2020

EMPLOYEE BENEFITS GUIDE

U.S. COTTON

U.S. COTTON

Welcome to the 2020 Benefits Open Enrollment

The U.S. Cotton annual insurance open enrollment period is about to begin.

We recognize the importance of benefits within the overall compensation package provided to all of our eligible employees. This year when we reviewed our employee benefits options, we focused not only on providing quality medical plans but also on controlling the cost and financial risk for our employees. We offer a benefits program that we feel meets the individual needs of our employees and their dependents.

Open enrollment runs

October 31 to November 14

Go to:

www.explainmybenefits.com/uscotton

NOT SURE HOW TO GET STARTED?
DON'T WORRY!

Prior to open enrollment, you will receive step-by-step enrollment instructions by email from our HR team.

Until then, now is the perfect time to prepare by doing the following:

- ✔ Checking that your personal information is accurate on the Explain My Benefits website.
- ✔ Reviewing the benefits in which you are currently enrolled
- ✔ Taking a look at the changes for 2020
- ✔ Checking out the program being offered for the coming year

In this booklet, you'll find easy-to-understand instructions to help you make your benefit decisions.

As always, we value you as a member of the U.S. Cotton family and look forward to a healthy and safe 2020.

CIGNA NETWORK

- Our benefits strategy for 2020 includes the Cigna network as our provider & facility network of choice. You will need to confirm that your chosen doctor or hospital are in the Cigna PPO network to take advantages of the lowest cost option for you and your covered family members. There are no changes to the plan design or contribution strategy for 2020, and the plan will still be administered by GPA (Group & Pension Administrators). We partner with Express Scripts for our pharmacy benefits.

REMEMBER:

Open enrollment is the one time of year you can make any adjustments you'd like for the upcoming plan year.

TABLE OF CONTENTS

CONTACT INFORMATION

If you have any questions regarding your benefits, please contact Explain My Benefits or your U.S. Cotton Human Resources representative.

Medical

GPA
www.gpatpa.com
972-238-7900 or 800-827-7223
Group# H880009

Dental

GPA
www.gpatpa.com
972-238-7900 or 800-827-7223
Group# H880009

Vision

GPA
www.gpatpa.com
972-238-7900 or 800-827-7223
Group# H880009

Basic Life and AD&D, Supplemental Term and AD&D, Short-Term Disability and Long-Term Disability

MetLife
www.metlife.com/mybenefits
800-438-6388

Employee Assistance Program

MetLife
metlifeeap.lifeworks.com
Username: metlifeeap
Password: eap
888-319-7819

Flexible Spending Accounts

Flores
www.flores247.com
800-532-3327

Throughout this booklet you will find video and link icons that will take you to resources that provide additional information on the benefits available to you.

MEDICAL INSURANCE

1

YOUR MEDICAL PLAN

Learn about your Medical plan design and the roles each of our vendor partners play.

- ☐ **Cigna PPO Network**
- ☐ **GPA TPA**
- ☐ **ELAP Services**
- ☐ **Express Scripts/Rx Benefits**

TIP: Get the most out of your insurance by using in-network providers.

FIND A CIGNA PHYSICIAN

- Log on to www.cigna.com
- Click on *Find a Doctor, Dentist or Facility*
- Click *Employer or School*
- Enter your Address, City, or Zip Code
- Click your preferred search method—either *Doctor by Type*, *Doctor by Name*, or Facility *Locations* by name or type

REGISTER FOR MYCIGNA.COM ACCESS TO FIND PROVIDERS, VIEW YOUR ID CARD, ACCESS CLAIM INFORMATION, AND MORE

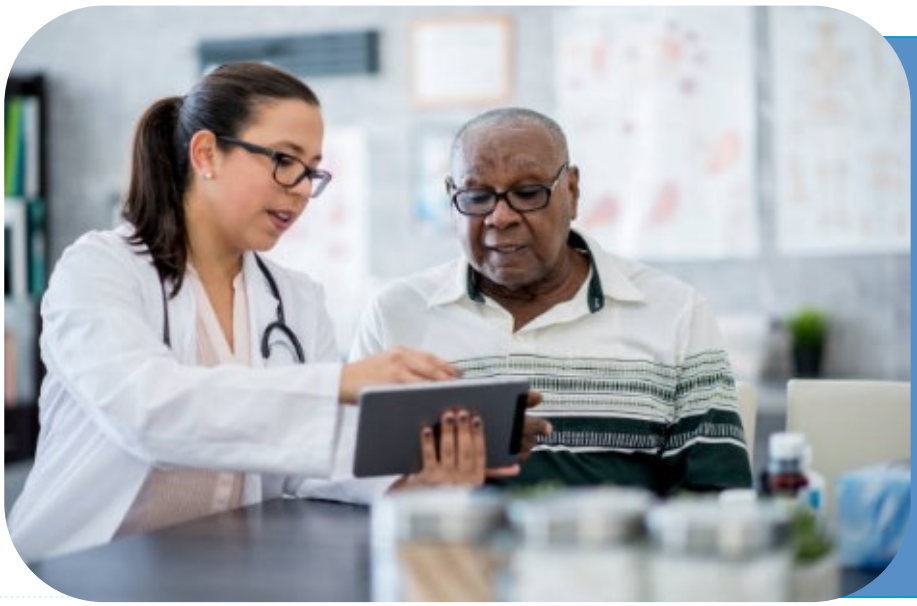
2020 Medical Program
There are no changes to the plan design or contribution strategy, and the medical plan remains administered by GPA (Group & Pension Administrators).

