AXIOS Industrial Group

2019 EMPLOYEE BENEFITS PROGRAM

IMPORTANT CONTACTS

COVERAGE	PROVIDER	GROUP NO.	WEBSITE/EMAIL	PHONE
Medical	UnitedHealthcare	915950	www.myuhc.com	866-633-2446
Health Savings Account	Optum Bank	915950	www.optumbank.com	866-314-0335
Dental	MetLife	KM05949833	www.metlife.com	800-GET-MET8 (800-438-6388)
Vision	MetLife	KM05949833	www.metlife.com	800-GET-MET8 (800-438-6388)
Life and AD&D	MetLife	KM05949833	www.metlife.com	800-GET-MET8 (800-438-6388)
Disability	UnitedHealthcare	915950	www.myuhc.com	888-299-2070
Accident	MetLife	KM05949833	www.metlife.com	800-GET-MET8 (800-438-6388)
Critical Illness	MetLife	KM05949833	www.metlife.com	800-GET-MET8 (800-438-6388)
Hospital Indemnity	MetLife	KM05949833	www.metlife.com	800-GET-MET8 (800-438-6388)
Legal Plan	MetLife	KM05949833	www.metlife.com	800-GET-MET8 (800-438-6388)
Auto and Home	MetLife	KM05949833	www.metlife.com	800-GET-MET8 (800-438-6388)
Human Resources	Axios Industrial	N/A	humanresources@axiosindustrial.com	713-277-7803
Enrollment Services	SmartBen	N/A	axios@smartbenassist.com	855-317-8191

SMARTBEN CUSTOMER SERVICE

Employee benefits can be complicated. The **SmartBenassist Center** can help you with the following:

- Enrollment
- Benefit information
- Eligibility issues
- Password resets

Call **855-317-8191** to speak with a representative Monday through Friday from 7:00 a.m. to 7:00 p.m. CT. If you reach voicemail, your call will be returned within 24 hours or the next business day. Bilingual representatives are also available.

You can also email questions or requests to **axios@smartbenassist.com**.

WELCOME

We are pleased to offer you a comprehensive benefits package intended to protect your well-being and financial health. This guide is your opportunity to learn more about the benefits that are available to you and your eligible dependents beginning January 1, 2019.

To get the best value from your health care plan, please take the time to evaluate your coverage options and determine which plans best meet the health care and financial needs of you and your family. By being a wise consumer, you can support your health and maximize your health care dollars.

OPEN ENROLLMENT

Each year during Open Enrollment, you have the opportunity to make changes to your benefit plans. The enrollment decisions you make this year will remain in effect through December 31, 2019. After Open Enrollment, you may make changes to your benefit elections only when you have a Qualifying Life Event.

AVAILABILITY OF SUMMARY HEALTH INFORMATION

Your plan offers three medical options. To help you make an informed choice and compare your options, a Summary of Benefits and Coverage (SBC) is available which summarizes important information about your health coverage options in a standard format. A printed copy of the SBC is available by contacting Human Resources at **713-277-7803**. You can view and/or download a copy by visiting **https://smartben.com**.

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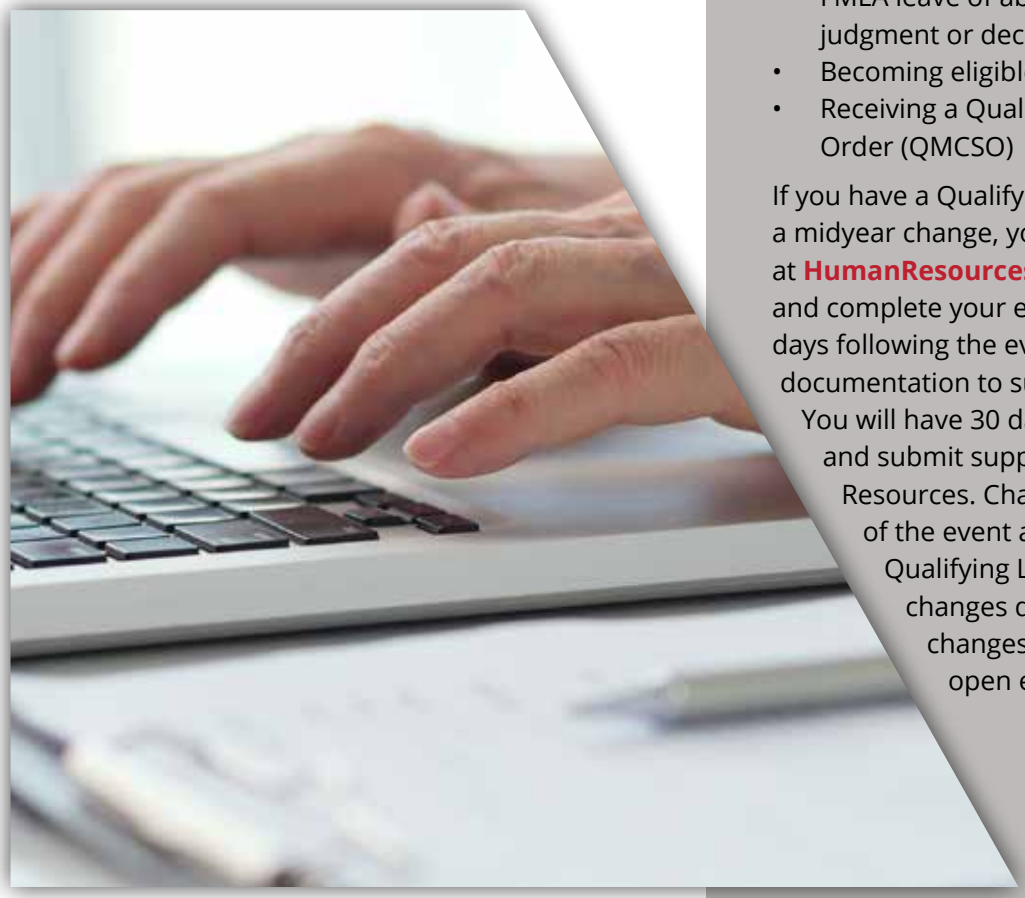
If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see page 20 for more details.

ELIGIBILITY

You are eligible for benefits if you are a regular, full-time employee working an average of 30 hours per week. Your coverage is effective the first of the month following 60 days of employment. You may also enroll eligible dependents for benefits coverage. Your cost for dependent coverage will depend on the number of dependents you enroll and the particular plans you choose. When covering dependents, you must select the same plans for your dependents as you select for yourself.

ELIGIBLE DEPENDENTS INCLUDE:

- Your legal spouse
- Children under the age of 26, regardless of student, dependency or marital status
- Children over the age of 26 who are fully dependent on you for support due to a mental or physical disability and who are indicated as such on your federal tax return



QUALIFYING LIFE EVENTS

Once you elect your benefit options, they remain in effect for the entire plan year until the following Open Enrollment. You may only change coverage during the plan year if you have a Qualifying Life Event, and you must do so within 30 days of the event.

