2019 | U.S. Benefits Plan Information

Effective January 1, 2019

GP STRATEGIES®

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GP Strategies® has designed a health plan to provide you and your family with excellent benefits. Understanding the features of this plan is the first step to maximizing the benefits of your health care coverage.

2019 | U.S. Benefits Plan

We want to help you understand your options because the decisions you make now will shape how you manage your future health care expenses.

Important Plan Information

During a time when health care costs are increasing at unprecedented rates, GP Strategies is committed to providing excellent, affordable benefits. Health and welfare benefits available to regular employees scheduled to work 40 hours per week include the following:

- Medical & Prescription Insurance
- Dental Insurance
- Vision Insurance
- Disability Insurance
- Life and Supplemental Life Insurance
- Spouse and Dependent Child Life Insurance
- Health Savings Account
- Health Care Flexible Spending Account
- Dependent Care Flexible Spending Account
- Health Improvement & Prevention Program (HI&P)

Health and welfare benefits available to part-time regular employees scheduled to work 24-39 hours per week and classified as benefits eligible include the following:

- Medical & Prescription Insurance
- Dental Insurance
- Vision Insurance
- Health Savings Account
- Health Care Flexible Spending Account
- Dependent Care Flexible Spending Account
- Health Improvement & Prevention Program (HI&P)

More detailed information for all of the benefits mentioned above may be found on the Benefits pages of the GP Strategies intranet. These benefits are available to you and your eligible dependents. Eligible dependents include the following:

- Spouse- defined as (a) your opposite-sex or same-sex spouse as determined under applicable state or foreign law at the time and location that the marriage was entered into (excluding common-law marriage), or (b) a person of the same sex with whom you have entered into a legally registered civil union, or legally registered domestic partnership in a state that sanctions such unions by law and that is valid pursuant to such law at the time that the parties enter into the relationship, and such relationship (whether under (a) or (b) above) has not been dissolved under the law of the state or country in which such relationship was initially or is currently recognized.
- Your or your spouse's natural children*
- Your or your spouse's adopted children*
- Children* placed in your home for adoption by you or your spouse
- Children* for whom you or your spouse are legal guardian
- Your or your spouse's disabled child of any age

*Refer to the section titled Dependent Children Eligibility for age limits.

Benefits Eligibility

For new hires who are eligible for benefits, coverage will begin on the first day of the month following the date of hire, or on the date of hire if hired on the first day of the month. For employees who are changing employment status and become newly eligible for benefits, coverage will begin on the first day of the month following the status change, or on the date of the status change if the change is effective on the first day of the month.

Dependent Children Eligibility

For medical insurance, dependent children are eligible until they reach age 26. For dental insurance, dependent children are eligible until they reach age 19 or until age 25 if enrolled as full time students. For vision insurance and child life insurance, dependent children are eligible until they reach age 19 or until age 24 if enrolled as full time students. Documentation demonstrating that the dependent child is a full-time student must be provided every semester. This may include a letter from the registrar's office or a copy of the student's school schedule that includes number of credits or indicates full-time student status. The documentation must also include the student's name, school name and the beginning and end dates of the semester.

Can I Decline Benefits?

Yes. But consider your decision carefully. If you decline coverage now, you may only enroll later if a special enrollment situation occurs, during an open enrollment period or if a qualified change in life status event occurs, as described below.

Special enrollment situation

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

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

Special enrollment rights also may exist in the following circumstances:

1. If you or your dependents experience a loss of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP) coverage and you request enrollment within 60 days after that coverage ends; or
2. If you or your dependents become eligible for a state premium assistance subsidy through Medicaid or a state CHIP with respect to coverage under this plan and you request enrollment within 60 days after the determination of eligibility for such assistance.

To request special enrollment or obtain more information, contact the GP Strategies Benefits Department.

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

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.HealthCare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your state Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

Open enrollment period

Open enrollment is a period of time designated by a plan during which an employee who waived his or her initial enrollment opportunity may enroll in the plan.

Qualified change in life status event

The IRS allows individuals to make changes to their enrollment based on certain qualified "change in life" status events, such as special enrollment situations, a significant reduction or increase in working hours and a spouse's open enrollment. To avoid denial of claims, you must submit an updated enrollment form within 30 days if you wish to add a dependent as a result of a special enrollment situation or qualified change in life status event. Documentation supporting the qualified change in life status event will need to be submitted as well. For more information, please see your Summary Plan Description (SPD) in the Benefits Plan Details and Summaries section of the GP Strategies intranet. This can be found in the Human Resources section under the Benefits tab on the Health and Welfare page.

Are you or a dependent covered by another medical plan? If so, you have several options:

1. Enroll yourself and your dependents;
2. Enroll yourself and decline coverage for some or all of your dependents; or
3. Decline coverage for yourself and all your dependents.

If you decline coverage now and the other plan later terminates, you may be permitted to enroll in GP Strategies' plan within 30 days following the termination date of the other plan. If you choose to be covered by both plans, the two plans will enter into a coordination of benefits. Depending on whether you or your employed spouse is the patient, one of the plans will be considered the primary plan and the other the secondary plan. A plan is primary if it covers the patient as an employee. A plan is secondary if it covers the patient as a dependent.

Coordination of Benefits

If your spouse is covered by GP Strategies' plan and his/her employer's plan, his/her employer's plan would be primary. For example, **the primary plan will pay 75% of covered services for a specific procedure. GP Strategies' plan would normally pay for the same procedure at 90% of covered services if GP Strategies' plan were primary. In the case of coordination of benefits with GP Strategies' plan being the secondary payer, GP Strategies' plan would pay the difference between GP Strategies' benefit and the primary plan's benefit; that is, GP Strategies would only pay 15% of covered services.**

Which Plan Is Primary for My Dependent Children?

The birthday rule answers this question. Under the birthday rule, the parent who has the first birthday in the year carries the primary coverage for all dependent children. The parent whose birthday falls later in the year carries the secondary coverage. If both parents have the same birth date, the plan that has covered a dependent child for the longer period of time is primary.

Notifying GP Strategies of Changes in Eligibility

Special enrollment situations and qualified "change in life" status events

To avoid a denial of claims, you must notify GP Strategies and submit an updated benefits enrollment form within 30 days if you wish to add a dependent as a result of a special enrollment situation or a qualified change in life status event.

Loss of eligibility

You must also notify your employer and submit an updated benefits enrollment form within 30 days of any event that results in a loss of coverage for any of your dependents, such as divorce or dependent children exceeding the maximum age. If you wish to continue coverage through COBRA for these dependents, you must notify your employer within 60 days from the date of the COBRA election notice.

Notice of COBRA Continuation Coverage Rights

Continuation Coverage Rights Under COBRA

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

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

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

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

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

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

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

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

When Is COBRA Continuation Coverage Available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee.

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

How Is COBRA Continuation Coverage Provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

Are There Other Coverage Options Besides COBRA Continuation Coverage?

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

If You Have Questions

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

Keep Your Plan Informed of Address Changes

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

Plan Contact Information

GP Strategies Benefits Department,
1100 Broken Land Parkway, Suite 200, Columbia, MD 21044.

Federal Newborns' and Mothers' Health Protection Act

Under federal law, a medical plan may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, your plan may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act of 1998

Special Rights Following Mastectomy. A group health plan generally must, under federal law, make certain benefits available to participants who have undergone a mastectomy. In particular, a plan must offer mastectomy patients benefits for:

1. Reconstruction of the breast on which the mastectomy has been performed
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance
3. Prostheses
4. Treatment of physical complications of mastectomy

Our Plans comply with these requirements. Benefits for these items generally are comparable to those provided under our Plans for similar types of medical services and supplies. Of course, the extent to which any of these items is appropriate following mastectomy is a matter to be determined by consultation between the attending physician and the patient. Our Plan neither imposes penalties (for example, reducing or limiting reimbursements) nor provides incentives to induce attending providers to provide care inconsistent with these requirements.

Notice of Privacy Practices

This notice describes how you may obtain a copy of the plan's notice of privacy practices, which describes the ways that the plan uses and discloses your protected health information.

The Plan provides health benefits to eligible employees of **GP Strategies** (the "Company") and their eligible dependents as described in the summary plan description(s) for the Plan. The Plan creates, receives, uses, maintains and discloses health information about participating employees and dependents in the course of providing these health benefits. The Plan is required by law to provide notice to participants of the Plan's duties and privacy practices with respect to covered individuals' protected health information, and has done so by providing to Plan participants a Notice of Privacy Practices, which describes the ways that the Plan uses and discloses protected health information. To receive a copy of the Plan's Notice of Privacy Practices you should contact GP Strategies' Benefits Manager who has been designated as the Plan's contact person for all issues regarding the Plan's privacy practices and covered individuals' privacy rights. You can reach this contact person by phone at 1.866.727.6677 option 3 or by mail at GP Strategies, 11000 Broken Land Parkway, Suite 200, Columbia, MD 21044.

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of your health and claims records

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

Ask us to correct health and claims records

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

Request confidential communications

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

Ask us to limit what we use or share

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

Get a list of those with whom we've shared information

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

Get a copy of this privacy notice

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

Choose someone to act for you

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

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on this page.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201; calling 1.877.696.6775; or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. **Tell us what you want us to do, and we will follow your instructions.**

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends or others involved in payment for your care
- Share information in a disaster relief situation
- Contact you for fundraising efforts

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

In these cases, we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

- We can use your health information and share it with professionals who are treating you.
  Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- **We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.** This does not apply to long-term care plans.
  Example: We use health information about you to develop better services for you.

Pay for your health services

- We can use and disclose your health information as we pay for your health services.
  Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

- We may disclose your health information to your health plan sponsor for plan administration.
  Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

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

Help with public health and safety issues

- We can share health information about you for certain situations such as:
  - Preventing disease
  - Helping with product recalls
  - Reporting adverse reactions to medications
  - Reporting suspected abuse, neglect, or domestic violence
  - Preventing or reducing a serious threat to anyone's health or safety

Do research

- We can use or share your information for health research.

Comply with the law

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

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner or funeral director when an individual dies.

Address workers' compensation, law enforcement and other government requests

- We can use or share health information about you:
  - For workers' compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security and presidential protective services

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order or in response to a subpoena.

Our Responsibilities

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

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

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The notice will be available upon request on our web site, and we will mail a copy to you.

Patient Protection and Affordable Care Act

All medical plans offered by GP Strategies meet the requirements of the Patient Protection and Affordable Care Act (PPACA).

