MONDO

Benefits Enrollment Guide

2018

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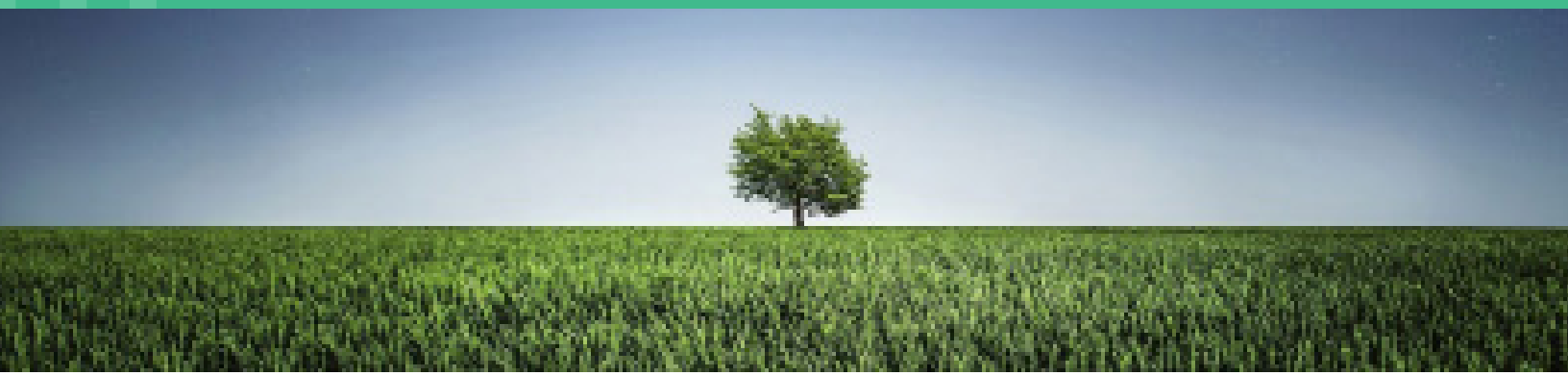

While health care reform is helping to increase access to health care for millions, many employers, employees and employees' families continue to struggle with the cost of healthcare premiums and care.

We value our employee's dedication to Mondo, and offering healthcare coverage is of paramount importance. Our goal is to remain an employer of choice by providing the best in class coverage and ensuring employees and their families have access to high quality, comprehensive healthcare at an affordable cost. Mondo is proud to offer our full-time employees medical, dental & vision benefits. Mondo's Medical and Dental plan options are offered through Cigna Health Plans and our Vision benefits are through United Healthcare.

NICOLE GULOTTA
Human Resources Director

BEFORE ENROLLMENT:

Before enrollment begins, take the time to educate yourself on all of the benefit options that are available to you. Review this Benefits Guide carefully as you consider your plan choices.

If you are electing to cover your dependents on your medical, dental or vision benefits, proof of dependent eligibility is required. These documents must accompany your paperwork or your dependents will not be added. Acceptable documentation can be found on page 14 of this guide.

DURING ENROLLMENT:

Be sure to make your elections within 31 days after your eligibility date. If you do not make elections, then you may not be able to get coverage until the next open enrollment period.

AFTER ENROLLMENT:

Medical coverage: If you are electing coverage for the first time, you will receive an ID card in the mail that you should use for all medical and prescription services. Your ID card contains important information about you, your employer group, and the benefits to which you are entitled. Always remember to carry your ID card with you, present it when receiving health care services or supplies, and make sure your provider always has an updated copy of your ID card.

Dental coverage: For dental services, coverage will be verified by your social security number. Be sure to give this to your provider at time of service.

Vision coverage: For vision services, coverage will be verified by your social security number. Be sure to give this to your provider at time of service.

GENERAL:

The plan year is a calendar year - January 1 through December 31.

You may enroll, terminate or make changes to your benefits each year during open enrollment. You may also add or drop dependents. Elections you make during open enrollment take effect on the first day of the following calendar year and remain in effect throughout the year, unless you have a qualified change in status.

If you are a full-time employee scheduled to work 30 hours per week or more, and have satisfied the 90 day waiting period, you may enroll yourself and your eligible dependents in benefits.

