EMPLOYEE
BENEFITS
GUIDE

Southeast Healthcare Partners

2025 - 2026

Rev. July 9, 2025 11:49 AM

WELCOME

Dear Team Member,

Open enrollment will begin on July 10th and end on July 22nd. This is your one-time opportunity to make benefit elections/ changes for the upcoming plan year without a qualifying event. We encourage you to walk through the enrollment process to review your benefits carefully and make changes as needed. All current benefits will be terminated. All employees must enroll in benefits if they wish to be covered for the 2025/2026 plan year.

To make the enrollment process as easy as possible, we have a dedicated call center team to guide you through the benefits and complete your enrollment. Call the Enrollment Call Center at 678.918.8387. The enrollment call center is open for you to enroll or ask any benefit related questions from 9am-6pm EDT or 8am-5pm CDT July 10 - 22.

To make the interview process easy, we have two ways for you to enroll:

By Phone

Call the Enrollment Call Center at (678) 918-8387. The enrollment call center is open for you to enroll or ask any benefit related questions from 9am-6pm EDT or 8am-5pm CDT, Monday - Friday.

Online

Visit metlife.benselect.com/SoutheastHC. The username will be your full social security number and the password will be the last four digits of your social security number & the last two digits of your year of birth.

Plan Documents and Notices

Please visit the forms library section at metlife.benselect.com/SoutheastHC to review important benefit documentation for our plans, including the Benefit Guide, the Health and Welfare Plan Summary, the Medical Plan Summary, Dental and Vision plan summaries and other plan documents and required notices. The benefit guide provides a detailed description of each benefit. The forms library can be reached by clicking on the scroll icon in the upper right corner of the screen.

Thank you,
HR Team

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ELIGIBILITY
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QUALIFYING EVENTS

OVERVIEW OF BENEFITS

ELIGIBILITY

Employees who are scheduled to work 30 or more hours per week are eligible 1st of the month following 60 days of full time employment. Terminations due to termination of employment are effective as of employees' last day worked. You can elect medical, dental, and vision coverage for your spouse and dependent/adult children up to 26 years old. Your employer reserves the right to request proof of marriage and birth certificates in order to add dependents.

WHEN COVERAGE BEGINS AND ENDS

Your benefits become effective the 1st of the month following 60 days of hire provided you've submitted a completed enrollment with a benefit counselor within 30 days of your benefits effective date. Any applicable waiting periods or additional exceptions are covered under each benefit description.

Your coverage under the benefits plans will end the date on your last day worked, the day you no longer meet the plan's eligibility requirements, your contributions are discontinued, or the Group Insurance Policy is terminated.

QUALIFYING EVENTS

Eligible employees may enroll or make changes to their benefits elections during the annual open enrollment period. As with most benefits, once you elect an option you are bound to that choice for the entire plan year unless you experience a Qualifying Event.

These may include, but not limited to: Changes in employment status, legal marital status or number of dependents, taking an unpaid leave of absence, Dependent satisfies or ceases to satisfy eligibility requirement, a COBRA-qualifying event, Entitlement to Medicare or Medicaid, or a change in the place of residence of the employee, resulting in the current carrier not being available.

THINGS TO CONSIDER

Consider your personal situation and the difference between the plan options and their costs when making your decision. You may also elect to waive coverage.

Ask yourself the following questions
- Will your current doctor be in or out-of-network?
- Do you have any planned surgeries this year?
- How many family members will you cover?
- How often do you visit the doctor?
- Are you planning to have a baby this year?

By reading this guide cover to cover, you will become familiar with your benefits options. After enrolling, verify that your payroll deductions are correct. If not, please contact your payroll representative.

This enrollment booklet is a summary description of your benefits. If there is a discrepancy between these summaries and the written legal plan documents, the plan documents shall prevail. This booklet and plan summaries do not constitute a contract of employment. These plans are provided by your employer and employer's insurance broker. Although every effort has been made to provide complete and accurate information, we make no warranties, express or implied, or representations as to the accuracy of content on this booklet. We assumes no liability or responsibility for any error or omissions in the information contained in the booklet. View your plan summaries online at southeasthcbenefits.com/.

EMPLOYER PAID BENEFITS

BASIC LIFE INSURANCE

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Employer Paid Life and AD&D

$30,000 Life and Accidental Death & Bodily Injury Insurance is provided to you as an employee. When you make your benefit elections you must elect a beneficiary to receive this benefit. If you feel you need additional life coverage, please refer to the supplemental life section on page 20.

This benefit is reduced by a percentage of Basic Term Life Insurance in force at age 64 when certain age milestones are reached:
35% at age 65, 55% at age 70, 70% at age 75, 80% at age 80, and 85% at age 85

Employee Assistance Program (EAP)

We provide short-term counseling, financial coaching, caregiving referrals and a wide range of well-being benefits to reduce stress, improve mental health, and make your life easier.

EAP benefits are free of charge, 100% confidential, available to all family members regardless of location, and easily accessible through ACI's 24/7, live-answer, toll-free number.

The following services are free to use, confidential, and available to you and your family members:

Mental Health Sessions

Up to 3 in-person, telephonic, or video counseling sessions to help manage stress, anxiety & depression, resolve conflict, improve relationships, overcome substance abuse and address any personal issues.

Financial Consultation

Build financial wellness related to budgeting, buying a home, paying off debt, managing taxes, preventing identify theft, & saving for retirement or tuition.

Life Management

Information and referrals when seeking childcare, adoption, special needs support, eldercare, housing, transportation, education, and pet care.

Medical Advocacy

Navigate insurance, obtain doctor referrals, secure medical equipment or transportation, and plan for transitional care and discharge.

Legal Consultation

Help with a variety of personal legal matters including estate planning, wills, real estate, bankruptcy, divorce, custody, and more.

Life Coaching

Reach personal and professional goals, manage life transitions, overcome obstacles, strengthen relationships, and build balance.

Personal Assistant

Manage everyday tasks and give back time by providing information and referrals for home services, repairs, travel, entertainment, dining & personal services.

Member Portal and App

Access your benefits 24/7/365 with online requests and chat options, and explore thousands of articles, webinars, podcasts and tools covering total well-being.

Live Webinars

Scheduled throughout the year to provide information on important topics. Webinar Schedule and Library: https://allonehealth.com/webinars/