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

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

What is the Health Insurance Marketplace?

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

Can I save money on my health insurance premiums in the Marketplace?

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

Does employer health coverage affect eligibility for premium savings through the Marketplace?

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

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

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

How can I get more information?

For more information about coverage offered by your employer, please check your summary plan description or contact Ann Prendergast, Benefits Manager by phone at 443.367.9693 or via email at aprendergast@gpstrategies.com.

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name GP Strategies Corporation		4. Employer Identification Number 52-0845774
5. Employer address 1100 Broken Land Parkway, Suite 200		6. Employer phone number 866-727-6677
7. City Columbia	8. State Maryland	9. ZIP code 21044
10. Who can we contact about employee health coverage at this job? Ann Prendergast, Benefits Manager		
11. Phone number 443-367-9693	12. Email address aprendergast@gpstrategies.com	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  _____ All employees.
  __X__ Some employees. Eligible employees are:

You are eligible to enroll in the Plan if you are a:

1. Regular full-time Participant,
2. Regular benefits-eligible part-time Participant who is scheduled to work at least 24 hours per week,
3. Full time or part time employee who is deemed eligible due to the Affordable Care Act.

- With respect to dependents:
  _____We do not offer coverage.
  __X__We do offer coverage. Eligible dependents are:

1. Spouse: A Spouse is defined as (a) your opposite-sex or same-sex spouse as determined under applicable state or foreign law at the time and location that the marriage was entered into (excluding common-law marriage), or (b) a person of the same sex with whom you have entered into a legally registered civil union, or legally registered domestic partnership in a state that sanctions such unions by law and that is valid pursuant to such law at the time that the parties enter into the relationship, and such relationship (whether under (a) or (b) above) has not been dissolved under the law of the state in which such relationship was initially or is currently recognized.
2. Dependent Child: A Dependent Child is defined as your or your Spouse's child who is under age 26, including a natural child, stepchild, a legally adopted child, a child placed for adoption or a child for whom you or your Spouse are the legal guardian; or an unmarried child age 26 or over who is or becomes disabled and dependent upon you.

GP Strategies' medical plan coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages. An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986).

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

If you decide to shop for coverage in the Marketplace, www.HealthCare.gov will guide you through the process.

Medical Benefits

GP Strategies offers four medical plan options: the Traditional PPO Plan, the Gold HDHP, the Silver HDHP, and the Bronze HDHP. The Traditional PPO Plan and all three High Deductible Health Plans (HDHP) offer open access to health care providers and specialty care physicians within a network without the need to choose a Primary Care Physician. Prescription coverage is included in the medical coverage. These options are provided to ensure that coverage may be selected based on each employee's individual preferences. Below you will find some basic information about the medical plans; for more detailed information, please refer to the Medical, Prescription & Virtual Visits Benefits page of the GP Strategies intranet.

GP Strategies makes a generous contribution toward the cost of your health plan. Your personal contribution for each plan option, should you select it, is depicted in the following table. All amounts listed are on a per pay period basis (24 pay periods per year).

Coverage Level	Traditional PPO Plan	Gold HDHP	Silver HDHP	Bronze HDHP
Employee:	$127.00*/ $157.00	$64.00*/ $94.00	$39.00*/ $69.00	$18.00*/ $48.00
Employee + child(ren):	$249.00*/ $279.00	$148.00*/ $178.00	$113.00*/ $143.00	$65.00*/ $95.00
Employee + spouse:	$343.00**/ $373.00*/ $403.00	$201.00**/ $231.00*/ $261.00	$147.00**/ $177.00*/ $207.00	$95.00**/ $125.00*/ $155.00
Employee + family:	$420.00**/ $450.00*/ $480.00	$235.00**/ $265.00*/ $295.00	$174.00**/ $204.00*/ $234.00	$109.00**/ $139.00*/ $169.00

* Employee OR Spouse participating in the Health Improvement Program (HI&P)
** Employee AND Spouse participating in the Health Improvement Program (HI&P)

While your contribution is important, it's not the only issue to consider when weighing your alternatives. If you enroll in the Gold HDHP or the Silver HDHP, GP Strategies will contribute to a Health Savings Account (HSA) on your behalf.

IMPORTANT NOTE: **The Traditional PPO plan is closed to new enrollments. In order to enroll in the Traditional PPO Plan in 2019, you must have been enrolled in the plan in 2018. We expect to eliminate the Traditional PPO Plan on 12/31/19.**

You Will Be Responsible for Some Out-of-Pocket Expenses

Co-payments (co-pays) and deductibles are costs you will encounter when you receive health care services. After you meet any applicable deductible, you will still pay a portion of your medical costs. Your plan pays for a percentage, such as 90%, 80% or 60%, of the costs your health care provider charges. The remaining difference, such as 10%, 20% or 40%, is your responsibility. Your plan has an out-of-pocket maximum, which is the most money you are expected to pay in a calendar year for covered health expenses. Deductibles and out-of-pocket maximums run on a calendar-year basis (January–December).

Under the Traditional PPO Plan, office visit co-pays and prescription costs are not subject to and do not count towards your deductible.

Tiered Provider Program

UHC has designated certain in-network doctors, specialists, and imaging, surgery, and lab facilities as Tier 1 providers. If you live in an eligible location and visit a Tier 1 provider instead of a non-tier provider, you will pay a lower co-pay or co-insurance in all medical plans.

If you live in AK, CA, HI, ME, MO, MT, NH, VT, WY, or Puerto Rico, the Tiered Provider Program will not apply. Also, if you live in certain counties in MI (Washtenaw County) or NY (Clinton County, Erie County, Niagara County or Tompkins County), the Tiered Provider Program will not apply.

Medical Benefits	Traditional PPO		Gold HDHP		Silver HDHP		Bronze HDHP	
GP's Annual H.S.A. Contribution	None		$500 Individual/$1,000 Family		$500 Individual/$1,000 Family		None	
Annual Deductible (calendar year)	**In Network**	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Individual (per person)	$1,000	$4,000	$1,500	$1,500	$2,000	$4,000	$3,000	$6,650
Family (maximum limit)	$2,000	$8,000	$3,000	$3,000	$4,000	$8,000	$6,000	$13,300
Out of Pocket Maximum	*(includes deductible)*		*(includes deductible)*		*(includes deductible)*		*(includes deductible)*	
Individual (per person)	$4,000	$8,000	$3,000	$6,000	$4,000	$8,000	$6,750	$13,500
Family (maximum limit)	$7,900	$16,000	$6,000	$12,000	$7,900	$16,000	$13,300	$26,600
Lifetime Maximum	Unlimited		Unlimited		Unlimited		Unlimited	
Coinsurance (percentage you pay)*	20%*	40%*	10%*	30%*	20%*	40%*	30%*	50%*
Preventive Care	$0	0%	0%	0%	0%	0%	0%	0%
Office Visit Tier 1 (non-preventive)	$35	40%*	10%*	30%*	20%*	40%*	30%*	50%*
Office Visit (non-preventive)	$45	40%*	20%*	30%*	30%*	40%*	40%*	50%*
Specialist Visit Tier 1	$50	40%*	10%*	30%*	20%*	40%*	30%*	50%*
Specialist Visit	$60	40%*	20%*	30%*	30%*	40%*	40%*	50%*
Virtual Visit	$49	N/A	10%*	N/A	20%*	N/A	30%*	N/A
Urgent Care Visit	$50	40%*	10%*	30%*	20%*	40%*	30%*	50%*
Emergency Room Visit	$200	$200	10%*	10%*	20%*	20%*	30%*	30%*
In-patient Care	20%*	40%*	10%*	30%*	20%*	40%*	30%*	50%*
Imaging, Surgery & Lab – Freestanding	20%*	40%*	10%*	30%*	20%*	40%*	30%*	50%*
Imaging, Surgery & Lab - Hospital-Based	30%*	40%*	20%*	30%*	30%*	40%*	40%*	50%*
Prescription Benefits	**Traditional PPO**		**Gold HDHP**		**Silver HDHP**		**Bronze HDHP**	
	In Network	Out of Network	In Network*	Out of Network	In Network*	Out of Network	In Network*	Out of Network
Prescription: Retail (up to 31 day supply)*	$10/$35/ $70/$100	Not Covered	$10/$35/ $70/$100	Not Covered	$10/$35/ $70/$100	Not Covered	$10/$35/ $70/$100	Not Covered
Prescription: Mail Order (90 day supply)**	$20/$70/ $140	Not Covered	$20/$70/ $140	Not Covered	$20/$70/ $140	Not Covered	$20/$70/ $140	Not Covered

*All coinsurance percentages and prescription co-pays are payable after the medical annual deductible has been met under the Gold HDHP, Silver HDHP and Bronze HDHP

** Tier 4 prescriptions are not available in 90 day supply (see Prescription Benefits below for definition of Tier 4 prescriptions)

Usual and Customary Limitations

Your plan reimburses charges from non-participating providers (out-of-network providers) that are charged for the same service:

1. In the same geographic area; and
2. By other providers in the same or similar medical area.

The fees charged by non-participating providers may exceed the usual and customary charges recognized by your plan. In such cases, the insurance carrier will process an amount equal to the usual and customary charge for the health care service you received, and you will be reimbursed for that amount according to your plan's out-of-network benefits. You will be responsible for paying the difference between the usual and customary charge and your out-of-network provider's fee (sometimes referred to as "balance billing"). Your payment of this difference does not apply towards your annual deductible or out-of-pocket maximum.

Preventive Routine Health Care

A "preventive" or "routine" physical exam is a medical examination given by a physician for a reason other than to diagnose or treat a suspected or identified sickness or injury. Included as part of the examination are laboratory tests, immunizations and other tests given in connection with the wellness examination, **if billed as preventive routine services**. Not included are charges for magnetic resonance imaging (MRIs); computerized axial tomography (CATs); and positron emission tomography (PETs), single photon emission computerized tomography (SPECTs) or other similar imaging tests, X-rays, ECGs or EKGs. Comprehensive Medical Covered Charges will not include, and no benefits will be paid for, Treatment or Service that is not for Medically Necessary Care or that is an Experimental or Investigational Measure.

Coverage for Preventive Routine Health Care

Under all of the medical plans, preventive medical care is paid at 100%, not subject to deductible.* However, in order for services to be covered as preventive care, your provider must bill the services as preventive care.

