Crowe Horwath

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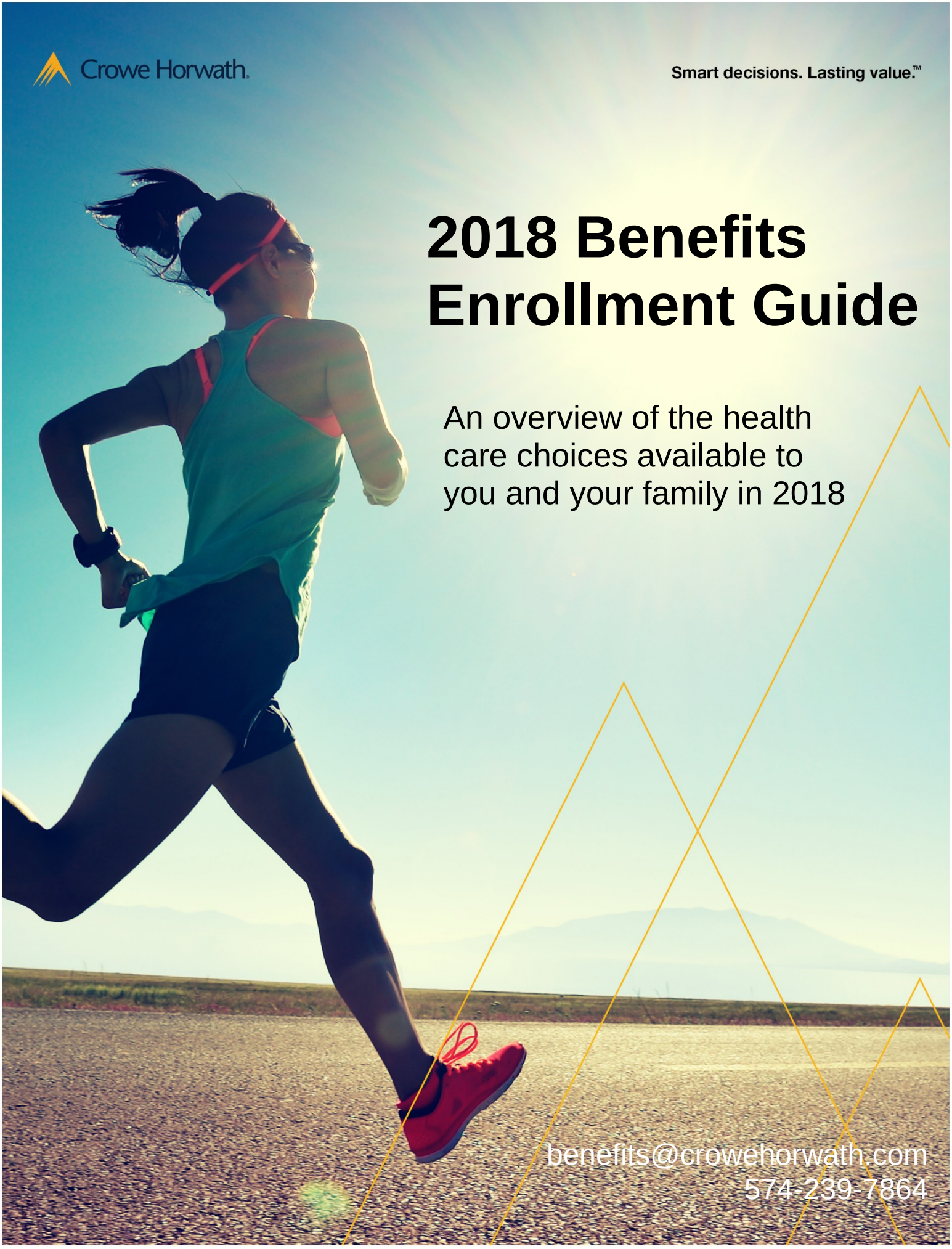

2018 Benefits Enrollment Guide

An overview of the health care choices available to you and your family in 2018

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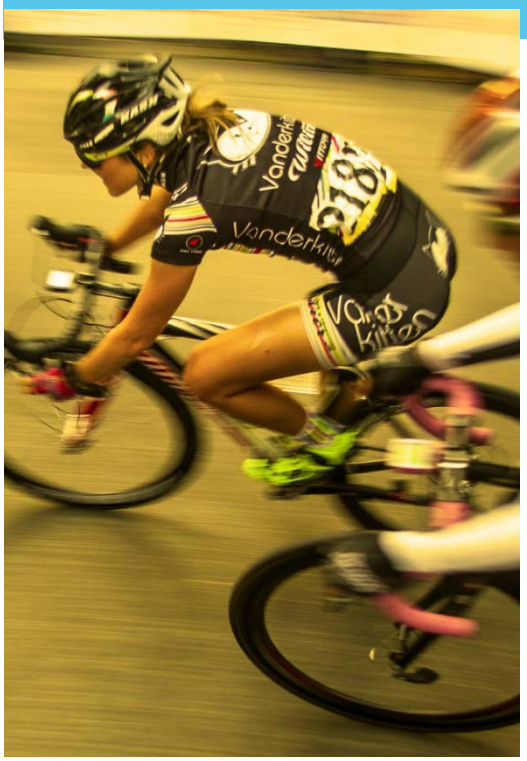
2018 Benefits Enrollment Guide



The employee benefit programs described in this guide are effective in 2018. The information in this guide is a summary of Crowe's benefits, and every attempt has been made to ensure its accuracy. The actual provisions of each benefit program will govern if there is any inconsistency between the information in this guide and Crowe's formal plans, programs, policies, or contracts, or any subsequent change in such plans, programs, policies, or contracts.

What's Inside

Welcome to Crowe

Crowe is pleased to provide comprehensive, high-quality medical, dental and vision insurance, as well as several flexible spending account choices. These benefit plans are available to all eligible personnel on their first day of employment. Premiums for most of these benefits will be made through payroll deduction on a pretax basis. Crowe's benefits may cover you and your eligible dependents, including same and opposite gender domestic partners (DP). DP benefits have specific tax implications which are outlined later in the booklet.

Please take the time to review this brochure to make sure you understand the benefits that are available to you and your family—then be sure to take action. You have only **30 days** from your hire date or date of benefits eligibility to enroll in these benefits:

Nicotine Status *(Required)*:

Check the Nicotine-free Certification box to indicate you are nicotine-free.

Medical *(Required)*:

(Surcharge does not apply to Partners)

My Choice PPO	My Choice PPO w/Surcharge	Waive Medical
My Choice Premium	My Choice Premium w/Surcharge	
My Choice Select	My Choice Select w/Surcharge	

Dental *(Required)*:

Cigna Standard DPPO
Cigna Basic DPPO
Waive Dental

Vision *(Required)*:

Vision Service Plan (VSP)
Waive Vision

Health Savings Account (HSA) and Flexible Spending Accounts (FSAs)

HSA – *must be enrolled in the My Choice Premium or Select medical plan*
Healthcare FSA
Dependent Care FSA

Disability and Life Insurance

Short-term Disability – *Eligible employees automatically enrolled*
Long-term Disability – *Eligible employees automatically enrolled*
Basic Life Insurance – *Eligible employees automatically enrolled*

Supplemental Life Insurance	1 – 6 times annual earnings
Spouse/Domestic Partner Life Insurance	$10,000 – $250,000
Child(ren) Life Insurance	$10,000

Other Benefits

Accident Insurance	High Plan	Low Plan
Hospital Confinement Insurance	High Plan	Low Plan

READY TO ENROLL? VIEW INSTRUCTIONS ON PAGE 22

General Information

Terms to Know

This guide was created to help you make important decisions about your health care. Before you begin, we think that understanding certain words will help you better understand the choices you need to make. So here are some definitions of words and phrases that you'll see in this guide.

Coinsurance: A fixed percentage of covered health care services or prescription drug costs that you pay, after the deductible amount (if any) has been paid. The medical plan pays the rest.

Copay: A fixed dollar amount you pay at the time health care services or prescription drugs are received, regardless of the total charge for service.

Deductible: A fixed annual dollar amount that you pay out-of-pocket during the calendar year, toward health care services before the medical plan begins to pay.

- **Embedded Deductible:** This is when the plan begins to make payments as soon as one member of the family has reached the individual deductible limit.
- **Non-embedded Deductible:** This is when the plan will not make payments until the entire family deductible has been collected. Since there is no individual deductible in the family coverage, no one receives the plan benefit until the total deductible is met.

Dependent: A family members of an employee that is eligible to be covered under Crowe's benefit plans. An eligible dependent is defined as:

- A spouse
- A same or opposite gender domestic partner (DP)
- Biological or adopted children (up to age 26) who live in the employee's home or a child whose healthcare is the responsibility of the employee. This includes children, stepchildren, children of a spouse and children of a DP.
- Children of any age who are mentally or physically handicapped and unable to support or care for themselves

Domestic Partner (DP): A person of the same or opposite gender with whom you have a legal or personal relationship in which you live together and share a common domestic life.

To be eligible for DP coverage, the following must be true:

- The partner must share a dedicated relationship with the participant for at least the prior 6-months. The partner and participant must be financially interdependent.
- Neither partner nor participant can be married to anyone else under statutory or common law.
- This relationship must be the sole domestic partner relationship.

Health Savings Account (HSA): A tax-free, individually-owned savings account used to pay for your eligible medical expenses in the current year or in future years.

High-Deductible Health Plan (HDHP): These plans feature lower premiums and higher out-of-pocket costs, with deductibles before the plan begins covering costs. The HDHP is offered in conjunction with a HSA.

In-network: Health care professionals and facilities that have contracts with the medical, pharmacy, or dental plan to deliver services at a negotiated rate (discount). You pay a lower amount for those services.

Out-of-network: A health care professional or facility that doesn't participate in your plan's network and doesn't provide services at a discounted rate. Using an out-of-network health care professional or facility will cost you more.

Out-of-pocket Maximum: The most you pay before the medical plan begins to pay 100% of covered charges.

Premium: is the amount you pay for insurance, using pre-tax or post-tax dollars. Your premium is deducted from your paycheck.

Prescription Drugs: A pharmaceutical drug that legally requires a medical prescription to be dispensed.

- **Generic:** Have the same active ingredients, dosage, and strength as their brand-name counterparts. You'll usually pay less for generic medications.
- **Preferred Brand:** Preferred brand medications will usually cost more than generics but may cost less than non-preferred brands on your plan.
- **Non-preferred Brand:** Non-preferred brand medications generally have generic alternatives and/or one or more preferred brand options within the same drug class. You'll usually pay more for non-preferred brand medications.

Qualifying Life Event: A change in your situation — like getting married, having a baby or losing health coverage — that can make you eligible for a Special Enrollment Period, allowing you to enroll in health insurance outside the yearly Open Enrollment Period.

General Benefit Information

Benefits Eligibility

Benefits eligibility is determined by the total number of annual hours worked. Detailed benefit eligibility information can be found in the appendix of this booklet.

Changing Elections

The IRS only allows participants to change their benefit elections during the plan year within 30-days of a qualifying life event. Changes to the coverage must be made on ESS within **30 calendar days** of the qualifying life event. To make a "life event" change, contact the Benefits team at **benefits@crowehorwath.com**.

Examples of qualifying life events:

- Birth, adoption, or guardianship
- Death of a dependent, spouse, or DP
- Divorce or end of a DP relationship
- Marriage or beginning of a DP relationship
- Involuntary loss of insurance due to spouse or DP employment change
- Involuntary loss of coverage due to dependent turning age 26

Benefit changes without a qualifying life event are allowed during the firm's annual open enrollment every fall to become effective January 1 of the following year.

Enrollment Eligibility

Medical insurance is available to regular employees on their first day of employment. An employee must be enrolled in a plan to enroll a dependent in that plan. Employees will not be able to enroll until after their hire date.

Domestic Partner (DP) Tax Implications

The IRS does not recognize a DP, for the purpose of taxation, as either a spouse or a dependent. Therefore, premiums paid by the employee for a DP or the DP's children must be taken as a post-tax deduction. The employee portion of the premium can still be made on a pre-tax basis. In addition, the fair market value of coverage for the DP and/or DP's children is also taxable and must be reported as such on the employee's W-2.

To summarize, the premium paid by the employee on behalf of the DP ***does not qualify*** as a pre-tax deduction, so this amount will be deducted after federal, state, and local taxes have been taken. Wages will not be reduced prior to taxation.

The portion of the premium paid by Crowe on behalf of the DP is treated as income to the employee and is taxed. This is called imputed income. Additional information about imputed income can be obtained from your tax advisor or from the firm's Benefits Team.

Domestic Partner (DP) Tax Implications – Same Gender Domestic Partner

Benefits for same gender spouses may be pre-tax or may be subject to payroll taxation as directed by Federal and State law, which varies by state. Under Federal rules, any individual married in a state or foreign country that recognizes same-sex marriage will be treated as married for all purposes of the Internal Revenue Code. This applies even if the individual resides in a state that does not recognize same-sex marriage. The ruling also clarifies that the term "marriage" does not include registered domestic partnerships, civil unions, or other similar formal relationships recognized under state law that are not denominated as a marriage under that state's law. If you are "married under state law" and covering your same gender spouse with Crowe benefits, please e-mail **benefits@crowehorwath.com** so that you're spousal benefits may be setup for the correct tax treatment.