U.S. Cotton offers one PPO medical plan with copays for in-network office visits and prescription drugs, giving you straightforward access that's easy to plan for when using in-network services. The plan has a low deductible in the event you have an inpatient hospital stay or an outpatient procedure. The deductible runs from January 1—December 31.

Our plan uses the Cigna PPO Network. You can save money by using in-network providers because Cigna has negotiated significant discounts with them.

If you have out-of-network services, we will continue to use ELAP (ERISA Liability Assurance Program) Services, LLC, to provide you lower-cost resolution to non-network services.

We partner with Express Scripts for our pharmacy benefits.



Care Options

While we recommend that you seek routine medical care from your primary care physician whenever possible, there are alternatives available to you. Services may vary, so it's a good idea to visit the care provider's website. Be sure to check that the facility is in-network by calling the toll-free number on the back of your medical ID card, or by visiting www.mycigna.com to search.

PRIMARY CARE

- Routine, primary/ preventive care
- Non-urgent treatment
- Chronic Disease Management

CONVENIENCE CARE

- Common infections (Ear infections, pink eye, strep throat & Bronchitis)
- Flu shots
- Pregnancy tests
- Vaccines
- Rashes
- Screenings

URGENT CARE

- Sprains
- Small cuts
- Strains
- Sore throats
- Minor infections
- Mild Asthma Attacks
- Back Pain or strains

EMERGENCY ROOM

- Heavy bleeding
- Large open wounds
- Chest pain
- Spinal injuries
- Difficulty breathing
- Major burns
- Severe head injuries

Primary Care vs. Urgent Care vs. ER

If you believe you are experiencing a medical emergency, go to the nearest emergency room or call 911, even if your symptoms are not described here.

CALL 9-1-1

PRIMARY CARE

For routine, primary/ preventive care or non-urgent treatment, we recommend going to your doctor's office. Your doctor knows you and your health history and has access to your medical records. You may also pay the least amount out of pocket.

CONVENIENCE CARE

These providers are a good alternative when you are not able to get to your doctor's office and your condition is not urgent or an emergency.

They are often located in malls or retail stores (such as CVS, Walgreens, Wal-Mart and Target), and generally serve patients 18 months of age or older without an appointment. Services may be provided at a lower out-of-pocket cost than an urgent care center.

URGENT CARE

Sometimes you need medical care fast, but a trip to the emergency room may not be necessary.

During office hours, you may be able to go to your doctor's office. Outside regular office hours—or if you can't be seen by your doctor immediately—you may consider going to an Urgent Care Center where you can generally be treated for many minor medical problems faster than at an emergency room.

EMERGENCY ROOM

An emergency medical condition is any condition (including severe pain) which you believe that, without immediate medical care, may result in serious injury or is life threatening.

Emergency services are always considered in-network. If you receive treatment for an emergency in a non-network facility, you may be transferred to an in- network facility once your condition has been stabilized.