Preventive Routine Health Care Includes:

Well Care

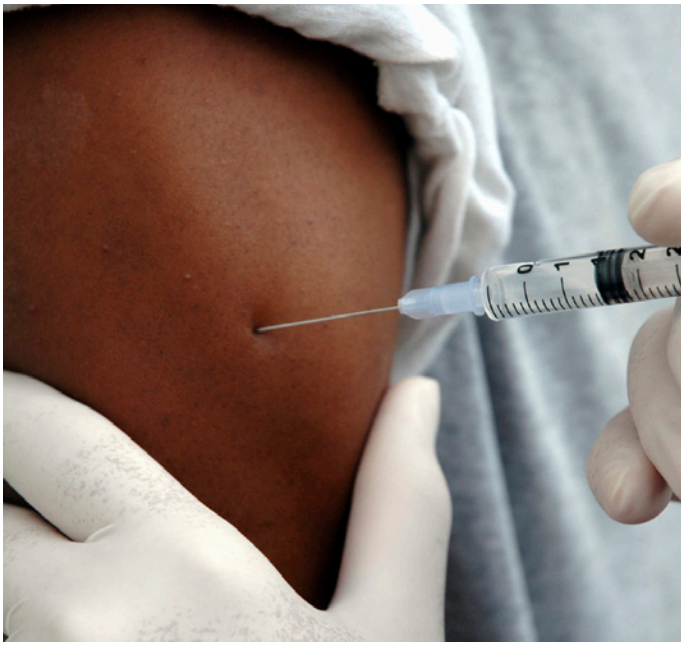
Well care is defined as evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved. With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration. With respect to women, to the extent not described above, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration. For children, this care includes well child care visits and an annual physical exam. For adults, this care includes an annual routine physical exam and an annual routine gynecological exam.

Routine Immunizations, Child

Routine immunizations for routine use in children that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved. Hepatitis B (HepB); Diphtheria, Tetanus, Pertussis (DtaP); Haemophilus influenzae type b (Hib); Inactivated Poliovirus (IPV); Human Papillomavirus (HPV); Measles, Mumps, Rubella (MMR); Varicella; Influenza; Pneumococcal; Hepatitis A; Meningococcal (MPSV4 or MCV4); and all immunizations recommended by the CDC for travel purposes.

Routine Immunizations, Adult

Routine immunizations for routine use in adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved. Hepatitis B; Diphtheria, Tetanus, Pertussis (Td/Tdap); Haemophilus influenzae type b (Hib); Inactivated Poliovirus (IPV); Human Papillomavirus (HPV); Measles, Mumps, Rubella (MMR); Varicella; Influenza; Pneumococcal (polysaccharide); Hepatitis A; Meningococcal; and all immunizations.



Preventive Laboratory Tests

Urinalysis, cholesterol screening (total cholesterol and HDL), Complete Blood Count (CBC), SMAC19/General Health Panel (comprehensive metabolic panel, complete blood count, white blood count, thyroid stimulating hormone), TB screening, diabetes screening, triglycerides and blood sugar.

Preventive Routine Cancer Screenings paid at 100%, not subject to deductible.*

- Fecal occult screenings
- Mammograms
- Sigmoidoscopy
- Prostate blood test
- Colonoscopy
- Testicular cancer screening
- PAP smears

* In order for the services mentioned above to be paid as preventive care, they must be billed as preventive care by the provider. Follow-up tests to monitor a diagnosed condition are not considered preventive care. All other medical care not identified in this document as preventive routine health care is not considered preventive care and is paid as a non-preventive service.

Prescription Benefits

Prescription coverage is included in medical coverage. Your prescription benefits are administered by OptumRx, a division of UnitedHealthcare (UHC), one of the largest independent pharmacy benefit managers in the U.S. **For the Gold HDHP, Silver HDHP, and Bronze HDHP, you will have to pay up front for all of your prescriptions until you have met your deductible.** After you have satisfied the plan deductible, your prescription coverage will be based on a four-tier design. For the Traditional PPO Plan (closed to new enrollees), prescription coverage will be based on a four-tier design with no annual deductible. When a brand name medication becomes available as a generic, the tier status of the brand name medication will be evaluated. Medications may move to a higher tier. When a medication changes tiers, the cost will change. These changes may occur without prior notice to you.

The Patient Protection and Affordable Care Act (PPACA) requires coverage of FDA-approved contraceptive methods for women at 100%, without charging a co-payment, coinsurance or deductible, when filled at a network pharmacy. Items available without a prescription, such as condoms and spermicidal agents, are not covered under the health reform law. To comply with PPACA, UHC has created a list of Tier 1 contraceptives that will be covered at 100% under all GP Strategies medical plans. Please note that the cost for Tier 2 and Tier 3 contraceptives will remain unchanged and will follow the current cost guidelines for prescriptions. Under Gold HDHP, Silver HDHP, and Bronze HDHP, Tier 2 and Tier 3 contraceptives, like all other medications, will need to be paid in full by the member until the medical plan deductible is reached.

TIER 1:

Includes many generics and a very small number of brand name drugs. These drugs have the lowest co-pay. You should consider Tier 1 medications if your doctor decides they are right for your treatment.

TIER 2:

Includes preferred brand name drugs in selected drug classes. These drugs have the second lowest co-pay. Most of these drugs do not have a generic equivalent.

TIER 3:

Includes many brand name drugs not in Tier 2. These drugs have the third lowest co-pay. If you are currently taking a Tier 3 drug, you may wish to ask your doctor whether there are Tier 1 or Tier 2 alternatives that may be right for your treatment. Please see the Prescription Drug Benefit Summaries and the Prescription Drug List Reference Guide for more information regarding coverage and costs.

TIER 4:

Includes Specialty Medications. These drugs have the highest co-pay. If you are currently taking a Tier 4 drug, you may wish to ask your doctor whether there are alternatives that may be right for your treatment. Please see the Prescription Drug Benefit Summaries and the Prescription Drug List Reference Guide for more information regarding coverage and costs. Tier 4 prescriptions are not available in 90 day supply.

As noted above, certain contraceptives in Tier 1 will be covered at 100% with no co-pay.

Prescription Benefits	Traditional PPO Plan		Gold HDHP		Silver HDHP		Bronze HDHP	
	In Network	Out of Network	In Network*	Out of Network	In Network*	Out of Network	In Network*	Out of Network
Prescription: Retail (up to 31 day supply)*	$10/$35/ $70/$100	Not Covered	$10/$35/ $70/$100	Not Covered	$10/$35/ $70/$100	Not Covered	$10/$35/ $70/$100	Not Covered
Prescription: Mail Order (up to 90 day supply)**	$20/$70/ $140	Not Covered	$20/$70/ $140	Not Covered	$20/$70/ $140	Not Covered	$20/$70/ $140	Not Covered

*Prescription copays will apply after the medical annual deductible has been met under the Gold HDHP, Silver HDHP and Bronze HDHP.
** Tier 4 prescriptions are not available in 90 day supply

Generic Drugs: The Facts

1. You save the most money when you and your doctor choose generic drugs. Generics usually cost less than their brand name counterparts.
2. Generic drugs are regulated by the FDA. They are tested and approved in the same manner as brand name drugs.
3. Generic drugs contain the same active ingredients, in the same amounts and dosages, as their brand name counterparts. This means that generic drugs have the same medical effect as brand name drugs.
4. Generic drugs look different than their brand name counterparts because they contain different inactive ingredients, which affect their color, shape and size. Inactive ingredients don't change the way in which active ingredients work.
5. Nearly half of all brand name drugs have a generic counterpart.

IMPORTANT NOTE: Not all classes of medication, or all specific medications, are covered by the plan. Over-the-counter medications and drugs used for cosmetic purposes are excluded. Other drug classes may also be excluded. Contact OptumRx customer service for additional information.

Prior Authorization and Step Therapy Are Required for Certain Drugs

ProgressionRx is OptumRx's step therapy program that helps steer members to less expensive, but equally effective, medications. Members get the treatment they need, usually at a lower cost, and our customers save money. Most therapeutic classes have multiple medication options. Although their clinical effectiveness may be similar, their prices vary widely. For more information, please refer to the Prescription: Benefits Plan Details and Summaries section posted in the Health and Welfare page under the Benefits tab in the Human Resources section of the GP Strategies intranet.

Specialty Pharmacy Program

Specialty medications treat some of the most complex and life-threatening diseases. They can enhance quality of life and, for some people, extend their life. However, these medications come at a high price due to the development time and effort required to create them for a relatively small number of people. Adding to the high cost are biologics—specialty medications created from human proteins to treat diseases at the cellular level. Effectively managing these issues requires support focused around the patient and their diseases, not simply medication management. OptumRx tailors the programs and services to specific medical conditions, addressing the complicated issues that can lead to physical and emotional hardships. Programs are coordinated between clinical pharmacists, OptumRx nurses and physicians to keep individuals on track with the most appropriate medication therapy and care regimen. For more information, please visit the Prescription Benefits page on the GP Strategies intranet.

Health Improvement & Prevention Program (HI&P)

Wellness and chronic disease prevention comprise the foundation of the health continuum, with the primary purpose of identifying and reducing risks person by person and preventing increased levels of risk. The ultimate goal is to improve the health and behaviors of those who fall outside of healthy guidelines while helping and encouraging the healthy to remain within guidelines or further improve their health in order to prevent future chronic conditions. Preventing chronic conditions, identifying risks early, and addressing higher risks more aggressively are key.

GP Strategies continues to partner with Provant Health (formerly Accountable Health Solutions) to offer the Health Improvement & Prevention Program (HI&P Program). This program provides a variety of time-saving and convenient tools to help you define and reach for your wellness goals. You will find that our program includes many interesting features such as Monthly Put-Into-Practice Challenges, Quarterly Incentives, and Wellness Workshops.The Program offers numerous opportunities to participate in a variety of wellness activities and earn points.

Studies show that improving wellness can have a profound effect on an individual's quality of life: it can lead to better physical health, greater job satisfaction, and a more positive mental outlook. Other benefits include increased stamina, lower levels of stress, and higher self-esteem.

Whether you want to maintain your good health, improve your health, stop smoking, increase energy, lose weight, manage stress or improve your diet, this valuable online resource can help you succeed. GP Strategies encourages all employees and spouses enrolled in a GP Strategies medical plan to participate in the HI&P Program.

Please note that throughout this document, the term "you" refers to both employees and spouses enrolled in a GP Strategies medical plan.