Qualifying Life Events include:

- Marriage, divorce, legal separation or annulment
- Birth, adoption or placement for adoption of an eligible child
- Death of a spouse or child
- Change in your spouse's employment that affects benefits eligibility
- Change in your child's eligibility for benefits (i.e., reaching the age limit)
- Change in residence that affects your eligibility for coverage
- Significant change in coverage or cost in your, your spouse's or child's benefit plans
- FMLA leave of absence, COBRA event, court judgment or decree
- Becoming eligible for Medicare or Medicaid
- Receiving a Qualified Medical Child Support Order (QMCSO)

If you have a Qualifying Life Event and want to request a midyear change, you must notify Human Resources at **HumanResources@axiosindustrial.com** and complete your election changes within 30 days following the event. Be prepared to provide documentation to support the Qualifying Life Event. You will have 30 days to make your benefit elections and submit supporting documentation to Human Resources. Changes will be effective on the day of the event and must be consistent with your Qualifying Life Event. If you do not make your changes during the 30-day period, your changes cannot be made until the next open enrollment period.

ENROLLMENT INSTRUCTIONS

Axios is using SmartBen as our online enrollment tool. You can either call the SmartBenassist Call Center or go online to the SmartBen website. If you are using the website, follow the steps below:

1. Log on to **https://smartben.com** and enter your Username (AX+SSN – i.e., AX111223333) and Password (eight digit date of birth, MMDDYYYY format).
2. On the home page, you will see a "Benefits Enrollment" box. This box has a countdown number of the days remaining in Open Enrollment. Underneath the countdown, there is a "Begin Enrollment" button. Click the button to begin your enrollment.
3. Select the "Annual Enrollment" button to begin your enrollment session.
4. Review and Elect Benefits – You will start your enrollment process on the Benefit Manager page. All benefits will show with a red light until you have clicked through the benefit and made an election.
5. Once all of your elections are complete each benefit will have a green light. To proceed to the next step, click the green button labeled "Elect & Continue."
6. Verify Required Data – If you have not entered all required information, SmartBen will not process your enrollment. Click on each item in the Enrollment Task List and SmartBen will take you to the required page for corrections. Make your corrections, click "Submit," "Enroll" or "Save," whichever is applicable.
7. Review Confirmation – Review your elections thoroughly. To confirm, enter your initials at the bottom of the Confirmation page and click "Continue".
8. You have successfully completed the enrollment process. Select the "Click Here" link for a copy of your Confirmation Statement.
9. Review your Confirmation Statement carefully to ensure your benefit elections are accurate.

Note: At any time during Open Enrollment, you can log back into SmartBen and make changes. Always remember to print a Confirmation Statement to serve as your confirmation of benefit elections.

MEDICAL

Axios is pleased to offer three medical plan options through **UnitedHealthcare (UHC)** that are designed to protect you and your family from major financial hardship in the event of illness or injury. To access a list of preferred providers, go to **www.myuhc.com** or call **866-633-2446** for assistance.

EXCLUSIVE PROVIDER ORGANIZATION (EPO)

All three medical plans are EPO's, which are network-only plans. With the exception of a true emergency, benefits are only payable if services are provided by an in-network physician or facility. If you receive services from an out-of-network provider, you will be responsible for all costs.

You are not required to select a primary care physician and you do not need a referral to see a specialist However, it is best to confirm that your doctor and all specialists are in-network before you seek care.

EPO WITH AN HSA (EPO/HSA)

On the EPO/HSA plan you must satisfy a higher deductible that applies to almost all health care expenses, including those for prescription drugs. Preventive care is covered at 100% with the deductible waived. Once your deductible and out-of-pocket has been met, the plan pays 100%.

If you enroll in one of the EPO/HSA plans, you may be eligible to open a Health Savings Account (HSA). See page 10 for more information on the HSA.

HEALTH COVERAGE REMINDER

The Patient Protection and Affordable Care Act (PPACA) requires most individuals to have minimum essential health coverage. You may obtain coverage through your employer or through the Marketplace.

- Depending on your income and the coverage offered by your employer, you may be able to obtain lower cost private insurance in the Marketplace.
- If you buy insurance through the Marketplace, you may lose any employer contribution to your health benefits.
- Visit **www.healthcare.gov** for Marketplace information.

REMINDER: You may only purchase insurance through the Marketplace if you experience a Qualifying Life Event OR during Open Enrollment. The Federal Marketplace Open Enrollment dates are November 1 through December 15.

UNITEDHEALTHCARE MEDICAL BENEFITS SUMMARY

	HSA 6350 PLAN 1	HSA 3000 PLAN 2	TRADITIONAL PLAN 3
	In-Network Only	In-Network Only	In-Network Only
CALENDAR YEAR DEDUCTIBLE			
Individual	$6,350	$3,000	$1,500
Family	$12,700	$6,000	$3,000
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (INCLUDES DEDUCTIBLE)			
Individual	$6,350	$4,000	$5,000
Family	$12,700	$8,000	$10,000
Lifetime Maximum	Unlimited	Unlimited	Unlimited
	YOU PAY	YOU PAY	YOU PAY
COINSURANCE / COPAYS			
Preventive Care	$0	$0	$0
Virtual Visits	$0 after deductible	$0 after deductible	$0
Primary Care Physician – Under age 19	$0 after deductible	$0 after deductible	$0
Primary Care Physician – Over age 19	$0 after deductible	$0 after deductible	$25 copay
Specialist - Designated Network	$0 after deductible	$0 after deductible	$25 copay
Specialist - Other	$0 after deductible	$0 after deductible	$50 copay
Diagnostics X-ray and Lab	$0 after deductible	$0 after deductible	$0
Complex Imaging	$0 after deductible	$0 after deductible	20% after deductible
Urgent Care	$0 after deductible	$0 after deductible	$75 copay
Emergency Room	$0 after deductible	$0 after deductible	$250 copay + 20%
Inpatient Hospital Care	$0 after deductible	$0 after deductible	20% after deductible
Outpatient Surgery	$0 after deductible	$0 after deductible	20% after deductible
PHARMACY			
RETAIL Rx (UP TO 31-DAY SUPPLY)			
Tier 1	$0 after deductible	$10 after deductible	$15 copay
Tier 2	$0 after deductible	$35 after deductible	$30 copay
Tier 3	$0 after deductible	$60 after deductible	$65 copay
MAIL ORDER Rx (UP TO 90-DAY SUPPLY)			
Tier 1	$0 after deductible	$25 after deductible	$37.50 copay
Tier 2	$0 after deductible	$87.50 after deductible	$75 copay
Tier 3	$0 after deductible	$150 after deductible	$162.50 copay

Plan 1 – Once you meet your deductible/out-of-pocket maximum, the plan will cover all further expenses at 100%.

Plan 2 – Once you meet your deductible, the plan will cover all further medical expenses at 100%. You will continue to pay pharmacy copays until your out-of-pocket maximum is met, at which time the plan will pay 100% for all services.

