



Employee Benefits Enrollment Guide

Effective: 08/01/26 through 07/31/27

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.

Contact Information

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

TRES HEALTH INSURANCE:

Eligibility and Benefits Information: (888) 653-3508
www.member.tres.health
Teladoc: www.mdlive.com/treshealth
Find a Provider: www.hstconnect.com
portal.hstechnology.com/PHCS

APEX MEC INSURANCE:

Eligibility and Benefits Information: (877) 959-9952
www.loomisco.com
Teladoc: (800) Teladoc
www.teladoc.com
Find a Provider: (888) 342-7427
www.multiplan.com

METLIFE DENTAL, VISION, VOLUNTARY LIFE and AD&D:

Provider: (800) MET-LIFE (1-800-638-5433)
www.metlife.com

AXIS HEALTHSELECT:

Claims Information – Axis: (800) 964-7096
Find a Provider: (800) 226-5116

AXIS EMPLOYEE ASSISTANCE PROGRAM (EAP):

Provider: (888) 881-5462

AFLAC:

Provider:
(800) 433-3036

Telemedicine, Health Advocacy, Medical Bill Saver
(855) 423 - 8585

www.aflacgroupinsurance.com

BENEFIT QUESTIONS and SERVICE ISSUES:

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

Pinnacle Benefits Team: (210) 344 - 2088 benefits@pinnaclepeo.com

Medical Plans

TRES

UNDERSTANDING YOUR BENEFITS ENROLLMENT GUIDE

At Tres Health, we strive to support your well-being through our robust benefits package. This enrollment guide is your resource to explore the available benefit options. Please keep in mind that open enrollment is your annual opportunity to adjust your elections, except in cases when enrollment is tied to a change in status for you or your family member.

■ ABOUT TRES HEALTH

Reinventing Affordable Healthcare

We know the healthcare industry forward and backward, and every year, premiums, deductibles, and out-of-pocket maximums continue to rise. We set out to change the way healthcare is designed, managed, and administered, and developed plan offerings that are tech-forward but also people-first, modern but simple, and high-quality but affordable.

Tres offers health plans you can count on, with:

- ✓ Telemedicine and behavioral health services
- ✓ \$0 co-pay for preventive drugs

■ ABOUT OUR CARRIERS & PARTNERS

PHCS MULTIPLAN

Network for Minimum Essential Coverage Plans, Minimum Value Plans, and Reference Based Pricing Plans.

CIGNA PBM

Pharmacy Benefits Manager on all Plans.

Medwatch

Member Advocacy Services.

MDLive

Telemedicine Services.

MedMo

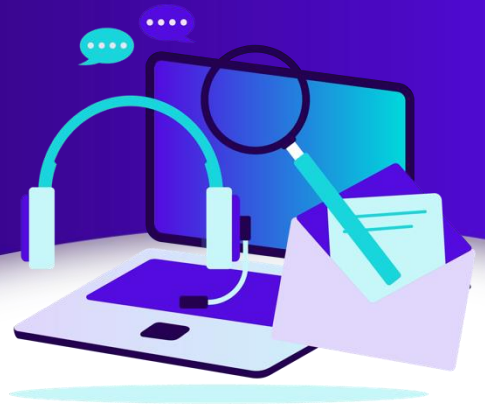
Imaging Center Advocacy.

Connect DME

Medical Device Solutions.



MEMBER ADVOCACY MEDWATCH



Member Experience

Our partnership with MedWatch is designed to empower you with comprehensive support and personalized assistance to manage your health care. By integrating their services with our benefits program, we can provide you with a seamless and efficient health management experience.

How MedWatch Benefits You

Single Point of Contact: Centralized contact for all your health needs, from benefits information to nurse consultations and diagnosis assistance.

Comprehensive Support: Helps you find providers, schedule appointments, provides education on reference-based pricing, and answers health plan questions. They also assist with balance billing, EOB explanations, and pre-certification.

Personalized Advocacy: Uses advanced health data and research-based standards to provide tailored solutions, to help support you and achieve optimal results.

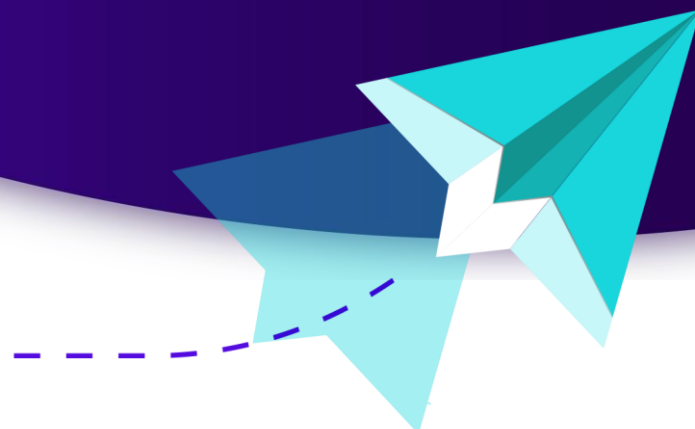
CALL your Concierge when you need help with:

- ✓ Understanding your diagnosis and proposed treatment
- ✓ Questions about your medications
- ✓ Precertification support for upcoming medical procedures *
- ✓ Identifying the best options for quality providers and convenient service locations
- ✓ Referrals to available health related programs (such as wellness, diabetic monitoring, EAP, telemedicine and more)
- ✓ Billing questions and support (claim status, balance billing, grievances, appeals, EOBs and more)
- ✓ Making or changing an appointment with a care provider
- ✓ Managing self-care needs, including education and skill training
- ✓ Education, resources and support for you, your family and your care support system

**Precertification is a benefit of your health plan that helps determine if the procedure or treatment is medically necessary and covered by the policy.*

MEMBER EXPERIENCE ROADMAP

Understanding reference-based pricing health plans and finding a provider doesn't have to be complicated. Here's how Value Driven Health Plans with RBP work with HST Connect.



Step One

Visit hstconnect.com and login to find a provider. Or go to portal.hstechnology.com/PHCS to login as a guest.

Step Two

Medical service or procedure is performed and provider submits a bill to the TPA.

Step Three

Based on HST's pricing and/or negotiations the TPA remits payment.

Step Four

TPA sends you an Explanation of Benefits (EOB).

Step Five

You pay the Member Responsibility portion of the bill to the provider.

WHAT IS REFERENCE BASED PRICING *RBP* ?

This is a cost strategy for an employer so their healthcare costs are set and claims are paid based on a benchmark or predetermined rate for a specific medical procedure or service. Traditional fully-insured plans are negotiated between the insurance carrier and the healthcare provider.

Types of services covered may vary. With Tres Health, please call Medwatch to verify your benefits and any hospital-based service at 888.653.3508.

HOW IT ALL FITS TOGETHER

UNDERSTANDING WHO TO CONTACT FOR WHAT

TRES HEALTH Tres has worked to ensure we have the best partners in place to support your health benefit needs. Information on our partners, and how to access support, are all available on your ID card or the member app.

PROVIDER NETWORK You can find your provider network on the front, top right of your ID card. This is found under the 'Medical Plan' section of your ID card. Here you will find the website and phone number that you can use for your network inquiries.

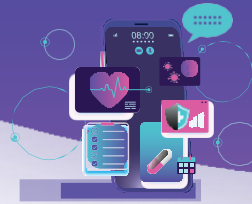
PRESCRIPTION BENEFIT Please view the Pharmacy Plan on the front of your ID card. This is found at the bottom right of the card. You are welcome to search the listed website or call the number provided for any prescription or pharmacy related question.

CUSTOMER SERVICE The Customer Service phone number is located on the back of your ID card under the 'Member' section. You may also find helpful plan information in your personal portal through our Third-Party Administrator (TPA), Loomis.

TELEMEDICINE We don't always have time to drive to a doctor for a non-urgent care. That is why we are bringing medical care for some of the more common conditions to you. Information related to this service from MDLive is found on the back under the 'Member' section of your ID card. Please utilize your Telemedicine benefit to access Board Certified Physicians around the clock (24/7/365) via telephone or secure video. Doctors are there to answer questions, give advice, and even diagnose and treat illnesses without long wait times. To activate your account, visit www.mdlive.com/treshealth and click on the button to activate account. You can also download the app from the App Store or Google Play Store.

PRECERTIFICATION Review your Plan documents, housed in your Medxoom portal, to become familiar with the medical services that require precertification. Your provider needs to pre-certify all inpatient hospitalization and surgeries 7 to 10 days prior to admittance or procedure. If you are admitted to the hospital through the ER, you or your physician must notify us within 48 hours. Refer to your plan documents for more detail. You can find the website and phone number for inquiries under the Pre-Certification section on the back of your ID card. You will also find a phone number for providers to call to pre-certify on the back section of your ID card. Follow the rules of your plan, to maximize your benefits and pay the least amount out of pocket.

