2016

EMPLOYEE BENEFITS SUMMARY

This summary is intended only to highlight your benefits, should be used strictly as a reference guide, and should not be relied upon to fully determine coverage. If this summary conflicts in any way with the Plan Documents, the Plan Documents prevail. A detailed explanation of each benefit is provided in the applicable Summary Plan Description.

EMPLOYEE BENEFITS SUMMARY

The chart below lists the benefits available to HEADWATERS employees and when they become effective. These benefits are available to eligible Regular, Full-time employees:**

Benefit	Eligibility	What You Receive
Health Care Coverage* (Voluntary)	*The first of the month following 60 days of employment	See following pages
Basic Life Insurance	*The first of the month following 60 days of employment	Employee: 1.5 times base annual earnings Spouse: $10,000 Dependent Children: $5,000 to age 26
Basic Accidental Death and Dismemberment Insurance	*The first of the month following 60 days of employment	Employee: 1.5 times base annual earnings
Voluntary Life*** (Voluntary)	*The first of the month following 60 days of employment	Employee: Units of $10,000 up to $500,000 maximum (based on approved application) Spouse: $10,000 to $500,000 Children: (to age 19) $2,000, $4,000, $6,000, $8,000 or $10,000 (Employee must be covered for Children to get coverage)
Voluntary Accidental Death and Dismemberment Insurance (Voluntary)	*The first of the month following 60 days of employment	Employee: Units of $10,000 up to 10 times annual earnings or $500,000 maximum, whichever is less Spouse: Units of $10,000 up to $500,000 maximum Dependent Children: Units of $2,000 up to $10,000
Short-Term Disability	*The first of the month following 60 days of employment	60% of base weekly earnings up to $1,000 per week. Max 26 weeks. (State disability plan pays first if applicable)
Long-Term Disability	*The first of the month following 60 days of employment (180 days waiting period for benefits)	60% of base monthly earnings up to $10,000 per month
401(k) Savings Plan (Voluntary) • **Traditional 401(k) , or** • **Roth 401(k)**	March 1st, June 1st, September 1st or December 1st following 2 months of service	Company Matching Contribution is $1.00 for each $1.00 that you contribute up to the first 3% of your eligible pay, and $.50 for each $1.00 that you contribute of the next 2% of your eligible pay. Company Match is immediately vested.
Employee Assistance Program	Date of Hire	See following pages
Flexible Spending Plan (Voluntary)	*The first of the month following 60 days of employment	See following pages
Health Savings Accounts (Voluntary for HDHP participants only)	*The first of the month following 60 days of employment	See following pages
Employee Stock Purchase Plan (Voluntary)	March 1st, June 1st, September 1st or December 1st following 2 months of service	You can acquire company stock at a discount through payroll deductions
Tuition Reimbursement (Voluntary, Supervisor Approved)	**The first of the month following 60 days of employment	75% of cost of tuition, registration fees and books up to $2,000 per calendar year.

*Eligibility date is date of hire for exempt employees.
**Benefits may be changed from time to time at the sole discretion of the Company.
***Voluntary Life and Dependent Life Plans are subject to minimum participation requirements.

Medical/Prescription/Dental/Vision

Rates

See your open enrollment letter for current rates. The rates include medical, prescription, dental and vision coverage. The Dental, and Vision coverage is the same on all the medical plans.

Medical & Prescription Drug Coverage

Regence Blue Cross Blue Shield of Utah (www.myregence.com) is the third party administrator to process/pay medical claims.

Your benefits will be provided under the BCBS Organization (PPO) Plan. "In Network" and "Out-of-Network" coverage is available through the PPO Plan. You will receive a much greater benefit when you utilize In-Network PPO Providers, however, you can go to any doctor you choose and still be covered. ***You should always use In-Network providers when and where they are available***. If you choose to use Out-of-Network providers, you may be balance billed for the amount due which is over the allowed amount with the BlueCross BlueShield PPO.

Traditional Plans

We have two traditional plans– the Standard Plan and the Buy Up Plan. There is no copay for preventive care in both our Standard and Buy Up Plan. The co-pays for regular office visits are listed in the chart below.

Benefit	Standard Plan	Buy up plan
Lifetime/Annual Maximum	Unlimited	Unlimited
Deductible (sgl/fam)	$1,500/$3,000	$500/$1,000
Out of pocket maximum (sgl/fam)	$4,000/$8,000	$3,000/$5,000
Co-Insurance	20%	20%
Primary office copay	$35	$20
Specialist office copay	$60	$40
Urgent care copay	$60	$20
Preventative/wellness copay	$0	$0
Pre-existing condition exclusion	None	None
Prescription drug benefit Tier 1/Tier 2/Tier 3	$10/15-$35-40%	$10/15-$35-40%

OmedaRx (omedarx.com) processes prescription drug claims for our traditional plans. You may fill your prescriptions at the pharmacy or by mail order. Either way, the copay for a one-month prescription on the Standard and Buy Up plans is $15 for Generic drugs, $35 for Formulary and 40% for Non-formulary.

If you choose to use a Pharmacy in the Align network, your copay for Generic drugs is $10.

If you chose to use the convenient mail order option through Walgreens Pharmacy, you will pay two copays for a three-month supply.

HDHP Plan

We also offer a High Deductible Health Plan. On this plan, the **employee must meet the deductible before Regence will share in the cost**. However, there is no charge for preventive care. For other services employees are responsible for 100% of the contracted rate until the deductible is met. After the deductible is met, the employee is responsible for 20% coinsurance until the out of pocket maximum is reached. After the out of pocket max is reached, the plan will pay 100% of the contracted amount. **Prescription coverage with the HDHP plan is provided by Omeda Rx.**

Benefit	HDHP w/ HSA*
Lifetime/Annual Maximum	Unlimited
Deductible (sgl/fam)	$2,000/$4,000
Out of pocket maximum (sgl/fam)	$4,000/$8,000
Co-Insurance	20%
Primary office copay	20% after deductible
Specialist office copay	20% after deductible
Urgent care copay	20% after deductible
Preventative/wellness copay	$0
Pre-existing condition exclusion	None
Prescription drug benefit Tier 1-Tier 2-Tier 3	 $10/15-$35-40%
**Deductible on HDHP applies to all services except preventative wellness exams, and maintenance prescription drugs.*	

OmedaRx (www.omedarx.com) processes prescription drug claims for our HDHP plan. You may fill your prescriptions at the pharmacy or by mail order. Prescriptions are subject to the deductible on the HDHP plan. You will pay 100% of the contracted amount until you reach your deductible. After reaching the deductible, the co-pay for a one-month prescription $15 for Generic drugs, $35 for Formulary and 40% for Non-formulary.

If you choose to use a Pharmacy in the Align network, your copay for Generic drugs is $10.

Maintenance prescription drugs are not subject to the deductible. For a list of maintenance prescription drugs please go to www.omedarx.com and look for the **Optimum Value Medication list.**

If you chose to use the convenient mail order option through Walgreen's Pharmacy, you will pay two copays for a three-month supply.

For a more in-depth look at your options, please see the summary of benefits for each plan following this page.

Contact Info:
Blue Cross Blue Shield of Utah | Customer Service: 1-866-240-9580 | www.bcbs.com or www.regencecom

Omeda Rx | Customer Service: 1-866-240-9580 | www.omedarx.com
Mail Order through Walgreens 1-888-832-5462 | 24 hours a day, 7 days a week

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Dental

Tall Tree is our dental program administrator. We are on the DenteMax network.You may go to any ADA certified dentist of your choice, but you will pay less if you go to a dentist in the DenteMax network. Preventive dental services are covered at 100%, basic restorative services are covered at 75% and major restorative services are covered at 50%. For more details, see the Dental Benefits Summary following this page.

Contact Info:
Tall Tree Administrators | Customer Service: (877) 453-4201| www.talltreehealth.com | www.dentemax.com to see if your dentist is in the network.

Vision

Vision Service Plan (VSP) is our vision program administrator and we are on the VSP Choice Network. See the Vision Benefits Summary following this page.

Contact Info:
Vision Services Plan (VSP) |Phone: (800) 877-7195 | www.vsp.com

Headwaters, Inc. HDHP Medical Plan

Coverage Period: 01/01/2016 - 12/31/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual & Eligible Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.Regence.com or by calling 1 (866) 240-9580.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$2,000** claimant / **$4,000** family per calendar year. Doesn't apply to certain preventive care. Amounts in excess of the **allowed amount** do not count toward the **deductible**.	Single: You must pay all the costs up to the single **deductible** amount before this plan begins to pay for covered services you use. Family: Claimants collectively must pay all the costs up to the family deductible amount before this plan begins to pay for any claimant's covered services. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. **$4,000** claimant / **$8,000** family per calendar year.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	**Premiums**, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Does this plan use a network of providers?	Yes. See **www.Regence.com** or call **1 (866) 240-9580** for lists of in-network or out-of-network **providers**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a **specialist**.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	After deductible, you pay 20% coinsurance	After deductible, you pay 40% coinsurance	————————none————————
	Specialist visit	After deductible, you pay 20% coinsurance	After deductible, you pay 40% coinsurance	
	Other practitioner office visit	After deductible, you pay 20% coinsurance for spinal manipulations	After deductible, you pay 40% coinsurance for spinal manipulations	Coverage is limited to 24 spinal manipulations / year.
	Preventive care/ screening/immunization	No charge	0% coinsurance	————————none————————
If you have a test	Diagnostic test (x-ray, blood work)	After deductible, you pay 20% coinsurance	After deductible, you pay 40% coinsurance	————————none————————
	Imaging (CT/PET scans, MRIs)	After deductible, you pay 20% coinsurance	After deductible, you pay 40% coinsurance	