Contact ACI Specialty Benefits

855-775-4357
rsli@acieap.com
Company Code: RSLI859
rsli.acieap.com

MEDICAL BENEFITS

In-Network Plan Details	BASE PLAN	OAP PLAN
Deductible (Single/Family)	$5,000 / $10,000	None†
Out-of-Pocket Limit (Single/Family)	$7,000 / $14,000	$8,000 / $16,000
Health care provider's office or clinic visit		
Primary care visit in person/virtual	20% Co-insurance*	$30 copay and plan pays 100%
Specialty Care visit in person/virtual	20% Co-insurance*	$40 copay and plan pays 100%
Surgery Performed in Office	20% Co-insurance*	Plan pays 100%
Telemedicine from MDLIVE	20% Co-insurance*	$30 copay $40 copay for Specialty Care services
Laboratory and Radiology Services		
Physician Services/Office Visit	20% Co-insurance*	Plan pays 100%
Independent Lab (Blood work only)	20% Co-insurance*	Plan pays 100%
Outpatient Facility	20% Co-insurance*	Plan pays 100%
Advanced Radiological Imaging (ARI)	Includes MRI, MRA, CAT Scan, PET Scan, etc.	
Physician's Services/Office Visit	20% Co-insurance*	Plan Pays 100%
Outpatient Facility	20% Co-insurance*	$300 scan/day copay
Prescription Drugs	30 day Retail / 90 day Mail Order	
Generic (Tier 1)	$10* / $25*	$10 / $30
Preferred (Tier 2)	$30* / $75*	$35 / $105
Non-Preferred (Tier 3)	$50* / $125*	$55 / $165
Specialty (Tier 4)	$25%*	25%
Member Choice Cigna 90 Now: This network of pharmacies includes major retail chains of Walgreens and CVS, in addition to other grocery, retailer, and independent pharmacies. You will be aligned to either the Walgreens or CVS network based on your existing pharmacy relationship. Where no relationship exists, you will be aligned to Plan sponsor elected CVS pharmacy. If that designation is not right for you, there is the option to select Walgreens. For more information, go to myCigna.com or call the number on the back of your ID card. Retail drugs for a 30 day supply may be obtained In-Network at a wide range of pharmacies across the nation although prescriptions for a 90 day supply (such as maintenance drugs) will be available at select network pharmacies.		
Outpatient Therapy Services		
Physical Therapy (20 Visit annual Limit. Not Applicable to mental heal conditions)	20% Co-insurance*	$40 copay
Speech, Hearing & Occupational Therapy (20 Visit annual Limit)	20% Co-insurance*	$40 copay
Chiropractic Care (20 Visit annual Limit)	20% Co-insurance*	$40 copay
Outpatient Services		
Facility Services	20% coinsurance*	$1000/admission deductible
Professional Services (Surgeon, Radiologist, Pathologist, Anesthesiologist)	20% coinsurance *	Plan pays 100%
Emergency Services		
Emergency room services	20% co-insurance*	$500 Copay
Emergency medical transit	20% coinsurance *	Plan pays 100%
Urgent Care	20% coinsurance *	$60 Copay

† There is a deductible of 100/individual or $200/family for prescription drugs; $1,000 for in-network outpatient hospital visit; $1,000 per day for in-network hospital stay. There are no other specific deductibles.

MEDICAL BENEFITS

	BASE PLAN	OAP PLAN
Inpatient Services		
Hospital Facility Services (Labs, Radiology, ARI, and medical specialty drugs)	20% co-insurance*	$1,000/day deductible, Limit 3/day deductibles annually
Professional Services (Surgeon, Radiologist, Pathologist, Anesthesiologist)	20% co-insurance*	Plan pays 100%
Skilled Nursing Facility, Rehab Hospital, Sub-Acute Facilities (Annual limit: 60 days)	20% co-insurance*	Plan pays 100%
Preventative Care		
Office Visits	Plan pays 100%	Plan pays 100%
Immunizations	Plan pays 100%	Plan pays 100%
Services	Plan pays 100%	Plan pays 100%
Preventative services include Mammogram, PAP Smear, Prostate Specific Antigen (PSA) and Colo-rectal Screenings.		
Mental Health and Substance Abuse Disorder		
All Outpatient services	20% co-insurance*	$ 40 copay
Inpatient services (Mental Health, Substance use Disorder)	20% co-insurance*	$1,000/day deductible, Limit 3/day deductibles annually
Covered medical services listed above, which are received to diagnose or treat a Mental Health or Substance Use Disorder condition will be payable according to this section titled “Mental Health and Substance Use Disorder” in the Benefit Summary.		
Family Planning		
Women’s Services	Plan pays 100%	Plan pays 100%
Includes contraceptive devices as ordered or pr prescribed by a physician and surgical sterilization services, such as tubal ligation (excludes reversals)		
Other Healthcare and Facility Services		
Home health care	20% co-insurance*	Plan pays 100%
Annual Limit: 60 visits (The limit is not applicable to mental health and substance use disorder conditions.)		
Organ Transplants	Covered same as Inpatient Benefit	Plan pays 100%
Services paid at in-network level if performed at Cigna LifeSOURCE Transplant Network® Facilities. Travel maximum - Cigna LifeSOURCE Transplant Network® Facility Only: After the plan deductible is met, $10,000 maximum per Transplant		
Condition-Specific Care	Plan pays 100%	Plan pays 100%
Must be enrolled in the Condition-Specific Care program for orthopedic treatment prior to surgery and receive care from a specifically designated provider in order to qualify. Includes specific services for surgery, including Facility and Professional charges from admission through discharge. Some limitations may apply. Travel Maximum - After the deductible is met, $600 per procedure		
Durable Medical Equipment and External Prosthetic Appliances	20% co-insurance*	Plan pays 100%
Breast Feeding Equipment and Supplies	Plan pays 100%	Plan pays 100%
Limited to the rental of one breast pump per birth as ordered or prescribed by a physician. Includes related supplies		
Hospice Services	Plan pays 100%	Plan pays 100%
Inpatient Facilities and Outpatient Care		
Out of network Benefits		
Deductible (Single/Family)	$15,000 / $30,000	$5,000 / $10,000
Max out of pocket (Single/Family)	$19,050 / $38,100	$15,000 / $30,000
Co-insurance	40% Co-insurance	30% Co-insurance

*** Services where plan deductible applies**

MEMBER CHOICE BENEFITS

MDLIVE for Cigna offers reliable 24/7 health care by phone or video. Our national network of board-certified doctors, pediatricians, dermatologists, psychiatrists, and therapists provides personalized care for hundreds of medical and behavioral health needs. With an average of 10 years* of experience, MDLIVE doctors and therapists are dedicated to helping you get better and stay well on your schedule. No surprise costs. No hassle. Visit us at www.mdliveforcigna.com or call us at 888.726.3171

*MDLIVE credentialed providers as of 2021, subject to change.

URGENT CARE

When you're not feeling well or need care fast, have a visit in just minutes with an MDLIVE board-certified doctor.

- See a doctor in less then 15 minutes
- Reliable and affordable alternative to urgent care clinics
- Prescriptions available if appropriate

BEHAVIORAL HEALTH

Appointments are private, convenient, and affordable. You can choose the same provider for each visit or switch at any time.

Licensed Therapists

- With hundreds of licensed therapists in the MDLIVE network, it's easy to find a provider that is the right fit for you.
- Have your first therapy appointment in a week or less compared to the weeks or months it could take to schedule an in-person visit.

Board-Certified Psychiatrists

- MDLIVE board-certified psychiatrists can diagnose medical illnesses and prescribe and assess medication, when necessary.
- You're encouraged to build an ongoing relationship with your doctor.

PRIMARY CARE

MDLIVE for Cigna's convenient primary care option makes it easy to connect to a board-certified primary care physician (PCP) for routine care, or preventive care on a schedule that works for you.

Preventative Care with a Wellness Screening

- Your MDLIVE board-certified doctor will help identify any potential health issues, discuss ways to improve your health, and recommend follow-up care, if necessary.
- Your preventive care benefit includes a health risk assessment and wellness screenings which, with associated lab work for your visit, are covered at no cost to you.*
- Have labs, blood work, and biometrics completed at local facilities.**
- Receive referrals to specialists as appropriate.

Routine Care

- Routine care helps you manage ongoing conditions and establish a relationship with your Primary Care Provider (PCP).
- Your doctor will help manage your health and well-being through regular visits, labs, diagnostics, and specialist referrals, when appropriate.
- Receive prescriptions, if appropriate, that can be sent to a local or home delivery pharmacy.

*For customers who have a non-zero preventive care benefit, MDLIVE virtual wellness screenings will not cost $0 and will follow their preventive benefit.
**Limited to LabCorp and Quest labs contracted with MDLIVE for virtual primary care.