Insurance ID Cards

Insurance ID cards for the medical and prescription drug plans will be mailed to the participant's home address by the insurance provider and should arrive in 10-15 business days after enrollment in ESS. ID cards will only be issued in the name of the subscriber. The dental and vision plans do not issue ID cards.

Claim filing information and claim forms can be found on InCrowe and are also provided at the time of enrollment in case benefit services are required prior to receipt of insurance cards.

Health and Welfare

Medical and Prescription Drug

The medical plans listed below are offered by Anthem Blue Cross and Blue Shield. All three plans cover 100% of preventive care costs include: annual physicals, well-baby and well-child visit and immunizations. They also provide prescription drug coverage. You can learn more about these plans, and which one would best meet your needs, by viewing the detailed medical plan comparisons found in the appendix of this guide and on the Benefits InCrowe pages.

Medical Plans

My Choice PPO: This plan is for people who want a high level of coverage with higher premiums, but relatively low out-of-pocket costs. Plan participants receive healthcare services from the physician or facility of their choice, but out-of-pocket expenses are less if they receive care from an in-network provider. Under this plan, copays and prescription drug costs do not apply to deductible, but do apply to the out-of-pocket maximum

My Choice Premium with an HSA (HDHP): This plan is for people who want lower premiums, but are comfortable with higher deductibles. Participants in this plan must be prepared to pay medical and prescription expenses up to the deductible level before receiving any benefit payment. Under this plan, prescription drug costs apply to deductible and out-of-pocket maximum.

My Choice Select with an HSA (HDHP): This plan is for people who want even lower premiums, but are comfortable with slightly higher deductibles. Participants in this plan must be prepared to pay medical and prescription expenses up to the deductible level before receiving any benefit payment. Under this plan, prescription drug costs apply to deductible and out-of-pocket maximum.

Compare Plans

Below is a quick comparison of the plans. For more information, review the documents in the appendix, which includes the following:

- A premium rate chart showing you how much you will pay for each plan
- A health plan comparison chart detailing in- and out-of-network costs, copayments, coinsurance, and deductibles

Coverage*	My Choice PPO	My Choice Premium	My Choice Select
Deductible	$450/Person; $1,350/Family	$1,500/Employee Only; $3,000/All Other Coverage Levels	$3,000/Employee Only; $6,000/All Other Coverage Levels
Out-of-Pocket Maximum	$1,500/Person; $4,500/Family	$3,000/Employee Only; $6,000/All Other Coverage Levels	$3,000/Employee Only; $6,000/All Other Coverage Levels
Coinsurance	10%	10%	0%
Preventive Care	100% Coverage	100% Coverage	100% Coverage

* The coverage amounts included in the chart are for in-network services only.

How does an HDHP work?

- Except for in-network preventive care (for example, annual physicals and preventive screenings), you'll pay the full cost of all services, including prescriptions, until you reach your deductible. If you have family coverage, you need to meet the entire family deductible before the plan begins paying.
- Once you reach the deductible, you share the cost of care (coinsurance), with the plan paying most of the cost until you reach the annual out-of-pocket maximum. In-network and out-of-network costs can be combined to satisfy the deductible. The family deductible must be met before any benefit is paid for an individual.
- There are separate out-of-pocket maximums for in-network care and out-of-network care, which accrue separately. Once you reach these maximums, the plan pays 100% of costs for the rest of the calendar year.
- When you enroll in the HDHP, you can also open an HSA to help pay for current and future eligible health care expenses. You can withdraw that money, tax-free, to pay eligible out-of-pocket medical expenses as well as dental and vision expenses, or you can save that money for future health care expenses, including those incurred in retirement.
- See page 10 for additional information about the HSA, including information on eligibility, limitations and Crowe's annual tax-free contribution.

Waive Medical Coverage

A credit of $16 per-pay period ($384 annually) is provided to employees who are eligible for Crowe medical coverage, but decline coverage. This benefit credit will be paid out as taxable income.

To receive this credit, you must select the Waive Medical with Credit option in the ESS. By doing so, you certify that you have been given an opportunity to apply for coverage for yourself and your eligible dependents, if applicable.

If you waive medical coverage during open enrollment, you will not have another opportunity to enroll in medical coverage until the Firm's next annual open enrollment period or you experience a qualifying life event.

Nicotine-free Incentive

As part of Crowe's desire to promote well-being and provide motivation to pursue healthy habits and an active lifestyle, Crowe offers a discounted medical premium incentive to those who certify that they are nicotine-free. Employees who certify that they have been nicotine-free for the past 6-months, and pledge to remain nicotine-free indefinitely, will receive a $20 monthly premium discount. Employees are provided an opportunity to certify they qualify as Nicotine-free, upon their hire date with the firm and once annually during the firm's medical open enrollment period, typically in October or November each year. ***To receive the nicotine-free incentive, you must complete the required certification on ESS.***

The Nicotine-free Certification will also be used to determine non-smoker life insurance rates for basic and supplemental life insurance, if applicable.

If you are a nicotine user and complete a smoking cessation program during the benefit plan year, you will be eligible to receive the discounted medical and supplemental life insurance premium rates. Once you have completed the smoking cessation program, you must submit proof of program completion to **benefits@crowehorwath.com**. While you will be provided with the reduced premium rates, you will not be allowed to make an actual election change to your medical plan until the next open enrollment cycle.

Spouse/Domestic Partner Surcharge

Crowe employees must pay an additional cost to cover a spouse or domestic partner who has the option to elect comparable medical coverage through his or her employer. The additional cost, or surcharge, to Crowe employees will be $25 a paycheck. If your spouse or domestic partner has access to comparable medical coverage and elects to remain on a Crowe medical plan, you should consider how the additional cost may impact your coverage choice.

A comparable medical plan is one that has similar cost and coverage to Crowe's plans. When reviewing for comparability, you should consider deductibles, out of pocket maximums, prescription drug coverage and premiums. It is up to you to determine if the coverage offered to your spouse or domestic partner is comparable to medical coverage offered by Crowe. Use your good judgment to make your own determinations. If you are unsure of the coverage available to your spouse or domestic partner, contact his or her employer's Benefits or Human Resource Department for specific health plan information.

Personnel are provided an opportunity to elect/waive the spouse or domestic partner surcharge upon his/her hire date with the firm, within thirty days of a qualifying life event and once annually during the firm's medical open enrollment period in the fall.

Well-Being Medical Premium Reduction

Crowe offers a $8.33/paycheck ($200 calendar year) premium reduction to those that reach Level 2 (3,000 points) in the Well-Being Portal and are enrolled in a Crowe medical plan. This premium reduction will take effect in 2019 and is not reflected in the rates in ESS. Employees have until December 11, 2018 to earn the necessary point in the Well-Being Portal. Those employees who are not enrolled in a Crowe medical plan will receive a $150 Tango Card in January of 2019.

Emergency Room (ER) Usage

If you chose to receive care for non-emergency ailments at the ER when a more appropriate setting is available, your claim will be reviewed using the prudent layperson standard* and potentially denied. The review by a medical director will take into consideration the symptoms that brought you to the emergency room even if the diagnosis turned out to be a non-emergency ailment.

CVS/Caremark is our prescription drug carrier. The prescription drug benefit is provided automatically to employees and their dependents that are enrolled in any of the medical plan options.

Prescription Drug

Prescription Drug Copayment Tiers

CVS/Caremark has a three-tier copayment schedule:	
Drug Tier	**Description**
Non-Preferred Brand	Highest-Cost Medications – Typically known by a highly marketed brand name.
Preferred Brand	Mid-Cost Medications – Name brand drugs that have usually been on the market longer, but do not yet have a generic equivalent.
Generic	Lowest-Cost Medications – Contain the same active ingredients as name-brand drugs but are sold at a lower price.

To better help you manage the impact of prescription medications, a detailed break-down of the copayment schedule can be found in the appendix of this guide.

Prescription Drug Deductible and Out-of-Pocket Maximums

If you are enrolled in the My Choice PPO plan, prescription drug copays **do not** count towards your medical deductible or out-of-pocket maximum. They apply to a separate, prescription drug out-of-pocket maximum ($1,500 single / $3,000 family).

If you are enrolled in the My Choice Premium or Select plan, prescription drug costs **do** count towards your medical plan deductible and out-of-pocket maximum.

Preventive Drug List

For certain health conditions, taking preventive care drugs prescribed by your doctor can help you stay healthy today, and help you save on future health care costs by managing health concerns before they become serious. For your better health, Crowe has added an enhanced benefit to the My Choice Premium and Select plans for preventive care drugs. Instead of having to meet your plan's deductible for certain prescription drugs, you just pay a copay for medications on the Preventive Drug List. The current Preventive Drug List can be found on the Prescription Drug page on InCrowe.

Filling prescriptions at a retail pharmacy

Simply use your Caremark identification card and you can receive a 30- or 90-day supply for each prescription purchased at a retail pharmacy. If you are unsure if your pharmacy is participating in the Caremark network, you can confirm participation with your pharmacist or a www.caremark.com.

Filling prescriptions using the mail-order pharmacy

For prescription medication used for an extended period of time or as a maintenance medication the Caremark Mail Service Program provides a convenient way for you to order up to a 90-day supply for direct delivery to your home. Mail order pricing is available at CVS pharmacies nationwide. Follow the instructions below for obtaining a 12-month prescription from your physician.

If your doctor has prescribed a maintenance drug, ask your doctor to write two prescriptions at the time of the visit. One, for a one-month supply to use at your local participating pharmacy; the second written for a 90-day supply with four refills to be sent to Caremark Mail Order pharmacy. A Caremark Mail Service Form will be included with your Caremark insurance card and can also be found at www.caremark.com.

Spending and Savings Accounts

Flexible Spending Accounts

By allowing you to set aside money directly from your paycheck before taxes are taken out, flexible spending accounts (FSAs) are a great way to save money for eligible expenses and to lower your taxable income. You can use that tax-free money to pay for eligible out-of-pocket healthcare and dependent care expenses.Crowe offers the following FSA options, administered by ConnectYourCare:

Healthcare FSA

- Pay for eligible medical, dental, and vision care expenses such as copays, coinsurance, deductibles, medical supplies and equipment, mental health and substance abuse treatment, orthodontia, and eyeglasses and contact lenses for yourself and your eligible dependents.
- If you enroll in a HDHP and elect a Healthcare FSA, you will automatically be enrolled in the Limited Purpose FSA. You can use this account to pay for out-of-pocket dental and vision care expenses for yourself and your dependents.
- Contribute up to $2,650 per year.
- You can spend up to the full amount of your annual election as soon as your account has been set up.
- A list of Healthcare FSA eligible expenses can be found on the Flexible Spending Account InCrowe page.
- All eligible expenses must be incurred on or after your hire date or date of benefits eligibility.
- You must elect this benefit within **30 days** of your hire date or first date of benefits eligibility.

Dependent Care FSA

- Pay for eligible dependent care for a child under age 13 or adult care expenses, including day care, care for a disabled spouse or dependent, after-school care, and many types of summer camps. This account is NOT for a dependent's health expenses.
- Contribute up to $5,000 per family per year ($2,500 if you are married and filing taxes separately).
- All eligible expenses must be incurred on or after your hire date or date of benefits eligibility.
- You must elect this benefit within **30 days** of your hire date or first date of benefits eligibility.

Estimate carefully with an FSA

FSAs are "use-it-or-lose-it" accounts, which means you will forfeit any amount left in the account at the end of the Plan Year. Therefore, it is important that you plan carefully so you get the most out of your FSA. Contribute only as much as you think you will need for the year. When determining the appropriate amount to contribute, it may help to consider:

- Your healthcare claims for the last two years;
- Your health status and that of your family;
- Potential price increases for dependent caregivers and summer camps; and
- If there is any time where you will not need dependent care services (i.e., vacations, leaves of absence, etc.).

You have until March 15, 2019, to incur eligible expenses and until April 1, 2019, to submit requests for reimbursement.

Managing your FSA

You can easily manage your FSA from the ConnectYourCare website at www.ConnectYourCare.com or via the ConnectYourCare mobile app. On both the website and the app, you can check your FSA balance, file claims, enroll in direct deposit for reimbursements and learn more about eligible expenses.

Paying for services

- You will receive a Healthcare FSA debit card. Although you do not need to file for reimbursement when using your debit card, you may be required to submit documentation, so be sure to save your receipts.
- You will not receive a debit card for the Dependent Care FSA.
- You can pay for expenses out of pocket and submit receipts for reimbursement to ConnectYourCare. FSA claim forms can be found on the Flexible Spending Account InCrowe page.