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.Regence.com	Generic drugs	After deductible, you pay $15 copay / retail prescription $30 copay / mail order prescription $10 copay / retail prescription at Align pharmacy		Coverage is limited to a 90-day supply from a retail (1 copay per 30-day supply), 90-day supply mail order. Coverage is limited to a 30-day supply for self-injectable medications from either retail or mail order supplier. **Deductible** does not apply to certain preventive drugs, women's contraceptives or immunizations at a participating pharmacy. **Deductible** also waived for generic or preferred brand drugs specifically designated as preventive for treatment of certain chronic diseases that are on the Optimum Value Medication List. Medications used as part of an outpatient cancer drug treatment regimen that is provided and dispensed in a professional setting will be subject to these prescription benefits. The first fill of generic and brand-name (non-self-administrable cancer chemotherapy) specialty drugs is allowed at a retail pharmacy; additional fills for generic and brand-name specialty drugs and all self-administrable cancer chemotherapy drugs must be filled by a specialty pharmacy.
	Preferred brand drugs	After deductible, you pay $35 copay / retail prescription $70 copay / mail order prescription		
	Non-preferred brand drugs	After deductible, you pay 40% coinsurance / retail and mail order prescription		
	Specialty drugs	After deductible, you pay 40% coinsurance / retail and mail order prescription		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	After deductible, you pay 10% coinsurance for ambulatory surgical center, 20% coinsurance for all other facilities	After deductible, you pay 40% coinsurance	——————none——————
	Physician/surgeon fees	After deductible, you pay 10% coinsurance for ambulatory surgical center physicians, 20% coinsurance for all other physicians.	After deductible, you pay 40% coinsurance	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	After deductible, you pay 20% coinsurance	After deductible, you pay 20% coinsurance	——————none——————
	Emergency medical transportation	After deductible, you pay 20% coinsurance	After deductible, you pay 0% coinsurance	——————none——————
	Urgent care	After deductible, you pay 20% coinsurance	After deductible, you pay 40% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	After deductible, you pay 20% coinsurance	After deductible, you pay 40% coinsurance	——————none——————
	Physician/surgeon fee	After deductible, you pay 20% coinsurance	After deductible, you pay 40% coinsurance	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	After deductible, you pay 20% coinsurance	After deductible, you pay 40% coinsurance	——————none——————
	Mental/Behavioral health inpatient services	After deductible, you pay 20% coinsurance	After deductible, you pay 40% coinsurance	
	Substance use disorder outpatient services	After deductible, you pay 20% coinsurance	After deductible, you pay 40% coinsurance	
	Substance use disorder inpatient services	After deductible, you pay 20% coinsurance	After deductible, you pay 40% coinsurance	
If you are pregnant	Prenatal and postnatal care	After deductible, you pay 20% coinsurance	After deductible, you pay 40% coinsurance	——————none——————
	Delivery and all inpatient services	After deductible, you pay 20% coinsurance	After deductible, you pay 40% coinsurance	
If you need help recovering or have other special health needs	Home health care	After deductible, you pay 20% coinsurance	After deductible, you pay 40% coinsurance	——————none——————
	Rehabilitation services	After deductible, you pay 20% coinsurance for outpatient services; inpatient services not covered	After deductible, you pay 40% coinsurance for outpatient services; inpatient services not covered	Coverage is limited to 24 outpatient visits / year.
	Habilitation services	Not covered	Not covered	——————none——————
	Skilled nursing care	After deductible, you pay 20% coinsurance	After deductible, you pay 40% coinsurance	Coverage is limited to 120 inpatient days / year.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Durable medical equipment	After deductible, you pay 20% coinsurance	After deductible, you pay 40% coinsurance	————————none————————
	Hospice service	After deductible, you pay 20% coinsurance	After deductible, you pay 40% coinsurance	————————none————————
If your child needs dental or eye care	Eye exam	$15 copay / visit	$15 copay / visit (limited to $45)	Vision benefits are administered by VSP, not Regence BlueCross BlueShield of Utah. Contact VSP at 1 (800) 877-7195 for additional coverage information.
	Glasses	$130 allowance / frames and lenses every 12 months	Lenses limited to $100 for single vision, $120 for bifocal	
	Dental check-up	No charge	No charge	Dental benefits are administered by Tall Tree Administrators, not Regence BlueCross BlueShield of Utah. Contact Tall Tree Administrators at 1 (877) 453-4201 for coverage information.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery, except congenital anomalies
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs except for nutritional counseling

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Hearing aids (Child)
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1 (866) 240-9580. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1 (877) 267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the plan at 1 (866) 240-9580 or visit www.Regence.com. You may also contact your state insurance department at 1 (800) 439-3805 or www.insurance.utah.gov or the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

In order for certain types of health coverage (for example, individually purchased insurance or job-based coverage) to qualify as minimum essential coverage, the plan must pay, on average, at least 60 percent of allowed charges for covered services. This is called the "minimum value standard." **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1 (866) 240-9580.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $4,330
- **Patient pays:** $3,210

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2,000
Copays	$0
Coinsurance	$1,060
Limits or exclusions	$150
Total	**$3,210**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $2,700
- **Patient pays:** $2,700

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$2,000
Copays	$0
Coinsurance	$660
Limits or exclusions	$40
Total	**$2,700**

"Patient pays" amounts in this coverage example are based on Individual coverage. Different amounts may apply in Family coverage. Consult your plan documents for more information about your cost-sharing.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.Regence.com or by calling 1 (866) 240-9580.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,500** claimant / **$3,000** family per calendar year. Doesn't apply to certain preventive care. **Copayments** or amounts in excess of the **allowed amount** do not count toward the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. **$4,000** claimant / **$8,000** family per calendar year.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	**Premiums**, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Does this plan use a network of providers?	Yes. See **www.Regence.com** or call **1 (866) 240-9580** for lists of **preferred** or participating **providers**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a **specialist**.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $20) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use a **preferred provider** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 copay / visit	After deductible, you pay 40% coinsurance	**Copayment** applies to each **preferred** office visit only, **deductible** waived. All other services are covered at the **coinsurance** specified, after **deductible**.
	Specialist visit	$60 copay / visit	After deductible, you pay 40% coinsurance	
	Other practitioner office visit	$35 copay / visit for spinal manipulations	After deductible, you pay 40% coinsurance for spinal manipulations	Coverage is limited to 24 spinal manipulations / year. **Deductible** waived for spinal manipulations for **preferred providers**.
	Preventive care/ screening/immunization	No charge	0% coinsurance	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	No charge	After deductible, you pay 40% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	No charge	After deductible, you pay 40% coinsurance	

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.Regence.com	Generic drugs	$15 copay / retail prescription $30 copay / mail order prescription $10 copay / retail prescription at Align pharmacy		**Out-of-pocket limit**: $3,600 claimant / $7,200 family per year. Coverage is limited to a 90-day supply retail (1 copay per 30-day supply) or 90-day supply mail order. **Deductible** does not apply to generic drugs, certain preventive drugs, women's contraceptives and immunizations at a **preferred** pharmacy or self-administrable cancer chemotherapy drugs. Medications used as part of an outpatient cancer drug treatment regimen that is provided and dispensed in a professional setting will be subject to these prescription benefits. You are responsible for the difference in cost between a dispensed brand-name drug and the equivalent generic drug, in addition to the **copayment** and/or **coinsurance**.
	Preferred brand drugs	$35 copay / retail prescription $70 copay / mail order prescription		
	Non-preferred brand drugs	40% coinsurance / retail and mail order prescription		
	Specialty drugs	40% coinsurance / retail and mail order prescription		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	After deductible, you pay 10% coinsurance for ambulatory surgical center, 20% coinsurance for all other facilities.	After deductible, you pay 40% coinsurance	——————none——————
	Physician/surgeon fees	After deductible, you pay 10% coinsurance for ambulatory surgical center physicians, 20% coinsurance for all other physicians	After deductible, you pay 40% coinsurance	——————none——————
If you need immediate medical attention	Emergency room services	After deductible, you pay 20% coinsurance	After deductible, you pay 20% coinsurance	——————none——————
	Emergency medical transportation	After deductible, you pay 20% coinsurance	After deductible, you pay 20% coinsurance	——————none——————
	Urgent care	$60 copay / visit	After deductible, you pay 40% coinsurance	**Deductible** waived for **preferred providers**.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	After deductible, you pay 20% coinsurance	After deductible, you pay 40% coinsurance	——————none——————
	Physician/surgeon fee	After deductible, you pay 20% coinsurance	After deductible, you pay 40% coinsurance	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$35 copay / primary physician visit or $60 copay / specialist visit; other services 20% coinsurance	After deductible, you pay 40% coinsurance	**Deductible** waived for outpatient services for **preferred providers**.
	Mental/Behavioral health inpatient services	After deductible, you pay 20% coinsurance	After deductible, you pay 40% coinsurance	
	Substance use disorder outpatient services	$35 copay / primary physician visit or $60 copay / specialist visit; other services 20% coinsurance	After deductible, you pay 40% coinsurance	
	Substance use disorder inpatient services	After deductible, you pay 20% coinsurance	After deductible, you pay 40% coinsurance	
If you are pregnant	Prenatal and postnatal care	After deductible, you pay 20% coinsurance	After deductible, you pay 40% coinsurance	——————none——————
	Delivery and all inpatient services	After deductible, you pay 20% coinsurance	After deductible, you pay 40% coinsurance	
If you need help recovering or have other special health needs	Home health care	After deductible, you pay 20% coinsurance	After deductible, you pay 40% coinsurance	——————none——————
	Rehabilitation services	$35 copay / visit for outpatient services; 20% coinsurance for inpatient services	After deductible, you pay 40% coinsurance	**Deductible** waived for outpatient services for **preferred providers**. Coverage is limited to 24 outpatient visits / year.
	Habilitation services	Not covered	Not covered	——————none——————
	Skilled nursing care	After deductible, you pay 20% coinsurance	After deductible, you pay 40% coinsurance	Coverage is limited to 120 inpatient days / year.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
	Durable medical equipment	After deductible, you pay 20% coinsurance	After deductible, you pay 40% coinsurance	——————none——————
	Hospice service	After deductible, you pay 20% coinsurance	After deductible, you pay 40% coinsurance	——————none——————
If your child needs dental or eye care	Eye exam	$15 copay / visit	$15 copay / visit (limited to $45)	Vision benefits are administered by VSP, not Regence BlueCross BlueShield of Utah. Contact VSP at 1 (800) 877-7195 for additional coverage information.
	Glasses	$130 Allowance frames and lenses every 12 months	Lenses limited to $100 for single vision, $120 for bifocal	
	Dental check-up	No charge	No charge	Dental benefits are administered by Tall Tree Administrators, not Regence BlueCross BlueShield of Utah. Contact Tall Tree Administrators at 1 (877) 453-4201 for coverage information.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery, except congenital anomalies
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs except for nutritional counseling

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Hearing aids (Child)
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1 (866) 240-9580. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1 (877) 267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the plan at 1 (866) 240-9580 or visit www.Regence.com. You may also contact your state insurance department at 1 (800) 439-3805 or www.insurance.utah.gov or the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

In order for certain types of health coverage (for example, individually purchased insurance or job-based coverage) to qualify as minimum essential coverage, the plan must pay, on average, at least 60 percent of allowed charges for covered services. This is called the "minimum value standard." **This health coverage does meet the minimum value standard for the benefits it provides**.

