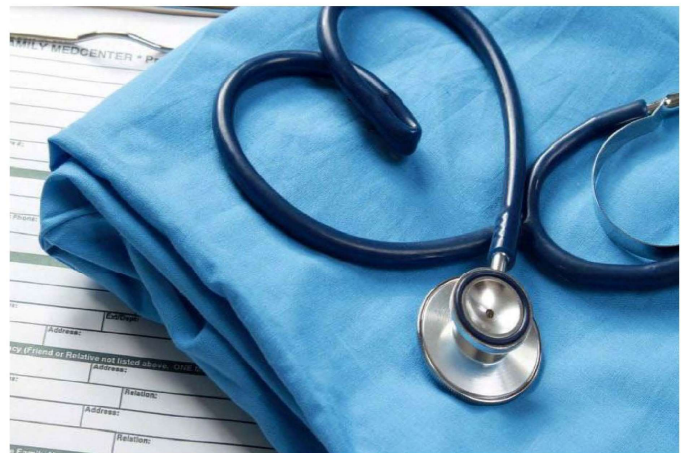
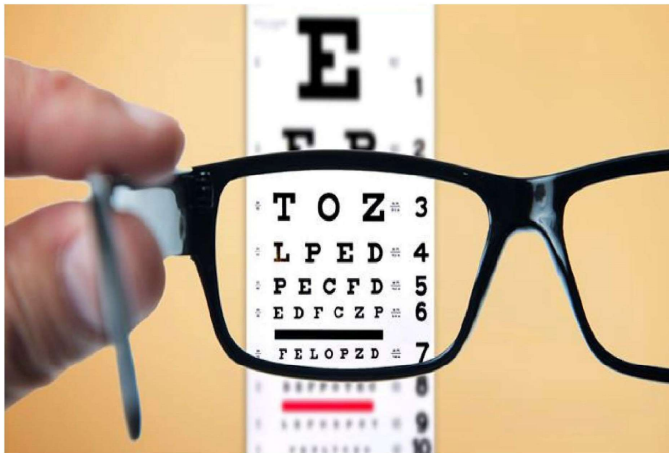


# ***Master Plans***



## **Employee Benefits Enrollment Guide**

*Effective: 08/01/23 through 07/31/24*



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# Eligibility

Full-time Employees are eligible to begin participation in any health insurance plan(s) on the first of the month following 60 days of full-time employment. Full-time employment is 30+ hours per week.

Part-time and variable-hour Employees are eligible to begin participation in Aflac insurance plan(s) on the first of the month following 60 days of employment.

## Contact Information

*\*\*\*Refer to this list when you need to contact one of your benefit vendors.  
For general information, please contact your Benefits Department.*

### **APEX MEC INSURANCE:**

|                                       |  |
|---------------------------------------|--|
| Eligibility and Benefits Information: | (800) 795-7772<br><a href="http://www.regionalcare.com">www.regionalcare.com</a> |
| Teladoc:                              | (800) Teladoc<br><a href="http://www.teladoc.com">www.teladoc.com</a>            |
| Find a Provider:                      | (888) 342-7427<br><a href="http://www.multipian.com">www.multipian.com</a>       |

### **TERNIAN LIMITED MEDICAL:**

|                            |  |
|----------------------------|--|
| Claims Information – Axis: | (800) 964-7096   |
| Find a Provider:           | (800) 226-5116<br><a href="http://www.myternian.com">www.myternian.com</a> |

### **CIGNA DENTAL:**

|           |  |
|-----------|--|
| Provider: | (800) 244-6224<br><a href="http://www.cigna.com">www.cigna.com</a> |
|-----------|--|

### **METLIFE DENTAL. VISION. VOLUNTARY LIFE and AD&D:**

|          |   |
|----------|---|
| Provider | (800) MET-LIFE (1-800-638-5433)<br><a href="http://www.metlife.com">www.metlife.com</a> |
|----------|---|

### **TERNIAN EMPLOYEE ASSISTANCE PROGRAM (EAP):**

|           |                |
|-----------|----------------|
| Provider: | (888) 881-5462 |
|-----------|----------------|

### **AFLAC:**

|                     |  |
|---------------------|--|
| Provider:           | (800) 433-3036<br><a href="http://www.aflacgroupinsurance.com">www.aflacgroupinsurance.com</a> |
| Telemedicine:       | (855) 423-8585   |
| Health Advocacy:    | (855) 423-8585   |
| Medical Bill Saver: | (855) 423-8585   |

### **BENEFIT QUESTIONS and SERVICE ISSUES:**

For questions concerning your benefits or for service issues please contact the following:

|                         |  |
|-------------------------|--|
| Pinnacle Benefits Team: | (210) 344-2088<br><a href="mailto:benefits@pinnaclepeo.com">benefits@pinnaclepeo.com</a> |
|-------------------------|--|

## Apex MEC Satisfies Penalty A of the PPACA\*

TELADOC

PHCS

WellDyncRx

|   | MEC   | MEC PLUS                                  | MEC PLUS ADVANTAGE                                       |
|---|---|---|--|
| MEC plans cover 100% of preventative benefits under PPACA |   |   |  |
| PREVENTATIVE  |   |   |  |
| TELADOC 24/7 (Multilingual) <sup>2</sup>                  |   | FREE (unlimited)                          |  |
| PPO NETWORK SERVICES <sup>2</sup>                         |   |   |  |
| Primary Care Physician Visits                             | \$0 Copay<br>(max 1 visit per plan year)                              | \$0 Copay<br>(max 2 visits per plan year) | \$20 Copay<br>(max 3 visits per plan year)               |
| Specialist Office Visits                                  | Not Covered   |   | \$50 Copay<br>(max 3 visits per plan year)               |
| Urgent Care   |   |   | \$50 Copay<br>(max 3 visits per plan year)               |
| Diagnostic X-ray and Lab                                  |   |   | \$50 Copay<br>(in offices, max 5 services per plan year) |
| CT Scan/MRI (outpatient only)                             |   |   | \$200 Copay<br>(max 1 CT Scan or 1 MRI per plan year)    |
| PRESCRIPTION BENEFITS <sup>2</sup>                        |   |   |  |
| Tier 1 - Low Cost   | Discount Card<br>Up to 75% Discount<br>on FDA Approved<br>Medications |   | \$1 Copay  |
| Tier 2 - Generics   |   |   | 10% Coinsurance  |
| Tier 3 - Preferred  |   |   | 20% Coinsurance  |
| Tier 4 - Non-Preferred                                    |   |   | 40% Coinsurance  |
| Tier 5 - Generic & Preferred Specialty                    |   |   | 10% Coinsurance<br>(Plan pays 90% up to max of \$150)    |
| Tier 6 - Non-Preferred                                    |   |   | 20% Coinsurance<br>(Plan pays 80% up to max of \$250)    |
| HOSPITALIZATION BENEFITS                                  |   |   |  |
| Daily In-Hospital   |   |   |  |
| Hospital Admission  |   |   |  |
| Inpatient Surgery   | Not Covered   |   |  |
| Outpatient Major Surgery                                  |   |   |  |
| Anesthesia  |   |   |  |
| ER - Injury   |   |   |  |

### MEC PLUS ADVANTAGE with Beazley Group Limited Indemnity (GLI)

MEC plans cover 100% of  
preventative benefits under PPACA

**FREE (unlimited)**

**\$20 Copay**

(max 3 visits per plan year)

**\$50 Copay**

(max 3 visits per plan year)

**\$50 Copay**

(max 3 visits per plan year)

**\$50 Copay**

(in offices, max 5 services per plan year)

**\$200 Copay**

(max 1 CT Scan or 1 MRI per plan year)

**\$1 Copay**

**10% Coinsurance**

**20% Coinsurance**

**40% Coinsurance**

**10% Coinsurance**

(Plan pays 90% up to max of \$150)

**20% Coinsurance**

(Plan pays 80% up to max of \$250)

**GLI Underwritten by  
Beazley Insurance Company, Inc.**

**\$750 per day**

30 days per plan year

**\$2,000 per admission**

1 day per plan year

**\$1,000 benefit per day**

1 day per plan year

**\$500 benefit per day**

1 day per plan year

**\$300 benefit per day**

1 day per plan year

**\$150 benefit per day**

1 day per plan year

\* All MEC plans are PPACA compliant and eliminate Penalty A. MEC stands for Minimum Essential Coverage.

<sup>1</sup> Group Limited Indemnity is not major medical insurance. GLI does not satisfy any PPACA penalties.

<sup>2</sup> Non-insurance benefits are included with Apex MEC plans.

# Your Apex MEC plan is ACA Compliant

The list below summarizes some but not all services. Please reference the US Preventive Services Task Force website for the entire list. [www.HealthCare.gov/center/regulations/prevention.html](http://www.HealthCare.gov/center/regulations/prevention.html)

## Covered Preventive Services for Adults (ages 18 and older)

1. Abdominal Aortic Aneurysm one time screening for age 65-75
2. Alcohol Misuse screening and counseling
3. Aspirin use for men ages 45-79 and women ages 55-79 to prevent CVD when prescribed by a physician
4. Blood Pressure screening
5. Cholesterol screening for adults
6. Colorectal Cancer screening for adults starting at age 50 limited to one every 5 years
7. Depression screening
8. Type 2 Diabetes screening
9. Diet counseling
10. HIV screening
11. Obesity screening and counseling
12. Immunizations vaccines (Hepatitis A & B, Herpes Zoster, Human Papillomavirus, Influenza (flu shot), Measles, Mumps, Rubella, Meningococcal, Pneumococcal, Tetanus, Diphtheria, Pertussis, Varicella)
13. Sexually Transmitted Infection (STI) prevention counseling
14. Tobacco Use screening and cessation interventions
15. Syphilis screening
16. Hepatitis B screening for non-pregnant adolescents and adults.
17. Lung Cancer screening-55-80 y/o who smoke 30 packs a year.
18. Fall Prevention -Physical therapy and vitamin D for 65 and older at risk for falling
19. Hepatitis C screening for high risk individuals and a onetime screening for HGV infection if born between 1945-1965.
20. Skin Cancer behavioral counseling for adults to age 24 with fair skin

## Covered Preventive Services for Women, Including Pregnant Women

1. Anemia screening on a routine basis for pregnant women
2. Bacteriuria urinary tract or other infection screening for pregnant women
3. BRCA counseling and genetic testing for women at higher risk
4. Breast Cancer Mammography screenings every year for women age 40+
5. Breast Cancer Chemo Prevention counseling for women
6. Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women.
7. Cervical Cancer screening
8. Chlamydia Infection screening
9. Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs
10. Domestic and interpersonal violence screening and counseling for all women
11. Folic Acid supplements for women who may become pregnant when prescribed by a physician
12. Gestational diabetes screening
13. Gonorrhea screening
14. Hepatitis B screening for pregnant women
15. Human Immunodeficiency Virus (HIV) screening and counseling
16. Human Papillomavirus (HPV) DNA Test: HPV DNA testing every three years for women with normal cytology results who are 30 or older
17. Osteoporosis screening over age 60
18. Rh Incompatibility screening for all pregnant women and follow-up testing
19. Tobacco Use screening and interventions and expanded counseling for pregnant tobacco users
20. Sexually Transmitted Infections (STI) counseling
21. Syphilis screening
22. Well-woman visits to obtain recommended preventive services
23. Aspirin for Preeclampsia prevention
24. Routine prenatal visits for pregnant women

## Covered Preventive Services for Children

1. Alcohol and Drug Use assessments
2. Autism screening for children limited to two screenings up to 24 months
3. Behavioral assessments for children limited to 5 assessments to age 17
4. Blood Pressure screening
5. Cervical Dysplasia screening
6. Congenital Hypothyroidism screening for newborns
7. Depression screening for adolescents age 12 and older
8. Developmental screening for children under age 3, and surveillance throughout childhood
9. Dyslipidemia screening for children
10. Fluoride Chemo Prevention supplements for children without fluoride in their water source when prescribed by a physician
11. Gonorrhea preventive medication for the eyes of all newborns
12. Hearing screening for all newborns
13. Height, Weight and Body Mass Index measurements for children
14. Hematocrit or Hemoglobin screening for children
15. Hemoglobinopathies or sickle cell screening for newborns
16. HIV screening for adolescents
17. Lead screening for children
18. Immunization vaccines for children from birth to age 18; doses, recommended ages, and recommended populations vary: Diphtheria, Tetanus, Pertussis, Hepatitis A & B, Human Papillomavirus, Inactivated Poliovirus, Influenza (Flu Shot), Measles, Mumps, Rubella, Meningococcal, Pneumococcal, Rotavirus, Varicella, Haemophilus influenza type b
19. Iron supplements for children up to 12 months when prescribed by a physician
20. Medical History for all children throughout development ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
21. Obesity screening and counseling
22. Oral Health risk assessment for young children up to age 10
23. Phenylketonuria (PKU) screening in newborns
24. Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents
25. Tuberculin testing for children
26. Vision screening for all children under the age of 5
27. Skin Cancer Behavioral Counseling -age 10-24 for exposure to sun
28. Tobacco intervention and counseling for children



## **Enroll Now! Time is Limited**

### **Ternian Health Select Limited Medical Plan**

**Search First Heath network providers at: [my.ternian.com](http://my.ternian.com) or call 1-800-226-5116.**

- You do not need to use these providers
- The provide discounts should you choose to visit them.
- You can visit any licensed physician and present your insurance card

Regardless  
you still have  
insurance  
coverage as  
outlined in  
this brochure

### **Health Select**

- \$10 Doctor Visit Pre Pay\*
- Inpatient Hospital Coverage
- Out Patient Accident Coverage
- Accidental Death & Dismemberment Coverage
- Prescription Drug Coverage

#### **Also Available:**

- CriticalMed Plans

#### **Ternian Services:**

- \$10 Doctor Visit Pre-Pay
- Consult a Doctor Telephone Doctor Office Visits
- New Direction Nurseline
- Employee Assistance Plan "EAP"
- First Health PPO Network discounts

**NOTICE:** These plans DO NOT fulfill the Individual Mandate for Health Insurance Coverage required under the Affordable Care Act.



