BasicCare Program

Summary Plan Description of the

Five Below BasicCare Program

(the "Benefit Program")

This booklet provides important information about the Benefit Program offered by your Employer.

PLEASE NOTE: A person can only be covered if eligible for the coverage; if enrolled; and if the required premium has been paid. If you have any questions about deductions, please contact your Employer (for example, if the amounts deducted from your paycheck do not match the amounts on the form you used to enroll).

The BasicAdvantage Outpatient Plus Coverage described in this Summary Plan Description is not a substitute for comprehensive health insurance and does not qualify as minimum essential health coverage under the Affordable Care Act.

The Essential Coverage described in this Summary Plan Description is intended to provide minimum essential coverage under the Affordable Care Act.

This booklet, together with the copy of the form used to enroll, makes up the Summary Plan Description.

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BENEFIT PROGRAM INFORMATION

Carrier:	Reliance Standard Life Insurance Company
Carrier's Address:	1700 Market Street, Suite 1200, Philadelphia, PA 19103-3938
IMPORTANT FACTS ABOUT THE BENEFIT PROGRAM	
Eligible Employees:	All part-time employees working under 30 hours per week
Eligibility:	Immediate
Coverage Begins:	Coverage begins on the first day of the pay period following the pay period in which a premium deduction occurs.
Coverage Year:	November 1, 2020 – October 30, 2021
ERISA INFORMATION	
ERISA Plan Name:	Five Below BasicCare Program
Type of ERISA Plan:	Health and Welfare Benefits
ERISA Plan Number:	501
ERISA Plan Fiscal Year End:	October 31
ERISA Plan Sponsor:	Five Below
ERISA Plan Administrator:	Lori Kovach Director / HRIS 701 Market Street, Suite 600 Philadelphia, PA 19106 Phone: (215) 546-7909
Agent for Service:	ERISA Plan Administrator
Employer Identification #:	75-3000378

The terms and conditions of the benefits described in this booklet apply to most states; however, state laws do vary. The laws of the state in which the carrier issues the group policies may affect this Benefit Program. These differences generally do not reduce your benefits. For more information regarding any changes in your coverage because of these variances, please see the next page.

BEFORE-TAX PREMIUM DEDUCTIONS
Premiums for the BasicAdvantage Outpatient Plus and Essential Coverages are payroll deducted on a BEFORE-TAX, pretax basis. By paying premiums pretax, an employee's TAKE HOME PAY INCREASES when compared to after-tax payments because employment and income taxes are NOT withheld on the amounts used to pay premiums. Pretax deductions may, however, reduce Social Security benefits for some employees in the future.

Questions?
Call RSL Specialty Products Administration at 1-866-375-0775; representatives are ready to answer your coverage questions Monday through Friday, from 8:30 am to 5:30 pm, ET.

You also may get more information, download claim forms, check claim status or request a new ID Card by visiting our website at www.helpwithmyplan.com.

Preguntas? Este folleto contiene un resumen en ingles de su Programa de Beneficios de Grupo. Si usted tiene dificultad en entender cualquier parte, llame al numero gratuito 1-866-375-0775. Representantes de consulta estan disponibles lunes a viernes, de 8:30 am a 5:30 pm (hora del Este), para darle asistencia en espanol.

ID CARDS

Please Remember:

- ID Cards are only valid if 1) you have enrolled AND 2) your first premium has been paid.
- Your ID Card should be in the same package that included this booklet. You will not receive a separate ID Card for the prescription benefit; the ID Card included with this package includes information your pharmacist will use when you have a prescription filled.
- If you have elected BasicAdvantage Outpatient Plus Coverage, the VSP Access Plan Membership Card is included below.
- Carry your ID Card(s) with you when you visit a health care provider. Information on the card(s) will help the provider to file a claim for you.
- ID Cards are not proof of coverage under any plan.
- ID Cards become void if your coverage is terminated.

IF YOU HAVE ENROLLED FOR BASICADVANTAGE OUTPATIENT PLUS COVERAGE, CUT OUT THE VSP ACCESS PLAN MEMBERSHIP CARD AND KEEP IN YOUR WALLET.

VSP Access PLAN

VSP

As a VSP member, you'll receive the following Access Plan discounts from a VSP network doctor:

- 20% discount on your eye exam
- 20% discount on your frame, lenses and lens options when a complete pair of prescription glasses is purchased
- 15% discount on your contact lens exam (fitting & evaluation)
- Discounts on laser vision correction

These discounts are only available from the VSP network doctor who provided your eye exam within the past 12 months.

Questions? Visit our Web site at vsp.com or
Call VSP at 800-877-7195

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STATE OF PENNSYLVANIA REQUIREMENTS

The group insurance policies that provide the insurance benefits of the Benefit Program are issued in the state of Pennsylvania, which requires the following changes to the noted sections.

General Questions:

Eligibility for a child who is a full-time student will be extended beyond age 25 if the child is a member of the Pennsylvania National Guard or any reserve component of the armed forces of the United States and is called or ordered to active duty, other than active duty for training, for a period of 30 or more consecutive days. In that case, eligibility will be extended for a period equal to the duration of such child's service on active duty or active State duty, or until he or she is no longer a full-time student.

GENERAL QUESTIONS

Can I change my enrollment choices?

Under IRS rules, your coverage elections may not be changed until the next open enrollment period. This means you cannot DROP, ADD, OR CHANGE COVERAGE during the plan year, UNLESS you experience a life event change that under IRS rules allows you to modify your coverage. For example, if you didn't enroll your dependents in BasicAdvantage Outpatient Plus Coverage because they were already covered under another plan, and that coverage is lost, you can request a special enrollment within 31 days of the loss of that other coverage.

Reasons for losing other medical coverage:

- Divorce, legal separation, or death;
- Termination of a dependent's employment;
- Reduction of a dependent's hours;
- Termination of COBRA rights; or
- Loss of employer's contribution to spouse's medical coverage.

If you have a change in your family situation, such as a divorce, legal separation, death, marriage, or birth/adoption of a child, you can request a special enrollment within 31 days of that change.

YOU MUST COMPLETE A LIFE EVENT CHANGE FORM to make any enrollment change. That form is available from your Employer.

When will coverage end?

Coverage ends if:

- premiums aren't paid in full;
- you enter an Armed Service on full-time active duty;
- you are no longer eligible for the coverage; or
- the group policies terminate.