FOR MEDICAL BENEFITS

Eligible dependents shall include:

- Any lawful spouse or domestic partner
- Your biological, adopted, step- or foster children who have not attained the age of 26
- Dependents who are 27 or more years old, primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap

FOR DENTAL BENEFITS

Eligible dependents shall include:

- Any lawful spouse or domestic partner
- Your biological, adopted, step- or foster children who have not attained the age of 26
- Dependents who are 27 or more years old, primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap

CHANGING BENEFIT ELECTIONS

As an employee who is eligible for benefits, you are allowed to make changes to your medical, dental, and vision plan choices during the annual open enrollment period. After the open enrollment period ends you will not be allowed to make changes to your elections unless you experience a qualifying event. Some qualifying events include:

- Change in marital status (marriage, death of spouse, legal separation)
- Change in number of dependents (birth, death, adoption, eligibility status child support order)
- Change in employment status for you or your spouse (new employment, termination, leave of absence, full-time to part-time or vice versa)
- Special enrollment rights under HIPPA
- Medicare Coverage

Using your health plan to see a participating (network) doctor or go to a participating facility can sometimes cost you money, but using nonparticipating (out-of-network) doctors and facilities could cost you a lot more money. Below is a general idea of the costs (other than your premium) that you may have to pay. Keep in mind, the amount you pay is based on your plan benefits.

TYPE OF COST	MEANING
Cost Sharing	Cost Sharing is when you pay some of the costs of your health.
Deductible	The amount you owe for health care services before your health insurance or plan begins to pay. The deductible may not apply to all services.
Co-payment	A fixed amount (for example, $25) you pay for covered health care services, usually when you receive the service. The amount can vary by the type of covered health care services.
Co-insurance	Your share of the costs of a covered health care service, calculated as a percent (for example, 20 %) of the allowed amount for the service. You pay co-insurance plus any deductible you owe.
Balance Billing	Balance billing is when a provider bills you for the difference between their charge and what your health plan will pay.

CIGNA: BASE PLAN - HIGH DEDUCTIBLE OPEN ACCESS EPO

The Base Plan is a High Deductible Health Plan (HDHP) which pays medical expenses once the deductible has been satisfied. As a member of an EPO, you can use the doctors and hospitals within the EPO network, but cannot go outside the network for care. There are no out-of-network benefits. By enrolling in the HDHP you are eligible to contribute to a Health Savings Account (HSA). Which is a tax advantage bank account used to pay for unreimbursed medical expenses.

CIGNA: MIDDLE PLAN - OPEN ACCESS EPO

The Middle Plan is a network based program which exclusively offers access to Cigna HealthCare 's network. This plan provides benefits for expenses incurred in-network. Please be sure to confirm your doctor participation with Cigna prior to your visit. There are no out-of-network benefits.

CIGNA: BUY-UP PLAN - OPEN ACCESS PLUS POS

The Buy-up Plan is a network-based program that features an in-network and an out-of network component. The in-network component allows participants to choose any health care provider from the Cigna HealthCare network. At the same time, with the out-of-network component, participants are able to select health care practitioners and facilities from outside of the Cigna HealthCare network at reduced benefit levels. As a result, participants may choose health care providers, including specialists, as needed on their own and coordinate their own health care based on their needs and personal situation. Please keep in mind that members are responsible for balance billing exposure when using out-of-network providers.

QUESTIONS	ANSWERS
Do I pay less if I see certain doctors?	Yes. You will pay less out-of-pocket when you use preferred network doctors.
Do I need a referral to see a specialist?	No. You can always go directly to a specialist. However, you will receive out-of-network benefits if the specialist is not in the preferred network.
Can I use mail-order for prescription drugs I use regularly?	Yes for Certain Drugs* **(In Network Benefit Only)**
Do reasonable and customary limits apply? **Will I receive balance due bills?**	Only if you see a doctor outside the network. If the charge is above reasonable and customary, you will receive a balance due bill. Preferred doctors charge a negotiated fee which is always lower than reasonable and customary.

* Must meet criteria for therapeutic classes.

* By enrolling in this plan you are entitled to participate in a health savings account. Please see page 9 for more information.