Language Access Services:

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1 (866) 240-9580.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,705
- **Patient pays** $2,835

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,500
Co-pays	$35
Co-insurance	$1,150
Limits or exclusions	$150
Total	**$2,835**

Managing type 2 diabetes
(routine maintenance of a well–controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $2,870
- **Patient pays** $2,530

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,500
Co-pays	$600
Co-insurance	$390
Limits or exclusions	$40
Total	**$2,530**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.Regence.com or by calling 1 (866) 240-9580.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$500** claimant / **$1,000** family per calendar year. Doesn't apply to certain preventive care. **Copayments** or amounts in excess of the **allowed amount** do not count toward the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. **$3,000** claimant / **$5,000** family per calendar year.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	**Premiums**, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Does this plan use a network of providers?	Yes. See **www.Regence.com** or call **1 (866) 240-9580** for lists of **preferred** or participating **providers**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a **specialist**.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $20) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use a **preferred provider** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay / visit	After deductible, you pay 40% coinsurance	**Copayment** applies to each **preferred** office visit only, **deductible** waived. All other services are covered at the **coinsurance** specified, after **deductible**.
	Specialist visit	$40 copay / visit	After deductible, you pay 40% coinsurance	
	Other practitioner office visit	$20 copay / visit for spinal manipulations	After deductible, you pay 40% coinsurance for spinal manipulations	Coverage is limited to 24 spinal manipulations / year. **Deductible** waived for spinal manipulations for **preferred providers**.
	Preventive care/ screening/immunization	No charge	0% coinsurance	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	No charge	After deductible, you pay 40% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	No charge	After deductible, you pay 40% coinsurance	

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.Regence.com	Generic drugs	$15 copay / retail prescription $30 copay / mail order prescription $10 copay / retail prescription at Align pharmacy		**Out-of-pocket limit**: $3,600 claimant / $7,200 family per year. Coverage is limited to a 90-day supply retail (1 copay per 30-day supply) or 90-day supply mail order. **Deductible** does not apply to generic drugs, certain preventive drugs, women's contraceptives and immunizations at a **preferred** pharmacy or self-administrable cancer chemotherapy drugs. Medications used as part of an outpatient cancer drug treatment regimen that is provided and dispensed in a professional setting will be subject to these prescription benefits. You are responsible for the difference in cost between a dispensed brand-name drug and the equivalent generic drug, in addition to the **copayment** and/or **coinsurance**.
	Preferred brand drugs	$35 copay / retail prescription $70 copay / mail order prescription		
	Non-preferred brand drugs	40% coinsurance / retail and mail order prescription		
	Specialty drugs	40% coinsurance / retail and mail order prescription		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	After deductible, you pay 10% coinsurance for ambulatory surgical center, 20% coinsurance for all other facilities.	After deductible, you pay 40% coinsurance	——————none——————
	Physician/surgeon fees	After deductible, you pay 10% coinsurance for ambulatory surgical center physicians, 20% coinsurance for all other physicians	After deductible, you pay 40% coinsurance	——————none——————
If you need immediate medical attention	Emergency room services	After deductible, you pay 20% coinsurance	After deductible, you pay 20% coinsurance	——————none——————
	Emergency medical transportation	After deductible you pay 20% coinsurance	After deductible you pay 20% coinsurance	——————none——————
	Urgent care	$20 copay / visit	After deductible, you pay 40% coinsurance	**Deductible** waived for **preferred providers**.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	After deductible, you pay 20% coinsurance	After deductible, you pay 40% coinsurance	——————none——————
	Physician/surgeon fee	After deductible, you pay 20% coinsurance	After deductible, you pay 40% coinsurance	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 copay / primary physician visit or $40 copay / specialist visit; other services 20% coinsurance	After deductible, you pay 40% coinsurance	**Deductible** waived for outpatient services for **preferred providers**.
	Mental/Behavioral health inpatient services	After deductible, you pay 20% coinsurance	After deductible, you pay 40% coinsurance	
	Substance use disorder outpatient services	$20 copay / primary physician visit or $40 copay / specialist visit; other services 20% coinsurance	After deductible, you pay 40% coinsurance	
	Substance use disorder inpatient services	After deductible, you pay 20% coinsurance	After deductible, you pay 40% coinsurance	
If you are pregnant	Prenatal and postnatal care	After deductible, you pay 20% coinsurance	After deductible, you pay 40% coinsurance	——————none——————
	Delivery and all inpatient services	After deductible, you pay 20% coinsurance	After deductible, you pay 40% coinsurance	
If you need help recovering or have other special health needs	Home health care	After deductible, you pay 20% coinsurance	After deductible, you pay 40% coinsurance	——————none——————
	Rehabilitation services	$20 copay / visit for outpatient services; 20% coinsurance for inpatient services	After deductible, you pay 40% coinsurance	**Deductible** waived for outpatient services for **preferred providers**. Coverage is limited to 24 outpatient visits / year.
	Habilitation services	Not covered	Not covered	——————none——————
	Skilled nursing care	After deductible, you pay 20% coinsurance	After deductible, you pay 40% coinsurance	Coverage is limited to 120 inpatient days / year.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
	Durable medical equipment	After deductible, you pay 20% coinsurance	After deductible, you pay 40% coinsurance	——————none——————
	Hospice service	After deductible, you pay 20% coinsurance	After deductible, you pay 40% coinsurance	——————none——————
If your child needs dental or eye care	Eye exam	$15 copay / visit	$15 copay / visit (limited to $45)	Vision benefits are administered by VSP, not Regence BlueCross BlueShield of Utah. Contact VSP at 1 (800) 877-7195 for additional coverage information.
	Glasses	$130 allowance frames and lenses every 12 months	Lenses limited to $100 for single vision, $120 for bifocal	
	Dental check-up	No charge	No charge	Dental benefits are administered by Tall Tree Administrators, not Regence BlueCross BlueShield of Utah. Contact Tall Tree Administrators at 1 (877) 453-4201 for coverage information.

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See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,520
- **Patient pays** $2,020

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$500
Co-pays	$20
Co-insurance	$1,350
Limits or exclusions	$150
Total	**$2,020**

Managing type 2 diabetes
(routine maintenance of a well–controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,370
- **Patient pays** $2,030

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$420
Co-pays	$1,570
Co-insurance	$0
Limits or exclusions	$40
Total	**$2,030**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

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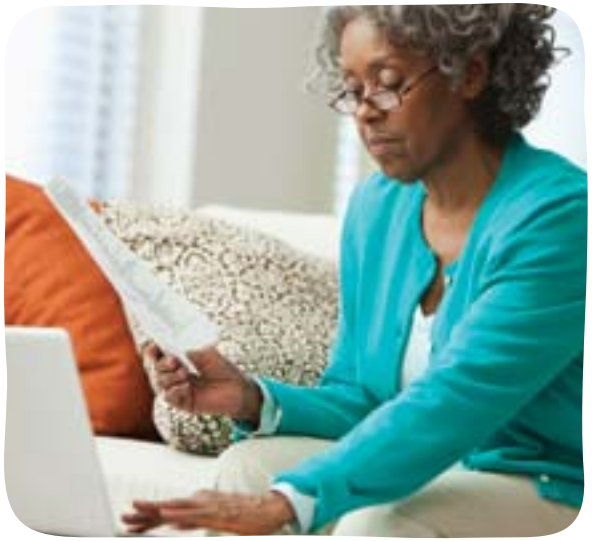
✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.



Savings with Generics

Generic medications offer the same benefits as their brand-name counterparts and usually cost significantly less. We review every prescription order to see if there is a less-expensive generic medication available. It is standard pharmacy practice to substitute generic equivalents for brand-name medications. Walgreens will dispense a generic equivalent if it's available and permitted by your prescriber. If you do not want a generic equivalent or have questions regarding your mail service prescription(s), please call our Customer Care Center.

Privacy and security

The information you provide us is kept confidential in accordance with HIPAA and other applicable state privacy laws. In addition, we use technology that is designed for use with secure Web servers. This technology ensures that your personal, health, prescription and credit card information cannot be accessed when submitted over the Internet.

Mail prescriptions to:
Walgreens
P.O. Box 29061
Phoenix, AZ 85038-9061

Walgreens Customer Care Center
1-877-347-1708
TTY: 800-573-1833

Hours of operation:
24 hours a day, 7 days a week

En español: 800-778-5427
TTY: 877-220-6173

For more information, visit:
Walgreens.com/omedarx

Walgreens
AT THE CORNER OF HAPPY & HEALTHY™

MAIL SERVICE PHARMACY

Medication delivery for the members of:

OmedaRx™

Walgreens
AT THE CORNER OF HAPPY & HEALTHY™

Your pharmacy benefit includes mail service, offering you convenient delivery of your maintenance medications from Walgreens to the location of your choice.

Maintenance medications are used to treat chronic (long-term) conditions. You may receive up to a three-month supply or the maximum allowed by your plan.

Getting Started

It's easy to register and order your first prescription.

Online: Register at Walgreens.com/omedarx. From the registration confirmation page, follow the instructions to submit your new prescription.

By mail: Complete the registration form included with your enrollment packet. Mail the form along with your original prescription.

By phone: Call our Customer Care Center and have your insurance information handy.

Additional ordering options after registration. Ask your prescriber to fax or e-prescribe your new prescription.*

- **Fax:** Use the enclosed fax form or log in to your online account to print a prescriber fax form. Give the form to your prescriber to complete and fax to the number listed on the form.
- **E-prescribe:** If your prescriber has the technology to submit prescriptions electronically, request that he or she do so.