DERMATOLOGY

When you need to see a dermatologist, it's important to get care quickly. Now, you can connect easily with a board-certified dermatologist through MDLIVE for Cigna without the long wait. There's no appointment required.*

How to use Virtual Dermatology

- Access virtual dermatology by logging in and select 'Dermatology." No appointment is necessary.
- Choose a provider and describe your dermatology concern, and upload photos to your MDLIVE account.
- Get a diagnosis and treatment plan, usually within 24 hours.
- Prescriptions will be sent directly to your preferred pharmacy, if appropriate.
- Have follow-up questions? Message the dermatologist for 30 days after the visit at no additional cost.

*Virtual dermatological visits through MDLIVE are completed via asynchronous messaging. Diagnoses requiring testing cannot be confirmed. Customers will be referred to seek in-person care. Treatment plans will be completed within a maximum of 3 business days, but usually within 24 hours.

Please note: Cigna members must choose an "Anchor" pharmacy, CVS, or Walgreens

- If CVS or Walgreens isn't select, Cigna will ether go with the anchor pharmacy selected by the client (in this case CVS).
- This DOES NOT affect local retail pharmacies. Members can go to those whenever needed. No disruption. This only affects CVS and Walgreens customers.
- 90-day fills can only be ordered by certain local pharmacies. Members will have to connect with their pharmacy for further information. through

PHARMACY NETWORKS AND NURSE ADVOCATE

Your network options

Both networks have over 55,000 pharmacies* in them, including local independent pharmacies, grocery stores, retail chains and wholesale warehouse stores – all places where you may already shop.

*** Network as of April 2023. Subject to change.**

Network with CVS	Network with Walgreens
• You can fill 30-day and 90-day supplies at any in-network retail pharmacy, including CVS. • Walgreens is not in this network. This means your plan may not cover any prescriptions you fill there.	• You can fill 30-day and 90-day supplies at any in-network retail pharmacy, including Walgreens. • CVS is not in this network. This means your plan may not cover any prescriptions you fill there.
• Both networks include the option to fill 90-day prescriptions through our home delivery pharmacy.	

Changing Your Pharmacy Network

1. Call customer service using the toll-free number on your Cigna HealthcareSM ID card. Let them know you'd like to change your pharmacy network.
2. When your new plan year starts, log in to the myCigna® App or myCigna.com®. Go to the profile page and follow the on-screen instructions.

Unsure about a fever? Have questions about a medication? We're here to help.

Cigna's no-cost Health Information Line puts you in touch with a personal nurse advocate* via chat or phone. They're here to answer your health questions and help you make the best choice for your needs.

Nurse advocates are available for questions like:

- I've had a fever for 2 days. Should I go to the emergency room?
- Is virtual care a good option for my needs?
- Is there a good orthopedic doctor in my area?
- I take a maintenance medication. How can I save on my prescription and get it delivered?

» **Chat**

Monday – Friday
9:00 a.m. – 8:00 p.m. EST
excluding holidays via myCigna.com or the myCigna® App.

» **Call**

24/7/365.
Just dial the number on the back of your Cigna ID card.

DENTAL BENEFITS

Plan Details	
Deductible: Individual/Family	$50/$150
Annual Maximum Benefit Per Person	$1,000, Class 1 applies
Class 1 Expenses - Preventative & Diagnostic Care	**100%, No Deductible**
Oral Exams	2/ Calendar year
Cleanings	2/ Calendar year
Routine X-rays	Bitewings: 2 per calendar year
Fluoride Application	1/ Calendar year for people under 19
Sealants	Limited to posterior tooth. One treatment per tooth every three years up to age 14
Space Maintainers (non-orthodontic)	No frequency limit for participants under age 19
Non-Routine X-rays	Full mouth: 1 every 3 calendar years. Panorex: 1 every 3 calendar years
Emergency Care to relieve pain Administrated at In Network Co-insurance	
Class 2 Expenses - Basic Restorative Care	**80% After Deductible**
Fillings	
Oral Surgery	
Surgical Extraction of Impacted Teeth	
Anesthetics	
Minor Periodontics	Various limitations depending on the service
Major Periodontics	Various limitations depending on the service
Root Canal Therapy / Endodontics	
Relines, Rebases and Adjustments	Covered if more than 6 months after installation
Repairs - Crowns, Inlays	
Repairs - Dentures, Bridges	Reviewed if more than once
Brush Biopsy	
Class 3 Expenses - Major Restorative Care	**50% After Deductible**
Crowns / Inlays / Onlays	Replacement every 5 years
Stainless Steel / Resin Crowns	
Dentures	Replacement every 5 years
Bridges	Replacement every 5 years
Class 4 Expenses - Orthodontia	**Not Covered**

VISION BENEFITS

For just a few dollars a month, this coverage saves you money on optical wellness, as well as providing discounts on eye wear, contacts, and corrective vision services

Benefit Features	In-Network Member Cost	Out-of-Network Reimbursement
Eye Examination		
Eye Exam	$20 copay	Up to $45 Allowance
Retinal Screening	Up to $39	Not Covered
Materials / Eye wear (Either Glasses or Contacts)		
Single Vision Lenses	$20 Copay	Up to $32 Allowance
Lined Bifocal Lenses	$20 Copay	Up to $55 Allowance
Lined Trifocal Lenses	$20 Copay	Up to $65 Allowance
Lenticular Lenses	$20 Copay	Up to $80 Allowance
Frames	80% after $130 Allowance	Up to $71 Allowance
Contact Lenses (Elective)	Balance over $130 Allowance	Up to $105 Allowance
Contact Lenses (Therapeutic)	$0	Up to $210 Allowance
Oversize lenses	$0	Not Covered
Rose#1 and #2 Solid Tints	$0	Not Covered
Polycarbonate Lenses (Under 19 years of age)	$0	Not Covered
Standard Polycarbonate	$40	Not Covered
Standard Progressives	$65	Not Covered
Plastic Dye Tints	$15	Not Covered
Photochromic	$75	Not Covered
Standard Scratch Coating	$15	Not Covered
Standard UV Coating	$15	Not Covered
Standard Anti-Reflective Coating	$45	Not Covered
Hi-Index Lenses	20% Off Retail	Not Covered
All Other Lense Options	20% Off Retail	Not Covered
Service Frequencies		
Exams	Every calendar year	
Lenses (for glasses or contact lenses)‡‡	Every calendar year	
Frames	Every two calendar years	
In-Network Value Added Savings	Up to 40% off additional complete pairs of glasses. 20% off any item not covered by the plan, including non-prescription sunglasses, but excluding professional services.	

One frame for prescription lenses – frame of choice covered up to retail plan allowance, plus a 20% savings on amount that exceeds frame allowance

How to use your Cigna Vision Benefits

Finding a Doctor

- Log into myCigna.com, under "Coverage", select Vision page. Click on Visit Cigna Vision. Then select "Find a Cigna Vision Network Eye Care Professional" to search the Cigna Vision – serviced by EyeMed Directory.
- Don't have access to myCigna.com? Go to Cigna.com, top of the page select "Find A Doctor, Dentist or Facility", click on Cigna Vision serviced by EyeMed Directory, from the Additional Directories drop down listing.
- Prefer the phone? Call the toll-free number found on your Cigna insurance card and talk with a Cigna Vision customer service representative

Schedule and appointment

Identify yourself as a Cigna Vision customer when scheduling an appointment. Present your Cigna Vision serviced by EyeMed information at the time of your appointment, which will quickly assist the doctor's office with accessing your plan details and verifying your eligibility.

