NORTHWEST
EXTERMINATING

- Medical
- Dental
- Vision
- Basic Life & AD&D
- Supplemental Life
- Supplemental Dependent Life
- Voluntary Short Term Disability
- Voluntary Long Term Disability
- Flexible Spending Account

Employee Benefit Guide

2018

June 1, 2018—May 31, 2019

Medical Benefits

Eligibility
Benefits are available to full-time employees working a minimum of 30 hours per week. Benefits are effective on the first of the month following the 30 day anniversary.

Changing your Coverage
Make your benefit elections carefully, including the choice to waive coverage. Your pre-tax elections will remain in effect until the next annual open enrollment period unless you experience an IRS approved qualifying change in status.

Qualifying change in status events include, but are not limited to:

- Marriage, divorce, or legal separation
- Death of spouse or other dependent
- Birth or adoption of a child
- A spouse loses coverage under another employer group medical health plan
- A dependent's eligibility status changes due to age
- You or your spouse are covered under a group health plan and experience a change in work hours
- Relocation into or outside of your plan's service area

Medical Benefits - UnitedHealthcare

Effective June 1, 2018 your medical benefits will be provided through UnitedHealthcare. Also eligible for coverage are your legal spouse and/or children to age 26. A summary of each of these plans is included here for your review. Please be sure to review your Summary of Benefits and Coverage carefully.

	UnitedHealthcare High Deductible Plan (HDHP 4000)		UnitedHealthcare Point of Service 3500 (POS 3500)		UnitedHealthcare Point of Service 1500 (POS 1500)	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Calendar Year Deductible						
Individual	$4,000	$15,000	$3,500	$10,000	$1,500	$3,000
Family	$8,000	$30,000	$7,000	$20,000	$3,000	$6,000
Out-of-Pocket Maximum						
Individual	$5,500	$30,000	$6,500	$20,000	$3,000	$6,000
Family	$11,000	$60,000	$13,000	$40,000	$6,000	$12,000
Coinsurance	0% after ded.	30% after ded.	20% after ded.	30% after ded.	20% after ded.	40% after ded.
Office Visit Copay						
Primary	0% after ded.	30% after ded.	$30	30% after ded.	$30	40% after ded.
Specialist	0% after ded.	30% after ded.	$40	30% after ded.	$40	40% after ded.
Preventative Care	Covered at 100%	30% after ded.	Covered at 100%	30% after ded.	Covered at 100%	40% after ded.
Telemedicine		N/A	$10 copay	N/A	$10 copay	N/A
Hospital/Inpatient Services	0% after ded.	30% after ded.	20% after ded.	30% after ded.	20% after ded.	40% after ded
Emergency Room Services	0% after deductible		$500 Copay, waived if admitted		$350 Copay, waived if admitted	
Urgent Care Provider	0% after ded.	30% after ded.	$75	30% after ded.	$75	40% after ded.
Short Term Therapies						
Physical, Occup & Chiro	0% after ded.	30% after ded.	$30 copay	30% after ded.	$30 copay	40% after ded
Outpatient Services	0% after ded.	30% after ded.	20% after ded.	30% after ded.	20% after ded.	40% after ded
Prescription Drugs	Retail / Mail-Order		Retail / Mail-Order		Retail / Mail-Order	
Generic	$15 after ded. / $38 after ded.		$15 / $38		$15 / $38	
Brand Preferred	$40 after ded. / $100 after ded.		$30 / $75		$30 / $75	
Brand Non-Preferred	$75 after ded. / NA		$70 / NA		$70 / NA	
Maximum Lifetime Benefit	Unlimited		Unlimited		Unlimited	

For rates, please see your payroll deduction sheet. For enrollment, please log on to ADP.COM.

Dental & Vision

NORTHWEST EXTERMINATING

Dental Insurance

Our dental plan includes benefits for preventive, basic and major services. If you choose to receive treatment from a non-network provider it could result in increased expense and balance billing. Your out of pocket expenses will be reduced when using an in-network provider.

This dental plan includes a valuable feature that allows qualifying plan participants to carryover part of their unused annual maximum. A participant earns dental rewards by submitting at least one claim for dental expenses incurred during the benefit year, while staying at or under the threshold amount for benefits received for that year. Employees and their covered dependents may accumulate rewards up to the stated maximum carryover amount, then use those rewards for any covered dental procedures subject to applicable coinsurance and plan provisions. If a plan participant doesn't submit a dental claim during a benefit year, all accumulated rewards are lost. But you can begin earning rewards again the very next year.