CIGNA: BASE PLAN – HDHP OPEN ACCESS EPO

	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible* Individual / Family	$3,000 / $6,000	In-network coverage only
Annual Out-of-pocket Maximum* Individual / Family (includes ded)	$4,500 / $9,000 Individual in a family $6,550	In-network coverage only
Coinsurance	Plan pays 80% after deductible	In-network coverage only
Maximum Policy Benefit	No Maximum Benefit	No Maximum Benefit
Office Visit PCP / Specialist	Covered 80% after deductible	In-network coverage only
Preventive Care / Well-women Care Routine Physical Exams / Immunizations (Adult and Child)	Plan pays 100%, no copay or deductible	In-network coverage only
Lab, X-Ray or other preventive tests	Covered 80% after deductible	In-network coverage only
Lab, X-Ray and Major Diagnostics CT, PET, MRI, and Nuclear Medicine Out Patient	Covered 80% after deductible	In-network coverage only
Emergency Health Services– Out Patient Pre Service Notification if results in inpatient stay	Covered 80% after in-network deductible is met	Covered 80% after in-network deductible is met
Hospital-Inpatient Stay Pre Service Notification	Covered 80% after deductible	In-network coverage only
Ambulance Pre Service Notification for non-emergency	Covered 80% after deductible	In-network coverage only
Urgent Care Facility	Covered 80% after deductible	In-network coverage only
Mental Health Inpatient & Outpatient	Covered 80% after deductible	In-network coverage only
Prescription Drugs Retail (31-day supply)		
Rx Deductible	Plan Deductible	N/A
Generic	$15 copay after deductible is met	Not Covered
Preferred-Brand / Brand	$35/$70 copay after deductible is met	Not Covered
Mail-Order (90-day supply)		
Generic	$37.50 copay after deductible is met	In Network Benefit Only
Preferred-Brand / Brand	$87.50/$175 copay after deductible is met	In Network Benefit Only

Annual Deductible and Out-of-pocket Maximums reset every January 1st.
This is not a complete list of covered services. For more details please refer to Cigna plan documents.

CIGNA: MIDDLE PLAN – OPEN ACCESS EPO

	IN-NETWORK
Annual Deductible* Individual / Family	$2,000 / $4,000
Annual Out-of-pocket Maximum* Individual / Family (includes ded)	$4,000 / $8,000 Pharmacy $2,500 / $5,000
Coinsurance	Plan pays 80% after deductible
Maximum Policy Benefit	No Maximum Benefit
Office Visit PCP / Specialist	$25 / $40
Preventive Care / Well-women Care Routine Physical Exams / Immunizations (Adult and Child)	Plan pays 100%, no copay or deductible
Lab, X-Ray or other preventive tests	Plan pays 100%, no copay or deductible
Lab, X-Ray and Major Diagnostics CT, PET, MRI, and Nuclear Medicine Out Patient	Member pays 20% after deductible
Emergency Health Services– Out Patient Pre Service Notification if results in inpatient stay	$200 copay
Hospital-Inpatient Stay Pre Service Notification	Member pays 20% after deductible
Ambulance Pre Service Notification for non-emergency	Member pays 20% after deductible
Urgent Care Facility	$50 copay
Mental Health Inpatient	Member pays 20% after deductible
Mental Health Outpatient	$40 copay
Prescription Drugs Retail (31-day supply)	
Rx Deductible (Brand name drugs)	$100 Individual / $200 Family
Generic	$15 copay
Preferred-Brand	$45 copay
Brand	$80 copay
Mail-Order (90-day supply)	
Generic	$37.50 copay
Preferred-Brand	$112.50 copay
Brand	$200 copay

* Annual Deductible and Out-of-pocket Maximums reset every January 1st.
This is not a complete list of covered services. For more details please refer to Cigna plan documents.

CIGNA: BUY-UP PLAN – OPEN ACCESS PLUS POS

	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible* Individual / Family	$2,000 / $4,000	$3,000 / $6,000
Annual Out-of-pocket Maximum* Individual / Family (includes ded)	$4,000 / $8,000 Pharmacy $2,500 / $5,000	$6,000 / $12,000 Pharmacy $2,500 / $5,000
Coinsurance	Plan pays 80% after deductible	Plan pays 60% after deductible
Maximum Policy Benefit	No Maximum Benefit	No Maximum Benefit
Office Visit PCP / Specialist	$25 / $40	40% after deductible
Preventive Care / Well-women Care Routine Physical Exams / Immunizations (Adult and Child)	Up to age 18 & age 19 and older plan pays 100%, no copay or deductible	Up to age 18 40% after deductible Age 19 and older not covered
Lab, X-Ray or other preventive tests	Plan pays 100%, no copay or deductible	40% after deductible
Lab, X-Ray and Major Diagnostics CT, PET, MRI, and Nuclear Medicine Out Patient	20% after deductible	40% after deductible
Emergency Health Services– Out Patient Pre Service Notification if results in inpatient stay	$100 copay	$100 copay
Hospital-Inpatient Stay Pre Service Notification	20% after deductible	40% after deductible
Ambulance Pre Service Notification for non-emergency	20% after deductible	40% after deductible
Urgent Care Facility	$50 copay	40% after deductible
Mental Health Inpatient	20% after deductible	40% after deductible
Mental Health Outpatient	$40 copay	40% after deductible
Prescription Drugs Retail (31-day supply)		
Rx Deductible	$100 Individual / $200 Family	N/A
Generic	$15 copay	Not Covered
Preferred-Brand	$45 copay	Not Covered
Brand	$80 copay	Not Covered
Mail-Order (90-day supply)		
Generic	$37.50 copay	In Network Benefit Only
Preferred-Brand	$112.50 copay	In Network Benefit Only
Brand	$200 copay	In Network Benefit Only