CORE \$2500 DEDUCTIBLE



TRES

KEY FEATURES (BEST SELLER)

- ✓ Simplified underwriting
- ✓ Qualifies as MV Plan to satisfy requirement for ACA Penalty B Covers >60% of allowed cost
- ✓ \$0 co-pay on preventive generic drugs or services
- ✓ Substantial in- & out-patient hospitalization coverage

What's covered*

- ✓ Preventive Care
- ✓ Physician Services
- ✓ Telemedicine Services
- ✓ Diagnostic Services and Supplies
- ✓ Emergency Services
- ✓ Inpatient Services
- ✓ Outpatient Services
- ✓ Therapy Services
- ✓ Home Healthcare
- ✓ Preventive Drugs
- ✓ Tier 1 Drugs

What's not covered*

- ⊗ Cardiac Rehabilitation
- ⊗ Diabetic Supplies
- ⊗ Durable Medical Equipment (DME)
- ⊗ Sleep Studies (Home)
- ⊗ Tier 2 Drugs
- ⊗ Tier 3 Drugs

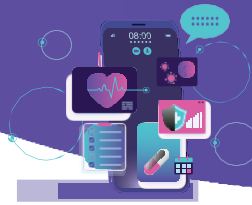
DISCLAIMER: BENEFITS LISTED IN THIS ENROLLMENT GUIDE ARE INTENDED TO BE A BRIEF SUMMARY AND ARE SUBJECT TO CHANGE, REFER TO THE SUMMARY OF BENEFITS FOR FULL DETAILS OF THE BENEFITS INCLUDING DESCRIPTION OF COVERAGE AND A LIST OF EXCLUSIONS.

PLAN AT A GLANCE*

COPAY*

Routine Well Care (Non-Hospital Services) Telemedicine Services w/ MDLive	\$0
Diagnostic Testing- MEDMO (Radiology & Advanced Imaging) – Non-Hospital Based Preventive Drugs	\$0
Tier 1 Drugs	\$30
Primary Care Visit (In-Person & Virtual) This is the encounter fee only. (8 per year)	\$25
Specialist Visit (In-Person & Virtual) This is the encounter fee only. (8 per year) Other Services Performed in Physician Office In addition to office visit copay.(per visit) Diagnostic Testing- OUTSIDE MEDMO (Radiology) – Non-Hospital Based (3 per year) Home Health Care (10 per year)	\$50
Urgent Care (2 per year) Applied Behavioral Analysis (8 per year) Chiropractic Care (8 per year) Occupational, Physical & Speech Therapy (8 combined per year)	\$75
Diagnostic Testing (Lab) – Hospital Based (1 per year)	\$0
Diagnostic Testing- OUTSIDE MEDMO	
Outpatient Services or Surgery – Non-Hospital Based Includes anesthesia when Medically Necessary. (1 per year)	\$350
Ambulance Services Ground ambulance only. (1 per year)	\$500
Emergency Services (1 per year) Inpatient Services (5 days per year) Inpatient Surgery Includes anesthesia when Medically Necessary. (1 per year) Outpatient Services or Surgery – Hospital-Based Includes anesthesia when Medically Necessary (1 per year)	\$750
Deductible (Individual/Family)	\$0/\$0
Maximum Out of Pocket (Individual/Family)	\$9,100/\$18,200

CHOICE \$2500 DEDUCTIBLE



TRES

KEY FEATURES (BEST SELLER)

- ✔ Co-pay driven
- ✔ Simplified underwriting
- ✔ Qualifies as MV Plan to satisfy requirement for ACA Penalty B
- ✔ Covers >60% of allowed cost
- ✔ \$0 co-pay on preventive generic drugs or services
- ✔ Substantial in- & out-patient hospitalization coverage

What's covered*

- ✔ Preventive Care
- ✔ Physician Services
- ✔ Telemedicine Services
- ✔ Diagnostic Services and Supplies
- ✔ Emergency Services
- ✔ Inpatient Services
- ✔ Outpatient Services
- ✔ Therapy Services
- ✔ Home Healthcare
- ✔ Preventive Drugs
- ✔ Tier 1 Drugs
- ✔ Diabetic Supplies
- ✔ Durable Medical Equipment (DME)
- ✔ Sleep Studies (Home)
- ✔ Tier 2 Drugs
- ✔ Tier 3 Drugs

What's not covered*

- ✘ Chemotherapy
- ✘ Radiation Kidney
- ✘ Dialysis Specialty
- ✘ Drugs
- ✘ Cardiac Rehabilitation

PLAN AT A GLANCE*

COPAY*

Routine Well Care (Non-Hospital Services) Telemedicine Services w/ MDLive	
Diagnostic Testing- MEDMO (Radiology & Advanced Imaging) – Non-Hospital Based Preventive Drugs	\$0
Tier 1 Drugs	\$30
Primary Care Visit (In-Person & Virtual) This is the encounter fee only. (12 per year)	\$25
Diabetic Supplies <i>Glucose monitors must be obtained (Per Item)</i>	\$35
Specialist Visit (In-Person & Virtual) This is the encounter fee only. (12 per year) Other Services Performed in Physician Office <i>In addition to office visit copay. (per visit)</i> Diagnostic Testing- OUTSIDE MEDMO (Radiology) – Non-Hospital Based (5 per year) Home Health Care (20 per year)	\$50
Urgent Care (3 per year) Applied Behavioral Analysis (12 per year) Chiropractic Care (12 per year) Occupational, Physical & Speech Therapy (12 combined per year) Cardiac Rehabilitation (12 combined per year)	\$75
Sleep Studies (Home)(per study)	\$300
Diagnostic Testing- OUTSIDE MEDMO (Advanced Imaging) – Non-Hospital Based (3 per year) Outpatient Services or Surgery – Non-Hospital Based <i>Includes anesthesia when Medically Necessary. (2 per year)</i>	\$350
Durable Medical Equipment (DME) <i>CPAP only and must be obtained through ConnectDME. (Per Item)</i>	\$400
Ambulance Services <i>Ground ambulance only. (2 per year)</i>	\$500
Emergency Services (2 per year)	\$750
Diagnostic Testing (Lab) – Hospital Based (3 per year) Inpatient Services (10 days per year) Inpatient Professional Services (per admission) Inpatient Surgery <i>Includes anesthesia when Medically Necessary. (2 per year)</i> Outpatient Services or Surgery – Hospital-Based <i>Includes anesthesia when Medically Necessary (1 per year)</i>	After Deductible, 30% Coinsurance*
Tier 2 Drugs	\$75
Tier 3 Drugs	\$150
Deductible (Individual/Family)	\$2,500/\$5,000
Maximum Out of Pocket (Individual/Family)	\$9,100/\$18,200

DISCLAIMER: BENEFITS LISTED IN THIS ENROLLMENT GUIDE ARE INTENDED TO BE A BRIEF SUMMARY AND ARE SUBJECT TO CHANGE, REFER TO THE SUMMARY OF BENEFITS FOR FULL DETAILS OF THE BENEFITS INCLUDING DESCRIPTION OF COVERAGE AND A LIST OF EXCLUSIONS.

Covered Services



PREVENTIVE/WEALTHNESS BENEFITS*

MEC benefits cover 100% of the cost of certain preventive health services, when delivered by a doctor or provider in your plan's network. Visit www.HealthCare.gov/center/regulations/prevention.html for benefits.

Teladoc - TELEMEDICINE 24/7 (Multilingual)²

Clever Health - BEHAVIORAL HEALTH SERVICES (Multilingual)²

PHCS - PPO NETWORK SERVICES²

Primary Care Physician Visits

Specialist Office Visits

Urgent Care

Diagnostic X-ray and Lab

CT Scan/MRI (outpatient only)

Citizens Rx - PRESCRIPTION BENEFITS²

Tier 1 - Low Cost

Tier 2 - Generics

Tier 3 - Preferred



LIMITED INDEMNITY BENEFITS

Hospital Indemnity Benefits

Hospital Confinement

For treatment in a hospital, due to sickness or injury for 23 or more continuous hours (i.e., not less than a day)

Note: Maternity benefit is payable as any other illness for both mother and child

Hospital Intensive Care Unit

For intensive and comprehensive care, when confined in an area equipped with lifesaving equipment (ICU)

Hospital Admission

Lump sum benefit for a hospital admission, due to sickness or injury

Note: Admission benefit for birth of a healthy child covers mother only. Benefit is payable for newborn if admitted to ICU

Surgery/Anesthesia Benefits

Inpatient Surgery

For inpatient surgery in hospital due to sickness or injury

Outpatient Major Surgery

For outpatient major surgery in hospital or freestanding surgery center, due to sickness or injury

Outpatient Minor Surgery

For outpatient minor surgery in hospital or freestanding surgery center, due to sickness or injury

Anesthesia

For general anesthesia administered by an anesthesiologist or Certified Registered Nurse Anesthetist (payable with inpatient and outpatient major surgeries only)

Emergency Room Benefits

Emergency Room for Sickness

For treatment in an ER due to sickness

Emergency Room for Injury

For treatment in an ER due to injury (treatment must occur within 72 hours of the accident)