Commuter Accounts

Commuter Parking Account

- Pay for qualified work-related parking expenses—including expenses incurred on/near your employer's premises that are necessary for you to work. You may also reimburse parking expenses incurred on/near a location from which you commute to work by van-pooling in a commuter highway vehicle or by car-pool.
- Contribute up to $260 a month.
- You can enroll in or makes changes to this benefit anytime during the year at www.ConnectYourCare.com.

Commuter Transit Account

- Pay for qualified public transit expenses—including train, subway, bus, ferry or vanpool—as part of your daily commute to and from work.
- Contribute up to $260 a month.
- You can enroll in or makes changes to this benefit anytime during the year at www.ConnectYourCare.com.

Health Savings Account

If you enroll in the My Choice Premium or Select plan, you can also open a Health Savings Account (HSA) to help pay for current and future eligible health care expenses. An HSA is similar to an FSA, but with some important differences.

How does an HSA work?

If you enroll in the HDHP, you should also open an HSA at the same time.

- Once your HSA is open, Crowe will make a tax-free contribution to your HSA based on your start date and coverage level. The contribution schedule for 2018 can be found in the appendix of this guide.
- You can also make tax-free contributions via payroll deductions (up to federal limits).
- You can withdraw that money, tax-free, to pay eligible out-of-pocket medical expenses as well as dental and vision expenses, or you can save that money for future health care expenses.
- You will receive a debit card to use with your HSA from BenefitWallet, the HSA administrator.
- Once the balance in your HSA reaches a specified amount, you can invest your funds in your choice of investment options—all of which enable you to generate tax-free earnings.
- In addition to the HSA, you can enroll in a Limited Purpose FSA to pay for out-of-pocket dental and vision care expenses for yourself and your dependents.

Who is eligible for an HSA?

- You cannot be enrolled in Medicare.
- You cannot be covered under a non-HDHP plan (such as a spouse's plan) or Healthcare FSA.
- Your spouse, if you are married, cannot be enrolled in a Healthcare FSA, but his/her enrollment in a Limited Purpose FSA is permitted.
- You cannot be claimed as a dependent on someone else's tax return.

To receive the Crowe contribution, you **must** enroll in the HSA. If you don't want to contribute your own money, simply make a $0 election.

Helpful Tip: With an HSA, the money in the account is yours to keep. Unlike an FSA, your funds don't expire, which means you can roll your money over from year to year.

How much can you contribute to an HSA?

2018 HSA Maximum Contributions		
Coverage Level	**HSA Contribution under age 55**	**HSA contribution for age 55+**
Employee Only	$3,450 (including Crowe Contribution)	$4,450 (including Crowe Contribution)
+ Domestic Partner	$3,450 (including Crowe Contribution)	$4,450 (including Crowe Contribution)
+ Spouse	$6,900 (including Crowe Contribution)	$7,900 (including Crowe Contribution)
+ Child(ren)	$6,900 (including Crowe Contribution)	$7,900 (including Crowe Contribution)
+ Family	$6,900 (including Crowe Contribution)	$7,900 (including Crowe Contribution)

Dental

As a Crowe employee, you may participate in one of the two dental PPO plans offer through Cigna Dental: the Standard DPPO plan and the Basic DPPO plan.

The DPPO Network

Crowe participates in the DPPO Radius network, which is one of the nation's largest dental networks. In addition, no referrals are necessary to see a specialist. Both dental PPO plans provide you the flexibility of receiving services from an in- or out-of-network provider. Although you may use non-participating dentists, you'll pay more than you would if you used a participating dentist.

Provider listings for the CIGNA DPPO plans are available at www.cigna.com or by calling CIGNA's member services at (800) 244-6224. Knowledgeable member services representatives can answer your questions and assist you in finding a network provider in your area.

Standard DPPO

The Standard DPPO plan provides you with a high level of coverage in exchange for higher premiums.

Plan Features:

- $50 individual/$150 family deductible for in- or out-of-network services
- 100% coverage for cleanings and examinations
- 80% coverage for basic restorative care and oral surgery
- 50% coverage for major restorative care
- $1,500 per person annual plan maximum for dental services
- $1,500 per person lifetime maximum for orthodontia services

The Standard DPPO plan covers orthodontia for both adults and dependent children. Participants already receiving orthodontic treatment on the effective date of coverage will be subject to standard coverage limits. Contact CIGNA at **(800) 244-6224** for a breakdown of covered services.

Basic DPPO

The Basic DPPO plan provides you with a slightly lower level of coverage in exchange for lower premiums.

Plan Features:

- $50 individual/$150 family deductible for in- or out-of-network services
- 100% coverage for cleanings and examinations
- 50% coverage for basic and major restorative care and oral surgery
- $750 per person annual plan maximum for dental services

When will I receive my dental ID card?
Cigna no longer sends our dental ID cards to employees enrolled in the plan. You can access your plan information and ID number at www.cigna.com.

Dental Predetermination

Cigna Dental strongly recommends that you have extensive, unusual or costly dental procedures pre-determined (pre-approved) before the procedure is performed. Pre-determination means that your dentist will submit a treatment plan to the insurance provider in advance. Cigna will review the treatment plan and notify the dentist what procedures will be covered and how much the participant will need to pay out-of-pocket.

Pre-determination provides your dental provider with dental consultants who are licensed in general dentistry and specialty areas, and can suggest alternative courses of treatment when there is more than one treatment method available.

Cigna will send copies of the pre-determination notice to your dentist to review with you before proceeding with treatment. If the treatment plan changes or if you do not receive the treatment within 90-days, you will need to have the plan pre-determined again.

Helpful Tip: Minimize your out-of-pocket expense for dental care by asking your dentist for a pre-treatment estimate from Cigna before you agree to receive any prescribed major treatment. Your dentist may be able to present alternative treatment options that will lower your share of the bill while still meeting your basic dental care needs.

Vision

As a Crowe employee you may also opt to enroll in a comprehensive vision care plan, provided by VSP. It offers greatly reduced rates on vision exams, frames, lenses, and contacts. Be sure to enroll within **30 days** of your hire date to get the coverage you need.

To locate a vision provider:

- Call VSP customer service call center at **(800) 877-7195**
- Visit the VSP website at www.vsp.com

When will I receive my vision ID card?
The VSP plan does not require ID cards. Simply, identify yourself as a VSP member and provide the covered member's social security number. The eye doctor will then confirm eligibility directly with VSP.

Vision Coverage

Benefit	Description	Copay	Frequency
WellVision Exam	Focuses on your eyes and overall wellness	$10	Every calendar year
Prescription Glasses		**$25**	**See frame and lenses**
Frames	- $150 allowance for a wide selection of frames - $170 allowance for featured frame brands - 20% savings on the amount over your allowance	Included	Every other calendar year
Lenses	- Single vision, lined bifocal and lined trifocal lenses - Polycarbonate lenses for dependent children	Included	Every calendar year
Lens Enhancements	- Standard progressive lenses - Premium progressive lenses - Custom progressive lenses - Average savings of 20-25% on other lens enhancements	$55 $95 - $105 $150 - $175	Every calendar year
Contacts (instead of glasses)	- $150 allowance for contacts; copay does not apply - Contact lens exam (fitting and evaluation)	Up to $60	Every calendar year
Diabetic Eyecare Plus Program	- Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). - Retinal screening for eligible members with diabetes.	$20	As needed

Laser Vision Correction Surgery

Laser vision correction surgery is available through VSP with an average 15% off the regular price or 5% off the promotions price. Discounts are only available through contracted facilities. Getting started is simple, just follow the steps below.

- Confirm that your VSP network doctor is a laser vision care doctor, or find a laser vision doctor.
- Make an appointment with your VSP laser vision care doctor for a screening, which will help determine if you're a good candidate for laser vision surgery. The doctor will then coordinate your surgery with a VSP-contracted laser vision center they are affiliated with so the doctor and center can co-manage your treatment.
- After surgery, the laser vision center will have you return to your VSP network doctor for post-operative care and ongoing eye health management.
- After your laser vision surgery, you may be able to use your VSP frame benefit for non-prescription sunglasses. Ask your VSP network doctor for details.

Obtaining Vision Services

To obtain vision care services, simply call your VSP doctor to make an appointment. Identify yourself as a VSP member and provide the covered member's social security number. The VSP plan does not require identification cards. The VSP doctor will contact VSP directly to verify eligibility, plan coverage, and obtain authorization for services and materials. If you are not eligible, the VSP doctor is responsible for communicating this to you.

Accident and Hospital Confinement Insurance

Crowe offers its employees the option to enroll in Accident and/or Hospital Confinement Insurance provided by Voya. Both insurance offerings have two plan options, a high plan and a low plan, so you can choose the plan that best suits your needs. Be sure to enroll within **30 days** of your hire date to get the coverage you need.

Accident Insurance

Accident Insurance pays you benefits for specific injuries and events resulting from a covered accident that occurs on or after your coverage effective date. The benefit amount depends on the type of injury and care received. You have the option to elect Accident Insurance to meet your needs. Accident Insurance is a limited benefit policy. It is not health insurance and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.

Other features of Accident Insurance include:

- **Guaranteed issue**: No medical questions or tests are required for coverage.
- **Flexible**: You can use the benefit payments for any purpose you like.
- **Payroll deductions**: Premiums are paid through convenient payroll deductions.
- **Portable**: If you leave your current employer or retire, you can take your coverage with you.

How can Accident Insurance help?

Below are a few examples of how your Accident Insurance benefits could be used:

- Medical expenses, such as deductibles and copays
- Home healthcare costs
- Lost income due to lost time at work
- Everyday expenses like utilities and groceries

What accident benefits are available?

A summary of the benefits provided under this plan can be found in the appendix of this guide and on the Accident Insurance page on InCrowe.

Hospital Confinement Insurance

Hospital Confinement Indemnity Insurance pays a daily benefit if you have a covered stay in a hospital* or critical care unit. The benefit amount is determined based on the type of facility and the number of days you stay. You have the option to elect Hospital Confinement Indemnity Insurance to meet your needs. Hospital Confinement Indemnity Insurance is a limited benefit policy. It is not health insurance and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.

Features of Hospital Confinement Indemnity Insurance include:

- **Guaranteed Issue**: No medical questions or tests required for coverage.
- **Flexible**: You can use the benefit money for any purpose you like.
- **Payroll deductions**: Premiums paid through convenient payroll deductions.
- **Affordable coverage**: Rates are typically lower when you purchase coverage through your employer.
- **Portable**: Should you leave your current employer or retire, you can take the policy with you.

How can Hospital Confinement Insurance help?

Below are a few examples of how your Hospital Confinement Indemnity Insurance benefit could be used:

- Medical expenses, such as deductibles and copays
- Travel, food and lodging expenses for family members
- Child care
- Everyday expenses like utilities and groceries

What benefits are available?

A summary of the benefits provided under this plan can be found in the appendix of this guide and on the Hospital Confinement Insurance page on InCrowe.

Employee Assistance Program (EAP) and Advocacy

Health Advocate's All-in-1 Benefit offers two main features, Healthcare Advocacy and EAP+Work/Life, to help you and your family with healthcare related problems and personal and work/life issues. The Healthcare Advocacy service will provide you and your family with personalized assistance to help navigate the complexities of the healthcare system. The EAP+Work/Life program will help address personal and work/life issues. Health Advocate is provided at no cost.

Health Advocate services will be accessible every day of the year, 24-hours a day by toll-free phone at (866) 799-2728 or through self-service on the Health Advocate web site at www.HealthAdvocate.com/members.

Health Advocate offers many services including the following:

Healthcare Advocacy:

- Find the right doctors, dentists, specialists and other providers
- Schedule appointments, arrange for special treatments and tests
- Locate the right treatment facilities and clinical trials
- Answer questions about test results, treatments and medications
- Research and locate newest treatments; secure second opinions
- Help transfer medical records, X-rays and lab results
- Uncover errors on medical bills
- Get estimates, negotiate fees, make payment arrangements
- Supply providers with required information to pay a claim
- Get to the bottom of coverage denials
- Advise about appeals rights
- Explain coverage stipulations, alternatives for non-covered services
- Get appropriate approvals for covered services

Employee Assistance Program + Work/Life:

- Stress, depression, anxiety
- Relationship issues, divorce
- Job stress, work conflicts
- Anger, grief and loss
- Addiction, eating disorders, mental illness
- Childcare services
- Eldercare Services
- Legal Services
- Financial Services

Help Is Only a Phone Call Away

24/7 support is available via:

Phone: 866-799-2728
Email: answers@HealthAdvocate.com
Web: www.HealthAdvocate.com/members

These lists represents many, but not all, areas of counseling or assistance that are available through Health Advocate. All of this is available 24-hours a day, 7-days a week, any day of the year, by phone or at the click of your mouse.

What is EAP and Work/Life?

The EAP and Work/Life program is a comprehensive program designed to help you lead a happier and more productive life at home and at work. All of us have experienced some type of personal problem, concern or emotional crisis at one time or another. Balancing the needs of work, family and personal responsibilities isn't always easy. This program offers the right support at the right time.