Please share this information with your spouse if your spouse is enrolled in a GP Strategies medical plan.

2019 Medical Premiums

The 2019 medical insurance premiums are listed in the chart below. Employees/spouses who complete the HI&P requirements will pay a **reduced rate** (indicated in orange) for medical coverage.

As you can see, if you and/or your spouse complete the HI&P Program requirements, you will pay $30-$60 less per pay period.

Coverage Level	Traditional PPO Plan	Gold HDHP	Silver HDHP	Bronze HDHP
Employee:	$127.00*/ $157.00	$64.00*/ $94.00	$39.00*/ $69.00	$18.00*/ $48.00
Employee + child(ren):	$249.00*/ $279.00	$148.00*/ $178.00	$113.00*/ $143.00	$65.00*/ $95.00
Employee + spouse:	$343.00**/ $373.00*/ $403.00	$201.00**/ $231.00*/ $261.00	$147.00**/ $177.00*/ $207.00	$95.00**/ $125.00*/ $155.00
Employee + family:	$420.00**/ $450.00*/ $480.00	$235.00**/ $265.00*/ $295.00	$174.00**/ $204.00*/ $234.00	$109.00**/ $139.00*/ $169.00

* Employee OR Spouse participating in the Health Improvement Program (HI&P)
** Employee AND Spouse participating in the Health Improvement Program (HI&P)

The HI&P Portal

The HI&P Portal is your primary resource for the Health Improvement & Prevention Program. On 5/1/18, the HI&P Portal moved to Provant Health's new platform, which required all users to set up new log-in credentials. This can be accomplished by following the steps outlined in the HI&P Portal Log-In Instructions. You may log in to the updated portal to complete your online wellness assessment, biometric health screening, participate in health coaching and other wellness activities.

Spouses who are also enrolled in a GP Strategies medical plan should set up their own log-in credentials by following the steps outlined in the HI&P Portal Log-In Instructions.

The HI&P Portal also allows employees and spouses to view historical health screening results, access the latest information on various health and lifestyle topics, track participation in wellness challenges and incentives, and monitor progress in wellness activities.

Program Requirements in 2018 and 2019

The HI&P Program year runs from May 1 – April 30, with the corresponding incentive period running July 1 – June 30. The program requirements include an **On-line Wellness Assessment,** a **Biometric Screening**, and an **Outcomes Based Requirement,** as described below.

To receive the medical premium discount **during the next plan year July 1, 2018 – June 30, 2019**, you (and your spouse, if applicable) must do the following **before the current program year deadline** (see below for specific deadlines).

Complete an **On-line Wellness Assessment** AND

Complete a **Biometric Screening** AND

ONE of the following **Outcomes Based Requirements***:

- **Maintain – meet at least 3 out of the 5** biometric recommended levels measured on your Biometric Screening; OR
- **Improve – improve by 10%** in each biometric category where the recommended level was not met on your previous program year's Biometric Screening results; OR
- **Earn – have earned 30 wellness credits by *proactively* completing wellness activities** during the previous program year (by 4/30/18) as described on the HI&P Portal and communicated regularly via email announcements.

*Please note that individuals completing a Biometric Screening ***for the first time*** in 2018 will be exempt from the Outcomes Based Requirement. The Outcomes Based Requirement will begin with your second annual Biometric Screening.

To receive the medical premium incentive **during the period 7/1/19- 6/30/20**, you (and your spouse, if applicable) must do the following **before the next program year deadline** (see below for specific deadlines).

- ✓ Complete an **On-line Wellness Assessment (10 points)** AND
- ✓ Complete a **Biometric Screening (10 points)** AND
- ✓ NEW: **Outcomes Based Requirement: Earn a total of 70 points by completing the Wellness Assessment and Biometric Screening in May/June 2019 (10 points each as noted above) and by proactively completing Wellness Activities during the period 5/1/18-4/30/19. (*See below for more details regarding the new point system.*)**

Deadlines

Next Program Year: 5/1/18 - 4/30/19 Corresponding Incentive Year: 7/1/18 - 6/30/19	Deadline to complete requirements
Deadline to *proactively* earn **30** wellness credits (as described in the announcements for the 2017-2018 wellness year)	**4/30/2018**
Biometric Screening and Wellness Assessment: Employees/spouses with medical coverage effective 4/1/18 or earlier	**6/22/18**
Biometric Screening and Wellness Assessment: Employees/spouses with medical coverage effective 4/2/18 - 1/1/19 (new hires/status changes/new spouses)	**Last day of 3rd full month of medical coverage (no later than 4/30/19)**

Next Program Year: 5/1/19 - 4/30/20 Corresponding Incentive Year: 7/1/19 - 6/30/20	Deadline to complete requirements
Deadline to *proactively* earn **70** points (as described later in this announcement)	**4/30/2019**
Biometric Screening and Wellness Assessment: Employees/spouses with medical coverage effective 4/1/19 or earlier	Screenings begin 5/1/19, end June 2020 (exact date TBD)
Biometric Screening and Wellness Assessment: Employees/spouses with medical coverage effective 4/2/19 - 1/1/20 (new hires/status changes/new spouses)	Last day of 3rd full month of medical coverage

IMPORTANT: Spouses covered under a GP Strategies medical plan must meet the same deadlines listed above in order for an employee to be eligible for the full medical premium discount.

If you and/or your spouse miss the deadline:

Your medical premiums will be reduced to the participating rate only after GP Strategies receives verification from Provant Health that you have completed your on-line wellness assessment, submitted your biometric health screening kit, and met the outcomes-based requirement. We regret that you are not eligible to receive a reimbursement for the difference between the participating premium and the non-participating premium for the period prior to Provant Health verifying the completion of the program requirements.

More about Biometrics

A primary goal of the HI&P program is to assist you in maintaining or continually improving your health. Wellness assessments and biometric screenings help catch and treat conditions early and they can provide you with a better understanding of your health. Knowing this valuable information is the first step in making necessary changes to improve your health and quality of life. Participating in a biometric screening can save lives and reduce healthcare costs by detecting conditions before they develop or worsen. Learning your baseline values early allows you to start working on improving your results by the following year's screening.

Once you've completed your Biometric Screening, the chart below can help you determine the categories that need improvement and those which you need to maintain.

Biometric Categories		
Recommended Level	**Women**	**Men**
HDL Cholesterol	≥ 50	≥ 40
Triglycerides	< 150	< 150
Waist Circumference or BMI	< 35 inches; or < 25 BMI	< 40 inches; or < 25 BMI
Blood Pressure	< 130/80	< 130/80
Fasting Glucose (Blood Sugar)	< 100	< 100

The Health Improvement and Prevention Program (HI&P Program)

There are five basic steps to take when following the of the HI&P Program: complete your Wellness Assessment, complete your Biometric Screening, check your results, use the many tools provided by GP Strategies and United HealthCare to maintain or improve your results, and earn points. More details on each step are available below.

Step One: Complete an Online Wellness Assessment

The on-line wellness assessment is a questionnaire asking about your physical activity, nutrition, and other lifestyle habits which affect your health. It can be completed through the HI&P Portal. Spouses completing an on-line assessment should use their own log-in credentials to sign in to the HI&P Portal.

Step Two: Complete a Biometric Health Screening

The Health Screening page of the HI&P Portal **(after logging in to the Portal, click on the tab at the top titled Screening) allows you to choose one of four ways to complete the Biometric Health Screening:**

Option 1: Participate in an **On-site Screening**. Annual on-site screenings are held at larger GP offices each year during the month of May.

Option 2: Take a **Physician's Kit** to your doctor (download any time from the HI&P Portal)
Note: your spouse must also log into the HI&P Portal using his/her own log-in credentials to to download and print their personalized Physician's Kit.

Option 3: Go to a Quest location after downloading the Quest screening (download any time from the HI&P Portal)
Note: your spouse must also log into the HI&P Portal using his/her own log-in credentials to to download and print their own form.

Option 4: Order an **At-Home Kit** (order kit via the HI&P Portal)
Note: your spouse must also log into the HI&P Portal using his/her own log-in credentials to order their personalized At-Home Kit.

Step Three: Get Your Results

One of the goals of the HI&P Program is to maintain or continually improve your results. After you've completed your Wellness Assessment and Biometric Screening, you can view your results on the HI&P Portal.

Step Four: Improve Your Results Using Wellness & Preventive Tools

Consult Your Physician

We encourage you to follow up with your physician if any of your biometric screening results fall outside of the desirable levels.

The HI&P Portal

On the HI&P Portal you will find many activities in which you can participate throughout the year to assist you in maintaining or improving your biometric results and earning points. You will receive HI&P Tips emails (via GP Strategies email) which include information regarding various wellness activities which you can complete to earn points.

The HI&P Portal even has tracking programs for weight, food, and exercise, as well as pre-made exercise plans/guides for activities such as preparing to run a marathon, walking programs for beginners, intermediate strength training, 5 weeks to a 5k, etc. In addition, you can find demonstration videos for a variety of different exercises and healthy recipes.

Monthly Put-Into-Practice Challenges & Quarterly Incentives

You have access to the **Wellbeing Center** in the HI&P Portal with a monthly health topic delivered through articles, inspirational messaging, lifestyle tips and other creative tools. You can put these monthly activities into practice to increase your engagement and drive behavior change, and earn points!

Simply visit the HI&P Portal to learn everything you need to know, including how to complete your Monthly Put-Into-Practice Activities and Quarterly Incentives activities to earn points. *See below for the list of wellness activities and available points per activity.*

real appeal

Real Appeal Weight Loss Program

Real Appeal is available to employees, spouses, and dependent children age 18+ who are enrolled in a GP medical plan and who have a BMI of 25 or greater. It is a web-based program which includes one individual personalization meeting plus regular weekly group coaching sessions.* In order to receive points for successful participation, you must complete ten coaching sessions. You are encouraged to attend more than ten sessions as Real Appeal is meant to be a year-long program. You can participate in this web-based program using personal devices with speaker and camera capability.

*Individuals with BMI>30 or BMI 25-29.9 with qualifying comorbidity are eligible for individual coaching sessions.

Tobacco Cessation Program

Tobacco use is a long-confirmed risk factor for a range of serious illnesses, including heart disease, emphysema and many types of cancer. If you use tobacco products, we encourage you to take advantage of the free Tobacco Cessation Program offered through Provant Health. The program provides personal telephone coaching and tobacco cessation resources to help you become tobacco and nicotine free.

