KLEEN-TECH

2025 Benefits Guide

Labor

This publication contains important information about your employee benefit program.

Please read thoroughly.

Eligibility and Enrollment

When it comes to benefits, we understand what matters—plans created to support you and your family. Our comprehensive benefits program allows you to choose the benefits best for you. Kleen-Tech provides Overhead employees with 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 of employment. Please note you cannot make changes to your elections during the plan year unless you experience a qualifying life 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 will be automatically enrolled in all company-paid benefits.

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** or scan the QR Code.

- Login: Username is Employee ID or full SSN
- Password is a 6-digit PIN consisting of the last 4 digits of your SSN followed by your 2-digit birth year.
  - For example, a team member with a SSN of ###-##-8977 and a DOB of 07/05/1983 would have a PIN of 897783.
- Once logged in you will be prompted to change your password.

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

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.

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.

THE HEALTH BENEFIT ALLIANCE
YOUR ALLY IN HEALTH™

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 Limited to **2 visits** per plan year†		No	**$25 Copay**	**$25 Copay**
Specialist Office Visit Limited to **2 visits** per plan year†		No	**$50 Copay**	**$50 Copay**
Other Physician Services Performed in the Office[4] (Limited to Primary Care/Specialist visits per plan year)		Yes[5]	**$50 Copay**	**$50 Copay**
Urgent Care 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** (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** (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**

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.

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 Limited to **8 visits** per plan year†		No	**$25 Copay**	**$25 Copay**
Specialist Office Visit Limited to **8 visits** per plan year†		No	**$50 Copay**	**$50 Copay**
Other Physician Services Performed in the Office[4] (Limited to Primary Care/Specialist visits per plan year)		Yes[5]	**$50 Copay**	**$50 Copay**
Urgent Care 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 Limited to **5 days** per plan year†		Yes	**$350 Copay per admission** (Subject to Reference Based Pricing)	
Inpatient Visits - Physician Limited to **5 visits** per plan year†		No	Included in Inpatient Hospitalization Copay	
Inpatient Surgery - Physician Charges 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 Limited to **1 visit** per plan year†		Yes	**$350 Copay** (Subject to Reference Based Pricing)	
Anesthesia 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 Limited to **1 visit** per plan year†		No	**$350 Copay** (Subject to Reference Based Pricing)	
PREGNANCY BENEFITS				
Professional Services		No	**$350 Copay**	**$350 Copay**
Maternity/Childbirth/Delivery (Considered Inpatient Hospital Stay)		No	**$350 Copay per admission** (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.

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.

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.

THE HEALTH BENEFIT ALLIANCE
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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 Limited to **12 visits** per plan year†		No	**$15 Copay**	**$15 Copay**
Specialist Office Visit Limited to **12 visits** per plan year†		No	**$25 Copay**	**$25 Copay**
Other Physician Services Performed in the Office[4] (Limited to Primary Care/Specialist visits per plan year)		Yes[5]	**$25 Copay**	**$25 Copay**
Urgent Care 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**
	Hospital Based	No	**Not Covered**	**Not Covered**
HOSPITAL/FACILITY SERVICES ***(Subject to Reference Based Pricing)***				
Inpatient Hospitalization Limited to **10 days** per plan year†		Yes	**$350 Copay per admission** (Subject to Reference Based Pricing)	
Inpatient Visits - Physician Limited to **10 visits** per plan year†		No	Included in Inpatient Hospitalization Copay	
Inpatient Surgery - Physician Charges 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 Limited to **2 visit** per plan year†		Yes	**$350 Copay** (Subject to Reference Based Pricing)	
Anesthesia 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 Limited to **2 visit** per plan year†		No	**$350 Copay** (Subject to Reference Based Pricing)	
PREGNANCY BENEFITS				
Professional Services		No	**$350 Copay**	**$350 Copay**
Maternity/Childbirth/Delivery (Considered Inpatient Hospital Stay)		No	**$350 Copay per admission** (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.