# Benefits at a Glance (Ternian)

This information is a brief description of the important features of the insurance plan. It is not a contract of insurance. The terms and conditions of coverage are set forth in the policies issued in the state in which policy is delivered. Complete details may be found in the policies on file at your employer's office. The policy is subject to the laws of the state in which it is issued. Coverage may not be available in all states or certain terms may be different if required by state law. Please keep this information as a reference.

## HealthSelect

A fixed indemnity medical plan which provides limited coverage for accidents, illness, and specified disease to help cover basic, minor-medical expenses. The HealthSelect benefits outlined below do not have a pre-existing condition limitation.

### Ternian HealthSelect Indemnity Plans

|  | Plan 1 - Basic               | Plan 2 - Choice          | Plan 3 - Max                        |
|--|------------------------------|--------------------------|-------------------------------------|
| <b>INPATIENT</b> <sup>(1)</sup>  |                              |                          |                                     |
| Hospital Confinement   |                              |                          |                                     |
| Day 1 benefit amount   | \$2,000 per day x 1 day      | \$2,500 per day x 1 day  | \$3,000 per day x 1 day             |
| Days 2+! benefit! amount per day   | \$750 thereafter             | \$1,500 thereafter       | \$2,000 thereafter 10 days per year |
| Maximum benefit  | 5 days per year              | 5 days per year          | \$2,500 per day x 2 days            |
| Surgery benefit amount (incl. maternity) - per day   | \$1,000 per day x 1 day      | \$2,000 per day x 2 days | \$625 per day x 2 days              |
| Anesthesia benefit amount - per day  | \$250 per day x 1 day        | \$500 per day x 2 days   |                                     |
| <b>OUTPATIENT</b> <sup>(1)</sup>   |                              |                          |                                     |
| Physician Office Visit Pre-pay <sup>(2)</sup>  | \$10                         | \$10                     | \$10                                |
| Benefit amount per day   | \$65 per day x 5 days        | \$75 per day x 5 days    | \$85 per day x 5 days               |
| Wellness benefit amount per day  | \$100 per day x 1 day        | \$100 per day x 1 day    | \$100 per day x 1 day N/A           |
| Well child care (up to age 4) benefit amount   | N/A                          | N/A                      | \$10,000 per year 80% U&C           |
| Accident maximum benefit amount per year up to   | \$5,000 per year             | \$7,500 per year         | \$0                                 |
| Benefit % payable  | 80% U&C                      | 80% U&C                  | \$750 per day x 1 day               |
| Deductible per accident  | \$0                          | \$0                      | \$1,750 per day x 1 day             |
| Emergency Room (sickness) benefit amount per day   | \$300 per day x 1 day        | \$500 per day x 1 day    | \$437.50 per day x 1 day            |
| Surgery benefit amount per day   | N/A                          | \$1,000 per day x 1 day  |                                     |
| Anesthesia benefit amount - per day  | N/A                          | \$250 per day x 1 day    | \$30 per day x 2 days               |
| Diagnostic, X-ray, Lab - benefit amount per test   |                              |                          |                                     |
| Class I: Blood work, CMP, Lipid Panel, ECG, Pap/PSA, urinalysis and all other laboratory tests | \$30 per day x 2 days        | \$30 per day x 2 days    | \$175 per day x 2 days              |
| Class II: Radiology, Ultrasound, Mammogram, Sonogram, Angiogram                                | \$50 per day x 2 days        | \$75 per day x 2 days    | \$200 per day x 1 day               |
| Class III: Imaging CT, PET   | \$75 per day x 1 day         | \$125 per day x 1 day    | \$750 per day x 1 day               |
| Class IV: Other Diagnostic tests- Endoscopy, Bronchoscopy, Colonoscopy without Biopsy, MRI     | N/A                          | N/A                      | \$10                                |
| <b>PRESCRIPTION</b> <sup>(3)</sup>   |                              |                          |                                     |
| Retail - Generic RX co-pay   | Discount Only <sup>(2)</sup> | \$10                     | \$30                                |
| Retail - Preferred Brand RX co-pay   |                              | \$30                     | \$60                                |
| Mail Order - Generic RX co-pay   |                              | \$30                     | \$300/600                           |
| Mail Order - Preferred Brand RX co-pay   |                              | \$90                     |                                     |
| Monthly benefit maximum - INDIVIDUAL/FAMILY  |                              | \$200/400                |                                     |
| <b>AD&amp;D</b>  |                              |                          |                                     |
| Accidental Death & Dismemberment benefit amount*   | \$10,000/5,000/1,000         | \$15,000/5,000/1,000     | \$25,000/5,000/1,000                |
| *Benefit amounts listed are for: Employee/Spouse/Child(ren)                                    |                              |                          |                                     |
| <b>OTHER SERVICES</b> <sup>(4)</sup>   |                              |                          |                                     |
| Teladoc: Telephonic Doctor Office Visits   | Yes                          | Yes                      | Yes                                 |
| SupportLinc-EAP  | Yes                          | Yes                      | Yes                                 |
| First Health PPO Discounts   | Yes                          | Yes                      | Yes                                 |

(1) The Fixed Indemnity, Outpatient Accidental-Only, Critical Illness and AD&D Benefit Plans (are underwritten by AXIS Insurance Company. HealthSelect is a limited medical plan. It is not considered creditable coverage under HIPAA, is not major medical insurance, and is NOT designed to replace, provide, or modify major medical insurance. This information is a brief description of the important features of the insurance plan. It is not a contract of insurance. The terms and conditions of coverage are set forth in the policy issued in the state in which the policy is delivered. The policy is subject to the laws of the state in which it is issued. Coverage may not be available in all states or certain terms may be different if required by state law. This insurance does not apply to the extent that trade or economic sanctions or regulations prohibit us from providing insurance, including, but not limited to, the payment of claims. (2) The office visit pre-pay is a service through the First Health PPO Network. (3) The prescription benefits are underwritten by an A.M. Best Rated Carrier. (4) These services are not insurance and are not provided by AXIS Insurance Company.

# What's Not Covered

## Under the Group Hospital Indemnity

We will not pay for any loss, injury or sickness that is caused by, or results from:

- Intentionally self-inflicted injury, suicide or attempted suicide.
- War or any act of war, whether declared or not.
- Service in the military, naval or air service of any country or international organization.
- Piloting or serving as a crew member or riding in any aircraft except as a fare-paying passenger on a regularly scheduled or charter airline.
- Commission of, or attempt to commit, a felony.
- Commission of or active participation in a riot, or insurrection.
- Bungee cord jumping, parachuting, skydiving, parasailing, hang-gliding.
- Flight in, boarding or alighting from any aircraft except as a fare-paying passenger on a regularly scheduled commercial airline.
- An accident if the Insured Person is the operator of a motor vehicle and does not possess a valid motor vehicle operator's license, except while participating in Driver's Education Program.
- Medical or surgical treatment, diagnostic procedure, administration anesthesia, or medical mishap or negligence, including malpractice. (This exclusion applies to the Accidental Death and Dismemberment benefit only.)
- Travel or activity outside the United States, Canada or Mexico, except for a Medical Emergency.
- Travel in any aircraft owned, leased or controlled by the Policyholder, or any of its subsidiaries or affiliates. An aircraft will be deemed to be "controlled" by the Policyholder if the aircraft may be used as the Policyholder wishes for more than 10 straight days, or more than 15 days in any year.
- Alcoholism, drug addiction or the use of any drug or narcotic except as prescribed by a Physician unless specifically provided herein.
- Repair or replacement of existing dentures, partial dentures, braces, fixed or removable bridges, or other artificial dental restoration.
- Repair, replacement, examinations for prescriptions, or the fitting of eyeglasses or contact lenses.
- While the Insured Person is legally intoxicated (as determined by that state's laws) or while ministered under the influence of any drug unless administered under the advice and consent of a Physician.
- Elective Abortion. Elective Abortion means an abortion for any reason other than to preserve the life of the female upon whom the abortion is performed.
- Mental and Nervous Disorders.
- Cosmetic surgery, except for reconstruction surgery needed as the result of an injury or sickness.
- Experimental or Investigational drugs, services, supplies or any procedure held to be experimental or investigatory by Us at the time the procedure is done.
- Treatment for being overweight, gastric bypass or stapling, intestinal bypass, and any related procedures, including complications.
- Sexual reassignment surgery, sexual transformation surgery, sexual transgendering surgery.
- Services related to sterilization, reversal of vasectomy or tubal ligation; in vitro fertilization and diagnostic treatment of infertility or other problems related to the inability to conceive a child, unless such infertility is a result of a covered Injury or Sickness.
- Treatment or services provided by a private duty nurse, unless provided for in the Policy.
- Organ or tissue transplants and related services.
- Personal comfort or convenience items.
- Rest or custodial cares.
- Hearing aids.
- Radial keratotomy.
- Treatment by a family member or member of the Insured Person's household.
- Routine dental care and treatment, except for treatment of Injury as specified in the Policy.

Under the Accident Medical Expense Policy We will not pay for loss, injury or sickness that is caused by, or results from:

- Suicide or attempted suicide, intentionally self-inflicted injury.
  - War or any act of war, whether declared or not.
  - A Covered Accident that occurs while on active duty service in the military, naval or air force of any country or international organization. Upon Our receipt of proof of service, We will refund any premium paid for this time. Reserve or National Guard active duty training is not excluded unless it extends beyond 31 days.
  - Sickness, disease, or any bacterial infection, except one that results from an accidental cut or wound or pyogenic infections that result from accidental ingestion of contaminated substances.
  - Piloting or serving as a crew member or riding in any aircraft except as a fare-paying passenger on a regularly scheduled or charter airline.
  - Injury that occurs while the Insured Person is legally intoxicated (as determined by that state's law) or while under the influence of any drug unless administered under the advice and consent of a Physician.
  - Medical or surgical treatment, diagnostic procedure, administration of anesthesia, or medical mishap or negligence, including malpractice.
  - Commission of, or attempt to commit, a felony.
  - Aggravation or re-injury of a prior Injury the Insured Person suffered prior to his or her coverage effective date, unless We receive a written medical release from the Insured Person's Physician.
- In addition to the above Exclusions, under the Accident Medical Expense Policy, We will not pay for any loss, treatment or services resulting from or contributed to by:
- Treatment by persons employed or retained by the Policyholder, or by any Immediate Family or member of the Insured Person's household.
  - Treatment of sickness, disease or infections except pyogenic infections or bacterial infections that result from the accidental ingestion of contaminated substances.
  - Treatment of hernia, Osgood-Schlatter's Disease, osteochondritis, appendicitis, osteomyelitis, cardiac disease or conditions, pathological fractures, congenital weakness, detached retina unless caused by an Injury, or mental disorder or psychological or psychiatric care or treatment (except as provided in the Policy), whether or not caused by a Covered Accident.
  - Pregnancy, childbirth, miscarriage, abortion or any complications of any of these conditions.
  - Mental and nervous disorders (except as provided in the Policy).
  - Injury covered by Workers' Compensation, Employer's Liability Laws or similar occupational benefits, including any insurance policy that provides benefits to the Insured Person for injuries resulting from an occupational accident, or while engaging in activity for monetary gain from sources other than the Policyholder.
  - Cosmetic surgery, except for reconstructive surgery needed as the result of an Injury.
  - Any elective treatment, surgery, health treatment, or examination, including any service, treatment or supplies that: (a) are deemed by Us to be experimental; and (b) are not recognized and generally accepted medical practices in the United States.
  - Eyeglasses, contact lenses, hearing aids, examinations or prescriptions for them, or repair or replacement of existing artificial limbs, orthopedic braces, or orthotic devices.
  - Expenses payable by any automobile insurance Policy without regard to fault. (This exclusion does not apply in any state where prohibited.)
  - Damage to or loss of dentures or bridges, or damage to existing orthodontic equipment (except as specifically covered by the Policy).
  - Expenses incurred for treatment of temporomandibular or craniomandibular joint dysfunction and associated myofascial pain (except as provided by the Policy).
  - Conditions that are not caused by a Covered Accident.
  - Participation in any activity or hazard not specifically covered by the Policy.
  - Any treatment, service or supply not specifically covered by the Policy.