Your Health Advocate benefit can be accessed 24 hours a day, 7 days a week. Normal business hours are Monday-Friday, between 8 am and 9 pm Eastern Time. After hours and during weekends, staff is available for assistance.

Your privacy is protected

The staff of Health Advocate follows careful protocols and complies with all government privacy standards. Your medical and personal information is strictly confidential.

Well-Being@Crowe

Crowe has developed a comprehensive well-being program that includes health screening, fitness challenges, health coaching, a Fitness Center Incentive Program, a Nicotine-free Incentive and discounted health club memberships. The firm's goal is to promote health and well-being to all personnel and their families by creating a healthy work environment and providing the tools necessary to be physically, emotionally and financially well.

Well-Being Portal

The Well-Being Portal gives you access to a well-being assessment, well-being challenges and initiatives, human performance coaching, support resources and interactive webinars.

As you participate in this portal to achieve your personal well-being goals, you'll receive recognition for your efforts in several forms including: gift cards, health care premium reductions and entries into raffles for prizes.

All Crowe personnel are eligible to use the well-being portal except, contractors, interns and temporary employees. Spouse, domestic partners and dependents are also not eligible to use the portal.

Strict HIPAA guidelines are followed to protect your information and results. Crowe can see aggregate views of well-being issues for their general workforce, but never any personally identifiable information.

Human Performance Coaching Programs

Ignite Your Life can help you achieve positive, significant and lasting change with our unique lifestyle management programs. Aduro offers personalized one-on-one coaching and group webinars that give you the tools, resources and motivation to create the life you want. Some of the coaching programs offered are:

- Mission Nutrition
- Change Your Habits
- Live Empowered
- Mood & Food
- Lighten Up
- Breathe Easy
- Sleep Mode
- Get Moving
- Budget Basis
- Dream Big
- Health, Wealthy and Wise
- Savings 101
- Think Green, Go Green
- Making a Difference
- Intro to Mindfulness
- Change Resilience
- Happy (Stress-free) Holidays
- New Expectations
- Parental Fundamental
- Step Up and Lead
- Adventures in Parenting
- Body Image Beautiful
- Letting Go: Forgive and Forget
- Be a Change Maker

Each coaching program consists of six weekly webinar sessions designed to educate and inspire you to be your best self. If you are unable to attend the Live Webinar, you will have access to watch it on demand. Within 45 minutes of each session, you will receive a weekly email update from the leading coach mentor with information regarding how to participate via the recorded sessions, whether you attended live or not.

Health Screenings

Each summer/fall, Crowe offers individuals the opportunity to participate in an on- or off-site health screening provided by Aduro. These screenings evaluate the following potential risk factors associated with chronic illness:

- Blood pressure
- Heart rate
- Cholesterol
- Blood glucose
- Body mass index (BMI)
- Waist to height ratio (WtHR)

Participants receive results in a comprehensive, confidential report that can be shared with medical providers.

Flu Shots

Each fall, Crowe offers individuals the opportunity to receive an on- or off-site flu shot. On-site flu shots are available in most of Crowe's large offices and are available to all Crowe personnel free of cost.

Flu shots are also offered at retail pharmacy locations through our Prescription Drug program. These shots are available at no cost to employees enrolled in a Crowe medical plan and their spouses, domestic partners and dependent children.

Fitness Center Incentive Program

Crowe recognizes the benefits of a healthy workforce and promotes an active lifestyle for its employees. To motivate our people to pursue healthy habits and an active lifestyle, Crowe offers an annual fitness subsidy to all Crowe employees who participate in fitness-related activities and programs.

A cash incentive of $20-a month ($240 per calendar year) will be provided to individuals who certify they: 1) paid a monthly membership to an eligible facility as defined below and, 2) utilized the facility at least five times per month or sixty times during the calendar year.

Eligible Facilities/Memberships:

- Fitness/Health/Workout Clubs and facilities
- Yoga studios
- Cross-fit/kick-boxing/martial arts studios
- Athletic clubs (such as running, biking, skiing, swimming)

Expenses not eligible for reimbursement:

- Fitness equipment purchases
- Fitness apparel and/or shoe purchases
- Golf club or country club dues, including social clubs which offer fitness facilities

Nicotine-free Incentive

As part of Crowe's desire to promote well-being and provide motivation to pursue healthy habits and an active lifestyle, Crowe offers a discounted medical premium incentive to those who certify that they are nicotine-free. Employees who certify that they have been nicotine-free for the past 6-months, and pledge to remain nicotine-free indefinitely, will receive a $20 monthly premium discount. Employees are provided an opportunity to certify they qualify as Nicotine-free, upon their hire date with the firm and once annually during the firm's medical open enrollment period, typically in October or November each year. ***To receive the nicotine-free incentive, you must complete the required certification on ESS.***

The Nicotine-free Certification will also be used to determine non-smoker life insurance rates for basic and supplemental life insurance, if applicable.

If you are a nicotine user and complete a smoking cessation program during the benefit plan year, you will be eligible to receive the discounted medical and supplemental life insurance premium rates. Once you have completed the smoking cessation program, you must submit proof of program completion to **benefits@crowehorwath.com**. While you will be provided with the reduced premium rates, you will not be allowed to make an actual election change to your medical plan until the next open enrollment cycle

Fitness Center Discounts

Crowe currently offers employees discounts to the following fitness centers:

- Chicago Athletic Clubs
- Equinox
- YMCA of Grand Rapids and Louisville

Crowe employees also have access to GlobalFit which is the leading provider of physical activity programs for American businesses. Benefits of GlobalFit include:

- The Most Gyms – Access 10,000+ gyms, including 24 Hour Fitness, Anytime Fitness, and local favorites.
- Lowest Price Guarantee – If a participating gym offers a lower rate than GlobalFit, they'll beat the rate by 5%.
- Membership Options – Optional benefits include: access to in-network gyms when traveling and account freezing.

Disability and Life

Short- and Long-term Disability

Short-term Disability

Crowe provides employees with Short-term Disability (STD) benefits at no cost should they become unable to work due to a disability or illness.

- The plan pays 100% of your salary for days 8 – 30 of your leave.
- The plan pays 60% of your salary for days 31 – 90 of your leave.
- You must apply available PTO toward the first 7 calendar days of their leave (maximum of 5 working days within this period). After this period of time you will be compensated by Liberty Mutual, our short-term disability provider if your physician renders you unable to work.
- Enrollment is automatic for regular employees who work a minimum of 24 hours per week on average and have been with the firm for 60 days.
- Leave necessitated by pregnancy or the birth of a child (maternity leave) is treated in the same manner as any other medical condition requiring a leave of absence. Short-term disability leave runs concurrently with Family Medical Leave Act (FMLA).

The firm's provides for partial disability should a reduced schedule become necessary and the business unit is able to accommodate a reduction in hours. Liberty Mutual will offset up to 100% of any pay earned by the employee during the disability leave.

Long-term Disability

If you are unable to work for over 90 calendar days due to illness or injury, you can protect your family from serious financial hardship with Harvard's Long-term Disability (LTD) coverage.

- The plan pays 60% of your salary up to a maximum of $15,000 per month, for as long as you are determined by the LTD carrier to be disabled, up to the maximum benefit period, which is determined by your age when your disability begins.
- You are automatically enrolled in this coverage, but must pay your own premiums for this benefit. However, since premiums are deducted from your after-tax pay, LTD benefits are paid to you tax-free.
- Generally, benefits, other than continuing medical insurance coverage through COBRA, do not continue beyond the ninety (90)-day paid medical leave. However, if a return to a regular employment schedule is expected (as certified by a physician) within three (3) months after the end of the ninety (90)-day firm-paid leave, group insured benefits will continue until the person returns or the end of the three (3) months, whichever is sooner.
- You are asked to discuss the dates of your medical leaves with appropriate management personnel at least 30 days in advance, if possible, to allow time to schedule for the absences. Benefits should be notified as soon as a medical leave is known. Management personnel should notify Benefits whenever they become aware of an illness-related absence in excess of one week.
- LTD leave shall be considered leave under the FMLA and shall run concurrently with FMLA leave, if the reason for the leave is qualified under the act. If the leave is qualified under FMLA, the individual will be notified.
- PTO will not accrue while on LTD leave.

Calculating LTD Premiums

The cost is $.195 (19.5 cents) per $100 coverage.

((Annual Salary / 24 pay periods) 100) x .195 rate = Premium per paycheck.

Basic and Supplemental Life Insurance

Basic Life Insurance

Crowe provides Basic Group Term Life Insurance at no cost to all eligible employees working, on average 24 hours or more per week annually. This coverage is provided by Securian.

- For employees, your coverage is equal to one times your annual base salary, rounded to the nearest $1,000 (up to a maximum of $200,000).*
- For Partners and Directors, your coverage is a fixed amount defined in your offer letter.
- This coverage includes a matching Accidental Death & Disability (AD&D) benefits payable for covered accidents.
- You are automatically enrolled in this coverage.
- Coverage becomes effective on your date of hire.

Supplemental Life Insurance

If you'd like additional protection, you can purchase optional term life insurance, with a benefit of 1x, 2x, 3x, 4x, 5x or 6x your current annual base salary, rounded to the nearest $1,000 up to a maximum of $1,000,000*.

The cost of coverage is based on your age and the amount of coverage you elect. Premiums are deducted from your pay on an after-tax basis. If you elect Supplemental Life Insurance within 30 days of your hire, you will be automatically approved for coverage in the amount of 1x, 2x or 3x your current annual base salary.

If you enroll in 1x or 2x coverage during your initial eligibility period, you can increase your coverage by one step (1x) each Open Enrollment until you reach 3x without having to provide Evidence of Insurability (EOI).

If you elect coverage at any other time, or elect coverage that exceeds 3x, you may need to complete Evidence of Insurability (EOI), which Securian will review, and your coverage will not become effective until approved. Once your coverage is approved, you will be notified of the effective date and premium payments will begin at that time.

Spouse/Domestic Partner Coverage

If you'd like additional protection for your spouse/domestic partner, you can purchase optional term life insurance, with a benefit of $10,000; $25,000; $50,000; $100,000; $150,000; $200,000 or $250,000*.

You are eligible to enroll for spouse/domestic partner coverage of up to $50,000 without proof of good health if enrollment is made within 30 days of the date of marriage or establishment of a registered domestic partnership.

The coverage for your spouse/domestic partner cannot exceed your basic and supplemental coverage combined.

Child(ren) Coverage

You can also purchase $10,000 worth of coverage for your child(ren). Children are eligible from live birth to age 26. Disabled children may be eligible to continue coverage beyond this age. All eligible children covered under one policy.

Child coverage may be added without proof of good health if application is made within 30 days of the date you acquire an eligible child through marriage, birth or adoption.

Evidence of Insurability (EOI)

You will need to complete an EOI if you apply for more insurance than the guarantee issue amount of $500,000, if you increase your coverage by more than one times your annual salary during open enrollment or if you do not enroll within a period of initial eligibility. The life insurance carrier will evaluate the health statement and contact you if they require additional information or tests (blood, urine). A detailed list of life insurance options that require EOI can be found in the appendix of this booklet.

Note: If you apply for Voluntary Term Life coverage that requires EOI and are denied, you will not be eligible to increase your coverage level in the future.

* At age 70, coverage reduces to 50% of the amount in effect prior to age 70.

Premium Rates

Your premium rate will change when you move into a new age bracket. Age is determined as of December 31st of each year. Also, the rates for coverage vary according to whether or not the applicant uses nicotine. A nicotine user is defined as an individual who has used tobacco in any form during the past six months or is currently using nicotine in any form. If a nicotine status is not designated, premiums will be deducted at nicotine rates.

Children can be covered for $10,000 beginning at live birth for a fixed amount of $0.64 per month, regardless of how many children are in the family.

Supplemental and Spouse/Domestic Partner Monthly Rates

Age	Non-Nicotine Rate per $1,000	Nicotine Rate per $1,000	Age	Non-Nicotine Rate per $1,000	Nicotine Rate per $1,000
Under 25	0.050	0.080	50 – 54	0.220	0.480
25 – 29	0.040	0.080	55 – 59	0.370	0.830
30 – 34	0.060	0.100	60 – 64	0.630	1.160
35 – 39	0.070	0.130	65 – 69	1.020	1.830
40 – 44	0.090	0.170	70 – 74	1.940	3.000
45 – 49	0.140	0.310	75 & Over	2.060	5.030

Supplemental Life Insurance Premium:

$ _____	÷	$1,000	X	$ _____	=	$ _____
Coverage Amount				Monthly Rate		Monthly Cost

Spouse/Domestic Partner Insurance Premium:

$ _____	÷	$1,000	X	$ _____	=	$ _____
Coverage Amount				Monthly Rate		Monthly Cost

Child(ren) Insurance Premium:

$10,000		$0.64
Coverage Amount		Monthly Cost

Beneficiaries

It's important to designate at least one beneficiary for your life insurance policy at www.LifeBenefits.com.