If coverage ends, you may be entitled to continue your coverage under COBRA. There is information about COBRA later in this booklet. If you enter full-time active duty in an Armed Service, you may be able to continue your coverage under the Uniformed Services Employment and Re-employment Rights Act (USERRA). There is information about USERRA later in this booklet.

How much does the Benefit Program cost?

The premium due for the Benefit Program varies depending upon the coverage you selected and which family members you cover. You should check your copy of the form you used to enroll to determine the amount due for your coverage.

Note: Premium amounts are subject to change over time.

What if I don't have a payroll deduction?

This is a question asked frequently, since many people have irregular hours or only work part-time. But, as long as you're still eligible for the Benefit Program, you can pay your premium directly. Just complete a Missed Premium Payment Form (located at the back of this booklet). Make a copy of the form in case you'll need to use it again in the future. Follow the steps on the form very carefully.

Note: You may not start coverage with a direct premium payment. Coverage can only begin if a premium is paid through payroll deduction.

Can I pay just a part of a missed premium?

No. You must pay the full premium for all consecutive missed pay periods. Partial payments will not be accepted.

How long do I have to pay a missed premium?

Your payment must be mailed within 45 days after the date of the missed deduction. If you miss more than one deduction, this 45-day rule applies to each missed deduction.

Will my insurance be canceled if I don't make up missed premiums?

No. Your coverage will not be canceled. But, no claims will be paid for losses which occur during the period that is unpaid.

Who is an eligible dependent?

Eligible dependents are:

- your lawful spouse; or
- your qualified domestic partner, and
- your eligible children through age 25.

Eligible children include your children by birth, stepchildren, foster children, legally adopted children, children living with you while you are completing adoption procedures, children of your Qualified Domestic Partner who would be eligible for coverage if they were your children, and children for whom coverage has been court-ordered.

Note: If you have a covered child who turns 26 and is disabled and unable to earn a living, they may still be eligible for coverage. You must notify your Employer within 31 days to ensure continued eligibility for that child. Proof of continued eligibility may be required from time to time.

We will not share your personal information for marketing purposes or sell your personal information unless you give us your written permission to do so.

OUR USES AND DISCLOSURES

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.

Example: We use health information about you to develop better coverage and service offerings for our insured members, including you.

Pay for your health services

- We can use and disclose your health information as we pay for your health services.

Example: We share information about you with other health benefit plans that you might also be covered by to coordinate payment for your health services.

Administer your health plan

- We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

HOW ELSE CAN WE USE OR SHARE YOUR HEALTH INFORMATION?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/ consumers/index.html.

Help with public health and safety issues – We can share your health information in certain situations such as to help prevent disease or to report suspected abuse, neglect or domestic violence.

Comply with the law – We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Address workers' compensation, law enforcement, and other government requests – We can share health information about you:

- For workers' compensation claims.
- For law enforcement purposes or with a law enforcement official.
- With health oversight agencies for activities authorized by law.

Respond to lawsuits and legal actions – We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this Notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

This Revised Notice is effective 9/23/13.

HIPAA NOTICE

Reliance Standard Life Insurance Company
First Reliance Standard Life Insurance Company
Reliance Standard Life Insurance Company of Texas

THIS NOTICE OF PRIVACY PRACTICES ("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.

This Notice applies to the BasicCare Program within Reliance Standard Life Insurance Company, First Reliance Life Insurance Company, and Reliance Standard Life Insurance Company of Texas (collectively "Reliance Standard"). We are required to abide by the terms of this Notice as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make the new Notice effective for all personal health information maintained by us.

Reliance Standard Office Contact Information: To assert any of your rights with respect to this Notice, or to obtain an authorization form, please call 1-800-487-5553 and request the appropriate form. Please direct any questions about this Notice or requests for further information, or to file a complaint: The Privacy Office, Attn. HIPAA Privacy, 1700 Market Street, Suite 1200, Philadelphia, PA 19103-3938

YOUR RIGHTS

You have the right to:

Get a copy of your claims records
- You can ask to see or get a copy of your claims records we maintain about you. Ask us how to do this.
- We will provide a copy or a summary of your claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Correct your claims records
- You can ask us to correct your claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days

Request confidential communication
You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit the information we share
- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect payment for your care.

Get a list of those with whom we've shared your information
- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make).
- We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this Privacy Notice
You can ask for a paper copy of this Notice at any time, even if you have agreed to receive the Notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you believe your privacy rights have been violated
- You can complain if you feel we have violated your rights by contacting us using the contact information above.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/ privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
- Answer coverage questions from your family and friends
  At your directions we will share information with your family, close friends, or others involved in payment for your care.
- Share information in a disaster relief situation.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

Who is a "qualified domestic partner"?
A qualified domestic partner is:
- a person who, together with you, meets the definition of domestic partner as defined by the state in which you reside; or
- if the state in which you reside does not recognize domestic partnerships, a person: who is at least 18 years of age; who is not related to you by blood; who has been living together with you 12 consecutive months or more; who is financially interdependent with you for all living expenses; and, for whom a written affidavit of domestic partnership, acceptable to the carrier, has been completed.

You may not have more than one qualified domestic partner nor may a person be a qualified domestic partner for more than one person. You must notify the carrier within 30 days if there is any change in the domestic partner status between you and qualified domestic partner. A signed statement of termination of domestic partnership will be required.

When does coverage begin and end for my dependents?
Your dependents' coverage begins when your coverage begins if you enrolled them when you enrolled. It ends when yours does, or when the dependent is no longer eligible. Your child born while coverage is in force is covered for injury and sickness (including covered events that provide necessary care and treatment of congenital defects, birth abnormality and premature birth), preventive health services, as well as routine newborn care for the first 31 days. The child will remain covered after the first 31 days only if you apply for coverage and pay any required premium within the 31-day period after the child's birth. A minor child who comes under your care and control while the coverage is in force is covered for injury and sickness and preventive health services provided you file a petition to adopt. The child will be covered from the date of placement in your home if you apply for coverage and pay any required premium within 31 days after the date of placement. However, coverage shall begin at the moment of birth if the petition for adoption, application for coverage and payment of premium occurs within 31 days after the child's birth. The carrier reserves the right to approve or disapprove any late application to cover a dependent.

If a court order requires that I provide coverage for my dependents, how will this begin?
You and your Employer will both receive the court order requiring coverage to begin for your dependents. Your Employer will then be responsible for making the appropriate arrangements and notifying the carrier.

What if both my spouse and I work for the same Employer?
You can either both choose single coverage or where spouse coverage is available, one of you may choose family coverage. You may not be covered twice. If you and your spouse have one or more eligible children, only one of you may cover all dependents (spouse and children).