**In addition, Critical Illness Benefits will not be paid for:**

- Injury or Sickness, other than one of the Covered Illnesses, even though such Injury or Sickness may have been complicated by one of the Covered Illnesses.
- Any complication of Human Immune deficiency Virus (HIV) infection or any variance thereof including AIDS and AIDS Related complex, except for residents of TX, FL, MO, NC.
- The use, existence or escape of nuclear weapons, material or ionizing radiation from or contamination by radioactivity from any nuclear fuel or waste from the combustion of nuclear fuel.
- Misuse of medication or the abuse of drugs or intoxicants.
- Any Pre-existing Condition, except where coverage has been in effect for a period of twenty-four (24)\* consecutive months following the Insured Person's effective date of coverage. "Pre-existing Condition" means a Sickness suffered by a Insured Person for which he or she sought or received medical advice, consultation, investigation, or diagnosis, or for which treatment was required or recommended by a Physician during the 24\* months immediately prior to the Insured Person's effective date of coverage, that directly or indirectly causes the condition to occur within the first 24\* months from the Insured Person's most recent effective date of coverage.

**No Prescription Drug Benefits will be paid for:**

- All over-the-counter products and medications unless shown in the definition of Prescription Drug. This includes, but is not limited to, electrolyte replacement, infant formulas, miscellaneous nutritional supplements, and all other over-the-counter products and medications.
- Blood glucose meters and insulin injecting devices.
- Depo-Provera; condoms, contraceptive sponges, and spermicides; sexual dysfunction drugs.
- Biologicals (including allergy tests); blood products; growth hormones; hemophiliac factors; MS injectables; immunizations; and all other injectables unless shown in the definition of Prescription Drug.
- Medical supplies and durable medical equipment.
- Liquid nutritional supplements; pediatric Legend Drug vitamins; prescribed versions of Vitamins A, D, K, B12, Folic Acid, and Niacin – used in treatment verses as a dietary supplement; and all other Legend Drug vitamins and nutritional supplements.
- Anorexiants; any cosmetic drugs including, but not limited to, Renova and skin pigmentation preps; any drugs or products used for the treatment of baldness; and topical dental fluorides.
- Refills in excess of that specified by the prescribing Physician, or refills dispensed after one year from the original date of the prescription.
- Any drug labeled "Caution – limited by Federal Law for Investigational Use" or experimental drugs.
- Any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment.
- Drugs needed due to conditions caused, directly or indirectly, by a Insured Person taking part in a riot or other civil disorder; or the Insured Person taking part in the commission of a felony.
- Drugs needed due to conditions caused, directly or indirectly, by declared or undeclared war or any act of war; or drugs dispensed to an Insured Person while on active-duty service in any armed forces.
- Any expenses related to the administration of any drug.
- Drugs or medicines taken while in or administered by a Hospital or any other health care facility or office.
- Drugs covered under Worker's Compensation, Medicare, Medicaid or other governmental program.
- Drugs, medicines or products which are not medically necessary.
- Diaphragms; erectile dysfunction Legend Drugs; and infertility Legend Drugs.
- Epi-Pen, Epi-Pen Jr., Ana-Kit, Ana-Guard; Glucagon-auto injection; and Imitrex-auto injection. Smoking deterrents, Legend or over-the-counter drugs.
- Replacement of stolen medication (except under circumstances approved by us), or lost, spilled, broken or dropped Prescription Drugs.
- Vacation supplies of Prescription Drugs (except under circumstances approved by us).
- All newly marketed pharmaceuticals or currently marketed pharmaceuticals with a new FDA approved indication for a period of one year from such FDA approval for its intended indication.

The following applies to the Group Term Life Insurance benefit: **SUICIDE EXCLUSION:** We will not pay a death benefit if an insured person dies by suicide, while sane or insane, within two years of the date his/her insurance starts. If You or Your spouse dies by suicide, We will refund the premiums paid for Your insurance (if a dependent child dies by suicide, We will refund the premiums paid for the dependent children's insurance only if You have no surviving insured dependent children). If any death benefit is increased, this suicide exclusion starts anew, but will apply only to the amount of the increase.

\*Please note that certain exclusions and limitations listed in the "What's Not Covered" sections may vary by state law.

**IMPORTANT NOTICE:** Insurance policies providing certain health insurance coverage issued or renewed on or after September 23, 2010, are required to comply with all applicable requirements of the Patient Protection and Affordable Care Act (PPACA). However, there are a number of insurance coverages that are specifically exempt from the requirements of PPACA (See §2791 of the Public Health Services Act). AXIS maintains that the Limited Accident and Sickness Plan presented in this brochure is "fixed indemnity insurance", and is therefore, exempt from the requirements of PPACA.

## Frequently Asked Questions

**Q: When will I get my ID card?**

**A:** You will get your ID card within 10 business days of your employer approved enrollment.

You will receive a separate ID card for each product you enroll in.

**Q: How do I find a First Health network provider?**

**A:** Please visit [www.myternian.com](http://www.myternian.com) or call 1-800-226-5116

**Q: Is this major medical or comprehensive medical coverage?**

**A:** No this Limited Medical Plan is a combination of limited scope, fixed indemnity, and accident-only coverages which provide limited benefits for accidents, illness, and specified diseases to help cover basic, minor medical expenses.



**Claims Administered by:**

Administrative Concepts, Inc. (ACI)  
994 Old Eagle School Road, Ste. 1005  
Wayne, PA 19087  
1-800-964-7096

Fixed indemnity medical, accident-only accidental death and dismemberment, critical illness, short-term disability and prescription drug coverages are underwritten by AXIS Global Accident and Health Insurance Company. Term life insurance is underwritten by Minnesota Life Insurance Company. These plans are not major medical insurance and are NOT designed to replace, provide or modify major medical insurance. This insurance does not apply to the extent that trade or economic sanctions or regulations prohibit Us from providing insurance, including, but not limited to, the payment of claims. Marketed and administered by Ternian Insurance Group LLC. [www.ternian.com](http://www.ternian.com)

# Dental

|                                      | <b>Cigna</b> | <b>Metlife</b>  | <b>Metlife</b>   | <b>Metlife</b>      |
|--------------------------------------|--------------|-----------------|------------------|---------------------|
|                                      | <b>DHMO</b>  | <b>LOW Plan</b> | <b>HIGH Plan</b> | <b>PREMIER Plan</b> |
| Annual Maximum                       | Unlimited    | \$1,250         | \$2,000          | \$3,000             |
| Deductible                           |              |                 |                  |                     |
| Individual                           | \$0          | \$50            | \$50             | \$25                |
| Family                               | \$0          | \$150           | \$150            | \$75                |
| Type I - Preventive Services         | Fee Schedule | 100%            | 100%             | 100%                |
| Type II - Basic Services             | Fee Schedule | 80%             | 90%              | 90%                 |
| Type III - Major Services            | Fee Schedule | 50%             | 60%              | 60%                 |
| Type IV - Orthodontic Services       | Fee Schedule | 50%             | 50%              | 50%                 |
| Type IV - Lifetime Maximum           | Fee Schedule | \$1,250         | \$2,000          | \$2,000             |
| Late Entrant Penalty                 | No           | Yes             | Yes              | Yes                 |
| Annual Open Enrollment               | Yes          | Yes             | Yes              | Yes                 |
| Endo/Perio - Basic or Major          | Fee Schedule | Major           | Major            | Major               |
| Simple Oral Surgery - Basic or Major | Fee Schedule | Major           | Major            | Major               |
| Out of Network Benefit               | Not Covered  | Negotiated Fee  | Negotiated Fee   | Negotiated Fee      |

## Diagnostic/Preventive

All covered by plan 100%

Consultation

Office Visit for Observation

Periodic and Limited Oral Evaluation

All X-Rays

Cleanings covered every 6 months.

Call Cigna for a Charge Schedule on the following:

- Restorative (Fillings)
- Crown and Bridge (All charges for crown and bridge are per unit) (Each replacement or supporting tooth equals one unit – replacement limit 1 every 5 years)
- Endodontics (Root canal treatment, excluding final restorations)
- Periodontics (Treatment of supporting tissues [gum and bone] of the teeth)
- Prosthetics (Removable tooth replacement – dentures) (Includes up to 4 adjustments within first 6 months after insertion – replacement limit 1 every 5 years)
- Repair to Prosthetics
- Denture Relining (Limit 1 every 36 months)
- Interim Dentures (Limit 1 every 5 years)
- Oral Surgery (Includes routine post-operative treatment)
- Orthodontics (Tooth movement)
- General Anesthesia/I.V. Sedation
- Emergency Services

Select a dentist from a list of network providers on [www.cigna.com](http://www.cigna.com). Customer Service toll free #: 1-800-244-6224



# Dental

Metropolitan Life Insurance Company

## Pinnacle Dental PPO Low Plan

The Preferred Dentist Program was designed to help you get the dental care you need and help lower your costs. You get benefits for a wide range of covered services — both in and out of the network. The goal is to deliver affordable protection for a healthier smile and a healthier you.

| Coverage Type:   | In-Network <sup>1</sup><br>% of PDP Fee <sup>2</sup> | Out-of-Network <sup>1</sup><br>% of PDP Fee <sup>2</sup> |
|--|--|--|
| <b>Type A</b> - Preventive   | 100%   | 100%   |
| <b>Type B</b> - Basic Restorative  | 80%  | 80%  |
| <b>Type C</b> - Major Restorative  | 50%  | 50%  |
| <b>Type D</b> - Orthodontia  | 50%  | 50%  |
| <b>Deductible<sup>3</sup></b>  |  |  |
| Individual   | \$50   | \$50   |
| Family   | \$150  | \$150  |
| <b>Annual Maximum Benefit:</b>   |  |  |
| Per Individual   | \$1250   | \$1250   |
| <b>Orthodontia Lifetime Maximum -<br/>Ortho applies to Adult and Child</b>   | Up to dependent age limit                            |  |
|  | \$1250 per Person                                    | \$1250 per Person  |
| <p><sup>1</sup> "In-Network Benefits" refers to benefits provided under this plan for covered dental services that are provided by a participating dentist. "Out-of-Network Benefits" refers to benefits provided under this plan for covered dental services that are not provided by a participating dentist.</p> <p><sup>2</sup> Negotiated fees refer to the fees that participating dentists have agreed to accept as payment in full for covered services, subject to any copayments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.</p> <p><sup>3</sup> Applies to Type B and C services only.</p> |  |  |

# Dental

Metropolitan Life Insurance Company

## Pinnacle Dental PPO High Plan

The Preferred Dentist Program was designed to help you get the dental care you need and help lower your costs. You get benefits for a wide range of covered services — both in and out of the network. The goal is to deliver affordable protection for a healthier smile and a healthier you.

| <b>Coverage Type:</b>   | <b>In-Network<sup>1</sup><br/>% of PDP Fee<sup>2</sup></b> | <b>Out-of-Network<sup>1</sup><br/>% of PDP Fee<sup>2</sup></b> |
|---|--|--|
| <b>Type A</b> - Preventive  | 100%   | 100%   |
| <b>Type B</b> - Basic Restorative   | 90%  | 90%  |
| <b>Type C</b> - Major Restorative   | 60%  | 60%  |
| <b>Type D</b> - Orthodontia   | 50%  | 50%  |
| <b>Deductible<sup>3</sup></b>   |  |  |
| Individual  | \$50   | \$50   |
| Family  | \$150  | \$150  |
| <b>Annual Maximum Benefit:</b>  |  |  |
| Per Individual  | \$2000   | \$2000   |
| <b>Orthodontia Lifetime Maximum -<br/>Ortho applies to Adult and Child</b>  |  |  |
|   | Up to dependent age limit                                  |  |
|   | \$2000 per Person  | \$2000 per Person  |
| <sup>1</sup> "In-Network Benefits" refers to benefits provided under this plan for covered dental services that are provided by a participating dentist. "Out-of-Network Benefits" refers to benefits provided under this plan for covered dental services that are not provided by a participating dentist.<br><sup>2</sup> Negotiated fees refer to the fees that participating dentists have agreed to accept as payment in full for covered services, subject to any copayments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.<br><sup>3</sup> Applies to Type B and C services only. |  |  |

## Dental

Metropolitan Life Insurance Company

### Pinnacle Dental PPO Premier Plan

#### Network: PDP Plus

| Coverage Type   | In-Network<br>% of Negotiated Fee* | Out-of-Network<br>90% of R&C Fee*** |
|---|------------------------------------|-------------------------------------|
| <b>Type A: Preventive</b><br>(cleanings, exams, X-rays)     | 100%                               | 100%                                |
| <b>Type B: Basic Restorative</b><br>(fillings, extractions) | 90%                                | 90%                                 |
| <b>Type C: Major Restorative</b><br>(bridges, dentures)     | 60%                                | 60%                                 |
| <b>Type D: Orthodontia</b>                                  | 50%                                | 50%                                 |
| <b>Deductible†</b>  |                                    |                                     |
| Individual  | \$25                               | \$25                                |
| Family  | \$75                               | \$75                                |
| <b>Annual Maximum Benefit</b>                               |                                    |                                     |
| Per Person  | \$3,000                            | \$3,000                             |
| <b>Orthodontia Lifetime Maximum</b>                         |                                    |                                     |
| Per Person  | \$2,000                            | \$2,000                             |

**Child(ren)'s eligibility** for dental coverage is from birth up to age 26, age 26 if a full-time student.  
**Late enrollment waiting period:** There is a one year waiting periods for all services following date of request.