If you need your medication right away. Request two prescriptions from your prescriber: one for an initial short-term supply (e.g., 30-day supply or the amount allowed by your plan) that your local pharmacy can fill immediately and one for a 90-day supply with three refills (or the maximum amount allowed by your plan) for your doctor to submit to Walgreens.

*By law, prescription fax forms and e-prescriptions are valid only if sent from a prescriber's office.

Free standard shipping. Please allow 10 business days from the time you place your order until you receive it at the address you specified.

Flexible Payment Options

Payment in full—by credit card or check—is required with every prescription order. We accept all major credit cards. For your convenience, we can keep your credit card on file for future orders by adding it to your secure online account. Simply complete the fields on your registration form or call our Customer Care Center.

Walgreens Mail Service Registration & Prescription Order Form

OmedaRx

9910000MEDAOME001

Use this form to register/submit your first prescription order. You can also register at **Walgreens.com/omedarx. DO NOT** staple, tape or paperclip anything to this form.

Please print clearly using only **BLACK INK** and **UPPERCASE** letters. Fill in the applicable circles completely (●). **Not all ID and Group Number boxes may be needed.**

MEMBER INFORMATION

○ Male ○ Female

Date of Birth [MM/DD/YYYY] / /

Intercom: OMEDA **UPI#: OME001**

Member ID Number *(Located on card)*

Suffix *(If on card)*

Group Number

Email Address *(To receive information regarding the processing of your order)*

Last Name

First Name

Cell Phone Text Msg* ○ Yes ○ No

Permanent Address Line 1

Daytime Phone

Permanent Address Line 2

Evening Phone

City

State ZIP Code

Government ID *(Most states require ID for controlled Rx substances by law)†*

Prescriber Last Name

Prescriber First Initial

Prescriber Phone

Prescriber Fax

MEMBER

Allergies	Health Conditions	Order Preference
○ Aspirin	○ Arthritis	○ Large-print vial labels
○ Cephalosporin	○ Asthma	○ Spanish vial labels
○ Codeine derivatives	○ Diabetes	
○ Morphine derivatives	○ Glaucoma	
○ Penicillin	○ Heart disease	
○ Sulfa drugs	○ Hypertension	
○ None known	○ Pregnancy	
○ Other *(Use lines below)*	○ Thyroid disease	
_____	○ None known	_____
_____	○ Other *(Use lines at right)*	_____

Payment Options

Payment is required at time of order. Please do not send cash.
We accept American Express®, Discover®, MasterCard® and Visa®.

○ Check made payable to Walgreens

○ Charge credit card below for this order only

○ Place credit card below on file for this and all future orders

Credit Card Number

Expiration Date [MM/YY] /

I authorize Walgreens to charge my credit card for services for which I am financially responsible. If the credit card provided is not able to fulfill payment for any reason, I agree to pay my statement balance upon receipt of the statement and understand that failure to do so may result in discontinuation of pharmacy services.

Cardholder Signature _____ Date _____

**Standard text message and data rates may apply.*
†Driver's license, state ID number, social security number, military ID or passport ID.

9920000MEDAOME001

DEPENDENT INFORMATION

○ Male
○ Female

Date of Birth [MM/DD/YYYY] / /

For separate shipping, please contact the Customer Care Center toll free at 1-877-347-1708.

Dependent Last Name

Dependent First Name

Suffix *(If on card)*

Email address *(To receive information regarding the processing of your order)*

Prescriber Last Name

Prescriber First Initial

Prescriber Phone – –

Prescriber Fax – –

DEPENDENT

Allergies

○ Aspirin
○ Cephalosporin
○ Codeine derivatives
○ Morphine derivatives
○ Penicillin
○ Sulfa drugs
○ None known
○ Other *(Use lines below)*

Health Conditions

○ Arthritis
○ Asthma
○ Diabetes
○ Glaucoma
○ Heart disease
○ Hypertension
○ Pregnancy
○ Thyroid disease
○ None known
○ Other *(Use lines below)*

Order Preference

○ Large-print vial labels
○ Spanish vial labels

ORDER INFORMATION—*If including a prescription order, please complete this section.*

Please allow 10 business days from the time that you place your order to receive your prescription(s). A refill order form and return envelope will be included with your shipment.

It is standard pharmacy practice to substitute generic equivalents for brand-name medications. Walgreens will dispense a generic equivalent if it's available and permitted by your prescriber. If you do not want a generic equivalent or have questions regarding your mail service prescription(s), please call our Customer Care Center at 1-877-347-1708, TTY 1-800-573-1833.

By submitting this form, you have authorized release of all information to Walgreens (and other necessary parties) as required to process your order under your benefit plan.

Total number of prescriptions in this order.....

Total included for copay(s)..... $.

○ Standard Shipping **NO CHARGE**
○ Next Business Day ($19.95†) $.
○ 2nd Business Day ($12.95†) $.

Total Payment Due..... $.

†*Shipping prices may be subject to change by carrier without notification and may vary depending upon weight and zone.*

Please print your name and date of birth on all prescriptions; enclose them along with this completed form and mail to:

Walgreens
P.O. Box 29061
Phoenix, AZ 85038-9061

Headwaters Incorporated Dental Plan

2016 Schedule of Dental Benefits

Dental Plan Option: HDW2D

Group # SFHDW

Claims Address: P.O. Box 71747

Salt Lake City, Utah 84171

Customer Service 877-453-4201

EDI Payor ID: 88067

Dental Network: DenteMax

$$$ You and Your family will save money with contracted discounts, when your dentist is on the DenteMax Network

Coverage begins: Exempt Employees on the Date of hire; Non-exempt employees on the first of the month following 60 days

Coverage ends the last day of month following termination

Minimum weekly hours for full time: 30

Coverage Information	DenteMax In-Network	Out-of-Network	Benefit Limits January 1st-December 31st
Annual Maximum	$1,500 per member for Class I, II, and III Services		Per Calendar Year
Deductible	$25.00 Individual, $50.00 Family		Applies to Class II,III and Orthodontia Services
	Member Co-Insurance		
Class I Services: Preventive	0%	0%	Deductible waived; No waiting period
Class II Services: Basic	25%	25%	No waiting period
Class III Services: Major	50%	50%	No waiting period
Class IV Services: Orthodontics	50%	50%	6 month wait for placement of appliances only
Lifetime Orthodontic Maximum	$1,500 per person		Covered for dependent children up to and including age 18
Class I Services: Preventive	**DenteMax In-Network**	**Out-of-Network**	**Benefit Limits January 1st-December 31st**
Fluoride Treatment	Covered 100% of discounted rate	Covered 100% of billed charges	Twice per Calendar Year, up to and including age 18
Oral Exams (Routine Evaluations)	Covered 100% of discounted rate	Covered 100% of billed charges	Twice per Calendar Year
Palliative Emergency Treatment	Covered 100% of discounted rate	Covered 100% of billed charges	
Prophylaxis (Teeth Cleaning)	Covered 100% of discounted rate	Covered 100% of billed charges	Twice per Calendar Year
Sealants	Covered 100% of discounted rate	Covered 100% of billed charges	Once per tooth every 36 Months, (Permanent Molars), up to and including age 19
Space Maintainers	Covered 100% of discounted rate	Covered 100% of billed charges	Once per quadrant per lifetime, up to and including age 18
X-Rays Bitewings	Covered 100% of discounted rate	Covered 100% of billed charges	Twice per Calendar Year
X-Rays Periapicals	Covered 100% of discounted rate	Covered 100% of billed charges	
X-rays Full-mouth and Panoramic	Covered 100% of discounted rate	Covered 100% of billed charges	Once every 60 Months
Class II Services: Basic	**DentaMax In-Network**	**Out-of-Network**	**Benefit Limits January 1st-December 31st**
Anesthesia (General) or IV Sedation	Deductible, then Covered at 75% of discounted rate	Deductible, then Covered at 75% of billed charges	When medically necessary and performed with oral or dental surgery (Outpatient only)
Endodontics	Deductible, then Covered at 75% of discounted rate	Deductible, then Covered at 75% of billed charges	
Fillings - Composite or Amalgam	Deductible, then Covered at 75% of discounted rate	Deductible, then Covered at 75% of billed charges	Once every 12 Months
Crowns, Inlays and Onlays	Deductible, then Covered at 75% of discounted rate	Deductible, then Covered at 75% of billed charges	Once every 60 Months, payable for members 12 and older
Nitrous Oxide or other Analgesia Inhalant	Deductible, then Covered at 75% of discounted rate	Deductible, then Covered at 75% of billed charges	
Occlusal Adjustment	Deductible, then Covered at 75% of discounted rate	Deductible, then Covered at 75% of billed charges	Up to five times in 60 Month period
Oral Exam/Consultation (Problem focused)	Deductible, then Covered at 75% of discounted rate	Deductible, then Covered at 75% of billed charges	
Oral Surgery including Extractions	Deductible, then Covered at 75% of discounted rate	Deductible, then Covered at 75% of billed charges	Including wisdom teeth
Periodontics	Deductible, then Covered at 75% of discounted rate	Deductible, then Covered at 75% of billed charges	
Perio Maintenance	Deductible, then Covered at 75% of discounted rate	Deductible, then Covered at 75% of billed charges	Twice per Calendar Year