Summary of Dental Benefits—The Standard

Benefit	LOW PLAN In Network	HIGH PLAN In Network
Deductible		
Individual / Family	$50 / $150	$50 / $150
Annual Maximum		
Calendar Year *(Type 1, 2, 3)*	$1,000	$1,500
Orthodontia	N/A	N/A
Coinsurance		
Preventive *(Type 1)*	100%	100%
Basic *(Type 2)*	80%	80%
Major *(Type 3)*	50%	50%
Orthodontics *(Type 4)*	Not Covered	Not Covered
Rollover Provision		
Rollover Threshold	$500	$750
Rollover Reward	$250	$250
Rollover Max Bank	$1,000	$1,000
Plan Reimbursement	90% U&C*	90% U&C*

Deductions for dental coverage are taken on a pre-tax basis.

* The Usual and Customary (U&C) allowance is determined using information from a national independent data source. Plan participants are reimbursed based on the appropriate charges in the dentist's ZIP Code area. U&C allowances are reviewed annually.

Get quick and easy information about your dental benefits by calling **The Standard** at **800-547-9515** (8am—1am EST Mon– Thurs and 8am—7:30pm EST Friday).

Assurant - DentiCare Plus HMO Plan

Coinsurance	
Preventive	Copays vary
Basic & Major	*See Assurant dental benefit summary for details*

Vision Insurance

Our vision plan provides an extensive network of participating providers and retail locations nationwide to provide professional vision care for Plan participants.

- Balanced Care Vision I plans feature the money-saving eye care provider network of VSP. VSP's network emphasizes independent private-practice eye doctors offering one-stop care. Every doctor in the network provides exam and eyewear services, so there's no need to have a comprehensive exam in one location then travel to another for lenses and frames.
- Making an appointment and receiving claims payment through VSP is easy. There is no paperwork or claim to file. Simply make an appointment with a VSP doctor, state that you have coverage that includes the VSP network, and visit the doctor. VSP handles the rest.
- VSP's retail chain affiliate providers, which include Costco® Optical and Visionworks, give participants added convenience and choices.

Summary of Vision Benefits - VSP

Benefit	In Network	Out-of-Network
Routine Eye Exam — Every 12months		
Per Person	$10	Up to $45
Eyeglass Frames — Every 24 months from date of service you may select any frame -$130 allowance with 20% off over the allowance		
Per Person	$130 allowance	Up to $70
Eyeglass Lenses — Every 12 months from date of service you may select any lenses		
Single Vision *(1 pair)*	$25	Up to $30
Lined Bifocal Lenses *(1 pair)*	$25	Up to $50
Lined Trifocal Lenses *(1 pair)*	$25	Up to $65
Contact Lenses — Every 12 months in lieu of glasses- $130 allowance		
Elective Conventional Lenses	Up to $60 copay for exam	Up to $105
Elective Disposable Lenses	Up to $60 copay for exam	Up to $105

Deductions for vision coverage are taken on a pre-tax basis.

Get quick and easy information about your vision benefits by calling **VSP** at **800-877-7195** (8am—10pm EST, Mon- Fri). You can locate a VSP provider at www.standard.com/services.

Life Insurance

Basic Life and AD&D Insurance

Basic Term Life/Accidental Death and Dismemberment (AD&D) Plan is a company paid benefit available to all eligible employees.

Basic Life Insurance helps provide financial protection to your loved ones at little or no cost to you. In the event of your death, an individual *(or individuals)* of your choosing will receive a cash payment from the insurance provider.

BASIC LIFE AND AD&D PLAN	
Carrier Name	Lincoln Financial
Life Benefit Amount All full-time benefit eligible employees	$25,000
AD&D Benefit Amount	Equal to Life Amount
Conversion Option	Included
Living Benefit Rider / Accelerated Death Benefit *(Terminal Illness)*	Included
Age Reduction Schedule *(% of benefit offered)*	65% at age 65 30% at age 70

Conversion Option: A group life insurance provision that allows an employee whose coverage terminates for specified reasons to convert his/her group coverage to an individual whole life insurance policy without presenting evidence of insurability.

Living Benefit Rider I Accelerated Death Benefit:
In the event that you become chronically or terminally ill, a percentage of your life insurance benefit will be paid to you to offset expenses.

Supplemental Life and AD&D Insurance

In addition to the basic group life insurance coverage provided to you by the company, you can purchase Voluntary *(Supplemental)* Life and AD&D* through Lincoln Financial for yourself and your dependents.