COBRA – EXTENDED COVERAGE

What is COBRA?
As noted previously, if your coverage ends you may be entitled to have continued coverage in some circumstances. A federal law known as COBRA gives you this continuation right. It stands for the Consolidated Omnibus Budget Reconciliation Act of 1985. The continuation right extends to BasicAdvantage Outpatient Plus Coverage and Essential Coverage. The employee must be enrolled in the specific coverage(s) in order for that coverage to be continued.

While you may elect COBRA continuation coverage on behalf of your dependents, each person who was covered at the time coverage ends has his or her own right to elect COBRA and/or any other state continuation or conversion rights. This means that your dependents may elect such coverage even if you decide not to. So, if you have enrolled your eligible spouse or children, please share this information with them. If you would like additional copies of this booklet to share with your spouse or children, please contact your Employer. For more information about your COBRA rights, contact your Employer.

When am I eligible for COBRA?
You and your covered dependents are eligible for COBRA continuation if your coverage ends because you quit or lose your job for any reason, other than gross misconduct, or your hours are reduced. Generally, you and your dependents are entitled to continue health coverage for 18 months. However, if you or your dependents are disabled, then the period may be extended to a total term of 29 months (see "What if I am disabled when my employment ends?").

What about my dependents?
Your dependents are also eligible for COBRA continuation if they lose coverage at any time due to:
- your death;
- your divorce or legal separation;
- your becoming entitled to Medicare while on COBRA; or
- your dependent no longer meeting the eligibility definition under the Benefit Program (for example, a dependent child reaching the age limit).

In any of these qualifying events your dependents are entitled to continue health coverage for 36 months from the date of the event.

What must I do to elect COBRA?

Your Employer must provide notice when you lose or quit your job, your hours are reduced, or you become entitled to Medicare. Your Employer will notify you of your right to elect COBRA by sending you a COBRA election notice. Within 60 days of that notification, you must respond, in writing, of your election.

Do my dependents and I have to keep my Employer informed?

Yes. You and your dependents must notify your Employer of your current address and, if different, the address(es) of your dependents (spouse and children). You and/or your dependents must provide notice of: (1) your divorce or legal separation; (2) your dependent's loss of coverage for any of the reasons previously listed (see "What about my dependents?"); and (3) a determination by the Social Security Administration that you or your covered dependents are disabled. You and your dependents must mail or hand-deliver written notice of these events within 60 days to your Employer.

When does COBRA end?

COBRA coverage will end on the earliest of:

- the expiration of the maximum allowable term of 18, 29 or 36 months;
- the date the required premium is not paid when due;
- the date the group health coverage is terminated for active employees;
- the date the person on COBRA coverage first becomes covered under any other group health plan, without limitation as to any pre-existing condition that affects coverage; or
- the date the person on COBRA coverage becomes entitled to Medicare benefits.

What if I am on extended sick leave when my employment ends?

Under the federal Family and Medical Leave Act of 1993 (FMLA), you may be entitled to extended sick leave from your employment. If during that period you do not pay your premium, you can still elect COBRA if your employment ends during your FMLA leave. In such a case, you would not have to make up the missed premium for any time when you were on FMLA leave, but you would not be covered for any gaps in coverage.

What if I am disabled when my employment ends?

In order to extend continuation coverage for you and your dependents to 29 months, you or a covered family member must be disabled before or within the first 60 days of COBRA coverage. If this is the case, a copy of the Social Security Administration's "determination of disability" must be sent to your Employer within 60 days of the determination, and within the original 18 months of your COBRA coverage. The premium to be paid for this additional 11 months of coverage may be substantially greater than the premium for the initial 18-month period and you will be notified of the additional cost of the extended coverage. If, during the 11-month extension, you or your covered dependents are no longer disabled, you must notify your Employer within 30 days. The extended COBRA coverage will end when you or your dependent are no longer disabled.

Is there another way to extend COBRA coverage?

Yes. If, while under the initial 18-month COBRA continuation coverage, your covered dependents experience another event that separately entitled them to COBRA continuation, they may get up to 18 additional months of continuation coverage. Notice of the second qualifying event must be given to your Employer. This extension is available only if the event would have caused the dependent to lose coverage under the Benefit Program had the first loss of coverage not occurred.

When will I pay for COBRA coverage?

Your COBRA election notice identifies premium amounts due for your election(s). You may submit a premium payment when you return your COBRA election notice. If you do, you will be sent payment coupons for future COBRA premium payments.

If you do not pay your premium with your COBRA election notice, you must make your first premium payment within 45 days from the date of your election. After your initial premium payment, you must pay the regular monthly payments (shown on your COBRA election notice) by the first of each month. A monthly bill will not be sent to you.

What premium has to be paid for COBRA coverage?

Generally, you will pay the rate for similarly situated active employees under the Benefit Program, plus a 2% administrative fee. If the rate changes for active employees, your rate will change accordingly. As noted above, the premium for the 11-month extension because of disability could be substantially higher than normal.

What rights does a person on COBRA have during an open enrollment period?

A person on COBRA has the same rights at open enrollment as other covered persons under the Benefit Program.

Is there a way, other than COBRA, to extend coverage?

In some limited circumstances, and as governed by state law, you may be entitled to extended coverage if you lose your coverage and do not elect COBRA. At such time, you should contact your Employer to determine what rights, if any, you might have.

Are there any other insurance options available after coverage under this program terminates?

There may be other health insurance options available to you and your family. You are also able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for

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coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

YOUR RIGHTS UNDER ERISA

As a participant in the Benefit Program, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

What are my ERISA rights?

ERISA provides that all Benefit Program participants are entitled to:

- examine, without charge, at your Employer's office, all Benefit Program documents, including insurance contracts and copies of all documents filed by the ERISA Plan Administrator with the U.S. Department of Labor or the Internal Revenue Service, such as detailed annual reports and Benefit Program descriptions;
- obtain copies of all Benefit Program documents and other Benefit Program information upon written request to the ERISA Plan Administrator, who may make a reasonable charge for copies of the materials; and
- continue health care coverage for yourself or dependents if there is a loss of coverage under the Benefit Program as a result of a qualifying event (see the topic "COBRA – EXTENDED COVERAGE"). You or your dependents may have to pay for such coverage.

Review this booklet and the documents governing the Benefit Program for the rules governing your COBRA continuation coverage rights.

How long does it take to receive copies?