Periodontal Scaling and Planing	Deductible, then Covered at 75% of discounted rate	Deductible, then Covered at 75% of billed charges	Once every 24 Months
Recementing of Crowns, Inlays, Onlays and Bridges	Deductible, then Covered at 75% of discounted rate	Deductible, then Covered at 75% of billed charges	Three per Calendar Year
Relining or Rebasing of Partials or Dentures	Deductible, then Covered at 75% of discounted rate	Deductible, then Covered at 75% of billed charges	Once every 36 Months per arch
Repair to Existing Dentures, Crowns or Bridges	Deductible, then Covered at 75% of discounted rate	Deductible, then Covered at 75% of billed charges	Up to one-half the approved amount for a new denture in any 12 Month period
Root Canal Therapy	Deductible, then Covered at 75% of discounted rate	Deductible, then Covered at 75% of billed charges	Once every 12 Months for teeth with one or more canals
Tissue Conditioning	Deductible, then Covered at 75% of discounted rate	Deductible, then Covered at 75% of billed charges	Once every 36 Months
X-rays (Diagnostic)	Deductible, then Covered at 75% of discounted rate	Deductible, then Covered at 75% of billed charges	
Class III Services: Major	**DenteMax In-Network**	**Out-of-Network**	**Benefit Limits January 1st-December 31st**
Dentures - Removable or Replacement, Complete and Partials	Deductible, then Covered at 50% of discounted rate	Deductible, then Covered at 50% of billed charges	Once every 60 Months
Fixed Bridges	Deductible, then Covered at 50% of discounted rate	Deductible, then Covered at 50% of billed charges	Once every 60 Months for members age 16 and older
Implants	Deductible, then Covered at 50% of discounted rate	Deductible, then Covered at 50% of billed charges	
Veneers	Not Covered	Not Covered	
Class IV Services: Orthodontic	**DenteMax In-Network**	**Out-of-Network**	**Benefit Limits January 1st-December 31st**
Full - Banding Treatment	Deductible, then Covered at 50% of discounted rate	Deductible, then Covered at 50% of billed charges	25% of the total charge is allowed for the initial placement, payable the first month of treatment. Plan requires monthly billings as the difference between the down payment and the number of months left in the treatment plan
Habit Breaking Appliances/Mouth Guards	Deductible, then Covered at 50% of discounted rate	Deductible, then Covered at 50% of billed charges	
Minor Tooth Guidance Appliances	Deductible, then Covered at 50% of discounted rate	Deductible, then Covered at 50% of billed charges	
Monthly, Active Treatment Visits	Deductible, then Covered at 50% of discounted rate	Deductible, then Covered at 50% of billed charges	

Effective January 1, 2016

Dependents Covered to Age 26
Timely Filing - 12 months from date service incurred
COB - Supplemental up to 100% of eligible expense
This plan does not require Pre-Determination

www.talltreeadministrators.com

Your VSP Vision Benefits Summary

HEADWATERS INCORPORATED and VSP provide you with an affordable eyecare plan.

VSP Vision care for life

VSP Provider Network: VSP Choice

Benefit	Description	Copay	Frequency
	Your Coverage with a VSP Provider		
WellVision Exam	• Focuses on your eyes and overall wellness	$15	Every 12 months
Prescription Glasses		$25	See frame and lenses
Frame	• $130 allowance for a wide selection of frames • $150 allowance for featured frame brands • 20% savings on the amount over your allowance • $70 allowance for a frame at Costco Optical	Included in Prescription Glasses	Every 24 months
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children	Included in Prescription Glasses	Every 12 months
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 20-25% on other lens enhancements	$55 $95 - $105 $150 - $175	Every 12 months
Contacts (instead of glasses)	• $130 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every 12 months
Diabetic Eyecare Plus Program	• Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details.	$20	As needed
Extra Savings	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam. **Retinal Screening** • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam **Laser Vision Correction** • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		

Your Coverage with Out-of-Network Providers

Visit **vsp.com** for details, if you plan to see a provider other than a VSP network provider.

Exam.....up to $45	Single Vision Lenses.....up to $30	Lined Trifocal Lenses.....up to $65	Contacts.....up to $105
Frame.....up to $70	Lined Bifocal Lenses.....up to $50	Progressive Lenses.....up to $50	

Coverage with a participating retail chain may be different. Once your benefit is effective, visit vsp.com for details.
Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location.

Contact us. **800.877.7195 | vsp.com**

[1] Brands/Promotion subject to change.
[2]Blueocean Market Intelligence National Vision Plan Member Research, 2014

Tobacco Cessation Programs

Health Coaching
Headwaters' medical benefit plans include access to a health coach free of charge. The health coach will provide you with tools and resources to help you quit. To get started with a health coach, call 1-800-856-8543.

Chantix with GetQuit® Plan
Headwaters' prescription drug coverage allows one course (12 weeks) of treatment on Chantix to help you kick the habit. Chantix is a very effective medication that helps lessen the pleasurable physical effects a person gets from tobacco use and reduces the symptoms of withdrawal. Studies have shown a 44% success in quitting rate based on the 12 week program. Along with your prescription of Chantix, you may enroll in the GetQuit Plan for a full year of online support. The GetQuit Plan offers you a step-by-step plan designed to help you prepare for a tobacco free life. Chantix is only available by prescription, so you must speak to your doctor before using it. For more information on this program, go to www.chantix.com.

There are also many free programs that offer support for quitting tobacco. Some of them are listed below:

www.SmokeFree.gov
www.betobaccofree.gov
www.quitnet.com
www.becomeanex.org

Employee Assistance Program

Headwaters provides an Employee Assistance Program, through LifeMap. The **Employee Assistance Program (EAP)** is a **professional and confidential** service available to all full-time Headwaters employees that provides instant access to experienced counselors with no special paperwork, co-pays or deductibles. Together the counselor and the participant determine a treatment plan and work together to resolve the problem. The EAP program is designed to help you and your family members with personal, job or family related problems and can help you and your dependents identify, resolve and gain control over personal problems that may be interfering with work and daily life. Generally 80-90% of all distressing problems can be handled by the EAP through its experienced counselors and therapists.

Counseling services are 100% confidential and free to employees and their dependents.

EAP Benefits Summary

24/7 Service
The EAP is available around the clock for emergency or crisis situations. Employees and family members can speak or meet with a professional counselor 24/7 for immediate attention.

- 24 hours a day – 7 days a week – 365 days a year **866-750-1327**
- Unlimited phone visits per incident
- 4 face-to-face visits per incident

The **Employee Assistance Program (EAP)** is your resource to resolve anything that is distressing in your life. Some Common Reasons to use the EAP include:

- Marital & Relationship Counseling
- Substance Abuse/Drug & Alcohol Addictions
- Stress, Anxiety or Depression
- Work-Life counseling
- Financial or Legal Difficulties
- Personal & Emotional Difficulties
- Issue With Children (Behavioral Issues)
- Grief & Loss
- Life Transitions
- Divorce/Separation
- Elderly Care planning
- Any Other Distressing Issue

Services are confidential and free!

Contact Info:
LifeMap | Phone: 866.750.1327 | www.myrbh.com (Group Code: LifeMap)

Flexible Spending Plan

Flexible Spending Accounts can save money by reducing taxable income, while helping cover out-of-pocket health care costs and dependent care expenses. Headwaters provides three accounts under the Plan as follows:

Health Care Spending Account*	**Dependent Care Spending Account****	**Limited Flexible Spending Account *****
This account lets you set aside money to pay for medical and health services and supplies not covered by our Medical Plan. ***Maximum amount per year $2,550***	This account can be used to cover expenses such as a child's daycare or in-home care for an elderly or disabled family member. ***Maximum amount per year $5,000***	This account is available for employees on the HDHP. It lets you set aside money to pay for dental and vision services not covered by our Medical Plan. ***Maximum amount per year $2,550***
**The Health Care Spending Account is not available if you are enrolled in the High Deductible Health Plan (HDHP). See Limited FSA and HSA Section.*	***Dependent care account eligible expenses include **day care expenses for dependent children and disabled adults** so that you and your spouse can work or go to school full-time. Children must be under the age of 13 and claimed on your taxes. Disabled dependents must be claimed on your taxes.*	****The Limited FSA is only available if you are enrolled in the High Deductible Health Plan (HDHP).*

You may sign up to have up to the maximum dollar amount withheld from your paycheck and deposited to your spending account. Your taxable income will be reduced by the amount you elect to withhold (reducing your tax liability), and you may withdraw from your account to cover eligible expenses.

If you choose to participate in the Flexible Spending Account program, you will be issued a debit card. You may use the debit card for eligible expenses. However, Discovery Benefits may require verification of the purchased items, so keep your receipts!

Contribution amounts <u>may not be changed</u> during the tax year unless you have an IRS defined change in family status.

- Eligible expenses must be incurred between January 1, 2016 and December 31, 2016
- Claims must be submitted by April 30, 2017
- You may rollover up to $500 for use in 2017 if you find that you have a surplus of funds at the end of the year

For claim forms, eligible expenses and instructions for accessing your account at www.discoverybenefits.com, see the following pages.

Contact Info:
Discovery Benefits | Phone: (866) 451-3399 | www.discoverybenefits.com

Health Savings Plan

Only available if you enroll on the High Deductible Health Plan (HDHP)

Health Spending Accounts can save money by reducing taxable income, while helping cover out-of-pocket health care costs**.** If you choose enroll in the High Deductible Health Plan, you will be automatically enrolled in a Health Savings Account and **Headwaters will contribute $500 to your account once your account information has been verified.**

You may elect to have up to the maximum dollar amount (less the $500 Headwaters contribution) withheld from your paycheck and deposited to your spending account. Your taxable income will be reduced by the amount you elect to withhold (reducing your tax liability), and you may withdraw from your account to cover eligible expenses.

Money deferred into an Health Savings Account rolls over from year to year and is yours to keep if you leave the Company.

Below are the maximum deferral amounts by account type:

Individual	Family*
Up to $3,350 for Single coverage (Additional $1,000 if age 55 or older)	Up to $6,750 for family coverage (Additional $1,000 if age 55 or older) **Family includes all plan types except Employee Only*

When you enroll in the HSA, you will be issued a debit card. You may use the debit card for eligible expenses or submit paper reimbursement forms. You should keep your receipts in case of an IRS audit.

For claim forms, eligible expenses and instructions for accessing your account at www.discoverybenefits.com, see the following pages.

Contact Info:

Discovery Benefits | Phone: (866) 451-3399 | www.discoverybenefits.com

Medical Flexible Spending Accounts or Health Savings Accounts

Eligible Expenses

Expenses can be reimbursed from your Medical FSA or HSA for the diagnosis, cure, mitigation, treatment or prevention of diseases and for treatments affecting any part or function of the body. The expenses must be primarily to alleviate or prevent a physical or mental defect or illness. Expenses solely for cosmetic reasons generally are not expenses for medical care. Also, expenses that are merely beneficial to your general health are not eligible.