\*Negotiated Fee refers to the fees that participating dentists have agreed to accept as payment in full for covered services, subject to any copayments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.

\*\*\*R&C fee refers to the Reasonable and Customary (R&C) charge, which is based on the lowest of (1) the dentist's actual charge, (2) the dentist's usual charge for the same or similar services, or (3) the charge of most dentists in the same geographic area for the same or similar services as determined MetLife.†Applies to Type B & C Services.



## Vision

Metropolitan Life Insurance Company

|   | MetLife<br>LOW Plan<br>In-Network   | MetLife<br>HIGH Plan<br>In-Network  |
|---|---|---|
| <b>Eye exam</b> <ul style="list-style-type: none"> <li>Eye health exam, dilation, prescription and refraction for glasses: Covered in full after copay</li> <li>Retinal imaging: Routine retinal screening when performed by a private practice.</li> </ul>   | Once every 12 months<br><br>Exam - \$10 Copay<br><br>Imaging - Max \$39   | Once every 12 months<br><br>Exam - \$10 Copay<br><br>Imaging - Max \$39   |
| <b>Frame</b> <ul style="list-style-type: none"> <li>You will receive an additional 20% savings on the amount that you pay over your allowance. This offer is available from all participating locations except Costco</li> </ul>  | Once every 24 months<br><br>\$130 Allowance after \$25 eyewear Copay<br><br>Costco: \$70 Allowance after \$25 eyewear Copay | Once every 12 months<br><br>\$150 Allowance after \$10 eyewear Copay<br><br>Costco: \$85 Allowance after \$10 eyewear Copay |
| <b>Standard corrective lenses</b> <ul style="list-style-type: none"> <li>Single vision, lined bifocal, lined trifocal, lenticular: Covered in full after eyewear copay</li> </ul>   | Once every 12 months<br><br>\$25 Copay  | Once every 12 months<br><br>\$10 Copay  |
| <b>Standard lens enhancements</b> <ul style="list-style-type: none"> <li>Polycarbonate (child up to age 18), and Ultraviolet (UV) coating: Covered in full.</li> <li>Progressive, Polycarbonate (adult), Photochromic, Anti-reflective and Scratch-resistant coatings and Tints: Your cost will be limited to a copay that MetLife has negotiated for you. These copays can be viewed after enrollment at <a href="http://metlife.com/mybenefits">metlife.com/mybenefits</a></li> </ul> | Once every 12 months<br><br>\$25 Copay  | Once every 12 months<br><br>\$10 Copay  |
| <b>Contact lenses (instead of eye glasses)</b> <ul style="list-style-type: none"> <li>Contact fitting and evaluation: Covered in full with a maximum copay.</li> <li>Elective lenses</li> <li>Necessary lenses: Covered in full after eyewear copay.</li> </ul>   | Once every 12 months<br><br>Fitting - Max \$60 Copay<br><br>Elective - \$130 Allowance<br><br>Necessary - \$25 Copay        | Once every 12 months<br><br>Fitting - Max \$60 Copay<br><br>Elective - \$150 Allowance<br><br>Necessary - \$10 Copay        |

# Vision Plan Summary

## Pinnacle Vision Low Plan

### With your Vision Preferred Provider Organization Plan, you can:

- Go to any licensed vision specialist and receive coverage. Just remember your benefit dollars go further when you stay in-network.
- Choose from a large network of ophthalmologists, optometrists and opticians from private practices to retailers like Costco® Optical and Vision works.
- Take advantage of our service agreement with Walmart and Sam's Club—they check your eligibility and process claims even though they are out-of-network.

### In-network value added features:

In addition to standard lens enhancements, enjoy an average 20-25% savings on all other lens enhancements.<sup>1</sup>

Savings on glasses and sunglasses: Get 20% savings on additional pairs of prescription glasses and non-prescription sunglasses, including lens enhancements. At times, other promotional offers may also be available.<sup>1</sup>

Laser vision correction:<sup>2</sup> Savings averaging 15% off the regular price or 5% off a promotional offer for laser surgery including PRK, LASIK and Custom LASIK. This offer is only available at MetLife participating locations.

### In-network benefits

There are no claims for you to file when you go to an in-network vision specialist. Simply pay your copay and, if applicable, any amount over your allowance at the time of service.

|   | Frequency            |
|---|----------------------|
| <b>Eye exam</b>   | Once every 12 months |
| <ul style="list-style-type: none"><li>• Eye health exam, dilation, prescription and refraction for glasses: Covered in full after a <b>\$10</b> copay.</li><li>• Retinal imaging: Covered in full Up to a <b>\$39</b> copay on a routine retinal screening performed by a private practice.</li></ul>   |                      |
| <b>Frame</b>  | Once every 24 months |
| <ul style="list-style-type: none"><li>• Allowance: <b>\$130</b> after <b>\$25</b> eyewear copay</li><li>• Costco: <b>\$70</b> allowance after <b>\$25</b> eyewear copay</li></ul> <p>You will receive an additional <b>20%</b> savings on the amount that you pay over your allowance. This offer is available from all participating locations except Costco.</p>  |                      |
| <b>Standard corrective lenses</b>   | Once every 12 months |
| <ul style="list-style-type: none"><li>• Single vision, lined bifocal, lined trifocal, lenticular: Covered in full after <b>\$25</b> eyewear copay.</li></ul>  |                      |
| <b>Standard lens enhancements<sup>1</sup></b>   | Once every 12 months |
| <ul style="list-style-type: none"><li>• Polycarbonate (child up to age 18), and <b>Ultraviolet(UV) coating</b>: Covered in full after <b>\$25</b> eyewear copay.</li><li>• Progressive, Polycarbonate (adult), Photochromic, Anti-reflective and Scratch-resistant coatings and Tints: Your cost will be limited to a copay that MetLife has negotiated for you. These copays can be viewed after enrollment at <a href="http://metlife.com/mybenefits">metlife.com/mybenefits</a>.</li></ul> |                      |
| <b>Contact lenses</b> (instead of eyeglasses)   | Once every 12 months |
| <ul style="list-style-type: none"><li>• Contact fitting and evaluation: Covered in full with a maximum copay of <b>\$60</b>.</li><li>• Elective lenses: <b>\$130</b> allowance.</li><li>• Necessary lenses: Covered in full after <b>\$25</b> eyewear copay.</li></ul>  |                      |

### We're here to help

Find a Vision provider at [metlife.com/insurance/vision-insurance](http://metlife.com/insurance/vision-insurance)

Download a claim form at [metlife.com/mybenefits](http://metlife.com/mybenefits)

For general questions go to [metlife.com/mybenefits](http://metlife.com/mybenefits) or call 1-855-MET-EYE1 (1-855-638-3931)

## Out-of-network reimbursement

You pay for services and then submit a claim for reimbursement. The same benefit frequencies for **in-network benefits** apply. Once you enroll, visit [metlife.com/mybenefits](https://www.metlife.com/mybenefits) for detailed out-of-network benefits information.

|                                |   |  |
|--------------------------------|---|--|
| • Eye exam: up to <b>\$45</b>  | • Single vision lenses: up to <b>\$30</b> | • Lined trifocal lenses: up to <b>\$65</b> |
| • Frames: up to <b>\$70</b>    | • Lined bifocal lenses: up to <b>\$50</b> | • Progressive lenses: up to <b>\$50</b>    |
| • Contact lenses:              | • Lenticular lenses: up to <b>\$100</b>   |  |
| - Elective up to <b>\$105</b>  |   |  |
| - Necessary up to <b>\$210</b> |   |  |

## Exclusions and Limitations of Benefits

This plan does not cover the following services, materials and treatments.

### SERVICES AND EYEWEAR

- Services and/or materials not specifically included in the Vision Plan Benefits Overview (Schedule of Benefits).
- Any portion of a charge above the Maximum Benefit Allowance or reimbursement indicated in the Schedule of Benefits.
- Any eye examination or corrective eyewear required as a condition of employment.
- Services and supplies received by you or your dependent before the Vision Insurance starts.
- Missed appointments.
- Services or materials resulting from or in the course of a Covered Person's regular occupation for pay or profit for which the Covered Person is entitled to benefits under any Worker's Compensation Law, Employer's Liability Law or similar law. You must promptly claim and notify the Company of all such benefits.
- Local, state, and/or federal taxes, except where MetLife is required by law to pay.
- Services or materials received as a result of disease, defect, or injury due to war or an act of war (declared or undeclared), taking part in a riot or insurrection, or committing or attempting to commit a felony.
- Services and materials obtained while outside the United States, except for emergency vision care.

- Services, procedures, or materials for which a charge would not have been made in the absence of insurance.
- Services: (a) for which the employer of the person receiving such services is not required to pay; or (b) received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital.
- Plano lenses (lenses with refractive correction of less than  $\pm 0.50$  diopter).
- Two pairs of glasses instead of bifocals.
- Replacement of lenses, frames and/or contact lenses, furnished under this Plan which are lost, stolen, or damaged, except at the normal intervals when Plan Benefits are otherwise available.
- Contact lens insurance policies and service agreements.
- Refitting of contact lenses after the initial (90 day) fitting period.
- Contact lens modification, polishing, and cleaning.

- The following items are not covered under the covered contact lenses enhancement: Corneal Refractive Therapy (CRT) or Orthokeratology (a procedure using contact lenses to change the shape of the cornea in order to reduce myopia); replacement of lost or damaged lenses; insurance policies or service agreements; plan lenses (i.e., when patient's refractive error is less than a  $\pm 0.50$  diopter power); plane lenses to change eye color cosmetically; artistically painted lenses; additional office visits associated with contact lens pathology; contact lens modification, polishing or cleaning; and refitting after the initial (90 day) fitting period.

### TREATMENTS

- Orthoptics or vision training and any associated supplemental testing.
- Medical and surgical treatment of the eye(s).

### MEDICATIONS

- Prescription and non-prescription medications.

<sup>1</sup> All lens enhancements are available at participating private practices. Maximum copays and pricing are subject to change without notice. Please check with your provider for details and copays applicable to your lens choice. Please contact your local Costco to confirm your availability of lens enhancements and pricing prior to receiving services. Additional discounts may not be available in certain states.

<sup>2</sup> Custom LASIK coverage only available using wavefront technology with the microkeratome surgical device. Other LASIK procedures may be performed at an additional cost to the member. Additional savings on laser vision care is only available at participating locations.

**Important:** If you or your family members are covered by more than one health care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and hospitals, and it may be impossible to comply with both plans at the same time. Before you enroll in this plan, read all of the rules very carefully and compare them with the rules of any other plan that covers you or your family.

M130D-10/25

MetLife Vision benefits are underwritten by Metropolitan Life Insurance Company, New York, NY. Certain claims and network administration services are provided through Vision Service Plan (VSP), Rancho Cordova, CA. VSP is not affiliated with Metropolitan Life Insurance Company or its affiliates.

Like most group benefit programs, benefit programs offered by MetLife and its affiliates contain certain exclusions, exceptions, reductions, limitations, waiting periods, and terms for keeping them in force. Please contact MetLife or your plan administrator for costs and complete details.

# Vision Plan Summary

## Pinnacle Vision High Plan

### With your Vision Preferred Provider Organization Plan, you can:

- Go to any licensed vision specialist and receive coverage. Just remember your benefit dollars go further when you stay in-network.
- Choose from a large network of ophthalmologists, optometrists and opticians from private practices to retailers like Costco® Optical and Visionworks.
- Take advantage of our service agreement with Walmart and Sam's Club—they check your eligibility and process claims even though they are out-of-network.