The ERISA Plan Administrator is required to provide you copies of requested materials within 30 days. If you do not receive the material within this time frame, you may file suit in federal court. In such a case, the court may require the ERISA Plan Administrator to provide the requested materials and pay you up to $110 a day until you receive them, unless the delay was beyond the control of the ERISA Plan Administrator.

What if I believe my rights have been denied?

ERISA imposes duties upon the people or companies who are responsible for the operation of the Benefit Program. These people or companies are referred to as Fiduciaries. Fiduciaries must act solely in the interest of you and your dependents, as Benefit Program participants. As the ERISA Plan Sponsor your Employer is a Fiduciary and, as such, must not discharge you or otherwise discriminate against you in any way to prevent you from obtaining a benefit under the Benefit Program or exercising your rights under ERISA.

What if I believe that I have been discriminated against?

You have the right to file suit in a federal court if you think your Employer or anyone else is discriminating against you or otherwise stopping you from exercising your rights under ERISA. If you win your lawsuit, the court may require the losing party to pay your legal costs and fees, in addition to whatever other penalties it may impose. However, if you lose, the court may order you to pay the costs and fees, (for example if it finds your claim was frivolous).

Is filing suit my only option?

No. If you have any questions or problems with the Benefit Program, you should first contact the ERISA Plan Administrator, who is also the agent for service of legal process. If the ERISA Plan Administrator does not satisfactorily help you, contact the nearest area office of the Pension and Welfare Benefits Administration, United States Department of Labor. This federal agency is responsible for enforcing the law under ERISA and will be able to give you guidance as to what your rights are and how you can enforce them.

Where can I get more information on my rights under ERISA?

If you have any questions about this statement or about your rights under ERISA or COBRA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or: The Division of Technical Assistance and Inquiries Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210. You can also visit the Employee Benefits Security Administration's website at www.dol.gov/ebsa.

CONFORMITY WITH THE LAW

If any provision of the Benefit Program is contrary to any law to which it is subject, such provision is hereby amended to conform thereto. Nothing in the Benefit Program is intended to replace or affect any requirements for coverage by Workers' Compensation insurance.

BENEFIT PROGRAM TERMINATION, AMENDMENT, AND ADMINISTRATION

Your Employer intends to continue the Benefit Program but reserves the right at any time, at its discretion, to terminate the Benefit Program, to modify the Benefit Program, to provide different cost-sharing between your Employer and participants, or to amend the Benefit Program in any respect. In the event the Benefit Program is terminated, any assets held in trust for the Benefit Program will be used to provide welfare benefits for employees of the ERISA Plan Sponsor or a successor, or they will be used in other ways not prohibited by the Internal Revenue Service regulations.

UNIFORMED SERVICES EMPLOYMENT and RE-EMPLOYMENT RIGHTS ACT (USERRA)

A federal law known as USERRA requires an Employer to offer continuation of coverage when an enrolled

employee is called to serve in the military. The continuation right extends to BasicAdvantage Outpatient Plus Coverage and Essential Coverage. The employee must be enrolled in the specific coverage(s) in order for it to be continued.

If you are called to military duty for more than 30 days, you may elect to continue coverage for you and your covered dependents for up to 24 months, but you may be required to pay up to 102% of the premium for your coverage. Your Employer is required to provide coverage for you as though you had remained on the job if you are out on military service for less than 31 days. In this case, you will be charged only your share of the premium. When you return to work, your coverage will be reinstated with no new waiting periods.

SUMMARY PLAN DESCRIPTION

This booklet, together with the copy you made of the form you used to enroll, is a Summary Plan Description. It provides a summary of the major provisions and benefits of the Benefit Program. It is also intended to tell you about the limitations and exclusions of the Benefit Program. Because this booklet is only a summary, it has not been written with all of the technical words and legal phrases used in the official Benefit Program documents. For full details about the insurance coverage, you may obtain a copy of the policy(ies) from your Employer. The official Benefit Program documents remain the final authority and, in the event of a conflict with this booklet, shall govern in all cases.

ASRM

ASRM is a Third Party Administrator that provides records keeping and claims paying services for the carrier identified under "BENEFIT PROGRAM INFORMATION". The carrier is the underwriter of the insurance contract(s). As a Third Party Administrator, ASRM has no discretionary powers under the Benefit Program and, in particular, has no discretionary power in the paying or denying of claims. ASRM is referred to as "RSL Specialty Products Administration" throughout this booklet.

PROGRAM FUNDING

Benefits will be provided on a fully-insured basis through the insurance contract(s) issued by the carrier directly to the ERISA Plan Sponsor. Participants are responsible for all required premiums, less any Employer contribution. The carrier provides certain policyholder and claims processing through ASRM (see above). The carrier serves as the claims review fiduciary with respect to the insurance contract(s) and the Benefit Program. The claims review fiduciary has the discretionary authority to interpret the Benefit Program and the insurance contract(s) and to determine eligibility for benefits. Decisions by the claims review fiduciary are complete, final and binding on all parties.

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MISSED PREMIUM PAYMENT FORM

REMOVE THIS PAGE AND MAKE A COPY OF THIS FORM FOR FUTURE USE

Please be sure the amount you are paying matches the full premium amount(s) due for your insurance coverage. Your payment must match the amount(s) due EXACTLY or the check will be returned to you.

We cannot accept overpayments or underpayments of premium.

INSTRUCTIONS

To make sure that your coverage is uninterrupted when a premium payroll deduction is missed:

1. Make copies of this form before filling it out so that you have a copy when needed.
2. Complete the form.
3. For each payroll deduction that was missed, you must attach a personal or cashier's check (or a money order) made payable to RSL Specialty Products Administration. If consecutive payroll deductions are missed, you must submit the total premium due for all missed payroll deductions.
4. Mail the form and your payment to the address below within 45 days from the date of the missed deduction.

IMPORTANT INFORMATION

- We will not accept a Missed Premium Payment if you have never had a premium payment deducted from your paycheck or if you are no longer part of the eligible group (for example: if your employment has been terminated).
- We will not accept a Missed Premium Payment after 45 days from the date of the missed deduction.
- Once you have sent in payment for three (3) consecutive missed premium payroll deductions, you must then begin to submit a copy of your paycheck stub for the 4th consecutive period, and any that follow.
- We will not accept your Missed Premium Payment without a completed Missed Premium Payment Form and, when required, a copy of your paycheck stub.
- You may not select the coverage period. Premium will be applied to the earliest coverage period for which premium was not paid.

Remember: FAILURE TO PAY PREMIUMS, either through payroll deduction or by sending in a Missed Premium Payment, means that your insurance coverage is interrupted for that time period.