Examples of eligible expenses:*

Acupuncture	Immunization fees	Over-the-counter	Oxygen
Chiropractor's fees	Eyeglasses	products*	Medical services
Psychiatric care	Artificial limbs	Sterilization	Crutches
Hospital services	Osteopathic physicians	medication	Wheelchair
Operations	Psychologist visits	Laboratory fees	Braces
Diagnostic fees	Insulin	Guide dog	Prescription drugs
Ambulance	Contact lenses	Birth control (pills,	Hearing aid batteries
Christian Science	Eye exams	condoms, spermicides)	Nursing services
practitioners' fees	Artificial teeth	Contact lenses solution	Dental fees
Psychoanalysis	Hearing aids	Transplants (organs)	X-ray

*A detailed list, IRS Publication 502, Medical and Dental Expenses, is available at DiscoveryBenefits.com. Over-the-counter medicines and drugs will require a physician's prescription in order for them to be eligible for tax-free reimbursement from the HSA or FSA.

Dependent Care Flexible Spending Account

Eligible Expenses

Expenses can be reimbursed from your Dependent Care FSA for day care provided to your eligible family members during the hours you and your spouse are working, looking for work or attending school full-time.

You can be reimbursed for day care expenses for the following family members:

- Children up to age 13 claimed on your taxes
- A disabled tax dependent of any age
- A disabled spouse

Limited Purpose Flexible Spending Account

Eligible Expenses

Expenses can be reimbursed from your Dependent Care FSA for out-of-pocket dental and vision expenses ONLY.

Examples of eligible expenses:

Dental treatment	Orthodontics	Prescription Glasses and
Dental co-insurance/Copays/Deductible	Dentures Denture Adhesive and Cleaners	Sunglasses
Cleanings	Vision Correction Procedures	Contact Lenses
Fillings	(i.e., Lasik)	Vision Screenings
Crowns	Eye Exams	Refractions
		Eye Drops

Discovery Benefits®
FSA • HSA • HRA • COBRA • Transportation

www.DiscoveryBenefits.com
Phone: 866-451-3399 • Fax: 866-451-3245
PO Box 2926 • Fargo, ND 58108-2926
customerservice@discoverybenefits.com

Reimbursement Request Form

This form is for reimbursement of any out-of-pocket expenses. Claims can also be submitted by logging into your account at www.discoverybenefits.com. Documentation to substantiate purchases made with your Discovery Benefits debit card must be submitted with a copy of a Receipt Reminder or uploaded via your online account.

*= Required Fields

Step 1: Participant Information

* Participant Name (First, MI, Last)

*Social Security Number

* Employer Name (Do not abbreviate)

Employee ID

Updates or changes to your information can be made by logging into your account at www.discoverybenefits.com

Step 2: Reimbursement Information

Step 2a: Claim Information

*Plan Type	*Date(s) Expense(s) Incurred	*Merchant/Provider Name	*Name of Person Receiving Product/Service	*Claim Amount
				$
				$
				$
				$
			*Total Reimbursement Requested	$

***Plan Types: MSA**-Medical Spending Account; **DCA**-Dependent Care Account; **LMSA**-Limited Medical Spending Account; **EMSA**-Employer Funded Medical Spending Account; **EDCA-**Employer Funded Dependent Care; **HRA**-Health Reimbursement Arrangement; **RMSA-**Retiree Medical Savings/Spending Account; **IPA**-Individual Premium Account

If you are unable to provide a receipt for any claim(s) submitted for your Dependent Care Account, your dependent care provider must complete Step 2b.

Step 2b: Dependent Care Provider Signature and Certification (for dependent care claims only)

I certify the information provided is accurate.

*Dependent Care Provider Signature

Step 3: Participant Certification

To the best of my knowledge the provided information is complete and accurate. I certify that the requests I am submitting are eligible expenses as defined by the IRS and that I have not been previously reimbursed for these expenses nor am I seeking reimbursement from any other source. I understand that Discovery Benefits, including its agents and employees, will not be held liable if I submit ineligible expenses for reimbursement. If submitting expenses for my Dependent Care Account, I have obtained or made reasonable efforts to obtain the provider's Tax ID (TIN) and I will include the TIN on IRS Form 2441 which I must attach to my federal income tax return. If there are any changes in the provided information, I understand it is my responsibility to notify Discovery Benefits. By submitting this form I certify the above.

I understand that I should retain a copy of all submitted documentation in the event of an IRS audit.

F001

Basic Life Insurance

Headwaters provides each regular full-time employee with Basic Life Insurance. Exempt (salaried) employees are covered from the date of hire while non-exempt (hourly) employees' coverage starts the first day of the month after 60 days of employment. Basic life insurance covers you and your family in case of death. Employees are covered for 1.5 times their base annual earnings up to $500,000. A spouse is covered for $10,000 and dependent children up to age 26, are covered for $5,000.

This insurance ends when you leave the company and may be converted to an individual policy within 31 days of termination of employment.

Basic Accidental Death and Dismemberment (AD&D) Insurance

Headwaters provides Basic AD&D Insurance for all employees. Exempt (salaried) employees are covered from the date of hire while non-exempt (hourly) employees' coverage starts the first day of the month after 60 days of employment. Basic AD&D covers the employee in case an accident, on or off the job causes the loss of life, limb, sight, speech or hearing. The total benefit amount depends on what kind of loss you suffer from. The "Principal Sum" is equal to that of 1.5 times your annual salary. (Your dependants are not covered under this program).

Some of the losses and benefit amounts are:

Loss	Benefit
Life, Both Hands or Both Feet, Sight of Both Eyes, One Hand and One Foot, One hand or Fort and Sight of One Eye, Quadriplegia	The Principal Sum
Triplegia or Paraplegia	Three-quarters of the Principal Sum
Hemiplegia, One Hand, One Foot, or Sight of One Eye, Loss of Speech or Hearing	One-half of the Principal Sum
Uniplegia, Thumb and Index Finger on either hand	One-quarter of the Principal Sum

MAXIMUM PER PERSON: If an Insured Person sustains more than one loss resulting from the same accident, the benefit will be the one largest amount listed, but will not exceed the principal sum.

See following pages for the summary of benefits for Basic Life and AD&D coverage.

Contact Info:
Life Map | Customer Service: 800-794-5390 | www.lifemapco.com

LifeMap®
Insurance for every step of life.

Basic Life and AD&D Insurance

For **Headwaters, Inc.**

Life is full of many twists and turns. LifeMap Basic Life and AD&D coverage protects your family's future, no matter what life may throw your way.

How the Plan Works

- **Eligibility Requirement**
  You must be an active full time employee working a minimum of 30 hours per week.
- **Guarantee Issue**
  Enrolling today in Basic Life and AD&D Insurance with LifeMap provides you a safety net for your family's future – no questions asked. Guarantee issue for this plan is $500,000 for both Life and AD&D coverage.
- **Premium Contribution Structure**
  Basic Life/AD&D Insurance is employer-paid. Employer-paid Insurance means you are not required to pay the premium for this coverage.

Benefits Summary

Plan Benefits	
Employee Life Insurance	1.5 times annual earnings to a maximum of $500,000
Employee AD&D Insurance	1.5 times annual earnings to a maximum of $500,000
Dependents Life Insurance	$10,000 Spouse/$5,000 Child

Plan Guarantee Issue	
Employee	$500,000
Dependent	$10,000 Spouse/$5,000 Child

Plan Features	
Accelerated Benefit	Members who are diagnosed terminally ill may receive a portion of the life insurance benefit before death. Remaining benefits are reserved for the member's beneficiary.
Conversion	Option of converting to an individual life policy, without proof of insurability, for up to amount of group coverage within 31 days of termination.
Portability	You may elect to port your Voluntary Life insurance to continue your coverage under the group policy. If elected, portability coverage will end the earliest of when you reach age 65 or when this master policy terminates.
Waiver of Premium	Life coverage continued without payment of premium if insured becomes totally and permanently disabled (proof of disability required).

Reduction Schedule

If you are still working the required number of hours to be eligible for this insurance at age 65, your benefits will reduce to 65% at age 65, to 45% at age 70, to 30% at age 75, to 20% at age 80, to 15% at age 85 and to 10% at age 90.

Accidental Death & Dismemberment

If due to an accident you die, lose a limb, sight of an eye or become paralyzed, benefits are available.

AD&D Benefits Included

- Adaptive Home/Vehicle and Rehabilitative Benefit
- Air Bag and Seat Belt
- Spouse and Child Education
- Coma
- Day Care
- Exposure and Disappearance
- Felonious Assault

LifeMapCo.com
1 (800) 794-5390

LifeMap®
Insurance for every step of life.

Additional Benefits

- **Beneficiary Assistance Program**
  The BAP can help you and other household members cope with a serious illness or loss.

- **Travel Assistance**
  When traveling 100 or more miles away from home, or outside of your home country, you can obtain emergency medical, travel, and personal security assistance 24 hours a day, anywhere in the world.

- **Repatriation**
  If death occurs more than 100 miles from your primary residence, we will pay to prepare and ship your body to the place of burial or cremation.

- **Seat Belt**
  If you die in an automobile accident and were wearing your seat belt, your beneficiary(ies) will collect an amount equal to the AD&D benefit to a maximum of $10,000 in addition to the Basic Life and Basic AD&D benefits described above.

AD&D Limitations and Exclusions

Benefits are not payable for losses due to intentionally self-inflicted injury -- or any attempt to injure oneself while sane; or taking part in a riot; or any war or act of war -- declared or undeclared; or military service; or taking part in an assault or a felony; or the voluntary use or consumption of any poison, chemical compound or drug except as prescribed by a physician; or bodily infirmity or disease from bacterial infections (except accidental ingestion of contaminated foods) -- other than infection caused from an injury covered under this coverage.

Note: This summary is not all inclusive. Additional information about the exclusions for AD&D coverage will be included in the certificate of coverage, which you will receive after enrolling. Please contact your employer if you have any questions.

LifeMapCo.com
1 (800) 794-5390

Voluntary Life Insurance

Headwaters also offers Voluntary Life Insurance for full-time employees who want some extra coverage. You can purchase more coverage in increments of $10,000 up to $500,000. The premiums for Voluntary Life Insurance are completely paid for by the employee.

Monthly premium rates are based on your age as of January 1st of the current year. Premium rates will change on January 1st as you advance to a higher age bracket.

This insurance ends when you leave the company and may be converted to an individual policy within 31 days of termination of employment.

If you want this extra coverage, you must apply for it on the online enrollment system.

More information on coverage amounts and rates can be found on the Voluntary Life Insurance Summary of Benefits following this page.