Out-of-network plan reimbursement

Send a completed Cigna Vision service by EyeMed claim form and itemized receipt to: Cigna Vision, Claims Dept. c/oFAA
PO Box 8504, Mason, OH 45040-7111

To get a Cigna Vision serviced by EyeMed claim form:

- Go to Cigna.com and go to Forms, Vision Forms, select the Cigna Vision serviced by EyeMed form
- Go to myCigna.com and go to your vision coverage page

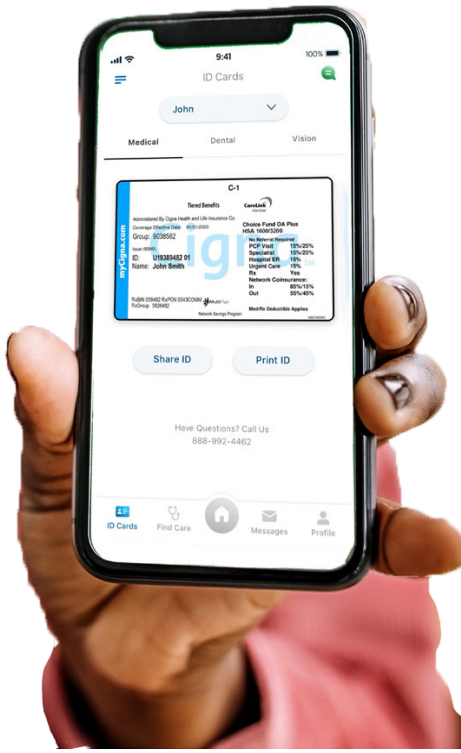
Cigna Vision will pay for covered expenses within ten business days of receiving the completed claim form and itemized receipt.

ID CARDS
FINDING A PROVIDER

Big news: You never have to worry about misplacing your ID card. It's always right there on myCigna®, whenever and wherever you need it.*

Accessing your digital ID cards is easy.

1. Log in to myCigna.com or the myCigna® App
2. Click or tap "ID Cards"
3. View your card(s), as well as any dependents' card(s)
4. Email cards directly to doctors
5. Save your digital ID cards in your Apple Wallet



Not registered on myCigna yet? Visit myCigna.com or scan the QR code to download the myCigna® App and register now.

Search our directory to find providers in four simple steps!

STEP 1 Go to Cigna.com and click on "Find a Doctor" at the top of the screen. Under "How are you covered?" select "Employer or School." (If you're already a Cigna customer, log in to myCigna.com or the myCigna® app to search your current plan's network.)

STEP 2 Change location to the city/state or zip you want to search. Select the search type and enter a name, specialty or other search term. Click on one of our suggestions or the magnifying glass icon to see your results.

STEP 3 Answer any clarifying questions, and then verify where you live

STEP 4 Optional: Select one of the plans offered by your employer during open enrollment.

You can refine your search by distance, years in practice, specialty, languages spoken and more. Our directory search is just the beginning!

After you enroll, you'll have access to myCigna.com – your one-stop source for managing your health plan, anytime, just about anyplace. On myCigna.com, you can estimate your health care costs, manage and track claims, learn how to live a healthier life and more.

GROUP ACCIDENT

Pre-Existing Condition Limitation

A pre-existing condition includes any condition/symptom for which you, in the 12 months period prior to coverage in this plan, consulted with a physician, received treatment, or took prescribed drugs. Any claim that is caused by a pre-existing condition in the 1st 12 months of coverage will not be covered. If you have a similar plan which this plan is replacing, the pre-existing condition limitation will use that plan's start date instead.

Benefit Amounts

Hospital, Surgery and Rehabilitation

Hospital Admission Max 2 per year	$1,500
Hospital Confinement 365 days maximum per accident	$225
Hospital intensive Care Unit Admission Max 2 per year	$2,000
Hospital Intensive Care Unit Confinement 30 days maximum per accident	$600
Hospital Observation Unit 1 day maximum per accident	$300
Exploratory Surgery 1 per accident	$150
Anesthesia 1 administration per accident	$25

Accidents and Injuries

Animal bite 1 shot per accident	$70
Burn 1 maximum treatment per accident	Up to $7,500
Burn Skin Graft 1 skin graft per accident	40% of burn benefit
Coma 1 per accident	$10,00
Concussion 1 per accident	$300
Dislocation *(doubles for open reduction)* 1 per accident	$4,000
Emergency Dental Work 1 repair per accident	$300
Eye Injury 1 surgery or removal of foreign object per accident	$75
Fracture *(doubles for open reduction)* *1 per accident*	Up to $5,250
Gunshot 1 maximum treatments per accident	$1,500
Knife Wound 1 maximum treatment per accident	50%
Ear Injuries 1 ear lifetime limit	Up to $200
Laceration 1 treatment per accident	Up to $600
Paralysis 1 per accident	Up to $12,500

Transportation

Ambulance - Air 1 per accident	$2,000
Ambulance - Ground or Water 1 per accident	$150
Transportation 3 times per accident	$250

Treatment and Follow-Up Care

Accident Emergency Initial Treatment maximum 2	$75
Accident Follow-Up Doctor Visit Maximum 2	$75
Ambulatory Surgical Center	$150
Blood/Plasma/Platelets 3 transfusions per accident	20%
Chiropractic Treatment and Alternative Therapy 6 visits per accidents	$25
Outpatient X-ray, Echocardiography and Cardiovascular Ultrasound max 1 total outpatient	$200
Outpatient X-ray, Echocardiography and Cardiovascular Ultrasound max 1 total outpatient	$200
Outpatient Injection max 1	$200
Outpatient Prescription Drugs 2 prescriptions per accident	$40
Pain Management 1 injection per accident	$30
Therapy: Occupational, Physical, or Speech max 3	$25

Additional Benefits

Appliance: Major (Minor is 1/2 Major) 1 per accident	$75
Lodging for Companion 30 days per accident	$125
Modification of Residence or Automobile 1 per accident	$1,250
Organized Sporting Activity *Percentage of Accident Maximum during 12 month period	25%*
Prosthetic Device/Artificial Limb 1 device per accident	$1,000
Service Dog	$200

Death and Dismemberment

Accidental Death	$25,000
Accidental Death - Common Carrier	$50,000
Accidental Dismemberment 1 per lifetime	$25,000

SHORT-TERM DISABILITY

PRESIDENTIAL LIFE INSURANCE

What is Short-Term Disability Insurance? Short-term- disability, or income replacement, is a type of insurance or employee benefit that provides financial support to individuals who are temporarily unable to work due to illness, injury, or a medical condition. It aims to protect employees' income during a limited period of incapacity, typically covering a portion of their salary for a short duration, facilitating their recovery without a significant financial burden.

Short Term Disability Benefits	
Total Disability Monthly Benefit	**Up to 60% of Salary**
Benefit Period	**3 Months**
Elimination Period Injury / Sickness	**0 / 7 or 14 / 14**
Guaranteed Issue	**$2,500 per month**
Partial Disability Benefit	**50% of Totals Disability Monthly Benefit 3 month Benefit Period**
Waiver of Premium Benefits	**Included**

Plan Features

Partial Disability
The Partial Disability Benefit helps you transition back into full-time work after suffering a disability. If, after being Totally Disabled, you remain partially disabled and are only able to work four hours per day, this plan will still pay you half of your selected monthly benefit for up to three months

Waiver of Premium
Premiums may be waived if you should become disabled

Elimination Period
Refers to the time period between an injury and you start receiving benefit payments. In this case you may select either 0 days for injury and 7 for sickness or 14 days for both when you sign up for this benefit.

Guaranteed Issue
The first time this benefit is available to you, to the amounts listed, you and your family automatically qualify for this benefit without having to answer health questions. You will continue to carry this for as long as you maintain the policy.