- You may designate separate beneficiaries for basic and supplemental coverage, or make your designation applicable to all of your coverage.
- You, the employee, are automatically the beneficiary on any child and spouse or domestic partner coverage.
- As minors cannot directly receive insurance proceeds, to determine the best approach for protecting the financial future of minors, consult an estate planning attorney.

You may view or update your beneficiary designations at any time on the LifeBenefits website. Once a designation is on file, click on "View Beneficiary" to view your current designation, and click on "Update Designation" if you need to make changes.

Exclusions

- Voluntary coverage for you and your spouse/DP is subject to a two year suicide exclusion. Voluntary benefits are not payable if you or your insured spouse/domestic partner die by suicide within two years of the effective date of voluntary coverage.
- Refer to your Certificate of Insurance for more information regarding exclusions for AD&D insurance.

Portability

If you leave the firm, you may be eligible to continue your coverage by paying premiums directly to Securian through portability or conversion. Refer to your Certificate of Insurance for more information on portability or conversion.

Retirement

The Crowe Retirement Plan administered by The Vanguard Group, makes it easy for you to:

- Save regularly for your future financial needs in retirement;
- Pre-tax contributions reduce the amount of federal, and in most cases, state income taxes you pay today; and
- Defer paying taxes on your investment earnings until they are distributed from your account; or
- Contribute to the Roth 401k and pay taxes now to avoid paying taxes on your earnings in retirement.

Within your first couple of weeks at the firm, Vanguard will send you a letter, to your home address, explaining how to set up your online account. You will need to login to www.Vanguard.com to set up an online ID and password. Crowe's plan ID is 091521. All changes to your retirement plan account will be made on the website. Refer to the Summary Plan Document located on InCrowe under People\Benefits\Retirement – 401k for complete information on Crowe's Retirement Plan or contact Crowe's plan administrator, Wendy Hogrewe at wendy.hogrewe@crowehorwath.com.

For your convenience:

- You'll automatically be enrolled in the Crowe Retirement Plan 30 days after your eligibility date at a pre-tax payroll deduction rate of 5% if you do not log into your account to confirm or change payroll deductions.The deductions will start on the second paycheck.
- Your savings will be automatically invested in the date-specific Vanguard Target Retirement Fund closest to the year you will reach age 65. Your fund will automatically be adjusted to decrease risk as you approach retirement. A Target Retirement Fund provides you with an efficient, well-diversified portfolio designed and managed according to your anticipated retirement date.
- You are also automatically enrolled in the One Step program. The one step program increases your deductions each year by 1% until you are contributing 10% of your salary. This is the industry recommended savings rate to make sure you will have enough for retirement.

If you choose not to participate in the plan, be sure to contact Vanguard within 30 days of your hire date. You can opt out by logging on to www.Vanguard.com or calling Vanguard Participant Services at 800-523-1188. Individuals who choose not to make pre-tax/post-tax salary deferrals when they are first eligible may begin making deferrals at any time. You can change your options or choose not to participate in your plan at any time.

Eligibility and Exclusions

You are eligible to participate in the Crowe Retirement Plan on your first day of employment if you are:

- At least 21 years of age
- A regular Crowe employee (see exclusions below)

Contractors, co-ops, interns, seasonal, temporary and foreign national employees not paid by Crowe are not eligible to participate in the firm's retirement plan.

IRS Contribution Limit

The IRS limits plan contributions. Below are the contribution limits for 2018.

Maximum Pre-tax Contribution Amount	2018
Employee Contribution – Under Age 50 (Pre-tax and/or Roth)	$18,500
Employee Contribution – Age 50 or Older (Pre-tax and/or Roth)	$24,500*

* If you are age 50 or older or will turn age 50 by the end of the year, and if you contribute the maximum allowed, you can make $6,000 in catch-up contributions if your plan permits them.

If you contributed to a previous employer's plan this year, be aware that the annual IRS limit applies to the sum of your contributions to all employer plans for the current year. You should monitor your contributions to ensure that your total contributions for the current year do not exceed the annual IRS limit.

If you are age 50 or older, or will turn 50 by year's end, and you contribute the maximum allowed, you may make catch-up contributions. Catch-up contributions allow you to save above the normal IRS annual limit on a pre-tax or Roth basis. You must designate catch-up contributions separately on the Vanguard website and can contribute to both the regular 401k and the catch up concurrently.

Crowe Matching Contribution

Crowe matches 50% of voluntary salary deferrals made by the participant during the current fiscal year and contributes this to the individual's retirement account. This match applies to the first 5% of fiscal base pay that a participant redirects into the Plan whether through Pre-tax or Roth contributions (i.e. Crowe will match $0.50 of every $1 you contribute up to 5% of your pay).

Contributions made by the participant will be matched after the close of the fiscal year as long as the employee is actively employed on March 31.

Crowe Basic “Age-Based” Contribution

In addition to the matching contributions, it is also Crowe’s intent to make an annual discretionary age-based contribution. In order to receive the Firm’s annual discretionary contribution, you must be at least 21 years of age, have completed one year of employment, and be employed on March 31 (the last day of the plan year). A firm-paid contribution will be made regardless of whether the individual has made any voluntary salary contributions into the Plan. These contributions are called "basic employer contributions" or “age-based contributions.”

The amount available to make basic employer contributions is at the discretion of Crowe. If the firm chooses to make basic employer contributions, they will be allocated according to the age-based contribution method are computed using the participant's age, fiscal year base pay and an "allocation factor." The age used is the participant's age as of the last day of the plan year (March 31). Fiscal base pay is the base salary or wages received during the fiscal year and does not include bonuses or incentives. The allocation factor is a percentage that increases with each year of age. The allocation factor may be adjusted for an inflation rate selected by the firm.

The following table demonstrates how age-based contributions are computed. The complete Age-Based Allocation Factor Table can be found in the appendix of this guide.

Participant	Age as of March 31	Allocation Factor	Fiscal Year Base Pay	Contribution (Allocation Factor x Fiscal Pay)
Participant A	25	0.6181%	$40,000	$247.24
Participant B	35	1.3345%	$40,000	$533.80
Participant C	45	2.8811%	$40,000	$1,152.44
Participant D	55	6.2199%	$40,000	$2,487.96

To receive the basics “age-based” contribution, you must complete 12 months of service. You will be eligible in the next quarterly enrollment period. Once you become eligible, you will receive the contribution as stated above as long as you are actively employed on March 31. The following table demonstrated the eligibility timing:

Hired Between	Enter the Plan	First Age-Based Contribution
January 2, 2018 – March 31, 2018	April 1, 2019	March 31, 2020
April 1, 2018 – June 20, 2018	July 1, 2019	March 31, 2020
July 1, 2018 – September 30, 2018	October 1, 2019	March 31, 2020
October 1, 2018 – January 1, 2019	January 1, 2020	March 31, 2020

Vesting

Vesting refers to your right of ownership to the money in your account. You are always 100% vested in your own contributions and their earnings. You become vested in both your Crowe matching contributions and annual discretionary contributions after 3 years of service.

Rollovers

You can roll over money from a previous employer’s 401(k) or other qualified plan, 403(b) plan, or 457 plan into the Crowe Retirement Plan at any time. You may also roll over assets from certain IRAs.

To initiate a rollover, log into your account at www.Vanguard.com and follow the instructions for moving money into this plan.

Enroll

How to Enroll

You have 30 days from your date of hire or first date of benefits eligibility to enroll via Employee Self-Service (ESS). For details, view the ESS Instructions available on the Benefits InCrowe page. (You may waive Crowe medical, dental and/or vision coverage if you have coverage elsewhere. See question #4 on page 23 for more information about enrolling at a later date.)

When enrolling, remember to do the following:
- Complete your Nicotine-free Certification
- Add eligible dependents (using your start date with the firm as their effective date)
- Designate life insurance beneficiaries at www.LifeBenefits.com
- Review your benefit confirmation statement to make sure your elections are correct

To learn more, visit the Benefit pages on InCrowe

Benefits Eligibility

A chart detailing benefits eligibility can be found in the appendix of this guide.

Changing Your Benefits During the Year

IRS regulations limit when you can make changes to your benefits during the year. Once you've submitted your benefits elections, you cannot change your elections (except for HSA) outside the annual Open Enrollment period, which takes place each fall, unless you experience an IRS-defined Qualifying Life Event as listed below. Changes in enrollment must be consistent with the change in status.

If you experience one of these life events, please contact Benefits at Benefits@crowehorwath.com as soon as possible because you have only 30 days from the date of the qualifying life event to make changes. A Benefits representative will then open a life event enrollment for you in Employee Self-Service (ESS) that will allow you to make the necessary changes to your benefit elections.

Qualifying Life Events

- Marriage/registering a domestic partnership
- Divorce/ending a domestic partnership
- Birth/adoption
- Death
- Change in number of dependents
- Change in employment status:
  - beginning or end of employment for you or your spouse/domestic partner,
  - beginning of or return from an unpaid leave of absence,
  - going from benefits-ineligible to benefits-eligible,
  - beginning or ending family medical leave
- Dependent losing eligibility – dependent child reaching the maximum age of 26
- Dependent gaining eligibility
- Change in health coverage—significant change in health care coverage or cost for you or your eligible dependent
- Retirement

Paying for Benefits

While many of your benefit contributions are deducted from your paycheck on a pre-tax basis, some benefit contributions are made on an after-tax basis.

You make pre-tax contributions for these benefits:
- Medical, dental and vision
- Healthcare Flexible Spending Account (FSA)
- Dependent Care Flexible Spending Account (FSA)
- Health Savings Account (HSA)
- Commuter Transit and Parking

You make after-tax contributions for these benefits:
- Long-term Disability
- Supplemental Life Insurance
- Spouse/Domestic Partner Life Insurance
- Child(ren) Life Insurance
- Accident Insurance
- Hospital Confinement Insurance
- Premiums for domestic partner benefits coverage. The value of this coverage is considered imputed income. (See page 5 for additional information.)

Need to update your address? To ensure that you receive time-sensitive mailings, be sure to keep your address updated in Employee Self-Service (ESS).

Answers to Frequently Asked Questions

FAQs

1. Can I enroll in my benefits prior to my hire date?

No. Even if you have your Harvard University ID number, you won't be able to access Employee Self-Service (ESS) to make your benefits elections until your hire date or the first day you're eligible for benefits.

2. Is there a deadline for submitting my benefits elections?

Yes. You need to elect your benefits within 30 days of your hire date or the first day of benefits eligibility.

3. When will I get my medical, dental, vision care and/or prescription cards?

You will receive your Anthem, Cigna and CVS/Caremark ID cards two to three weeks after you submit your enrollment elections in Employee Self-Service (ESS). If you need to use a benefit before receiving your ID card, call the benefit provider to obtain your member number. You will not receive ID cards from VSP.

4. What if I miss the 30-day enrollment period for benefits?

If you miss the 30-day enrollment period, you will not be able to enroll until the next annual Open Enrollment period (occurring each fall) unless you experience an IRS-defined qualifying life event, such as a birth or change in marital status. Enrollment changes must be consistent with the change in status and must be submitted within 30 days of the status change. Changes made during the annual Open Enrollment period will go into effect on January 1 of the upcoming calendar year.

5. When will my coverage start?

Your benefit elections are retroactive to your date of hire or the first day of your benefits eligibility. You will be charged premiums retroactively for your benefits coverage.

6. I have medical, dental, and/or vision coverage outside of Crowe. Can I defer my enrollment in the Crowe-sponsored plans for these benefits until my current/other coverage ends?

Yes, you can. Just elect the "waive" option in Employee Self-Service (ESS) for the Crowe benefit offerings you wish to waive.

If you are eligible for and want to enroll in other Crowe benefits, such as Supplemental, Spouse/Domestic Partner and/or Child(ren) Life, you still must enroll within your initial 30-day enrollment period for automatic approval of coverage.

7. How do the various pre-tax accounts—the Healthcare Flexible Spending Account (FSA), Limited Purpose FSA, Health Savings Account (HSA), and Dependent Care FSA—differ?

There are three kinds of FSAs: Healthcare, Limited Purpose and Dependent Care. An HSA is a different kind of account for employees in one of the HDHPs. All four accounts allow you to deduct money from your paycheck before taxes, thereby reducing your taxable income, to pay for eligible expenses.

- Healthcare FSAs can be used to pay eligible out-of-pocket expenses for yourself and your eligible dependents, such as copays for medical office visits and prescriptions, coinsurance and deductibles, dental expenses, and eyeglasses and contact lenses.
- Limited Purpose FSAs can be used to pay deductibles, coinsurance, and copays for dental and vision care only. If you are enrolled in a Health Savings Account (HSA) and elect a Healthcare FSA, you will automatically be enrolled in the Limited Purpose FSA. The HSA can be used to cover out-of-pocket medical expenses (in addition to dental and vision expenses).
- Dependent Care FSAs can be used to pay for eligible dependent child (under age 13) and adult care so that you (and your spouse) can work or look for work. They can be used to pay for eligible dependent care providers and day care facilities, including senior centers, after-school care, or day summer camp, though some specialty camps are not eligible.
- Health Savings Accounts (HSAs) can be opened only if you are enrolled in one of the HDHPs. This account is fully owned by you, and you keep the money in your HSA even if you leave Crowe. You can use it for eligible medical, dental and vision expenses like copays, coinsurance, and deductibles, or you can save the money for future health care expenses. Unlike the FSAs, unused contributions will roll over from year to year.