MISSED PREMIUM INFORMATION

Company Name: Five Below

Employee Name:

Employee SSN:

Amount Enclosed: $

Please be sure the amount you are paying matches the full premium amount(s) due for your insurance coverage.

Employee Signature: _____ Date: _____

SEND THIS FORM along with your payment and a copy of your paycheck stub (when required) to:

RSL SPECIALTY PRODUCTS ADMINISTRATION
MISSED PREMIUM DEPARTMENT
505 S. LENOLA ROAD, SUITE 231
MOORESTOWN, NJ 08057

FILING A CLAIM

How do I file a claim under the BasicAdvantage Outpatient Plus or Essential Coverage?

Your provider will most likely want to file a claim for you using his or her own form. If you need to file a claim yourself, you may request a claim form from your Employer, or you may call the RSL Specialty Products Administration at 1-866-375-0775 or by visiting www.helpwithmyplan.com. Claims should be mailed to: RSL Specialty Products Administration, Claims Department, 505 S. Lenola Road, Suite 231, Moorestown, NJ 08057. Claims must be submitted within one year of the date of the loss. Under the BasicAdvantage Outpatient Plus Coverage, the carrier reserves the right to require a medical examination at its expense. For Claims Customer Service call 1-866-375-0775, Monday through Friday, 8:30 a.m. to 5:30 p.m., ET.

How do I file a claim for my dependent's contraceptive prescription under the Essential Coverage?

You may request a claim form from your Employer, or you may call the RSL Specialty Products Administration at 1-866-375-0775. You can then fill out the claim form, include a copy of the receipt showing the name of the drug and the date the prescription was filled and mail it to: RSL Specialty Products Administration, Claims Department, 505 S. Lenola Road, Suite 231, Moorestown, NJ 08057. Claims must be submitted within one year of the date of the loss. For Claims Customer Service call 1-866-375-0775, Monday through Friday, 8:30 a.m. to 5:30 p.m., ET.

When will I know if my BasicAdvantage Outpatient Plus or Essential Coverage claim is denied?

If all or a part of your claim is denied, you will be notified in writing within 30 days from the date your claim was received. Under some circumstances, the carrier can notify you that it is extending this 30-day time frame by an additional 15 days. The denial notice will include: (a) the specific reason(s) for the denial; (b) the specific policy provision(s) on which the decision is based; (c) a description of any information needed to make the claim complete; (d) a statement of your right to review (on request and at no charge) relevant internal guidelines, documents, and other information; and (e) an explanation of how to appeal for reconsideration of the decision, including your right to bring a lawsuit. If you are required to submit additional information to support your claim, you will have 45 days to do so.

How do I appeal a denied claim under the BasicAdvantage Outpatient Plus or Essential Coverage?

If you disagree with the decision, you may request a review within 180 days of the initial denial. If you do not submit your appeal on time, you generally will lose the right to appeal the denial. Your appeal must be in writing, clearly stating the reason you believe the denial is incorrect, and include any additional documentation that you feel would support a further review of your claim. You (on request and at no charge) may have reasonable access to and receive copies of all relevant documents concerning your claim. The reviewer of your appeal will be a different person or persons from the reviewer of your initial claim and will not be a subordinate of the initial reviewer. Your claim will be reviewed and a decision will be issued within 60 days from the date your appeal was received. If the decision on appeal continues to deny your claim, you will be furnished with a notice of adverse benefit determination on review, setting forth: (a) the specific reason(s) for the denial; (b) the specific policy provision(s) on which the decision is based; (c) a statement of your right to review (on request and at no charge) relevant internal guidelines, documents, and other information; and (d) a statement of your right to bring a lawsuit.

Is there any coordination of benefits under the BasicAdvantage Outpatient Plus or Essential Coverage?

Neither the BasicAdvantage Outpatient Plus Coverage nor the Essential Coverage coordinate its benefits with any other coverage you might have. That means your benefits will not be reduced because you have other coverage that pays you for the same expenses. If you have coverage from another source, that other coverage could reduce their benefits based on what the BasicAdvantage Outpatient Plus or Essential Coverage pays. An example would be the Medicare or Medicaid programs. Their rules require that your benefits under those programs be reduced by the amount of benefits you would receive under the BasicAdvantage Outpatient Plus or Essential Coverage.

What if I miss a deadline for filing or appealing any claim?

If you do not submit a claim on time, do not appeal on time, or do not otherwise follow the claims procedures, you may lose the right to file suit in court because of failure to exhaust the internal administrative appeals rights, which may be a prerequisite to bringing suit.

BASICADVANTAGE OUTPATIENT PLUS COVERAGE

What are the benefits for outpatient doctors' visits?

The Coverage pays a daily benefit for each day a covered person visits a doctor as an outpatient. The daily benefit amount and maximum number of daily benefits vary based on the type of visit. Outpatient doctors' visits daily benefit amounts and per person maximums are:

Doctor's office or urgent care facility:	$50 per day; maximum of 10 daily benefit per coverage year
Mental and nervous office visit:	$50 per day; maximum of 3 daily benefits per coverage year
Outpatient surgery (Surgeon's Fee):	$100 per day; maximum of 1 daily benefit per coverage year

What are the outpatient radiology benefits?

The Coverage pays a daily benefit for each day a covered person has outpatient diagnostic radiology services. The daily benefit amount and maximum number of daily benefits vary based on the type of diagnostic radiology service. The Coverage will not pay more than 1 outpatient radiology daily benefit per day for each covered person. Outpatient radiology daily benefit amounts and per person maximums are:

Magnetic Resonance Imaging (MRI):	$100 per day; maximum of 1 daily benefit per coverage year
Computerized Tomography (CT) Scan:	$100 per day; maximum of 1 daily benefit per coverage year
All other radiology services:	$50 per day; maximum of 3 daily benefits per coverage year

Note: If these services occur as part of an emergency room visit, they are NOT covered under this benefit. See "What if I use an emergency room?" below.

Are outpatient pathology services covered?

Yes. The Coverage pays $40 for each day a covered person has outpatient diagnostic pathology services, subject to a per person maximum of 3 daily benefits each coverage year. The Coverage will not pay more than 1 outpatient pathology daily benefit per day for each covered person.

Note: If these services occur as part of an emergency room visit, they are NOT covered under this benefit. See "What if I use an emergency room?" below.

Are visits to an urgent care facility covered?

Yes. The Coverage pays a daily benefit of $100 for each day a covered person visits an urgent care facility and receives treatment, subject to a per person maximum of 2 daily benefit each coverage year.