	MEC	MEC PLUS	MEC PLUS ADVANTAGE	MEC PLUS ADVANTAGE & GLOBE LIFE GLI ¹
PREVENTIVE/WEALTHNESS BENEFITS*	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%
Teladoc - TELEMEDICINE 24/7 (Multilingual) ²	FREE & Unlimited	FREE & Unlimited	FREE & Unlimited	FREE & Unlimited
Clever Health - BEHAVIORAL HEALTH SERVICES (Multilingual) ²	FREE & Unlimited	FREE & Unlimited	FREE & Unlimited	FREE & Unlimited
PHCS - PPO NETWORK SERVICES ²				
Primary Care Physician Visits	\$0 Copay - 1 visit PPY	\$0 Copay - 2 visits PPY	\$20 Copay - 3 visits PPY	\$20 Copay - 3 visits PPY
Specialist Office Visits	Not Included	Not Included	\$50 Copay - 3 visits PPY	\$50 Copay - 3 visits PPY
Urgent Care			\$50 Copay - 3 visits PPY	\$50 Copay - 3 visits PPY
Diagnostic X-ray and Lab			\$50 Copay - in offices 5 tests PPY	\$50 Copay - in offices 5 tests PPY
CT Scan/MRI (outpatient only)			\$200 Copay - 1 CT Scan or 1 MRI PPY	\$200 Copay - 1 CT Scan or 1 MRI PPY
Citizens Rx - PRESCRIPTION BENEFITS ²				
Tier 1 - Low Cost	Discount Card Up to 75% Discount on FDA Approved Medications	Discount Card Up to 75% Discount on FDA Approved Medications	\$1 Copay	\$1 Copay
Tier 2 - Generics			10% Coinsurance	10% Coinsurance
Tier 3 - Preferred			20% Coinsurance	20% Coinsurance
LIMITED INDEMNITY BENEFITS	Not Included	Not Included	Not Included	GLI Underwritten by Globe Life
Hospital Indemnity Benefits				\$1,000 per day - 30 days PPY
Hospital Confinement				\$1,500 per day - 10 days PPY
Hospital Intensive Care Unit				\$2,500 per day - 1 day PPY
Hospital Admission				\$1,000 per day - 2 days PPY
Inpatient Surgery				\$750 per day - 1 day PPY
Outpatient Major Surgery				\$200 per day - 1 day PPY
Outpatient Minor Surgery				\$300 per day - 1 day PPY
Anesthesia				\$50 per day - 2 days PPY
Emergency Room for Sickness				\$300 per day - 2 days PPY

PPY: Per Plan Year

* The Apex MEC plans are PPACA compliant; they are offered by Apex Management Group and administered by Loomis. Globe Life does not underwrite the MEC plans or the non-insurance benefits.

¹ GLI plans are not PPACA compliant and do not satisfy any PPACA penalties.

² Non-insurance benefits are included with Apex MEC plans.

³ Globe Life premium is illustrated in green and is offered with a 1-year rate guarantee.

This is a solicitation for insurance. Insurance is underwritten by Globe Life And Accident Insurance Company, 3700 S Stonebridge Dr, McKinney, TX 75070. Globe Life is rated A (Excellent) by A.M. Best. This is a limited benefit policy. Coverage is not available in all states. Policy, Certificate and Rider forms: GBLI, GBLIC, GBLITLR, GBLIABR, GBLIADR, GBLIAER, GBLIALR, GBLIASR, GBLIDR, GBLIVR, GBLICIR, GBLITDR. Benefits may vary by state. Pre-existing condition limitations may apply. Premium will vary based on the plan chosen. A waiting period for late entrants may apply. Policies are renewable at the option of Globe Life Group Benefits. Refer to the Master Policy and Certificate for all terms.

Your Coverage Network

Your coverage includes the following benefits -
learn more about when and how to use them.



24/7 Multilingual Telemedicine
Free & Unlimited for member & family
teladoc.com • 800-835-2362

When to Use Telemedicine Services

Teladoc's board-certified physicians have expertise in primary care, pediatrics and family medicine. They can help right away with cold and flu symptoms, allergies, respiratory infections, skin problems and other non-emergency medical issues. Contact Teladoc from the comfort of your home.



Prescription Drug Benefits
National, local, on-line pharmacies available
citizensrx.com • 877-532-7912

To Find an In-Network Pharmacy or Buy Prescription Drugs Online

Citizens Rx is a full-service prescription benefit manager with a retail network of 67,000 pharmacies nationwide. Citizens Rx manages your pharmacy benefits, enabling you to receive discounts on your prescriptions.



Multilingual Behavioral Health
Free & Unlimited for member
cleverhealth.ai/apex

Connect with Behavioral Health Specialists via Mobile App

A better, more clever way to support mental wellness. Download the app today.



Healthcare Decision Assistance

Provides current, unbiased, and accurate
information from medical experts

medexpert.com
800-999-1999



Identity Theft Protection

Consumer ID Theft Program
northpointidtheft.com/apex
800-562-3918

To Use Your Free MEC Preventive Physician Office Visit

1. Locate a network provider using the instructions below.
2. Confirm that the provider is participating in the MEC program when you make your appointment.
3. **Request all preventive services you require when making the initial appointment.**
4. Present your ID card when you receive covered preventive services.
(Your provider will bill Loomis for the cost of your care.)

NOTE: MEC services are only free when delivered by a doctor or other provider in your plan's network. There are 3 sets of preventive services - for adults, women and children. Refer to your plan documents to confirm the MEC services you are eligible to receive. *(Globe Life does not underwrite the MEC plans or the non-insurance benefits.)*

Locating Your Network Provider



PHCS is a comprehensive network of more than 900,000 in-network providers around the U.S.

To find a provider visit: **multiplan.com** and follow the directions for your selected plan.

For the MEC Plus Advantage Plan

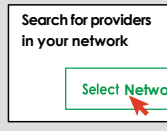
Click "**Find a Provider**" in the top right corner



Click "**OK**" at the bottom right corner



Click "**Select Network**"



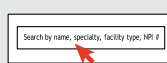
Click "**PHCS**" inside pop-up box



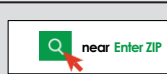
Click "**Specific Services**" inside pop-up box



Enter type of provider (urgent care, primary care, etc...) in the search box



Enter zip code and click the search icon



For the MEC Plus Advantage with GLI Plan

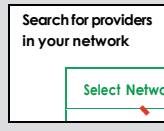
Click "**Find a Provider**" in the top right corner



Click "**OK**" at the bottom right corner



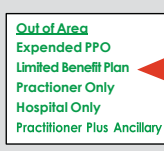
Click "**Select Network**"



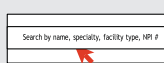
Click "**PHCS**" inside pop-up box



Click "**Limited Benefit Plan**" inside pop-up box



Enter type of provider (urgent care, primary care, etc...) in the search box

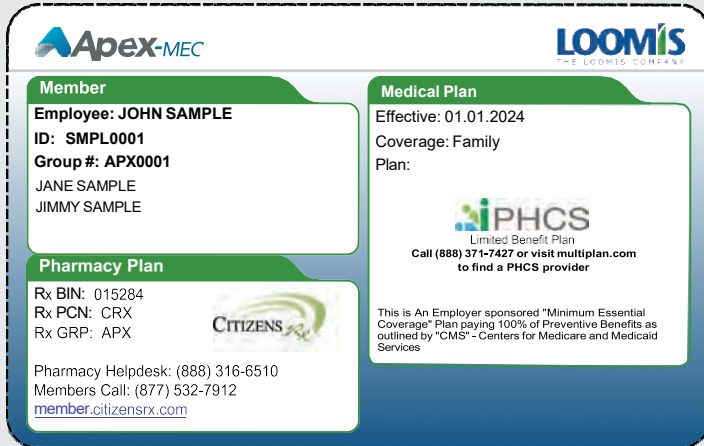


Enter zip code and click the search icon



One ID Card for Apex Benefits

Loomis will send your ID card to your home. Call the Customer Service number first with any questions. After you enroll, you may use the information on the ID card for help with eligibility, benefit and claim questions.



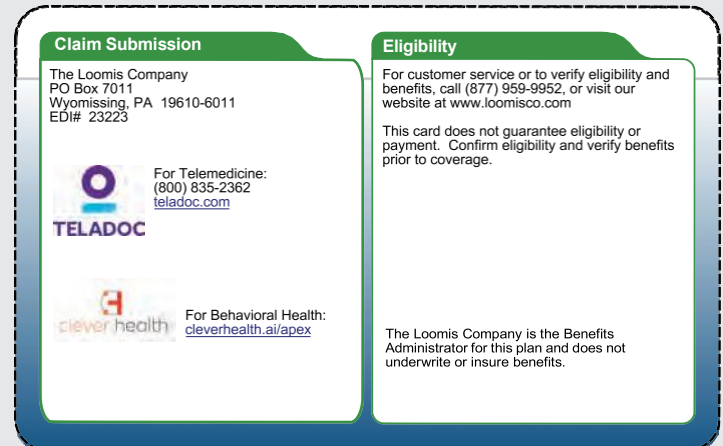
Apex-MEC **LOOMIS**
THE LOOMIS COMPANY

Member
Employee: JOHN SAMPLE
ID: SMPL0001
Group #: APX0001
JANE SAMPLE
JIMMY SAMPLE

Medical Plan
Effective: 01.01.2024
Coverage: Family
Plan:
PHCS
Limited Benefit Plan
Call (888) 371-7427 or visit multiplan.com to find a PHCS provider

Pharmacy Plan
Rx BIN: 015284
Rx PCN: CRX
Rx GRP: APX
CITIZENS RX
Pharmacy Helpdesk: (888) 316-6510
Members Call: (877) 532-7912
member.citizensrx.com

This is An Employer sponsored "Minimum Essential Coverage" Plan paying 100% of Preventive Benefits as outlined by "CMS" - Centers for Medicare and Medicaid Services



Claim Submission
The Loomis Company
PO Box 7011
Wyomissing, PA 19610-6011
EDI# 23223

TELADOC
For Telemedicine:
(800) 835-2362
teladoc.com

clever health
For Behavioral Health:
cleverhealth.ai/apex

Eligibility
For customer service or to verify eligibility and benefits, call (877) 959-9952, or visit our website at www.loomisco.com

This card does not guarantee eligibility or payment. Confirm eligibility and verify benefits prior to coverage.

The Loomis Company is the Benefits Administrator for this plan and does not underwrite or insure benefits.

Filing a Claim

When you go to a provider, present your ID card to show you have coverage. At that time, you can also assign benefits to the provider, authorizing them to submit the claim on your behalf.

NOTE: You should make sure all your claims are filed with BOTH plan administrators (see back of ID card).