* UCR reimbursement -110% of Medicare. Annual Deductible and Out-of-pocket Maximums reset every January 1st.
This is not a complete list of covered services. For more details please refer to Cigna plan documents.

A Health Savings Account (HSA) is a bank account that allows members to save pre-tax funds to pay for current and future qualified medical expenses using pre-tax dollars. An HSA allows dollars to "roll over" annually. Your HSA provides a triple tax advantage; contributions are tax deductible, balances grow tax free, and all withdrawals for qualified expenses are tax free.

You have an opportunity to open an HSA through Select Account, which partners with Cigna to provide the employees of Mondo with seamless administration of their benefits. Contributions to your HSA can be made via payroll deduction in this case. Should you choose to use a different financial institution to manage your HSA, you will need to fund that account directly on your own.

ELIGIBILITY REQUIREMENTS:

- Must be enrolled in a High Deductible Health Plan (Mondo's base plan)
- Must not be enrolled in Medicare
- Must not be covered by other medical insurance(s) (With the exception of other qualified high deductible plans)
- Must not have received VA medical benefits at any time in the past three months
- Must not be contributing to / participating in a general-purpose FSA
- Spouse may not be contributing to FSA through his/her employer to be eligible to use HSA funds.

MAXIMUM TAX-DEDUCTIBLE CONTRIBUTION TO AN HSA FOR 2018:

- $3,450 for an individual medical insurance plan
- $6,850 for employee plus one and family medical insurance plan
- Catch up provision for anyone over the age of 55 is $1,000 per year

DEBIT CARD

An HSA debit card will be provided to all new participants. This debit card is linked to your HSA account and can be used to pay for qualified medical expenses (e.g. Acupuncture, Bandages and Hearing Aids). A full list of all qualified medical expenses is available on the IRS website at www.irs.gov.

Good dental health is important to your overall well being. At the same time, we all need different levels of dental treatment. It is for this reason that Mondo is offering eligible employees a comprehensive dental plan through Cigna.

CIGNA DENTAL PPO PLAN

The Cigna Dental PPO Plan offers a balance of savings and choice. This plan gives participants the freedom to receive care from participating Cigna providers or to visit any dentist of their choice outside of the network. The Cigna Dental PPO Plan puts into action two strengths: 1) managing a network that focuses on patient satisfaction and savings and 2) fast, accurate claims processing.

CIGNA DENTAL PPO PLAN

	IN-NETWORK	OUT-OF-NETWORK
Plan Details	When you use a PPO dentist, you pay	When you do not use a network dentist, you pay
Annual Deductible (Single / Family)	$50 / $150	$50 / $150
Calendar Year Maximum per person	$1,500	$1,500
Reimbursement Levels	Based on negotiated fees	Based on negotiated fees
Class I Preventive & Diagnostic	No charge	No charge
Class II Basic Restorative Care	20% after deductible of PPO allowance	20% after deductible of PPO allowance
Class III Major Restorative Care	50% after deductible of PPO allowance	50% after deductible of PPO allowance
Class IV Orthodontia	50% of PPO allowance	50% of PPO allowance
Orthodontia Lifetime Maximum	Available to children under age 19	Available to children under age 19
Orthodontia Lifetime Maximum	$1,000	$1,000

You can find a DPPO network dentist from the online directory on Cigna.com. Click on “Find a Doctor” at the top of the screen. Then, choose from a Directory by clicking on the “If your insurance plan is offered through Work or School” option. Next, click on “Find a...Dentist”. Lastly, enter Location and Select a Plan by choosing from the drop down menu.

* Please note that anytime you use a out-of-network dentist you will be responsible for balance billed charges.