### In-network value added features:

In addition to standard lens enhancements, enjoy an average 20-25% savings on all other lens

enhancements.<sup>1</sup>

Savings on glasses and sunglasses:

Get 20% savings on additional pairs of prescription glasses and non-prescription sunglasses, including lens enhancements. At times, other promotional offers may also be available.<sup>1</sup>

Laser vision correction: <sup>2</sup>  
Savings averaging 15% off the regular price or 5% off a promotional offer for laser surgery including PRK, LASIK and Custom LASIK. This offer is only available at MetLife participating locations.

### In-network benefits

There are no claims for you to file when you go to an in-network vision specialist. Simply pay your copay and, if applicable, any amount over your allowance at the time of service.

|  | Frequency            |
|--|----------------------|
| <b>Eye exam</b>  | Once every 12 months |
| <ul style="list-style-type: none"><li>• Eye health exam, dilation, prescription and refraction for glasses: Covered in full after a <b>\$10</b> copay.</li><li>• Retinal imaging: Up to a <b>\$39</b> copay on a routine retinal screening performed by a private practice.</li></ul>  |                      |
| <b>Frame</b>   | Once every 12 months |
| <ul style="list-style-type: none"><li>• Allowance: <b>\$150</b> after <b>\$10</b> eyewear copay</li><li>• Costco: <b>\$85</b> allowance after <b>\$10</b> eyewear copay</li></ul> <p>You will receive an additional <b>20%</b> savings on the amount that you pay over your allowance. This offer is available from all participating locations except Costco.</p>   |                      |
| <b>Standard corrective lenses</b>  | Once every 12 months |
| <ul style="list-style-type: none"><li>• Single vision, lined bifocal, lined trifocal, lenticular: Covered in full after <b>\$10</b> eyewear copay.</li></ul>   |                      |
| <b>Standard lens enhancements<sup>1</sup></b>  | Once every 12 months |
| <ul style="list-style-type: none"><li>• Polycarbonate (child up to age 18), and <b>Ultraviolet(UV) coating</b>: Covered in full after <b>\$10</b> eyewear copay.</li></ul> <p>Progressive, Polycarbonate (adult), Photochromic, Anti-reflective and Scratch-resistant coatings and Tints: Your cost will be limited to a copay that MetLife has negotiated for you. these copays can be viewed after enrollment at <a href="http://metlife.com/mybenefits">metlife.com/mybenefits</a>.</p> |                      |
| <b>Contact lenses</b> (instead of eyeglasses)  | Once every 12 months |
| <ul style="list-style-type: none"><li>• Contact fitting and evaluation: Covered in full with a maximum copay of <b>\$60</b>.</li><li>• Elective lenses: <b>\$150</b> allowance.</li><li>• Necessary lenses: Covered in full after copay.</li></ul>   |                      |

### We're here to help

Find a Vision provider at [metlife.com/insurance/vision-insurance](http://metlife.com/insurance/vision-insurance)

Download a claim form at [metlife.com/mybenefits](http://metlife.com/mybenefits)

For general questions go to [metlife.com/mybenefits](http://metlife.com/mybenefits) or call 1-855-MET-EYE1 (1-855-638-3931)

## Out-of-network reimbursement

You pay for services and then submit a claim for reimbursement. The same benefit frequencies for **in-network benefits** apply. Once you enroll, visit [metlife.com/mybenefits](http://metlife.com/mybenefits) for detailed out-of-network benefits information.

|                                |   |  |
|--------------------------------|---|--|
| • Eye exam: up to <b>\$45</b>  | • Single vision lenses: up to <b>\$30</b> | • Lined trifocal lenses: up to <b>\$65</b> |
| • Frames: up to <b>\$70</b>    | • Lined bifocal lenses: up to <b>\$50</b> | • Progressive lenses: up to <b>\$50</b>    |
| • Contact lenses:              | • Lenticular lenses: up to <b>\$100</b>   |  |
| - Elective up to <b>\$105</b>  |   |  |
| - Necessary up to <b>\$210</b> |   |  |

## Exclusions and Limitations of Benefits

This plan does not cover the following services, materials and treatments.

### SERVICES AND EYEWEAR

- Services and/or materials not specifically included in the Vision Plan Benefits Overview (Schedule of Benefits).
- Any portion of a charge above the Maximum Benefit Allowance or reimbursement indicated in the Schedule of Benefits.
- Any eye examination or corrective eyewear required as a condition of employment.
- Services and supplies received by you or your dependent before the Vision Insurance starts.
- Missed appointments.
- Services or materials resulting from or in the course of a Covered Person's regular occupation for pay or profit for which the Covered Person is entitled to benefits under any Worker's Compensation Law, Employer's Liability Law or similar law. You must promptly claim and notify the Company of all such benefits.
- Local, state, and/or federal taxes, except where MetLife is required by law to pay.
- Services or materials received as a result of disease, defect, or injury due to war or an act of war (declared or undeclared), taking part in a riot or insurrection, or committing or attempting to commit a felony.
- Services and materials obtained while outside the United States, except for emergency vision care.

- Services, procedures, or materials for which a charge would not have been made in the absence of insurance.
- Services: (a) for which the employer of the person receiving such services is not required to pay; or (b) received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital.
- Plano lenses (lenses with refractive correction of less than  $\pm 0.50$  diopter).
- Two pairs of glasses instead of bifocals.
- Replacement of lenses, frames and/or contact lenses, furnished under this Plan which are lost, stolen, or damaged, except at the normal intervals when Plan Benefits are otherwise available.
- Contact lens insurance policies and service agreements.
- Refitting of contact lenses after the initial (90 day) fitting period.
- Contact lens modification, polishing, and cleaning.

- The following items are not covered under the covered contact lenses enhancement: Corneal Refractive Therapy (CRT) or Orthokeratology (a procedure using contact lenses to change the shape of the cornea in order to reduce myopia); replacement of lost or damaged lenses; insurance policies or service agreements; plan lenses (i.e., when patient's refractive error is less than a  $\pm 0.50$  diopter power); plan lenses to change eye color cosmetically; artistically painted lenses; additional office visits associated with contact lens pathology; contact lens modification, polishing or cleaning; and refitting after the initial (90 day) fitting period.

### TREATMENTS

- Orthoptics or vision training and any associated supplemental testing.
- Medical and surgical treatment of the eye(s).

### MEDICATIONS

- Prescription and non-prescription medications.

<sup>1</sup> All lens enhancements are available at participating private practices. Maximum copays and pricing are subject to change without notice. Please check with your provider for details and copays applicable to your lens choice. Please contact your local Costco to confirm your availability of lens enhancements and pricing prior to receiving services. Additional discounts may not be available in certain states.

<sup>2</sup> Custom LASIK coverage only available using wavefront technology with the microkeratome surgical device. Other LASIK procedures may be performed at an additional cost to the member. Additional savings on laser vision care is only available at participating locations.

**Important:** If you or your family members are covered by more than one health care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and hospitals, and it may be impossible to comply with both plans at the same time. Before you enroll in this plan, read all of the rules very carefully and compare them with the rules of any other plan that covers you or your family.

### M150A\_10-10

MetLife Vision benefits are underwritten by Metropolitan Life Insurance Company, New York, NY. Certain claims and network administration services are provided through Vision Service Plan (VSP), Rancho Cordova, CA. VSP is not affiliated with Metropolitan Life Insurance Company or its affiliates.

Like most group benefit programs, benefit programs offered by MetLife and its affiliates contain certain exclusions, exceptions, reductions, limitations, waiting periods, and terms for keeping them in force. Please contact MetLife or your plan administrator for costs and complete details.



# Employee Assistance Program (EAP)

At some point in our lives, each of us faces a problem or situation that is difficult to resolve. When these instances arise, SupportLinc/CuraLinc Healthcare will be there to help. SupportLinc/CuraLinc Healthcare is a confidential resource that helps you deal with life's challenges and the demands that come with balancing home and work. The program provides professional counseling and expert referrals for a wide array of personal and work-related concerns, such as:

Addictive Behaviors  
Anxiety  
Drug Use and Abuse  
Grief and Loss  
Relationship Concerns

Alcohol Abuse  
Care Giver Support  
Family/Marital Problems  
Legal Problems  
Stress-Related Concerns

Anger Management  
Dependent Care Issues  
Financial Issues  
Organizational Change  
Work Life Balance

This benefit is available to all employees who enroll in any benefit mentioned in this benefit guide.

To learn more about it, please contact the Benefits Department [benefits@pinnacle.com](mailto:benefits@pinnacle.com)

# Voluntary Life

## Supplemental Term Life



### Pinnacle Voluntary Life

**For All Active Full-Time Employees working at least 30 hours per week.**

**Build Your Benefit:** With MetLife's Supplemental Term Life insurance, your employer gives you the opportunity to buy valuable life insurance coverage for yourself, your spouse and your dependent children -- all at affordable group rates.

|   | Employee  | Spouse & Child  |   |
|---|---|---|---|
|   |   | Spouse <sup>1</sup>   | Child   |
| <b>Life Coverage:</b><br>provides a benefit in the event of death<br>Schedules:   | Increments of \$10,000  | Increments of \$5,000   | Flat Amount: \$1,000, \$2,000, \$4,000, \$5,000, or \$10,000    |
| <b>Non-Medical Maximum</b>  | \$50,000  | \$25,000  | \$10,000  |
| <b>Overall Benefit Maximum</b>  | The lesser of 5 times Your Basic Annual Earnings, or \$500,000  | \$100,000   | \$10,000  |
| <b>AD&amp;D Coverage:</b><br>provides a benefit in the event of death or dismemberment resulting from a covered accident.<br>Schedules: | Yes (benefit amount is same as Supplemental Term Life coverage) | Yes (benefit amount is same as Supplemental Term Life coverage) | Yes (benefit amount is same as Supplemental Term Life coverage) |
| <b>AD&amp;D Maximum</b>   | Maximum amount is same as Supplemental Term Life coverage       | Maximum amount is same as Supplemental Term Life coverage       | Maximum amount is same as Supplemental Term Life coverage       |
| <b>Employee Contribution</b>  | 100%  | 100%  | 100%  |

Any purchase or increase in benefits, which does not take place within 31 days of employee's or dependent's eligibility effective date is subject to evidence of insurability. Coverage is subject to the approval of MetLife.

#### To request coverage:

1. Choose the amount of employee coverage that you want to buy.
2. Look up the premium costs for your age group for the coverage amount you are selecting on the chart below.
3. Choose the amount of coverage you want to buy for your spouse. Again, find the premium costs on the chart below.  
Note: Premiums are based on your age, not your spouse's.
4. Choose the amount of coverage you want to buy for your dependent children. The premium costs for each coverage option are shown below.
5. Fill in the enrollment form with the amounts of coverage you are selecting. (To request coverage over the non-medical maximum, please see your Human Resources representative for a medical questionnaire that you will need to complete.) Remember, you must purchase coverage for yourself in order to purchase coverage for your spouse or children.

## How to Calculate Your Premium

### Example

$$\boxed{\$50,000} \times \boxed{1.08} \div 10,000 = \boxed{5.40}$$

*For age 30*

### Employee Rate

$$\boxed{\phantom{000000}} \times \boxed{\phantom{000000}} \div 10,000 = \boxed{\phantom{000000}}$$

Employee's coverage  
\* Increments of \$10k  
\* Max is lesser of 5x Annual Earnings or \$500k

Rate from Chart  
\* Based on your age

Monthly Rate

\* \$50k guaranteed

*Plus*

### Spouse Rate

$$\boxed{\phantom{000000}} \times \boxed{\phantom{000000}} \div 10,000 = \boxed{\phantom{000000}}$$

Spouse's coverage  
\* Increments of \$5k  
\* Max is \$100k

Rate from Chart  
\* Based on EMPLOYEE age

Monthly Rate

\* \$25k guaranteed

*Plus*

### Child Rate

Choose Rate from Chart

One deduction covers all children

$$\boxed{\phantom{000000}} \div 10,000 = \boxed{\phantom{000000}}$$

Monthly Rate

*Equals*

$$\boxed{\phantom{000000}} \div 10,000 = \boxed{\phantom{000000}}$$

Monthly Rate

| Employee Age | Employee & Spouse Coverage -- Monthly Premium For: |          |          |          |          |           |  |
|--------------|--|----------|----------|----------|----------|-----------|--|
|              | \$1,000  | \$10,000 | \$20,000 | \$40,000 | \$50,000 | \$100,000 |  |
| Under 30     | \$0.09   | \$0.90   | \$1.80   | \$3.60   | \$4.50   | \$9.00    |  |
| 30-34        | \$0.11   | \$1.08   | \$2.16   | \$4.32   | \$5.40   | \$10.80   |  |
| 35-39        | \$0.13   | \$1.27   | \$2.54   | \$5.08   | \$6.35   | \$12.70   |  |
| 40-44        | \$0.17   | \$1.69   | \$3.38   | \$6.76   | \$8.45   | \$16.90   |  |
| 45-49        | \$0.23   | \$2.32   | \$4.64   | \$9.28   | \$11.60  | \$23.20   |  |
| 50-54        | \$0.35   | \$3.46   | \$6.92   | \$13.84  | \$17.30  | \$34.60   |  |
| 55-59        | \$0.54   | \$5.44   | \$10.88  | \$21.76  | \$27.20  | \$54.40   |  |
| 60-64        | \$0.93   | \$9.26   | \$18.52  | \$37.04  | \$46.30  | \$92.60   |  |
| 65-69        | \$1.48   | \$14.75  | \$29.50  | \$59.00  | \$73.75  | \$147.50  |  |
| 70+          | \$2.76   | \$27.57  | \$55.14  | \$110.28 | \$137.85 | \$275.70  |  |

| Dependent Child Coverage <sup>2</sup> Monthly Premium For: |        |
|--|--------|
| \$1,000  | \$0.38 |
| \$2,000  | \$0.76 |
| \$4,000  | \$1.52 |
| \$5,000  | \$1.90 |
| \$10,000   | \$3.79 |

# Aflac General Information

## Need help with healthcare? We've got your lifeline.

Introducing Health Advocacy, Medical Bill Saver™ and Telemedicine services, now part of your Aflac plan.