For MEC Claims:

To receive the services included with the MEC plan, you must use a network provider who will file the claim.

For GLI Claims:

If you assign benefits to the provider:

- Provider submits the claim to the address on your ID card.
- Claim is processed and payment is sent to the provider.

If you do not assign benefits to the provider:

- You request an itemized bill from the provider.
- You submit the itemized bill to the address on your member card, or via email at GlobeClaims@LoomisLive.com (no claim form required).
- Claim is processed and payment is sent to you.
- You pay the provider.

Your MEC plan is PPACA 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

Covered preventive services for all adults (ages 18 and older)

1. Abdominal aortic aneurysm one-time screening for men of specific ages who have ever smoked
2. Alcohol misuse screening and counseling
3. Aspirin use to prevent cardiovascular disease and colorectal cancer for adults 50 to 59 years with a high cardiovascular risk
4. Blood pressure screening
5. Cholesterol screening for adults of certain ages or at higher risk
6. Colorectal cancer screening for adults 45 to 75
7. Depression screening
8. Diabetes (Type 2) screening
9. Diet counseling for adults at higher risk for chronic disease
10. Falls prevention (with exercise or physical therapy and vitamin D use)
11. Hepatitis B screening for people at high risk, including people from countries with 2% or more Hepatitis B prevalence
12. Hepatitis C screening for adults age 18 to 79 years
13. HIV screening for everyone age 15 to 65, at increased risk
14. PrEP (pre-exposure prophylaxis) HIV prevention medication for HIV-negative adults at high risk for getting HIV through sex or injection drug use
15. Immunizations for adults — doses, recommended ages, and recommended populations vary: Chickenpox (Varicella), Diphtheria, Flu (influenza) Hepatitis A, Hepatitis B, Human Papillomavirus (HPV), Measles, Meningococcal, Mumps, Whooping Cough (Pertussis), Pneumococcal, Rubella, Shingles, Tetanus
16. Lung cancer screening for adults 50 to 80 at high risk for lung cancer
17. Obesity screening and counseling
18. Sexually transmitted infection (STI) prevention counseling
19. Statin preventive medication for adults 40 to 75 at high risk
20. Syphilis screening for adults at higher risk
21. Tobacco use screening for all adults and cessation interventions for tobacco users

Covered preventive services for pregnant women or women who may become pregnant

1. Breastfeeding support and counseling from trained providers, and access to breastfeeding supplies, for pregnant and nursing women
2. Birth control: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs). This does not apply to health plans sponsored by certain exempt "religious employers." Learn more about contraceptive coverage.
3. Gestational diabetes screening for women 24 weeks pregnant (or later) and those at high risk of developing gestational diabetes
4. Folic acid supplements for women who may become pregnant
5. Hepatitis B screening for pregnant women at their first prenatal visit
6. Maternal depression screening for mothers at well-baby visits
7. Preeclampsia prevention and screening for pregnant women with high blood pressure
8. Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk
9. Syphilis screening
10. Expanded tobacco intervention and counseling for pregnant tobacco users
11. Urinary tract or other infection screening

Other covered preventive services for women

1. Bone density screening for all women over age 65 or women age 64 and younger that have gone through menopause
2. Breast cancer genetic test counseling (BRCA) for women at higher risk
3. Breast cancer mammography screenings
 - Every 2 years for women 50 and over
 - As recommended by a provider for women 40 to 49 or women at higher risk for breast cancer
4. Breast cancer chemoprevention counseling for women at higher risk
5. Cervical cancer screening
 - Pap test (also called a Pap smear) for women age 21 to 65
6. Chlamydia infection screening for younger women and other women at higher risk
7. Domestic and interpersonal violence screening and counseling for all women
8. Gonorrhea screening for all women at higher risk
9. Urinary incontinence screening for women yearly
10. Well-woman visits to get recommended services for all women

Covered preventive services for children

1. Alcohol, tobacco, and drug use assessments for adolescents
2. Autism screening for children at 18 and 24 months
3. Behavioral assessments for children: Age 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
4. Bilirubin concentration screening
5. Blood pressure screening for children
6. Blood screening for newborns
7. Depression screening for adolescents beginning routinely at age 12
8. Developmental screening for children under age 3
9. Dyslipidemia screening for all children once between 9 and 11 years and once between 17 and 21 years, and for children at higher risk of lipid disorders
10. Fluoride supplements for children without fluoride in their water source
11. Fluoride varnish for all infants and children as soon as teeth are present
12. Gonorrhea preventive medication for the eyes of all newborns
13. Hearing screening for all newborns; and regular screenings for children and adolescents as recommended by their provider
14. Height, weight and body mass index (BMI) measurements taken regularly for all children
15. Hematocrit or hemoglobin screening for all children
16. Hemoglobinopathies or sickle cell screening for newborns
17. Hepatitis B screening for adolescents at higher risk
18. Hypothyroidism screening for newborns
19. PrEP (pre-exposure prophylaxis) HIV prevention medication for HIV-negative adolescents at high risk for getting HIV through sex or injection drug use
20. Immunizations for children from birth to age 18 — doses, recommended ages, and recommended populations vary: Chickenpox (Varicella), Diphtheria, tetanus, and pertussis (DTaP), Haemophilus influenzae type b, Hepatitis A, Hepatitis B, Human Papillomavirus (HPV), Inactivated Poliovirus, Influenza (flu shot), Measles, Meningococcal, Mumps, Pneumococcal, Rubella, Rotavirus
21. Lead screening for children at risk of exposure
22. Obesity screening and counseling
23. Oral health risk assessment for young children from 6 months to 6 years
24. Phenylketonuria (PKU) screening for newborns
25. Sexually transmitted infection (STI) prevention counseling and screening for adolescents at higher risk
26. Tuberculin testing for children at higher risk of tuberculosis: Age 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
27. Vision screening for all children
28. Well-baby and well-child visits

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Teladoc's U.S. board-certified doctors are available 24/7/365 to resolve many of your medical issues through phone or video consults. Set up your account today so when you need care now, **a Teladoc doctor is just a call or click away.**

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1

Download the clever health app by scanning the QR code below.

2

Enter your mobile phone number then create your clever story.
Select "clever connections", then "get care".

3

Complete the prompted onboarding screens.
Schedule an appointment or **request** to connect immediately.

Common feelings:

- Feeling overwhelmed
- Need to vent
- Career challenges
- Feeling isolated
- Financial difficulties
- LGBTQIA+ community
- Parenting
- Fearing vulnerability

Why use clever connections?

- Service is available 24/7
- Connect one-on-one with a clever connector
- Anonymous conversations
- Discuss real-world challenges
- Be connected to emergency resources immediately, if necessary
- Access helpful resources and programs
- Receive proactive check-ins



Confidential therapy on your terms

 cleverhealth.ai/apex

  Download the app

Consumer ID Theft Program



Providing protection for consumers digital life.

Every year millions of Americans fall victim to identity thieves. It's a real threat, and protection has become a necessity.

Program Overview

The program is deployed on an embedded basis and cannot be sold as an "opt-in". Enrolled consumers must reside in the United States in order to be eligible. Composite rate per household.

Identity Restoration

Recovering from identity theft on your own can be time consuming. Let us help make it less of a pain. Our dedicated, highly qualified, ID restoration specialists will work on your behalf to help you recover from ID theft.

Lost Wallet Assistance

Losing your wallet is a headache. We make it a less painful ordeal by helping you cancel and reissue your credit and ID cards and up to 15 different forms of identification.

Up to \$1M Identity Theft Insurance

This Consumer ID Theft Program provides up to \$1 million in coverage for certain out-of-pocket expenses related to the theft of your personal information.

Stolen Funds (Cash Recovery) Replacement

Lost funds due to identity theft can be difficult to replace. As part of your Consumer ID Theft Program, it provides coverage terms up to \$100,000 in cash recovery for unauthorized electronic funds transfer from a credit/debit card, checking or money market account established for personal use.

Credit Monitoring Powered by Experian®

You'll have access to a suite of tools powered by Experian® to alert you to suspicious activity involving identity fraud. These tools include access to your Experian® Credit Report, Experian® VantageScore®, Credit Monitoring and Alerts and Dark Web Monitoring.

About NorthPoint / Experian®

The program is deployed in collaboration with Experian®, one of the world's largest & most respected consumer services companies. NorthPoint, a majority veteran owned entity, is entirely focused on delivering unique cyber insurance products through its proprietary platforms.

For additional information, please call 800-562-3918 or visit: <https://northpointidtheft.com/apex/>

The Identity Theft Insurance is underwritten and administered by American Bankers Insurance Company of Florida, an Assurant company under group or blanket policy(ies). The description herein is a summary and intended for informational purposes only and does not include all terms, conditions and exclusions of the policies described. Please refer to the actual policies for terms, conditions, and exclusions of coverage. Coverage may not be available in all jurisdictions. Review the Summary of Benefits.



MedExpert



New Services Available

MedExpert provides you access to current, accurate, & unbiased information from professionals recognized as experts in their field. There's no cost to you.

When to call MedExpert

- Assistance locating a primary care provider
- Questions & assistance surrounding preventative screening
- Coordinating and scheduling lab work

MedExpert assists your healthcare team

MedExpert uses information published around the world daily to answer your questions & support your healthcare needs.

With one toll-free call, you can be connected with a MedExpert doctor. We can help you learn about the latest available treatments, research and help coordinate all services that can improve the quality of your life.

To contact MedExpert please call **1-800-999-1999 • 7am to 7pm PST, M-F**

Who is MedExpert?

