# 2024 BENEFITS GUIDE
## Labor

This publication contains important information about your employee benefit program.

**Please read thoroughly.**

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# Eligibility and Enrollment

When it comes to benefits, we understand what matters—plans created to support you and your family. Our benefits program allows you to choose the benefits best for you. Kleen-Tech provides Labor employees with access to medical, dental, and vision benefits and pays a major portion of the employee premium to make these important benefits more affordable for you. If you have questions regarding your benefits, please contact Human Resources at **866.385.0672**. This guide provides an overview of the plans available to you. Please review your plan documents for full details.

## Eligibility and Enrollment

You are eligible for benefits the first day of the month following 30 days. Please note you cannot make changes to your elections during the plan year unless you experience a qualifying event. You may also wish to cover your family. Your eligible dependents generally include your legally married spouse and children up to age 26. This includes natural and adopted children, step-children, and children for whom you are the court-appointed legal guardian. Some age limitations may apply to specific insurance programs.

Each year in late September or October (for a November 1 effective date) you have the option of changing your elections, but please note that if you do not elect coverage when you are first eligible, you may have waiting periods for some services. Please contact Human Resources with questions or for more details.

## Changing Benefits Mid-Year

Once you make your elections, you won't be able to change them until next year's annual enrollment, unless you experience a qualifying life event. Examples of qualifying events include a change in:

- Legal marital status (e.g., marriage, divorce, death of spouse, legal separation)
- Number of dependents (e.g., birth, adoption, death of dependent, ineligibility due to age)
- A dependent's eligibility status (e.g., a dependent child is no longer eligible)
- Employment or job status

You must make changes to your benefits within 30 days of your qualifying life event. If you miss the deadline, you will have to wait until next year's annual enrollment unless you experience a qualifying life event.

# Benefits Overview

## Benefit Options

- Medical
  - 2 Minimum Essential Coverage options
  - 2 Minimum Value Plans
- Dental
- Vision
- Voluntary Term Life and AD&D
- Additional Protection Benefits
  - Accident Insurance
  - Critical Illness
  - Hospital Indemnity

## How to Enroll

You must actively enroll in all benefits that require employee contributions. You may enroll online or via the call center.

To enroll (or make changes) to your benefits, you may access the Self-Serve Enrollment website at **https://cigna.benselect.com/ktech**.

- Login: Username your Employee ID or full SSN
- Password is a 6-digit PIN consisting of the employee's last 4 digits of SSN followed by their 2-digit year of birth.
- For example, a team member with a SSN of ###-##-8977 and a DOB of 07/05/1983 would have a PIN of 897783.

You may also enroll via the Call Center at **970.300.0333** (open 8 a.m.-5 p.m. CT).

Once enrolled you will receive an email within one business day of the completion of your enrollment certifying your elections. If you do not see your confirmation email within one business day, be sure to check your junk and/or spam folder.

# Medical Plan Options

The health plans offered at Kleen Tech consist of two Minimum Essential Coverage (MEC) options and two Minimum Value Plan (MVP) options. All four plans have a ZERO dollar deductible, so when you need to access care, you will simply pay the designated copay.

Basic MEC plans, like MEC 1, cover 78 Affordable Care Act Preventive Services (wellness services designed to prevent sickness before it starts), telehealth and certain pharmacy benefits. As you move to MEC 2, there are also limited benefits for in-office physician services and non-hospital based lab/x-ray services.

The MVP plans include all of the benefits you find in the MEC plans, but also add coverage for surgery, hospital stays, emergency room visits, and enhanced pharmacy benefits. The main differences in the MVP Bronze Plus and MVP Gold are the number of physician office visits and hospital days that are covered each year, as well as reduced copays for primary care and specialist visits under the MVP Gold plan.

These plans all have limitations on the number of visits or number of days in each category. For a complete overview of these limits as well as other exclusions, please refer to the Summary of Benefits for each plan.

## Benefits Portal

Log into **member.medxoom.com** and click “Sign Up” to register. You will need to provide your name, email address and create a password on the “Sign Up” screen (each covered adult dependent 18 or older must register separately). You will then complete your registration by providing either your Social Security Number/date of birth or date of birth/member number/group number from your ID card. You may download the “Medxoom” app on your mobile device as well.

Note: The same account registration procedure applies for the web portal and the mobile app. Once you’ve completed the registration on one device, you can access your account through both…no need to register twice.

You can now access, track and manage your plan benefits, including:

- View, print, and share digital ID cards
- Find providers and procedures
- Track plan benefits and out-of-pocket max
- View claims (with notifications as they are available)
- Start a telehealth session
- And more
    - You may log into **www.HBAeHealth.com** and click “Activate Your Benefit” to register your email address, create a password and add covered dependents (each covered adult dependent 18 or older must manage their own records and will receive a Welcome Email once added).

# Health Plan Administrator—Aither Health

As your health plan administrator, Aither Health processes claims in accordance with plan provisions, including preauthorization requests. The Aither service team is here to assist you in finding a doctor or other provider, answer questions about a recently filed claim, review how plan provisions may apply to an upcoming procedure, or simply provide more information about your benefits.

To contact your Aither Care Team call **844.378.2042** (also located on the front of your ID card).

# MINIMUM ESSENTIAL COVERAGE - MEC PLAN 1™

## Limited Day Medical℠ Plan

MEC Plan 1™ covers Preventive and Wellness Services, Telephonic Physician and Behavioral Health Services, and Pharmacy Benefits. Rather than an annual deductible, the plan requires copays for various covered services. Some services are subject to limits† on the number of days or visits for which benefits are payable.

| Deductible[1] | Participating Providers (In-Network) | Non-Participating Providers (Out-of-Network)[2] |
|---|---|---|
| Individual | $0 | |
| Family | $0 | |

| Out-of-Pocket Maximum[1] | Participating Providers (In-Network) | Non-Participating Providers (Out-of-Network)[2] |
|---|---|---|
| Individual | Not Applicable | |
| Family | Not Applicable | |

The following table represents the medical services currently covered under MEC Plan 1™, as well as the permitted interval and any requirements of such medical services. This plan does not utilize a network for any facilities. All services performed in a medical facility (for example, a hospital as opposed to a primary care physician's office) will be subject to Reference Based Pricing (RBP) reimbursements based on a multiple of the Medicare Reimbursement Rate.

| Plan Provisions | | Prior Auth Required[3] | Participating Providers (In-Network) | Non-Participating Providers (Out-of-Network)[2] |
|---|---|---|---|---|
| | | | Member Pays | |
| ***PHYSICIAN SERVICES*** | | | | |
| Primary Care Office Visit | | No | Not Covered | Not Covered |
| Specialist Office Visit | | No | Not Covered | Not Covered |
| Urgent Care | | No | Not Covered | Not Covered |
| Telemedicine Services | | No | $0 Copay | Not Covered |
| ***PREVENTIVE & WELLNESS SERVICES*** | | | | |
| (See Schedule of Preventive Health Services) | Non-Hospital Based | No | $0 Copay | $0 Copay |
| | Hospital Based | No | Not Covered | Not Covered |
| ***HOSPITAL/FACILITY SERVICES*** *(Subject to Reference Based Pricing)* | | | | |
| Inpatient Hospitalization | | No | Not Covered | Not Covered |
| Inpatient Visits - Physician | | No | Not Covered | Not Covered |
| Inpatient Surgery - Physician Charges | | No | Not Covered | Not Covered |
| Outpatient Hospital or Freestanding Facility Services and Surgery | | No | Not Covered | Not Covered |
| Anesthesia | | No | Not Covered | Not Covered |
| Emergency Room Services | | No | Not Covered | Not Covered |
| ***OUTPATIENT: DIAGNOSTIC SERVICES*** | | | | |
| Laboratory Service | Non-Hospital Based | No | Not Covered | Not Covered |
| | Hospital Based | No | Not Covered | Not Covered |
| Radiology | Non-Hospital Based | No | Not Covered | Not Covered |
| | Hospital Based | No | Not Covered | Not Covered |
| CT/MRI/MRA/PET Scan | Non-Hospital Based | No | Not Covered | Not Covered |
| | Hospital Based | No | Not Covered | Not Covered |
| ***PREGNANCY BENEFITS*** | | | | |
| Professional Services | | No | Not Covered | Not Covered |
| Maternity/Childbirth/Delivery | | No | Not Covered | Not Covered |

This summary is intended as an overview of plan benefits. In the event of a discrepancy between this summary and the governing plan documents, the Summary Plan Description (SPD) and Schedule of Benefits (SOB) shall prevail.

MEC PLAN 1™_POE SUMMARY_JUL2023

| Plan Provisions | | Prior Auth Required[3] | Participating Providers (In-Network) | Non-Participating Providers (Out-of-Network)[2] |
|---|---|---|---|---|
| | | | Member Pays | |
| ***OTHER SERVICES*** | | | | |
| **Allergy Services** | | No | **Not Covered** | **Not Covered** |
| **Second Surgical Opinion** | | No | **Not Covered** | **Not Covered** |
| **Home Health Care** | | No | **Not Covered** | **Not Covered** |
| **Treatment for Chemical Abuse & Dependency** | **Inpatient or Partial Day** | No | **Not Covered** | **Not Covered** |
| | **Outpatient** | No | **Not Covered** | **Not Covered** |
| **Rehabilitation/Habilitation Services** | | No | **Not Covered** | **Not Covered** |
| **Emergency Medical Transportation** | | No | **Not Covered** | **Not Covered** |

| ***PHARMACY BENEFITS***[4] | Retail *(30-day supply)* | Retail *(90-day supply)* | Mail Order *(90-day supply)* |
|---|---|---|---|
| **HBAScripts℠ (Subject to Formulary[5])** | Member Pays | | |
| Acute *(up to 30-day supply)* | **$0 Copay** | **N/A** | **N/A** |
| Chronic *(limited to two (2) 30-day fills, then 90-day fills required)* | **$0 Copay** | **$0 Copay** | **$0 Copay** |
| Insulin *(ReliOn™ Novolin 70/30 and NovoLog®)* | **Vials $10 / Pens $25** | **Vials $20 / Pens $50** | **Vials $20 / Pens $50** |
| **All Other Prescriptions (Subject to Formulary)** | | | |
| Tier 1 - ACA Preventive Drugs | **$0 Copay** | **$0 Copay** | **$0 Copay** |
| Tier 2 - Generic *(non-preventive)* | **Not Covered** | **Not Covered** | **Not Covered** |
| Tier 3 - Preferred Brand | **Not Covered** | **Not Covered** | **Not Covered** |
| Tier 4 - Non-Preferred Brand | **Not Covered** | **Not Covered** | **Not Covered** |
| Tier 5 - Specialty | **Not Covered** | **Not Covered** | **Not Covered** |

[1] Deductible and Out-of-Pocket amounts are combined across In-Network and Out-of-Network Providers.
[2] In addition to the copay listed, the member will also be responsible for any billed charges in excess of the 85th Percentile of the Usual, Customary, and Reasonable (UCR) charge.
[3] Prior authorization is required for any service or procedure over $1,000. If prior authorization is not obtained for services requiring a prior authorization, the benefits payable by the Plan for such services will be reduced to 50% of the allowed charges after the copay.
[4] To be eligible for pharmacy benefits covered prescriptions must be dispensed through participating pharmacies and mail order channels.
[5] The HBAScripts℠ formulary consists of acute and chronic generic drugs that represent over 90% of the most commonly-dispensed prescriptions in the U.S., as well as specific (non-insulin) diabetic supplies available at no cost to covered participants.
† Visit, service and Out-of-Pocket limits accumulate during a calendar year and reset on January 1st each year.