Pre-Existing Condition Limitation
A pre-existing condition includes any condition/symptom for which you, in the 12 months period prior to coverage in this plan, consulted with a physician, received treatment, or took prescribed drugs. Any claim that is caused by a pre-existing condition in the 1st 12 months of coverage will not be covered. If you have a similar plan which this plan is replacing, the pre-existing condition limitation will use that plan's start date instead.

RELIANCE STANDARD
LIFE INSURANCE COMPANY

LONG-TERM DISABILITY

Disability income protection insurance provides a benefit for long term disability resulting from a covered injury or sickness. Benefits begin at the end of the elimination period and continue while you are disabled up to the maximum benefit duration

Long Term Disability Details	
Maximum Percentage of Income	60%
Monthly Benefit Maximum	$6,000
Elimination Period	90 days
Disability Definition	24 months Own Occupation
Benefit Duration	Extended-ADEA-B*
Survivor Benefit	3 Months
Worksite Modification	100% up to $2,000
Limitations	
Mental/Nervous/Substance	24 Months
Pre-Existing	12 / 12

Age Discrimination and Employment Act (ADEA). The ADEA requires that either the level of benefits or the costs of the benefit be the same for older employees as for younger employees.

Maximum Benefit Duration

Benefits will not extend beyond the longer of your Social Security Normal Retirement Age or Duration of Benefits below:

Age at Disablement	Duration of Benefits
Prior to age 62	to age 65
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and over	12 months

Terms to Remember

Elimination Period
Refers to the time period between an injury and you start receiving benefit payments. In other words, it is the length of time between the beginning of an injury or illness and receiving benefit payments from your insurer.

Disability Definition
Generally, you are considered disabled, due to sickness, pregnancy or accidental injury, you are receiving appropriate care and treatment and are complying with the requirements of the treatment, and, you are unable to earn more than 80% of your pre-disability earnings at your own occupation.

Limitations
Your Disability benefits to a combined lifetime maximum for any and all of some conditions such as substance abuse or mental disorders is equal to the lesser 24 months or the maximum benefit period

Pre-Existing Condition
A pre-existing condition is defined as any sickness or injury (whether specifically diagnosed or not) for which the Insured received medical treatment, consultation, car or services, including diagnostic procedures or took prescribed drugs or medicines, during a specific period (as outlined in the policy) immediately prior to the Insured's effective date of coverage.

Benefit Duration
RDB w/SSNRA means that your benefits last until your social security normal retirement age unless you are 62 or older. In that case you would refer to the chart to the left.

Survivor Benefit
Your Policy provides a lump sum to the survivor of an insured person upon their death and had been receiving LTD benefits and had met the "Total Disability" definition for at least 180 days upon their death. The lump sum amount will equal three times the insured's net monthly benefit before death.

Own Occupation
An insured is considered disabled from his/her own occupation if unable, as a result of sickness or injury, to perform the material duties of his/her regular occupation as normally performed in the national economy

CRITICAL ILLNESS INSURANCE

PRESIDENTIAL LIFE INSURANCE

Critical illness insurance provides financial support in the event that you are diagnosed with a serious illness, such as cancer, heart attack, stroke, or kidney failure. These types of illnesses can be devastating not just emotionally and physically, but also financially. Medical bills, lost income, and other expenses can quickly add up and put a significant strain on your finances.

By purchasing critical illness insurance, you can have peace of mind knowing that you'll have financial support to help cover these expenses if you're ever faced with a serious illness. This can help alleviate some of the stress and anxiety that often comes with a diagnosis and allow you to focus on your recovery.

Benefits of Critical Illness Insurance:

1. **Maintain your lifestyle:** If you're unable to work due to a serious illness, critical illness insurance can help cover your living expenses so you can maintain your lifestyle and avoid dipping into your savings or retirement funds.

2. **Provide additional support:** Even if you have health insurance, the out-of-pocket expenses associated with a serious illness can be substantial. Critical illness insurance can provide financial support to help cover these costs.

3. **Customized to your needs:** Choose the level of coverage that best meets your needs and budget, have peace of mind knowing that you're covered in the event of a serious illness.

Critical illness insurance is a valuable investment for anyone who wants to protect themselves and their finances from the unexpected. While nobody likes to think about the possibility of being diagnosed with a serious illness, critical illness insurance provides a sense of security and peace of mind.

Plan Benefits

Cancer	
Non-Invasive Cancer	25%
Skin Cancer	$250
Heart	
Heart Attack	100%
Heart Transplant	100%
Stroke	100%
Angioplasty	25%
Aortic Surgery	25%
Coronary Artery Bypass Surgery	25%
Heart Valve Replacement/Repair Surgery	25%
Major Events	
Coma	100%
Kidney Failure (ESRD)	100%
Major Organ Transplant, other than heart	100%
Paralysis	100%
Other Covered	
Advanced Alzheimer's Disease, Advanced Parkinson's Disease, and Loss of Hearing, Sight, Speech	

Additional Coverages may include Transient Ischmeic Attack and Benign Brain Tumor. Please review Certificate for full coverage information.

Pre-Existing Condition Limitation

A pre-existing condition includes any condition/symptom for which you, in the 12 months period prior to coverage in this plan, consulted with a physician, received treatment, or took prescribed drugs. Any claim that is caused by a pre-existing condition in the 1st 12 months of coverage will not be covered. If you have a similar plan which this plan is replacing, the pre-existing condition limitation will use that plan's start date instead.

What Makes us Unique

Reoccurence and Additional Diagnosis

If you have a reocurrence or an additional diagnosis of a Critical Illness Benefits may be payable for the same Critical illness as outlined in your Certificate of Coverage.

PRESIDENTIAL LIFE INSURANCE

HOSPITAL INDEMNITY INSURANCE

Life is unpredictable. Without any warning, an illness or injury can lead to a hospital confinement and medical procedures and/or visits, which mean costly out-of-pocket expenses.

Base Benefits

Hospital Confinement Benefit

We will pay the amount in the Benefit Schedule for each day that an Insured is confined to a Hospital as an inpatient as the result of a Covered Accidental Injury or Covered Sickness. To be eligible to receive this benefit for Accidental Injuries resulting from a Covered Accident, the Insured must be confined to a Hospital within six months of the date of the Covered Accident

Wellness and Preventative Care Benefit

For each day that an Insured receives Wellness and Preventive Care under the supervision of a Physician, We will pay the Benefit Amount shown in the Certificate Schedule of Benefits.

Hospital Indemnity Benefits

	Plan 1
Inpatient Hospital Admission (per admission)	$1,000
Inpatient Hospital Confinement (per day)	$250
ICU Confinement (per day)	$250
Wellness and Preventive Benefit	$50

Hospital Admission Benefit

The Company will pay this benefit when an Insured is admitted to a Hospital and confined as an inpatient because of a Covered Accidental Injury or Covered Sickness. To be eligible to receive this benefit, an Insured must be admitted to a Hospital within six months of the date of the Covered Accident.

Hospital Intensive Care Unit Benefit

When an Insured is confined in and charged for a Hospital Intensive Care Unit for treatment of a Sickness or an Injury, the Company will pay the Daily Hospital Intensive Care Unit Benefit shown in the Certificate Schedule of Benefits for each day an Insured is confined in and charged for a Hospital Intensive Care Unit.

Pre-Existing Condition Limitation

A pre-existing condition includes any condition/ symptom for which you, in the 12 months period prior to coverage in this plan, consulted with a physician, received treatment, or took prescribed drugs. Any claim that is caused by a pre-existing condition in the 1st 12 months of coverage will not be covered. If you have a similar plan which this plan is replacing, the pre-existing condition limitation will use that plan's start date instead.