Voluntary Accidental Death and Dismemberment (AD&D) Insurance

As an employee of Headwaters, you have the option of purchasing additional AD&D Insurance coverage. You can get up to 10 times your base annual earnings in $10,000 increments, with $500,000 as the maximum for you, up to $500,000 for your spouse and up to $10,000 for dependent children. Non-exempt (hourly) full-time employees become eligible for this benefit on the first day of the month following 60 days of employment. Exempt (salaried) employees become eligible the first day of employment.

If you want this extra coverage, you must elect it on the online enrollment system.

More information on coverage amounts and rates can be found on the Voluntary Accidental Death and Dismemberment Insurance Summary of Benefits following this page.

Contact Info:
Life Map | Customer Service: 800-794-5390 | www.lifemapco.com

LifeMap®
Insurance for every step of life.

Voluntary Life and AD&D Insurance

For **Headwaters, Inc**

Life is full of many twists and turns. LifeMap Voluntary Life and AD&D coverage protects your family's future, no matter what life may throw your way.

How the Plan Works

- **Dependent Eligibility Requirement**
  You must be a legal spouse and or child(ren) up to age 26 to be eligible for coverage.
- **Premium Contribution Structure**
  Voluntary Life and AD&D Insurance is paid for by the employee.
- **Guarantee Issue**
  If you enroll within 31 days of your initial eligibility period, you are eligible for guarantee issue (no medical questions). Guarantee issue for this plan is $250,000 for employee coverage, $50,000 for spouse coverage and all amounts for dependent children. All amounts over guarantee issue require the medical questions to be answered and LifeMap approval. Any coverage requiring LifeMap approval is not in force until you are notified in writing by LifeMap. Voluntary AD&D is guarantee issue for employee, spouse and child at all times.
- **Future Annual Enrollment**
  If you (the employee) enroll for an amount of $10,000 or greater in employee Voluntary Life coverage during the initial open enrollment or your initial 31 day eligibility period, you can, at any future annual enrollment period, increase your coverage up to the guarantee issue amount stated above (employee only) without medical questions. If you did not enroll in the minimum $10,000 when you were initially eligible, all amounts of coverage will require medical questions and approval by LifeMap. All Voluntary Life amounts for spouses and dependent children require the medical questions and approval by LifeMap. All amounts of Voluntary AD&D for employee, spouse and dependent child(ren) are guarantee issue.

Benefits Summary

Plan Benefits

Employee Life Insurance	Coverage is available in $10,000 increments, from $10,000 to a maximum of $500,000
Employee AD&D Insurance (Separate election from Vol Life)	Coverage is available in $10,000 increments, from $10,000 to a maximum of $500,000 or 10 times annual earnings, whichever is less
Spouse Life and AD&D Insurance (Spouse AD&D is a separate election from the Vol Life)	Coverage is available in $10,000 increments, from $10,000 to a maximum of $500,000
Dependent Child(ren) Life and AD&D Insurance. (Dep Child AD&D is a separate election from the Vol Life)	$2,000 increments, to a maximum of $10,000. Child(ren) may enroll as long as the employee enrolls in and is approved for coverage

Plan Features

Accelerated Benefit	Members who are diagnosed terminally ill may receive a portion of the life insurance benefit before death. Remaining benefits are reserved for the member's beneficiary.
Conversion	Option of converting to an individual life policy, without proof of insurability, within 31 days of termination.
Portability	You may elect to port your Voluntary Life insurance to continue your coverage under the group policy. If elected, portability coverage will end the earliest of when you reach age 65 or when this master policy terminates.
Waiver of Premium	Life coverage continued without payment of premium if insured becomes totally disabled (proof of disability required).

Accidental Death & Dismemberment

If due to an accident you die, lose a limb, sight of an eye or become paralyzed, benefits are available.

AD&D Benefits Included

- Adaptive Home/Vehicle Benefit
- Rehabilitative Benefit
- Air Bag and Seat Belt
- Spouse and Child Education
- Coma
- Day Care
- Exposure and Disappearance
- Felonious Assault
- Repatriation

Reduction Schedule

If you are still working the required number of hours to be eligible for this insurance at age 65, your benefits will reduce to 65% at age 65, to 45% at age 70; to 30% at age 75; to 20% at age 80; to 15% at age 85 and to 10% at age 90.

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Insurance for every step of life.

Limitations & Exclusions

Life − Benefits are not payable for losses due to suicide or attempted suicide during the first two years of coverage.
AD&D − The policy does not cover any loss including, but not limited to:

- suicide or such attempts
- participation in a riot, war or act of war; military service for any country
- committing an assault or felony;
- sickness, disease, pregnancy, heart attack or stroke
- bacterial or viral infections not the result of an injury
- taking medications or drugs unless administered by a prescribing or licensed physician
- travel, flight in or descent from any aircraft, including balloons and gliders, except as a fare-paying passenger on a regularly scheduled flight
- the insured Employee's intoxication

Monthly Rates

Voluntary Life - Employee and Spouse	
Age	**Rate Per $1,000 of Benefit**
24 and under	$0.070
25-29	$0.070
30-34	$0.070
35-39	$0.090
40-44	$0.160
45-49	$0.260
50-54	$0.410
55-59	$0.600
60-64	$0.820
65-69	$1.550
70-74	$2.730
75 and over	$2.730
Voluntary Child Life	
Dependent Child $0.18 per $2,000 increment regardless of the number of children in the family	
Voluntary AD&D Rates	
Employee $0.035 per $1,000 increment	
Spouse $0.035 per $1,000 increment	
Child $0.011 per $1,000 increment	

Monthly Premium Calculation

To calculate your monthly payroll deduction, use the formula indicated below:

1. Enter your age on Line 1.
2. Enter your benefit election, in $1,000 increments, on Line 2.
3. Select your rate from the rate table above and enter on Line 3.
4. Multiply Line 2 by the amount entered on Line 3, enter on line 4.

Line 1: _____
Line 2: _____
Line 3: _____
Line 4: _____

The amount shown on Line 4 is your estimated monthly payroll deduction. *Actual deductions may vary slightly due to rounding and payroll frequency.*

Example using the steps above:
Jane Doe is 42 and wants $60,000 in Voluntary Life Coverage

Line 1: 42
Line 2: 60 (60,000/1,000)
Line 3: 0.160
Line 4: 9.60 (60 x .160)

$9.60 is Jane Doe's estimated monthly payroll deduction

Disability Plans

Headwaters provides both Short and Long Term Disability coverage at no cost to employees.

You are automatically enrolled for coverage on the first month following 60 days of employment if you are a non-exempt (hourly) employee and your first day of employment if you are an exempt (salaried) employee.

Short Term Disability
If you are disabled due to an accident or illness off the job, you may be eligible to receive up to 60% of your weekly base earnings to a weekly maximum benefit of $1,000. Short Term Disability coverage is not to exceed 26 weeks for non-exempt and 24 weeks for exempt employees.

Exempt employees must meet the elimination period of 14 days for injuries or illness. Non-exempt employees must meet the elimination period of zero days for injury or seven days for illness.

Long Term Disability
Long Term Disability covers you in the event you are unable to resume your job after 180 days, due to an accident or illness. If you are disabled, you will be eligible to receive up to 60% of your monthly base earnings to a monthly maximum benefit $10,000. If you are disabled prior to age 60, benefits will be paid to age 65 or your social security retirement age. If you become disabled after age 60, you will be paid according to the Age Discrimination Employment Act.

Total Disability Definition
A person is totally disabled if during the elimination period and the next 24 months the employee, due to injury or sickness, is unable to perform all of the material and substantial duties of his or her own occupation. After benefits have been paid to you for 24 months you will continue to be totally disabled if you are unable to perform all of the material and substantial duties of any occupation for which you are or become reasonably qualified for by education, training or experience. To qualify for benefits, the employee must satisfy the elimination period with the required number of days to totally disability, partial disability or a combination of total or partial days of disability.

Elimination Period
You have 180 days at the beginning of each continuous period of total disability for which no benefits will be paid. The elimination periods means a period of continuous days of total or partial disability for which no LTD benefit is payable. If the employee returns to work for 15 working days or less during the elimination period and cannot continue working, the total or partial disability will be treated as continuous. Only those days that the employee is totally or partially disabled will count toward satisfying the elimination period

An outline of benefits follows:

	Short Term Disability		Long Term Disability
	Non-Exempt	**Exempt**	**Both Exempt and Non-Exempt**
Benefit Elimination Period	0 day injury 7 days illness	14 days injury 14 days illness	180 days
Benefit Duration	26 weeks	24 weeks	Later of age 65 or Social Security Normal Retirement Age
Benefit Amount	60% of weekly base earnings to $1,000 per week maximum**		60% of monthly base earnings to $10,000 per month maximum**

*Consult the Human Resources Department for details regarding any sick leave allowances.
**Benefits from other sources may be considered a part of the maximum benefit.

Contact Info:
Disability RMS (contracted thru LifeMap) | 877-254-0085 | Contact HR for the claim form

401(K) Savings Plan

Headwaters' 401(K) Savings Plan has been established to encourage and assist eligible Company employees to:

1. Adopt a regular savings and investment program
2. Shelter income generated on funds invested in the Plan
3. Provide additional financial security for retirement years

Eligible employees may elect to contribute to either a Traditional 401(k) or a Roth 401(k) through payroll deductions. Employees become eligible on the first enrollment date (see below) following two (2) months of continuous service with Headwaters. Changes to already existing accounts may be made at any time.