If you're enrolled in an HSA, you are not eligible for the Healthcare FSA—but you may enroll in the Limited Purpose FSA, which works like the Healthcare FSA but can be used only for dental and vision care expenses.

For more details about filing timeframes and IRS annual limits, please read pages 9–10 of this guide. Also, you can learn more about these accounts on the Benefits InCrowe pages.

Appendix

Benefits Eligibility

Determined by the total number of annual hours worked				
Annual Hour Guidelines for Benefit Eligibility	**Less than 1,248 Annual Hours (<24 hours/week)**	**1,248 Annual Hours***	**1,560 or More Annual Hours***	**2,080 or More Annual Hours***
Medical/HSA	No	No	Yes	Yes
Dental	No	Yes	Yes	Yes
Vision	No	Yes	Yes	Yes
Flexible Spending Accounts	No	Yes	Yes	Yes
Accident Insurance	No	Yes	Yes	Yes
Hospital Confinement Insurance	No	Yes	Yes	Yes
Holidays	No	Yes (Prorated)	Yes (Prorated)	Yes
PTO	No	Yes (Prorated)	Yes (Prorated)	Yes
Short-term Disability*	No	Yes (Prorated)	Yes (Prorated)	Yes
Long-term Disability*	No	Yes (Prorated)	Yes (Prorated)	Yes
Life Insurance*	No	Yes*	Yes*	Yes
401(k) Retirement Savings Plan	Yes	Yes	Yes	Yes

* Short-term, long-term disability and life insurance benefits eligibility requires a minimum of 1,248 Annual Hours. Seasonal Flex schedules focused on working during peak periods to fill client needs and may include months where total hours per week exceed 40. However, schedules may also include extended periods where 0 hours are worked. Flexible schedules that include periods throughout the year where weekly hours decrease to level below 24-hours a week (0-23) will not meet the eligibility requirements for disability or life insurance benefits.

Plan Premiums

Medical									
Medical Premiums (Per Paycheck)	My Choice PPO			My Choice Premium			My Choice Select		
	Without Incentives	With NFI	With Both Incentives*	Without Incentives	With NFI	With Both Incentives*	Without Incentives	With NFI	Without Incentives*
Member Only	$101.00	$91.00	$82.67	$83.50	$73.50	$65.17	$54.50	$44.50	$36.17
+ Spouse/DP	$192.50	$182.50	$174.17	$126.00	$116.00	$107.67	$104.00	$94.00	$85.67
+ Spouse/DP + Surcharge	$217.50	$207.50	$199.17	$151.00	$141.00	$132.67	$129.00	$119.00	$110.67
+ Child(ren)	$156.00	$146.00	$137.67	$104.50	$94.50	$86.17	$86.00	$76.00	$67.67
+ Family	$286.50	$276.50	$268.17	$172.00	$162.00	$153.67	$142.00	$132.00	$123.67
+ Family + Surcharge	$311.50	$301.50	$293.17	$197.00	$187.00	$178.67	$167.00	$157.00	$148.67

* Both incentives refers to the Nicotine-free Incentive and Well-Being Medical Premium Reduction. The Well-Being Medical Premium Reduction will not be reflected in the rates in ESS.

Nicotine-free Incentive: A $10/paycheck incentive provided to employees/partners who certify that they are nicotine-free.

Spouse/Domestic Partner Surcharge *(Not applicable to Partners)*: A $25/paycheck surcharge for spouses or domestic partners who have the option to elect comparable medical coverage through their employer, but choose to remain on a Crowe medical plan.

Well-Being Medical Premium Reduction: A $8.33/paycheck or $200/year incentive provided to employees/partners who have achieved Level 2 (3,000 points) in the Well-Being Portal.

Dental		
Dental Premiums (Per Paycheck)	Standard DPPO	Basic DPPO
Member Only	$17.00	$11.00
+ Spouse/DP	$32.00	$20.50
+ Child(ren)	$40.00	$25.50
+ Family	$64.50	$41.50

Vision	
Vision Premiums (Per Paycheck)	Vision Service Plan
Member Only	$4.97
+ Spouse/DP	$7.94
+ Child(ren)	$8.13
+ Family	$13.06

Detailed Comparison of Medical Plans

	My Choice PPO		My Choice Premium w/HSA		My Choice Select w/HSA	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible[1]	$450 per Person/ $1,350 Family	$900 per Person/ $2,700 Family	$1,500 Employee Only Coverage/ $3,000 All Other Coverage Levels	$3,000 Employee Only Coverage/ $6,000 All Other Coverage Levels	$3,000 Employee Only Coverage/ $6,000 All Other Coverage Levels	$6,000 Employee Only Coverage/ $12,000 All Other Coverage Levels
Out-of-pocket Maximum[2]	$1,500 per Person/ $4,500 Family	$3,000 per Person/ $9,000 Family	$3,000 Employee Only Coverage/ $6,000 All Other Coverage Levels	$6,000 Employee Only Coverage/ $12,000 All Other Coverage Levels	$3,000 Employee Only Coverage/ $6,000 All Other Coverage Levels	$6,000 Employee Only Coverage/ $12,000 All Other Coverage Levels
Coinsurance	Plan Pays 90%, Insured Pays 10%*	Plan Pays 60%, Insured Pays 40%*	Plan Pays 90%, Insured Pays 10%*	Plan Pays 60%, Insured Pays 40%*	Plan Pays 100%, Insured Pays 0%*	Plan Pays 100%, Insured Pays 0%*
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Coordination of Benefits	Non-Duplication	Non-Duplication	Non-Duplication	Non-Duplication	Non-Duplication	Non-Duplication
Termination of Benefits	Last Day of Month	Last Day of Month	Last Day of Month	Last Day of Month	Last Day of Month	Last Day of Month
Eligible Dependent Children	To Age 26; Any Age if Incapacitated	To Age 26; Any Age if Incapacitated	To Age 26; Any Age if Incapacitated	To Age 26; Any Age if Incapacitated	To Age 26; Any Age if Incapacitated	To Age 26; Any Age if Incapacitated
Balance Billing	Waived by Network Providers	Subject to Balance Billing, Usual & Customary	Waived by Network Providers	Subject to Balance Billing, Usual & Customary	Waived by Network Providers	Subject to Balance Billing, Usual & Customary
Annual Reinstatement	No	No	No	No	No	No
3-month Carryover	No	No	No	No	No	No
Pre-Existing Conditions	N/A	N/A	N/A	N/A	N/A	N/A
Allergy Care						
Office Visit (Physician/Specialist)	$20/$30 Copay	40% Coinsurance*	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*
Testing	10% Coinsurance*	40% Coinsurance*	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*
Serum & Allergy Shots	10% Coinsurance (Not Subject to Calendar Year Deductible)	40% Coinsurance*	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*
Behavioral Health/Substance Abuse Care Failure to obtain pre-authorization for inpatient services may result in non-coverage or reduced benefits.						
Applied Behavioral Analysis (Outpatient)	10% Coinsurance*	40% Coinsurance*	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*
Hospital Inpatient Services	10% Coinsurance*	40% Coinsurance*	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*
Methadone Maintenance Treatment	10% Coinsurance*	40% Coinsurance*	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*
Outpatient Services	$20 Copay	40% Coinsurance*	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*
Physician Services (Home & Office Visits)	$20 Copay	40% Coinsurance*	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*
Residential Treatment	10% Coinsurance*	40% Coinsurance*	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*
Diagnostic Physician Services Diagnostic services (including second opinion) by a Physician or Specialist Physician – office visit or home visit Note: The office visit Copayment applies to the office visit procedure code, all other services billed for a Physician visit are subject to the calendar year Deductible and Coinsurance.						
Primary Care Physician	$20 Copay	40% Coinsurance*	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*
Specialist Physician	$30 Copay	40% Coinsurance*	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*
Diagnostic X-ray, CT, PET, MRI & Lab Work (Office or Independent Lab)	10% Coinsurance*	40% Coinsurance*	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*

[1] Copayments and charges in excess of the Allowed Amount do not contribute to the Deductible. Amounts satisfied toward the Network calendar year Deductible will be applied toward the Out-of-Network calendar year Deductible and amounts satisfied toward the Out-of-Network calendar year Deductible will be applied toward the Network calendar year Deductible.

[2] Includes Coinsurance, the calendar year Deductible and Copayments. Does NOT include precertification penalties, or charges in excess of the Maximum Allowed Amount or Non-Covered Services.

* After deductible has been met.

	My Choice PPO		My Choice Premium w/HSA		My Choice Select w/HSA	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Emergency Room, Urgent Care and Ambulance Services **Note: If an emergency visit is rendered in an office setting, the $20 Primary Care Physician or $30 Specialist Copayment will apply.** **Note: Care received Out-of-Network for an Emergency Medical Condition will be provided at the Network level of benefits if the following conditions apply: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:** **(1) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) Serious impairment to bodily functions; or (3) Serious dysfunction of any bodily organ or part.**						
Emergency Room for an Emergency Medical Condition	$125 Copay	$125 Copay	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*
Emergency Room for a Non-emergency Condition	10% Coinsurance*	40% Coinsurance*	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*
Urgent Care Clinic Visit	$25 Copay	40% Coinsurance*	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*
Ambulance Services **Land/Air (Medically Necessary)**	10% Coinsurance*	40% Coinsurance*	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*
Hospital Inpatient Services – Precertification Required						
Choice of Hospitals	Any Network Hospital		Any Network Hospital		Any Network Hospital	
Room & Board **(Semi-private or ICU/CCU)**	$150 Copay, then 10% Coinsurance*	$150 Copay, then 40% Coinsurance*	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*
Private Room **(Medically Necessary)**	$150 Copay, then 10% Coinsurance*	$150 Copay, then 40% Coinsurance*	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*
Hospital Services & Supplies	10% Coinsurance*	40% Coinsurance*	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*
Preadmission Testing	10% Coinsurance*	40% Coinsurance*	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*
Physician Services **(Surgeon, Anesthesiologist, Radiologist, Pathologist)**	10% Coinsurance*	40% Coinsurance*	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*
Maternity Care (Includes Pre-and Post-Natal and Delivery) **Newborn stays in the Hospital after the mother is discharged, as well as any stays exceeding 48 hours for a vaginal delivery or 96 hours for a cesarean section, must be pre-certified. Physician Hospital/Birthing Center Services must be pre-certified.**						
Primary Care/ Specialist Physician (Includes Obstetrician/ Gynecologist)	$20 Copay for Initial Visit, then 10% Coinsurance*	40% Coinsurance*	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*
Midwife **(Precertification Required)**	10% Coinsurance*	40% Coinsurance*	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*
Physician Services (Hospital)	10% Coinsurance*	40% Coinsurance*	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*
Newborn Nursery Services (Well Baby Care)	10% Coinsurance*	40% Coinsurance*	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*
Circumcision	10% Coinsurance*	40% Coinsurance*	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*
Medical Supplies and Equipment						
Medical Supplies	10% Coinsurance*	40% Coinsurance*	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*
Durable Medical Equipment	10% Coinsurance*	40% Coinsurance*	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*
Orthotics (Foot & Shoe)	10% Coinsurance*	40% Coinsurance*	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*
Prosthetic Appliances (External)	10% Coinsurance*	40% Coinsurance*	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*
	Wigs/Toupees are limited to one per benefit period and are subject to medical necessity.					
Outpatient Hospital/Facility Services						
Outpatient Facility	10% Coinsurance*	40% Coinsurance*	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*
Lab & X-ray Services	10% Coinsurance*	40% Coinsurance*	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*
Outpatient Physician Services **(Surgeon, Anesthesiologist, Radiologist, Pathologist)**	10% Coinsurance*	40% Coinsurance*	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*
Physician Services						
Preventative Care **(Including Screenings & Immunizations)**	Plan Covers 100% (Deductible Does Not Apply)	40% Coinsurance*	Plan Covers 100% (Deductible Does Not Apply)	40% Coinsurance*	Plan Covers 100% (Deductible Does Not Apply)	0% Coinsurance*
Primary Care Physician	$20 Copay	40% Coinsurance*	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*
Specialty Physician	$30 Copay	40% Coinsurance*	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*
Office Surgery	$20/30 Copay	40% Coinsurance*	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*
Online Visit	$20 Copay	40% Coinsurance*	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*
Prescription Injectable & Drugs (Dispensed in Physician's Office)	10% Coinsurance*	40% Coinsurance*	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*

* After deductible has been met.