Plan 3 – This plan has copays for physician office visits, urgent care and pharmacy. Preventive care and telemedicine are covered at 100%. All other services are covered at your coinsurance level after your deductible has been met.

WHERE TO GO FOR HEALTH CARE

When you need medical attention, you should go to your primary care doctor whenever you can. Your doctor knows you best and has quick access to your medical records. However, there are times when you might need to go to a facility other than your doctor's office. This list shows examples of various care providers and the services they generally provide. The cost of medical care can vary widely. Your cost depends on where and how you receive care. Knowing the facts can help you manage your health and your health care dollars.

 TELEMEDICINE/ VIRTUAL VISIT	 DOCTOR'S OFFICE	 RETAIL HEALTH CLINIC	 URGENT CARE CENTER	 HOSPITAL EMERGENCY ROOM	 FREESTANDING EMERGENCY ROOM
$	$	$	$$$	$$$$$	$$$$$$$
• Available 24/7/365 • Talk with a doctor via your computer or mobile phone • Use for non-emergency conditions • Medication may be prescribed • Takes 10-15 minutes **FOR HELP WITH** • Allergies • Cough/cold/flu • Infections • Diarrhea • Rash • Sore throat • Fever • Stomachache You can access care online at any time. To learn more, login to www.uhc.com/virtualvisits to choose from provider sites where you can register for a virtual visit. After registering and requesting a visit, you will pay your portion according to your medical plan.	• Office hours vary • Generally best place for routine, preventive or non-emergency care • Established relationship and able to treat based on knowledge of medical history **FOR HELP WITH** • Routine exam • Vaccinations • Preventive services • General health management • Common infections • Minor skin conditions • Minor injuries • Earache • Sprains and strains	• Based on retail store hours • Usually lower out-of-pocket costs than urgent care • Often located in stores and pharmacies to provide low-cost treatment for minor medical problems **FOR HELP WITH** • Common infections • Minor skin conditions • Vaccinations • Pregnancy tests • Minor injuries • Earache	• Hours vary and usually open evenings, weekends and holidays • Use when doctor's office is closed and not a true emergency • Average wait time is 11-20 minutes • Online and/ or telephone check-in **FOR HELP WITH** • Sprains and strains • Minor infections • Small cuts that may require stitches • Minor burns	• Open 24/7/365 • Place to go for true emergency or trauma • Average wait time is over 4 hours • Multiple bills for services such as doctor and facility **FOR HELP WITH** • Any life-threatening or disabling condition • Sudden loss of consciousness • Major injuries • Chest pain; numbness in face, arm or leg; difficulty speaking • Severe shortness of breath • High fever • Coughing or vomiting blood • Cut or wound that will not stop bleeding • Broken bones	• Open 24/7/365 • Does not include trauma care or cardiac services requiring catheterization • May be out-of-network, which means you will pay more for care and possibly balance billed • Charged fees for facility, laboratory and each doctor you see • May provide imaging and lab services • Does not always accept ambulances **FOR HELP WITH** • Most major injuries except trauma • Severe pain

HEALTH SAVINGS ACCOUNT

If you enroll in the High Deductible Health Plan (HDHP), you may be eligible to open a Health Savings Account (HSA) through **Optum Bank**. An HSA is a personal savings account which you can use to pay qualified out-of-pocket medical expenses with pretax dollars. You own and control the money in your HSA. The money in your account (including interest and investment earnings) grows tax-free, and if the funds are used to pay for qualified medical expenses, it is spent tax-free. The account automatically rolls over year after year; and, since it is an individual account, the balance is yours to keep even if you change health plans or jobs.

HSA ELIGIBILITY

You are eligible to open and contribute to an HSA if you:

- Are enrolled in an HSA-eligible HDHP
- Are not covered by other non-HDHPs, such as your spouse's health plan or a Health Care Flexible Spending Account
- Are not eligible to be claimed as a dependent on someone else's tax return
- Are not enrolled in Medicare or TRICARE
- Have not received Veterans Administration benefits

You can use the money in your HSA to pay for qualified medical expenses now or in the future. Your HSA can be used for your expenses and those of your spouse and dependents, even if they are not covered by the HDHP.

MAXIMUM CONTRIBUTIONS

Your HSA contributions, when combined with Axios Industrial Group contributions, may not exceed the annual maximum amount established by the IRS. The annual contribution maximum for 2019 is based on the coverage option you elect:

- Individual: $3,500
- Family: $7,000

You decide whether to use the money in your account to pay for qualified expenses or let it grow for future expenses. If you are 55 or older, you may make a yearly catch-up contribution of up to $1,000 to your HSA. If you turn 55 at any time during the plan year, you are eligible to make the catch-up contribution for the entire plan year.

OPENING AN HSA

When you open an HSA, you will receive a debit card to manage your HSA account reimbursements. Keep in mind, available funds are limited to the balance in your HSA. To view your account information, go to **www.optumbank.com**.

Always ask your health care provider to file your claims with your medical provider so network discounts can be applied. Then you can pay the provider with your HSA debit card based on the balance due after discount.

You, not your employer, are responsible for maintaining ALL records and receipts for HSA reimbursements in the event of an IRS audit.

Note: You may open an HSA at any financial institution of your choice. However, payroll deductions and Axios Industrial Group contributions are available only for HSAs opened through Optum Bank.

MOTION®

When you enroll in one of our medical plans, you have the UHC Motion® program available to you and your covered spouse at no cost to you.

The Motion program uses the power of simple walking and is designed to help motivate you and your covered spouse to do more of what you already do – walk. The program is convenient, provides immediate feedback on goal achievement and rewards you with deposits into your HSA or an HRA. The program is designed to help you:

- Lose weight
- Improve cholesterol and blood sugar
- Reduce the risk of diabetes and heart disease
- Decrease symptoms of depression and anxiety
- Increase energy and productivity

Go to **unitedhealthcaremotion.com** to create an account. Select an activity tracker from the website or use a Motion-compatible activity tracker you already own. Once you set up your device, begin walking to meet your daily FIT (Frequency, Intensity, Tenacity) goals and sync your device weekly.

If you enroll in one of the HDHP/HSA medical plans (Plans 1 or 2), UHC will automatically make deposits into your HSA. If you enroll in the Traditional PPO plan (Plan 3), UHC will open a Health Reimbursement Account (HRA) for you and make deposits. Each day you can earn a $3 incentive, deposited quarterly into your HSA or HRA. All you have to do is walk to earn up to $1,095 per year.

UNITEDHEALTHCARE – VALUE ADDS

Care24® is a health and well-being concierge service which will connect you with a single point of contact to guide you to clinical, wellness, financial, legal or counseling services through NurseLine℠ and the Employee Assistance Program (EAP) – 24 hours a day, 7 days a week.