THE HEALTH BENEFIT ALLIANCE
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Medical

Plan	Coverage Tier	Employee Bi-Weekly Contribution	Employee Weekly Contribution
MEC 1	EE Only	$40.92	$20.46
	EE+Sp	$68.91	$34.46
	EE+Ch	$63.20	$31.60
	Family	$81.48	$40.74
MEC 2	EE Only	$60.92	$30.46
	EE+Sp	$98.19	$49.09
	EE+Ch	$86.32	$43.16
	Family	$122.80	$61.40
MVP Bronze Plus	EE Only	$80.77	$40.38
	EE+Sp	$282.54	$141.27
	EE+Ch	$229.19	$114.59
	Family	$413.53	$206.76
MVP Gold	EE Only	$121.85	$60.92
	EE+Sp	$328.94	$164.47
	EE+Ch	$260.37	$130.19
	Family	$462.63	$231.32

Dental

We partner with Alpha Dental to offer you and your family a dental discount program. Visit **www.alphadentalplan.com** to see how you can save up to 20%-50% on almost every dental visit.

Finding In-Network Providers

To find a list of participating dental providers, visit **www.alphadentalplan.com/find-dentists**.

Sample AlphaUS Dental Plan Savings

Procedure	Regular Cost*	Plan Cost**	Savings	Savings %
Adult Cleaning	$40	$63	$77	55%
Routine Checkup	$85	$33	$52	61%
Four Bitewing X-Rays	$94	$42	$52	55%
Composite (white), filling (front teeth)	$220	$98	$122	55%
Crown (porcelain fused to noble metal)	$1,557	$804	$753	48%

* Determined using the American Dental Association (ADA) 2022 nationwide survey of dental fees. May vary by provider.

** The average discounted procedure fee for participating general dentistry providers.

Prices subject to change.

Dental Premiums

	Employee Bi-Weekly Contribution	Employee Weekly Contribution
Employee	$4.04	$2.02
Employee + 1	$6.92	$3.46
Family	$7.62	$3.81

Additional Features

Your Alpha Dental Plan includes some additional features—vision savings, hearing aids, and prescription savings. Find out more at **www.alphadentalplan.com**.

Vision Savings Through VSP Savings Pass

At no additional cost, this VSP vision discount program can save money on frames as well as provide additional discounts on exams, lenses, contact lenses, and other vision care services! You get easy access to national vision care providers at leading optical retailers.

Access Hearing Discounts Through Yes Hearing

Alpha Dental has teamed up with Yes Hearing to bring you convenient, comprehensive hearing healthcare and best-in-class hearing aids—for less. To assess your hearing needs, schedule your free personal consultation with a hearing care expert at **health.yeshearing.com/alphadental** today!

- Savings of up to 60% off standard retail pricing
- The latest hearing technology from top brands
- A national network of hearing care providers

Prescription Drug Savings with Alpha Rx

Free to everyone—a prescription discount card. These prescription drug discounts offer savings up to $95 on prescription drugs, depending on the pharmacy and medication, allowing you to save each time you fill your prescription! You get easy access to over 35,000 pharmacies nationwide, providing discount pricing on FDA approved brand name or generic drugs. Visit **www.alphadentalplan.com/rx** to search for medications at a pharmacy near you.

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.

	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

	Employee Bi-Weekly Contribution	Employee Weekly Contribution
Employee	$2.47	$1.23
Employee + 1	$4.79	$2.40
Family	$7.03	$3.52

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**.

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's accident insurance plan. 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 discretion.

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. Employees may also elect coverage for their spouse or child(ren) at 50% of their own coverage amount. To elect coverage for dependents, an employee must first elect coverage for themselves.

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 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

Voluntary Pet Insurance

Kleen Tech is happy to offer Wishbone Pet Insurance.

Nobody wants to imagine their pet getting sick or injured—but when it comes to your pet's health, it's best to expect the unexpected. Wishbone Pet Insurance is accepted at any vet in the U.S., including emergency hospitals. Our simple online claims process means you get your money back fast, whether it's for routine care or an accident.

