or contact benefits@teleperformance.com or call 866–934–4966.

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.
PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

<table>
<thead>
<tr>
<th>3. Employer name</th>
<th>4. Employer Identification Number (EIN)</th>
</tr>
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<tbody>
<tr>
<td>Teleperformance</td>
<td>87-0512021</td>
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</table>

<table>
<thead>
<tr>
<th>5. Employer address</th>
<th>6. Employer phone number</th>
</tr>
</thead>
<tbody>
<tr>
<td>6510 South Millrock Drive</td>
<td>801-257-5800</td>
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</table>

<table>
<thead>
<tr>
<th>7. City</th>
<th>8. State</th>
<th>9. ZIP code</th>
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</thead>
<tbody>
<tr>
<td>Holladay</td>
<td>UT</td>
<td>84121</td>
</tr>
</tbody>
</table>

10. Who can we contact about employee health coverage at this job?
    Teleperformance Benefits Department

11. Phone number (if different from above) 12. Email address
    866–934–4966 Benefits@teleperformance.com

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - X All employees.
  - □ Some employees. Eligible employees are:

- With respect to dependents:
  - X We do offer coverage. Eligible dependents are:
    
    Eligible dependents include your:
    - Legal spouse
    - Domestic partner
    - Dependent children up to age 26, regardless of student status, marital status, residence or financial dependence on you. For purposes of this plan, the term “child” is defined as:
      - Your natural child
      - A child for whom you are the legally appointed guardian of with full financial responsibility
      - Your stepchild
      - Your legally adopted child or child placed with you for adoption
      - A child named in a Qualified Medical Child Support Order
      - Your child age 26 or older who is incapable of self-support because of a total physical or mental disability that occurred while covered under the plan.

  - □ We do not offer coverage.

- X If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

  ** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here’s the employer information you’ll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.
The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

   **Yes** (Continue)
   13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? (mm/dd/yyyy) (Continue)

   **No** (STOP and return this form to employee)

14. **Does the employer offer a health plan that meets the minimum value standard?**

   **Yes** (Go to question 15)  **No** (STOP and return form to employee)

15. **For the lowest-cost plan that meets the minimum value standard offered only to the employee (don't include family plans):** If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

   a. How much would the employee have to pay in premiums for this plan? $
   b. How often? Weekly Every 2 weeks Twice a month Monthly Quarterly Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don’t know, STOP and return form to employee.

16. **What change will the employer make for the new plan year?**

   Employer won’t offer health coverage
   Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard. (Premium should reflect the discount for wellness programs. See question 15.)

   a. How much will the employee have to pay in premiums for that plan? $
   b. How often? Weekly Every 2 weeks Twice a month Monthly Quarterly Yearly

   Date of change (mm/dd/yyyy):

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• 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 (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)
Children’s Health Insurance Program Reauthorization Act of 2009 (CHIP)

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](http://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](tel:18774476677) or [www.insurekidsnow.gov](http://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](http://www.askebsa.dol.gov) or call [1-866-444-EBSA (3272)](tel:18664443272).

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, 2016. Contact your State for more information on eligibility –

**ALABAMA – Medicaid**
Website:  [www.myalhipp.com](http://www.myalhipp.com)
Phone:  1-855-692-5447

**ALASKA – Medicaid**
The AK Health Insurance Premium Payment Program
Website:  [http://myakhipp.com/](http://myakhipp.com/)
Phone:  1-866-251-4861
Email:  CustomerService@MyAKHIPP.com
Medicaid Eligibility:  [http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx](http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx)

**ARKANSAS – Medicaid**
Website:  [http://myarhipp.com/](http://myarhipp.com/)
Phone:  1-855-MyARHIPP (855-692-7447)

**COLORADO – Medicaid**
Medicaid Website:  [http://www.colorado.gov/hcpf](http://www.colorado.gov/hcpf)
Medicaid Customer Contact Center:  1-800-221-3943

**FLORIDA – Medicaid**
Website:  [http://flmedicaidtplrecovery.com/hipp/](http://flmedicaidtplrecovery.com/hipp/)
Phone:  1-877-357-3288

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

**INDIANA – Medicaid**
Healthy Indiana Plan for low-income adults 19-64
Website:  [http://www.hip.in.gov](http://www.hip.in.gov)
Phone:  1-877-438-4479
All other Medicaid
Website:  [http://www.indianamedicaid.com](http://www.indianamedicaid.com)
Phone 1-800-403-0864

**IOWA – Medicaid**
Website:  [http://www.dhs.state.ia.us/hipp/](http://www.dhs.state.ia.us/hipp/)
Phone:  1-888-346-9562

**KANSAS – Medicaid**
Website:  [http://www.kdheks.gov/hcf/](http://www.kdheks.gov/hcf/)
Phone:  1-785-296-3512

**KENTUCKY – Medicaid**
Website:  [http://chfs.ky.gov/dms/default.htm](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](http://dhh.louisiana.gov/index.cfm/subhome/1/n/331)
Phone:  1-888-695-2447

**MAINE – Medicaid**
Phone:  1-800-442-6003
TTY: Maine relay 711

**MASSACHUSETTS – Medicaid and CHIP**
Website:  [http://www.mass.gov/MassHealth](http://www.mass.gov/MassHealth)
Phone:  1-800-462-1120
MINNESOTA – Medicaid
Website: http://mn.gov/dhs/ma/
Phone: 1-800-657-3739

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx
Phone: 1-855-632-7633

NEVADA – Medicaid
Medicaid Website: http://dwss.nv.gov/
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 603-271-5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahr/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website: http://www.nyhealth.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: http://www.ncdhhs.gov/dma
Phone: 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://www.oregonhealthylivingkids.gov
http://www.hijossaludablesoregon.gov
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website: http://www.dhs.pa.gov/hipp
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid
Website: http://www.eohhs.ri.gov/
Phone: 401-462-5300

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
Website: Medicaid: http://health.utah.gov/medicaid
CHIP: 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
Medicaid Phone: 1-800-432-5924
CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm
CHIP Phone: 1-877-543-7669

WASHINGTON – Medicaid
Website: http://www.hca.wa.gov/medicaid/premiumpyt/pages/index.aspx
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid
Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx
Phone: 1-877-598-5820, HMS Third Party Liability

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: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2016, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa • 1-866-444-EBSA (3272)

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