Health Coaching Program

After completing your biometric screening, you may qualify to enroll in the **Health Coaching** program offered through Provant Health if you meet the **Health Coaching qualification criteria**. This program helps you improve your health and reduce risks with the assistance of a professional Health Coach who will guide you to making lifestyle improvements through personal, one-on-one coaching sessions. You'll see how easy it can be to make healthy choices, build momentum and focus on personal strengths! Health coaching sessions are conducted primarily by phone and scheduled at convenient times for you. Each session is unique and highly personalized to your needs and goals. To enroll in the program, please call 1-800-354-1721 and press option 1.

United HealthCare's Disease Management Program

UHC offers a Disease Management Program for members who are identified to have or be at risk for a variety of chronic conditions. UHC will proactively contact members who are eligible for this program.

Preventive Care Tools and Other Tools Available through United HealthCare

UHC's **Preventive Care Guide** and the **Preventing Serious Health Risks** tool can assist you in learning more about preventive care and planning your overall wellness strategy.

UHC also offers a **free Nurse Line** which is available 24/7. You can reach a nurse by phone at 1-888-887-4114 or you may chat online with a nurse on www.myuhc.com.

There are also a variety of health and wellness tools available to you on **www.myuhc.com** including UHC TV, Healthcare Lane, Source4Women, and more.

Step Five: Plan for the Future by Earning Points

On the new Provant Health HI&P Portal which takes effect on 5/1/18, wellness credits are called points. These points will be tracked differently on the new Provant Health platform in order to simplify the program requirement tracking process. In addition, participants will earn points for many things which were not previously earned through wellness credits. As shown in the chart on the following page, participants will receive points for completing the required online wellness assessment and biometric screening, and may also earn points based on their screening results.

To receive the medical premium discount during the period **7/1/19-6/30/20**, you (and your spouse, if applicable) must earn 70 points. Please note that the Wellness Assessment and Biometric Screening must be completed during **May/June 2019**, and the Wellness Activities must be completed during the period **5/1/18-4/30/19. As you will not know until May/June 2019 what your screening results will be, we strongly urge** everyone to be proactive an earn points!!

Wellness Activities

Required Assessment Activities	Points Per Activity
On-line Wellness Assessment in May/June 2019- REQUIRED	**10**
Biometric Screening in May/June 2019- REQUIRED	**10**
Screening Results and Other Activities	**Points Per Activity**
Screening Results- based on May/June 2019 Biometric Screening	
HDL: ≥ 40 Male; ≥50 Female -OR-10% Improvement over 2018 screening	10
Blood Pressure: <130/80 -OR-10% Improvement over 2018 screening	10
Glucose: <100 -OR-10% Improvement over 2018 screening	10
BMI or Waist Circumference: BMI: < 25 -OR- Waist Circumference: < 40 Male; <35 Female -OR-10% Improvement over 2018 screening	10
Triglycerides: <150 -OR-10% Improvement over 2018 screening	10
Wellness Activities-to be completed proactively 5/1/18- 4/30/19	
Completion of Provant Health's Coaching Program -OR-participation in UHC's Disease Management Program (for qualifying individuals)	30
Monthly Put-Into-Practice Challenges	2 points each, maximum of 10
HI&P Quarterly Incentive Q2 2018: ***Complete Two of Your Requirements Early*** (only available 5/1/18- 6/14/18)	10
HI&P Quarterly Incentive Q3 2018: ***Step It Up*** (90 day incentive, only available during July-Sept 2018)	10
HI&P Quarterly Incentive Q4 2018: ***TBD*** (90 day incentive, only available during Oct-Dec 2018)	10
HI&P Quarterly Incentive Q1 2019: ***TBD*** (90 day incentive, only available during Jan-March 2019)	10
Provant Health's Wellness Workshops	5 points each, maximum of 20
Successful participation in the Real Appeal weight loss program (for qualifying individuals) -OR-Participation in another Weight Loss Program*	10
Preventive Exam* (annual physical, well-woman, immunizations, colonoscopy, mammogram, dental check-up, vision exam)	2 points per exam, maximum of 10
Community Events* (examples: race, walk, sports team participation)	1 point per event, maximum of 5
Activity Tracking* (30 minutes of exercise per day for 20 days)	10
Sleep Tracking* (sleep 7-9 hours per night for 20 days)	10
Water Tracking* (drink 64oz of water per day for 20 days)	10
HI&P Committee Participation	5

*Activity will be self-reported on the Activities page of the HIP Portal

Frequently Asked Questions

How can I learn more about the HI&P Program?

All employees and spouses enrolled in a GP medical plan will be able to view a recorded version of the HI&P 2018-2019 Webcast, which will be posted on the Wellness Benefits page of the GP Strategies intranet and on the **HI&P Portal**.

If I met the HI&P Program requirements in 2017, but do not meet them in 2018, will I lose my medical premium discount?

Yes, you will lose your medical premium discount for the period 7/1/18-6/30/19 if you did not meet all the 2018 HI&P requirements**, including the outcomes based requirement.**

However, after your 2018 screening, if you earn 50 points then you can re-earn your medical premium discount. Earning these 50 points will allow you to pay the discounted participating premium beginning with the pay period that begins after you earn the 50 points (as reported by Provant Health) through 6/30/19. You will **not** be reimbursed for any non-participation amounts you have paid prior to earning 50 points.

Who should earn 70 points?

Everyone will need to earn 70 points in order to meet the outcomes based requirement needed to earn the discounted medical premiums for the period of 7/1/19-6/30/20. Please note that you will earn 20 points by completing the required wellness assessment and biometric screenings during the period of May/June 2019; depending on your testing results, you may earn more points (see table pg 20). However, as you do not know what your 2019 biometric screening results will be, we suggest you proactively earn points by completing Wellness Activities. **Keep in mind that the Wellness Activities must be completed during the period 5/1/18-4/30/19.**

I have a condition or illness that makes it impossible for me to meet the recommended biometric levels or engage in vigorous physical activity. What should I do?

Earn points! Many of the wellness activities, incentives, and challenges can be completed by anyone, regardless of physical ability or fitness level.

What is Provant Health's privacy policy?

Provant Health and GP Strategies value and understand that your privacy is very important, and we have put many steps in place to ensure confidentiality. All information obtained is Protected Health Information (PHI) and is secured in accordance with the Health Insurance Portability and Accountability Act (HIPAA). ***GP Strategies will not have access to individual results.*** Based on the program's criteria, Provant Health provides a report to GP Strategies benefits department indicating "yes" or "no" if a participant is eligible for the medical premium discount. An annual statistical Executive Summary Report report is created to help identify areas of need for GP Strategies as a whole.

Who should I contact with other questions about the HI&P Program?

Please contact Ann Prendergast in Human Resources at aprendergast@gpstrategies.com or 800-727-6677, ext. 69693 with any questions about the HI&P Program.

Dental Benefits

GP Strategies offers a rich dental plan through Delta Dental for all employees and their dependents with no network requirements. However, you will pay less if you visit an in-network provider. Below you will find some basic information about the dental plan; for more detailed information, please refer to the Delta Dental information posted on the Benefits pages of the GP Strategies intranet. All amounts listed are on a per pay basis

2019 Pay Period Premiums

DENTAL	Employee	Employee + One	Family
	$11.00	$22.00	$33.00

DELTA DENTAL®

SERVICES	PERCENTAGE Plan Pays
Diagnostic and Preventive (exams, X-rays, consultations, cleanings, sealants, fluoride treatment and space maintainers)	100%
Basic Restorative (fillings)	80%*
Major Restorative (inlays, onlays, crowns)	60%*
Oral Surgery (extractions)	80%*
Endodontics (root canal therapy)	80%*
Periodontics (treatment of gums)	80%*
Prosthodontics (bridges and dentures)	60%*
Implants	60%*
Stainless Steel Crowns	80%*
Orthodontics (Dependent children to the end of the month they reach age 19)	50%*
Deductible (per person/per family) (Diagnostic, Preventive and Orthodontic services are exempt)	$50/$150
Annual Plan Maximum (per person)	$3,000
Orthodontic Lifetime Maximum (per child)	$2,000

*Subject to annual deductible.

Vision Benefits

Your plan provides voluntary vision care coverage for various vision–related services and materials. You may use the Vision Service Plan (VSP) network to save on your exam, frames, lenses and contacts. You may continue to obtain vision services and supplies from any vision care provider if you choose a provider outside the network. However, by choosing a provider in the VSP network, you can spend less. If you do visit a VSP provider, please indicate when making an appointment and again on the date of your visit that you are a VSP participant in order to receive VSP discounts. Below you will find some basic information about the two vision plans; for more detailed information, please refer to the Vision Benefits Plan Details and Summaries section that is posted on the Benefits pages of the GP Strategies intranet.

2019 Pay Period Premiums

VISION	Employee	Employee + Child(ren)	Employee + Spouse	Family
Standard Vision	$3.52	$6.72	$6.40	$10.36
Easy Options Vision	$8.90	$14.14	$13.46	$21.80

VSP® Vision care for life

Your Coverage From a VSP Provider

VSP IN NETWORK BENEFITS	Standard Choice Vision Plan	Easy Options Vision Plan
Well Vision Exam	$10 copay	$10 copay
Materials (Spectacle Lenses or Contact Lenses)	$25 copay	$25 copay
Well Vision Exam Every:	12 Months	12 Months
Spectacle Lenses Every:	12 Months	12 Months
Frame Every:	24 Months	**12 Months**
Diabetic Eyecare Plus Program (provides additional coverage for members with diabetic eye disease, glaucoma or age-related macular degeneration)	$20 copay	$20 copay
Frame Allowance[1]	$150	$150
Contact Lens Exam (fitting and evaluation)	$60 copay	$60 copay
Elective Contact Lenses Allowance[1] (in lieu of lenses and frame every 12 months)	$130	$130
Necessary Contact Lenses (in lieu of lenses and frame every 12 months)	Covered in full after $25 materials copay	Covered in full after $25 materials copay
Spectacle Lenses:		
Single Vision	Covered in full after copay	Covered in full after copay
Lined Bifocal	Covered in full after copay	Covered in full after copay
Lined Trifocal	Covered in full after copay	Covered in full after copay
Lenticular	Covered in full after copay	Covered in full after copay
Spectacle Lens Enhancements:		
Standard Scratch-resistant coating	$17 copay	$17 copay
Polycarbonate	Single Vision $31 copay Multifocal $35 copay	Single Vision $31 copay Multifocal $35 copay
Polycarbonate for children	Covered in full	Covered in full
Anti-reflective Coatings[1]	$41 - $85 copay	$41 - $85 copay
Progressive Lenses[1]	Multifocal $55- $175 copay	Multifocal $55- $175 copay
Photochromic Tints[1]	Single Vision $70 copay Multifocal $82 copay	Single Vision $70 copay Multifocal $82 copay

CUSTOMIZABLE UPGRADE OPTIONS	Standard Choice Vision Plan	Easy Options Vision Plan
Customizable Upgrade Options:		**Choose ONE of the five options below:**
Anti-reflective Coatings	Not Applicable	**Covered in full***
Progressive Lenses	Not Applicable	**Covered in full***
Photochromic Tints	Not Applicable	**Covered in full***
Frame Allowance	Not Applicable	**$250***
Elective Contact Lenses Allowance* (in lieu of lenses and frame every 12 months)	Not Applicable	**$200 Elective Contact Lens Allowance***

ADDITIONAL VSP DISCOUNTS & SAVINGS

1 - Easy Option Frame Allowance increases to $250, or Contact Lens Allowance increases to $200, either Anti-reflective Coatings, or Progressive Lenses or Photochromic Tints may be covered in full.