The **NurseLine** connects you with registered nurses who can help with:

- Answering questions about an illness or injury
- Providing support on managing a chronic condition or assessing treatment options
- Identifying UHC providers and even scheduling appointments
- Coaching on medication adherence, drug interactions and medication alternatives
- Providing preventive care information and healthy lifestyle coaching

Virtual Visits offers access to online care anytime and lets you see and talk with a doctor from your mobile device or computer without an appointment. Most visits take about 10-15 minutes and doctors can prescribe medications. Common conditions treated through a virtual visit are:

- Bladder infection/urinary tract infection
- Cold/Flu/Bronchitis
- Fever
- Migraine/headaches
- Sinus problems/sore throat

Health4Me™ offers a quick and easy way for you to estimate your health care costs on myuhc.com. In just a few minutes, you can get a preview of your health care costs and see how your costs are impacted by your deductible, co-insurance and out-of-pocket maximum. To access the cost estimator, follow the steps below:

- Visit **myuhc.com** or Health4Me
- Search for a condition or treatment (enter your ZIP Code)
- Get a quick estimate
- Select a provider and/or facility
- Get your final estimate

Health4Me is available in the app store for your mobile device.

Advocate4Me is there to help you understand and manage your healthcare benefits. They can help with:

- Explain if a treatment is covered
- Review how much services may cost
- Explain the charges on a bill you receive
- Help you find a doctor

Real Appeal™ provides you with a plan for lasting weight loss. If you are enrolled in one of our medical plans, this program is provided to you at no additional cost. Real Appeal includes:

- A personalized transformation coach for an entire year who will guide you through the program, customizing it to fit your needs, personal preferences, goals and medical history.
- Staying accountable to goals is easier than ever with 24/7 online support and the mobile app, where you can access:
  - Customizable food, activity, weight and goal trackers
  - Unlimited digital content including streaming workout videos
  - Success group support which lets you chat with others who are participating in the program
  - Weekly Real Appeal All-Star Show featuring healthy tips from celebrities, athletes and health experts
  - Weekly analysis, feedback and goal reporting
- Success Kit with all the gadgets you need to kick-start your weight loss and keep you going strong:
  - Personal blender
  - Digital food scale
  - Measuring cups and spoons
  - “Perfect” portion plate
  - Resistance band
  - Pedometer
  - Real Appeal water bottle
  - Electronic body weight scale
  - Body tape measure
  - Exercise DVDs
  - And more delivered to your door after you attend your first group coaching session

VOLUNTARY DENTAL

Our voluntary dental plan helps you maintain good oral health through affordable options for preventive care, including regular checkups and other dental work. Orthodontia coverage has been added to the plan. Premium contributions for dental will be deducted from your paycheck on a pretax basis. Coverage is provided through **MetLife**.

DPPO PLAN

Two levels of benefits are available with the DPPO plan depending on whether your dentist is in-network or out-of-network. You have the flexibility to select the provider of your choice, but your level of coverage may vary based on the provider you see for services. Staying in-network and going to a contracted DPPO provider will provide you with the highest level of benefits and the deepest discounts your plan offers.

	DENTAL PLAN	
	In-Network	Out-of-Network*
CALENDAR YEAR DEDUCTIBLE		
Individual	$50	$50
Family	$150	$150
CALENDAR YEAR BENEFIT MAXIMUM		
Per Individual	$1,500	
	YOU PAY	
SERVICES		
Office Visit	N/A	N/A
PREVENTIVE AND DIAGNOSTIC CARE		
Exams, cleanings, X-rays, fluoride treatments, sealants, space maintainers	$0	$0
BASIC CARE		
Fillings, simple extractions, oral surgery, endodontics, repairs of bridges, crowns and inlays	20% after deductible	20% after deductible
MAJOR CARE		
Anesthesia, periodontics, crowns, dentures, bridges	50% after deductible	50% after deductible
ORTHODONTIA		
Children to age 19	50% up to a lifetime maximum of $1,500	

* Out-of-network providers: When you use out-of-network providers, your services will be paid based on a Contracted Fee Schedule (a set amount for each type of service that is determined by MetLife). If your dentist's fee is lower than the scheduled fee, the plan will pay benefits based on the actual fee. If the fee is higher, the plan will pay benefits based only on the schedule fee and you are responsible for the difference. Pretreatment review is highly recommended when dental treatment proposed is over $200.

HOW TO FIND A DENTIST

To find an in-network dentist, visit **www.metlife.com** or call **800-GET-MET8 (800-438-6388)** to speak with member services.

VOLUNTARY VISION

The voluntary vision plan through **MetLife** is designed to provide your basic eyewear needs and to preserve your health and eyesight. In addition to identifying vision and eye problems, regular exams can detect certain medical issues such as diabetes or high cholesterol. You may seek care from any licensed optometrist, ophthalmologist or optician, but plan benefits are better if you use an in-network provider.

	In-Network	Out-of-Network
	YOU PAY	REIMBURSEMENT UP TO
COST		
Exam	$10	$45
Materials	$25	See below
COVERED SERVICES – FRAMES AND LENSES		
Single Vision	$25	$30
Bifocals	$25	$50
Trifocals	$25	$65
Lenticular	$25	$100
Frames	$130 allowance	$70
COVERED SERVICES – CONTACTS (IN LIEU OF FRAMES AND LENSES)		
Elective	$130 allowance; Fitting and evaluation copay not to exceed $60	$105
Medically Necessary	$0	$210
LASIK SURGERY		
	15% off regular price or 5% off promotional price	Not covered
BENEFIT FREQUENCY		
Exams	Once every 12 months	
Lenses	Once every 12 months	
Frames	Once every 12 months	
Contacts	Once every 12 months	

HOW TO FIND A VISION PROVIDER

To find an in-network vision provider, visit **www.metlife.com** or call **800-GET-MET8 (800-438-6388)** to speak with member services.

LIFE AND AD&D INSURANCE

Life insurance is an important part of your financial security, especially if others depend on you for support. Even if you are single, your beneficiary can use your Life insurance to pay off your debts, such as credit cards, mortgages and other final expenses.

Accidental Death and Dismemberment (AD&D) insurance provides you specified benefits for a covered accidental bodily injury that directly causes dismemberment (e.g., the loss of a hand, foot or eye). In the event that death occurs from an accident, 100% of the AD&D benefit would be payable to your beneficiary(ies).

Basic Life and AD&D Insurance
Axios is pleased to provide you with Basic Life and AD&D insurance at not cost to you. Log into the SmartBen system to see your employer paid benefit amount.

DESIGNATING A BENEFICIARY

A beneficiary is the person or entity you designate to receive the death benefits of your Life and AD&D insurance policies. You can name more than one beneficiary and you can change beneficiaries at any time. If you name more than one beneficiary, you must identify the share for each.

VOLUNTARY LIFE AND AD&D INSURANCE

You may purchase Voluntary Life and AD&D insurance for you and your eligible dependents. If you decline Voluntary Life and AD&D insurance when first eligible or if you elect coverage and wish to increase your benefit amount at a later date, Evidence of Insurability (EOI) — proof of good health — may be required before coverage is approved.

You must elect Voluntary Life and AD&D insurance for yourself in order to elect coverage for your spouse or children. Coverage is provided through **MetLife**. If you leave Axios Industrial Group, you may be able to take the insurance with you.