## Exclusions

The following exclusions apply to the benefits offered under this Plan:

1. Office visits, physical examinations, immunizations, and tests when required solely for the following:
    a. Sports,
    b. Camp,
    c. Employment,
    d. Travel,
    e. Insurance,
    f. Marriage,
    g. Legal proceedings
2. Routine foot care for treatment of the following:
    a. Flat feet,
    b. Corns,
    c. Bunions,
    d. Calluses,
    e. Toenails,
    f. Fallen arches,
    g. Weak feet,
    h. Chronic foot strain
3. Dental Procedures
4. Any other medical service, treatment, or procedure not covered under this Schedule of Benefits
5. Any other expense, bill, charge, or monetary obligation not covered under this Plan, including but not limited to all non-medical service expenses, bills, charges, and monetary obligations. Unless the medical service is explicitly provided by an appendix or otherwise explicitly provided in the Plan Document, this Plan does not cover the medical service or any related expense, bill, charge, or monetary obligation to the medical service
6. Claims unrelated to treatment of medical care or treatment
7. Cosmetic surgery unless authorized as medically necessary. Such authorization is based on the following causes for cosmetic surgery: accidental injury, correction or congenital deformity within six (6) years of birth, or as a treatment of a diseased condition
8. Any treatment with respect to treatment of teeth or periodontium, any treatment of periodontal or periapical disease involving teeth surrounding tissue, or structure. Exceptions to this exclusion include only malignant tumors or benefits specifically noted in the schedule of benefits to the Plan Document
9. Any claim related to an injury arising out of or in the course of any employment for wage or profit that would be covered by other coverage for which the member is eligible
10. Claims for which a participant is not legally required to pay or claims which would not have been made if this Plan had not existed
11. Claims for services which are not medically necessary as determined by this Plan or the excess of any claim above reasonable and customary rates when a PPO network has not been contracted
12. Charges which are or could be reimbursed by any public health program irrespective of whether such coverage has been elected by a participant
13. Claims due to an act of war, declared or undeclared, not including acts of terrorism
14. Claims for eyeglasses, contacts, hearing aids (or examinations for the fitting thereof) or radial keratotomy
15. Abortion services
16. Travel, unless specifically provided in the schedule of benefits
17. Custodial care for primarily personal, not medical, needs provided by persons with no special medical training or skill
18. Claims from any provider other than a healthcare provider as defined in the Plan Document unless explicitly permitted in the schedule of benefits
19. Investigatory or experimental treatment, services, or supplies unless specifically covered under Approved Clinical Trials
20. Services or supplies which are primarily educational
21. Claims due to attempted suicide or intentionally self-inflicted injury while sane or insane, unless the claim results from a medical condition such as depression
22. Claims resulting from, or which arise due to the attempt or commission of, an illegal act. Claims by victims of domestic violence will not be subject to this exclusion
23. Claims with respect to any treatment or procedure to change one's physical anatomy to those of the opposite sex and any other treatment or study related to sex change
24. Claims from a medical service provider who is related by blood, marriage, or legal adoption to a participant
25. Any claims for fertility or infertility treatment
26. Claims for weight control, weight reduction, or surgical treatment for obesity or morbid obesity, unless explicitly provided in the schedule of benefits
27. Claims for disability resulting from reversal of sterilization
28. Claims for the completion of forms, or failure to keep scheduled appointments
29. Recreational or diversional therapy
30. Personal hygiene or convenience items, including but not limited to air conditioning, humidifiers, hot tubs, whirlpools, or exercise equipment, irrespective of the recommendations or prescriptions of a medical service provider
31. Claims due to participation in a dangerous activity, including but not limited to sky-diving, motorcycle or automobile racing, bungee jumping, rock climbing, rappelling, or hang gliding
32. Claims that arise primarily due to medical tourism
33. Supportive devices of the foot
34. Treatments for sexual dysfunction
35. Aquatic or massage therapy
36. Biofeedback training
37. Skilled nursing facilities
38. Durable medical equipment and prosthetics
39. Hospice care, private duty nursing, or long-term care
40. Residential facility – for charges from a residential halfway house or home, or any facility which is not a health care institution licensed for the primary purpose of treatment of an illness or injury
41. Claims for temporomandibular joint syndrome
42. Claims for biotech or specialty drugs, including biologics and hemophiliac drugs
43. Genetic testing unless explicitly covered in the schedule of benefits
44. Human Cell, Tissue and Organ transplantation
45. Claims for cosmetic surgery, not related to mastectomy reconstruction to produce a symmetrical appearance or prosthesis, or physical complications which result from such procedures
46. Chiropractic care
47. Radiation and chemotherapy
48. Dialysis
49. Acupuncture
50. Alternative medicine/homeopathy
51. Pediatric dental and vision
52. Neonatal intensive care (NICU)
53. Rehabilitative therapies
54. PCP surgery
55. Routine eye care (Adult)
56. Any claim arising from service received outside of the United States and its territories of American Samoa, Guam, the Northern Mariana Islands, Puerto Rico and the U.S. Virgin Islands
57. Pregnancy Benefits, including office visits and childbirth/delivery professional and facility services
58. This coverage does not include benefits for grandchildren (unless they are under your legal guardianship)
59. Use of emergency room services for non-emergency care
60. Emerging gene and cell therapies
61. Diagnosis and treatment for sleep apnea
62. CAR-T therapies

The purpose of this list of exclusions is solely to provide additional clarity regarding treatments, procedures, products, services, or any other items which are not covered under this plan. Accordingly, no exclusion shall be interpreted by negative implication, or otherwise, as evidence of the existence of coverage under this plan.

# MINIMUM ESSENTIAL COVERAGE - MEC PLAN 2™

## Limited Day Medical℠ Plan

MEC Plan 2™ covers Preventive and Wellness Services, Physician Services and Pharmacy Benefits. Rather than an annual deductible, the plan requires copays for various covered services. Some services are subject to limits† on the number of days or visits for which benefits are payable.

| Deductible[1] | Participating Providers (In-Network) | Non-Participating Providers (Out-of-Network)[2] |
|---|---|---|
| Individual | $0 | |
| Family | $0 | |

| Out-of-Pocket Maximum[1] | Participating Providers (In-Network) | Non-Participating Providers (Out-of-Network)[2] |
|---|---|---|
| Individual | $7,350 | |
| Family | $14,700 | |

The following table represents the medical services currently covered under MEC Plan 2™, as well as the permitted interval and any requirements of such medical services. This plan does not utilize a network for any facilities. All services performed in a medical facility (for example, a hospital as opposed to a primary care physician's office) will be subject to Reference Based Pricing (RBP) reimbursements based on a multiple of the Medicare Reimbursement Rate.

| Plan Provisions | | Prior Auth Required[3] | Participating Providers (In-Network) | Non-Participating Providers (Out-of-Network)[2] |
|---|---|---|---|---|
| | | | Member Pays | |
| ***PHYSICIAN SERVICES*** | | | | |
| **Primary Care Office Visit**<br>Limited to **2 visits** per plan year† | | No | **$25 Copay** | **$25 Copay** |
| **Specialist Office Visit**<br>Limited to **2 visits** per plan year† | | No | **$50 Copay** | **$50 Copay** |
| **Other Physician Services Performed in the Office**[4]<br>(Limited to Primary Care/Specialist visits per plan year) | | Yes[5] | **$50 Copay** | **$50 Copay** |
| **Urgent Care**<br>Limited to **2 visits** per plan year† | | No | **$50 Copay** | **$50 Copay** |
| **Telemedicine Services** | | No | **$0 Copay** | **Not Applicable** |
| ***PREVENTIVE & WELLNESS SERVICES*** | | | | |
| (See Schedule of Preventive Health Services) | **Non-Hospital Based** | No | **$0 Copay** | **$0 Copay** |
| | **Hospital Based** | No | **Not Covered** | **Not Covered** |
| ***HOSPITAL/FACILITY SERVICES** (Subject to Reference Based Pricing)* | | | | |
| **Inpatient Hospitalization** | | No | **Not Covered** | **Not Covered** |
| **Inpatient Visits - Physician** | | No | **Not Covered** | **Not Covered** |
| **Inpatient Surgery - Physician Charges** | | No | **Not Covered** | **Not Covered** |
| **Outpatient Hospital or Freestanding Facility Services and Surgery** | | No | **Not Covered** | **Not Covered** |
| **Anesthesia** | | No | **Not Covered** | **Not Covered** |
| **Emergency Room Services** | | No | **Not Covered** | **Not Covered** |
| ***OUTPATIENT: DIAGNOSTIC SERVICES*** | | | | |
| **Laboratory Service** | **Non-Hospital Based**<br>(Combined limit of **1 visit** per plan year with Radiology)† | No | **$50 Copay** | **$50 Copay** |
| | **Hospital Based** | No | **Not Covered** | **Not Covered** |
| **Radiology** | **Non-Hospital Based**<br>(Combined limit of **1 visit** per plan year with Laboratory Service)† | No | **$50 Copay** | **$50 Copay** |
| | **Hospital Based** | No | **Not Covered** | **Not Covered** |
| **CT/MRI/MRA/PET Scan** | **Non-Hospital Based** | No | **Not Covered** | **Not Covered** |
| | **Hospital Based** | No | **Not Covered** | **Not Covered** |

This summary is intended as an overview of plan benefits. In the event of a discrepancy between this summary and the governing plan documents, the Summary Plan Description (SPD) and Schedule of Benefits (SOB) shall prevail.