Wishbone offers different plan options to fit your budget. You may enroll in both for maximum coverage.

Accident & Illness Coverage

- 90% reimbursement
- $250 deductible
- $25,000 annual limit
- Includes lost pet recovery service and 24/7 pet telehealth

Rates are based on your pet's breed, age, and zip code.

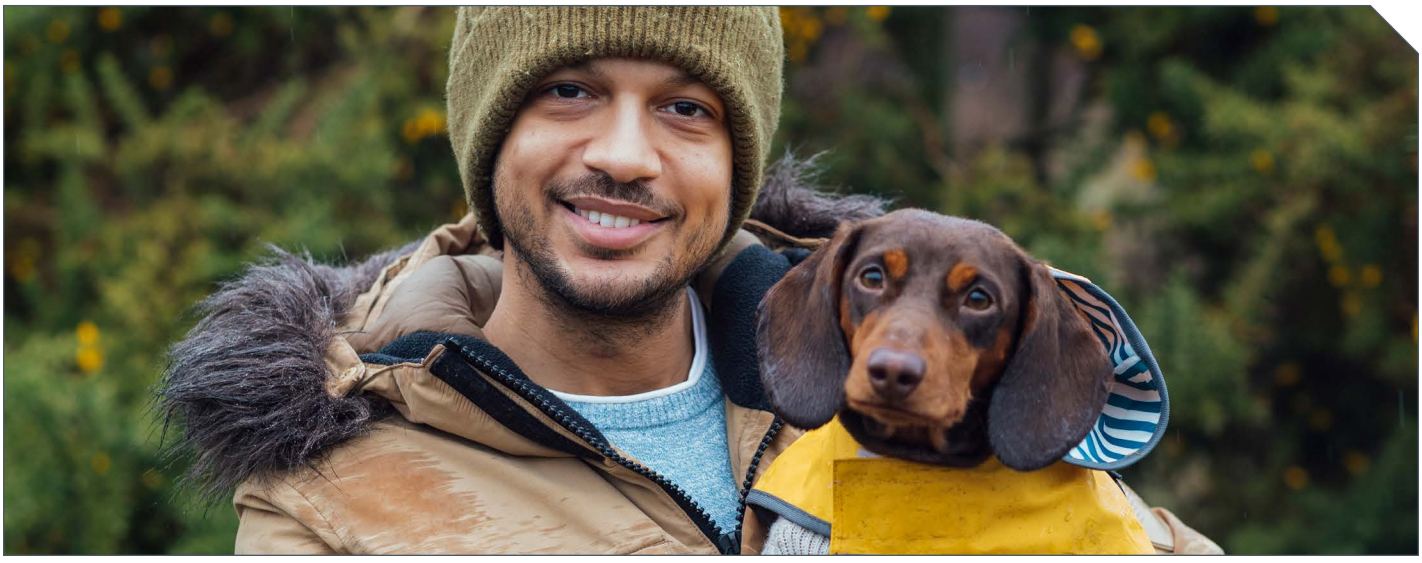
Wellness Coverage

Covers your regular routine visits

Essential Plan	Premium Plan
Up to $300 in coverage $14/month	Up to $575 in coverage $25/month

This coverage is based on a schedule of benefits

For more information or to get a quote you may enroll at **www.wishboneinsurance.com/kleentech**.



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

Alpha Dental
800.807.0706
www.alphadentalplan.com

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
800.754.3207
SuppHealthClaims.com

CRITICAL ILLNESS

Cigna
800.754.3207
SuppHealthClaims.com

HOSPITAL INDEMNITY

Cigna
800.754.3207
SuppHealthClaims.com

PET INSURANCE

Wishbone Insurance via Pet Benefit Solutions
800.887.5708
help@wishboneinsurance.com
www.wishboneinsurance.com/kleentech

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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