### We've enhanced your plan without adding cost.

Now, if you have Aflac Group Critical Illness, Group Accident or Group Hospital Indemnity plans, you also have access to three new services that make it easier to access care, reduce out-of-pocket medical expenses and navigate the healthcare system with greater ease:

- Get answers and expert help with Health Advocacy from Health Advocate
- Let advocates negotiate your medical bills with Medical Bill Saver™, also from Health Advocate.
- Connect with health providers via phone, app or online with MeMD.

These three services are now embedded in your group plan. Best of all, you can start using them as soon as your Aflac coverage starts.

Start using Health Advocacy and Medical Bill Saver™ from Health Advocate and Telemedicine from MeMD when your coverage begins.

Questions? Call 855-423-8585

### DID YOU KNOW?

You can also use Health Advocate's Health Advocacy and Medical Bill Saver™ services for your spouse, dependent children, parents and parents-in-law, while Telemedicine is available for you and your family.

HealthAdvocate™

MeMD™

Aflac®



SERVICES  
AVAILABLE AS  
SOON AS YOUR  
COVERAGE  
STARTS

# Get more without spending more.



## More than just peace of mind. Health Advocacy from Health Advocate

You have 24/7 access to Personal Health Advocates who start helping from the first call:

- Find doctors, dentists, specialists, hospitals and other providers.
- Schedule appointments, treatments and tests
- Resolve benefits issues and coordinate benefits.
- Assist with eldercare issues, Medicare and more.
- Help transfer medical records, lab results and X-rays.
- Work with insurance companies to obtain approvals and clarify coverage.



## More than just cash benefits. Medical Bill Saver™ from Health Advocate

Aflac already pays claims quickly. Now, with Medical Bill Saver™, Health Advocate professionals also help you negotiate medical bills not covered by health insurance:

- Just send in your medical and dental bills of \$400 or more
- They contact the provider to negotiate a discount.
- Negotiations can lead to a reduction in out-of-pocket costs.
- Once an agreement is made, the provider approves payment terms and conditions.
- You get an easy-to-read personal Savings Result Statement, summarizing the outcome and payment terms.



## More than just care. Telemedicine from MeMD

You can quickly connect with board-certified, U.S. licensed health providers online for 24/7/365 access to medical care — fast:

- Create your account at [www.MeMD.me/Aflac](http://www.MeMD.me/Aflac)
- When you have a health issue, log on and request a provider consultation.
- You can request consultations via webcam,
- app or phoneGet Prescriptions,\* referrals and more
- Use it for a range of health issues, from allergies and colds to medication refills.
- \$25.00 per visit!

CAIC's affiliation with the Value-Added Service providers is limited only to a marketing alliance, and CAIC and the Value-Added Service providers are not under any sort of mutual ownership, joint venture, or are otherwise related. CAIC makes no representations or warranties regarding the Value-Added Service Providers and does not own or administer any of the products or services provided by the Value Added Service providers. Each Value-Added Service Provider offers its products and services subject to its own terms, limitations and exclusions. Value Added Services are not available in Idaho or Minnesota. Value Added Services are also not available with group plans underwritten by American Family Life Assurance Company of New York. State availability may vary.

Medical Bill Saver has restrictions for negotiations on in-network deductibles and co-insurance in Arizona, Colorado, District of Columbia, Illinois, Indiana, New Jersey, New York, North Carolina, Ohio, South Dakota, Texas, Utah and Vermont.

### Telemedicine by MeMD

Due to Arkansas state regulations, insureds physically located in Arkansas at the time of a telemedicine session may only receive consultation services from physicians. Physicians are prohibited from providing diagnoses or prescribing drugs to persons located in Arkansas at the time of service.

\*When medically necessary, MeMD providers can submit a prescription electronically for purchase and pick-up at your local pharmacy.

Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers, is a wholly owned subsidiary of Aflac Incorporated and underwrites group coverage. CAIC is not licensed to solicit business in New York, Guam, Puerto Rico, or the Virgin Islands. For groups issued in California, group coverage is underwritten by Continental American Life Insurance Company.

[aflacgroupinsurance.com](http://aflacgroupinsurance.com) | 1.800.433.3036

Continental American Insurance Company | Columbia, South Carolina



# Aflac Short Term Disability

## Overview

For many employees, a temporary loss of income could have long-term financial consequences. Aflac's Short-Term Disability insurance policy provides employees with a monthly benefit amount– and helps provide peace-of-mind.

Personal finances are a careful balancing act for many workers. Aflac Short-Term Disability insurance provides benefits that allow employees to help manage their bills, even during a temporary loss of income due to a disability.

## Plan Benefits

| Benefits           |          |
|--------------------|----------|
| Benefit Duration   | 3 Months |
| Elimination Period | 0/7 Days |

### Total Disability Benefit

#### Total Disability Benefit

This benefit pays the monthly benefit when a covered employee is totally disabled and unable to work due to sickness or injury. Benefits begin following the expiration of an applicable elimination period.

Total Disability Benefits will end when:

- The employee is cleared by the doctor and returns to his full-time job, or
- The employee earns 80% or more of pre-disability income working at any job, or
- The employee reaches the end of the total disability benefit period.

### Partial Disability Benefit

This benefit pays 50% of the monthly benefit when a covered employee is partially disabled and returns to work earning less than 80% of base income due to sickness or injury. Benefits begin following the expiration of an applicable elimination period.

Partial Disability Benefits will end when:

- The employee is cleared by the doctor and returns to his full-time job, or
- The employee earns 80% or more of pre-disability income working at any job, or
- The employee reaches the end of the partial disability benefit period, a maximum of 3 months.

The Partial Disability Benefit has its own benefit period; it is not subject to the Total Disability Benefit Period. The employee may be eligible for the Partial Disability Benefit even if he has not received the Total Disability Benefit.

### Pre-Existing Conditions

#### Pre-Existing Condition Limitation

Pre-existing Condition is an illness, disease, infection, disorder, pregnancy, or injury that existed within the 12-month period before the effective date of coverage.

For a condition to have been pre-existing:

- A doctor must have advised, diagnosed, or treated the covered employee, or
- Symptoms existed that would ordinarily cause a prudent person to seek medical advice or treatment.

We will not pay benefits for any disability resulting from or affected by a pre-existing condition if the disability was diagnosed within the 12-month period after the effective date of coverage.

We will not reduce or deny a claim for benefits for any disability due to a pre-existing condition that was diagnosed more than 12-months after the effective date of coverage.

### Pregnancy Limitation

Within the first nine months of the effective date of coverage, we will not pay benefits for a disability that is caused by, or occurs as a result of, pregnancy or childbirth. Disability due to complications of pregnancy will be covered to the same extent as a covered sickness.

After this coverage has been in force for nine months from the effective date of coverage, disability benefits for childbirth will be payable. The maximum period of disability allowed for disability due to childbirth is six weeks for non-cesarean delivery and eight weeks for cesarean delivery, less the elimination period, unless proof is furnished that disability continues beyond these time frames due to complications of pregnancy.

**Please request a sample policy for full benefit descriptions and definitions.**

## Benefit and Premium Rates

| Monthly Rates per \$100 of monthly benefit |        |        |        |
|--|--------|--------|--------|
| Age Band                                   | 18-49  | 50-64  | 65-74  |
| Premium Rate                               | \$3.38 | \$3.64 | \$4.16 |

| Annual Salary Range  | Monthly Benefit | AGE 18-49 | AGE 50-64 | AGE 65-74 |
|----------------------|-----------------|-----------|-----------|-----------|
| \$9,000 to \$9,999   | \$400           | \$13.61   | \$14.52   | \$16.68   |
| \$10,000 to \$11,999 | \$500           | \$16.99   | \$18.16   | \$20.84   |
| \$12,000 to \$13,999 | \$600           | \$20.37   | \$21.80   | \$25.05   |
| \$14,000 to \$15,999 | \$700           | \$23.79   | \$25.44   | \$29.21   |
| \$16,000 to \$17,999 | \$800           | \$27.17   | \$29.08   | \$33.37   |
| \$18,000 to \$19,999 | \$900           | \$30.55   | \$32.72   | \$37.53   |
| \$20,000 to \$21,999 | \$1,000         | \$33.97   | \$36.36   | \$41.73   |
| \$22,000 to \$23,999 | \$1,100         | \$37.35   | \$40.00   | \$45.89   |
| \$24,000 to \$25,999 | \$1,200         | \$40.78   | \$43.59   | \$50.05   |
| \$26,000 to \$27,999 | \$1,300         | \$44.16   | \$47.23   | \$54.21   |
| \$28,000 to \$29,999 | \$1,400         | \$47.54   | \$50.87   | \$58.41   |
| \$30,000 to \$31,999 | \$1,500         | \$50.96   | \$54.51   | \$62.57   |
| \$32,000 to \$33,999 | \$1,600         | \$54.34   | \$58.15   | \$66.73   |
| \$34,000 to \$35,999 | \$1,700         | \$57.76   | \$61.79   | \$70.89   |
| \$36,000 to \$37,999 | \$1,800         | \$61.14   | \$65.43   | \$75.10   |
| \$38,000 to \$39,999 | \$1,900         | \$64.52   | \$69.07   | \$79.26   |
| \$40,000 to \$41,999 | \$2,000         | \$67.95   | \$72.67   | \$83.42   |
| \$42,000 to \$43,999 | \$2,100         | \$71.33   | \$76.31   | \$87.58   |
| \$44,000 to \$45,999 | \$2,200         | \$74.71   | \$79.95   | \$91.78   |
| \$46,000 to \$47,999 | \$2,300         | \$78.13   | \$83.59   | \$95.94   |
| \$48,000 to \$49,999 | \$2,400         | \$81.51   | \$87.23   | \$100.10  |
| \$50,000 to \$51,999 | \$2,500         | \$84.93   | \$90.87   | \$104.30  |
| \$52,000 to \$53,999 | \$2,600         | \$88.31   | \$94.51   | \$108.46  |
| \$54,000 to \$55,999 | \$2,700         | \$91.69   | \$98.15   | \$112.62  |
| \$56,000 to \$57,999 | \$2,800         | \$95.12   | \$101.75  | \$116.78  |
| \$58,000 to \$59,999 | \$2,900         | \$98.50   | \$105.39  | \$120.99  |
| \$60,000 to \$61,999 | \$3,000         | \$101.92  | \$109.03  | \$125.15  |

**PLEASE CONTACT PINNACLE BENEFITS DEPARTMENT TO RECEIVE INFORMATION REGARDING LIMITATIONS AND EXCLUSIONS.**

# Aflac Accident

## Overview

Aflac pays cash benefits directly to you, unless otherwise assigned. This means that you will have added financial resources to help with medical costs or ongoing living expenses. Aflac group accident insurance plans are designed to provide you with cash benefits throughout the different stages of care, such as the following:

- Emergency treatment
- Hospital admission
- Intensive care unit
- Travel expenses to distant treatment centers
- Everyday living expenses, like your rent or mortgage, utility bills, groceries, and more

## Benefits Summary

### Initial Accident Treatment Category – Base Plan

#### Initial Treatment

Payable for initial treatment received under the care of a doctor. This benefit is not payable for treatment via telemedicine services.