| Plan Provisions | | Prior Auth Required[3] | Participating Providers (In-Network) | Non-Participating Providers (Out-of-Network)[2] |
|---|---|---|---|---|
| | | | Member Pays | |
| ***PREGNANCY BENEFITS*** | | | | |
| **Professional Services** | | No | **Not Covered** | **Not Covered** |
| **Maternity/Childbirth/Delivery** | | No | **Not Covered** | **Not Covered** |
| ***OTHER SERVICES*** | | | | |
| **Allergy Services** | | No | **Not Covered** | **Not Covered** |
| **Second Surgical Opinion** (Telephonic/Online Service) | | No | **$0 Copay** | **Not Applicable** |
| **Home Health Care** | | No | **Not Covered** | **Not Covered** |
| **Treatment for Chemical Abuse & Dependency** | **Inpatient or Partial Day** | No | **Not Covered** | **Not Covered** |
| | **Outpatient** | No | **Not Covered** | **Not Covered** |
| **Rehabilitation/Habilitation Services** | | No | **Not Covered** | **Not Covered** |
| **Emergency Medical Transportation** | | No | **Not Covered** | **Not Covered** |
| ***VISION BENEFITS[6]*** | | | | |
| **In-Office Comprehensive Vision Exams** | | No | **$0 Copay** | Up to $35 benefit |
| **Eyewear Allowance** for frames or contacts | | No | **$150** every two (2) years | |

| ***PHARMACY BENEFITS[7]*** | Retail *(30-day supply)* | Retail *(90-day supply)* | Mail Order *(90-day supply)* |
|---|---|---|---|
| **HBAScripts℠ (Subject to Formulary[8])** | Member Pays | | |
| Acute *(up to 30-day supply)* | **$0 Copay** | **N/A** | **N/A** |
| Chronic *(limited to two (2) 30-day fills, then 90-day fills required)* | **$0 Copay** | **$0 Copay** | **$0 Copay** |
| Insulin *(ReliOn™ Novolin 70/30 and NovoLog®)* | **Vials $10 / Pens $25** | **Vials $20 / Pens $50** | **Vials $20 / Pens $50** |
| **All Other Prescriptions (Subject to Formulary)** | | | |
| Tier 1 - ACA Preventive Drugs | **$0 Copay** | **$0 Copay** | **$0 Copay** |
| Tier 2 - Generic *(non-preventive)* | **$10 Copay** | **N/A** | **$30 Copay** |
| Tier 3 - Preferred Brand | **Not Covered** | **Not Covered** | **Not Covered** |
| Tier 4 - Non-Preferred Brand | **Not Covered** | **Not Covered** | **Not Covered** |
| Tier 5 - Specialty | **Not Covered** | **Not Covered** | **Not Covered** |

[1] Deductible and Out-of-Pocket amounts are combined across In-Network and Out-of-Network Providers.
[2] In addition to the copay listed, the member will also be responsible for any billed charges in excess of the 85th Percentile of the Usual, Customary, and Reasonable (UCR) charge.
[3] If prior authorization is not obtained for services requiring a prior authorization, the benefits payable by the Plan for such services will be reduced to 50% of the allowed charges after the copay.
[4] The plan will only reimburse buy and bill drugs up to the lessor of the allowed amount or network rate or the amount that the Third-Party Administrator or Pharmacy Benefits Manager could source the drug for.
[5] Prior authorization is required for any service or procedure over $1,000.
[6] Vision benefits are provided outside of the Group Health Plan through a service contract and are subject to provisions and limitations in the HBAVision℠ Summary of Benefits.
[7] To be eligible for pharmacy benefits covered prescriptions must be dispensed through participating pharmacies and mail order channels.
[8] The HBAScripts℠ formulary consists of acute and chronic generic drugs that represent over 90% of the most commonly-dispensed prescriptions in the U.S., as well as specific (non-insulin) diabetic supplies available at no cost to covered participants.
† Visit, service and Out-of-Pocket limits accumulate during a calendar year and reset on January 1st each year.

MEC PLAN 2™ _POE SUMMARY_JUL2023

## Exclusions

The following exclusions apply to the benefits offered under this Plan:

1. Office visits, physical examinations, immunizations, and tests when required solely for the following:
    a. Sports,
    b. Camp,
    c. Employment,
    d. Travel,
    e. Insurance,
    f. Marriage,
    g. Legal proceedings
2. Routine foot care for treatment of the following:
    a. Flat feet,
    b. Corns,
    c. Bunions,
    d. Calluses,
    e. Toenails,
    f. Fallen arches,
    g. Weak feet,
    h. Chronic foot strain
3. Dental Procedures
4. Any other medical service, treatment, or procedure not covered under this Schedule of Benefits
5. Any other expense, bill, charge, or monetary obligation not covered under this Plan, including but not limited to all non-medical service expenses, bills, charges, and monetary obligations. Unless the medical service is explicitly provided by an appendix or otherwise explicitly provided in the Plan Document, this Plan does not cover the medical service or any related expense, bill, charge, or monetary obligation to the medical service
6. Claims unrelated to treatment of medical care or treatment
7. Cosmetic surgery unless authorized as medically necessary. Such authorization is based on the following causes for cosmetic surgery: accidental injury, correction or congenital deformity within six (6) years of birth, or as a treatment of a diseased condition
8. Any treatment with respect to treatment of teeth or periodontium, any treatment of periodontal or periapical disease involving teeth surrounding tissue, or structure. Exceptions to this exclusion include only malignant tumors or benefits specifically noted in the schedule of benefits to the Plan Document
9. Any claim related to an injury arising out of or in the course of any employment for wage or profit that would be covered by other coverage for which the member is eligible
10. Claims for which a participant is not legally required to pay or claims which would not have been made if this Plan had not existed
11. Claims for services which are not medically necessary as determined by this Plan or the excess of any claim above reasonable and customary rates when a PPO network has not been contracted
12. Charges which are or could be reimbursed by any public health program irrespective of whether such coverage has been elected by a participant
13. Claims due to an act of war, declared or undeclared, not including acts of terrorism
14. Claims for eyeglasses, contacts, hearing aids (or examinations for the fitting thereof) or radial keratotomy
15. Abortion services
16. Travel, unless specifically provided in the schedule of benefits
17. Custodial care for primarily personal, not medical, needs provided by persons with no special medical training or skill
18. Claims from any provider other than a healthcare provider as defined in the Plan Document unless explicitly permitted in the schedule of benefits
19. Investigatory or experimental treatment, services, or supplies unless specifically covered under Approved Clinical Trials
20. Services or supplies which are primarily educational
21. Claims due to attempted suicide or intentionally self-inflicted injury while sane or insane, unless the claim results from a medical condition such as depression
22. Claims resulting from, or which arise due to the attempt or commission of, an illegal act. Claims by victims of domestic violence will not be subject to this exclusion
23. Claims with respect to any treatment or procedure to change one's physical anatomy to those of the opposite sex and any other treatment or study related to sex change
24. Claims from a medical service provider who is related by blood, marriage, or legal adoption to a participant
25. Any claims for fertility or infertility treatment
26. Claims for weight control, weight reduction, or surgical treatment for obesity or morbid obesity, unless explicitly provided in the schedule of benefits
27. Claims for disability resulting from reversal of sterilization
28. Claims for the completion of forms, or failure to keep scheduled appointments
29. Recreational or diversional therapy
30. Personal hygiene or convenience items, including but not limited to air conditioning, humidifiers, hot tubs, whirlpools, or exercise equipment, irrespective of the recommendations or prescriptions of a medical service provider
31. Claims due to participation in a dangerous activity, including but not limited to sky-diving, motorcycle or automobile racing, bungee jumping, rock climbing, rappelling, or hang gliding
32. Claims that arise primarily due to medical tourism
33. Supportive devices of the foot
34. Treatments for sexual dysfunction
35. Aquatic or massage therapy
36. Biofeedback training
37. Skilled nursing facilities
38. Durable medical equipment and prosthetics
39. Hospice care, private duty nursing, or long-term care
40. Residential facility – for charges from a residential halfway house or home, or any facility which is not a health care institution licensed for the primary purpose of treatment of an illness or injury
41. Claims for temporomandibular joint syndrome
42. Claims for biotech or specialty drugs, including biologics and hemophiliac drugs
43. Genetic testing unless explicitly covered in the schedule of benefits
44. Human Cell, Tissue and Organ transplantation
45. Claims for cosmetic surgery, not related to mastectomy reconstruction to produce a symmetrical appearance or prosthesis, or physical complications which result from such procedures
46. Chiropractic care
47. Radiation and chemotherapy
48. Dialysis
49. Acupuncture
50. Alternative medicine/homeopathy
51. Pediatric dental and vision
52. Neonatal intensive care (NICU)
53. Rehabilitative therapies
54. Routine eye care (Adult)
55. Any claim arising from service received outside of the United States and its territories of American Samoa, Guam, the Northern Mariana Islands, Puerto Rico and the U.S. Virgin Islands
56. Pregnancy Benefits, including office visits and childbirth/delivery professional and facility services
57. All maternity coverage for dependent children, including adult children up to age 26, and all coverage for the resultant newborn child. However, ACA mandated Preventive Health Services are not excluded
58. This coverage does not include benefits for grandchildren (unless they are under your legal guardianship)
59. Use of emergency room for non-emergency care
60. Emerging gene and cell therapies
61. Diagnosis and treatment for sleep apnea
62. CAR-T therapies

The purpose of this list of exclusions is solely to provide additional clarity regarding treatments, procedures, products, services, or any other items which are not covered under this plan. Accordingly, no exclusion shall be interpreted by negative implication, or otherwise, as evidence of the existence of coverage under this plan.

THE HEALTH BENEFIT ALLIANCE
YOUR ALLY IN HEALTH™

# Minimum Value Plan - MVP BRONZE PLUS™
## Limited Day Medical℠ Plan

The MVP BRONZE PLUS™ Plan covers Preventive and Wellness Services, Inpatient and Outpatient Hospital, Physician Services and Pharmacy Benefits. Rather than an annual deductible, the plan requires copays for various covered services. Some services are subject to limits† on the number of days or visits for which benefits are payable.

| Deductible[1] | Participating Providers (In-Network) | Non-Participating Providers (Out-of-Network)[2] |
|---|---|---|
| **Individual** | $0 | |
| **Family** | $0 | |

| Out-of-Pocket Maximum[1] | Participating Providers (In-Network) | Non-Participating Providers (Out-of-Network)[2] |
|---|---|---|
| **Individual** | $7,350 | |
| **Family** | $14,700 | |

The following table represents the medical services currently covered under the MVP BRONZE PLUS™ Plan, as well as the permitted interval and any requirements of such medical services. This plan does not utilize a network for any facilities. All services performed in a medical facility (for example, a hospital as opposed to a primary care physician's office) will be subject to Reference Based Pricing (RBP) reimbursements based on a multiple of the Medicare Reimbursement Rate.