If you elect this coverage after your initial eligibility or wish to increase the coverage you already have *(employee, spouse or child),* all amounts require evidence of insurability *(i.e., completing a health questionnaire)* be provided to Lincoln Financial and approval of coverage is subject to their review.

You must purchase Voluntary *(Supplemental)* Life and AD&D* for yourself, in order to enroll your dependents for this benefit.

Guaranteed Issue: The amount offered to any eligible applicant without regard to health status, up to a certain defined *(Guaranteed Issued)* amount.

- For the Employee- $200,000
- For a Spouse- $25,000
- For a Dependent Child- all amounts

Employee Coverage: $10,000 to $500,000 in $10,000 increments. *(Guaranteed Issue: $200,000),* life insurance benefits cannot exceed five times your annual salary.

Spouse Coverage: $5,000 to $500,000 in $5,000 increments; cannot exceed 100% of employee life.

Child Coverage *(Birth to 26 Years):* $2,000 to $10,000 in $1,000 increments; not to exceed 50% of EE life

Conversion Option: included

Portability Option: included

** Voluntary AD&D amount is same as Voluntary Life*

Disability

NORTHWEST EXTERMINATING

Voluntary Short Term Disability Insurance

Northwest Exterminating offers you the opportunity to purchase voluntary short term disability coverage at group rates through payroll deduction. Voluntary STD insurance helps replace lost income because of a disabling injury or illness. The Plan is provided by Lincoln Financial.

If you enroll in the plan after your initial eligibility, coverage is not subject to review of evidence of insurability by the insurance carrier, but is subject to pre-existing conditions limitations.

Since you pay 100% of the voluntary short term disability premium, your STD benefit payment will not have taxes deducted.

VOLUNTARY SHORT TERM DISABILITY PLAN	
Benefit	60% of your weekly income
Max Weekly Benefit	$2,000
Max Benefit Period	12 weeks
Benefits Begin: Accident Illness	 8th calendar day 8th calendar day
Pre-Existing Condition	3/6 Months

Deductions for STD coverage are taken on a post-tax basis.

Maximum Benefit Period: If you become disabled, STD benefits may continue during disability up to 12 weeks. This is the max period for which STD benefits are payable for any 1 period of continuous disability.

Pre-Existing Condition Limitations: A Pre-existing Condition means any Injury or Sickness for which you received medical treatment, advice or consultation, care or services including diagnostic measures, or had drugs or medicines prescribed or taken in the 3 months prior to the day you become insured under the policy. No benefits for disability will be paid for 6 months after being continuously insured under the policy due to a pre-existing condition.

Voluntary Long Term Disability Insurance

All full time employees working 30 hours or more are eligible to purchase LTD coverage through Lincoln Financial. The benefit is 60% of monthly earnings up to $10,000. The premium for this benefit will be paid by you.

Since you pay 100% of the voluntary long term disability premium, your LTD benefit payment will not have taxes deducted.

VOLUNTARY LONG TERM DISABILITY PLAN	
Benefit	60% of your monthly income
Min Monthly Benefit	$100
Max Monthly Benefit	$10,000
Max Benefit Period	Age based
Elimination Period	90 Days
BENEFIT LIMITATIONS	
Pre-Existing Condition	3/12 Months

Deductions for LTD coverage are taken on a post-tax basis.

Elimination Period: The period of time that must elapse from the onset of a disability before you are eligible to receive monthly benefits.

Pre-Existing Condition Limitations: The plan doesn't pay a long term disability benefit for an illness or injury for which you received medical care of treatment, including prescription drugs, during the 90 days leading up to your coverage effective date. Eligibility for coverage for a disability related to this illness or injury begins once you're covered under the plan for 12 consecutive calendar months and have been actively at work.

Flex Accounts

Are you using after-tax money to pay for healthcare and daycare?

You don't have to!

Flexible Spending Accounts (FSAs) allow you to set aside pre-tax dollars to pay for certain health care and dependent care expenses. Each dollar you put into the Health Care Flexible Spending Account (HCFSA) or Dependent Care Flexible Spending Account (DCFSA) is a dollar not taxed. The Flexible Spending Accounts are administered by Contiuon Services.

Health Care Flexible Spending Account

You and your dependents can use it to pay for eligible healthcare expenses not covered under your plans, such as medical, dental, vision deductibles, coinsurance, prescription drug copays, over-the-counter (OTC) drugs that are prescribed, LASIK eye surgery and more. For more information on eligible expenses, please review IRS Publication 502 on www.irs.gov.