United Healthcare Vision has been trusted for more than 40 years to deliver affordable, innovative vision care solutions to the nation's leading employers through experienced, customer-focused people and the nation's most accessible, diversified vision care network. In-network, covered-in-full benefits (after applicable copay) include a comprehensive exam, eye glasses with standard single vision, lined bifocal, or lined trifocal lenses, standard scratch-resistant coating and the frame, or contact lenses in lieu of eye glasses.

BENEFIT	FREQUENCY	COPAY	UHC PROVIDER	OUT-OF-NETWORK
Exam	12 months	$10	Covered in full	Reimbursed up to $50
Lenses	12 months	$20	Single vision, bifocal and trifocal lenses are covered in full	Reimbursed up to $50 / single vision Reimbursed up to $75 / bifocal Reimbursed up to $100 / trifocal
Frames	24 months	None	Covered up to $130 20% discount on addl. charges	Reimbursed up to $70
Elective Contact Lenses	12 months	None	Covered up to $130	Reimbursed up to $105
Laser Vision Correction	---	---	Discounted services, For more information call 1-888-563-4497 or visit us at www.uhclaik.com	Not covered

* Frequency is based on your last date of service

CIGNA: BASE PLAN HDHP OPEN ACCESS EPO

CONTRIBUTIONS PER-PAYROLL	
Employee Only:	$77.82
Employee + Spouse:	$164.98
Employee + Child(ren):	$149.41
Employee + Family:	$236.57

CIGNA: MIDDLE PLAN OPEN ACCESS EPO

CONTRIBUTIONS PER-PAYROLL	
Employee Only:	$113.96
Employee + Spouse:	$236.72
Employee + Child(ren):	$213.93
Employee + Family:	$336.69

CIGNA: BUY-UP PLAN OPEN ACCESS PLUS POS

CONTRIBUTIONS PER-PAYROLL	
Employee Only:	$130.02
Employee + Spouse:	$270.43
Employee + Child(ren):	$244.43
Employee + Family:	$384.85

CIGNA: DENTAL PPO PLAN

CONTRIBUTIONS PER-PAYROLL	
Employee Only:	$8.36
Employee + Spouse:	$19.08
Employee + Child(ren):	$16.72
Employee + Family:	$27.89

UNITED HEALTHCARE: VISION PLAN

CONTRIBUTIONS PER-PAYROLL	
Employee Only:	$1.62
Employee + Spouse:	$3.05
Employee + Child(ren):	$3.60
Employee + Family:	$5.03

If you are electing to cover your dependents on your medical, dental or vision benefits, proof of dependent eligibility is required. These documents must accompany your paperwork or your dependents will not be added. Acceptable documentation is outlined in the table below:

DEPENDENT	DOCUMENTATION NEEDED
Legal spouse	Copy of marriage certificate.
Biological child to age 26	Copy of birth certificate or copy of prior year federal tax return showing dependent claimed on taxes.
Step-child to age 26	Copy of birth certificate and copy marriage certificate showing your spouse as the biological parent.
Adopted child to age 26	Copy of papers showing placement of child in your home; or a copy of final adoption papers.
A partner's unmarried child	Copy of birth certificate or copy of prior year federal tax return showing dependent claimed on taxes and proof of incapacity must be received within 120 days after the date on which the maximum age is attained. Subsequent evidence of disability or dependency may be required as often as reasonably necessary to verify continued eligibility for benefits.

* (as described above) age 26 or older, primarily supported by the associate, and is incapable of selfsustaining employment because of mental or physical handicap

Affordable Care Act (ACA) - Frequently Asked Questions
Employees Eligible for the Company-Sponsored Medical Plan

WHAT IS THE AFFORDABLE CARE ACT?

The Patient Protection and Affordable Care Act, commonly called the Affordable Care Act (ACA) is a United States federal statute signed into law by President Obama in March 2010. The ACA includes subsidies, health insurance exchanges, and mandates, including an individual mandate that, with certain exceptions, requires all individuals beginning January 1, 2014 to have health insurance or pay a penalty. The law includes subsidies to help individuals with low incomes comply with the mandate. Coverage through the health insurance exchange is guaranteed; even if you have a pre-existing medical condition, your cost for coverage will be the same as all other applicants of the same age living in the same geographic location.

WHO IS REQUIRED TO HAVE HEALTH INSURANCE?

Beginning January 1, 2014, all Americans – with some exceptions – are required to have medical insurance coverage or incur a penalty. Qualified health insurance plans that meet the ACA requirements may include:

- Government-sponsored plans, such as:
    - Medicare or Medicaid
    - Children's Health Insurance Program (CHIP)
    - TRICARE
    - Veterans health care programs
- Employer-based or sponsored health care plans- the Transamerica Limited Benefit Hospital Indemnity Insurance is NOT considered qualified health insurance
- Individual private coverage

WILL THE COMPANY CONTINUE TO OFFER MEDICAL COVERAGE IN 2018?