* - Customizable Upgrade Options are only available in the Easy Options Vision Plan. Choose ONE of the five upgrade options at the time of service; the benefit indicated in the Customizable Upgrade Options section will supercede the benefit indicated in the VSP In Network Benefits section.

Extra Discounts and 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 the same VSP provider within 12 months of your 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 from contracted facilities

You get the best value from your benefit when you see a VSP doctor. If you see a non-VSP provider, you'll typically pay more out of pocket. You'll pay the provider in full and have six months to submit a claim to VSP for partial reimbursement less co-pays. Before seeing a non-VSP provider, call VSP at 1.800.877.7195.

Out-of-Network Reimbursement Amounts:

Exam ..... Up to $45.00

Single vision lenses ..... Up to $30.00

Lined bifocal lenses..... Up to $50.00

Lined trifocal lenses ..... Up to $65.00

Progressive Lenses ..... Up to $50.00

Frame ..... Up to $70.00

Contacts .....Up to $105.00

VSP guarantees service from VSP doctors only. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail.

TruHearing™

VSP TruHearing Discount

The TruHearing Discount program is free for VSP members. With this program you can save up to $1,300 per hearing aid purchases and receive deep discounts on additional batteries. Each hearing aid purchased from TruHearing includes:

- Three professional visits
- 45-day money-back guarantee
- 48 replacement batteries

Enroll at vsp.truhearing.com or call TruHearing at 1.877.396.7194 (members must identify themselves as being a VSP member).

Health Savings Account (HSA)

A Health Savings Account (HSA) is an individually owned account held by a bank, insurance company or other IRS-approved institution. Money placed into this account is tax deductible. The earnings grow tax-free, and the distributions from the account are tax-free if used for qualified health expenses. To be eligible for reimbursement under an HSA, you must be covered by a qualified high deductible health plan (HDHP). GP Strategies' Gold HDHP, Silver HDHP, and Bronze HDHP are considered to be qualified HDHPs. Also, you cannot be covered under any medical insurance that is not a qualified HDHP, and you cannot be covered as a dependent under someone else's non-qualified insurance. You cannot be enrolled in Medicare, Tri-Care, or Tri-Care for Life. You cannot be covered by an account that reimburses for medical expenses, such as a Health Care Flexible Spending Account (FSA). Your spouse's FSA or non-high deductible health plan coverage may disqualify you from participation in an HSA if you are covered as a dependent.

HSAs offer triple tax savings! With every health savings account (HSA) deposit you pay no federal, and in most cases, no state income taxes. That's like saving 30% on your qualified medical expenses. In addition, every dollar you deposit grows income tax-free and you don't have to pay income taxes on withdrawals used for qualified medical expenses.

Think of your HSA as a smart way to save today, tomorrow and well down the road. You can use your HSA to pay for medical expenses such as glasses or contacts, chiropractic care, surgeries, ambulance and hospital services, to name a few. And the savings you build in your HSA keep you ready for the unexpected, which means more peace of mind for you now and in the future.

Features of HSAs

- Contributions may be made by GP Strategies (only if enrolled in the HDHP) and through pre-tax employee contributions.
- Money rolls over indefinitely.
- Account is portable.
- Withdrawals are tax-free for qualified health expenses.
- All amounts are fully vested at all times.
- All amounts are available to be carried over indefinitely.

OPTUM™

GP Strategies will contribute $20.83 per pay period ($500 annually) to an HSA for employees with individual Gold HDHP or Silver HDHP coverage, or $41.66 per pay period ($1,000 annually) to an HSA for employees with family, employee + child(ren), or employee + spouse Gold HDHP or Silver HDHP coverage.

In addition, in 2019 you may contribute up to: $3,000 for employees with individual Gold HDHP or Silver HDHP coverage, or $6,000 for employees with family, employee + child(ren), or employee + spouse Gold HDHP or Silver HDHP coverage.; For employees enrolled in the Bronze HDHP, GP Strategies will not contribute to an HSA on your behalf; however, you may make your own HSA contributions up to the IRS maximum of $3,500 for an employee with individual coverage or $7,000 for employees with family, employee + child(ren), or employee + spouse coverage. In addition, employees 55 years or older are also eligible to elect catch-up contributions as allowed by the IRS ($1,000 in 2019).

Flexible Spending Accounts (FSA)

A Flexible Spending Account (FSA) allows you to set aside part of your salary before Social Security, federal and state taxes to pay for health care expenses not covered by an insurance policy, as well as for dependent care (daycare or elder care) expenses. If you have a question about whether something qualifies, your tax preparer can help since these expenses also qualify under federal income taxes.

Health Care Expenses Eligible for Reimbursement

Qualified expenses eligible for reimbursement from a Health Care FSA include the non-covered portion of medical, prescription, dental and vision expenses. Allowable expenses must be submitted to your medical, vision, dental and/or prescription drug plan before they can be considered for reimbursement. Only the portion of the qualified expense that is not covered by any other coverage can be paid under a Health Care FSA. You may elect a maximum of $2,650 per year to contribute to a Health Care FSA.

Health Care FSA Rules

- Expenses for any member of your household qualify.
- Costs cannot be paid by other sources or benefit programs.
- Premiums for benefit programs are not covered.
- Cosmetic procedures are generally not covered. These procedures are mainly directed at improving the patient's appearance and do not meaningfully promote proper body function or treat or prevent illness.
- The total annual election for eligible medical expenses (less any previous reimbursements paid) is available upon request.
- When filing for reimbursement, you must submit an itemized bill from the provider that includes the patient's name, date of service, name of service provider, description of the expense and the amount of the claim (net of any amount that has been or is going to be paid by insurance or other sources).
- Internal Revenue Service Publication 502 lists eligible tax-free expenses. An eligible expense means any item for which you could have claimed a medical expense deduction on an itemized federal income tax return for which you have not otherwise been reimbursed from insurance or some other source. You or your dependent must incur the expense while participating in the plan (not when you are billed).
- You cannot enroll in a Health Care FSA if you are enrolled in an HSA (Health Savings Account), unless you are ineligible to contribute to an HSA.

Dependent Care Expenses Eligible for Reimbursement

Eligible expenses include daycare in or outside your home for a dependent child or dependent adult care so that you and your spouse may work or go to school full time. You may elect a maximum of $5,000 per year to contribute to a Dependent Care FSA.

Dependent Care FSA Rules

- Care must be needed to allow you and your spouse to work, be a full-time student or seek employment. The cost of care must not exceed the lesser of the employee or spouse's income. If one parent is a full-time student, the IRS uses an earned income amount of $250 per month for one dependent or $500 per month if there are two or more dependents.
- Care cannot be provided for free.
- Care needed so that you may perform volunteer work is not eligible.
- Spouses and children do not qualify as providers.
- Coverage applies to specific individuals whom you claim as dependents for federal tax purposes, including:
  - Dependents under the age of 13
  - Dependent adults or children 13 years or older who are mentally or physically incapable of self-care
- Your maximum contribution amount cannot be more than the lesser of $5,000 per year if your tax filing status is "married filing jointly" or "single head of household" or $2,500 per year if your tax filing status is "married filing separately."
- All expenses for dependent care must be for "care." Education expenses for kindergarten, first grade and above are not eligible for reimbursement according to the Internal Revenue Service.
- Overnight camps, travel, clothing, entertainment and food expenses are not eligible.
- To be reimbursed, you must include a receipt from the provider that includes the provider's name, dates of service, how much you paid and the provider's signature.
- Type of dependent care:
  - If dependent care is provided in a more commercial center that has company letterhead, the receipt should be on their letterhead and include the dates of services and the amount charged.
  - If dependent care is provided in a private home, the receipt must state that the services provided were for dependent care, list the dates of services and be signed by the day care provider.
- The maximum amount you can be reimbursed during the time you are covered in the plan year cannot exceed the salary reduction amounts you have elected and made under the dependent care spending account less any previous reimbursements paid.

What You Need to Know About FSAs

While FSAs offer many advantages, you need to be aware of the following:

Income tax credits are affected

When you use FSA dollars to pay an expense, you cannot take a federal income tax credit for that expense. This affects many people who use the dependent care tax credit. Tax law reduces the expenses eligible for the end-of-the-year tax credit dollar for dollar by the expense amount funded through FSA. If the amount placed in the FSA exceeds the maximum expenses used to figure the tax credit, then the tax credit cannot be used. It is recommended that you contact a tax advisor to help determine if a tax credit or FSA is best for you.

Health and Dependent Care FSAs are separate

Money cannot be shifted between the two accounts.

Plan with care

Unused dollars at the end of the plan year are not refundable. Expenses are treated as having been incurred when the services are provided and not when you are formally billed or charged for or pay for the expenses.

Allow for the claims submission deadline

Please note that all claims for the Health Care FSA and the Dependent Care FSA must be submitted no later than 90 days following the earlier of:

- The end of the plan year, if you are enrolled in the applicable FSA during the entire plan year; or
- The end of plan participation if you are not enrolled in the FSA during the entire plan year.

Disability Benefits

GP Strategies offers disability coverage to regular employees who are scheduled to work 40 hours per week after they have been disabled for five consecutive business days. The disability program includes Salary Continuation, Short-Term Disability (STD) and Long-Term Disability (LTD). STD and LTD are provided by Cigna.