#### Ambulance

Payable when an insured receives transportation by a professional ambulance service.

#### Major Diagnostic Testing

Payable when one of the following exams is performed in a hospital, doctor's office, medical diagnostic imaging center, or an ambulatory surgical center:

- Computerized Tomography (CT/CAT scan)
- Magnetic Resonance Imaging (MRI)
- Electroencephalography (EEG)

#### Emergency Room Observation

Payable when an insured receives treatment in a hospital emergency room and is held in a hospital for observation without being admitted as an inpatient.

#### Prescriptions

Payable when a prescription is filled that is ordered by a doctor, dispensed by a licensed pharmacist, and medically necessary for the care and treatment of the insured. Certain items are excluded from this benefit. See Master Policy for details.

#### Pain Management

Payable when an insured is prescribed and receives, in a doctor's office, a nerve ablation and/or block, or an epidural injection administered into the spine. This benefit is not payable for an epidural administered during a surgical procedure.

#### Blood/Plasma/Platelets

Payable when an insured receives blood, plasma, or platelets.

#### Concussion

Payable when an insured is diagnosed by a doctor with a concussion.

#### Traumatic Brain Injury (TBI)

Payable when an insured is diagnosed by a neurologist with a TBI. To qualify as a TBI, the neurological deficit must require treatment by a neurologist, and a prescribed course of physical, speech, and/or occupational therapy under the direction of a neurologist.

#### Burns

Payable when an insured is burned and then treated by a doctor. This benefit is payable according to the percentage of body burned.

#### Emergency Dental Work

Payable when an insured has an accidental injury to natural teeth.

#### Eye Injury

Payable for eye injuries requiring the removal of a foreign body by a doctor, with or without anesthesia.

#### Lacerations

Payable when an insured receives a laceration that is repaired by a doctor. Liquid skin adhesive will be paid as stitches.

#### Fractures

Payable when an insured fractures a bone and is treated by a doctor. For multiple fractures (more than one bone fractured in one accident), we will pay a maximum of 200% of the benefit amount for the bone fractured that has the highest dollar amount.

For a chip fracture (a piece of bone that is completely broken off near a joint), we will pay 25% of the amount for the affected bone. This benefit is not payable for stress fractures.

## Dislocations

Payable when an insured dislocates a joint and is treated by a doctor. We will pay benefits only for the first dislocation of a joint. We will not pay for recurring dislocations of the same joint. If the insured dislocated a joint before the effective date of his certificate and then dislocates the same joint again, it will not be covered by the plan. For multiple dislocations (more than one dislocated joint in one accident), we will pay a maximum of 200% of the benefit amount for the joint dislocated that has the highest dollar amount. For a partial dislocation (joint is not completely separated, including subluxation), we will pay 25% of the amount for the affected joint.

## Outpatient Surgery and Anesthesia

Payable for each day that an insured has an outpatient surgical procedure performed by a doctor in one of the facilities listed. Surgical procedure does not include laceration repair. If an outpatient surgical procedure is covered under another benefit in the plan, we will pay the higher benefit amount.

## Facilities Fee for Outpatient Surgery

Payable once per each Outpatient Surgery and Anesthesia Benefit (in a hospital or ambulatory surgical center).

## Inpatient Surgery and Anesthesia

Payable for each day that an insured has an inpatient surgical procedure performed by a doctor. The surgery must be performed while the insured is confined to a hospital as an inpatient. If an inpatient surgical procedure is covered under another benefit in the plan, we will pay the higher of that benefit amount.

## Transportation

Payable for transportation when an insured is injured and requires doctor-recommended hospital treatment or diagnostic study that is not available in the insured's resident city.

## Hospitalization Category

### Hospital Admission

Payable when an insured is admitted to a hospital and confined as an inpatient. This benefit is not payable for confinement to an observation unit, for emergency room treatment, or for outpatient treatment.

### Hospital Confinement

Payable for each day that an insured is confined to a hospital as an inpatient. This benefit is payable for only one hospital confinement at a time even if caused by more than one covered accidental injury. This benefit is not payable for confinement to an observation unit or a rehabilitation facility.

### Hospital Intensive Care

Payable for each day an insured is confined in a hospital intensive care unit. We will pay benefits for only one confinement in a hospital intensive care unit at a time, even if it is caused by more than one covered accidental injury. This benefit is payable in addition to the Hospital Confinement Benefit.

### Intermediate Intensive Care Step-Down Unit

Payable for each day an insured is confined in an intermediate intensive care step-down unit. We will pay benefits for only one confinement in an intermediate intensive care step-down unit at a time, even if it is caused by more than one covered accidental injury. This benefit is payable in addition to the Hospital Confinement Benefit.

### Family Member Lodging

Payable for each night's lodging in a motel/hotel/rental property for an adult member of the insured's immediate family when the insured is confined to a hospital under the insured's treating doctor.

*If confinement benefits are paid, and the insured becomes confined again within six months because of the same or a related condition, it will be treated as the same period of confinement.*

## After Care Category

### Appliances

Payable when a doctor advises the insured to use a listed medical appliance as an aid in personal locomotion.

### Accident Follow-Up Treatment

Payable for doctor-prescribed follow up treatment for injuries received in a covered accident. Follow-up treatments may not include physical, occupational, or speech therapy, chiropractic and/or acupuncture procedures. See Master Policy for details.

### Post-Traumatic Stress Disorder (PTSD)

Payable when an insured is diagnosed with PTSD. An insured must meet the diagnostic criteria for PTSD, stipulated in the Diagnostic and Statistical Manual of Mental Disorders IV (DSM IV-TR), and be under the active care of either a psychiatrist or Ph.D.-level psychologist.

### Rehabilitation Unit

Payable when an insured receives treatment as an inpatient at a rehabilitation facility following an inpatient hospital confinement. This is not payable for the same days that the hospital confinement benefit is paid. The highest eligible benefit will be paid.

### Therapy

Payable when an insured has a covered doctor-prescribed therapy treatment.

### Chiropractic or Alternative Therapy

Payable when an insured has a covered therapy treatment due to injuries received in a covered accident.

## Life Changing Events Category

### **Dismemberment**

Payable when an insured loses a hand, foot or sight as the result of a covered accident. For Dismemberment definitions, see Master Policy. If the Dismemberment Benefit is paid and the insured later dies as a result of the same covered accident, we will pay the appropriate death benefit (if available), less any amounts paid under this benefit.

### **Paralysis**

Payable when an insured has permanent loss of movement of two or more limbs for more than 90 days (30 days in Utah) as the result of a covered accidental injury.

### **Prosthesis**

Payable when an insured receives a prosthetic device, prescribed by a doctor, as a result of a covered accidental injury. Prosthetic Device/Prosthesis means an artificial device designed to replace a missing part of the body. This benefit is not payable for hearing aids, wigs, or dental aids (to include false teeth), repair or replacement of prosthetic devices\* and /or joint replacements.

### **Prosthesis Repair/Replacement**

\* We will pay this benefit again once to cover the replacement of a prosthesis for which a benefit has been paid, provided the replacement takes place within three years of the initial benefit payment.

### **Residence/Vehicle Modification**

Payable for a permanent structural modification to an insured's primary residence or vehicle when the insured suffers total and permanent or irrevocable loss of the sight of one eye, the use of one hand/arm, or the use of one foot/leg.

## Wellness Rider

Payable when an insured has a covered test performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations.

**PLEASE CONTACT PINNACLE BENEFITS DEPARTMENT TO RECEIVE  
INFORMATION REGARDING LIMITATIONS AND EXCLUSIONS.**

# Aflac Hospital Indemnity

## Overview

Aflac pays cash benefits directly to you unless you otherwise assigned. This means that you will have added financial resources to help with medical costs or ongoing living expenses. Aflac group hospital indemnity insurance plans are designed to provide you with cash benefits to help with the following:

- Hospital admission
- Hospital confinement
- Intensive care unit
- Ambulance transportation
- Surgery and anesthesia
- Everyday living expenses, like your rent or mortgage, utility bills, groceries, and more

## Benefits Summary

### Hospitalization Benefits

#### Hospital Admission

Payable when an insured is admitted to a hospital and confined as an inpatient because of a covered accidental injury or because of a covered sickness. Not payable for confinement to an observation unit, or for emergency room treatment or outpatient treatment.

#### Hospital Confinement

Payable for each day that an insured is confined to a hospital as an inpatient as the result of a covered accidental injury or because of a covered sickness. If we pay benefits for confinement and the insured becomes confined again within six months because of the same or related condition, we will treat this confinement as the same period of confinement. This benefit is payable for only one hospital confinement at a time even if caused by more than one covered accidental injury, more than one covered sickness, or a covered accidental injury and a covered sickness.

#### Hospital Intensive Care

Payable for each day that an insured is confined in a hospital intensive care unit because of a covered accidental injury or because of a covered sickness. We will pay benefits for only one confinement in a hospital's intensive care unit at a time, even if it is caused by more than one covered accidental injury, more than one covered sickness or a covered accidental injury and a covered sickness. If we pay benefits for confinement in a hospital's intensive care unit and an insured becomes confined to a hospital's intensive care unit again within six months because of the same or related condition, we will treat this confinement as the same period of confinement.

*This benefit is payable in addition to the Hospital Confinement Benefit.*

#### Intermediate Intensive Care Step-Down Unit

Payable for each day that an insured is confined in an intermediate intensive care step-down unit because of a covered accidental injury or because of a covered sickness. We will pay benefits for only one confinement in an intermediate intensive care step-down unit at a time, even if it is caused by more than one covered accidental injury, more than one covered sickness or a covered accidental injury and a covered sickness. If we pay benefits for confinement in a hospital's intermediate intensive care step-down unit and an insured becomes confined to a hospital's intermediate intensive care step-down unit again within six months because of the same or related condition, we will treat this confinement as the same period of confinement.

*This benefit is payable in addition to the Hospital Confinement Benefit.*

*The insured must be admitted to a hospital within six months of the date of the covered accident for benefits to be payable.*

*Residents of Massachusetts are eligible for Hospital Admission, Hospital Confinement, Hospital Intensive Care and Intermediate Intensive Care Step-Down Unit Benefits only.*

### Treatment Benefits

#### Outpatient Doctor's Office Visit

- Payable for each day that an insured visits a doctor's office.
- This benefit is not payable for visits to a chiropractor's office.
- The Pre-Existing Condition Limitation and/or Pregnancy Limitation, do not apply to this benefit.

#### Telemedicine Services

Payable for each day that, because of a covered accidental injury or covered sickness, an insured seeks medical advice from a doctor via telemedicine services. The telemedicine services must be provided in lieu of an outpatient doctor's office visit.

- The Pre-Existing Condition Limitation and/or Pregnancy Limitation, do not apply to this benefit.



### Chiropractor Visit

Payable for each day that an insured receives services from a chiropractor for treatment of a covered accidental injury or because of a covered sickness. Visits to a chiropractor's office are not payable under the Outpatient Doctor's Office Visit Benefit.

- The Pre-Existing Condition Limitation and/or Pregnancy Limitation, do not apply to this benefit.

### Major Diagnostic Exams

Payable for each day that, due to a covered accidental injury or covered sickness, an insured requires one of the following exams:

- Computerized Tomography (CT/CAT scan)
- Magnetic Resonance Imaging (MRI)
- Electroencephalography (EEG)

If an insured has another covered major diagnostic exam because of the same or a related covered accident or covered sickness, we will not pay this benefit again in the same calendar year.

- The Pre-Existing Condition Limitation and/or Pregnancy Limitation, do not apply to this benefit.

### Out of Hospital Prescription Drug

Payable for each day an insured has a prescription filled. Prescription drugs must meet three criteria: (1) be ordered by a doctor; (2) be dispensed by a licensed pharmacist; and (3) be medically necessary for the care and treatment of the insured.

This benefit does not include benefits for: (a) therapeutic devices or appliances; (b) experimental drugs; (c) drugs, medicines or insulin used by or administered to a person while he is confined to a hospital, rest home, extended-care facility, convalescent home, nursing home or similar institution; (d) immunization agents, biological sera, blood or blood plasma; or (e) contraceptive materials, devices or medications or infertility medication, except where required by law.

The Pre-Existing Condition Limitation and/or Pregnancy Limitation, do not apply to this benefit.

### Hospital Emergency Room Visit

Payable for each day that an insured visits a hospital emergency room due to a covered accidental injury or for treatment due to a covered sickness. Any additional hospital emergency room visits will be payable under the Outpatient Doctor's Office Visit Benefit.

- The Pre-Existing Condition Limitation and/or Pregnancy Limitation, do not apply to this benefit.

### Emergency Room Observation

Payable for each period of observation that, because of a covered accidental injury or covered sickness, an insured:

Receives treatment in a hospital emergency room and is held in a hospital for observation without being admitted as an inpatient.