MedExpert is a U.S. company that uses on-staff doctors to help answer your health care questions. This program is completely confidential and is being offered at no additional cost to you. MedExpert DOES NOT replace your doctor—it is a program that lets you take your health care a step further. We encourage you to discuss your MedExpert call and any information you received with your doctor.

What can MedExpert do for me?

MedExpert uses research and individuals who are recognized as experts in their field to answer your medical questions over the phone. Examples of questions you might ask are: *Is this treatment right for me?* and *Can I take these drugs together?*

MedExpert can also help you:

- Identify how the best in the world would treat your medical condition
- Explain your treatment options and test results
- Understand what your medications are doing and review warnings about taking multiple medications
- Expedite your physician wait lists
- Transfer your medical records
- Consider whether a surgery is medically necessary
- Explain your medical bill
- Identify and connect you with support groups and other community programs that may enrich your life
- Coordinate your physicians

Will I speak to a live person? Where are they located?

Yes, when you call MedExpert, your call will be answered by a Medical Information Coordinator. Based on the nature of your call, you will have the opportunity to speak with a MedExpert doctor. All MedExpert personnel are located in the United States, mostly in California.

What communication can I expect from MedExpert?

In cooperation with your Apex MEC Plan, you may receive communication about the program. MedExpert may also make occasional phone calls to help you get started with the program. MedExpert strives to provide excellent, fast followup to your questions. You will get courteous, professional help when you call. If you do not want to be contacted by MedExpert, you can let them know by calling their toll-free phone number.

Dental, Vision & Life Plans

Dental

	Metlife	Metlife	Metlife
	LOW Plan	HIGH Plan	PREMIER Plan
Annual Maximum	\$1,250	\$2,000	\$3,000
Deductible			
Individual	\$50	\$50	\$25
Family	\$150	\$150	\$75
Type I - Preventive Services	100%	100%	100%
Type II - Basic Services	80%	90%	90%
Type III - Major Services	50%	60%	60%
Type IV - Orthodontic Services	50%	50%	50%
Type IV - Lifetime Maximum	\$1,250	\$2,000	\$2,000
Late Entrant Penalty	Yes	Yes	Yes
Annual Open Enrollment	Yes	Yes	Yes
Endo/Perio - Basic or Major	Major	Major	Major
Simple Oral Surgery - Basic or Major	Major	Major	Major
Out of Network Benefit	Negotiated Fee	Negotiated Fee	Negotiated Fee

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 ¹ % of PDP Fee ²	Out-of-Network ¹ % of PDP Fee ²
Type A - Preventive	100%	100%
Type B - Basic Restorative	80%	80%
Type C - Major Restorative	50%	50%
Type D - Orthodontia	50%	50%
Deductible³		
Individual	\$50	\$50
Family	\$150	\$150
Annual Maximum Benefit:		
Per Individual	\$1250	\$1250
Orthodontia Lifetime Maximum - Ortho applies to Adult and Child	Up to dependent age limit	
	\$1250 per Person	\$1250 per Person

1. "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.

2. 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.

3. Applies to Type B and C services only.

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.

Coverage Type:	In-Network¹ % of PDP Fee ²	Out-of-Network¹ % of PDP Fee ²
Type A - Preventive	100%	100%
Type B - Basic Restorative	90%	90%
Type C - Major Restorative	60%	60%
Type D - Orthodontia	50%	50%
Deductible³		
Individual	\$50	\$50
Family	\$150	\$150
Annual Maximum Benefit:		
Per Individual	\$2000	\$2000
Orthodontia Lifetime Maximum - Ortho applies to Adult and Child	Up to dependent age limit	
	\$2000 per Person	\$2000 per Person
<p>1. "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>2. 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>3. Applies to Type B and C services only.</p>		

Dental

Metropolitan Life Insurance Company

Pinnacle Dental PPO Premier Plan

Network: PDP Plus

Coverage Type	In-Network % of Negotiated Fee*	Out-of-Network 90% of R&C Fee***
Type A: Preventive (cleanings, exams, X-rays)	100%	100%
Type B: Basic Restorative (fillings, extractions)	90%	90%
Type C: Major Restorative (bridges, dentures)	60%	60%
Type D: Orthodontia	50%	50%
Deductible†		
Individual	\$25	\$25
Family	\$75	\$75
Annual Maximum Benefit		
Per Person	\$3,000	\$3,000
Orthodontia Lifetime Maximum		
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 LOW Plan In-Network	MetLife HIGH Plan In-Network
Eye exam <ul style="list-style-type: none"> • Eye health exam, dilation, prescription and refraction for glasses: Covered in full after copay • Retinal imaging: Routine retinal screening when performed by a private practice. 	Once every 12 months Exam - \$10 Copay Imaging - Max \$39	Once every 12 months Exam - \$10 Copay Imaging - Max \$39
Frame <ul style="list-style-type: none"> • 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 	Once every 24 months \$130 Allowance after \$25 eyewear Copay Costco: \$70 Allowance after \$25 eyewear Copay	Once every 12 months \$150 Allowance after \$10 eyewear Copay Costco: \$85 Allowance after \$10 eyewear Copay
Standard corrective lenses <ul style="list-style-type: none"> • Single vision, lined bifocal, lined trifocal, lenticular: Covered in full after eyewear copay 	Once every 12 months \$25 Copay	Once every 12 months \$10 Copay
Standard lens enhancements <ul style="list-style-type: none"> • Polycarbonate (child up to age 18), and Ultraviolet (UV) coating: Covered in full. • 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 metlife.com/mybenefits 	Once every 12 months \$25 Copay	Once every 12 months \$10 Copay
Contact lenses (instead of eye glasses) <ul style="list-style-type: none"> • Contact fitting and evaluation: Covered in full with a maximum copay. • Elective lenses • Necessary lenses: Covered in full after eyewear copay. 	Once every 12 months Fitting - Max \$60 Copay Elective - \$130 Allowance Necessary - \$25 Copay	Once every 12 months Fitting - Max \$60 Copay Elective - \$150 Allowance 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.¹

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.¹

Laser vision correction:² 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
Eye exam	Once every 12 months
<ul style="list-style-type: none">• Eye health exam, dilation, prescription and refraction for glasses: Covered in full after a \$10 copay.• Retinal imaging: Covered in full Up to a \$39 copay on a routine retinal screening performed by a private practice.	
Frame	Once every 24 months
<ul style="list-style-type: none">• Allowance: \$130 after \$25 eyewear copay• Costco: \$70 allowance after \$25 eyewear copay <p>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.</p>	
Standard corrective lenses	Once every 12 months
<ul style="list-style-type: none">• Single vision, lined bifocal, lined trifocal, lenticular: Covered in full after \$25 eyewear copay.	
Standard lens enhancements¹	Once every 12 months
<ul style="list-style-type: none">• Polycarbonate (child up to age 18), and Ultraviolet(UV) coating: Covered in full after \$25 eyewear copay.• 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 metlife.com/mybenefits.	
Contact lenses (instead of eyeglasses)	Once every 12 months
<ul style="list-style-type: none">• Contact fitting and evaluation: Covered in full with a maximum copay of \$60.• Elective lenses: \$130 allowance.• Necessary lenses: Covered in full after \$25 eyewear copay.	

We're here to help

Find a Vision provider at metlife.com/insurance/vision-insurance

Download a claim form at metlife.com/mybenefits

For general questions go to 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 for detailed out-of-network benefits information.

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

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 ± 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 ± 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.

¹ 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.

² 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.¹

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.¹

Laser vision correction:² 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
Eye exam	Once every 12 months
<hr/>	
<ul style="list-style-type: none">• Eye health exam, dilation, prescription and refraction for glasses: Covered in full after a \$10 copay.• Retinal imaging: Up to a \$39 copay on a routine retinal screening performed by a private practice.	
<hr/>	
Frame	Once every 12 months
<hr/>	
<ul style="list-style-type: none">• Allowance: \$150 after \$10 eyewear copay• Costco: \$85 allowance after \$10 eyewear copay <p>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.</p>	
<hr/>	
Standard corrective lenses	Once every 12 months
<hr/>	
<ul style="list-style-type: none">• Single vision, lined bifocal, lined trifocal, lenticular: Covered in full after \$10 eyewear copay.	
<hr/>	
Standard lens enhancements¹	Once every 12 months
<hr/>	
<ul style="list-style-type: none">• Polycarbonate (child up to age 18), and Ultraviolet(UV) coating: Covered in full after \$10 eyewear copay.	
<hr/>	
<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 metlife.com/mybenefits.</p>	
<hr/>	
Contact lenses (instead of eyeglasses)	Once every 12 months
<hr/>	
<ul style="list-style-type: none">• Contact fitting and evaluation: Covered in full with a maximum copay of \$60.• Elective lenses: \$150 allowance.• Necessary lenses: Covered in full after copay.	

We're here to help

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Download a claim form at metlife.com/mybenefits

For general questions go to 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 for detailed out-of-network benefits information.

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

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 ± 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 ± 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.

¹ 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.

² 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.