AVAILABLE COVERAGE	
Employee	Increments of $10,000 up to 5 times your annual salary to a maximum of $500,000; Guarantee Issue $100,000
Spouse	Increments of $5,000 not to exceed 50% of employee coverage up to a maximum of $100,000; Guarantee Issue $25,000
Child(ren)	Flat amounts of $1,000, $2,000, $4,000, $5,000 or $10,000; Guarantee Issue $10,000

EMPLOYEE AND SPOUSE VOLUNTARY LIFE AND AD&D RATES PER $1,000	
Age	Rate
<30	$0.090
30-34	$0.142
35-39	$0.174
40-44	$0.226
45-49	$0.412
50-54	$0.708
55-59	$1.314
60-64	$1.710
65-69	$2.708
70+	$4.446
Employee/Spouse Voluntary AD&D	$0.035
Child Life Rate per $1,000	$0.240
Child Voluntary AD&D	$0.050

DISABILITY INSURANCE

Short Term Disability (STD) and Long Term Disability (LTD) benefits provide partial income replacement if you can no longer work due to a covered accident or illness while insured. Axios Industrial Group offers you the opportunity to purchase STD and LTD insurance through **UnitedHealthcare (UHC)**.

VOLUNTARY SHORT TERM DISABILITY

You may purchase Voluntary STD for yourself. STD coverage provides short term income protection in case you become disabled due to an illness or covered accident. After a 8-day elimination period, if your disability claim is approved, you will be eligible to receive 60% of your covered weekly salary. Benefits from this program will be decreased by the same amount as any Social Security or disability benefit from other sources.

SHORT TERM DISABILITY	
Benefits Begin After	8 Days
Percent of Salary You Will Receive	60%
Maximum Benefit Amount	$1,000 per Week
Maximum Benefit Period	12 weeks
Pre-existing Condition Limitation	3/12*

*Benefits may not be paid for any condition for which you have been treated within the past 3 months prior to your effective date until you have been covered under this plan for twelve months.

VOLUNTARY SHORT TERM DISABILITY	
Age	Rate per $10
<25	$0.431
25-29	$0.469
30-34	$0.473
35-39	$0.464
40-44	$0.594
45-49	$0.550
50-54	$0.663
55-59	$0.812
60-64	$0.986
65+	$1.067

VOLUNTARY LONG TERM DISABILITY

You may also purchase Voluntary LTD for yourself. LTD coverage provides long term income protections in case you become disabled due to an illness or covered accident. After a 90 day elimination period, if your disability claim is approved, you will be eligible to receive 60% of your monthly salary. Benefits from this program will be decreased by the same amount as any Social Security or disability benefit from other sources.

LONG TERM DISABILITY	
Benefits Begin After	90 Days
Percent of Salary You Will Receive	60%
Maximum Benefit	$10,000 per Month
Maximum Benefit Period (Age 60 & under)	Social Security Normal Retirement Age (SSNRA)
Pre-existing Condition Limitation	12/12*

*Benefits may not be paid for any condition for which you have been treated within the past twelve months prior to your effective date until you have been covered under this plan for twelve months.

VOLUNTARY LONG TERM DISABILITY	
Age	Rate per $100
<25	$0.236
25-29	$0.291
30-34	$0.383
35-39	$0.585
40-44	$0.907
45-49	$1.414
50-54	$1.760
55-59	$2.086
60+	$1.873

ADDITIONAL BENEFITS

THE ADDITIONAL BENEFITS BELOW ARE PROVIDED THROUGH **METLIFE**.

ACCIDENT INSURANCE

Accident insurance pays a fixed benefit direct to you in the event of an accident, regardless of any other coverage you may have. Benefits are paid according to a fixed schedule for accident-related expenses including hospitalizations, fractures and dislocations, emergency room visits, major diagnostic exams and physical therapy. Please refer to the Summary of Benefits and Coverage for benefit details.

Axios Industrial Group is offering two Accident insurance plans.

SERVICE	BENEFIT	
	LOW PLAN	HIGH PLAN
Emergency Room	$50	$100
Ambulance – Ground/Air	$200/$750	$300/$1,000
Initial Hospitalization	$500	$1,000
Hospital Confinement	$100 per day – up to 31 days	$200 per day – up to 31 days
Intensive Care Unit	$200 per day – up to 31 days	$400 per day – up to 31 days
SPECIFIC SUM INJURIES		
Dislocations, ruptured discs, eye injuries, fractures, lacerations, concussions, etc.	$50 – $5,000	$100 – $10,000
ACCIDENTAL DEATH & DISMEMBERMENT*		
Employee	$25,000	$50,000
Spouse	$12,500	$25,000
Child	$5,000	$10,000

*Percentage of benefit paid for dismemberment is dependent on type of loss.

	WEEKLY RATES	
	LOW PLAN	HIGH PLAN
Employee Only	$1.68	$3.24
Employee + Spouse	$2.81	$5.37
Employee + Child(ren)	$3.45	$6.65
Employee + Family	$4.32	$8.32

CRITICAL ILLNESS INSURANCE

Critical Illness insurance helps pay the cost of nonmedical expenses related to a covered critical illness or cancer. The plan provides you a lump sum benefit payment upon first and second diagnosis of any covered critical illness or cancer to help cover expenses such as lost income, out-of-town treatments, special diets, daily living and household upkeep costs.

BENEFIT AMOUNTS AVAILABLE	
Employee	$15,000 or $30,000
Spouse	50% of employee benefit
Child	50% of employee benefit
CONDITION	FIRST OCCURRENCE BENEFIT
Alzheimer's disease, full benefit cancer, heart attack, stroke, heart, kidney or organ failure, heart transplant, coronary artery bypass	100% of benefit amount
Partial Benefit Cancer	25% of benefit amount
Health Screening Benefit – one per covered person per calendar year	$50
Pre-existing Condition Limitation	3/12*

* Benefits may not be paid for condition for which you have been treated within the past 3 months prior to your effective date until you have been covered under this plan for 12 months.

WEEKLY PREMIUM FOR $15,000 OF COVERAGE				
Attained Age	Employee Only	Employee + Spouse	Employee + Children	Employee + Spouse / Children
<25	$2.18	$3.53	$3.22	$4.60
25–29	$2.28	$3.70	$3.32	$4.78
30–34	$2.98	$4.64	$4.02	$5.68
35–39	$3.50	$5.43	$4.53	$6.47
40–44	$4.15	$6.33	$5.19	$7.37
45–49	$6.30	$9.10	$7.37	$10.14
50–54	$9.73	$13.47	$10.77	$14.54
55–59	$14.37	$19.38	$15.44	$20.42
60–64	$20.04	$26.65	$21.08	$27.69
65–69	$28.32	$37.11	$29.35	$38.15
70+	$40.85	$53.62	$41.92	$54.69

WEEKLY PREMIUM FOR $30,000 OF COVERAGE				
Attained Age	Employee Only	Employee + Spouse	Employee + Children	Employee + Spouse / Children
<25	$4.36	$7.06	$6.44	$9.21
25–29	$4.57	$7.41	$6.65	$9.55
30–34	$5.95	$9.28	$8.03	$11.35
35–39	$6.99	$10.87	$9.07	$12.95
40–44	$8.31	$12.67	$10.38	$14.75
45–49	$12.60	$18.21	$14.75	$20.28
50–54	$19.45	$26.93	$21.53	$29.08
55–59	$28.73	$38.77	$30.88	$40.85
60–64	$40.08	$53.31	$42.16	$55.38
65–69	$56.63	$74.22	$58.71	$76.29
70+	$81.69	$107.24	$83.84	$109.38

HOSPITAL INDEMNITY INSURANCE

Hospital Indemnity insurance provides financial assistance to enhance your current medical coverage. It helps you avoid using savings or borrowing money to pay out-of-pocket costs that health insurance does not cover. Hospital Indemnity insurance can help with expenses related to meals and transportation for family members, child care or time away from work due to a medical issue that requires hospitalization.