| Plan Provisions | | Prior Auth Required[3] | Participating Providers (In-Network) | Non-Participating Providers (Out-of-Network)[2] |
|---|---|---|---|---|
| | | | Member Pays | |
| ***PHYSICIAN SERVICES*** | | | | |
| **Primary Care Office Visit**<br>Limited to **8 visits** per plan year† | | No | **$25 Copay** | **$25 Copay** |
| **Specialist Office Visit**<br>Limited to **8 visits** per plan year† | | No | **$50 Copay** | **$50 Copay** |
| **Other Physician Services Performed in the Office**[4]<br>(Limited to Primary Care/Specialist visits per plan year) | | Yes[5] | **$50 Copay** | **$50 Copay** |
| **Urgent Care**<br>Limited to **2 visits** per plan year† | | No | **$50 Copay** | **$50 Copay** |
| **Telemedicine Services** | | No | **$0 Copay** | **Not Applicable** |
| ***PREVENTIVE & WELLNESS SERVICES*** | | | | |
| (See Schedule of Preventive Health Services) | **Non-Hospital Based** | No | **$0 Copay** | **$0 Copay** |
| | **Hospital Based** | No | **Not Covered** | **Not Covered** |
| ***HOSPITAL/FACILITY SERVICES*** *(Subject to Reference Based Pricing)* | | | | |
| **Inpatient Hospitalization**<br>Limited to **5 days** per plan year† | | Yes | **$350 Copay per admission**<br>(Subject to Reference Based Pricing) | |
| **Inpatient Visits - Physician**<br>Limited to **5 visits** per plan year† | | No | Included in Inpatient Hospitalization Copay | |
| **Inpatient Surgery - Physician Charges**<br>Second surgical opinion may be required; Limited to **2 surgeries** per plan year† | | Yes | Included in Inpatient Hospitalization Copay | |
| **Outpatient Hospital or Freestanding Facility Services and Surgery**<br>Limited to **1 visit** per plan year† | | Yes | **$350 Copay**<br>(Subject to Reference Based Pricing) | |
| **Anesthesia**<br>Limited to **2 inpatient** and **1 outpatient** anesthetic procedures per plan year† | | No | Included in Inpatient Hospitalization or Outpatient Hospital or Freestanding Facility Services and Surgery Copay | |
| **Emergency Room Services**<br>Limited to **1 visit** per plan year† | | No | **$350 Copay**<br>(Subject to Reference Based Pricing) | |
| ***PREGNANCY BENEFITS*** | | | | |
| **Professional Services** | | No | **$350 Copay** | **$350 Copay** |
| **Maternity/Childbirth/Delivery**<br>(Considered Inpatient Hospital Stay) | | No | **$350 Copay per admission**<br>(Subject to Reference Based Pricing) | |

This summary is intended as an overview of plan benefits. In the event of a discrepancy between this summary and the governing plan documents, the Summary Plan Description (SPD) and Schedule of Benefits (SOB) shall prevail.

**MVP BRONZE PLUS™_POE SUMMARY_JUL2023**

| Plan Provisions | | Prior Auth Required[3] | Participating Providers (In-Network) | Non-Participating Providers (Out-of-Network)[2] |
|---|---|---|---|---|
| | | | **Member Pays** | |
| ***OUTPATIENT: DIAGNOSTIC SERVICES*** | | | | |
| **Laboratory Service** | **Non-Hospital Based** (Combined limit of **3 visits** per plan year with Radiology)† | No | **$50 Copay** | **$50 Copay** |
| | **Hospital Based** | No | **Not Covered** | **Not Covered** |
| **Radiology** | **Non-Hospital Based** (Combined limit of **3 visits** per plan year with Laboratory Service)† | No | **$50 Copay** | **$50 Copay** |
| | **Hospital Based** | No | **Not Covered** | **Not Covered** |
| **CT/MRI/MRA/PET Scan** Limited to **1** per plan year† | **Non-Hospital Based** | Yes | **$350 Copay** (Subject to Reference Based Pricing) | |
| | **Hospital Based** | No | **Not Covered** | **Not Covered** |
| ***OTHER SERVICES*** | | | | |
| **Allergy Services** (Included in Primary Care Office Visit or Specialist Office Visit limits. The copay applies to the administration of the allergy service and is separate from the copay for the office visit) | | No | **$25 Copay** | **$25 Copay** |
| **Chiropractic Services** Limited to **10 visits** per plan year† | | No | **$50 Copay** | **$50 Copay** |
| **Second Surgical Opinion** (Telephonic/Online Service) | | No | **$0 Copay** | **Not Applicable** |
| **Home Health Care** Limited to **5 visits** per plan year† | | Yes | **$25 Copay** | **$25 Copay** |
| **Treatment for Chemical Abuse & Dependency** | **Inpatient or Partial Day** (Limited to **5 days** per plan year)† | Yes | **$250 Copay per day** (Subject to Reference Based Pricing) | |
| | **Outpatient** (Limited to **8 visits** per plan year)† | No | **$25 Copay** | **$25 Copay** |
| **Rehabilitation/Habilitation Services** Combined limit of **8 visits** per plan year with physical, speech, and occupational therapies† | | Yes | **$50 Copay** | **$50 Copay** |
| **Emergency Medical Transportation**[6] By land only; limited to **1 transport** per plan year† | | No | **$250 Copay** (Subject to Reference Based Pricing) | |
| ***VISION BENEFITS***[7] | | | | |
| **In-Office Comprehensive Vision Exams** | | No | **$0 Copay** | Up to $35 benefit |
| **Eyewear Allowance** for frames or contacts | | No | **$150** every two (2) years | |

| ***PHARMACY BENEFITS***[8] | Retail *(30-day supply)* | Retail *(90-day supply)* | Mail Order *(90-day supply)* |
|---|---|---|---|
| **HBAScripts℠ (Subject to Formulary[9])** | **Member Pays** | | |
| Acute *(up to 30-day supply)* | **$0 Copay** | **N/A** | **N/A** |
| Chronic *(limited to two (2) 30-day fills, then 90-day fills required)* | **$0 Copay** | **$0 Copay** | **$0 Copay** |
| Insulin *(ReliOn™ Novolin 70/30 and NovoLog®)* | **Vials $10 / Pens $25** | **Vials $20 / Pens $50** | **Vials $20 / Pens $50** |
| **All Other Prescriptions (Subject to Formulary)** | | | |
| Tier 1 - ACA Preventive Drugs | **$0 Copay** | **$0 Copay** | **$0 Copay** |
| Tier 2 - Generic *(non-preventive)* | **20% Coinsurance** | **N/A** | **20% Coinsurance** |
| Tier 3 - Preferred Brand | **20% Coinsurance** | **N/A** | **20% Coinsurance** |
| Tier 4 - Non-Preferred Brand | **Not Covered** | **Not Covered** | **Not Covered** |
| Tier 5 - Specialty | **Not Covered** | **Not Covered** | **Not Covered** |

[1] Deductible and Out-of-Pocket amounts are combined across In-Network and Out-of-Network Providers.
[2] In addition to the copay listed, the member will also be responsible for any billed charges in excess of the 85th Percentile of the Usual, Customary, and Reasonable (UCR) charge.
[3] If prior authorization is not obtained for services requiring a prior authorization, the benefits payable by the Plan for such services will be reduced to 50% of the allowed charges after the copay.
[4] The plan will only reimburse buy and bill drugs up to the lessor of the allowed amount or network rate or the amount that the Third-Party Administrator or Pharmacy Benefits Manager could source the drug for.
[5] Prior authorization is required for any service or procedure over $1,000.
[6] If the Plan covers Emergency Room and/or Ambulance Services, those services will be covered if they are provided by an Out-of-Network provider and will be reimbursed at the In-Network level of benefits
[7] Vision benefits are provided outside of the Group Health Plan through a service contract and are subject to provisions and limitations in the HBAVision℠ Summary of Benefits.
[8] To be eligible for pharmacy benefits covered prescriptions must be dispensed through participating pharmacies and mail order channels.
[9] The HBAScripts℠ formulary consists of acute and chronic generic drugs that represent over 90% of the most commonly-dispensed prescriptions in the U.S., as well as specific (non-insulin) diabetic supplies available at no cost to covered participants.
† Visit, service and Out-of-Pocket limits accumulate during a calendar year and reset on January 1st each year.

MVP BRONZE PLUS™_POE SUMMARY_JUL2023

## Exclusions

The following exclusions apply to the benefits offered under this Plan:

1. Office visits, physical examinations, immunizations, and tests when required solely for the following:
   a. Sports,
   b. Camp,
   c. Employment,
   d. Travel,
   e. Insurance,
   f. Marriage,
   g. Legal proceedings
2. Routine foot care for treatment of the following:
   a. Flat feet,
   b. Corns,
   c. Bunions,
   d. Calluses,
   e. Toenails,
   f. Fallen arches,
   g. Weak feet,
   h. Chronic foot strain
3. Dental Procedures
4. Any other medical service, treatment, or procedure not covered under this Schedule of Benefits
5. Any other expense, bill, charge, or monetary obligation not covered under this Plan, including but not limited to all non-medical service expenses, bills, charges, and monetary obligations. Unless the medical service is explicitly provided by an appendix or otherwise explicitly provided in the Plan Document, this Plan does not cover the medical service or any related expense, bill, charge, or monetary obligation to the medical service
6. Claims unrelated to treatment of medical care or treatment
7. Cosmetic surgery unless authorized as medically necessary. Such authorization is based on the following causes for cosmetic surgery: accidental injury, correction or congenital deformity within six (6) years of birth, or as a treatment of a diseased condition
8. Any treatment with respect to treatment of teeth or periodontium, any treatment of periodontal or periapical disease involving teeth surrounding tissue, or structure. Exceptions to this exclusion include only malignant tumors or benefits specifically noted in the schedule of benefits to the Plan Document
9. Any claim related to an injury arising out of or in the course of any employment for wage or profit that would be covered by other coverage for which the member is eligible
10. Claims for which a participant is not legally required to pay or claims which would not have been made if this Plan had not existed
11. Claims for services which are not medically necessary as determined by this Plan or the excess of any claim above reasonable and customary rates when a PPO network has not been contracted
12. Charges which are or could be reimbursed by any public health program irrespective of whether such coverage has been elected by a participant
13. Claims due to an act of war, declared or undeclared, not including acts of terrorism
14. Claims for eyeglasses, contacts, hearing aids (or examinations for the fitting thereof) or radial keratotomy
15. Abortion services
16. Travel, unless specifically provided in the schedule of benefits
17. Custodial care for primarily personal, not medical, needs provided by persons with no special medical training or skill
18. Claims from any provider other than a healthcare provider as defined in the Plan Document unless explicitly permitted in the schedule of benefits
19. Investigatory or experimental treatment, services, or supplies unless specifically covered under Approved Clinical Trials
20. Services or supplies which are primarily educational
21. Claims due to attempted suicide or intentionally self-inflicted injury while sane or insane, unless the claim results from a medical condition such as depression
22. Claims resulting from, or which arise due to the attempt or commission of, an illegal act. Claims by victims of domestic violence will not be subject to this exclusion
23. Claims with respect to any treatment or procedure to change one's physical anatomy to those of the opposite sex and any other treatment or study related to sex change
24. Claims from a medical service provider who is related by blood, marriage, or legal adoption to a participant
25. Any claims for fertility or infertility treatment
26. Claims for weight control, weight reduction, or surgical treatment for obesity or morbid obesity, unless explicitly provided in the schedule of benefits
27. Claims for disability resulting from reversal of sterilization
28. Claims for the completion of forms, or failure to keep scheduled appointments
29. Recreational or diversional therapy
30. Personal hygiene or convenience items, including but not limited to air conditioning, humidifiers, hot tubs, whirlpools, or exercise equipment, irrespective of the recommendations or prescriptions of a medical service provider
31. Claims due to participation in a dangerous activity, including but not limited to sky-diving, motorcycle or automobile racing, bungee jumping, rock climbing, rappelling, or hang gliding
32. Claims that arise primarily due to medical tourism
33. Supportive devices of the foot
34. Treatments for sexual dysfunction
35. Aquatic or massage therapy
36. Biofeedback training
37. Skilled nursing facilities
38. Durable medical equipment and prosthetics
39. Hospice care, private duty nursing, or long-term care
40. Residential facility – for charges from a residential halfway house or home, or any facility which is not a health care institution licensed for the primary purpose of treatment of an illness or injury
41. Claims for temporomandibular joint syndrome
42. Claims for biotech prescriptions
43. Genetic testing unless explicitly covered in the schedule of benefits
44. Human Cell, Tissue and Organ transplantation
45. Claims for cosmetic surgery, not related to mastectomy reconstruction to produce a symmetrical appearance or prosthesis, or physical complications which result from such procedures
46. Radiation and chemotherapy
47. Dialysis
48. Acupuncture
49. Alternative medicine/homeopathy
50. Pediatric dental and vision
51. Neonatal intensive care (NICU)
52. Routine eye care (Adult)
53. Inpatient facility claims for surgery after the inpatient hospital day limit per plan year has been exhausted
54. Any claim arising from service received outside of the United States and its territories of American Samoa, Guam, the Northern Mariana Islands, Puerto Rico and the U.S. Virgin Islands
55. All maternity coverage for dependent children, including adult children up to age 26, and all coverage for the resultant newborn child. However, ACA mandated Preventive Health Services are not excluded
56. This coverage does not include benefits for grandchildren (unless they are under your legal guardianship)
57. Use of emergency room for non-emergency care
58. Emerging gene and cell therapies
59. Diagnosis and treatment of sleep apnea
60. CAR-T therapies