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	Child
Life Coverage: provides a benefit in the event of death Schedules:	Increments of \$10,000	Increments of \$5,000	Flat Amount: \$1,000, \$2,000, \$4,000, \$5,000, or \$10,000
Non-Medical Maximum	\$150,000	\$25,000	\$10,000
Overall Benefit Maximum	The lesser of 5 times Your Basic Annual Earnings, or \$500,000	\$100,000	\$10,000
AD&D Coverage: provides a benefit in the event of death or dismemberment resulting from a covered accident. 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)
AD&D Maximum	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
Employee Contribution	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

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

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

Rate from Chart
 * Based on your age

Monthly Rate

* \$150k guaranteed

Plus

Spouse Rate

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

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

$$\boxed{} = \boxed{}$$

Monthly Rate

Equals

$$\boxed{} = \boxed{}$$

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 ² Monthly Premium For:	
\$1,000	\$0.38
\$2,000	\$0.76
\$4,000	\$1.52
\$5,000	\$1.90
\$10,000	\$3.79

Supplemental Plans

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
(888) 881-5462**

What is Axis HealthSelect?

Why choose HealthSelect?

Medical and hospital expenses can add up quickly. HealthSelect offers fixed-indemnity and accident medical insurance designed to help you offset commonly occurring medical expenses.



Guaranteed issue

No medical questions asked at enrollment. Family member coverage is also available.



Financial protection

Provides you with cash benefits to help offset out-of-pocket costs for medical expenses related to covered accidents and serious illnesses.



Competitive rates

Rates are based on group demographics by state, not-age rated. Allows employees in many situations access to coverage.

What is covered?

HealthSelect provides a set limit of benefits to help manage medical expenses arising from hospital visits, physician office visits, lab tests, and other health-related needs.



Inpatient Medical

Pays a daily benefit for covered hospitalizations.



Outpatient

Benefits paid to offset the unexpected medical expenses that may result from a covered accidental injury.



Prescription

Retail and mail order prescription benefits up to a maximum monthly benefit.



Critical Illness and AD&D

Indemnity benefits for covered accidents and illnesses.



Non-Insurance Supplemental Services*

Medical PPO Network, Pharmacy Network, Teladoc, and EAP.

THIS INSURANCE PROVIDES LIMITED BENEFITS. LIMITED BENEFIT PLANS ARE INSURANCE PRODUCTS WITH REDUCED BENEFITS AND ARE NOT INTENDED TO BE AN ALTERNATIVE TO OR INTEGRATED WITH COMPREHENSIVE COVERAGE. FURTHER, THIS INSURANCE DOES NOT COORDINATE WITH ANY OTHER INSURANCE PLAN. IT DOES NOT PROVIDE MAJOR MEDICAL OR COMPREHENSIVE MEDICAL COVERAGE AND IS NOT DESIGNED TO REPLACE MAJOR MEDICAL INSURANCE. FURTHER, THIS INSURANCE IS NOT MINIMUM ESSENTIAL BENEFITS AS SET FORTH UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE ADDITIONAL PAYMENT WITH YOUR TAXES.

COVERAGE IS SUBJECT TO EXCLUSIONS AND LIMITATIONS, AND MAY NOT BE AVAILABLE IN ALL US STATES AND JURISDICTIONS. PRODUCT AVAILABILITY AND PLAN DESIGN FEATURES, INCLUDING ELIGIBILITY REQUIREMENTS, DESCRIPTIONS OF BENEFITS, EXCLUSIONS OR LIMITATIONS MAY VARY DEPENDING ON LOCAL COUNTRY OR US STATE LAWS. FULL TERMS AND CONDITIONS OF COVERAGE, INCLUDING EFFECTIVE DATES OF COVERAGE, BENEFITS, LIMITATIONS AND EXCLUSIONS ARE SET FORTH IN THE POLICY.

THESE PLANS CONSIST ONLY OF AN AD&D, CRITICAL ILLNESS AND HOSPITAL INDEMNITY POLICY. THE COVERED LOSSES ARE LIMITED TO THOSE LOSSES LISTED ABOVE.

The Limited Benefit Plans are underwritten by AXIS Insurance Company under group policy form series numbers T-GOA-001-0112, T-GCI-001-0112, T-GHI-001-0112.

Disclaimer: The amount of benefits provided depends upon the plan selected; the premium will vary with the amount of the benefits selected. The benefits described above are provided only through a combination of policies.

*THE SERVICES DESCRIBED ABOVE ARE NOT INSURANCE AND ARE NOT PROVIDED BY AXIS INSURANCE COMPANY.

Axis Benefits at a Glance

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.

Axis HealthSelect Indemnity Plans

	Plan 1 - Basic	Plan 2 - Choice	Plan 3 - Max
INPATIENT ⁽¹⁾ Hospital Confinement Day 1 benefit amount Days 2+! benefit! Amount per day Maximum benefit Surgery benefit amount (incl. maternity) - per day Anesthesia benefit amount - per day	\$2,000perdayx1day \$750 thereafter 5 days per year \$1,000perday x1day \$250per day x 1 day	\$2,500perdayx1day \$1,500thereafter 5 days per year \$2,000perdayx 2 days \$500 per day x 2 days	\$3,000perdayx1 day \$2,000 thereafter 10 days per year \$2,500perdayx 2 days \$625perdayx2days
OUTPATIENT ⁽¹⁾ Physician Office Visit Pre-pay ⁽²⁾ Benefit amount per day Wellness benefit amount per day Well child care (up to age 4) benefit amount Accident maximum benefit amount per year up to Benefit % payable Deductible per accident Emergency Room (sickness) benefit amount per day Surgery benefit amount per day Anesthesia benefit amount - per day Diagnostic, X-ray, Lab - benefit amount per test Class I: Blood work,CMP, Lipid Panel, ECG, Pap/PSA, urinalysis and all other laboratory tests ClassII:Radiology, Ultrasound,Mammogram,Sonogram,Angiogram Class III: Imaging CT, PET Class IV: Other Diagnostic tests- Endoscopy, Bronchoscopy, Colonoscopy without Biopsy, MRI	\$10 \$65 per day x5days \$100perdayx 1 day N/A \$5,000 per year 80% U&C \$0 \$300perdayx 1 day N/A N/A \$30per dayx 2 days \$50per dayx 2 days \$75perdayx 1 day	\$10 \$75perday x 5 days \$100perdayx 1 day N/A \$7,500 per year 80% U&C \$0 \$500perdayx 1 day \$1,000perdayx 1 day \$250 per day x 1 day \$30per dayx 2 days \$30per dayx 2 days \$75per dayx 2 days \$125perdayx1 day N/A	\$10 \$85perdayx5days \$100perdayx1 day N/A \$10,000 per year 80% U&C \$0 \$750perdayx 1 day \$1,750perdayx 1 day \$437.50perdayx 1 day \$30 per day x 2 days \$175 per day x 2 days \$200 per day x 1 day \$750 per day x 1 day \$10 \$30 \$20 \$60 \$300/600
PRESCRIPTION ⁽³⁾ Retail - Generic RX co-pay Retail - Preferred Brand RX co-pay Mail Order - Generic RX co-pay Mail Order - Preferred Brand RX co-pay Monthly benefit maximum - INDIVIDUAL/FAMILY	N/A Discount Only ⁽²⁾	\$10 \$30 \$30 \$90 \$200/400	\$300/600
AD&D Accidental Death & Dismemberment benefit amount* *Benefit amounts listed are for: Employee/Spouse/Child(ren)	\$10,000/5,000/1,000	\$15,000/5,000/1,000	\$25,000/5,000/1,000
OTHER SERVICES ⁽⁴⁾ Teladoc: Telephonic Doctor Office Visits Support Line-EAP First Health PPO Discounts	Yes Yes Yes	Yes Yes Yes	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.

How Axis HealthSelect works

HealthSelect provides you with fixed indemnity benefits to help manage medical expenses arising from hospital visits, physician office visits, lab tests, and other health-related needs. Following are potential claim scenarios.

1. Broken bone



Employee injures her leg while playing softball and goes to the ER.



She has an X-ray to determine extent of her injury.



Her leg is broken; surgery or hospital stay is not required.

Cash benefit is paid of up to

\$6,007*

Amount payable is based on Sample Plan outpatient accident benefit (\$5,882, based on 80% of U&C of \$7,352, the average cost of a broken leg¹) and class II radiology benefit (\$125).

2. Pregnancy (normal delivery)



Employee visits OB to confirm pregnancy.



She receives routine OB care – no complications.



She delivers a healthy baby, and both are released after 2 days

Cash benefit is paid of up to

\$7,350*

Amount payable is based on Sample Plan benefit amounts for 2 days hospital confinement (\$2,500– mother, \$2,500– baby), typical OB care (\$2,000), lab test (\$100) and ultrasound (\$250).

3. Annual wellness check-up



Employee visits a doctor in First Health PPO Network for annual physical.



Doctor orders routine blood work.



Doctor prescribes a statin for slightly elevated cholesterol.

Cash benefit is prescription

paid of up to **\$135*** & co-pay of **\$90***

Amount payable is based on Sample Plan benefit amounts for wellness visit (\$85) and class I blood work (\$50). Prescription benefit of \$90 is based on mail order, preferred brand Rx co-pay.

4. Heart attack



Employee suffers a heart attack and is taken to the ER.



Physician admits him to the hospital for observation.



Surgery is not required. He is released the next day.

Cash benefit is paid of up to

\$16,625*

Amount payable is based on Sample Plan benefit amounts for critical illness (\$15,000), 1-day hospital confinement (\$1,500), and angiogram (class II diagnostic benefit \$125).