Dependent Care Flexible Spending Account

Use to pay for dependent daycare expenses, like charges for a daycare center, nursery school or preschool, after-school programs for children under age 13, as well as elder care. If you are married, your spouse must either be employed, a full-time student or disabled (unable to care for self) in order to enroll in the Dependent Care FSA.

This account may not be used for healthcare expenses for your dependents.

Grace Period

Your plan includes an annual grace period extension. This feature creates a grace period that immediately follows the end of the plan year. During this time frame, you may incur expenses and use the funds remaining in your account toward eligible FSA expenses. This benefit provides an additional 2 1/2 months beyond the end of the plan year. When this grace period expires, you will forfeit any unused funds. This is an IRS Regulation.

MAP® Health

Northwest Exterminating is excited to provide a new healthcare benefit, ***Medical Advocate Program (MAP®)***, to employees and their dependents enrolling in one of the sponsored medical plans. MAP® will help you get the most from your healthcare expenditures.

When it comes to healthcare, MAP® believes that researching critical data and costs for all healthcare providers and facilities, as well as providing guidance to members, is imperative to achieving quality healthcare for all. The primary goal of MAP® is to help members better understand their healthcare options and become more educated consumers of healthcare. This approach has proven that members receive the best that healthcare has to offer while at the same time drives down healthcare costs for everyone.

Researching and comparing your healthcare options has never been easier with MAP®!

MAP® makes it easy for you and your family to receive important medical information and answer to your healthcare questions and concerns, and to get help obtaining the highest quality medical services you need.

Call MAP® first for the any of the following:

- To get answers to your medical questions and concerns
- To identify the highest quality healthcare providers in your network
- To get a qualified second opinion *(surgery, cancer, etc.)*
- To discuss medical questions to ask your doctor
- To understand your different treatment options
- When you need to see a specialist or have a procedure done in a hospital or outpatient facility
- When you want to know more about a healthcare provider
- To save time and money

Here's how it works....an easy Step-by-Step Process— MAP® makes healthcare easy!

1 Call MAP® toll free 888-289-0700

Speak with a MAP® Nurse Advocate (RN) about your medical concerns. Have your insurance card ready when calling.

2 MAP® Solves Your Medical Concerns

Your MAP® Nurse Advocate will provide answers and offer options to help you make informed decisions about your healthcare.

3 MAP® Communicates Research Results

Your MAP® Nurse Advocate will discuss with you results and options, and email you a user-friendly written report. Now you're ready to see your provider.*

It's free. Start using MAP® today!

888-289-0700

Monday—Friday 8:30 am—8:30 pm EST

*** IMPORTANT** *When making an appointment with a MAP® preferred provider, be sure to insist upon the MAP® preferred provider to avoid an attempt the office staff to schedule you with a different provider/partner. If the provider is not readily available, request instead to be placed on a cancellation list. You may also request to have your primary care physician contact the Specialist directly to request or arrange for an earlier appointment.*

Legal Notices

NORTHWEST EXTERMINATING

Important information regarding legislative changes to healthcare benefits. If any information in these Legal Notices conflict with the plan documents and insurance policies, those plan documents and policies will govern.

Important Notice for Employees and Dependents Age 65 or Older About Your Prescription Drug Coverage and Medicare- Medicare Part D Notices (Credible Coverage)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

- 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.
- It has been determined that the prescription drug coverage offered by our Medical Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription 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 join a Medicare drug plan.

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 through December 7. 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.

If you decide to join a Medicare drug plan, your coverage will be affected. You cannot drop your prescription drug coverage and retain your medical coverage; you would only be able to drop your prescription drug coverage by dropping your entire medical plan.

If you do decide to join a Medicare drug plan and drop your medical/prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

You should also know that if you drop or lose your coverage with and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you will pay a higher premium *(a penalty)* to join a Medicare drug plan later. 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 base beneficiary premium. You may have to pay this higher premium *(a penalty)* as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

Northwest Exterminating Company, Inc.
Human Resources Department
(770) 293-2700

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 details 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 telephone numbers)* for personalized help.
- Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.
- If you have limited income & 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 800-772-1213 (TTY 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 whether or not you are required to pay a higher premium *(a penalty)*.