MEDICAL/RX INSURANCE

GPA/ EXPRESS SCRIPTS

Cost Sharing	In-Network	Out-of-Network
Deductible (Individual/Family)	$250 / $750	$500/$1,500
Coinsurance (Member Share)	15%	40%
Annual Out-of-Pocket Maximum (Individual / Family)	$1,500 / $3,000	$3,000 / $6,000
Plan Coverage	**In-Network**	**Out-of-Network**
Preventive / Wellness Benefits	Covered at 100%	Ded then 40%
Office Visit (includes exam, treatment, lab, x-ray, and office surgery)	Primary Care: $20 copay Specialist: $35 copay	Ded then 40%
Physician Hospital Visits / Surgeon	Ded then 15%	Ded then 40%
Mental / Nervous Disorders and Substance Abuse Office Visits	$35 copay	Ded then 40%
Urgent Care (includes lab and x-ray)	$35 copay	Ded then 40%
Ambulance Services	Ded then 15%	
Emergency Room Visit	$250 copay	
Outpatient Therapies Physical, Occupational, Manipulative Therapy and Chiropractic Speech and Hearing Therapy	Ded then 15% Ded then 15%	Ded then 40% Ded then 40%
Orthotics	15%	40%
Durable Medical Equipment and Medical Supplies	Ded then 15%	Ded then 40%
Inpatient Hospital Services	Ded then 15%	Ded then 40%
Maternity Inpatient Hospital Services	Ded then 15%	Ded then 40%
Skilled Nursing Facility	Ded then 15%	Ded then 40%
Hospital Emergency Room (all related charges)	Ded then 15%	Ded then 40%
Outpatient Surgical Facility	Ded then 15%	Ded then 40%
Pharmacy Benefits	**In-Network**	**Out-of-Network**
Tier 1—Generic Drugs	$5 copay	$5 copay
Tier 2—Preferred Brand name Drugs	$35 copay	$35 copay
Tier 3—Non-Preferred Brand Name Drugs	$40 copay	$40 copay
Specialty Drugs	$40 copay	$40 copay

Premiums can be withheld from your paycheck on a pre-tax basis for Medical, Dental, and Vision insurance. Based upon your individual tax bracket, this could save you a considerable amount of money.

Your election can only be changed during the plan year if you experience a qualifying life status change. You must notify Human Resources within 30 days of the event.

Both plans are detailed in GPA's 2020 Certificate of Coverage (COC). This is a brief summary only. For exact terms and conditions, please refer to your certificate.

FLEXIBLE SPENDING ACCOUNTS

2 SELECT FSA ACCOUNTS

- ☐ **Medical Flexible Spending Account**
- ☐ **Dependent Care Expense Account**

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

The Medical FSA can reimburse you for eligible medical expenses for you, your spouse (if you file a join tax return), your children (under age 26) and your tax dependents.

Copays, deductibles, orthodontia, prescription medications, eye wear, vision exams, and other dental procedures are all examples of covered expenses.

There is a $500 dollar carry over amount. Keep in mind that any amount that is unused is then forfeited.

You have until March 15, 2021 to access 2020 funds.

Eligible Expenses Examples

- Coinsurance and copayments
- Contraceptives
- Crutches
- Dental expenses
- Dentures
- Diagnostic expenses
- Eyeglasses, including exam fee
- Handicapped care and support
- Nutrition counseling
- Hearing devices and batteries
- Hospital bills
- Deductible Amounts
- Laboratory fees
- Licensed practical nurses
- Orthodontia
- Orthopedic shoes
- Oxygen
- Prescription drugs
- Psychiatric care
- Psychologist expenses
- Routine physical
- Seeing-eye dog expenses
- Prescribed vitamin supplements (medically necessary)

What is a Flexible Spending Account?

Full list of Eligible Examples

How the Health Care Flexible Spending Account Works

When you have out-of-pocket expenses (such as copayments and deductibles), you can either use your FSA debit card to pay for these expenses at qualified providers or submit an FSA claim form with your receipt to Flores. Reimbursement is issued to you through direct deposit into your bank account, or if you prefer, a check can be issued.

2020 Maximum Contributions

Health Care Flexible Spending Account	$2,750 max*
Dependent Care Expense Account	$5,000 max

DEPENDENT CARE EXPENSE ACCOUNT

The Dependent Care FSA can reimburse you for daycare expenses provided for your dependent(s) that allows you (and your spouse, if applicable) to work. Care must be for a dependent child under the age of 13 or a dependent of any age that lives in your household and is incapable of self-care.

Contact Information

Request a full statement of your accounts at any time by calling 800-532-3328 or log on to http://www.flores247.com to review your FSA balance.

At http://www.flores247.com you can:

Sample Instructions

- View account information and activity
- File claims
- Manage your profile
- View notifications
- Access forms

**At the time this guide was printed, $2,750 was the projected IRS maximum FSA limit for 2020. If the maximum is not increased for 2020, your election will be capped at $2,700.*

DENTAL INSURANCE

3 REVIEW YOUR DENTAL PLAN

CIGNA IS THE DENTAL NETWORK FOR 2020.

NEW FOR 2020: BENEFIT INCREASES!

The Annual Benefit Maximum is increasing to $1,500 AND the Lifetime Orthodontia Maximum is increasing to $1,500!