¹ <http://bmcmusculoskeletdisord.biomedcentral.com/articles/10.1186/1471-2474-14-42>

* Illustrative scenario is for informational purposes only based on Sample Plan design and is not a guarantee of payment. Not all factors can be accounted for in an illustrative claim scenario as actual claims received are processed individually and adjudicated according to the terms, provisions, limitations, and exclusions of each policy which may include state-specific provisions. In addition, medical providers determine and bill the insurance company with the applicable procedure code and diagnosis code for the services rendered. Provider billed amounts will vary. Provider discounts, if any, will vary based on geography and the provider's contractual obligation with the PPO network. This illustration provides only a brief description of the limited accident and sickness coverage available. The policy issued contains full details of the coverage, reductions, limitations, exclusions, and termination provisions which govern any conflicting information that may be presented in this illustration. Pregnancy claim example considers typical OB care for vaginal delivery, antepartum and postpartum care paid at \$2,000 and the ultrasound benefit is based on \$125/day x 2 days. For broker/employer use only. Not for individual or member solicitations.

Non-Insurance Supplemental Services

Valuable services and savings available to your employees through HealthSelect



First Health PPO Medical Network

Access to Network discounts at more than 5,000 hospitals and 590,000 physicians and healthcare professionals.



Pharmacy Network

RxSense provides innovative Pharmacy Benefit Administration (PBA) solutions to organizations across the US offering high quality, cost-effective prescription services. Members have access to unsurpassed service and superior savings on a wide variety of prescription drugs.



Prescription Discount Program

With ScriptSave, receive instant prescription savings on brand name and generic medications. Savings average 22%, with potential savings of up to 50% at over 500,000 participating pharmacies.



Telehealth Program

Teladoc provides 24/7 access to a national network of US board-certified doctors by phone or online for information, advice, and treatment, including prescriptions for common medical concerns.



Employee Assistance Program

SupportLinc provides 24/7 access to professional counselors by phone, video and web chat to provide professional referrals, assessments and up to 3 face-to-face sessions for personal and work-related concerns.

* THE SERVICES DESCRIBED ABOVE ARE NOT INSURANCE AND ARE NOT PROVIDED BY AXIS INSURANCE COMPANY.

Emotional wellbeing and work-life balance resources to keep you at your best

SupportLinc offers expert guidance to help you and your family address and resolve everyday issues.



In-the-moment support

Reach a licensed clinician by phone 24/7/365 for immediate assistance.



Financial expertise

Consultation and planning with a financial counselor.



Legal consultation

By phone or in-person with a local attorney.



Short-term counseling

Access up to **three (3) no-cost counseling sessions**, in-person or via video, to resolve stress, depression, anxiety, work-related pressures, relationship issues or substance abuse.



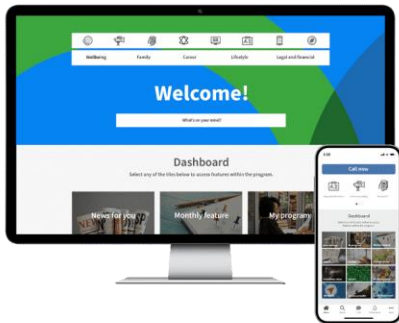
Convenience resources

Referrals for child and elder care, home repair, housing needs, education, pet care and so much more.



Confidentiality

Strict confidentiality standards ensure no one will know you have accessed the program without your written permission except as required by law.



Your web portal and mobile app

- The one-stop shop for program services, information and more.
- Discover on-demand training to boost wellbeing and life balance.
- Find search engines, financial calculators and career resources.
- Explore thousands of articles, tip sheets, self-assessments and videos.

Convenient, on-the-go support

- **Textcoach®**
Personalized coaching with a licensed counselor on mobile or desktop.
- **Animo**
Self-guided resources to improve focus, wellbeing and emotional fitness.
- **Virtual Support Connect**
Moderated group support sessions on an anonymous, chat-based platform



Start with Navigator

Take the guesswork out of your emotional fitness! Visit your web portal or mobile app to complete the short Mental Health Navigator survey. You'll immediately receive personalized guidance to access support and resources.



Download the mobile app today!



1-888-881-5462

supportlinc.com

group code:

axisgroup

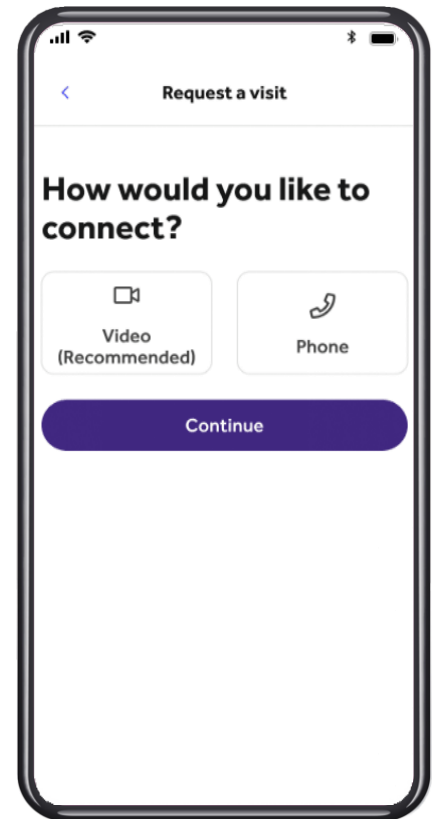
Don't let sickness slow you down.

Talk to a doctor by phone or video 24/7.



Teladoc Health is included in your health benefits.

We're here to help you and your family feel better while traveling, at work, or at home—day or night. Wherever you are, you've got access to doctors all year long by phone or video





Get treated for:

- Flu
- Sore throats
- Pink eye
- Bronchitis
- Sinus infections
- Rashes
- Allergies
- And more

Talk to a doctor 24/7

Visit [Teladoc.com](https://www.teladoc.com)

Call 1-800-TELADOC (800-835-2362) | Download the app  | 

*Teladoc Health is not available internationally.

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Axis: 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:

1. Intentionally self-inflicted injury, suicide or any attempt while sane or insane;
2. Commission or attempt to commit a felony or an assault;
3. Commission of or active participation in a riot or insurrection;
4. Declared or undeclared war or act of war;
5. Release, whether or not accidental, or by any person unlawfully or intentionally, of nuclear energy or radiation, including sickness or disease resulting from such release;
6. An injury or sickness 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, the Company will refund any premium paid for this time. Reserve or National Guard active duty training is not excluded unless it extends beyond 31 days;
7. Travel or activity outside the United States, Canada or Mexico, except for a Medical Emergency;
8. Flight in, boarding or alighting from an Aircraft except as: a fare-paying passenger on a regularly scheduled commercial or charter airline; a passenger in a non-scheduled, private Aircraft used for pleasure purposes with no commercial intent during the flight;
9. 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;
10. Bungee-cord jumping, parachuting, skydiving, parasailing, hang-gliding;
11. Voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage;
12. The Insured Person's intoxication. The Insured Person is conclusively deemed to be intoxicated if the level in his blood exceeds the amount at which a person is presumed, under the law of the locale in which the accident occurred, to be under the influence of alcohol if operating a motor vehicle, regardless of whether he is in fact operating a motor vehicle, when the injury occurs. An autopsy report from a licensed medical examiner, law enforcement officer's report, or similar items will be considered proof of the Insured Person's intoxication;
13. An Accident if the Insured Person is the operator of a motor vehicle and does not possess a valid motor vehicle operator's license, unless: (a) the Insured Person holds a valid learners permit and (b) the Insured Person is receiving instruction from a driver's education instructor;
14. Alcoholism, drug addiction or the use of any drug or narcotic except as prescribed by a Physician unless specifically provided herein;

15. Repair or replacement of existing dentures, partial dentures, braces, fixed or removable bridges, or other artificial dental restoration;
16. Repair, replacement, examinations for prescriptions or the fitting of eyeglasses or contact lenses;
17. 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;
18. Mental and nervous disorders;
19. Elective surgery or cosmetic surgery, except for reconstructive surgery needed as the result of a Covered Injury or Covered Sickness;
20. Experimental or Investigational drugs, services, supplies. For the purposes of this exclusion, "Experimental or Investigational" means medical services, supplies or treatments provided or performed in a special setting for research purposes, under a treatment protocol or as part of a clinical trial (Phase I, II or III). The covered service will also be considered Experimental or Investigational if the Insured Person is required to sign a consent form that indicates the proposed treatment or procedure is part of a scientific study or medical research to determine its effectiveness or safety. Medical treatment, that is not considered standard treatment by the majority of the medical community or by Medicare, Medicaid or any other government financed programs or the National Cancer Institute regarding malignancies, will be considered Experimental or investigational. A drug, device or biological product is considered Experimental or Investigational if it does not have FDA approval or approval under an interim step in the FDA process, i.e., an investigational device exemption or an investigational new drug exemption;
21. Treatment for being overweight, gastric bypass or stapling, intestinal bypass, and any related procedures, including complications;
22. Sexual reassignment surgery, sexual transformation surgery, sexual transgendering surgery;
23. Services related to sterilization, reversal of a 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 Covered Sickness;
24. Treatment or services provided by a private duty nurse;
25. Organ or tissue transplants and related services;
26. Personal comfort or convenience items;
27. Rest or custodial cures;
28. Hearing aids;
29. An Injury or Sickness for which the Insured Person is paid benefits under any Workers' Compensation or occupational disease law or under any insurance policy that provides benefits to the Insured Person for injuries resulting from an occupational accident.

In addition, benefits will not be paid for services or treatment rendered by any person who is:

1. Employed or retained by the Policyholder;
2. Living in the Insured Person's household;
3. An Immediate Family Member of either the Insured Person or the Insured Person's Spouse; or
4. The Insured Person.