If an insured is held in a hospital for observation more than once because of the same or a related condition, we will not pay this benefit again in the same calendar year.

### Rehabilitation Facility

Payable for each day that, due to a covered accidental injury or a covered sickness, an insured receives treatment as an inpatient at a rehabilitation facility. For this benefit to be payable, the insured must be transferred to the rehabilitation facility for treatment following an inpatient hospital confinement. We will not pay the Rehabilitation Facility Benefit for the same days that the Hospital Confinement Benefit is paid.

**PLEASE CONTACT PINNACLE BENEFITS DEPARTMENT TO RECEIVE  
INFORMATION REGARDING LIMITATIONS AND EXCLUSIONS.**

# Aflac Critical Illness

## Overview

Where Aflac pays cash benefits directly to you unless you choose otherwise. This means that you will have added financial resources to help with medical costs or ongoing living expenses. Aflac group critical illness insurance plans are designed to provide you with cash benefits, such as the following:

- Pays a lump sum benefit for a covered critical illness: cancer, heart attack, and stroke.

## Benefits Summary

Where applicable, covered conditions must be caused by underlying diseases as defined in the plan. Benefits will be based on the face amount in effect on the critical illness date of diagnosis.

### Initial Diagnosis+

An insured may receive up to 100% of his face amount upon the diagnosis of a covered critical illness.

### Additional Diagnosis+

Once benefits have been paid for a covered critical illness, we will pay benefits for each different critical illness when the date of diagnosis is separated by at least 6 consecutive months.

### Reoccurrence+

Once benefits have been paid for a covered critical illness, benefits are payable for that same critical illness when the date of diagnosis is separated by at least 6 consecutive months.

+If the claim is for a cancer diagnosis, the insured must be treatment-free from cancer for at least 12 months and must be in complete remission before the date of a subsequent cancer diagnosis.

### Health Screening Benefit

The Health Screening Benefit is payable once per calendar year for health screening tests performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations. This benefit is payable for the covered employee and spouse. This benefit is not paid for dependent children. See Master Policy for the full list of covered health screening tests.

\*Plan designs vary, and appearance of benefit provisions here does not guarantee coverage.

**PLEASE CONTACT PINNACLE BENEFITS DEPARTMENT TO RECEIVE INFORMATION REGARDING LIMITATIONS AND EXCLUSIONS.**

# Required Notices

## **Women's Health and Cancer Rights Act (WHCRA)**

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

- Reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications for all stages of a mastectomy, including Lymphedemas (swelling associated with the removal of lymph nodes).

These benefits may be subject to annual deductibles and coinsurance provisions that are appropriate and consistent with other benefits under your plan or coverage. If you would like more information on WHCRA benefits, contact the Benefits Department at (210) 344-2088.

## **Notice of Special Enrollment Rights**

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

If you are decline enrollment for yourself or your dependents (including your spouse) while coverage under Medicaid or a state Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' Medicaid or CHIP coverage ends. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or a CHIP program with respect to coverage under this plan, you may be able to enroll yourself and your dependents (including your spouse) in this plan. However, you must request enrollment within 60 days after you or your dependents become eligible for the premium assistance.

To request special enrollment or obtain more information, contact the Benefits Department (210) 344-2088.

# General Notice of COBRA Continuation Coverage Rights

## Introduction

You are getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

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

## What is COBRA continuation coverage?

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

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

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

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

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

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

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

## When is COBRA continuation coverage available?

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

- The end of employment or reduction of hours of employment.
- Death of the employee.
- *[add if Plan provides retiree health coverage: Commencement of a proceeding in bankruptcy with respect to the employer;];* or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the contact listed at the end of this document.

## How is COBRA continuation coverage provided?

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

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

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

### Disability extension of 18-month period of COBRA continuation coverage

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

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

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

## Are there other coverage options besides COBRA Continuation Coverage?

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

**If you have questions**

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

**Keep your Plan informed of address changes**

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

**Plan Administrator and Contact Information**

Pinnacle Health Insurance Plans  
Benefits Department  
1635 NE Loop 410, Suite 700  
San Antonio, TX 78209  
(210) 344-2088



## Children's Health Insurance Program (CHIP)

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

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

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

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

**If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2021. Contact your State for more information on eligibility –**

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

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|--|--|
| <b>GEORGIA-Medicaid</b>  | <b>MASSACHUSETTS-Medicaid and CHIP</b>   |
| Website: <a href="https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp">https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp</a><br>Phone: 678-564-1162 ext 2131   | Website: <a href="https://www.mass.gov/info-details/masshealth-premium-assistance-pa">https://www.mass.gov/info-details/masshealth-premium-assistance-pa</a><br>Phone: 1-800-862-4840  |
| <b>INDIANA-Medicaid</b>  | <b>MINNESOTA-Medicaid</b>  |
| Healthy Indiana Plan for low-income adults 19-64<br>Website: <a href="http://www.in.gov/fssa/hip/">http://www.in.gov/fssa/hip/</a><br>Phone: 1-877-438-4479<br>All other Medicaid<br>Website: <a href="https://www.in.gov/medicaid/">https://www.in.gov/medicaid/</a><br>Phone 1-800-457-4584  | Website:<br><a href="https://mn.gov/dhs/people-we-serve/children-and-families/healthcare/health-care-programs/programs-and-services/other-insurance's">https://mn.gov/dhs/people-we-serve/children-and-families/healthcare/health-care-programs/programs-and-services/other-insurance's</a><br>Phone: 1-800-657-3739 |
| <b>IOWA-Medicaid and CHIP (Hawki)</b>  | <b>MISSOURI-Medicaid</b>   |
| Medicaid Website:<br><a href="https://dhs.iowa.gov/ime/members">https://dhs.iowa.gov/ime/members</a><br>Medicaid Phone: 1-800-338-8366<br>Website:<br><a href="http://dhs.iowa.gov/Hawki">http://dhs.iowa.gov/Hawki</a><br>Hawki Phone: 1-800-257-8563<br>HIPPA Website:<br><a href="https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp">https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp</a><br>HIPPA Phone: 1-888-346-9562   | Website:<br><a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a><br>Phone: 573-751-2005   |
| <b>KANSAS-Medicaid</b>   | <b>MONTANA-Medicaid</b>  |
| Website: <a href="https://www.kancare.ks.gov/">https://www.kancare.ks.gov/</a> Phone:<br>1-800-792-4884  | Website:<br><a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP">http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP</a><br>Phone: 1-800-694-3084   |
| <b>KENTUCKY-Medicaid</b>   | <b>NEBRASKA-Medicaid</b>   |
| Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:<br><a href="https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx">https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx</a><br>Phone: 1-855-459-6328<br>Email: <a href="mailto:KIHIPP.PROGRAM@ky.gov">KIHIPP.PROGRAM@ky.gov</a><br><br>KCHIP Website:<br><a href="https://kidshealth.ky.gov/Pages/index.aspx">https://kidshealth.ky.gov/Pages/index.aspx</a><br><br>Phone: 1-877-524-4718<br><br>Kentucky Medicaid Website: <a href="https://chfs.ky.gov">https://chfs.ky.gov</a> | Website: <a href="http://www.ACCESSNebraska.ne.gov">http://www.ACCESSNebraska.ne.gov</a><br>Phone: 1-855-632-7633<br>Lincoln: 402-473-7000<br>Omaha: 402-595-1178  |
| <b>LOUISIANA-Medicaid</b>  | <b>NEVADA-Medicaid</b>   |
| Website: <a href="http://www.medicaid.la.gov">www.medicaid.la.gov</a> or <a href="http://www.ldh.la.gov/lahipp">www.ldh.la.gov/lahipp</a><br>Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (HIPPA)  | Medicaid Website: <a href="http://dhcfp.nv.gov">http://dhcfp.nv.gov</a><br>Medicaid Phone: 1-800-992-0900  |
| <b>MAINE-Medicaid</b>  | <b>NEW HAMPSHIRE-Medicaid</b>  |
| Enrollment Website:<br><a href="https://www.maine.gov/dhhs/ofi/applications-forms">https://www.maine.gov/dhhs/ofi/applications-forms</a><br>Phone: 1-800-442-6003<br>TTY: Maine relay 711  | Website: <a href="https://www.dhhs.nh.gov/oii/hipp.htm">https://www.dhhs.nh.gov/oii/hipp.htm</a> Phone:<br>603-271-5218<br>Toll free number for the HIPP program: 1-800-852-3345,<br>ext 5218  |

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|---|---|
| Private Health Insurance Premium Webpage:<br><a href="https://www.maine.gov/dhhs/ofi/applications-forms">https://www.maine.gov/dhhs/ofi/applications-forms</a><br>Phone: 1-800-977-6740<br>TTY: Maine relay 711   |   |
| <b>NEW JERSEY-Medicaid and CHIP</b>   | <b>SOUTH DAKOTA-Medicaid</b>  |
| Medicaid Website:<br><a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a><br>Medicaid Phone: 609-631-2392<br>CHIP Website: <a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a> CHIP<br>Phone: 1-800-701-0710 | Website: <a href="http://dss.sd.gov">http://dss.sd.gov</a><br>Phone: 1-888-828-0059   |
| <b>NEW YORK-Medicaid</b>  | <b>TEXAS-Medicaid</b>   |
| Website: <a href="https://www.health.ny.gov/health_care/medicaid/">https://www.health.ny.gov/health_care/medicaid/</a><br>Phone: 1-800-541-2831   | Website: <a href="http://gethipptexas.com/">http://gethipptexas.com/</a><br>Phone: 1-800-440-0493   |
| <b>NORTH CAROLINA-Medicaid</b>  | <b>UTAH-Medicaid and CHIP</b>   |
| Website: <a href="https://medicaid.ncdhhs.gov/">https://medicaid.ncdhhs.gov/</a><br>Phone: 919-855-4100   | Medicaid Website: <a href="https://medicaid.utah.gov/">https://medicaid.utah.gov/</a><br>CHIP Website: <a href="http://health.utah.gov/chip">http://health.utah.gov/chip</a><br>Phone: 1-877-543-7669 |
| <b>NORTH DAKOTA-Medicaid</b>  | <b>VERMONT-Medicaid</b>   |
| Website:<br><a href="http://www.nd.gov/dhs/services/medicalserv/medicaid/">http://www.nd.gov/dhs/services/medicalserv/medicaid/</a><br>Phone: 1-844-854-4825  | Website: <a href="http://www.greenmountaincare.org/">http://www.greenmountaincare.org/</a><br>Phone: 1-800-250-8427   |
| <b>OKLAHOMA-Medicaid and CHIP</b>   | <b>VIRGINIA-Medicaid and CHIP</b>   |
| Website: <a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a><br>Phone: 1-888-365-3742   | Website: <a href="https://www.coverva.org/hipp/">https://www.coverva.org/hipp/</a><br>Medicaid Phone: 1-800-432-5924<br>CHIP Phone: 1-855-242-8282  |
| <b>OREGON-Medicaid</b>  | <b>WASHINGTON-Medicaid</b>  |
| Website: <a href="http://healthcare.oregon.gov/Pages/index.aspx">http://healthcare.oregon.gov/Pages/index.aspx</a><br><a href="http://www.oregonhealthcare.gov/index-es.html">http://www.oregonhealthcare.gov/index-es.html</a> Phone:<br>1-800-699-9075  | Website: <a href="https://www.hca.wa.gov/">https://www.hca.wa.gov/</a><br>Phone: 1-800-562-3022   |
| <b>PENNSYLVANIA-Medicaid</b>  | <b>WEST VIRGINIA-Medicaid</b>   |
| Website:<br><a href="https://www.dhs.pa.gov/providers/Providers/Pages/Medicaid/HIPP-Program.aspx">https://www.dhs.pa.gov/providers/Providers/Pages/Medicaid/HIPP-Program.aspx</a><br>Phone: 1-800-692-7462  | Website: <a href="http://mywvhipp.com/">http://mywvhipp.com/</a><br>Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)  |
| <b>RHODE ISLAND-Medicaid and CHIP</b>   | <b>WISCONSIN-Medicaid and CHIP</b>  |
| Website: <a href="http://www.eohhs.ri.gov/">http://www.eohhs.ri.gov/</a><br>Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte<br>Share Line)  | Website:<br><a href="https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm">https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm</a><br>Phone: 1-800-362-3002                                  |
| <b>SOUTH CAROLINA-Medicaid</b>  | <b>WYOMING-Medicaid</b>   |
| Website: <a href="https://www.scdhhs.gov">https://www.scdhhs.gov</a><br>Phone: 1-888-549-0820   | Website:<br><a href="https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/">https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/</a><br>Phone: 1-800-251-1269    |

To see if any other states have added a premium assistance program since January 31, 2021, or for more information on special enrollment rights, contact either:

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

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

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