PERMANENT LIFE INSURANCE

PRESIDENTIAL LIFE INSURANCE

Term Life Benefit Amounts	
Covered Individual	**Coverage Limits**
Employee	up to $75,000
Spouse	the lesser of 50% of Employee's elections up to a max of $37,500
Child(ren)	up to $10,000 as long as the Employee has equal or more coverage on themselves

Restoration Rider

When the Lifetime Benefit Term Death Benefit is reduced below the Restoration Face Amount by the Accelerated Death Benefit for Long Term Care Rider, this Rider restores the Lifetime Benefit Term Death Benefit up to the Restoration Face Amount while this Rider is in force.

Accelerated Death Benefit for Long Term Care Rider

Death benefits will be reduced is an Accelerated Death Benefit is paid. The Accelerated Death Benefit or lien, if applicable, and the balance of the death benefit provided by the Certificate shall constitute full settlement on death of the Insured as provided under the Certificate.

This Rider provides that you may elect to receive a portion of the Death Benefit provided by the Certificate and shown on the Certificate Schedule. You can make this election when the Insured becomes eligible for benefits. The Insured must be certified as Chronically Ill and be confined to a Nursing or Assisted Living Facility or be receiving Home health or Adult Day Care. All other conditions of this Rider must also be met. Benefits are not payable under this Rider once the Insured has died.

Pre-Existing Condition Limitation

A pre-existing condition includes any condition/symptom for which you, in the 12 months period prior to coverage in this plan, consulted with a physician, received treatment, or took prescribed drugs. Any claim that is caused by a pre-existing condition in the 1st 12 months of coverage will not be covered. If you have a similar plan which this plan is replacing, the pre-existing condition limitation will use that plan's start date instead.

- An Initial Guaranteed Death Benefit until the latter of 25 years after the Coverage Date or age 70, but not beyond age 100. After this initial Period, a Reduced Guaranteed Death Benefits of 50% of the Initial Guaranteed Death Benefit is provided until age 121.
- Guaranteed Paid-Up Term benefits upon termination of payments after premiums have been paid for 10 full Coverage Years.
- Non-Guaranteed Paid-Up Term Benefits that may increase the Guaranteed Paid-Up Term benefit upon termination of premium payments after premiums have been paid for 10 full Coverage Years.
- After the Initial Guaranteed Death Benefit period, non-guaranteed One Year term Insurance which may increase the Reduced Guaranteed Death Benefit up to the Initial Guaranteed Death Benefit.
- Level Guaranteed Premiums payable to age 100.
- The Policy is non-participating and provides no cash surrender values or loan values.

RELIANCE STANDARD
LIFE INSURANCE COMPANY

SUPPLEMENTAL LIFE AND AD&D

Supplemental Life and AD&D		
Covered Individual	**Benefit Amount**	**Guarantee Issue**
Employee	$10,000 to $500,000* in increments of $10,000	$200,000
Spouse	Up to 50% of Employee Benefit in increments of $5,000	$50,000
Child(ren)	$1,000 to $10,000 in increments of $1,000	$10,000

Supplemental life and AD&D is in addition to the employer paid life listed on page 5

*Supplemental coverage is limited to the lesser of $500,000 or 5 times your annual earnings.

Guaranteed Issue

The first time this benefit is available to you, to the amounts listed, you and your family automatically qualify for this benefit without having to answer health questions. You will continue to carry this for as long as you maintain the policy.

Portability of Coverage

If you cease employment with your employer, you may elect to continue your coverage. You must have been continuously insured for at least 12 months under this plan and/or the prior plan just before the date your employment terminated.

Conversion

If an Insured Person's employment terminates for any reason, he/she may convert this coverage to an individual accident policy unless he/she is no longer eligible because of age or termination of the Policy. No medical examination or other evidence of insurability is needed regardless of age or state of health as long as application is made and the first premium is paid within 31 days after the coverage ends

Dependents

You must be insured for your dependents to be covered.
Dependents are:

- Your legal spouse who is not legally separated or divorced from you
- Your unmarried financially dependent children birth to 26 years
- A person may not have coverage as both an Employee and Dependent
- Only one insured spouse may cover dependent children

Benefit Reduction Due to Age

At age 70 the guarantee issue provision no longer applies, and the original benefit is reduced to 65%. Further reductions occur at age 75 (45%), 80 (30%), 85 (20%), & 90 (15%)

LEGAL SERVICES

MetLife

Unlike other voluntary benefits which are purchased as a safety net (with the hope that you never have to use them), the more you use a Legal Plan, the more you benefit. Like it or not, laws permeate every aspect of our lives. So, it's helpful to have an advocate in your corner dealing with expensive legal issues like identity theft or debt.

Plan Features			
Money Matters	Debt Collection Defense Financial Education Programs Identity Theft Defense	Identity Restoration Services Negotiations with Creditors Personal Bankruptcy	Promissory Notes Tax Audit Representation Tax Collection Defense
Home & Real Estate	Boundary & Title Disputes Mortgages Security Deposit Assistance Deeds	Property Tax Assessments Tenant Negotiations Eviction Defense Refinancing & Home Equity Loan	Zoning Applications Foreclosure Sale or Purchase of Home
Estate Planning	Codicils Living Wills	Revocable & Irrevocable Trusts Complex Wills	Complex Wills Powers of Attorney
Family & Personal	Adoption Guardianship Prenuptial Agreement Affidavits Immigration Assistance Protection from Domestic Violence	Conservatorship Juvenile Court Defense, Review of ANY Personal Legal Demand Letters Including Criminal Matters Document Divorce (20 hours)	Name Change School Hearings Garnishment Defense Parental Responsibility Matters Personal Properties Issues
Civil Lawsuits	Administrative Hearings Disputes Over Consumer Goods & Services	Pet Liabilities Civil Litigation Defense	Small Claims Assistance Incompetency Defense
Elder-care Issues	Consultation & Document Review for Issues Related to Your Parents: Medicaid Powers of Attorney	Medicare Prescription Plans Deeds Notes	Wills Leases Nursing Home Agreements
Traffic & Other Matters	Defense of Traffic Tickets Driving Privileges Restoration	Habeas Corpus Repossession	License Suspension Due to DUI
Family Coverage $9.85 per pay period			

MetLife

IDENTITY PROTECTION

Meet Aura

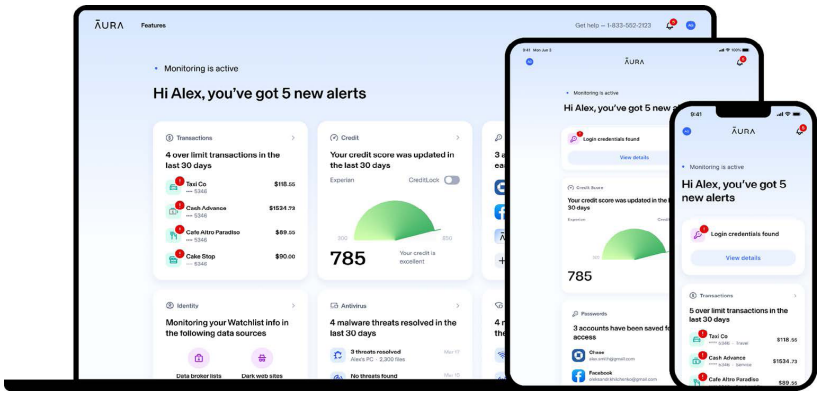
An all-in-one, easy to use online security solution designed to protect the entire family

Identity Theft Protection
Aura monitors your personal information and alerts you if any threats are detected.