The purpose of this list of exclusions is solely to provide additional clarity regarding treatments, procedures, products, services, or any other items which are not covered under this plan. Accordingly, no exclusion shall be interpreted by negative implication, or otherwise, as evidence of the existence of coverage under this plan.

# Minimum Value Plan - MVP GOLD™

## Limited Day Medical℠ Plan

The MVP GOLD™ Plan covers Preventive and Wellness Services, Inpatient and Outpatient Hospital, Physician Services and Pharmacy Benefits. Rather than an annual deductible, the plan requires copays for various covered services. Some services are subject to limits† on the number of days or visits for which benefits are payable.

| Deductible[1] | Participating Providers (In-Network) | Non-Participating Providers (Out-of-Network)[2] |
|---|---|---|
| Individual | $0 | |
| Family | $0 | |

| Out-of-Pocket Maximum[1] | Participating Providers (In-Network) | Non-Participating Providers (Out-of-Network)[2] |
|---|---|---|
| Individual | $5,000 | |
| Family | $10,000 | |

The following table represents the medical services currently covered under the MVP GOLD™ Plan, as well as the permitted interval and any requirements of such medical services. This plan does not utilize a network for any facilities. All services performed in a medical facility (for example, a hospital as opposed to a primary care physician's office) will be subject to Reference Based Pricing (RBP) reimbursements based on a multiple of the Medicare Reimbursement Rate.

| Plan Provisions | Prior Auth Required[3] | Participating Providers (In-Network) | Non-Participating Providers (Out-of-Network)[2] |
|---|---|---|---|
| | | Member Pays | |
| ***PHYSICIAN SERVICES*** | | | |
| **Primary Care Office Visit**<br>Limited to **12 visits** per plan year† | No | **$15 Copay** | **$15 Copay** |
| **Specialist Office Visit**<br>Limited to **12 visits** per plan year† | No | **$25 Copay** | **$25 Copay** |
| **Other Physician Services Performed in the Office**[4]<br>(Limited to Primary Care/Specialist visits per plan year) | Yes[5] | **$25 Copay** | **$25 Copay** |
| **Urgent Care**<br>Limited to **3 visits** per plan year† | No | **$35 Copay** | **$35 Copay** |
| **Telemedicine Services** | No | **$0 Copay** | **Not Applicable** |
| ***PREVENTIVE & WELLNESS SERVICES*** | | | |
| (See Schedule of Preventive Health Services) – **Non-Hospital Based** | No | **$0 Copay** | **$0 Copay** |
| (See Schedule of Preventive Health Services) – **Hospital Based** | No | **Not Covered** | **Not Covered** |
| ***HOSPITAL/FACILITY SERVICES*** ***(Subject to Reference Based Pricing)*** | | | |
| **Inpatient Hospitalization**<br>Limited to **10 days** per plan year† | Yes | **$350 Copay per admission**<br>(Subject to Reference Based Pricing) | |
| **Inpatient Visits - Physician**<br>Limited to **10 visits** per plan year† | No | Included in Inpatient Hospitalization Copay | |
| **Inpatient Surgery - Physician Charges**<br>Second surgical opinion may be required; Limited to **4 surgeries** per plan year† | Yes | Included in Inpatient Hospitalization Copay | |
| **Outpatient Hospital or Freestanding Facility Services and Surgery**<br>Limited to **2 visit** per plan year† | Yes | **$350 Copay**<br>(Subject to Reference Based Pricing) | |
| **Anesthesia**<br>Limited to **4 inpatient** and **2 outpatient** anesthetic procedures per plan year† | No | Included in Inpatient Hospitalization or Outpatient Hospital or Freestanding Facility Services and Surgery Copay | |
| **Emergency Room Services**<br>Limited to **2 visit** per plan year† | No | **$350 Copay**<br>(Subject to Reference Based Pricing) | |
| ***PREGNANCY BENEFITS*** | | | |
| **Professional Services** | No | **$350 Copay** | **$350 Copay** |
| **Maternity/Childbirth/Delivery**<br>(Considered Inpatient Hospital Stay) | No | **$350 Copay per admission**<br>(Subject to Reference Based Pricing) | |

This summary is intended as an overview of plan benefits. In the event of a discrepancy between this summary and the governing plan documents, the Summary Plan Description (SPD) and Schedule of Benefits (SOB) shall prevail.

**MVP GOLD™_POE SUMMARY_JUL2023**

| Plan Provisions | | Prior Auth Required[3] | Participating Providers (In-Network) | Non-Participating Providers (Out-of-Network)[2] |
|---|---|---|---|---|
| | | | Member Pays | |
| ***OUTPATIENT: DIAGNOSTIC SERVICES*** | | | | |
| **Laboratory Service** | **Non-Hospital Based** (Combined limit of **4 visits** per plan year with Radiology)† | No | **$50 Copay** | **$50 Copay** |
| | **Hospital Based)** | No | **Not Covered** | **Not Covered** |
| **Radiology** | **Non-Hospital Based** (Combined limit of **4 visits** per plan year with Laboratory Service)† | No | **$50 Copay** | **$50 Copay** |
| | **Hospital Based** | No | **Not Covered** | **Not Covered** |
| **CT/MRI/MRA/PET Scan** Limited to **3** per plan year† | **Non-Hospital Based** | Yes | **$350 Copay** (Subject to Reference Based Pricing) | |
| | **Hospital Based** | No | **Not Covered** | **Not Covered** |
| ***OTHER SERVICES*** | | | | |
| **Allergy Services** (Included in Primary Care Office Visit or Specialist Office Visit limits. The copay applies to the administration of the allergy service and is separate from the copay for the office visit) | | No | **$25 Copay** | **$25 Copay** |
| **Chiropractic Services** Limited to **10 visits** per plan year† | | No | **$25 Copay** | **$25 Copay** |
| **Second Surgical Opinion** (Telephonic/Online Service) | | No | **$0 Copay** | **Not Applicable** |
| **Home Health Care** Limited to **20 visits** per plan year† | | Yes | **$25 Copay** | **$25 Copay** |
| **Treatment for Chemical Abuse & Dependency** | **Inpatient or Partial Day** (Limited to **10 days** per plan year)† | Yes | **$250 Copay per day** (Subject to Reference Based Pricing) | |
| | **Outpatient** (Limited to **12 visits** per plan year)† | No | **$25 Copay** | **$25 Copay** |
| **Rehabilitation/Habilitation Services** Combined limit of **12 visits** per plan year with physical, speech, and occupational therapies† | | Yes | **$50 Copay** | **$50 Copay** |
| **Emergency Medical Transportation**[6] By land only; limited to **2 transports** per plan year† | | No | **$250 Copay** (Subject to Reference Based Pricing) | |
| ***VISION BENEFITS***[7] | | | | |
| **In-Office Comprehensive Vision Exams** | | No | **$0 Copay** | Up to $35 benefit |
| **Eyewear Allowance** for frames or contacts | | No | **$150** every two (2) years | |

| ***PHARMACY BENEFITS***[8] | Retail *(30-day supply)* | Retail *(90-day supply)* | Mail Order *(90-day supply)* |
|---|---|---|---|
| **HBAScripts℠ (Subject to Formulary[9])** | Member Pays | | |
| Acute *(up to 30-day supply)* | **$0 Copay** | **N/A** | **N/A** |
| Chronic *(limited to two (2) 30-day fills, then 90-day fills required)* | **$0 Copay** | **$0 Copay** | **$0 Copay** |
| Insulin *(ReliOn™ Novolin 70/30 and NovoLog®)* | **Vials $10 / Pens $25** | **Vials $20 / Pens $50** | **Vials $20 / Pens $50** |
| **All Other Prescriptions (Subject to Formulary)** | | | |
| Tier 1 - ACA Preventive Drugs | **$0 Copay** | **$0 Copay** | **$0 Copay** |
| Tier 2 - Generic *(non-preventive)* | **20% Coinsurance** | **N/A** | **20% Coinsurance** |
| Tier 3 - Preferred Brand | **20% Coinsurance** | **N/A** | **20% Coinsurance** |
| Tier 4 - Non-Preferred Brand | **Not Covered** | **Not Covered** | **Not Covered** |
| Tier 5 - Specialty | **Not Covered** | **Not Covered** | **Not Covered** |

[1] Deductible and Out-of-Pocket amounts are combined across In-Network and Out-of-Network Providers.
[2] In addition to the copay listed, the member will also be responsible for any billed charges in excess of the 85th Percentile of the Usual, Customary, and Reasonable (UCR) charge.
[3] If prior authorization is not obtained for services requiring a prior authorization, the benefits payable by the Plan for such services will be reduced to 50% of the allowed charges after the copay.
[4] The plan will only reimburse buy and bill drugs up to the lessor of the allowed amount or network rate or the amount that the Third-Party Administrator or Pharmacy Benefits Manager could source the drug for.
[5] Prior authorization is required for any service or procedure over $1,000.
[6] If the Plan covers Emergency Room and/or Ambulance Services, those services will be covered if they are provided by an Out-of-Network provider and will be reimbursed at the In-Network level of benefits
[7] Vision benefits are provided outside of the Group Health Plan through a service contract and are subject to provisions and limitations in the HBAVision℠ Summary of Benefits.
[8] To be eligible for pharmacy benefits covered prescriptions must be dispensed through participating pharmacies and mail order channels.
[9] The HBAScripts℠ formulary consists of acute and chronic generic drugs that represent over 90% of the most commonly-dispensed prescriptions in the U.S., as well as specific (non-insulin) diabetic supplies available at no cost to covered participants.
† Visit, service and Out-of-Pocket limits accumulate during a calendar year and reset on January 1st each year.