SERVICE	BENEFIT	
	LOW PLAN	HIGH PLAN
Hospital/ICU Admission	$500 per admission (one per calendar year)	$1,000 per admission (one per calendar year)
Hospital/ICU Confinement	$100 per day, limited to 15 days per insured per year	$200 per day, limited to 15 days per insured per year
Benefit Reduction Due to Age	Benefits reduce by 25% at age 65 and by 50% at age 70	

	WEEKLY RATES	
	LOW PLAN	HIGH PLAN
Employee Only	$2.72	$5.01
Employee + Spouse	$8.47	$15.59
Employee + Child(ren)	$5.34	$9.82
Employee + Family	$11.09	$20.40

LEGAL PLAN

MetLaw® through **Hyatt Legal Services** provides legal services that are affordable to you when the need arises. Plan benefits emphasize preventive legal care to help keep minor legal problems from becoming serious — or financially devastating. This plan offers assistance with a wide range of legal matters, which covers everyday situations when legal advice is helpful. Assistance includes:

- Advice and Consultation
- Consumer Protection
- Debt Matters
- Defense of Civil Lawsuits
- Document Preparation
- Family Law
- Immigration
- Personal Injury
- Real Estate Matters
- Traffic and Criminal Matters
- Wills and Estate Planning

The cost is $4.85 per week. This covers you, your spouse and eligible dependents.

AUTO AND HOME INSURANCE

Axios Industrial Group will be offering discounted Auto and Home Owners insurance through **MetLife**. Contact **MetLife** for additional information.

PREMIUM CONTRIBUTIONS

2019 WEEKLY CONTRIBUTIONS

	Employee Rate			Your 2019 Weekly Cost
MEDICAL – PLAN 1: HSA 6350				
Employee Only	$30.83			
Employee + Spouse	$143.98			
Employee + Children	$83.19			
Employee + Family	$196.34			
MEDICAL – PLAN 2: HSA 3000				
Employee Only	$64.00			
Employee + Spouse	$216.96			$
Employee + Children	$142.90			
Employee + Family	$295.86			
MEDICAL – PLAN 3: TRADITIONAL				
Employee Only	$75.11			
Employee + Spouse	$241.41			
Employee + Children	$162.90			
Employee + Family	$392.19			
DENTAL				
Employee Only	$3.35			
Employee + Spouse	$10.33			$
Employee + Children	$14.05			
Employee + Family	$21.03			
VOLUNTARY VISION				
Employee Only	$1.83			
Employee + Spouse	$3.68			$
Employee + Children	$4.05			
Employee + Family	$5.88			
HEALTH SAVINGS ACCOUNT				
Individual				$
Family				$
VOLUNTARY LIFE AND AD&D				
	Employee	**Spouse**	**Child**	
Voluntary Life and AD&D	Refer to page 14 for rates			$
VOLUNTARY DISABILITY				
Short Term Disability	Refer to page 15 for rates			$
Long Term Disability	Refer to page 15 for rates			$
ADDITIONAL BENEFITS				
Accident	Refer to page 16 for rates			$
Critical Illness	Refer to page 17 for rates			$
Hospital Indemnity	Refer to page 18 for rates			$
Legal Plan	Refer to page 18 for rates			$
Auto and Home	Contact MetLife for more information			$
YOUR TOTAL 2019 WEEKLY BENEFIT COST				$

IMPORTANT NOTICES

Women's Health and Cancer Rights Act of 1998

In October 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act. Please review this information carefully.

As specified in the Women's Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction in connection with a mastectomy is also entitled to the following benefits:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

Health plans must determine the manner of coverage in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan.

Special Enrollment Rights

This notice is being provided to ensure that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive coverage at this time.

Loss of Other Coverage or Becoming Eligible for Medicaid or a state Children's Health Insurance Program (CHIP)

If you are declining coverage for yourself or your dependents because of other health insurance or group health plan coverage, you may be able to later 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 enroll within 31 days after your or your dependents' other coverage ends (or after the employer that sponsors that coverage stops contributing toward the other coverage).

If you or your dependents lose eligibility under a Medicaid plan or CHIP, or if you or your dependents become eligible for a subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents in this plan. You must provide notification with 60 days after you or your dependent is terminated from, or determined to be eligible for such assistance.

Marriage, Birth or Adoption

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must enroll within 31 days after the marriage, birth, or placement for adoption.

For More Information or Assistance

To request special enrollment or obtain more information, contact:

Axios Industrial Group
Human Resources
10077 Grogans Mill Road
The Woodlands, TX 77380
713-277-7803

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 Axios Industrial Group and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to enroll in a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or the dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage through a Medicare Prescription Drug Plan or a Medicare Advantage Plan that offers prescription drug coverage. All Medicare prescription 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. Axios Industrial Group has determined that the prescription drug coverage offered by the Axios Industrial Group medical plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is considered Creditable Coverage.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare prescription drug plan, as long as you later enroll within specific time periods.

You can enroll in a Medicare prescription drug plan when you first become eligible for Medicare. If you decide to wait to enroll in a Medicare prescription drug plan, you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15 through December 7 but as a general rule, if you delay your enrollment in Medicare Part D, after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

You should compare your current coverage, including which drugs are covered at what cost, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. See the Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting Axios Industrial Group at the phone number or address listed at the end of this section.

If you choose to enroll in a Medicare prescription drug plan and cancel your current Axios Industrial Group prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage, you would have to re-enroll in the Plan, pursuant to the Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage.

If you cancel or lose your current coverage and do not have prescription drug coverage for 63 days or longer prior to enrolling in the Medicare prescription drug coverage, your monthly premium will be at least 1% per month greater for every month that you did not have coverage for as long as you have Medicare prescription drug coverage. For example, if nineteen months lapse without coverage, your premium will always be at least 19% higher than it would have been without the lapse in coverage.

For more information about this notice or your current prescription drug coverage:

Contact the Human Resources Department at **713-277-7803**.

NOTE: You will receive this notice annually and at other times in the future, such as before the next period you can enroll in Medicare prescription drug coverage and if this coverage changes. You may also request a copy.