You may defer to either the traditional 401(k) or the Roth 401(k) or a combination of both. Information on each option is below:

	Traditional 401(k)	Roth 401(k)
Contributions	Pre-tax	After-tax
Investment Earnings	Tax-deferred	Tax-free
Matching Contributions	Safe Harbor Company Match 1.00 for each $1.00 that you contribute up to the first 3% of your eligible pay, and $.50 for each $1.00 that you contribute of the next 2% of your eligible pay.	Safe Harbor Match (pre-tax contribution) 1.00 for each $1.00 that you contribute up to the first 3% of your eligible pay, and $.50 for each $1.00 that you contribute of the next 2% of your eligible pay.
2016 Contribution Limits	$18,000 ($24,000 if age 50 or older)	$18,000 ($24,000 if age 50 or older)
Taxes Paid	When money withdrawn	When contributed
Access to Money	Upon leaving job; disability, death, or (if plan provides) reach age 59½	Subject to same rules as traditional 401(k)
Tax-free Distribution	No	Yes. Specific Conditions must be met
Minimum Required Distribution	Age 70½	Age 70½. Can be rolled into Roth IRA where distribution rules do not apply

Investment Options. The Plan offers a wide range of investment options to choose from. You can choose to invest your contributions and the Company's contributions into several different investment funds. You can view the investment options on the online enrollment kit at www.plandestination.com/e-kit/Headwaters401kPlanE-kit05-2011/

Loan Feature. The Plan has a loan feature. You are allowed to borrow up to 50% of your vested account balance. The minimum loan is $1,000 and it is repaid to the Plan through payroll deduction. Your account information and loan provision may be accessed on the Internet at www.plandestination.com

The enrollment deadlines for entering Headwaters 401K Plan are: March 1st, June 1st, September 1st or December 1st. **When you are eligible to participate, you will receive a postcard in the mail with the following instructions.**

1. Review the enrollment kit online by going to: **https://www.plandestination.com/e-kit/Headwaters401kPlanE-kit05-2011/**
2. Enroll in the plan via www.plandestination.com, or by phone at 888-401-5488, by utilizing your Login ID *(Social Security number)* and PIN *(MMYY of your Date of Birth)*. You will be presented with Step-by-Step instructions for enrolling in the plan, with direct access to a Client Service Representative if needed.
3. You must electronically sign your online enrollment form for your elections to be recorded.
4. If you require your spouse to sign a "Spousal Consent" on the Beneficiary Form, please download the Beneficiary Form found in the Library on the participant website. If no spousal consent is needed, you will be able to complete the Beneficiary Form utilizing the online process.
5. Contact Jennifer Hawkins at 801-984-9400 if you have any questions.

Contact Info:

Newport Group | Client Services Center: 888-401-5488 | www.plandestination.com
P.O. Box 534044
St. Petersburg, FL 33747

Effective 01/01/2016

SUMMARY ANNUAL REPORT FOR
HEADWATERS INCORPORATED 401(K) SAVINGS & INVESTMENT PLAN

This is a summary of the annual report for the HEADWATERS INCORPORATED 401(K) SAVINGS & INVESTMENT PLAN (Employer Identification Number 87-0547337, Plan Number 001) for the plan year 01/01/2014 through 12/31/2014. The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Basic Financial Statement

Benefits under the plan are provided by a trust fund. Plan expenses were $6,859,695. These expenses included $167,879 in administrative expenses and $6,691,816 in benefits paid to participants and beneficiaries, and $0 in other expenses. A total of 2649 persons were participants in or beneficiaries of the plan at the end of the plan year, although not all of these persons had yet earned the right to receive benefits.

The value of plan assets, after subtracting liabilities of the plan, was $84,553,019 as of the end of the plan year, compared to $78,103,805 as of the beginning of the plan year. During the plan year the plan experienced a change in its net assets of $6,449,214. This change includes unrealized appreciation or depreciation in the value of plan assets; that is, the difference between the value of the plan's assets at the end of the year and the value of the assets at the beginning of the year or the cost of assets acquired during the year. The plan had total income of $13,308,909, including employer contributions of $2,577,397, employee contributions of $4,585,014, other contributions/other income of $2,236,207, and earnings from investments of $3,910,291.

Your Rights to Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

1. An accountant's report.

2. Financial information and information on payments to service providers.

3. Assets held for investment.

4. Information regarding any common or collective trusts, pooled separate accounts, master trusts or 103-12 investment entities in which the plan participates.

To obtain a copy of the full annual report, or any part thereof, write or call the plan administrator, at 10653 SOUTH RIVER FRONT PARKWAY SUITE 300, SOUTH JORDAN, UT 84095 and phone number, 801-984-9445.

You also have the right to receive from the plan administrator, on request and at no charge, a statement of the assets and liabilities of the plan and accompanying notes, or a statement of income and expenses of the plan and accompanying notes, or both. If you request a copy of the full annual report from the plan administrator, these two statements and accompanying notes will be included as part of that report.

You also have the legally protected right to examine the annual report at the main office of the plan: 10653 SOUTH RIVER FRONT PARKWAY SUITE 300, SOUTH JORDAN, UT 84095, and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N-1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Employee Stock Purchase Plan (ESPP)

The Company has established an Employee Stock Purchase Plan (ESPP). This program allows eligible employees to acquire shares of common stock at periodic intervals. The shares may be purchased at a discount, and the purchase price may be paid through payroll deductions.

You are eligible to participate in the purchase plan if:

1. On the date before an offering period begins, you are employed by the Company (or by any of its subsidiaries) on a basis that requires you to work more than 20 hours per week for more than five months per calendar year; and
2. You have been employed by the Company (or any participating subsidiary) for at least two (2) months.

The Enrollment deadlines for entering Headwaters ESPP are: March 1st, June 1st, September 1st or December 1st.

For an enrollment packet, contact your HR Representative.

If you are an eligible employee on the first day of any offering period, you may join the purchase plan at that time. To enroll an account must be set up at Stifel Nicolaus and a completed enrollment form must be provided to HR.

Contact Info:

Stifel Nicolaus | 866-457-3572 for initial account set up | Fax 434-974-6518

Tuition Reimbursement

The Company encourages and supports efforts by its employees to improve their skills and educate themselves for advancement in ways that benefit both the employee and the Company.

You are eligible to take advantage of tuition reimbursement if:

1. You are a full-time, regular employee
2. You have been employed by the Company (or participating subsidiary) for at least 60 consecutive days
3. You are taking courses at approved institutions.

Employees are encouraged to discuss their education plans with their supervisor, as supervisors must sign the application. Eligible employees must complete the application and return to HR, then complete the course work and return the receipts for reimbursement.

The Company will reimburse eligible employees for seventy-five percent of the cost of tuition, registration fees, and books related to enrollment in an approved course. The employee is responsible for all other costs. Reimbursement is limited to two courses per quarter or semester and cannot exceed the sum of $2,000 per calendar year. To be eligible for reimbursement, the employee must receive a grade of C or higher for a high school or undergraduate course or grade of B or higher for a graduate course.

Contact Info:

Headwaters Incorporated | 801-984-9445 | Fax 866-449-8117
Jennifer Hawkins
Benefits Manager
jhawkins@headwaters.com

OTHER INFORMATION

Qualified Changes in Family Status

Employees may make changes to their health care coverage during the calendar year due to an IRS defined Change in Family Status. The employee has **30 days** from the date of the Change to update coverage. **CHANGES REQUESTED AFTER 30 DAYS WILL NOT BE ACCEPTED.**

An employee may make changes by submitting a **LIFE EVENT FORM**. This form may be requested from your HR representative.

A qualified Change in Family Status is defined by the IRS as a change that materially affects benefit needs:

- marriage
- divorce
- birth or adoption of a child
- death of a spouse or dependent
- spouse terminates or commences employment
- change from either full-time to part-time or part-time to full-time employment status for either the employee or spouse
- a significant change in the health coverage attributable to your spouse's employment.

Pre-Existing Conditions

Coverage for your pre-existing conditions begins immediately. This is true even if you have been turned down or refused coverage due to a pre-existing condition in the past.

SUMMARY ANNUAL REPORT
Headwaters Incorporated
Employee
Health and Welfare Plan

This is a summary of the annual report of the Headwaters Incorporated Employee Health and Welfare Benefit Plan, EIN 87-0547337, Plan No. 501, for period January 01, 2014 through December 31, 2014. The annual report has been filed with the Employee Benefits Security Administration, U.S. Department of Labor, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Insurance Information

The plan has contracts with Vision Service Plan and Lincoln Financial Group, to pay Vision Plan Insurance, Basic Life Insurance, Voluntary Life Insurance, Long-term Disability Insurance, AD&D and Voluntary AD&D claims incurred under the terms of the plan. The total premiums paid for the plan year ending December 31, 2014 were $1,059,559.40.

Because some of them are so called "experience-rated" contracts, the premium costs are affected by, among other things, the number and size of claims. Of the total insurance premiums paid for the plan year ending December 31, 2014, the premiums paid to Vision Service Plan "experience-rated" contracts were $165,614 the total of all benefit claims paid under these contracts during the plan year was $127,298.

Your Rights to Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

- Insurance premiums paid for fully insured insurance contracts for Life, Voluntary Life, AD&D, Voluntary AD&D, and Long Term Disability Insurance.

To obtain a copy of the full annual report, or any part thereof, write or call the office of Headwaters Incorporated at 10701 S. River Front Parkway, Suite 300 South Jordan, UT 84095, or by telephone at (801) 984-9400. The charge to cover copying costs will be $10.00 for the full annual report, or $1.00 per page for any part thereof.

You also have the legally protected right to examine the annual report at the main office of the plan (Headwaters Incorporated, 10701 S. River Front Parkway, Suite 300, South Jordan, UT 84095) and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Benefit Contact Information

Benefit	Provider	Customer Service Number	Website/Other
Medical	**BlueCross BlueShield of Utah**	**1-866-240-9580**	**www.bcbs.com or www.myregence.com**
Prescription Drugs	**Omeda Rx**	**1-866-240-9580**	**www.omedarx.com**
Dental	**Tall Tree**	**1-877-453-4201**	**www.talltreehealth.com**
Vision	**Vision Services Plan (VSP)**	**1-800-877-7195**	**www.vsp.com**
Employee Assistance Program	**Life Map**	**1-866-750-1327**	**www.myrbh.com** Group Code: LifeMap
Flexible Spending Accounts or Health Savings Accounts	**Discovery Benefits**	**1-866-451-3399** **1-866-451-3245 Fax for claims**	**www.discoverybenefits.com**
Disability **(Short Term and Long Term)**	**Life Map**	**1-800-794-5390**	**www.lifemapco.com**
Life or AD&D Insurance	**Life Map**	**1-800-794-5390**	**www.lifemapco.com**
401(k)	**Newport Group**	**1-888-401-5488**	**www.plandestination.com**
Employee Stock Purchase Plan (ESPP)	**Stifel Nicolaus**	**1-866-457-3572** **Fax 434-974-6518**	