Salary Continuation

Salary continuation pays 100% of an employee's salary after five consecutive business days of total disability, through the 30th day of disability. The 30 calendar days begin on the first day of the absence due to disability. The first five days of an employee's disability must be charged to Paid Time Off (PTO) or Leave Without Pay (LWP). For employees at the director or executive level, the first ten business days must be charged to Flexible Time Off (FTO). Beginning the sixth business day (or eleventh day if the employee is at the director or executive level) of total disability, the employee charges his/her time to salary continuation for the remainder of the 30-calendar-day period. Partial days are covered, and a doctor's certification of disability is required. This portion of disability is fully funded by the Company; however, an employee must elect Short Term Disability in order to receive Salary Continuation.

Short-Term Disability (STD)

STD begins after the 30 calendar days of Salary Continuation and may continue through the 180th day of total or partial disability. Payment is based on approval by Cigna. STD provides 70% of an employee's hourly rate multiplied by the number of hours in the pay period for total disability up to a maximum of $10,000 per month. For partial disability, employees are paid 100% of the employee's hourly rate for hours worked and 70% of hours not worked due to disability up to a maximum of $10,000 per month. To be considered partially disabled, an employee must work less than 80% of normal workload, less than 6 hours per day per physician's orders and earn less than 80% of normal pay. STD must be elected by the employee and is partially funded by the employee.

Cost Per Month:
$.35 per $1,000 of annual salary

Your STD premium will increase on the date your salary increases (if applicable).

Long-Term Disability (LTD)

LTD begins after the 180th day of continuous total or partial (must work less than 80% of normal workload, less than 6 hours per day per physician's orders and earn less than 80% of normal pay) disability. Payment is based on approval by Cigna. LTD provides 66.66% of normal earnings (up to $12,500 per month) for up to two years for employees who are unable to work in their current occupation or up to a specified age (see LTD Note) if totally unable to work. Employees must elect and pay for LTD coverage on an after-tax basis.

LTD coverage changes requested after an employee's initial eligibility period will be subject to underwriting. The Evidence of Insurability Form for Disability is posted on the Life and Disability page under the Benefits tab in the Human Resources section of the GP Strategies intranet.

Disability or disabled means that, during the elimination period and for up to 24 months, you are prevented by accidental bodily injury, sickness, mental illness or substance abuse from performing one or more of the essential duties of your occupation; and, as a result, your current monthly earnings are no more than 80% of your pre-disability earnings. After that, you must be prevented from performing one or more of the essential duties of any occupation.

LTD Note: As long as you remain disabled, LTD benefits will be paid until the later of the Duration of Benefits (below) or the Normal Retirement Age as defined by the U.S. Social Security Act.

Under age 62: To age 65
Age 62: 42 months
Age 63: 36 months
Age 64: 30 months
Age 65: 24 months
Age 66: 21 months
Age 67: 18 months
Age 68: 15 months
Age 69+: 12 months

Cost Per $100 Per Month:
annual salary divided by 1,200 and then multiplied by age rate

AGE		AGE	
< 25	$0.064	45-49	$0.332
25-29	$0.074	50-54	$0.547
30-34	$0.094	55-59	$0.726
35-39	$0.139	60-64	$0.723
40-44	$0.190	65+	$0.706

Your LTD premium will increase on the date you move into a new age bracket. Your LTD premium will increase on the date your salary increases (if applicable).

Life Insurance Coverage Options

The following life insurance options provided by Cigna are available to regular employees who are scheduled to work 40 hours per week.

Basic Group Life and AD&D Insurance

Eligible employees may elect basic group life and AD&D insurance, which is partially funded by the employee. Approval is automatic upon initial eligibility to enroll. Basic life insurance coverage pays twice the employee's annual salary up to a maximum of $300,000 and double indemnity in case of accidental death or dismemberment (AD&D). Basic life and AD&D insurance coverage changes requested after an employee's initial eligibility period will be subject to underwriting. The Evidence of Insurability Form is located in the Life section that is posted on the Life and Disability page under the Benefits tab in the Human Resources section of the GP Strategies intranet.

2x salary up to $300,000 max; Cost per Month: $.07 per $1,000 coverage; annual salary divided by 1,000 and then multiplied by .07

Your Basic Group Life and AD&D premium will increase on the date your salary increases (if applicable).

Supplemental Life Insurance

In addition to basic group life insurance, eligible employees may purchase supplemental life insurance up to five times the employee's salary. An employee must have basic group life insurance in order to purchase supplemental life, and approval up to $375,000 (subject to the maximum of five times the employee's annual salary) is automatic upon initial eligibility to enroll. Supplemental life coverage amounts must be chosen in increments of $25,000.

All supplemental life insurance coverage changes requested after an employee's initial eligibility period will be subject to underwriting. All amounts elected over $375,000, regardless of when requested, are subject to underwriting. The Evidence of Insurability Form is located in the Life section that is posted on the Life and Disability page under the Benefits tab in the Human Resources section of the GP Strategies intranet.

Cost Per $1,000 Per Month:
amount elected divided by 1,000 and then multiplied by age rate

AGE		AGE	
< 30	$0.060	55-59	$0.646
30-34	$0.080	60-64	$0.918
35-39	$0.090	65-69	$1.590
40-44	$0.145	70-74	$2.729
45-49	$0.289	75-79	$4.990
50-54	$0.391		

Your Supplemental Life premium will increase on the date you move into a new age bracket.

Spouse Life Insurance

Eligible employees may purchase spouse life insurance up to $250,000 of coverage. An employee must have basic group life and supplemental life insurance in order to elect spouse life. The amount of spouse life elected may not exceed the total amount of the employee's basic group life and supplemental life insurance. Approval up to $50,000 is automatic upon initial eligibility to enroll. Spouse coverage amounts must be chosen in increments of $5,000.

All spouse life insurance coverage changes requested after an employee's initial eligibility period will be subject to underwriting. All amounts elected over $50,000, regardless of when requested, are subject to underwriting. The Evidence of Insurability Form is located in the Life section that is posted on the Life and Disability page under the Benefits tab in the Human Resources section of the GP Strategies intranet.

Cost Per $1,000 Per Month:
amount elected divided by 1,000 and then multiplied by age rate

AGE		AGE	
> 30	$0.060	55-59	$0.646
30-34	$0.080	60-64	$0.918
35-39	$0.090	65-69	$1.590
40-44	$0.145	70-74	$2.729
45-49	$0.289	75-79	$4.990
50-54	$0.391		

Your Spouse Life premium will increase on the date your spouse moves into a new age bracket.

Dependent Child Life Insurance

Eligible employees may purchase dependent child life insurance in the amount of $10,000 of coverage per child. An employee must have basic group life insurance in order to elect dependent child life, and approval is automatic upon initial eligibility to enroll. Eligible children are children up to age 19 or until age 24 if a full-time student.

Cost Per Pay: $0.25 per pay for one or more dependent children

Life/AD&D Reductions

If you or your spouse is age 65 or older, the life, supplemental life and/or the spouse life insurance benefit will be reduced by the percentage indicated below:

Age 65-69: 35%	Age 80-84: 79%
Age 70-74: 58%	Age 85+: 85%
Age 75-79: 73%	

The Life/AD&D Reductions listed above will go into effect on the date you or your spouse moves into a new age bracket.

Group Term Life (GTL) Taxation

IRS regulations require that employees pay taxes on any amount of life insurance coverage over $50,000. Taxation rates and calculation instructions are published by the IRS in Publication 15-B. Employers are instructed to include in an employee's wages the cost of GTL insurance beyond $50,000 worth of coverage, reduced by the amount the employee paid toward the insurance. The monthly cost of the insurance to include in the employee's wages is then calculated by multiplying the number of thousands of dollars of all insurance coverage over $50,000 (figured to the nearest $100) by the cost indicated in IRS Publication 15-B. For all coverage provided within the calendar year, the employer must use the employee's age on the last day of the employee's tax year.

GP Strategies' payroll system automatically calculates the tax owed by an employee based on the employee's age, the amount over $50,000 and the IRS tax rate. This taxable amount is added to the employee's gross wages so it can be taxed. Since it is not a true payment, it is then deducted from the employee's wages after the tax calculation is performed. In this way, the employee is taxed on the amount even though it is not actual income.

Cigna's Value-Added Programs

Cigna's Value-Added programs are available free of charge to full-time regular employees enrolled in a GP Strategies life or disability product through Cigna.

- Cigna Healthy Rewards offers up to 60% discounts on health and wellness services, including weight management and nutrition, vision and hearing care, tobacco cessation, alternative medicine, fitness and vitamins.
- Cigna Will Preparation offers self-service online tools that allow individuals to create legal documents such as their last will and testament, living will, health care power of attorney and financial power of attorney.
- Cigna Identity Theft Program offers assistance in preventing identity theft and handling identity theft issues.

LifeLock Identity Theft Protection

LifeLock services offer identity theft protection that a remediation-only or credit monitoring-only service can't. This includes:

- Identity alert via phone, email and text
- Monitoring more than a million transactions each second
- Live member support
- Annual Credit Report & Credit Score: One Bureau1 (Requires Advantage Membership)
- Annual Credit Reports & VantageScores: Three Bureaus (Requires Ultimate Plus Membership)
- Lost wallet protection
- Breach notifications
- Identity Restoration Support
- Million Dollar Protection™ Package
  - Stolen Funds Reimbursement up to $25,000, up to $100,000 or up to $1 million based on the limits of your plan
  - Service Guarantee
  - Personal Expense Compensation up to $25,000, up to $100,000 or up to $1 million based on the limits of your plan

For more information, please see the LifeLock related documents on the Benefits pages of the Human Resources section of the GP Strategies intranet.

Aflac Voluntary Benefits

With Aflac voluntary supplemental insurance, you can provide an additional level of financial protection for yourself and your family in the event of a covered accident or illness. Aflac provides coverage for individuals to help pay benefits that your medical insurance does not cover. Aflac pays you regardless of what your major medical plan pays. GP Strategies employees may elect voluntary benefits including Group Critical Illness, Group Accident, and Group Hospital Indemnity plans through Aflac. For more information, please see the Aflac related documents on the Benefits pages of the Human Resources section of the GP Strategies intranet.