Yes, we will continue to offer medical coverage to eligible employees and their eligible family members in 2018.

WHAT IS THE HEALTH INSURANCE EXCHANGE?

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

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

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under federal law, health care plans may not restrict any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal delivery, or less than 96 hours following a Cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother and with the mother's consent, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

CONTINUED COVERAGE UNDER COBRA

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

Under the Women's Health and Cancer Rights Act, group health plans must make certain benefits available to participants of health plans who have undergone a mastectomy. In particular, a plan must offer mastectomy patients benefits for:

- Reconstruction of the breast on which the mastectomy was performed
- Any necessary surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical conditions related to the mastectomy, including lymphedema.
- Our medical plans comply with these requirements. Benefits for these items are similar to those provided under the plan for similar types of medical services and supplies.

HIPAA REGULATIONS HELP TO PROTECT YOUR PRIVACY

The privacy provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) help to ensure that your health care-related information stays private. New employees will receive a Privacy Practice Notice which outlines the ways in which the medical plan may use and disclose protected health information (PHI). The notice also describes your rights. For more information, contact the Human Resources Department.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

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

NOTICE OF HIPAA SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In Addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

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

TERMINATION OF HEALTH COVERAGE FOR CAUSE, INCLUDING FRAUD OR INTENTIONAL MISREPRESENTATION

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

Failure to inform any of such persons that you or your dependents are covered under another group health plan or knowingly providing false information in order to obtain or continue coverage for an eligible dependent are examples of actions that constitute fraud under the plan.

YOUR RIGHTS UNDER MICHELLE'S LAW

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

MENTAL HEALTH PARITY

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

CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2009 (CHIP)

Signed in to expand state CHIP eligibility to more children and expectant mothers with an extended 60-day time frame to coordinate any changes to employer health elections in the event of gain or loss of eligibility and/or a subsidy under Medicaid or CHIP. Please see notice on pages 18-19.

STATE	PLAN	WEBSITE	PHONE
Alabama	Medicaid	http://myalhipp.com/	1-855-692-5447
Alaska	Medicaid	http://myakhipp.com/	1-866-251-4861
Arkansas	Medicaid	http://myarhipp.com/	855-692-7447
Colorado	Medicaid	http://www.colorado.gov/hcpf	1-800-221-3943
Florida	Medicaid	http://flmedicaidtplrecovery.com/hipp/	1-877-357-3268
Georgia	Medicaid	http://dch.georgia.gov/medicaid	404-656-4507
Indiana	Medicaid	http://www.hip.in.gov http://www.indianamedicaid.com	1-877-438-4479 1-800-403-0864
Iowa	Medicaid	http://www.dhs.state.ia.us/hipp/	1-888-346-9562
Kansas	Medicaid	http://www.kdheks.gov/hcf/	1-785-296-3512
Kentucky	Medicaid	http://chfs.ky.gov/dms/default.htm	1-800-635-2570
Louisiana	Medicaid	http://dhh.louisiana.gov/index.cfm/subhome/1/n/331	1-888-695-2447
Maine	Medicaid	http://www.maine.gov/dhhs/ofi/public-assistance/index.html	1-800-442-6003
Massachusetts	Medicaid /CHIP	http://www.mass.gov/MassHealth	1-800-462-1120
Minnesota	Medicaid	http://mn.gov/dhs/ma/	1-800-657-3739
Missouri	Medicaid	http://www.dss.mo.gov/mhd/participants/pages/hipp.htm	573-751-2005
Montana	Medicaid	http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP	1-800-694-3084
Nebraska	Medicaid	http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx	1-855-632-7633
Nevada	Medicaid	http://dwss.nv.gov/	1-800-992-0900
New Hampshire	Medicaid	http://www.dhhs.nh.gov/oii/documents/hippapp.pdf	603-271-5218
New Jersey	Medicaid /CHIP	http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ http://www.njfamilycare.org/index.html	Medicaid Phone: 609-631-2392 CHIP Phone: 1-800-701-0710