	My Choice PPO		My Choice Premium w/HSA		My Choice Select w/HSA	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Therapy Services (Outpatient) Physical, Occupational, and Speech Therapy limited to 60 visits per calendar year. Chiropractic care limited to 24 visits per calendar year. Note: Inpatient therapy services will be paid under the Inpatient Hospital benefit.						
Physical Therapy	$30 Copay	40% Coinsurance*	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*
Occupational Therapy	$30 Copay	40% Coinsurance*	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*
Speech Therapy	$30 Copay	40% Coinsurance*	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*
Cardiac Rehabilitation	10% Coinsurance*	40% Coinsurance*	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*
Acupuncture	10% Coinsurance*	40% Coinsurance*	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*
Chiropractic Care	$30 copay	40% Coinsurance*	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*
Radiation Therapy	10% Coinsurance*	40% Coinsurance*	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*
Chemotherapy	10% Coinsurance*	40% Coinsurance*	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*
Respiratory Therapy	10% Coinsurance*	40% Coinsurance*	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*
Vision Therapy	10% Coinsurance*	40% Coinsurance*	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*
Transplants See Detailed Plan Information for Additional Information. Use of a Center of Excellence May be Required.						
Bone Marrow & Stem Cell Transplant (Inpatient & Outpatient)	10% Coinsurance*	Not Covered	10% Coinsurance*	Not Covered	0% Coinsurance*	Not Covered
Eligible Travel/Lodging	Plan Covers 100% (Deductible Does Not Apply)	Not Covered	10% Coinsurance*	Not Covered	0% Coinsurance*	Not Covered
All Other Covered Transplant Services	10% Coinsurance*	Not Covered	10% Coinsurance*	Not Covered	0% Coinsurance*	Not Covered
Other Services						
Dental Services (Accidental injury to Natural Teeth)	10% Coinsurance*	40% Coinsurance*	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*
Oral Surgery/TMJ Services (Subject to Medical Necessity; Excludes Appliance & Orthodontic Treatment)	10% Coinsurance*	40% Coinsurance*	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*
Hearing Care – Audiometric Exam/ Hearing Evaluation Test	$20/$30 Copay	40% Coinsurance*	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*
Hearing Care – Cochlear implants	10% Coinsurance*	40% Coinsurance*	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*
Hearing Devices/Hearing Aids	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Home Health Care Services (Limited to 60 Visits a Calendar Year)	10% Coinsurance*	40% Coinsurance*	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*
Hospice Care Services	10% Coinsurance*	40% Coinsurance*	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*
Infertility (Diagnosis/Treatment of Underlying Medical Condition Only)	10% Coinsurance*	40% Coinsurance*	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*
Vasectomy	10% Coinsurance*	40% Coinsurance*	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*
Nutritional Counseling – Diabetes	10% Coinsurance*	40% Coinsurance*	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*
Nutritional Counseling – Eating Disorder	10% Coinsurance*	40% Coinsurance*	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*
Skilled Nursing (Limited to 120 Visits a Calendar Year)	10% Coinsurance*	40% Coinsurance*	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*
Surgical Services	10% Coinsurance*	40% Coinsurance*	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*
Gastric Bypass/Obesity Surgery (When medically Necessary; Precertification Required)	10% Coinsurance*	40% Coinsurance*	10% Coinsurance*	40% Coinsurance*	0% Coinsurance*	0% Coinsurance*

* After deductible has been met.

Comparison of Prescription Drug Coverage

	My Choice PPO		My Choice Premium w/HSA		My Choice Select w/HSA	
	Retail	**Mail Order**	**Retail**	**Mail Order**	**Retail**	**Mail Order**
Out-of-Pocket Maximum	$1,500/Person; $3,000/Family		Combined with Medical		Combined with Medical	
Generic	$10 Copy	$25 Copay	90% After Deductible is Met		90% After Deductible is Met	
Preferred	30% (min: $20, max: $50)	25% (min: $50, max: $125)	90% After Deductible is Met		90% After Deductible is Met	
Non-Preferred	40% (min: $40, max:$75)	40% (min: $100, max:$180)	90% After Deductible is Met		90% After Deductible is Met	
Preventive Drugs	Not Applicable		Generic: $10 Brand: $30	Generic: $25 Brand: $75	Generic: $10 Brand: $30	Generic: $25 Brand: $75

HSA Contribution Schedule

	Maximum Contribution Limit	**Employees who enroll:**				
		By 1/1/18	**1/2/18 – 3/31/18**	**4/1/18 – 6/30/18**	**7/1/18 – 9/30/18**	**10/1/18 – 12/15/18**
Employee Only	$3,450	$500	$400	$300	$200	$100
+ Domestic Partner	$3,450	$500	$400	$300	$200	$100
+ Spouse	$6,900	$800	$640	$480	$320	$160
+ Child(ren)	$6,900	$900	$720	$540	$360	$180
+ Family	$6,900	$1,000	$800	$600	$400	$200
Firm Contribution Pay Date	--------	**1/10/18**	**4/10/18**	**7/10/18**	**10/10/18**	**12/10/18**

You must be employed on the employer contribution pay-date to receive the amount listed.

Note: For those over the age of 55, you are eligible to contribute an additional $1,000 annually. The amounts above are based on the IRS maximum allowable amounts for 2018. When electing your contribution amounts, please deduct the Crowe contribution based on your hire date.

Comparison of Dental Plan Options

	Standard PPO	Basic PPO
Providers	Covers In-Network & Out-of-Network Providers	Covers In-Network & Out-of-Network Providers
Calendar Year Maximum	$1,500/person	$750/person
Calendar Year Deductible	$50 Individual/ $150 Family	$50 Individual/ $150 Family
Preventative & Diagnostic Care	100% - No Deductible	100% - No Deductible
Basic Restorative Care	80% Coverage After Deductible is Met	50% Coverage After Deductible is Met
Major Restorative Care	50% Coverage After Deductible is Met	50% Coverage After Deductible is Met
Oral Surgery & Periodontics	80% Coverage After Deductible is Met	50% Coverage After Deductible is Met
Orthodontia	50% up to $1,500, After Deductible is Met	No Coverage

Accident Insurance Summary Benefits

Event	Low	High
Surgery Open abdominal, thoracic	$600	$1,100
Surgery Exploratory or without repair	$85	$140
Blood, Plasma, Platelets	$300	$500
Hospital Admission	$750	$1,125
Hospital Confinement Per day, up to 365 days	$225	$350
Critical Care Unit Confinement Per day, up to 15 days	$350	$525
Rehabilitation Facility Confinement Per day, up to 30 days	$100	$150
Coma Duration of 14 or more days	$8,500	$14,500
Transportation Per trip, up to 3 per accident	$375	$650
Lodging Per day, up to 30 days	$90	$150
Family Care Per child per day, up to 45 days	$10	$20
Accident Care		
Initial Doctor Visit	$60	$75
Urgent Care Facility Treatment	$150	$200
Emergency Room Treatment	$150	$200
Ground Ambulance	$240	$300
Air Ambulance	$1,000	$1,250
Follow-up Doctor Treatment	$60	$75
Chiropractic Treatment Up to 6 per accident	$25	$40
Medical Equipment	$30	$100
Physical or Occupational Therapy Up to 6 per accident	$25	$40
Speech Therapy Up to 6 per accident	$25	$40
Prosthetic Device (One)	$375	$625
Prosthetic Device (Two or more)	$600	$1,000
Major Diagnostic Exam (1 per accident)	$60	$200
Outpatient Surgery (1 per accident)	$150	$200
X-ray	$25	$40
Common Injuries		
Burns 2nd degree, at least 36% of the body	$750	$1,125
Burns 3rd degree, at least 9 but less than 35 sq. in. of the body	$3,500	$6,000
Burns 3rd degree, 35 or more square inches of the body	$7,500	$12,500
Skin Grafts	25% of the burn benefit	25% of the burn benefit
Emergency Dental Work	175 crown, $45 extraction	$300 crown, $75 extraction
Eye Injury Removal of foreign object	$50	$80
Eye Injury Surgery	$175	$275
Torn Knee Cartilage Surgery with no repair or if cartilage is shaved	$125	$175
Torn Knee Cartilage Surgical repair	$400	$650
Laceration[1] Treated no sutures	$15	$25
Laceration[1] Sutures up to 2”	$30	$50
Laceration[1] Sutures 2” – 6”	$120	$200
Laceration[1] Sutures over 6”	$240	$400
Ruptured Disk Surgical repair	$400	$650
Tendon/Ligament/Rotator Cuff Exploratory arthroscopic surgery with no repair	$200	$350

Common Injuries		
Tendon/Ligament/Rotator Cuff One, surgical repair	$400	$675
Tendon/Ligament/Rotator Cuff Two or more, surgical repair	$600	$1,000
Concussion	$100	$175
Paralysis – Paraplegia	$8,000	$13,500
Paralysis – Quadriplegia	$12,000	$20,000
Dislocations	**Closed/Open Reduction[2]**	**Closed/Open Reduction[2]**
Hip Joint	$1,950 / $3,900	$3,200 / $6,400
Knee	$1,200 / $2,400	$2,000 / $4,000
Ankle or Foot Bone(s) Other than toes	$750 / $1,500	$1,200 / $2,400
Shoulder	$800 / $1,600	$1,500 / $3,000
Elbow	$550 / $1,100	$900 / $1,800
Wrist	$550 / $1,100	$900 / $1,800
Finger/Toe	$150 / $300	$250 / $500
Hand Bone(s) Other than finger	$550 / $1,100	$900 / $1,800
Lower Jaw	$550 / $1,100	$900 / $1,800
Collarbone	$550 / $1,100	$900 / $1,800
Partial Dislocations	25% of the closed reduction amount	25% of the closed reduction amount
Fractures	**Closed/Open Reduction[3]**	**Closed/Open Reduction[3]**
Hip	$1,500 / $3,000	$2,500 / $5,000
Leg	$1,200 / $2,400	$1,800 / $3,600
Ankle	$900 / $1,800	$1,500 / $3,000
Kneecap	$900 / $1,800	$1,500 / $3,000
Foot Excluding toes, heel	$900 / $1,800	$1,500 / $3,000
Upper Arm	$1,050 / $2,100	$1,750 / $3,500
Forearm, Hand, Wrist Except fingers	$900 / $1,800	$1,500 / $3,000
Finger, Toe	$120 / $240	$200 / $400
Vertebral Body	$1,680 / $3,360	$2,800 / $5,600
Vertebral Processes	$720 / $1,440	$1,200 / $2,400
Pelvis Except coccyx	$1,600 / $3,200	$2,750 / $5,000
Coccyx	$100 / $200	$300 / $600
Bone of Face Except nose	$600 / $1,200	$1,000 / $2,000
Nose	$300 / $600	$500 / $1,000
Upper Jaw	$750 / $1,500	$1,250 /$2,500
Lower Jaw	$720 / $1,440	$1,200 / $2,400
Collarbone	$720 / $1,440	$1,200 / $2,400
Rib or Ribs	$200 / $400	$350 / $700
Skull – Simple Except bones of face	$700 / $1,400	$1,250 / $2,500
Skull – Depressed Except bones of face	$1,500 / $3,000	$2,500 / $5,000
Sternum	$180 / $360	$300 / $600
Shoulder Blade	$900 / $1,800	$1,500 / $3,000
Chip Fracture	25% of the closed reduction amount	25% of the closed reduction amount

[1] Laceration benefits are a total of all lacerations per accident.
[2] Closed Reduction of Dislocation = Non-surgical reduction of a completely separated joint. Open Reduction of Dislocation = Surgical reduction of a completely separated joint.
[3] Closed Reduction of Fracture = Non-surgical. Open Reduction of Fracture = Surgical.

Hospital Confinement Summary Benefits

	Low	High
Hospital Confinement (up to 30 days per confinement)	$100	$200
Critical Care Unit (up to 15 days per confinement)	$300	$600
Initial Confinement Benefit (for first day of confinement)	$500	$1,000
Rehabilitation Facility (up to 30 days per confinement)	$50	$100

Supplemental Life Insurance Premiums

Employee/Partner and Spouse/Domestic Partner Rates

Age	Nicotine* Monthly rate per $1,000	Nicotine-Free* Monthly rate per $1,000
Under 25	0.080	0.050
25-29	0.080	0.040
30-34	0.100	0.060
35-39	0.130	0.070
40-44	0.170	0.090
45-49	0.310	0.140
50-54	0.480	0.220
55-59	0.830	0.370
60-64	1.160	0.630
65-69	1.830	1.020
70-74	3.000	1.940
75 and over	5.030	2.060

* To verify your Nicotine-free status, please email benefits@crowehorwath.com. If a nicotine status has not be certified, premiums will be deducted at nicotine rates.

All rates are subject to change.