The dental plan is a PPO that offers coverage in and out-of-network. It is to your advantage to utilize a network dentist in order to achieve the greatest cost savings. If you choose to go out-of-network, you will be responsible for any cost exceeding GPA's negotiated fees, plus any deductible and coinsurance associated with your procedure.

Dependent children are eligible until the end of the month in which they turn age 26.

GPA

FIND A DENTIST

To find a GPA provider in your area, visit the website at www.cigna.com

In-Network Providers: Provider is reimbursed based on contracted fees and cannot balance bill you.

Out-of-Network Providers: Provider is reimbursed based on Reasonable and Customary standards and balance billing is possible.

What is Dental Insurance?

GPA	Your Cost	
Deductible	$50	Applied to Basic & Major Services
Annual Maximum	$1,500	Applied to Preventive, Basic, and Major Services
	Carrier Pays	
Diagnostics/ Preventive Services	Carrier pays 100% (no deductible)	• Oral examinations • Bitewing X-rays • Fluoride treatments • Sealants • Prophylaxis: cleanings
Basic Services	80%	• Space maintainers • Full mouth, periapical & other X-rays • Fillings • Occlusal guards/bruxism appliances • Oral surgery—simple extractions • Labs & other tests • Emergency palliative treatment
Major Services	50%	• Endodontics • Periodontics • Fixed bridges • Inlays/onlays/crowns • Implants • Dentures • Occlusal adjustments • General anesthesia • Oral surgery: surgical extractions & other surgery
Orthodontia services Child(ren)	50% up to $1,500 lifetime maximum	• Diagnostics and treatment

VISION INSURANCE

GPA

4 REVIEW YOUR VISION PLAN

CIGNA IS THE VISION CARRIER FOR 2020.

NEW FOR 2020: BENEFIT INCREASES!

Lenses and Frames will now be covered up to $180, then the plan will pay 10%!

What is Vision Insurance?

The vision plan offers coverage both in-network and out-of-network. It is to your advantage to utilize a network provider in order to achieve the greatest cost savings. If you go out-of-network, your benefit is based on a reimbursement schedule.

Also, if you are considering Lasik surgery or other non-covered benefits, there are discounts available with some providers.

	In-Network	Out-of-Network
Routine Eye Exam	$20 Copay	Benefits Not Available
Lenses and Frames	**Covered up to $180, then the plan pays 10%** The plan will pay for either one pair of prescription eyeglasses, one pair of hard or soft contact lenses, or a one-year supply of disposable contact lenses per year. Any services in excess of this benefit period maximum are not covered services.	

To locate a vision provider, go to www.mycigna.com and log in to your account. From there, you will be able to locate a doctor inside your network.

LIFE INSURANCE AND AD&D

MetLife

5 REVIEW YOUR LIFE INSURANCE POLICY

- ☐ Add your spouse
- ☐ Add your dependents
- ☐ Increase your coverage

DID YOU KNOW?

U.S. Cotton provides you Basic Life and AD&D AT NO CHARGE

BASIC LIFE AND AD&D

U.S. Cotton provides 2x your annual earnings, rounded to the next higher $1,000 if not already a multiple thereof, to a maximum of $350,000.

This coverage is offered through MetLife **at no cost to you.**

What is Life and AD&D Insurance?

SUPPLEMENTAL LIFE AND AD&D AND DEPENDENT LIFE

You can purchase additional Life and AD&D Coverage beyond what U.S. Cotton provides. MetLife guarantees coverage during your initial enrollment period—which means you can't be turned down for coverage based on medical history, up to certain amounts.

Quick Facts:

- You must purchase additional supplemental life coverage on yourself if you would like to purchase supplemental life coverage for your spouse and/or eligible dependent children.
- For beneficiaries, please be sure to update your beneficiary information during your enrollment session.

Benefit Highlights—Supplemental Employee Life/AD&D	
Benefit Amount Options *Life/AD&D*	$10,000—$250,000 (in $10,000 increments)
Guaranteed Issue Amount	$150,000
Health Questions	Newly eligible enrollment greater than $150,000, New enrollment after initial period of eligibility, or increases of more than $10,000 require health questions, and approval is note guaranteed
Benefit Reduction	Coverage reduces to 35% at Age 75
Benefit Highlights—Supplemental Dependent Life/AD&D	
Benefit Amount Options *Life/AD&D*	**Spouse:** $10,000 or 50% of Employee's Supplemental election, whichever is less **Children:** $5,000
Guaranteed Issue Amount	**Spouse:** $10,000 ; **Children:** $5,000
Health Questions	Election after the initial period of eligibility will require health questions to be answered by each of the dependents
Benefit Reduction	Coverage reduces to 35% at Age 75

Please note: All Supplemental Life elections will include a corresponding election for Supplemental AD&D.