MVP GOLD™_POE SUMMARY_JUL2023

## Exclusions

The following exclusions apply to the benefits offered under this Plan:

1. Office visits, physical examinations, immunizations, and tests when required solely for the following:
   a. Sports,
   b. Camp,
   c. Employment,
   d. Travel,
   e. Insurance,
   f. Marriage,
   g. Legal proceedings
2. Routine foot care for treatment of the following:
   a. Flat feet,
   b. Corns,
   c. Bunions,
   d. Calluses,
   e. Toenails,
   f. Fallen arches,
   g. Weak feet,
   h. Chronic foot strain
3. Dental Procedures
4. Any other medical service, treatment, or procedure not covered under this Schedule of Benefits
5. Any other expense, bill, charge, or monetary obligation not covered under this Plan, including but not limited to all non-medical service expenses, bills, charges, and monetary obligations. Unless the medical service is explicitly provided by an appendix or otherwise explicitly provided in the Plan Document, this Plan does not cover the medical service or any related expense, bill, charge, or monetary obligation to the medical service
6. Claims unrelated to treatment of medical care or treatment
7. Cosmetic surgery unless authorized as medically necessary. Such authorization is based on the following causes for cosmetic surgery: accidental injury, correction or congenital deformity within six (6) years of birth, or as a treatment of a diseased condition
8. Any treatment with respect to treatment of teeth or periodontium, any treatment of periodontal or periapical disease involving teeth surrounding tissue, or structure. Exceptions to this exclusion include only malignant tumors or benefits specifically noted in the schedule of benefits to the Plan Document
9. Any claim related to an injury arising out of or in the course of any employment for wage or profit that would be covered by other coverage for which the member is eligible
10. Claims for which a participant is not legally required to pay or claims which would not have been made if this Plan had not existed
11. Claims for services which are not medically necessary as determined by this Plan or the excess of any claim above reasonable and customary rates when a PPO network has not been contracted
12. Charges which are or could be reimbursed by any public health program irrespective of whether such coverage has been elected by a participant
13. Claims due to an act of war, declared or undeclared, not including acts of terrorism
14. Claims for eyeglasses, contacts, hearing aids (or examinations for the fitting thereof) or radial keratotomy
15. Elective, voluntary abortions, except in the case of rape, incest, or congenital deformities of the fetus as determined through pre-natal testing, or when the life of the mother would be threatened if the fetus were carried to term
16. Travel, unless specifically provided in the schedule of benefits
17. Custodial care for primarily personal, not medical, needs provided by persons with no special medical training or skill
18. Claims from any provider other than a healthcare provider as defined in the Plan Document unless explicitly permitted in the schedule of benefits
19. Investigatory or experimental treatment, services, or supplies unless specifically covered under Approved Clinical Trials
20. Services or supplies which are primarily educational
21. Claims due to attempted suicide or intentionally self-inflicted injury while sane or insane, unless the claim results from a medical condition such as depression
22. Claims resulting from, or which arise due to the attempt or commission of, an illegal act. Claims by victims of domestic violence will not be subject to this exclusion
23. Claims with respect to any treatment or procedure to change one's physical anatomy to those of the opposite sex and any other treatment or study related to sex change
24. Claims from a medical service provider who is related by blood, marriage, or legal adoption to a participant
25. Any claims for fertility or infertility treatment
26. Claims for weight control, weight reduction, or surgical treatment for obesity or morbid obesity, unless explicitly provided in the schedule of benefits
27. Claims for disability resulting from reversal of sterilization
28. Claims for the completion of forms, or failure to keep scheduled appointments
29. Recreational or diversional therapy
30. Personal hygiene or convenience items, including but not limited to air conditioning, humidifiers, hot tubs, whirlpools, or exercise equipment, irrespective of the recommendations or prescriptions of a medical service provider
31. Claims due to participation in a dangerous activity, including but not limited to sky-diving, motorcycle or automobile racing, bungee jumping, rock climbing, rappelling, or hang gliding
32. Claims that arise primarily due to medical tourism
33. Supportive devices of the foot
34. Treatments for sexual dysfunction
35. Aquatic or massage therapy
36. Biofeedback training
37. Skilled nursing facilities
38. Durable medical equipment and prosthetics
39. Hospice care, private duty nursing, or long-term care
40. Residential facility – for charges from a residential halfway house or home, or any facility which is not a health care institution licensed for the primary purpose of treatment of an illness or injury
41. Claims for temporomandibular joint syndrome
42. Claims for biotech prescriptions
43. Genetic testing unless explicitly covered in the schedule of benefits
44. Human Cell, Tissue and Organ transplantation
45. Claims for cosmetic surgery, not related to mastectomy reconstruction to produce a symmetrical appearance or prosthesis, or physical complications which result from such procedures
46. Radiation and chemotherapy
47. Dialysis
48. Acupuncture
49. Alternative medicine/homeopathy
50. Pediatric dental and vision
51. Routine eye care (Adult)
52. Inpatient facility claims for surgery after the inpatient hospital day limit per plan year has been exhausted
53. Any claim arising from service received outside of the United States and its territories of American Samoa, Guam, the Northern Mariana Islands, Puerto Rico and the U.S. Virgin Islands
54. All maternity coverage for dependent children, including adult children up to age 26, and all coverage for the resultant newborn child. However, ACA mandated Preventive Health Services are not excluded
55. This coverage does not include benefits for grandchildren (unless they are under your legal guardianship)
56. Use of emergency room for non-emergency care
57. Emerging gene and cell therapies
58. Diagnosis and treatment for sleep apnea
59. CAR-T therapies

The purpose of this list of exclusions is solely to provide additional clarity regarding treatments, procedures, products, services, or any other items which are not covered under this plan. Accordingly, no exclusion shall be interpreted by negative implication, or otherwise, as evidence of the existence of coverage under this plan.

Medical

| Plan | Coverage Tier | Employee Bi-Weekly Contribution | Employee Weekly Contribution |
|---|---|---|---|
| MEC 1 | EE Only | $40.15 | $20.08 |
| | EE+Sp | $67.63 | $33.81 |
| | EE+Ch | $62.03 | $31.01 |
| | Family | $79.96 | $39.98 |
| MEC 2 | EE Only | $55.38 | $27.69 |
| | EE+Sp | $89.26 | $44.63 |
| | EE+Ch | $78.47 | $39.24 |
| | Family | $111.64 | $55.82 |
| MVP Bronze Plus | EE Only | $83.08 | $41.54 |
| | EE+Sp | $245.69 | $122.84 |
| | EE+Ch | $199.29 | $99.65 |
| | Family | $359.59 | $179.79 |
| MVP Gold | EE Only | $110.77 | $55.38 |
| | EE+Sp | $286.03 | $143.02 |
| | EE+Ch | $226.41 | $113.21 |
| | Family | $402.29 | $201.15 |

# Dental

We partner with GIS Careington to offer you and your family a dental discount program. GIS Benefits and Careington are making access to dental care simple for you and your employees.

**Affordable**: Exclusive, wholesale discounted rates available only through GIS Benefits

**Access**: Choice of providers from Careington's Maximum Care Discount network of 200,000+ practice locations

**Ease**: Since this plan is not insurance, there are no claim forms to submit. Discounts are applied when employees visit the dentist.

**Simplicity**: No minimum participation requirements

**Convenience**: Available as a stand-alone plan or can be paired with a dental insurance plan to be used on non-covered services, cosmetic procedures and after annual maximums have been met.

| Description | *Regular Cost | **Plan Cost | Savings $ | Savings % |
|---|---|---|---|---|
| Adult Cleaning | $132 | $63 | $69 | 52% |
| Child Cleaning | $94 | $46 | $48 | 51% |
| Routine Checkup | $78 | $31 | $47 | 60% |
| Extensive Oral Exam | $136 | $54 | $82 | 60% |
| Four Bitewing X-rays | $89 | $41 | $48 | 54% |
| Composite (White) Filling | $210 | $99 | $111 | 53% |
| Crown (Porcelain fused to noble metal) | $1,498 | $786 | $712 | 48% |
| Complete Upper Denture | $2,152 | $1,017 | $1,135 | 53% |
| Moral Root Canal | $1,459 | $771 | $688 | 47% |
| Extraction (single tooth) | $255 | $105 | $150 | 59% |

* Regular cost is based on the average 80th percentile usual and customary rates as detailed in the 2018 FAIR Health Report in the Los Angeles, Orlando, Chicago, and NYC metropolitan areas.

**These fees represent the average of the assigned DN14 fees in the Los Angeles, Orlando, Chicago, and NYC metropolitan areas. Prices subject to change.

# Dental Premiums

| Coverage Tier | Employee Bi-Weekly Contribution | Employee Weekly Contribution |
|---|---|---|
| EE Only | $3.00 | $1.50 |
| EE + 1 | $5.08 | $2.54 |
| Family | $6.46 | $3.23 |

## Finding In-Network Providers

To find a list of participating dental providers, visit **www.POS.SolutionsSimplified.com**.

# Vision

We partner with Superior Vision to offer you and your family members vision insurance. Visit **www.superiorvision.com** to find in-network providers and access a variety of online tools and programs.

## Finding In-Network Providers

Remember to visit in-network providers to receive the largest possible discount.

To find in-network providers, visit **www.superiorvision.com** or call **800.507.3800**.

| | In-Network | Out-of-Network |
|---|---|---|
| Copay | | |
| Exam | $20 | Up to $34 retail |
| Materials | $20 | See lens and frame amounts below |
| Lenses | | |
| Single | Covered in full after materials copay | Up to $28 retail |
| Bifocal | Covered in full after materials copay | Up to $42 retail |
| Trifocal | Covered in full after materials copay | Up to $58 retail |
| Frames | | |
| | $100 retail allowance | Up to $48 retail |
| Contacts | | |
| | $100 retail allowance | Up to $80 retail |
| Frequency | | |
| Exam | 12 months | 12 months |
| Lenses | 12 months | 12 months |
| Contacts (in lieu of glasses) | 12 months | 12 months |
| Frames | 24 months | 24 months |

# Vision Premiums

| Coverage Tier | Employee Bi-Weekly Contribution | Employee Weekly Contribution |
|---|---|---|
| EE Only | $2.47 | $1.23 |
| EE + 1 | $4.79 | $2.40 |
| Family | $7.03 | $3.52 |

# Voluntary Life and AD&D Insurance

Voluntary Life and AD&D insurance is provided through Mutual of Omaha.

## Employee Voluntary Life and AD&D Insurance

You’re eligible to purchase additional life and AD&D insurance in increments of 5 times your annual salary with a maximum benefit of $250,000. The guaranteed issue amount is $100,000. Your voluntary AD&D insurance amount will match your voluntary life insurance amount.