Legal Notices

Notice of Your Rights under COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) requires most group health plans to provide a temporary continuation of group health coverage that otherwise might be terminated. COBRA requires continuation coverage to be offered to covered employees, their spouses, their former spouses, and their dependent children when group health coverage would otherwise be lost due to certain specific events. Those events include the death of a covered employee, termination or reduction in the hours of a covered employee's employment for reasons other than gross misconduct, divorce, or legal separation from a covered employee, a covered employee's becoming entitled to Medicare, and a child's loss of dependent status *(and therefore coverage)* under the plan.

Genetic Information Nondiscrimination Act (GINA)

Under the Genetic Information Nondiscrimination Act (GINA), group health plans cannot:

- Request family medical history or other genetic information prior to plan enrollment.
- Use family medical history or other genetic information to adjust group premiums or contributions.
- Request family medical history or other genetic information to determine eligibility rules, apply pre-existing condition exclusions, or conduct other underwriting activities.

Coverage for Students on Medical Leave of Absence (Michelle's Law)

Dependent children over age 26, who are still eligible *(based on student status)* for the company plan due to state mandated eligibility are covered by Michelle's Law. If your dependent takes a medically necessary leave of absence from school or changes from full time to part time status due to a serious illness or injury, coverage will continue for up to one year, unless the dependent is no longer eligible for another reason. The student's treating physician must provide written certification to the company that the leave of absence or change in status is medically necessary. Dependents up to age 26 are eligible under the company's plan regardless of student status.

Providing Social Security Numbers During Enrollment

Due to federal requirements, you will need to provide Social Security Numbers for spouses, dependents and domestic partners when enrolling those dependents.

Mastectomy Benefits

The Women's Health and Cancer Rights Act of 1998 requires medical plans that offer mastectomy benefits to also provide coverage for reconstructive surgery. This coverage is paid according to the normal provisions of the plan you elect. Coverage includes: treatment to produce a symmetrical appearance following a mastectomy, prostheses and physical complications for all stages of a mastectomy, including lymphedemas *(swelling associated with the removal of the lymph nodes).*

Patriot Act Notice

To help the government fight the funding of terrorism and money laundering activities, federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account. What this means for you: When you open a health savings account, the associated financial institution will ask for your name, address, date of birth, and other information that will allow the financial institution to identify you. The financial institution may also ask to see your driver's license or other identifying documents.

Hospital Stays for Mother and Newborns

Health plans generally may not under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.

However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or newborn earlier than 48 hours *(or 96 hours as applicable).* In any case, plans may not under federal law, require that a provider obtain authorization from the plan for prescribing a length of stay not in excess of 48 hours *(or 96 hours)* .

NORTHWEST
EXTERMINATING

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

- If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.
- If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.
- If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

Please visit the below link to see if you live in one of the following States that may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 2016. You should contact your State for further information on eligibility.

— http:www.dol.gov/ebsa/pdf/chipmodelnotice

To see if any more States have added a premium assistance program since July 31, 2017, or for more information on special enrollment rights, you can 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

HIPAA NOTICE OF PRIVACY PRACTICES

In accordance with changes to the privacy provisions of the Health Insurance Portability and Accountability Act (HIPAA), the company posted an updated Notice of Privacy Practices (NPP) for the Company's group health. The NPP was updated to provide that the group health plan is required to notify any participant whose unsecured Protected Health Information has been compromised and that the group health plan does not use or disclose genetic information for any reason. The NPP was also updated to revise the list of self-insured component plans covered by the NPP.

If you would like a paper copy of the NPP, please contact the Human Resources Department at (770) 293-2700.

Contacts

NORTHWEST EXTERMINATING

Coverage	Vendor/Contact	Website/Email	Phone Number
MAP® Health	Medical Advocate Program (MAP®)	www.mapmember.com	888.289.0700
Medical	UnitedHealthcare	www.myuhc.com Advocate4Me@uhc.com	866.633.2446
Pharmacy	UnitedHealthcare	www.myuhc.com Advocate4Me@uhc.com	888.290.7789
Dental	The Standard	www.standard.com/dental	800.547.9515
Dental HMO (Copay)	Assurant	www.assurant.com	800.443.2995
Vision	VSP	www.standard.com/services	800.877.7195
Life and Disability	Lincoln Financial	www.lincolnfinancial.com	800.423.2765
Flexible Spending Account	Continuon Services	www.csllc.com	877.747.4141
Retirement Plan	Prudential	https://www.prudential.com/login	877.778.2100

The information in this Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Guide and the actual plan documents the actual plan documents will prevail. If you have any questions about your Guide, contact the HR Team at Northwest Exterminating Company, Inc.