STATE	PLAN	WEBSITE	PHONE
New York	Medicaid	http://www.nyhealth.gov/health_care/medicaid/	1-800-541-2831
North Carolina	Medicaid	http://www.ncdhhs.gov/dma	919-855-4100
North Dakota	Medicaid	http://www.nd.gov/dhs/services/medicalserv/medicaid/	1-844-854-4825
Oklahoma	Medicaid /CHIP	http://www.insureoklahoma.org	1-888-365-3742
Oregon	Medicaid /CHIP	http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html	1-800-699-9075
Pennsylvania	Medicaid	http://www.dhs.pa.gov/hipp	1-800-692-7462
Rhode Island	Medicaid	http://www.eohhs.ri.gov/	401-462-5300
South Carolina	Medicaid	http://www.scdhhs.gov	1-888-549-0820
South Dakota	Medicaid	http://dss.sd.gov	1-888-828-0059
Texas	Medicaid	http://gethipptexas.com/	1-800-440-0493
Utah	Medicaid /CHIP	http://health.utah.gov/medicaid http://health.utah.gov/chip	1-877-543-7669
Vermont	Medicaid	http://www.greenmountaincare.org/	1-800-250-8427
Virginia	Medicaid /CHIP	http://www.coverva.org/programs_premium_assistance.cfm http://www.coverva.org/programs_premium_assistance.cfm	Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
Washington	Medicaid	http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program	1-800-562-3022 ext. 15473
West Virginia	Medicaid	http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx	1-877-598-5820, HMS Third Party Liability
Wisconsin	Medicaid	https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf	1-800-362-3002
Wyoming	Medicaid	https://wyequalitycare.acs-inc.com/	307-777-7531

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employmentbased health coverage offered by your employer.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

CAN I SAVE MONEY ON MY HEALTH INSURANCE PREMIUMS IN THE MARKETPLACE?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

DOES EMPLOYER HEALTH COVERAGE AFFECT ELIGIBILITY FOR PREMIUM SAVINGS THROUGH THE MARKETPLACE?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

HOW CAN I GET MORE INFORMATION?

For more information about your coverage offered by your employer, please check your summary plan description or contact:

_____

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

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

3. EMPLOYER NAME: Mondo	**4. EMPLOYER IDENTIFICATION NUMBER (EIN):** 13-4149310	
5. EMPLOYER ADDRESS: 102 Madison Avenue	**6. EMPLOYER PHONE NUMBER:** 646-517-5606	
7. CITY: New York	**8. STATE:** NY	**9. ZIP CODE:** 10016
10. WHO CAN WE CONTACT ABOUT EMPLOYEE HEALTH COVERAGE AT THIS JOB?: Nicole Gulotta		
11. PHONE NUMBER (IF DIFFERENT FROM ABOVE):	**12. EMAIL ADDRESS:** HR@mondo.com	

Here is some basic information about health coverage offered by this employer:
As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

☒ Some employees. Eligible employees are:

Full-time employees who are scheduled to work 30 hours per week or more, and have satisfied the 90 day waiting period.

With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

Any lawful spouse or domestic partner
Biological, adopted, step or foster children who have not attained the age of 26 or are 27 or more years old, primarily supported by the employee incapable of self-sustaining employment by reason of mental or physical handicap.

☐ We do not offer coverage.

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

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

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. IS THE EMPLOYEE CURRENTLY ELIGIBLE FOR COVERAGE OFFERED BY THIS EMPLOYER, OR WILL THE EMPLOYEE BE ELIGIBLE IN THE NEXT 3 MONTHS?:

☐ Yes (Continue)

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

☐ No (STOP and return this form to employee)

14. DOES THE EMPLOYER OFFER A HEALTH PLAN THAT MEETS THE MINIMUM VALUE STANDARD*?:

☒ Yes (Go to question 15)

☐ No (STOP and return this form to employee)

15. FOR THE LOWEST-COST PLAN THAT MEETS THE MINIMUM VALUE STANDARD* OFFERED ONLY TO THE EMPLOYEE (DON'T INCLUDE FAMILY PLANS): IF THE EMPLOYER HAS WELLNESS PROGRAMS, PROVIDE THE PREMIUM THAT THE EMPLOYEE WOULD PAY IF HE/ SHE RECEIVED THE MAXIMUM DISCOUNT FOR ANY TOBACCO CESSATION PROGRAMS, AND DIDN'T RECEIVE ANY OTHER DISCOUNTS BASED ON WELLNESS PROGRAMS:

a. How much would the employee have to pay in premiums for this plan? $116.76

b. How often? ☐ Weekly ☒ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

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

16. WHAT CHANGE WILL THE EMPLOYER MAKE FOR THE NEW PLAN YEAR?: _____

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? $ _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

• An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Affordable Care Act (ACA): The Patient Protection and Affordable Care Act, commonly called the Affordable Care Act (ACA) is a United States federal statute signed into law by President Obama in March 2010. The law puts in place comprehensive health insurance reforms.