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 will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription 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 **877-486-2048**.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at **www.socialsecurity.gov**, or you can call them at **800-772-1213**. TTY users should call **800-325-0778**.

Remember: Keep this Creditable Coverage notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, 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 whether or not you are required to pay a higher premium (a penalty).

January 1, 2019
Axios Industrial Group
Human Resources
10077 Grogans Mill Road
The Woodlands, TX 77380
713-277-7803

Notice of HIPAA Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Effective Date of Notice: September 23, 2013

Axios Industrial Group's Plan is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

1. the Plan's uses and disclosures of Protected Health Information (PHI);
2. your privacy rights with respect to your PHI;
3. the Plan's duties with respect to your PHI;
4. your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and
5. the person or office to contact for further information about the Plan's privacy practices.

The term "Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, electronic).

Section 1 – Notice of PHI Uses and Disclosures

Required PHI Uses and Disclosures

Upon your request, the Plan is required to give you access to your PHI in order to inspect and copy it.

Use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Plan's compliance with the privacy regulations.

Uses and disclosures to carry out treatment, payment and health care operations.

The Plan and its business associates will use PHI without your authorization to carry out treatment, payment and health care operations. The Plan and its business associates (and any health insurers providing benefits to Plan participants) may also disclose the following to the Plan's Board of Trustees: (1) PHI for purposes related to Plan administration (payment and health care operations); (2) summary health information for purposes of health or stop loss insurance underwriting or for purposes of modifying the Plan; and (3) enrollment information (whether an individual is eligible for benefits under the Plan). The Trustees have amended the Plan to protect your PHI as required by federal law.

Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers.

For example, the Plan may disclose to a treating physician the name of your treating radiologist so that the physician may ask for your X-rays from the treating radiologist.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims processing, subrogation, reviews for medical necessity and appropriateness of care, utilization review and preauthorizations).

For example, the Plan may tell a treating doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

Health care operations include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. However, no genetic information can be used or disclosed for underwriting purposes.

For example, the Plan may use information to project future benefit costs or audit the accuracy of its claims processing functions.

Uses and disclosures that require that you be given an opportunity to agree or disagree prior to the use or release.

Unless you object, the Plan may provide relevant portions of your protected health information to a family member, friend or other person you indicate is involved in your health care or in helping you receive payment for your health care. Also, if you are not capable of agreeing or objecting to these disclosures because of, for instance, an emergency situation, the Plan will disclose protected health information (as the Plan determines) in your best interest. After the emergency, the Plan will give you the opportunity to object to future disclosures to family and friends.

Uses and disclosures for which your consent, authorization or opportunity to object is not required.

The Plan is allowed to use and disclose your PHI without your authorization under the following circumstances:

1. For treatment, payment and health care operations.
2. Enrollment information can be provided to the Trustees.
3. Summary health information can be provided to the Trustees for the purposes designated above.

4. When required by law.
5. When permitted for purposes of public health activities, including when necessary to report product defects and to permit product recalls. PHI may also be disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if required by law.
6. When required by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In which case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.
7. The Plan may disclose your PHI to a public health oversight agency for oversight activities required by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
8. The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request.
9. When required for law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Also, when disclosing information about an individual who is or is suspected to be a victim of a crime but only if the individual agrees to the disclosure or the Plan is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.
10. When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.
11. When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
12. When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke such authorization.

Uses and disclosures that require your written authorization.

Other uses or disclosures of your protected health information not described above will only be made with your written authorization. For example, in general and subject to specific conditions, the Plan will not use or disclose your psychiatric notes; the Plan will not use or disclose your protected health information for marketing; and the Plan will not sell your protected health information, unless you provide a written authorization to do so. You may revoke written authorizations at any time, so long as the revocation is in writing. Once the Plan receives your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Section 2 – Rights of Individuals

Right to Request Restrictions on Uses and Disclosures of PHI

You may request the Plan to restrict the uses and disclosures of your PHI. However, the Plan is not required to agree to your request (except that the Plan must comply with your request to restrict a disclosure of your confidential information for payment or health care operations if you paid for the services to which the information relates in full, out of pocket).

You or your personal representative will be required to submit a written request to exercise this right. Such requests should be made to the Plan's Privacy Official.

Right to Request Confidential Communications

The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations if necessary to prevent a disclosure that could endanger you.

You or your personal representative will be required to submit a written request to exercise this right.

Such requests should be made to the Plan's Privacy Official.

Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI. If the information you request is in an electronic designated record set, you may request that these records be transmitted electronically to yourself or a designated individual.

Protected Health Information (PHI)

Includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form.

Designated Record Set

Includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for the Plan; or other information used in whole or in part by or for the Plan to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained off site. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

You or your personal representative will be required to submit a written request to request access to the PHI in your designated record set. Such requests should be made to the Plan's Privacy Official.

If access is denied, you or your personal representative will be provided with a written denial, setting forth the basis for the denial, a description of how you may appeal the Plan's decision and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

The Plan may charge a reasonable, cost-based fee for copying records at your request.

Right to Amend PHI

You have the right to request the Plan to amend your PHI or a record about you in your designated record set for as long as the PHI is maintained in the designated record set.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

Such requests should be made to the Plan's Privacy Official.

You or your personal representative will be required to submit a written request to request amendment of the PHI in your designated record set.

Right to Receive an Accounting of PHI Disclosures

At your request, the Plan will also provide you an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting will not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) pursuant to your authorization; (4) prior to April 14, 2003; and (5) where otherwise permissible under the law and the Plan's privacy practices. In addition, the Plan need not account for certain incidental disclosures.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

Such requests should be made to the Plan's Privacy Official.

Right to Receive a Paper Copy of This Notice Upon Request

You have the right to obtain a paper copy of this Notice. Such requests should be made to the Plan's Privacy Official.

A Note About Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

1. a power of attorney for health care purposes;
2. a court order of appointment of the person as the conservator or guardian of the individual; or
3. an individual who is the parent of an unemancipated minor child may generally act as the child's personal representative (subject to state law).

The Plan retains discretion to deny access to your PHI by a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

Section 3 – The Plan's Duties

The Plan is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of the Plan's legal duties and privacy practices.

This Notice is effective September 23, 2013, and the Plan is required to comply with the terms of this Notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this Notice will be provided to all participants for whom the Plan still maintains PHI. The revised Notice will be distributed in the same manner as the initial Notice was provided or in any other permissible manner.

If the revised version of this Notice is posted, you will also receive a copy of the Notice or information about any material change and how to receive a copy of the Notice in the Plan's next annual mailing. Otherwise, the revised version of this Notice will be distributed within 60 days of the effective date of any material change to the Plan's policies regarding the uses or disclosures of PHI, the individual's privacy rights, the duties of the Plan or other privacy practices stated in this Notice.

Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. When required by law, the Plan will restrict disclosures to the limited data set, or otherwise as necessary, to the minimum necessary information to accomplish the intended purpose.