DISABILITY COVERAGE

6 REVIEW YOUR DISABILITY COVERAGE

- ☐ Short-Term Disability
- ☐ Long-Term Disability

MetLife

SHORT-TERM DISABILITY INSURANCE

Short-Term Disability insurance is offered through MetLife. U.S. Cotton pays 100% of the premium cost. The plan benefit is 60% of basic weekly earnings up to a maximum of $2,000 per week.

Benefits are paid after a waiting period of 0 days for an accident and 7 days for sickness. Benefits can continue for up to 26 weeks.

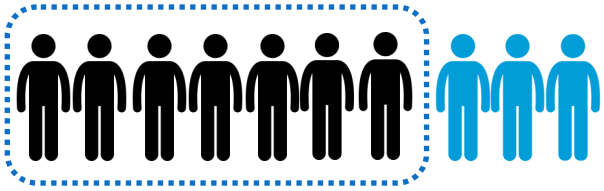
LONG-TERM DISABILITY INSURANCE

Long-Term Disability insurance offered through MetLife is provided at no cost to you. The plan benefit is 60% of basic monthly earnings up to a maximum of $6,000 per month. Basic earnings is the average of your gross monthly income for the year immediately prior to the onset of disability and excludes commissions, bonuses, overtime pay, shift differential pay, or any other earnings.

The benefits begin after a 180 day waiting period.

Could you pay the bills if you weren't working?

Less than **1/4** of U.S. consumers have enough emergency savings to cover six months or more of their expenses.



Nearly **70%** of workers that apply to Social Security Disability Insurance **are denied.**

Maximum Payment Duration	
Disability Begins…	
Less than age 60	To Social Security Normal Retirement Age (SSNRA)
60	60 months or to SSNRA, whichever is greater
61	48 months or to SSNRA, whichever is greater
62	42 months or to SSNRA, whichever is greater
63	36 months or to SSNRA, whichever is greater
64	30 months or to SSNRA, whichever is greater
65	24 months
66	21 months
67	18 months
68	15 months
69 and over	12 months

CRITICAL ILLNESS

Guardian

PROTECT YOUR FINANCES

7

- ☐ Elect Critical Illness coverage
- ☐ Elect Accident insurance

Benefit Highlights	
Plan Description	Designed to help employees offset the financial effects of a catastrophic illness with a lump-sum benefit if an insured is diagnosed with a covered specified disease
Type of Plan	Specified Disease with Cancer
Coverage Options	Employee/Child, Spouse
Child Coverage	Automatically included with Employee coverage, issue age to 26
Coverage Reduction	Plan reduces 50% on policy anniversary following insured's 70th birthday

Specified Disease Coverage	
Covered Conditions	Cancer, Carcinoma in Situ, Heart Attack, Coronary Artery Bypass Surgery, Stroke, End Stage Renal (Kidney) Failure, Major Organ Failure, Permanent Paralysis as the result of a Covered Accident, Coma as the result of Severe
Additional Covered Conditions for Dependent Children	Cerebral Palsy, Cleft Lip or Palate, Club Foot, Cystic Fibrosis, Down Syndrome, Muscular Dystrophy, Spina Bifida, Type 1 Diabetes

Benefit Options	
Coverage Amount – Employee	$5,000 - $30,000 (in $5,000 increments)
Coverage Amount – Spouse	$2,500 - $15,000 (in $2,500 increments)
Coverage Amount – Child	25% of Employee Coverage Amount
Guaranteed Issue Amount *(under age 70)*	**Employee**: $30,000 **Spouse**: $15,000
Evidence of Insurability	Only required for applicants over age 70
Pre-Existing Condition	12/12
Benefit Waiting Period	None
Wellness Benefit	$50 per insured per calendar year
Portability	Included

HOW CRITICAL ILLNESS COVERAGE WORKS

1. Critical Illness coverage is selected
2. You experience chest pains and numbness in your left arm
3. You visit the emergency room
4. A physician determines that you have suffered a heart attack

GROUP ACCIDENT INSURANCE

If you're like most people, you don't budget for life's unexpected moments. One mishap can send you on an unexpected trip to your local emergency room—and leave you with a flurry of unexpected bills.

That's where Accident Insurance jumps in.
In the event of a covered accident, the plan pays you cash benefits fast to help you pay for the costs associated with out-of-pocket expenses and bills—expenses major medical may not take care of.