## Spouse and Dependent Voluntary Life and AD&D Insurance

If you elect voluntary life and AD&D coverage for yourself, you can also elect voluntary life and AD&D coverage for your spouse and dependent children.

| Voluntary Term Life Insurance | | | |
|---|---|---|---|
| | Minimum | Guaranteed Issue | Maximum |
| Employee | $10,000 | 5 times annual salary, up to $100,000 | $250,000, in increments of $10,000, but no more than 5 times annual salary |
| Spouse | $5,000 | 100% of employee’s benefit, up to $50,000 | 50% of employee's benefit, up to $50,000 |
| Children | $2,000 | 100% of employee's benefit | 50% of employee's benefit, up to $10,000 |

# Spouse and Dependent Voluntary Life and AD&D Insurance Rates

| Employee Premium Table (12 Payroll Deductions Per Year) | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Age | $10,000 | $20,000 | $30,000 | $40,000 | $50,000 | $60,000 | $70,000 | $80,000 | $90,000 | $100,000 |
| 0-29 | $1.30 | $2.60 | $3.90 | $5.20 | $6.50 | $7.80 | $9.10 | $10.40 | $11.70 | $13.00 |
| 30-34 | $1.43 | $2.86 | $4.29 | $5.72 | $7.15 | $8.58 | $10.01 | $11.44 | $12.87 | $14.30 |
| 35-39 | $1.68 | $3.36 | $5.04 | $6.72 | $8.40 | $10.08 | $11.76 | $13.44 | $15.12 | $16.80 |
| 40-44 | $2.46 | $4.92 | $7.38 | $9.84 | $12.30 | $14.76 | $17.22 | $19.68 | $22.14 | $24.60 |
| 45-49 | $4.01 | $8.02 | $12.03 | $16.04 | $20.05 | $24.06 | $28.07 | $32.08 | $36.09 | $40.10 |
| 50-54 | $6.48 | $12.96 | $19.44 | $25.92 | $32.40 | $38.88 | $45.36 | $51.84 | $58.32 | $64.80 |
| 55-59 | $9.97 | $19.94 | $29.91 | $39.88 | $49.85 | $59.82 | $69.79 | $79.76 | $89.73 | $99.70 |
| 60-64 | $15.41 | $30.82 | $46.23 | $61.64 | $77.05 | $92.46 | $107.87 | $123.28 | $138.69 | $154.10 |
| 65-69 | $27.45 | $54.90 | $82.35 | $109.80 | $137.25 | $164.70 | $192.15 | $219.60 | $247.05 | $274.50 |
| 70-74 | $48.94 | $97.88 | $146.82 | $195.76 | $244.70 | $293.64 | $342.58 | $391.52 | $440.46 | $489.40 |
| 75-79 | $80.54 | $161.08 | $241.62 | $322.16 | $402.70 | $483.24 | $563.78 | $644.32 | $724.86 | $805.40 |
| 80+ | $162.89 | $325.78 | $488.67 | $651.56 | $814.45 | $977.34 | $1,140.23 | $1,303.12 | $1,466.01 | $1,628.90 |

Follow the method described above to select a benefit amount and calculate premiums for optional dependent spouse and/or child(ren) coverage. Your spouse's rate is based on your spouse's age, so find your spouse's age bracket in the far left column of the Spouse Premium Table. Your spouse's premium amount is found in the box where the row (the age) and the column (benefit amount) intersect. Your spouse's benefit amount must be in an increment of $5,000. Refer to the Coverage Guidelines section for minimums and maximums, if needed.

| Spouse Premium Table (12 Payroll Deductions Per Year) | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Age | $5,000 | $10,000 | $15,000 | $20,000 | $25,000 | $30,000 | $35,000 | $40,000 | $45,000 | $50,000 |
| 0-29 | $0.65 | $1.30 | $1.95 | $2.60 | $3.25 | $3.90 | $4.55 | $5.20 | $5.85 | $6.50 |
| 30-34 | $0.72 | $1.43 | $2.15 | $2.86 | $3.58 | $4.29 | $5.01 | $5.72 | $6.44 | $7.15 |
| 35-39 | $0.84 | $1.68 | $2.52 | $3.36 | $4.20 | $5.04 | $5.88 | $6.72 | $7.56 | $8.40 |
| 40-44 | $1.23 | $2.46 | $3.69 | $4.92 | $6.15 | $7.38 | $8.61 | $9.84 | $11.07 | $12.30 |
| 45-49 | $2.01 | $4.01 | $6.02 | $8.02 | $10.03 | $12.03 | $14.04 | $16.04 | $18.05 | $20.05 |
| 50-54 | $3.24 | $6.48 | $9.72 | $12.96 | $16.20 | $19.44 | $22.68 | $25.92 | $29.16 | $32.40 |
| 55-59 | $4.99 | $9.97 | $14.96 | $19.94 | $24.93 | $29.91 | $34.90 | $39.88 | $44.87 | $49.85 |
| 60-64 | $7.71 | $15.41 | $23.12 | $30.82 | $38.53 | $46.23 | $53.94 | $61.64 | $69.35 | $77.05 |
| 65-69 | $13.73 | $27.45 | $41.18 | $54.90 | $68.63 | $82.35 | $96.08 | $109.80 | $123.53 | $137.25 |

| Per Child Premium Table (12 Payroll Deductions Per Year)* | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| $2,000 | $3,000 | $4,000 | $5,000 | $6,000 | $7,000 | $8,000 | $9,000 | $10,000 |
| $0.24 | $0.36 | $0.48 | $0.60 | $0.72 | $0.84 | $0.96 | $1.08 | $1.20 |

* You pay the same premium amount for each child, so find the benefit amount "Per Child" and multiply the cost by the number of dependent children you have to find the total premium amount.

# Amount of Coverage Offered

The amount of coverage for a Dependent spouse cannot exceed 100% of the employee's Group Voluntary Term Life Amount and dependent child coverage amounts cannot exceed the spouse's coverage amount. Coverage for Spouse and child(ren) must be from same option. Both are subject to state limitation.

Any coverage for a spouse or children cannot become effective before the employee's coverage is approved. If a dependent is confined in any medical facility, rehabilitation center, convalescent care facility, nursing home or correctional facility on the date an employee's coverage is approved, that dependent coverage will not become effective until the dependent is discharged from the facility and contract requirements are satisfied.

Dependent life insurance coverage will follow the same reduction schedule as the employee's coverage. Reducing age will be based on employee's age. Dependent spouse coverage is subject to termination as outlined in the certificate of coverage.

# Dependent Voluntary Term Life and AD&D Insurance Premium Rates

## Spouse

Monthly Premium Rates per $1,000 of Coverage Based on Employee Age/Spouse Volume for Dependent Voluntary Term Life and AD&D Insurance:

| Age Category | Monthly Premium Rates per $1,000 of Coverage | Age Category | Monthly Premium Rates per $1,000 of Coverage |
|---|---|---|---|
| 0-19 | $0.076 | 50-54 | $0.524 |
| 20-24 | $0.076 | 55-59 | $0.771 |
| 25-29 | $0.076 | 60-64 | $0.912 |
| 30-34 | $0.092 | 65-69 | $1.448 |
| 35-39 | $0.123 | 70-74 | $3.245 |
| 40-44 | $0.205 | 75+ | $3.245 |
| 45-49 | $0.326 | | |
| Voluntary AD&D for all ages | $0.036 | | |

An eligible employee's age will be determined as of the Policyholder's anniversary date. If the anniversary date and effective date are one in the same, the eligible employee's age will be determined as of the Policyholder's effective date of coverage.

## Child(ren)

Monthly Premium Rates Per Unit of Coverage for Dependent Voluntary Term Life and AD&D Insurance:

| Child(ren) Rate | Voluntary Dependent Life Monthly Premium Rate Per Unit of Coverage | Voluntary Dependent AD&D Monthly Premium Rate Per Unit of Coverage |
|---|---|---|
| Option 1 | $2.160 | $0.350 |

# Employee Assistance Program (EAP)

We partner with Mutual of Omaha to provide an Employee Assistance Program to help you and your family members find solutions and resources to tackle life's challenges. Mutual of Omaha's team of master's level EAP professionals are available 24/7/365 to provide you and your loved ones resources for assistance with personal and workplace issues.

Online are valuable resources and links for additional assistance, including current events, family and relationships, emotional well-being, financial wellness, substance abuse and addiction, legal assistance and work and career. All employees may use these free resources and services.

## Accessing the EAP

- Phone consultations: **800.316.2796**; unlimited calls, 24/7
- Online submission form for employee convenience at **www.mutualofomaha.com/eap**.

Strict standards of confidentiality are in place to protect your privacy. Treatment information is not shared with anyone without your written permission.

### Counseling and Work Life Services

- Stress management
- Work and home relationships
- Depression and grief
- Alcohol and substance abuse
- Child, adult, and elder care
- Legal and financial consultations
- Identity theft

# Voluntary Benefits

Voluntary benefits administered by Cigna provide an added layer of financial protection for you and your family. These benefits will help cover any extra out-of-pocket expenses if you suffer an unexpected serious illness or qualifying accident.

You'll be able to elect Accident, Critical Illness, and Hospital Indemnity Insurance when you enroll.

## Accident Insurance

Injuries occurring off the job can be protected with Cigna Accident Insurance. This plan is designed to pay cash directly to the insured if they are injured in an accident. This additional cash support can be used to help supplement any out-of-pocket expenses or for anything you deem fit. Payments are made tax free, to be used at your direction.

Wellness Benefit: $50 per insured employee or dependent per year for completing routine wellness screenings.

| Example of Some Covered Benefits | Benefit Amount |
|---|---|
| Hospital Admission | $1,500 |
| Daily Hospital Confinement (up to 365 days) | $300 |
| Daily ICU Confinement (up to 15 days) | $600 |
| Burns | Up to $10,000 |
| Ambulance (Ground/Air) | $500/$2,000 |
| Torn Knee Cartilage | $600 |

| Example: Broken Ankle | Benefit Amount |
|---|---|
| Emergency Room with X-Ray | $400 |
| Broken Ankle, Closed Reduction (no surgery) | $2,250 |
| Physical Therapy (6 sessions) | $450 |
| Physician Follow-Up (per visit) | $125 |
| Crutches | $175 |
| **Total Dollars Payable to Employee** | **$3,400** |

| Accident Plan | Bi-Weekly Deduction | Weekly Deduction |
|---|---|---|
| Employee | $3.78 | $1.89 |
| Employee + Spouse | $6.25 | $3.12 |
| Employee + Child(ren) | $7.68 | $3.84 |
| Family | $10.15 | $5.08 |

## Critical Illness Insurance

There can be a lot of expenses associated with a critical illness and a major medical plan may not cover them all. Critical Illness coverage with Cigna pays cash directly to you, the employee, upon a covered critical illness.

You have the option to select the tiered coverage amount of your choice with no pre-existing condition limitations. Employees can elect up to $30,000 in guaranteed issue coverage. Spouses and Child(ren) can elect 50% of the employee's coverage amount. An employee must elect coverage for dependents to elect coverage as well.