Life Insurance Enrollment Options

Basic Life Insurance
(All eligible employees automatically enrolled – Firm paid)

Employee Maximum Coverage Age reductions apply[1]	1x annual earnings, Up to a maximum of $200,000
Partners, Directors and Officers Maximum Coverage Age reductions apply[1]	$250,000
Accidental Death & Dismemberment (AD&D)	Includes matching AD&D benefit

Supplemental Life Insurance
(Optional – Paid by the individual)

	Employee	Spouse/Domestic Partner	Child[2]
Coverage Options	1 – 6x annual earnings (rounded to next higher $1,000)	$10,000 / $25,000 / $50,000 / $100,000 / $150,000 / $200,000 / $250,000	$10,000
Maximum Coverage Age Reductions apply [1]	$1,000,000	Cannot exceed employee's coverage amount (basic & supplemental combined)	$10,000
Guaranteed Issue Amount	The lesser of 3x basic annual earnings or $500,000	$50,000	$10,000

[1] At age 70, coverage reduces to 50 percent of the amount in effect prior to age 70.
[2] Children eligible from live birth to age 26. Disabled children may be eligible to continue coverage beyond this age. All eligible children covered under one policy.

Employee Supplemental Term Life – Initial Enrollment Period Options

If you currently have	No coverage	you can elect	1 – 3x	guaranteed issue coverage	without	Evidence of Insurability (EOI)
If you currently have	No coverage	you can elect	4 – 6x	guaranteed issue coverage	**with**	Evidence of Insurability (EOI)

Employee Supplemental Term Life – Open Enrollment Options

If you currently have	No coverage	you can elect	1 – 6x	guaranteed issue coverage	**with**	Evidence of Insurability (EOI)
If you currently have	1x	Guaranteed issue coverage, you can elect	2x	guaranteed issue coverage	without	Evidence of Insurability (EOI)
If you currently have	1x	Guaranteed issue coverage, you can elect	3 – 6x	guaranteed issue coverage	**with**	Evidence of Insurability (EOI)
If you currently have	2x	Guaranteed issue coverage, you can elect	3x	guaranteed issue coverage	without	Evidence of Insurability (EOI)
If you currently have	2x	Guaranteed issue coverage, you can elect	4 – 6x	guaranteed issue coverage	**with**	Evidence of Insurability (EOI)
If you currently have	3x	Guaranteed issue coverage, you can elect	4 – 6x	guaranteed issue coverage	**with**	Evidence of Insurability (EOI)

401(k) Age-Based Allocation Factor Table

Multiply the fiscal year earnings times the percent to estimate the age based contribution.

Age	Percent	Age	Percent
20	0.0000%	43	2.4700%
21	0.4543%	44	2.6677%
22	0.4907%	45	2.8811%
23	0.5299%	46	3.1115%
24	0.5723%	47	3.3604%
25	0.6181%	48	3.6294%
26	0.6675%	49	3.9196%
27	0.7210%	50	4.2332%
28	0.7787%	51	4.5718%
29	0.8410%	52	4.9377%
30	0.9082%	53	5.3326%
31	0.9808%	54	5.7592%
32	1.0594%	55	6.2199%
33	1.1441%	56	6.7176%
34	1.2356%	57	7.2549%
35	1.3345%	58	7.8354%
36	1.4413%	59	8.4622%
37	1.5565%	60	9.1392%
38	1.6811%	61	9.8703%
39	1.8155%	62	10.6600%
40	1.9608%	63	11.5128%
41	2.1176%	64	12.4338%
42	2.2870%	65	13.4285%

COBRA Notification

Consolidated Omnibus Budget Reconciliation Act (COBRA)

A federal law (Public Law 99-272, Title X, commonly known as COBRA) requires that most employers sponsoring group insurance plans offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of the law.

Crowe personnel covered by the group insurance plan, have a right to continue coverage under COBRA if they experience a loss in group health coverage because of a reduction in hours or the termination of employment (for reasons other than gross misconduct).

The spouse of an employee covered by Crowe benefits also has the right to continue coverage for the loss in group health coverage for any of the following reasons:

- Death of your spouse;
- Termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment;
- Divorce or legal separation from your spouse; or
- Your spouse becomes entitled to Medicare.

In the case of a dependent child of an employee covered by the Plan, he or she has the right to continuation coverage if group health coverage under the Plan is lost for any of the following reasons:

- Death of a parent;
- Termination of a parent's employment (for reasons other than gross misconduct) or reduction in a parents hours of employment with Crowe;
- Parents' divorce or legal separation;
- A parent becomes entitled to Medicare; or
- The dependent ceases to be a "dependent child" under the Plan.

Under the law, the employee or a family member has the responsibility to inform Crowe of a divorce, legal separation or a child losing dependent status under the Plan within 60-days of the date of the event. Similar rights may apply to certain retirees, their spouses and their dependent children if the firm commences a bankruptcy proceeding and these individuals lose coverage. When notified that one of these events has happened, Crowe will, in turn, notify you and your covered dependent(s) of the right to choose continuation coverage. Under the law, you have 60-days from the date you would lose coverage because of one of the events described above to inform Crowe that you want continuation of coverage. If you do not choose continuation of coverage on a timely basis, your group health insurance coverage will end.

If you choose continuation coverage, Crowe is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated employees or family members. The law requires you be afforded the opportunity to maintain the continuation coverage for 36-months unless you lost group health insurance coverage because of a termination of employment or reduction in hours. In that case, the required continuation coverage period is 18-months. The 18-month period may be extended for affected individuals to 36-months from termination of employment if other events (such as a death, divorce, legal separation, or Medicare entitlement) occur during that 18-month period.

In no event will continuation coverage last beyond 36-months from the date of the event that originally made a qualified beneficiary eligible to elect coverage. The 18-months may be extended to 29-months if a qualified beneficiary is determined by the Social Security Administration to be disabled (for Social Security disability purposes) at any time during the first 60-days of COBRA coverage. This 11-month extension is available to all individuals who are qualified beneficiaries due to a termination or reduction in hours of employment. To benefit from this extension, a qualified beneficiary must notify Crowe of that determination within 60-days and before the end of the original 18-month period. The affected individual must also notify Crowe within 30-days of any final determination that the individual is no longer disabled.

A child who is born to or placed for adoption with the covered employee during a period of COBRA coverage will be eligible to become a qualified beneficiary. In accordance with the terms of the Plan and requirements of federal law, these qualified beneficiaries can be added to COBRA coverage upon proper notification to Crowe of the birth or adoption.

However, the law also provides that your continuation coverage may be cut short for any of the following reasons:

- Crowe no longer provides group health coverage to any of its employees;
- The premium for continuation coverage is not paid on time;
- The qualified beneficiary becomes covered under another group insurance plan that does not contain any exclusion or limitation with respect to any pre-existing condition he or she may have;
- The qualified beneficiary becomes entitled to Medicare; or
- The qualified beneficiary extends coverage for up to 29-months due to disability and there has been a final determination that the individual is no longer disabled.

HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the extent to which group health plans may impose pre-existing condition limitations. These rules are generally effective for plan years beginning after June 30, 1997. HIPAA coordinates COBRA's other coverage cut-off rule with these new limits as follows.
If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA coverage cannot be terminated early. However, if the other plans pre-existing condition rule does not apply to you by reason of HIPAA's restrictions on pre-existing condition clause; Crowe may terminate your COBRA coverage.

You do not have to show that you are insurable to choose continuation coverage. However, continuation coverage under COBRA is provided subject to your eligibility for coverage. Crowe reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible.

Under this law, you may have to pay all or part of the premium for your continuation coverage. There is a grace period of 30-days for payment of the regularly scheduled premium.

If you have any questions about COBRA, please contact benefits@crowehorwath.com. Also, if you have changed marital status, or you or your spouse have changed addresses, please notify benefits@crowehorwath.com.

Family & Medical Leave of Absence

The Family and Medical Leave Act of 1993 (FMLA) allows an employee to take up to twelve (12) weeks of unpaid, job-protected leave for certain family and medical reasons.

Reasons for Taking Leave
FMLA allows an individual with at least one year of service who have worked 1,250-hours during the prior twelve (12) months to take up to twelve (12) weeks of unpaid time off to care for self or a family member with a serious health condition. Unpaid time may be granted for the following reasons:

- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse/domestic partner, son or daughter, or parent (not parent in-law) who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform their job.

FMLA leave is unpaid however you may qualify for short-term disability or long term disability that will run concurrently with FMLA.

Requesting Leave
All arrangements for an FMLA leave must be discussed in advance (when feasible) with the appropriate management as well as Human Resources.

Human Resources will require the completion of a Request for Leave form and a Certification of Health Care Provider form prepared by the individual's physician. Human Resources will provide these forms when notified of a request for leave.

Advance Notice and Medical Certification
Whenever a leave is "foreseeable," advance notice of thirty (30)-days is required. When advance notice is not possible, the individual must provide the requested medical certification to HR no later than fifteen (15)-days after the onset of the leave.

Group Insurance Benefits
During an unpaid FMLA leave, benefits will continue as described below:

- All benefits may remain active during FMLA, or can be cancelled due to a qualifying event.
- Most benefit premium deductions are made on a pre-tax basis; therefore, all missed premiums will be deducted from future paychecks. Arrangements can be made to deduct these premiums prior to FMLA.

Paid Time Off
During an FMLA leave an individual will be required to use all paid time off (PTO) with the exception of eighty (80) hours that may be "reserved" for use at other times during the fiscal year. Remaining leave after the available PTO has been used will be unpaid.

Intermittent Leave
Leave under FMLA may be taken intermittently or on a reduced schedule, based on information provided by the individual's health care provider. The individual may request a reduced work week, reduced work day or time off as needed.

Situations not outlined in this policy will be determined on an individual basis, except as otherwise required by the Family and Medical Leave Act of 1993 and it regulations.

Servicemember Family and Medical Leave
FMLA entitles eligible employees to take leave for a covered family member's service in the Armed Forces ("Servicemember FMLA"). This policy supplements our FMLA policy and provides general notice of employee rights to such leave. Except as mentioned in this section, an employee's rights and obligations to Servicemember FMLA are governed by our existing FMLA policy.

Leave Entitlement
Servicemember FMLA provides eligible employees unpaid leave for any one, or for a combination of the following reasons:

- A "qualifying exigency" arising out of a covered family member's active duty or call to active duty in the Armed Forces in support of a contingency plan; and/or
- To care for a covered family member who has incurred an injury or illness in the line of duty while on active duty in the Armed Forces provided that such injury or illness may render the family member medically unfit to perform duties of the member's office, grade, rank or rating.

Duration of Servicemember FMLA

- When Leave is Due to a "Qualifying Exigency": An eligible employee may take up to 12-weeks of leave during any 12-month period.
- When Leave is to Care for an Injured or Ill Servicemember. An eligible employee may take up to 26-weeks of leave during a single 12-month period to care for the servicemember. Leave to care for an injured or ill servicemember, when combined with other FMLA-qualifying leave, may not exceed 26-weeks in a single twelve (12) month period.

Servicemember FMLA runs concurrent with other leave entitlements provided under federal, state and local law.

Leave Under State Military Leave Laws
A growing number of states provide leave for family members of servicemembers. The entitlements for such leave differ from state to state. Our policy is to comply with such laws in any circumstances where they apply to our employees.

Notice Regarding Wellness Program

Well-Being@Crowe is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a voluntary biometric screening, which will include a blood test for cholesterol and blood glucose. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will be eligible to receive the following incentives:

Incentive Level	Requirements	Incentive(s)
Level 1	- Earn 1,000 Point - Complete HRS - Join First Challenge	- $25.00 Tango Cardo
Level 2	- Earn 3,000 points	- $200.00 Well- Being Medical Premium Reduction (for those enrolled in a Crowe medical plan) ***or*** - $150.00 Tango Cardo (for those not enrolled in a Crowe medical plan)
Level 3	- Earn 5,000 points	- $75.00 Tango Cardo
Level 4	- Earn 7,000 points	- Entry into monthly raffle for prizes

Although you are not required to complete the HRA or participate in the biometric screening, only employees who complete the HRA and meet the requirements detailed above will be eligible to receive incentives. If you are unable to participate in any of the health-related activities, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting the Wellness Team at **wellness@crowehorwath.com**.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information
We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Crowe Horwath LLP may use aggregate information it collects to design a program based on identified health risks in the workplace, Well-Being@Crowe will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are health screeners and health coaches in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the Wellness Team at **wellness@crowehorwath.com**.

Health Care Exchange Notice

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

PART A: General information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and 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 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

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

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

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

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan descriptions or contact **Teri Diehl, Benefits Manager at (314) 802-2068**

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

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name	4. Employer Identification Number (EIN)	
Crowe Horwath LLP	**35-0921680**	
5. Employer address	6. Employer phone number	
320 East Jefferson Blvd.	**(574) 236-8646**	
7. City	8. State	9. ZIP code
South Bend	**IN**	**46601**
10. Who can we contact about employee health coverage at this job		
Teri Diehl		
11. Phone number (if different from above)	12. Email address	
(314) 802-2068	**teri.diehl@crowehorwath.com**	

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

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

  - ✓ Some employees. Eligible employees are:

    Employees who work 30 hours or more per week

- With respect to dependents:
  - ✓ We do offer coverage. Eligible dependents are:

    Dependents up to age of 26

  - ❑ We do not offer coverage.

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

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

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