Benefit Highlights	
Plan Description	Designed to help covered employees meet the out-of-pocket expenses and extra bills that can follow an accidental injury, whether minor or catastrophic.
Type of Plan	On/Off job
Benefit Option	Medium Benefit Plan Design (does not include sickness hospital confinement)
Family Coverage Options	Employee, Spouse, and Child
Pre-Existing Condition Rules	None
New Employee Waiting Period	30 days
Wellness benefit	$50 per insured per calendar year
Portability	Included under age 70
Schedule of Benefits	See following schedule for highlights

[What is Accident Insurance?]

PERMANENT LIFE—GUARDIAN

Guardian

Employee Coverage	
Coverage Amounts	$10,000 to $100,000
Issue Ages	Age 15 – 80
Evidence of Insurability	May enter at any level without EOI
Guaranteed Issue	Yes
Pre-Existing Condition Limitation	None

Spouse Coverage	
Coverage Amounts	$5,000 to $50,000 (up to 50% of Employee amount)
Evidence of Insurability	Required for coverage amounts over $10,000
EE Coverage Requirement	Employee coverage required
Guaranteed Issue	$10,000
Pre-Existing Condition Limitation	None

Child Coverage	
Coverage Amount	$10,000
Future Coverage	No increases are permitted
EE Coverage Requirement	Employee coverage required
Issue Ages	14 days to 26 years old
Child Term Rider	Employee can have both the Child Term Rider and Child standalone coverage
Guaranteed Issue	Yes
Pre-Existing Condition Limitation	None

EMPLOYEE ASSISTANCE PROGRAM

METLIFE

Program Highlights	
How it Works	Up to five confidential sessions with a counselor, financial planner, or attorney are available to you and your eligible family members each calendar year. Consultations may be face-to-face or over the phone.
Confidential Counseling	Stress, anxiety and depression, credit card or loan problems, job pressures, grief and loss, substance abuse
Financial Information and Resources	Getting out of debt, credit card or loan problems, tax questions, retirement planning, estate planning, saving for college
Legal Support	Divorce and family law, debt and bankruptcy, landlord/tenant issues, real estate transactions, civil and criminal actions, contracts, Identity theft.
Online Services	Visit the member portal for a wide range of tools and information to help you take charge of your well-being and simplify your life.

BENEFIT INQUIRIES

Phone: 888-319-7819
Website: http://metlifeeap.lifeworks.com
Username: metlifeeap
Password: eap

VIDEO LIBRARY

MEDICAL PLANS

- Medical Plans Explained
- Primary Care vs. Urgent Care vs. ER
- PPO Overview

INSURANCE 101

- Benefits Key terms Explained
- How to Read an EOB
- What is a Qualifying Event?

OPEN ENROLLMENT RUNS

OCTOBER 31 to NOVEMBER 14

TAX ADVANTAGE SAVINGS ACCOUNTS

- What is a Flexible Spending Account?
- What is a 401(K) Retirement Plan?

ANCILLARY BENEFITS

- What is Dental Insurance?
- What is Vision Insurance?
- What is Life and AD&D Insurance?
- What is Accident Insurance?
- What is Critical Illness Insurance?
- What is Paid Time Off?

GLOSSARY OF MEDICAL TERMS

Coinsurance—The plan's share of the cost of covered services which is calculated as a percentage of the allowed amount. This percentage is applied after the deductible has been met. You pay any remaining percentage of the cost until the out-of-pocket maximum is met. Coinsurance percentages will be different between in-network and non-network services.

Copays—A fixed amount you pay for a covered health care service. Copays can apply to office visits, urgent care or emergency room services. Copays will not satisfy any part of the deductible. Copays should not apply to any preventive services.

Deductible—The amount of money you pay before services are covered. Services subject to the deductible will not be covered until it has been fully met. It does not apply to any preventive services, as required under the Affordable Care Act.

Emergency Room—Services you receive from a hospital for any serious condition requiring immediate care.

Lifetime Benefit Maximum—All plans are required to have an unlimited lifetime maximum.

Medically Necessary—Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms, which meet accepted standards of medicine.

Network Provider—A provider who has a contract with your health insurer or plan to provide services at set fees. These contracted fees are usually lower than the provider's normal fees for services.

Out-of-pocket Maximum—The most you will pay during a set period of time before your health insurance begins to pay 100% of the allowed amount. The deductible, coinsurance and copays are included in the out-of-pocket maximum.

Preauthorization—A process by your health insurer or plan to determine if any service, treatment plan, prescription drug or durable medical equipment is medically necessary. This is sometimes called prior authorization, prior approval or precertification.