Financial Fraud Protection
Aura monitors your credit, financial accounts, and property titles and alerts you to any suspicious activity.

Privacy and Device Security
Get intelligent safety tools– like VPN, antivirus, password manager, and more – to protect your online privacy.

Family Safety
Loved ones with integrated parental controls, elder fraud prevention tools, and more.



In today's digital world, employees are spending more time online than ever which could put their personal information in the hands of cyber criminals.

Aura protects you and your families from fraud by helping to ensure your private information is not anywhere it shouldn't be.

24/7/365 Customer Support	White Glove Fraud Resolution	$5,000,000 Insurance Policy	Features at your fingertips
Aura's 100% US-based Customer Support team is available 24/7/365.	Aura's White Glove Resolution Specialists guide fraud victims through every step of the remediation process.	Each enrolled adult is backed by a generous $5M insurance policy* to cover eligible losses and expenses.	With Aura's easy to use mobile app, members enjoy a consistent experience across devices.

Protection Plan	Protection Plus Plan
1 Bureau credit monitoring & alerts	3 Bureau credit monitoring & alerts
2 Device limit: Anti-virus, Wifi Scanning & VPN	Unlimited Devices: Anti-virus, Wifi Scanning & VPN
	Social Media Monitoring & Takeover Alerts
Individual $ 6.45 per pay period	Individual $ 8.45 per pay period
Family $10.95 per pay period	Family $13.95 per pay period

PET INSURANCE

MetLife

MetLife Pet Insurance is committed to helping pet parents experience the joys of parenthood by providing them the confidence to care for their pet. Pet insurance helps to reimburse pet parents for covered unexpected veterinary expenses for their furry family members. This will help to give you the confidence that you can pay for treatment for your pets if they become sick or have an accidental injury.

Freedom of Comprehensive coverage

Flexibility to select various levels of coverage with no breed exclusions or upper age limits; ability to include multiple pets on one policy through our innovative family plans

- Optional wellness coverage (preventive care) included in annual limit
- Competitive rates with discounts, healthy pet incentive and the only provider offering family plans (i.e., multiple pets covered by one policy)
- Coverage of pre-existing conditions when switching providers, no initial exam or previous vet records to apply

Simple and delightful experience

Your home is perhaps your most valuable possession, so you'll want to make sure your in New mobile app experience that allows for easy claim submission & track claims with most claims processed within 10 days

• Team of pet advocates to assist with enrollment and service, access to telehealth concierge service.

• No waiting period for orthopedic coverage and among the industry's shortest wait period for accident and illness coverage.

Backed by MetLife's unmatched track record

Simple set up with no additional costs to you and a seamless integration across MetLife benefits. Ongoing support with customizable employee communications & tools

Umbrella Insurance

You work hard for the things that are important to you. For added coverage above and beyond the liability limits of your Auto or Home insurance policies, a Personal Umbrella insurance policy can provide added protection for your assets and future earnings

This benefit is not payroll deducted. Premiums must be paid directly to MetLife.

MetLife

HOME & AUTO INSURANCE

Insure what's important while enjoying saving

- **Automated payment options and discounts**
- **Claim-free driving rewards**
- **Multi-policy savings**
- **Roadside assistance**
- **24/7 claim reporting**

Access to quality insurance to protect your valuables, to help protect against personal liability, and that can help feel financially secure with 24/7 professional support they need to bounce back, if the unexpected happened. This program helps choose policies to fit your needs and that fit your budget with special savings based on where you work, among other discounts.

Auto Insurance
Comprehensive coverage? Collision coverage? Deductibles? Medical Payments? Where to begin? Your local Farmers agent can take the mystery out of selecting the right Car insurance coverage for your needs and budget. Get started with an online Auto insurance quote and learn about our insurance discounts that can help you save money.

Home Insurance
Your home is perhaps your most valuable possession, so you'll want to make sure your insurer has withstood the test of time. Farmers® has been providing insurance products for over 80 years, and will be there in the event disaster strikes and your home is damaged in a fire or due to another covered cause of loss. Plus, get competitive rates with our multi-line insurance discounts. Get a Home insurance quote now.

Renters Insurance
Your landlord may have an insurance policy, but if there's a fire in your building, that policy may not cover your possessions. That's why there's Renters insurance. Get a Renters insurance quote to see how affordable it is to protect your personal belongings: about the price of a movie and popcorn once a month.

Umbrella Insurance
You work hard for the things that are important to you. For added coverage above and beyond the liability limits of your Auto or Home insurance policies, a Personal Umbrella insurance policy can provide added protection for your assets and future earnings

This benefit is not payroll deducted. Premiums must be paid directly to MetLife.

CARRIER CONTACT INFORMATION

BenManage

For assistance understanding and enrolling your benefits, reach the enrollment call center at **(678) 918-8387** Monday-Friday 8am-5pm CST

Below is contact information for each of the carriers of the specific benefits available to you for when you need to make a claim or have questions relating to a specific condition, coverage, or loss.

Carrier Contact Information			
Benefit Enrollment Center	BenManage	(678) 918-8387	
Employee Assistance Program	ACI Specialty Benefits	(855) 775-4357	rsli.acieap.com
Medical Benefits	Cigna Healthcare	(866) 494-2111	mycigna.com
Pharmacy	Cigna Healthcare	(800) 997-1654	mycigna.com
Behavioral Health & Telemedicine	MDLIVE	(888) 726-3171	mdliveforcigna.com
Dental	Cigna Healthcare	(866) 494-2111	mycigna.com
Vision	Cigna Healthcare	(866) 494-2111	mycigna.com
Short Term Disability	Presidential Life	(855) 639-7542	plicvb.com
Accident	Presidential Life	(855) 639-7542	plicvb.com
Critical Illness	Presidential Life	(855) 639-7542	plicvb.com
Hospital Indemnity	Presidential Life	(855) 639-7542	plicvb.com
Permanent Life Insurance	Presidential Life	(855) 639-7542	plicvb.com
Long Term Disability, Employer Paid and Supplemental Life and AD&D	Reliance Standard	(800) 351-7500	reliancematrix.com
Legal Services	METLIFE	(800) 821-6400	legalplans.com
Identity Theft Protection	METLIFE	(800) 638-5433	metlife.com
Pet Insurance	METLIFE	(855) 591-7121	quote.metlifepetinsurance.com
Home & Auto Insurance	METLIFE with Farmers	877-330-6238 discount code: FSU	metlife.com

HIPAA Privacy Notice

When disclosing Personal Health Information (PHI), the Plan or Employer will only disclose the minimum amount of PHI which is required to accomplish the purpose for which the disclosure is made. For all disclosures that are made on a recurring and routine basis, the Plan or Employer will develop and implement policies and procedures that ensure that only the minimum amount of PHI necessary is disclosed. For all other disclosures, the Plan or Employer will develop and follow criteria designed to limit the disclosure of PHI to the minimum amount required to accomplish the purpose of the disclosure. Employee Designated as qualified to Release PHI (EDR) making any disclosure of PHI must follow the applicable policies and procedures.

NOTICE OF YOUR HIPAA SPECIAL ENROLLMENT RIGHTS

A federal law called HIPAA requires that we notify you about an important provision in the Plan—your right to enroll in the Plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program) –
If you are declining enrollment for yourself and/or your dependents (including your spouse) because of other health insurance coverage or group health plan coverage, you may be able to enroll yourself and/or your dependents in this plan if you or your dependents lose eligibility for that other coverage or if the employer stops contributing towards your or your dependent's coverage. You will be required to submit a signed statement that this other coverage is the reason for waiving enrollment originally. To be eligible for this special enrollment opportunity you must request enrollment within 30 days after your other coverage ends or after the employer stops contributing towards the other coverage.