Are visits to an emergency room covered?

The Coverage pays a daily benefit of $500 for each day a covered person goes to a hospital emergency room for the treatment of an injury, subject to a per person maximum of 1 daily benefit each coverage year. The Coverage will not pay more than 1 emergency room daily benefit per day for each covered person.

Is transportation in an ambulance covered?

The Coverage pays a daily benefit of $100 for each day a covered person is transported to a hospital emergency room for the treatment of an injury or sickness, subject to a per person maximum of 1 daily benefit each coverage year.

Are visits to an outpatient surgical facility or surgical center covered?

Yes. The Coverage pays a daily benefit of $100 for each day a covered person visits an outpatient surgical facility or surgical center and receives treatment, subject to a per person maximum of 1 daily benefit each coverage year.

Are outpatient events that are not specifically described in the benefits covered?

No. Only the types of events that are described and categorized as outpatient doctors' visits, outpatient diagnostic radiology and pathology services, emergency room visits, and outpatient prescription drug purchases are covered. Other events, such as injections and durable medical equipment, are not covered under the Coverage and there is no benefit for these types of events.

PRESCRIPTION DRUG BENEFITS

Is there a benefit for outpatient prescription drugs?

Yes. The Coverage pays a daily benefit of $25 for each day a covered person has a generic drug prescription filled or refilled by a pharmacist. Benefits for generic drugs are subject to a per person maximum of 8 daily benefits each coverage year.

Can I use any pharmacy?

Yes, but you can use the Prescription Drug ID Card received with the BasicAdvantage Outpatient Plus Coverage to help save money at a pharmacy that participates in the Express Scripts, Inc. network.

How does the Prescription Drug ID Card work?

Most pharmacies participate in the Express Scripts, Inc. network, but you should check with the pharmacy before you make your purchase or call Express Scripts, Inc. at 1-866-282-1491 for providers in your area. Participating pharmacies provide discounts of up to 15% on all prescriptions when you present your card. You will not have to file a claim on purchases made at participating pharmacies. The pharmacist will tell you exactly what to pay.

What if I use a non-participating pharmacy?

You must pay the full price up front. Then you must call Express Scripts, Inc. at 1-866-282-1491 and request a

claim form. File the claim with Express Scripts, Inc. Do not file your prescription drug claims with RSL Specialty Products Administration.

Are there other ways that I can lower the cost of my prescriptions?

If you take a generic medication on a regular basis, a mail order service is available that may provide an even larger discount. You may visit Express Scripts, Inc. at their website www.express-scripts.com or call Express Scripts, Inc. at 1-866-282-1491 for more information.

What if I have a prescription from my dentist?

You may only purchase medical prescriptions, except when the prescription is issued in connection with covered dental treatment for an accident covered under your BasicAdvantage Outpatient Plus Coverage.

COMMONLY USED TERMS

What is the "coverage year"?

It is the period of time during which benefit maximums accumulate. Each new coverage year, the maximums are reset. You will find the coverage year under "BENEFIT PROGRAM INFORMATION". The coverage year should not be confused with the ERISA Plan Fiscal Year End.

What are "covered events"?

The Coverage usually covers events that are for the treatment of injury and sickness. These events must be medically necessary, occur while the Coverage is still in force, and not excluded.

What is a "hospital"?

A hospital is an institution operated by law for the care and treatment of injured or sick persons that has organized facilities for diagnosis and surgery (or has a contract with another hospital for these services), and has 24-hour nursing service. A hospital is not an institution that is primarily a rest, nursing or convalescent home, a home for the aged, an alcoholism or drug addiction treatment facility, or a facility for treatment of mental disorders.

What does "injury" mean?

Injury is a covered person's bodily injury caused by an accident that results, directly and independently of all other causes, in a covered loss. All injuries sustained in one accident, including all related conditions and recurring symptoms of the injuries, will be considered one injury.

What are "outpatient" events?

Outpatient events are those that occur at doctors' offices, free-standing clinics, and hospitals when you are not admitted as an inpatient.

What does "sickness" mean?

Sickness is a covered person's sickness or disease that results, directly and independently of all other causes, in a covered loss.

EXCLUSIONS AND LIMITATIONS

No benefits will be paid for loss caused by or resulting from:

- Outpatient treatment of alcoholism or substance abuse;
- Intentionally self-inflicted injuries, suicide, or any attempt thereat while sane or insane;
- Acts of declared or undeclared war;
- The covered person's commission of a felony;
- Work-related injury or sickness;
- Normal health checkups;
- Eye examinations for glasses, any kind of eye glasses, or prescriptions therefore;
- Hearing examinations, or hearing aids;
- Dental care, treatment or supplies except covered events rendered in connection with the care of sound, natural teeth and gums required on account of accidental injury that happens while covered, and rendered within 6 months of the accident;
- Reading or interpreting the results of any diagnostic pathology or radiology tests;
- Care, treatment or supplies rendered in connection with cosmetic surgery, except covered events rendered in connection with surgery needed for breast reconstruction following a mastectomy or an accident that happens while covered under the BasicAdvantage Outpatient Plus Coverage. The surgery needed for an accident must be performed within 90 days of the accident;
- Brand name drugs or drugs not requiring a prescription;
- Care, treatment or supplies rendered while outside the United States of America; and
- Care, treatment or supplies rendered by an immediate family member or by the ERISA Plan Sponsor.

IMPORTANT NOTE: Your BasicAdvantage Outpatient Plus Coverage allows access to important medical provider and pharmacy provider networks that utilize negotiated charges which may save you money. You may contact MultiPlan (at 1-800-877-0005) or Express Scripts (at 1-866-282-1491) to find network providers in your area.

- Syphilis screening for all pregnant women or other women at increased risk;
- Tobacco Use screening and interventions for all women, and expanded counseling for pregnant tobacco users;
- Urinary tract or other infection screening for pregnant women;
- Urinary incontinence screening for women yearly;
- Well-woman visits to get recommended services for women under 65.