However, the minimum necessary standard will not apply in the following situations:

1. disclosures to or requests by a health care provider for treatment;
2. uses or disclosures made to the individual;
3. disclosures made to the Secretary of the U.S. Department of Health and Human Services;
4. uses or disclosures that are required by law; and
5. uses or disclosures that are required for the Plan's compliance with legal regulations.

De-Identified Information

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.

Summary Health Information

The Plan may disclose "summary health information" to the Trustees for obtaining insurance premium bids or modifying, amending or terminating the Plan. "Summary health information" summarizes the claims history, claims expenses or type of claims experienced by participants and excludes identifying information in accordance with HIPAA.

Notification of Breach

The Plan is required by law to maintain the privacy of participants' PHI and to provide individuals with notice of its legal duties and privacy practices. In the event of a breach of unsecured PHI, the Plan will notify affected individuals of the breach.

Section 4 – Your Right to File a Complaint With the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Plan. Such complaints should be made to the Plan's Privacy Official.

You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington, D.C. 20201. The Plan will not retaliate against you for filing a complaint.

Section 5 – Whom to Contact at the Plan for More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact the Plan's Privacy Official. Such questions should be directed to the Plan's Privacy Official at:

Axios Industrial Group
Human Resources
10077 Grogans Mill Road
The Woodlands, TX 77380
713-277-7803

Conclusion

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at 45 Code of Federal Regulations Parts 160 and 164. The Plan intends to comply with these regulations. This Notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this Notice and the regulations.

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 are 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 are not 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, 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 go to **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can 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 are not 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://www.myalhipp.com/ Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (1-855-692-7447)
COLORADO – Medicaid and CHP+
Medicaid Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943 TTY: State Relay 711 CHP+: www.Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991 TTY: 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: 404-656-4507

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone: 1-800-403-0864
IOWA – Medicaid
Website: http://www.dhs.iowa.gov/hawk-i Phone: 1-800-257-8563
KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 785-296-3512
KENTUCKY – Medicaid
Website: http://chfs.ky.gov 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
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840
MINNESOTA – Medicaid
Website: http://www.mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp 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://www.ACCESSNebraska.ne.gov Phone: 855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid
Website: http://dhcfp.nv.gov Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website: http://www.dhhs.nh.gov/ombp/nhhpp/ Phone: 603-271-5218 Hotline: NH Medicaid Service Center at 1-888-901-4999
NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid
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: 855-697-4347
SOUTH CAROLINA – Medicaid
Website: https://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
Medicaid and 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 ext. 15473
WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/ Toll Free Phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid
Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/ Phone: 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, you can 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

Continuation of Coverage Rights Under COBRA

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 Plans 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.

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:

Axios Industrial Group
Human Resources
10077 Grogans Mill Road
The Woodlands, TX 77380
713-277-7803

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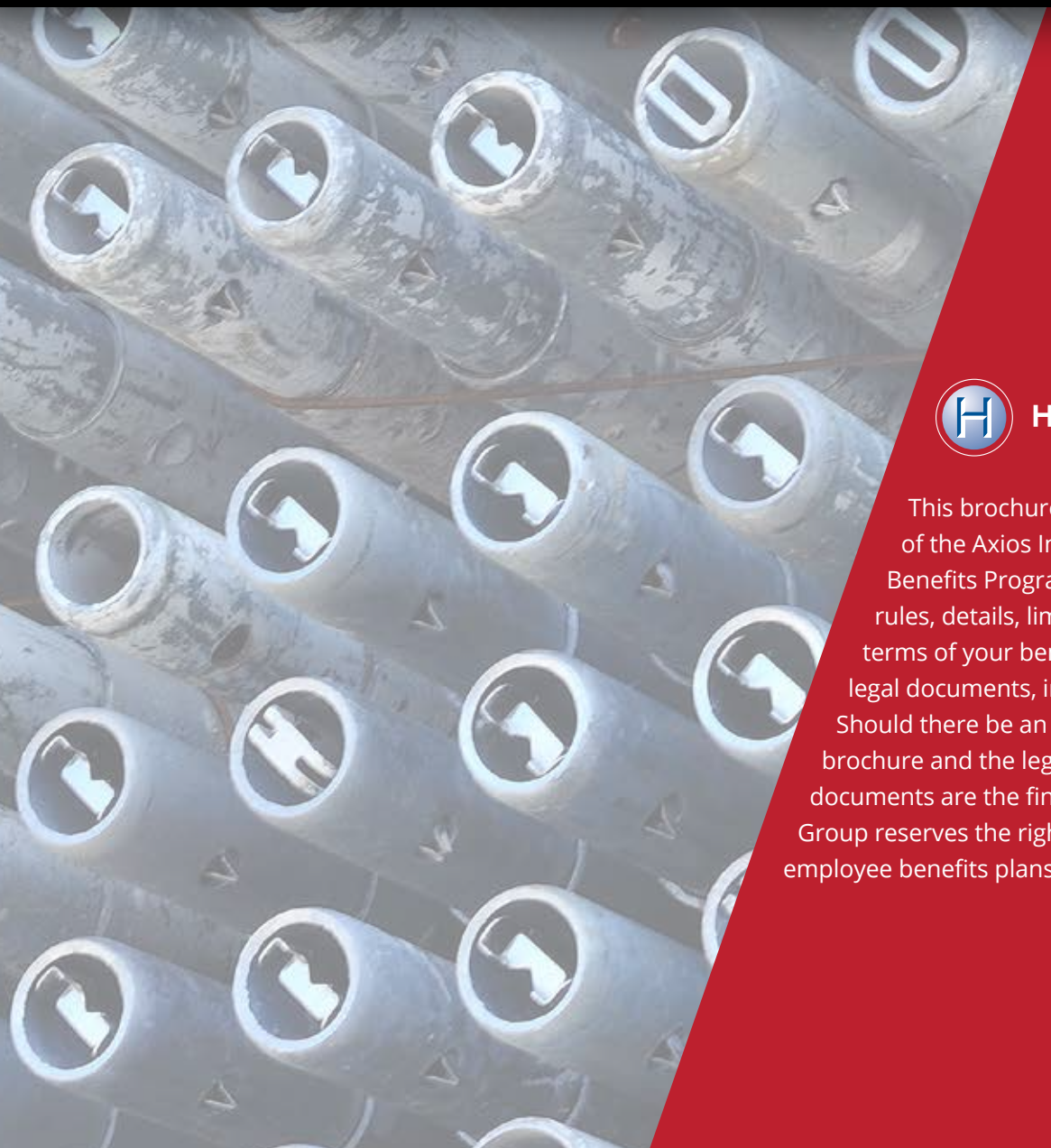

HIGGINBOTHAM™

This brochure highlights the main features of the Axios Industrial Group Employee Benefits Program. It does not include all plan rules, details, limitations and exclusions. The terms of your benefit plans are governed by legal documents, including insurance contracts. Should there be an inconsistency between this brochure and the legal plan documents, the plan documents are the final authority. Axios Industrial Group reserves the right to change or discontinue its employee benefits plans at any time.