Loss of Coverage for Medicaid or a State Children's Health Insurance Program –
If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent as a Result of Marriage, Birth, Adoption or Placement for Adoption –
If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and/or your dependent(s). To be eligible for this special enrollment opportunity you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Medicaid Coverage: The Southeast HC Partners LLC group health plan will allow an employee or dependent who is eligible, but not enrolled for coverage, to enroll for coverage if either of the following events occur:

- TERMINATION OF MEDICAID OR CHIP COVERAGE- If the employee or dependent is covered under a Medicaid plan or under a State child health plan (SCHIP) and coverage of the team member or dependent under such a plan is terminated as a result of loss of eligibility.

- ELIGIBILITY FOR PREMIUM ASSISTANCE UNDER MEDICAID OR CHIP- If the employee or dependent becomes eligible for premium assistance under Medicaid or CHIP, including under any waiver or demonstration project conducted under or in relation to such a plan. This is usually a program where the state assists employed individuals with premium payment assistance for their employer's group health plan rather than direct enrollment in a state Medicaid program.

To be eligible for this special enrollment opportunity you must request coverage under the group health plan within 60 days after the date the employee or dependent becomes eligible for premium assistance under Medicaid or SCHIP or the date you or your dependent's Medicaid or state-sponsored CHIP coverage ends.

To request special enrollment or obtain more information, please contact the BenManage enrollment team at (888) 778-6821.

Women's Health and Cancer Rights Act Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Contact the Human Resources Department for additional information.

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Please refer to the benefit summaries for the deductible and coinsurance for your plan.

Qualified Medical Child Support Order (QMCSO)

QMCSO is a medical child support order issued under State law that creates or recognizes the existence of an "alternate recipient's" right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An "alternate recipient" is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified, and to administer benefits in accordance with the applicable terms of each order that is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer on the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.

Newborn Acts Disclosure

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

Coverage Extension Rights under the Uniformed Services Employment & Reemployment Rights Act (USERRA)

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents (including spouse) for up to 24 months while in the military. Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions for pre-existing conditions except for service-connected injuries or illnesses.

Mental Health Parity and Addiction Equity Act of 2008

This act expands the mental health parity requirements in the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Services Act by imposing new mandates on group health plans that provide both medical and surgical benefits and mental health or substance abuse disorder benefits. Among the new requirements, such plans (or the health insurance coverage offered in connection with such plans) must ensure that:
The financial requirements applicable to mental health or substance abuse disorder benefits are no more restrictive that the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance abuse disorder benefits.

Patient Protection Disclosure

Southeast HC Partners LLC Health Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Human Resources Department.

You do not need prior authorization in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Human Resources Department.

Genetic Information Non-Discrimination Act (GINA)

GINA broadly prohibits covered employers from discriminating against an employee, individual, or member because of the employee's "genetic information," which is broadly defined in GINA to mean (1) genetic tests of the individual, (2) genetic tests of family members of the individual, and (3) the manifestation of a disease or disorder in family members of such individual.
GINA also prohibits employers from requesting, requiring, or purchasing an employee's genetic information. This prohibition does not extend to information that is requested or required to comply with the certification requirements of family and medical leave laws, or to information inadvertently obtained through lawful inquiries under, for example, the Americans with Disabilities Act, provided the employer does not use the information in any discriminatory manner. In the event a covered employer lawfully (or inadvertently) acquires genetic information, the information must be kept in a separate file and treated as a confidential medical
record, and may be disclosed to third parties only in very limited situations.

ACA Section 1557 Compliance

Southeast HC Partners LLC Health Plan complies with any applicable Federal and state civil rights laws regarding discrimination on the basis of race, color, national origin, age, disability or sex in respect of this medical plan, and shall administer, interpret, amend and construe the Plan benefits and exclusions to the extent such laws are deemed applicable, as determined by Southeast HC Partners LLC in its sole discretion.

Southeast HC Partners LLC:

- Provides free aids and services to people with disabilities to communicate effectively with the Plan, such as:
    - Qualified sign language interpreters.
    - Written information in other formats (large print, audio, accessible electronic formats, other formats).
    - Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters.
    - Information written in other languages

If you are in need of these services, please contact the Human Resources Department.

If you believe the Employer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, a grievance may be filed with: Southeast HC Partners LLC HR Department. A grievance may be filed in person or by mail, fax, or email.

A civil rights complaint may also be filed with the U.S. Department of Health & Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail/phone at:
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of March 17, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since March 17, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

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

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

OMB 0938-0990

Important Notice from Southeast HC Partners LLC Health Plan About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Southeast HC Partners LLC Health Plan and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

2. **Southeast HC Partners LLC has determined that the prescription drug coverage offered by the Southeast HC Partners LLC Health Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Southeast HC Partners LLC Health Plan coverage will not be affected. (e.g., they can keep this coverage if they elect part D and this plan will coordinate with Part D coverage; for those individuals who elect Part D coverage, coverage under the entity's plan will end for the individual and all covered dependents, etc.). *See* pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current Southeast HC Partners LLC Health Plan coverage, be aware that you and your dependents will not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Southeast HC Partners LLC Health Plan and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Southeast HC Partners LLC Health Plan changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

Contact--Position/Office: **CIGNA Customer Service**
Phone Number: 866-494-2111

SEMI-MONTHLY BENEFIT RATES

Medical	Base Plan	Open Access Plus
Employee Only	$56.50	$215.18
Employee & Spouse	$454.05	$723.39
Employee & Child(ren)	$396.85	$647.45
Family	$828.15	$1219.90
	Dental	**Vision**
Employee Only	$3.15	$0
Employee & Spouse	$15.05	$1.81
Employee & Child(ren)	$13.19	$1.62
Family	$24.84	$3.59

KEY TERMS TO REMEMBER

COINSURANCE
The amount or percentage that you pay for certain covered health care services under your health plan. This is typically the amount paid after a deductible is met and can vary based on the plan design.

DEDUCTIBLE
The amount you pay for covered health care services before your insurance plan starts to pay. After you pay your deductible, you usually pay only a copayment or coinsurance for covered services. Your insurance company pays the rest.

COPAYMENT
A flat fee that you pay toward the cost of covered medical services.

OPEN ACCESS PLUS (OAP)
Open Access Plus (OAP) plans make it easy to get quality, in-network care with access to a large, national network of providers. Plus, you have the option to choose a primary care provider to coordinate your care and you don't need specialist referrals.

CO-INSURANCE
The amount or percentage that you pay for certain covered health care services under your health plan. This is typically the amount paid after a deductible is met and can vary based on the plan design.

IN-NETWORK
The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

OUT-OF-NETWORK
Health care you receive without a physician referral, or services received by a non-network service provider. Out-of-network health care and play payments are SUBJECT to deductibles and copayments.

OUT-OF-POCKET MAXIMUM (OOPM)
The amount or percentage that you pay for certain covered health care services under your health plan. This is typically the amount paid after a deductible is met and can vary based on the plan design.

USUAL, CUSTOMARY AND REASONABLE (UCR)ALLOWANCE
The fee paid for services that is: (1) a similar amount to the fee charged from a health care provider to the majority of patients for the same procedure, (2) the customary fee paid to providers with similar training and expertise in a similar geographic area, and (3) reasonable in light of any unusual clinical circumstances.