For Children

- Alcohol, tobacco, and drug use assessments for adolescents;
- Autism screening for children at 18 and 24 months;
- Behavioral assessments for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years;
- Bilirubin concentration screening for newborns;
- Blood Pressure screening for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years;
- Blood screening for newborns;
- Cervical Dysplasia screening for sexually active females;
- Depression screening for adolescents;
- Developmental screening for children under age 3;
- Dyslipidemia screening for children at higher risk of lipid disorders at the following ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years;
- Fluoride Chemoprevention supplements for children without fluoride in their water source;
- Fluoride varnish for all infants and children as soon as teeth are present;
- Gonorrhea preventive medication for the eyes of all newborns;
- Hearing screening for all newborns;
- Height, Weight and Body Mass Index measurements for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years;
- Hematocrit or Hemoglobin screening for children;
- Hemoglobinopathies or sickle cell screening for newborns;
- HIV screening for adolescents at higher risk;
- HIV preexposure prophylaxis (PrEP) medication for people at increased risk of HIV acquisition;
- Hypothyroidism screening for newborns;
- Immunization vaccines for children from birth to age 18 —doses, recommended ages, and recommended populations vary: Diphtheria, Tetanus, Pertussis, Haemophilus influenzae Type B, Hepatitis A, Hepatitis B, Human Papillomavirus, Inactivated Poliovirus, Influenza (Flu Shot), Measles, Mumps, Rubella, Meningococcal, Pneumococcal, Rotavirus, Varicella (Chickenpox);
- Iron supplements for children ages 6 to 12 months at risk for anemia;
- Lead screening for children at risk of exposure;
- Medical History for all children throughout development at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years;
- Obesity screening and counseling;
- Oral Health risk assessment for young children Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years;
- Phenylketonuria (PKU) screening for this genetic disorder in newborns;
- Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk;
- Tuberculin testing for children at higher risk of tuberculosis at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years;
- Vision screening for all children.

- laboratory, radiology, or cardiovascular tests performed for the diagnosis or treatment of sickness, disease or injury; and
- preventive health services rendered by an immediate family member or provided by your employer.

COVERED PREVENTIVE HEALTH SERVICES

Listed below are most of the covered preventive health services. A service that is not listed may also be covered as long as it is a covered preventive health service.

Note: Many preventive health services have specific restrictions and/or limitations affecting the circumstances under which coverage will be provided.

For Adults

- Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked;
- Alcohol Misuse screening and counseling;
- Aspirin use to prevent cardiovascular disease and colorectal cancer for adults 50 to 59 years with a high cardiovascular risk;
- Blood Pressure screening for all adults;
- Cholesterol screening for adults of certain ages or at higher risk;
- Colorectal Cancer screening for adults over 50;
- Depression screening for adults;
- Diabetes (Type 2) screening for adults with high blood pressure;
- Diet counseling for adults at higher risk for chronic disease;
- HIV screening for everyone ages 15 to 65, and other ages at increased risk;
- HIV preexposure prophylaxis (PrEP) medication for people at increased risk of HIV acquisition;
- Immunization vaccines for adults--doses, recommended ages, and recommended populations vary:
  - Hepatitis A
  - Hepatitis B
  - Herpes Zoster
  - Human Papillomavirus
  - Influenza (Flu Shot)
  - Measles, Mumps, Rubella
  - Meningococcal
  - Pneumococcal
  - Tetanus, Diphtheria, Pertussis
  - Varicella
- Obesity screening and counseling for all adults;
- Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk;
- Statin preventive medication for adults 40 to 75 at high risk;
- Syphilis screening for all adults at higher risk;
- Tobacco Use screening for all adults and cessation interventions for tobacco users.

For Women

- Anemia screening on a routine basis for pregnant women;
- Breast Cancer Genetic Test Counseling (BRCA) for women at higher risk for breast cancer;
- Breast Cancer Mammography screenings every 1 to 2 years for women over 40;
- Breast Cancer Chemoprevention counseling for women at higher risk;
- Breastfeeding comprehensive support and counseling from trained providers, and access to breastfeeding supplies, for pregnant and nursing women;
- Cervical Cancer screening;
- Pap test (also called a Pap smear) every 3 years for women 21 to 65;
- Human Papillomavirus (HPV) DNA test with the combination of a Pap smear every 5 years for women 30 to 65 who don't want a Pap smear every 3 years;
- Chlamydia Infection screening for younger women and other women at higher risk;
- Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs);
- Diabetes screening for women with a history of gestational diabetes who aren't currently pregnant and who haven't been diagnosed with type 2 diabetes before;
- Domestic and interpersonal violence screening and counseling for all women;
- Folic Acid supplements for women who may become pregnant;
- Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes;
- Gonorrhea screening for all women at higher risk;
- Hepatitis B screening for pregnant women at their first prenatal visit;
- HIV screening and counseling for sexually active women;
- HIV preexposure prophylaxis (PrEP) medication for people at increased risk of HIV acquisition;
- Osteoporosis screening for women over age 60 depending on risk factors;
- Preeclampsia prevention and screening for pregnant women with high blood pressure;
- Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk;
- Sexually Transmitted Infections counseling for sexually active women;

NON-INSURANCE BENEFITS

Your BasicAdvantage Outpatient Plus Coverage allows access to important non-insurance benefits as described below. The suppliers of these plans are not affiliated with the carrier, which is not responsible for the content of the plans and cannot be held liable for any services provided or not provided by these suppliers.

What does membership in the VSP Access Plan give me?

Membership in the VSP Access Plan is a separate benefit that you receive when you are enrolled in the BasicAdvantage Outpatient Plus Coverage. This benefit, which is provided through Vision Service Plan, offers discounts on eye exams and prescription glasses from VSP network doctors. When you visit a network doctor, you can receive a 20% discount on your eye exam, a 15% discount on your contact lens exam, a 20% discount on your frame, lenses and lens options when a complete pair of prescription glasses is purchased. You also can receive discounts on laser vision correction. The discounts for prescription glasses and contact lenses are only available from the VSP network doctor who provided your eye exam within the past 12 months. For questions regarding the VSP Access Plan, call VSP at 1-800-877-7195 or visit their website at www.vsp.com.

What does membership in the On Call Travel Assistance Plan give me?

Membership in the On Call Travel Assistance Plan is a separate benefit that you receive when you are enrolled in the BasicAdvantage Outpatient Plus Coverage. This benefit offers a 24-hour, toll-free service that provides a comprehensive range of information, referral, coordination and arrangement services designed to respond to most medical care situations and many other emergencies you may encounter when you travel. This benefit also provides pre-trip assistance, including passport/visa requirements, foreign currency and weather information. All services under this benefit are provided by On Call International (On Call).