Wellness Benefit: $50 per insured Employee or covered dependent for completing routine wellness screenings.

Below is an example of how the Critical Illness Plan works.

Donna's life is turned upside down when she suffered a heart attack which was followed by a stroke only 6 months later. Not only did she miss work, but so did her husband to help her during her recovery. Their income took a hit and bills piled up. Donna had enrolled in Cigna's Critical Illness plan with a $30,000 Benefit Amount per diagnosis. She received a total benefit payment of $60,000 in her family's greatest time of need.

| Amount Paid to Donna | |
|---|---|
| Heart Attack | $30,000 |
| Stroke | $30,000 |
| **Total Direct Benefit Payment to Donna** | **$60,000** |

# Critical Illness Insurance

| Employee Paid Guaranteed Issue Level: $10,000 Dependents Receive 50% of the Employee Benefit Amount | | | | |
|---|---|---|---|---|
| Attained Age | Employee | Employee & Spouse | Employee & Child(ren) | Employee & Family |
| Bi-Weekly Rates | | | | |
| 0-24 | $1.46 | $2.32 | $2.46 | $3.32 |
| 25-29 | $1.65 | $2.60 | $2.64 | $3.60 |
| 30-34 | $1.97 | $3.09 | $2.96 | $4.08 |
| 35-39 | $2.77 | $4.28 | $3.76 | $5.28 |
| 40-44 | $3.60 | $5.59 | $4.60 | $6.59 |
| 45-49 | $4.46 | $6.98 | $5.35 | $7.87 |
| 50-54 | $6.66 | $10.46 | $7.66 | $11.46 |
| 55-59 | $9.28 | $14.73 | $10.28 | $15.72 |
| 60-64 | $11.89 | $18.73 | $12.88 | $19.73 |
| 65-69 | $15.39 | $24.45 | $16.38 | $25.45 |
| 70-74 | $20.19 | $31.95 | $21.19 | $32.95 |
| 75-79 | $26.45 | $41.68 | $27.44 | $42.67 |
| 80-84 | $30.84 | $49.15 | $31.83 | $50.14 |
| 85+ | $40.85 | $64.83 | $41.84 | $65.82 |
| Weekly Rates | | | | |
| 0-24 | $0.73 | $1.16 | $1.23 | $1.66 |
| 25-29 | $0.82 | $1.30 | $1.32 | $1.80 |
| 30-34 | $0.98 | $1.55 | $1.48 | $2.04 |
| 35-39 | $1.38 | $2.14 | $1.88 | $2.64 |
| 40-44 | $1.80 | $2.80 | $2.30 | $3.30 |
| 45-49 | $2.23 | $3.49 | $2.67 | $3.94 |
| 50-54 | $3.33 | $5.23 | $3.83 | $5.73 |
| 55-59 | $4.64 | $7.36 | $5.14 | $7.86 |
| 60-64 | $5.94 | $9.37 | $6.44 | $9.86 |
| 65-69 | $7.70 | $12.23 | $8.19 | $12.72 |
| 70-74 | $10.10 | $15.98 | $10.59 | $16.47 |
| 75-79 | $13.23 | $20.84 | $13.72 | $21.34 |
| 80-84 | $15.42 | $24.57 | $15.92 | $25.07 |
| 85+ | $20.43 | $32.41 | $20.92 | $32.91 |

| Employee Paid Guaranteed Issue Level: $20,000 Dependents Receive 50% of the Employee Benefit Amount | | | | |
|---|---|---|---|---|
| Attained Age | Employee | Employee & Spouse | Employee & Child(ren) | Employee & Family |
| Bi-Weekly Rates | | | | |
| 0-24 | $2.92 | $4.64 | $4.91 | $6.64 |
| 25-29 | $3.30 | $5.21 | $5.29 | $7.20 |
| 30-34 | $3.93 | $6.18 | $5.93 | $8.17 |
| 35-39 | $5.54 | $8.56 | $7.52 | $10.55 |
| 40-44 | $7.20 | $11.19 | $9.19 | $13.18 |
| 45-49 | $8.92 | $13.97 | $10.70 | $15.75 |
| 50-54 | $13.33 | $20.93 | $15.31 | $22.92 |
| 55-59 | $18.56 | $29.46 | $20.56 | $31.45 |
| 60-64 | $23.78 | $37.47 | $25.76 | $39.45 |
| 65-69 | $30.78 | $48.90 | $32.77 | $50.90 |
| 70-74 | $40.38 | $63.90 | $42.38 | $65.90 |
| 75-79 | $52.90 | $83.35 | $54.89 | $85.35 |
| 80-84 | $61.67 | $98.30 | $63.66 | $100.28 |
| 85+ | $81.70 | $129.66 | $83.69 | $131.65 |
| Weekly Rates | | | | |
| 0-24 | $1.46 | $2.32 | $2.46 | $3.32 |
| 25-29 | $1.65 | $2.60 | $2.64 | $3.60 |
| 30-34 | $1.97 | $3.09 | $2.96 | $4.08 |
| 35-39 | $2.77 | $4.28 | $3.76 | $5.28 |
| 40-44 | $3.60 | $5.59 | $4.60 | $6.59 |
| 45-49 | $4.46 | $6.98 | $5.35 | $7.87 |
| 50-54 | $6.66 | $10.46 | $7.66 | $11.46 |
| 55-59 | $9.28 | $14.73 | $10.28 | $15.72 |
| 60-64 | $11.89 | $18.73 | $12.88 | $19.73 |
| 65-69 | $15.39 | $24.45 | $16.38 | $25.45 |
| 70-74 | $20.19 | $31.95 | $21.19 | $32.95 |
| 75-79 | $26.45 | $41.68 | $27.44 | $42.67 |
| 80-84 | $30.84 | $49.15 | $31.83 | $50.14 |
| 85+ | $40.85 | $64.83 | $41.84 | $65.82 |

# Critical Illness Insurance

| Employee Paid Guaranteed Issue Level: $30,000<br>Dependents Receive 50% of the Employee Benefit Amount | | | | |
|---|---|---|---|---|
| Attained Age | Employee | Employee & Spouse | Employee & Child(ren) | Employee & Family |
| Bi-Weekly Rates | | | | |
| 0-24 | $4.38 | $6.96 | $7.37 | $9.96 |
| 25-29 | $4.94 | $7.81 | $7.93 | $10.80 |
| 30-34 | $5.90 | $9.28 | $8.89 | $12.25 |
| 35-39 | $8.31 | $12.84 | $11.28 | $15.83 |
| 40-44 | $10.80 | $16.78 | $13.79 | $19.77 |
| 45-49 | $13.38 | $20.95 | $16.05 | $23.62 |
| 50-54 | $19.99 | $31.39 | $22.97 | $34.38 |
| 55-59 | $27.84 | $44.18 | $30.84 | $47.17 |
| 60-64 | $35.67 | $56.20 | $38.64 | $59.18 |
| 65-69 | $46.18 | $73.36 | $49.15 | $76.35 |
| 70-74 | $60.58 | $95.86 | $63.57 | $98.85 |
| 75-79 | $79.35 | $125.03 | $82.33 | $128.02 |
| 80-84 | $92.51 | $147.45 | $95.50 | $150.42 |
| 85+ | $122.55 | $194.48 | $125.53 | $197.47 |
| Weekly Rates | | | | |
| 0-24 | $2.19 | $3.48 | $3.68 | $4.98 |
| 25-29 | $2.47 | $3.90 | $3.97 | $5.40 |
| 30-34 | $2.95 | $4.64 | $4.44 | $6.13 |
| 35-39 | $4.15 | $6.42 | $5.64 | $7.91 |
| 40-44 | $5.40 | $8.39 | $6.90 | $9.89 |
| 45-49 | $6.69 | $10.47 | $8.02 | $11.81 |
| 50-54 | $10.00 | $15.69 | $11.49 | $17.19 |
| 55-59 | $13.92 | $22.09 | $15.42 | $23.59 |
| 60-64 | $17.83 | $28.10 | $19.32 | $29.59 |
| 65-69 | $23.09 | $36.68 | $24.58 | $38.17 |
| 70-74 | $30.29 | $47.93 | $31.78 | $49.42 |
| 75-79 | $39.68 | $62.52 | $41.16 | $64.01 |
| 80-84 | $46.25 | $73.72 | $47.75 | $75.21 |
| 85+ | $61.28 | $97.24 | $62.76 | $98.74 |

# Hospital Indemnity Insurance

Hospital Indemnity insurance with Cigna is designed to provide financial assistance for an illness OR accident that results in a hospital admission or confinement, to supplement your current coverage. Employees can use the benefit shown below, to meet any out-of-pocket expenses and extra bills that can occur due to a hospitalization. Benefits are paid directly to you, regardless of the actual cost of treatment.

| Covered Benefits | Benefit Amount |
|---|---|
| Hospital Admission Benefit (1x per year) | $1,000 |
| ICU Admission Benefit | $1,400 |
| Daily Hospital Confinement Benefit (up to 30 days per confinement) | $200 |
| Daily ICU Confinement Benefit (up to 30 days per confinement) | $400 |
| Hospital Chronic Condition Admission Benefit | $100 |
| Hospital Observation Stay Benefit | $200 |

| Hospital Indemnity Plan | Bi-weekly Deduction | Weekly Deduction |
|---|---|---|
| Employee | $5.98 | $2.99 |
| Employee and Spouse | $14.34 | $7.17 |
| Employee and Child(ren) | $9.95 | $4.98 |
| Family | $18.32 | $9.16 |

# Contact Information

## KLEEN-TECH HUMAN RESOURCES

**866.385.0672**

## BENEFITS ENROLLMENT

**970.300.0333**
**https://cigna.benselect.com/ktech**

## MEDICAL PLANS

BayBridge through Creative Health Plan Solutions
**844.378.2042**
**www.Member.medxoom.com**

## VOLUNTARY DENTAL

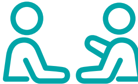
Careington
**800.290.0523**
**member.careington.com/index.aspx**

## VOLUNTARY VISION

Superior Vision
**800.507.3800**
**www.superiorvision.com**

## VOLUNTARY TERM LIFE

Mutual of Omaha
**800.655.5142**
**www.mutualofomaha.com**



## EMPLOYEE ASSISTANCE PROGRAM (EAP)

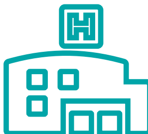
**800.316.2796**
**www.mutualofomaha.com/eap**

## ACCIDENT

Cigna
**866.494.2111**
**www.mycigna.com**

## CRITICAL ILLNESS

Cigna
**866.494.2111**
**www.mycigna.com**



## HOSPITAL INDEMNITY

Cigna
**866.494.2111**
**www.mycigna.com**

# Notes

# Notes

This benefit guide is only intended to highlight some of the major benefit provisions of the company plan and should not be relied upon as a complete detailed representation of the plan. Please refer to the plan's summary plan descriptions for further detail. Should this guide differ from the summary plan descriptions, the summary plan descriptions prevail.

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