Annual Maximum: Total dollar amount a plan pays during a calendar year toward the covered expenses of each person enrolled.

Out-of-Pocket Maximum: The maximum amount of coinsurance a Plan member must pay towards covered medical expenses in a calendar year for both network and non-network services. Once you meet this out-of-pocket maximum, the Plan pays the entire coinsurance amount for covered services for the remainder of the calendar year. Deductibles and copays apply to the annual out-of-pocket maximum.

Coinsurance: A percentage of the medical costs, based on the allowed amount, you must pay for certain services after you meet your annual deductible.

Conversion: An Associate changes or "converts" her/his Group Life coverage to an Individual Life Insurance policy without having to answer any medical questions. Conversion is for an Associate who is leaving her/his job, reducing hours, or has reached the age when coverage may be reduced or eliminated, and still wants to maintain the protection that life insurance provides.

Copayment: A set dollar amount you pay for network doctors' office visits, emergency room services and prescription drugs.

Deductible: Total dollar amount, based on the allowed amount, you must pay out of pocket for covered medical expenses each calendar year before the plan pays for most services. The deductible does not apply to network preventive care and any services where you pay a copayment rather than coinsurance. Some of your dental options also have an annual deductible, generally for basic and major dental care services.

Brand Formulary Drugs: The brand formulary is an approved, recommended list of brand-name medications. Drugs on this list are available to you at a lower cost than drugs that do not appear on this preferred list.

Generic Drugs: These drugs are usually most cost-effective. Generic drugs are chemically identical to their brand-name counterparts. Purchasing generic drugs allows you to pay a lower out-of-pocket cost than if you purchase formulary or non-formulary brand name drugs.

Maintenance Drugs: Prescriptions commonly used to treat conditions that are considered chronic or longterm. These conditions usually require regular, daily use of medicines. Examples of maintenance drugs are those used to treat high blood pressure, heart disease, asthma and diabetes.

Non-Formulary Drugs: These drugs are not on the recommended formulary list. These drugs are usually more expensive than drugs found on the formulary. You may purchase brand-name medications that do not appear on the recommended list, but at a significantly higher out-of pocket cost.

PDP Fee: PDP Fee refers to the fees that participating PDP dentists have agreed to accept as payment in full, subject to any copayments, deductibles, cost sharing and benefits maximums.

Portability: An Associate carries or "ports" her/his current Group Life coverage after employment ends, without having to answer any medical questions. Portability is for an Associate who is leaving her/his job and still wants to maintain the protection that life insurance provides.

Pre-tax Plan: A plan for active employees that is paid for with pre-tax money. The IRS allows for certain expenses to be paid for with tax-free dollars. The state takes premiums out of your check before taxes are calculated, increasing your spendable income and reducing the amount you owe in income taxes. Consequently, the IRS has tax laws that require you to stay in the plans you select for a full plan year (January through December). You can only make changes during Open Enrollment or if you have a Qualifying event.

Primary Care Physician (PCP): The health care professional who monitors your health needs and coordinates your overall medical care, including referrals for tests or specialists.

Provider: Any type of health care professional or facility that provides services under your plan.

Network: A group of health care providers, including dentists, physicians, hospitals and other health care providers, that agrees to accept pre-determined rates when serving members.

Qualifying Event: An occurrence that qualifies the Subscriber to make an insurance coverage change outside of the Open Enrollment.

Reasonable and Customary Charge (R&C): R & C fee refers to the Reasonable and Customary (R&C) charge, which is based on the lowest of (1) the dentist's actual charge, (2) the dentist's usual charge for the same or similar services, or (3) the charge of most dentist's in the same geographic area for the same or similar services as determined by Metlife.

Specialty Drugs: Prescription medications that require special handling, administration or monitoring. These drugs may be used to treat complex, chronic and often costly conditions.

PLAN	GROUP NUMBER	WEBSITE/EMAIL	PHONE
Cigna – Medical	Group # 613038	www.mycigna.com	1-866-494-2111
Cigna – Dental	Group # 613038	www.mycigna.com	1-800-244-6224
United Healthcare –Vision	Group # 901901	www.myuhcvision.com	1-888-563-4497

For general questions regarding: eligibility, enrollment, payroll deductions, benefit plan options, Qualifying Life Events, and COBRA, please contact:

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