Legal Resources

Legal Resources has been providing legal services and representation for employees and their dependents for over 20 years. Today, Legal Resources serves over 600 employer groups nationwide. The most often needed legal services are covered at 100%, meaning the employee and his/her dependents pay no attorney fees when they use the services (see chart below). Employees have access to one of the largest attorney networks in the industry, with over 12,000 attorneys nationwide. Additionally, there are no claim forms, deductibles or co-pays. Enrollees will pay a premium of $9 per pay period (after-tax) for this benefit.

Once enrolled, the employee may call his/her law firm directly to get legal help, or call the Legal Resources Member Services Department staffed by certified paralegals to ask coverage questions, update account information or change law firms.

Ask yourself the following questions:

- Do you need legal advice?
- Are you considering a divorce?
- Have you ever been cited for a speeding ticket or, worse, reckless driving?
- Do you need your will prepared or updated?
- Are you buying, selling or refinancing your home?
- Do you need someone to review a lease or contract before you sign it?

COMMONLY USED LEGAL SERVICES	Attorney Fees without the Plan*	With LEGAL RESOURCES**
Legal Advice and Consultation	$300 - 400 per hour	$0
Tenant Dispute with Landlord		
District Court Representation in a Civil Action		
Traffic Court Representation (including 1st offense DUI)	$750 - 1,500	
Will Preparation	$500 - 750 per person	
Uncontested Divorce Representation	$1,250 - 2,000	
Uncontested Domestic Adoption (includes name change)	$1,000 - 1,500	
Purchase, Sale or Refinance of Primary Residence	$400 - 700	
Defense of Child in Juvenile Court (misdemeanor)	$875 - 1,500	

For more information, contact our Member Services Department at 1.800.728.5768 or visit www.legalresources.com

*Demonstrates the potential savings the Legal Resources. Plan provides and does not represent actual payments but rather the standard fee or hourly rate an attorney would charge for that service.

**Member responsible for all non-attorney costs (filing tees, fines, court costs, etc.).The Plan covers the individual, spouse and dependent children under 19 years of age or under 23 years of age if a full-time student.12-month commitment required.

Please review the Legal Resources® Master Plan Contract for a complete description of all services, limitations and definition of district court by state PRIOR to enrollment.

Other Benefits Offered by GP Strategies

GP Strategies Retirement Savings Plan

Regular employees scheduled to work 40 hours per week, and part-time regular benefits eligible employees scheduled to work 24-39 hours per week may participate in the GP Strategies Retirement Savings Plan. Also, temporary employees who have completed 1,000 hours of service during their first year of employment or any following calendar year are eligible to participate in the Plan. Eligible employees may authorize a deduction of their gross regular pay contributed into a pre-tax 401(k) account and/or a Roth after-tax account beginning the first of the month following their hire date, or as soon as administratively feasible. Employees will be automatically enrolled at a 3% pre-tax payroll deduction level. Employees who do not want to participate in the plan should refer to the GP Strategies Retirement Savings Plan Highlights booklet for instructions regarding changing the pretax deferral percentage from 3% to 0%. An employee's combined pre-tax and Roth after-tax contributions may not exceed the IRS annual maximum. Highly compensated employees (HCEs) are limited to a 10% combined pre-tax and Roth after-tax contributions each pay period. Employees 50 years or older are eligible to elect catch-up contributions as allowed by the IRS. Participants elect the allocation of contributions to their investment account among available fund choices; funds are subject to change.

GP Strategies may, at its discretion, make matching employer contributions beginning on the first of the month following the completion of one year of employment. Employer contributions vest at the rate of 20% for each year the employee completes 1,000 hours of service.

Life Assistance Program

GP Strategies offers pre-paid confidential counseling and referral services to employees and their eligible dependents through Cigna's Life Assistance Program (LAP). The LAP provides counseling via telephone and three free face-to-face counseling sessions at an office environment convenient to the employee's home or place of work. The LAP counseling service assists individuals and their families in many areas such as stress management, relationship concerns, parental issues, conflicts at work, financial and legal concerns, substance abuse problems and other behavioral health concerns. The LAP's Work/Life referral service also assists individuals and their families in finding childcare and elder care referrals and much more.

Travel Insurance

Employees traveling on Company business are covered by travel accident insurance, for death or certain types of dismemberment, up to a maximum of $250,000. This coverage is automatic and the premium is paid in full by GP Strategies.

Educational Assistance

Upon hire, regular employees scheduled to work 40 hours per week are eligible for reimbursement of tuition, direct academic fees and books for up to six credit hours each semester for courses related to the employee's job. Reimbursement of educational assistance is subject to the discretion of each Business Unit and is limited to $5,250 per employee per year. In-house courses are also available in many subject areas at no cost to the employee. Employees who terminate employment within 12 months of receiving any educational assistance are required to pay back GP Strategies for any reimbursements received.

Holidays

GP Strategies observes eight paid holidays each year. Regular employees scheduled to work 40 hours per week receive eight hours of pay for each holiday, while part-time regular employees scheduled to work 24-39 hours per week and are classified as benefits eligible receive a prorated amount based on their regularly scheduled hours. Holidays observed include the following:

- New Year's Day
- Presidents' Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Thanksgiving Friday
- Christmas Day

Paid Time Off

Each regular employee scheduled to work 40 hours per week with more than six months of service is eligible to take Paid Time Off (PTO). PTO provides employees with a "bank" of time to be used for illnesses, vacations or personal reasons. PTO is earned incrementally and is credited in equal prorated amounts each pay period. Service time determines PTO eligibility. For example, regular employees scheduled to work 40 hours per week with...

- 6 months to < 5 years of service earn 112 hours of PTO per year (4.67 hours per pay period)
- 5 to < 10 years of service earn 152 hours of PTO per year (6.33 hours per pay period)
- 10 to < 15 years of service earn 176 hours of PTO per year (7.33 hours per pay period)
- 15 years or more of service earn 192 hours of PTO per year (8 hours per pay period)

Part-time regular benefits eligible employees working an average of 24-39 hours per week are eligible for a prorated amount of PTO according to the pay period accrual rates listed above. The number of PTO hours accrued is calculated by dividing the employee's actual hours worked within a pay period by 86.67 hours (the average number of hours in a pay period) and then multiplying the result by the appropriate accrual rate above.

Bereavement Leave

Regular employees scheduled to work 40 hours per week are eligible for 24 paid hours of bereavement leave per instance for the death of an immediate family member. Part-time regular benefits eligible employees working an average of 24-39 hours per week are eligible for a pro-rated number of hours of bereavement leave per instance, based on their regularly scheduled hours. Immediate family members include the following: spouse, domestic partner, child, parent, grandparent, grandchild or sibling of the employee or the employee's spouse or domestic partner.

Matching Gift Program

GP Strategies offers a matching gift program meant both to encourage increased individual support of educational, health and human services and youth and civic organizations as well as to direct a portion of GP Strategies' resources on a dollar-for-dollar basis (not to exceed $250 per employee per calendar year) to worthwhile organizations that are of greatest importance to GP Strategies employees. The Matching Gift Program also includes a volunteerism component. For every four (4) volunteer hours, GP Strategies will donate $50.00 to the charity. This amount will count against the employee's annual maximum of $250.00. Full-time regular employees are eligible to participate in this program after six months of service.

Employee Referral Program

This program provides an incentive to current regular employees to refer external candidates by providing referring employees a $1,000 taxable cash bonus for each applicant referred that is hired and remains employed with GP Strategies as a full-time regular employee scheduled to work 40 hours per week for a specified period of time.

529 College Savings Plan

CollegeAmerica provides our employees with a new way to save for their family members' higher education expenses through a tax-advantaged account invested in American Funds. This is offered through the Virginia College Savings Plan to all employees and lists many American Funds to choose from. Enrollment is available at any time of the year and you may establish an account for any U.S. citizen. This plan is available nationwide and allows tax-free earnings and withdrawals for qualified higher education expenses. The beneficiary of the account may attend any higher education school that is eligible to participate in a student financial program under Title IV of the Higher Education Act of 1965. Most community colleges, public and private colleges, universities and vocational schools in the U.S. are eligible, as are some foreign institutions. Once the account is established, anyone can contribute to the account and contributions can be made by check, wire transfer or an automated purchase plan.

Multiple Educational Discount Programs

GP Strategies employees are eligible to receive discounts on undergraduate and graduate courses through Ashford University, Boise State University, Capella University, Colorado Technical University, Excelsior College, Syracuse University, Trident University International and the University of Dayton. More information for each program is available on the GP Strategies intranet.

Multiple Vehicle Discount Programs

GP Strategies employees benefit from our relationship with both General Motors (GM) and Chrysler through their supplier discount programs. For GM vehicles, employees are eligible to purchase/lease a new car, truck, sport utility vehicle or minivan at GM employee price plus 4%. For Chrysler vehicles, our employees receive the discount of 1% below factory invoice when purchasing or leasing a new vehicle. More information for each program is available on the Benefits pages of the GP Strategies intranet.

Other Discount Programs

GP Strategies also participates in the following discount programs. More information is available on the Benefits pages of the GP Strategies intranet.

- AT&T Wireless
- Camp Bow Wow
- CDW Computer Discount Center
- Dell Employee Purchase Program
- National/Enterprise Rent-A-Car Discount Program
- Liberty Mutual Auto, Home and Life Insurance
- Microsoft Employee Discount Program
- NASA Federal Credit Union
- GP Strategies Perks (various retail discounts)
- Pet Insurance (Banfield and Nationwide/VPI)
- Tickets at Work (various entertainment, travel, & retail discounts)
- Working Advantage (various retail discounts)
- Verizon Wireless

The information contained in this document is only a summary, current as of January 1, 2019 and is not intended to be all-inclusive. Complete details are contained in the formal plan documents, insurance policies, and/or in written GP Strategies Policies. Questions may be addressed to Human Resources. These benefits are subject to change at the discretion of the Company.

GP Strategies at a Glance

Founded in 1966, GP Strategies is a global performance improvement solutions provider of sales and technical training, eLearning solutions, management consulting and engineering services. GP Strategies' solutions improve the effectiveness of organizations by delivering innovative and superior training, consulting and business improvement services customized to meet the specific needs of its clients.

Customers include Fortune 500 companies, manufacturing, process and energy industries, and other commercial and government organizations. GP Strategies is headquartered in Columbia, Maryland, USA. Additional information may be found at gpstrategies.com.

GP Strategies Vision and Mission

Our vision is a world where business excellence makes possibilities achievable. Our mission is to enable people and businesses to perform at their highest potential.

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Ref. Code: 2019 HRBenftsPlan US 12.17.18.indd