When traveling more than 100 miles from home or in a foreign country, the following services are offered:

Pre-Trip Assistance
- Inoculation requirements information
- Passport/visa requirements
- Currency exchange rates
- Consulate/embassy referral
- Health hazard advisory
- Weather information

Emergency Personal Services
- Urgent message relay
- Interpretation/translation services
- Emergency travel arrangements
- Recovery of lost or stolen luggage/personal possessions
- Legal assistance and/or bail

Emergency Medical Transportation*
- Emergency evacuation
- Medically necessary repatriation
- Visit by family member or friend
- Return of traveling companion
- Return of dependent children
- Return of vehicle
- Return of mortal remains

Medical Services Include:
- Medical referrals for local physicians/dentists
- Medical case monitoring
- Prescription assistance and eyeglass replacement
- Convalescence arrangements

*Emergency Medical Transportation services are subject to a maximum combined single limit of $250,000. Return of vehicle is subject to $2,500 maximum limit.

To use this benefit at any time before or during a trip, you may contact On Call for emergency assistance services. In the U.S., call toll-free at 1-800-456-3893. Worldwide, call collect at 1-603-328-1966

What does membership in the Broadreach Medical Resources (BMR) Telemedicine and Teletherapy plan give me?

Membership in the BMR Telehealth and Teletherapy plan is a separate benefit that you receive when you are enrolled in the BasicAdvantage Outpatient Plus Coverage. This benefit offers you the ability to talk or video chat with a doctor or licensed therapist and counsellor from the comfort and privacy of your own home or office. The service is not insurance and no referrals or approvals are ever needed to access plan benefits.

The benefits include:

- 24/7/365 Toll-free, confidential availability to talk or video chat access with licensed healthcare providers;
- On-line scheduling of 50-minute behavioral health sessions with licensed therapists, social workers and counselors;
- Medical diagnosis and personalized treatment for common illnesses and injuries;
- Lab test results reviewed;
- Medically necessary e-prescriptions (where permitted) delivered to a pharmacy of your choice;

To use this benefit, you may:

- Call toll-free 1-833-936-9633;
- Visit and login to RSL.YourBMRBenefits.com and enter the Group Validation Code (GVC): RSL2020;
- Use the free Apple iOS app which may be downloaded from the app store or use your camera to scan the QR Code and enter the Group Validation Code (GVC): RSL2020; or

- If you are using an Android device, go to the Google Play store and search 'Broadreach Medical Resources' or use your camera to scan the QR Code and enter the Group Validation Code (GVC): RSL2020.

If you need assistance with enrollment, validation or have general App and web usage questions related to the BMR Telemedicine and Teletherapy plan, please call 866-718-2375 or email care@bmr-inc.com.

What do Telemedicine and Teletherapy services cost?
Telehealth services are available after a $30 per-consultation fee has been paid. Teletherapy services are available after a $69 per-consultation fee has been paid. Credit card payment is required in order to access these benefits.

ESSENTIAL COVERAGE

What is the Essential Coverage?
The Coverage pays 100% of the charges a covered person incurs for covered preventive health services. There is a $50 co-pay per prescription for brand name contraceptive prescription drugs. There are no other co-pays, deductibles or maximums.

What does "covered preventive health services" mean?
Covered preventive health services are services that meet the requirements of the Affordable Care Act as determined by the federal government.

What does "co-pay" mean?
A co-pay is the specified amount that you are responsible for paying each time you incur charges for covered brand name contraceptive prescription drugs, before the Coverage begins to pay benefits.

What does "usual and customary" mean?
Usual and customary is a guideline that the carrier uses to determine how much of a charge the Coverage will consider. A "usual" charge is the charge made for a given service by a provider to the majority of its patients. A "customary" charge is one that is charged by the majority of providers within a community for the same services.

How do I file a claim to be reimbursed for payment of a covered expense?
Your provider will most likely want to file a claim for you using his or her own form; however, there are some instances when you may have to pay for services or supplies and submit a claim for reimbursement. For example, your doctor may place you on an aspirin regiment to prevent heart disease, but you must pay for the aspirin when you purchase it. In order to be reimbursed for that purchase, you may submit a claim for reimbursement.

You may request a claim form from your Employer, or you may call the RSL Specialty Products Administration at 1-866-375-0775. You can then fill out the claim form, include a copy of the receipt showing the name of the drug and the date the prescription was filled and mail it to: RSL Specialty Products Administration, Claims Department, 505 S. Lenola Road, Suite 231, Moorestown, NJ 08057. Claims must be submitted within one year of the date of the loss. For Claims Customer Service call 1-866-375-0775, Monday through Friday, 8:30 a.m. to 5:30 p.m., ET.

Can I use any pharmacy to get covered preventive prescription drugs?
Yes, but you can use the Prescription Drug ID Card received with the Coverage to help save money at a pharmacy that participates in the Express Scripts, Inc. network.

How does the Prescription Drug ID Card work?
Most pharmacies participate in the Express Scripts, Inc. network, but you should check with the pharmacy before you make your purchase or call Express Scripts, Inc. at 1-866-282-1491 for providers in your area. You will not have to file a claim on purchases you make for your own covered preventive prescriptions at participating pharmacies. The pharmacist will tell you exactly what to pay. If you have covered any of your dependents (spouse or child) under the Essential Coverage, you will have to pay the full, undiscounted price for their covered preventive prescription and submit a claim for reimbursement.

What if I use a non-participating pharmacy?
You must pay the full price up front for your covered preventive drug prescription. Then you must call Express Scripts, Inc. at 1-866-282-1491 and request a claim form. File the claim with Express Scripts, Inc. Do not file your prescription drug claims with RSL Specialty Products Administration. If your purchase at a non-participating pharmacy is for your covered dependent, follow the below instructions.

How do I file a claim to be reimbursed for payment of my covered dependent's covered preventive drug prescription?
You may request a claim form from your Employer, or you may call the RSL Specialty Products Administration at 1-866-375-0775. You can then fill out the claim form, include a copy of the receipt showing the name of the drug and the date the prescription was filled and mail it to: RSL Specialty Products Administration, Claims Department, 505 S. Lenola Road, Suite 231, Moorestown, NJ 08057. Claims must be submitted within one year of the date of the loss. For Claims Customer Service call 1-866-375-0775, Monday through Friday, 8:30 a.m. to 5:30 p.m., ET.

EXCLUSIONS AND LIMITATIONS
No benefits will be paid for loss caused by or resulting from:

- injury or self-inflicted bodily harm;
- sickness or disease of any kind;
- acts of declared or undeclared war;
- the covered person's commission of a felony;
- charges in excess of the lesser of actual or usual and customary charges;
- preventive health services not meeting the requirements of the Affordable Care Act;
- dental care, treatment or supplies, except those specifically included as a covered preventive health service for a child;