Prescription Drugs—Each plan offers its own unique prescription drug program. Specific copays apply to each tier and a medical plan can have one to five separate tiers. The retail pharmacy benefit offers a 30-day supply. Mail order prescriptions provide up to a 90-day supply. Sometimes the deductible must be satisfied before copays are applied.

Preventive Services—All services coded as Preventive must be covered 100% without a deductible, coinsurance or copayments.

UCR (Usual, Customary and Reasonable)—The amount paid for medical services in a geographic area based on what providers in the area usually charge for the same or similar service.

Urgent Care—Care for an illness, injury or condition serious enough that a reasonable person would seek immediate care, but not so severe to require emergency room care.

IMPORTANT NOTICES

NOTE: Details regarding U.S. Cotton plans can be found in the Summary Plan Description/ Summary of Benefits and Coverage documents. To request these documents please contact HR.

MEDICARE PART D CREDITABLE COVERAGE

Applies to all Medicare-eligible individuals including employees, former employees, and Medicare-eligible dependents covered by U.S. Cotton group health plan or who become eligible to enroll in group health plan.

This notice has information about your current prescription drug coverage and about your options under Medicare's prescription drug coverage. If you are eligible for Medicare, the following information can help you decide whether or not you want to join a Medicare drug plan. You should consider comparing your current coverage through our medical plan with the costs of plans offering Medicare prescription drug coverage in your area. Two important things you need to know about your current coverage and Medicare prescription drug coverage:

Medicare prescription drug coverage is available if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan.

All Medicare drug plans provide at least a standard level of coverage set by Medicare. More coverage may be offered at a higher premium.

GPA has determined that the prescription drug coverage offered by U.S. Cotton is on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because this coverage is Creditable Coverage, you can keep it and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

If you lose your current creditable prescription drug coverage through no fault of your own, you will be eligible for a two-month Special Enrollment Period to join a Medicare drug plan.

If you decide to join a Medicare drug plan, your current coverage may not be affected. This plan will coordinate with Part D coverage. If you drop your current coverage, be aware that you and your dependents may be able to get this coverage back.

If you drop or lose your current coverage and don't join a Medicare drug plan within 63 continuous days after your coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

This information is provided for the Medicare open enrollment period which began on October 15. If you want more information about Medicare plans that offer prescription drug coverage, you will find it in the "Medicare & You" handbook or you can visit medicare.gov or call 800.MEDICARE (800.633.4227).

TTY users: 800.486.2048. If you have limited income and resources, visit Social Security at socialsecurity.gov, or call 800.772.1213 (TTY users call 800.325.0778).

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

This notice is intended as a brief outline; please see Human Resources for more information.

GRANDFATHERED HEALTH PLANS NOTICE

This plan believes it is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at 888-243-4756. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

SPECIAL ENROLLMENT NOTICE

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact 888-243-4756.

Two additional special enrollment events are available to you and your eligible dependents. They are:

1. **Becoming ineligible for Medicaid or the Children's Health Insurance Program (CHIP).** If you or your dependents become ineligible for Medicaid or CHIP, you may be able to enroll yourself and your dependents in the [Name of Plan]. You must request enrollment within [insert "60 days" or any longer period that applies under the plan].
2. **Becoming eligible for Premium Assistance through Medicaid or CHIP.** If you or your dependents become eligible for premium assistance from Medicaid or CHIP, you may be able to enroll yourself and your dependents in the [Name of Plan]. You must request enrollment within [insert "60 days" or any longer period that applies under the plan].

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: $250 deductible per member, $750 per family, 15% in-network coinsurance. If you would like more information on WHCRA benefits, contact your plan administrator or HR.

WOMENS HEALTH AND CANCER RIGHTS ACT OF 1998

Did you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema)? Contact your Plan Administrator or HR for more information.

NOTICE OF MATERIAL CHANGE

U.S. Cotton has amended the Medical, Dental and Vision benefit plans. This benefit guide contains a summary of the modifications that were made. It should be read in conjunction with the Summary Plan Description or Certificate of Coverage, which is available to you once it has been updated by the carriers. If you would like a copy, please submit your request to Human Resources.

NOTICE OF PRIVACY PRACTICES

U.S. Cotton is subject to the HIPAA privacy rules. In compliance with these rules, it maintains a Notice of Privacy Practices. You have the right to request a copy of the Notice of Privacy Practices by contacting Human Resources.

IMPORTANT INFORMATION REGARDING 1095 FORMS

As an employer with 50 or more employees, we are required to provide 1095-C forms to all employees who were eligible for coverage under our group health plan in 2020. If you were eligible for coverage under our group plan, you'll receive a personalized 1095-C form. We are also required to send a copy of your 1095-C form to the IRS. Form 1095-C is also used by you and the IRS to determine eligibility for the premium tax credit. You'll need 1095 form to complete your Federal tax return.

INITIAL COBRA NOTICE

Introduction

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

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

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

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage [*choose and enter appropriate information:* must pay *or* aren't required to pay] for COBRA continuation coverage.

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

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

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

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

INITIAL COBRA NOTICE CONTINUED

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

You must provide this notice to Human Resources

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

INITIAL COBRA NOTICE CONTINUED

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

If you have questions

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

Keep your Plan informed of address changes

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

MEDICAID CHIP NOTICE

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).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2019. Contact your State for more information on eligibility.

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: myalhipp.com Phone: 855.692.5447	Website: flmedicaidtplrecovery.com/hipp Phone: 877.357.3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: myakhipp.com Phone: 866.251.4861 Email: customerservice@myakhipp.com Medicaid Eligibility: dhss.alaska.gov/dpa/pages/medicaid/default.aspx	Website: medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678.564.1162, ext 2131
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: myarhipp.com Phone: 1.855.MyARHIPP (855.692.7447)	Healthy Indiana Plan for Low-Income Adults 19-64 Website: www.in.gov/fssa/hip Phone: 877.438.4479 All Other Medicaid Website: www.indianamedicaid.com Phone: 800.403.0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: www.healthfirstcolorado.com Health First Colorado Member Contact Center: 800.221.3943, state relay 711 CHP+: www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 800.359.1991, state relay 711	Website: dhs.iowa.gov/hawki Phone: 800.257.8563
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: www.kdheks.gov/hcf Phone: 785.296.3512	Website: www.dhhs.nh.gov/oii/hipp.htm Phone: 603.271.5218 HIPP Phone: 800.852.3345, ext 5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: chfs.ky.gov Phone: 800.635.2570	Medicaid Website: www.state.nj.us/humanservices/dmahs/clients/medicaid Medicaid Phone: 609.631.2392 CHIP Website: www.njfamilycare.org/index.html CHIP Phone: 800.701.0710

LOUISIANA – Medicaid	NEW YORK – Medicaid
Website: dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 888.695.2447	Website: www.health.ny.gov/health_care/medicaid Phone: 800.541.2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 800.442.6003 TTY: Maine relay 711	Website: medicaid.ncdhhs.gov Phone: 919.855.4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: www.mass.gov/eohhs/gov/departments/masshealth Phone: 800.862.4840	Website: www.nd.gov/dhs/services/medicalserv/medicaid Phone: 844.854.4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 800.657.3739	Website: www.insureoklahoma.org Phone: 888.365.3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: www.dss.mo.gov/mhd/participants/pages/hipp. htm Phone: 573.751.2005	Website: healthcare.oregon.gov/pages/index.aspx www.oregonhealthcare.gov/index-es.html Phone: 800.699.9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: dphhs.mt.gov/montanahealthcareprograms/hipp Phone: 800.694.3084	Website: www.dhs.pa.gov/provider/medicalassistance/he althinsurancepremiumpaymenthippprogram/index.htm Phone: 800.692.7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid and CHIP**
Website: www.accessnebraska.ne.gov Phone: 855.632.7633 Lincoln: 402.473.7000 Omaha: 402.595.1178	Website: www.eohhs.ri.gov Phone: 855.697.4347, or 401.462.0311 (Direct RIte Share Line)
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: dhcfp.nv.gov Medicaid Phone: 800.992.0900	Website: www.scdhhs.gov Phone: 888.549.0820
SOUTH DAKOTA – Medicaid	**WASHINGTON – Medicaid**
Website: dss.sd.gov Phone: 888.828.0059	Website: www.hca.wa.gov Phone: 800.562.3022, ext 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: gethipptexas.com Phone: 800.440.0493	Website: mywvhipp.com Toll-Free Phone: 1.855.MyWVHIPP (855.699.8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: medicaid.utah.gov CHIP Website: health.utah.gov/chip Phone: 877.543.7669	Website: www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 800.362.3002
VERMONT – Medicaid	**WYOMING – Medicaid**
Website: www.greenmountaincare.org Phone: 800.250.8427	Website: wyequalitycare.acs-inc.com Phone: 307.777.7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 800.432.5924 CHIP Website: www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 855.242.8282	

To see if any other states have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
Www.dol.gov/agencies/ebsa
1.866.444.EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
Www.cms.hhs.gov
1.877.267.2323, Menu Option 4, Ext 61565

PAPERWORK REDUCTION ACT STATEMENT

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

Notes

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