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

1. Intentionally self-inflicted injury, suicide or any attempt while sane or insane;
2. Commission or attempt to commit a felony or an assault;
3. Commission of or active participation in a riot or insurrection;
4. Declared or undeclared war or act of war;
5. Release, whether or not accidental, or by any person unlawfully or intentionally, of nuclear energy or radiation, including sickness or disease resulting from such release;
6. An injury or sickness 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, the Company will refund any premium paid for this time. Reserve or National Guard active duty training is not excluded unless it extends beyond 31 days;
7. Flight in, boarding or alighting from an Aircraft except as a fare-paying passenger on a regularly scheduled commercial or charter airline;
8. 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;
9. Voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage;
10. Medical or surgical treatment, diagnostic procedure, administration of anesthesia, or medical mishap or negligence, including malpractice, unless it occurs during treatment of injuries sustained in a Covered Injury;
11. The Insured Person's intoxication. The Insured Person is conclusively deemed to be intoxicated if the level in his blood exceeds the amount at which a person is presumed, under the law of the locale in which the accident occurred, to be under the influence of alcohol if operating a motor vehicle, regardless of whether He is in fact operating a motor vehicle, when the injury occurs. An autopsy report from a licensed medical examiner, law enforcement officers report, or similar items will be considered proof of the Insured Person's intoxication;
12. Aggravation or re-injury of a prior injury the Insured Person suffered prior to His Coverage Effective Date, unless the Company receives a written medical release from the Insured Person's Physician;

What's Not Covered (continued)

13. 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.

In addition, benefits will not be paid for services or treatment rendered by any person who is:

1. Employed or retained by the Policyholder;
2. Living in the Insured Person's household;
3. An Immediate Family Member of either the Insured Person or the Insured Person's Spouse; or
4. The Insured Person.

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:

1. Treatment of sickness, disease or infections except pyogenic infections or bacterial infections that result from the accidental ingestion of contaminated substances;
2. Treatment of hernia, Osgood-Schlatter's Disease, osteochondritis, appendicitis;
3. Osteomyelitis, cardiac disease or conditions, pathological fractures, congenital weakness;
4. Detached retina unless caused by a Covered Accident;
5. Mental disorder or psychological or psychiatric care or treatment (except as provided in the Policy) whether or not caused by a Covered Accident;
6. Pregnancy, childbirth, miscarriage, abortion or any complications of any of these conditions.
7. Mental and nervous disorders;
8. Damage to or loss of dentures or bridges, or damage to existing orthodontic equipment (except as specifically covered by the Policy.)
9. Expenses incurred for treatment of temporomandibular or craniomandibular joint dysfunction and associated myofascial disorders;
10. 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.
11. All surgery, including cosmetic and elective surgery;
12. Any elective treatment, 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;
13. Eyeglasses, contact lenses, hearing aids, examinations or prescriptions for them, or repair or replacement of existing artificial limbs, orthopedic braces, or orthotic devices;
14. Expenses payable by any automobile insurance policy without regard to fault (This exclusion does not apply in any state where prohibited.)

15. Conditions that are not caused by a Covered Accident;
16. Any treatment, service or supply not specifically covered by the Certificate; or
17. Injuries paid under medical payment coverage or no-fault coverage contained in an automobile insurance policy or liability insurance policy.

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

1. the Insured Person's suicide or intentional self-inflicted injury or Sickness, while sane or insane;
2. the Insured Person's being under the influence of an excitant, depressant, hallucinogen, narcotic, and other drug, or intoxicant including those taken as prescribed by a Physician;
3. the Insured Person's commission of or attempt to commit an assault or felony;
4. the Insured Person's engaging in an illegal activity or occupation;
5. Any Pre-existing Condition, except where coverage has been in effect for a period of twelve (12)* consecutive months following the Covered Person's effective date of coverage. "Pre-existing Condition" means a Sickness suffered by a Covered 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 12* months immediately prior to the Covered Person's effective date of coverage, that directly or indirectly causes the condition to occur within the first 12* months from the Covered Person's most recent effective date of coverage.
***Will vary by state.**
6. the Insured Person's voluntary participation in a riot;
7. any illness, loss or condition specifically excluded from the definition of any Critical Illness;
8. a Critical Illness that was initially Diagnosed before the Coverage Effective Date;
9. war, whether declared or not;
10. balloon angioplasty, laser relief of an obstruction, and/or other intra-arterial procedure unless covered under this Certificate; or
11. any injury or Sickness covered under any state or federal Workers' Compensation, Employer's Liability law or similar law.

No Prescription Drug Benefits will be paid for:

1. 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.
2. Blood glucose meters and insulin injecting devices.
3. Depo-Provera; condoms, contraceptive sponges, and spermicides; sexual dysfunction drugs.
4. Biologicals (including allergy tests); blood products; growth hormones; hemophiliac factors; MS injectable; immunizations; and all other injectable unless shown in the definition of Prescription Drug.
5. Medical supplies and durable medical equipment.

6. 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.
7. Anorexiant; 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.
8. Refills in excess of that specified by the prescribing Physician, or refills dispensed after one year from the original date of the prescription.
9. Any drug labeled "Caution – limited by Federal Law for Investigational Use" or experimental drugs.
10. Any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment.
11. Drugs needed due to conditions caused, directly or indirectly, by a Covered Person taking part in a riot or other civil disorder; or the Covered Person taking part in the commission of a felony.
12. Drugs needed due to conditions caused, directly or indirectly, by declared or undeclared war or any act of war; or drugs dispensed to a Covered Person while on active duty service in any armed forces.
13. Any expenses related to the administration of any drug.
14. Drugs or medicines taken while in or administered by a Hospital or any other health care facility or office.
15. Drugs covered under Worker's Compensation, Medicare, Medicaid or other governmental program.
16. Drugs, medicines or products which are not medically necessary.
17. Diaphragms; erectile dysfunction Legend Drugs; and infertility Legend Drugs.
18. Epi-Pen, Epi-Pen Jr., Ana-Kit, Ana-Guard; Glucagon-auto injection; and Imitrex-auto injection. Smoking deterrents, Legend or over-the-counter drugs.
19. Replacement of stolen medication (except under circumstances approved by us), or lost, spilled, broken or dropped Prescription Drugs.
20. Vacation supplies of Prescription Drugs (except under circumstances approved by us).
21. 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.

*** Prescription benefits provided are not underwritten by AXIS Insurance Company but are underwritten by an A.M. Best Rated Carrier.**

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

AXIS Group Benefits, LLC

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Phoenix, Arizona 85020
888.376.5391

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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 Advocates
- 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
- When you have a health issue, log on and request a provider consultation.
- You can request consultations via webcam, app or phone. Get 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 | 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 Benefit 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

HIPAA Privacy Practices

Updated Effective 2/16/2026

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests

- Respond to lawsuits and legal actions

To the extent that we have your substance use disorder patient records, subject to 42 CFR part 2, we will not share that information for investigations or legal proceedings against you without (1) your written consent or (2) a court order and a subpoena.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home, office, or mobile phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say “no,” for example, if it could affect your care. If we agree to your request, we may still share this information in the event that you need emergency treatment.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one

accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If someone has authority to act as your personal representative, such as if someone has your medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting <https://www.hhs.gov/hipaa/filing-a-complaint/index.html>.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. And in all cases, if we have substance use disorder patient records about you, subject to 42 CFR part 2, we cannot use or share information in those records in civil, criminal, administrative, or legislative investigations or proceedings against you without (1) your consent or (2) a court order and a subpoena.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls

- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.

- We will not use or share your information other than as described in this notice unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Additional Information

- We do not use or share any of your information for marketing purposes.
- This notice applies to Pinnacle/On the Spot Management Group Health Plans.
- Contact Information for questions regarding this notice: Pinnacle/On the Spot Management/Solve HR, Benefits Department, benefits@pinnaclepeo.com, 866-344-4477.

HIPAA Privacy Practices – Part 2 Program

Your Information. Your Rights. Our Responsibilities.

Notice of Privacy Practices of Pinnacle/On the Spot Management Group Health Plans

This notice describes:

- HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED
- YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION
- HOW TO FILE A COMPLAINT CONCERNING A VIOLATION OF THE PRIVACY OR SECURITY OF YOUR HEALTH INFORMATION, OR OF YOUR RIGHTS CONCERNING YOUR INFORMATION

YOU HAVE A RIGHT TO A COPY OF THIS NOTICE (IN PAPER OR ELECTRONIC FORM) AND TO DISCUSS IT WITH AMY MOORE AT 866-344-4477 AND BENEFITS@PINNACLEPEO.COM IF YOU HAVE ANY QUESTIONS.

In this notice, your health information means your substance use disorder patient record.

Your Rights

You have the right to:

- Consent to most uses and disclosures of your health information
- Ask us to limit the information we share
- Get a copy of this privacy notice
- Discuss this notice with someone in our program
- Get a list of those with whom we've shared your electronic records*
- Get a list of health care providers who have received your information through certain third parties
- Choose in advance whether to receive fundraising communications
- File a complaint if you believe your privacy rights have been violated

Your Choices

With your consent, we can use and share your information as we:

- Treat you
- Run our organization
- Bill for our services
- Fulfill your requests to share information with your consent
- Prevent multiple program enrollments

* The compliance date for this requirement will be set when the same right is revised in the HIPAA Privacy Rule.

- Report about court-referred treatment
- Report to prescription drug monitoring programs

Our Uses and Disclosures

We may use and share your information without your consent as we:

- Communicate within our program and with our contractors
- Help with medical emergencies
- Help with public health
- Report crimes (and threats of crimes) on our premises and suspected child abuse and neglect
- Aid scientific research
- Respond to audits and evaluations of our program
- Assist cause of death inquiries
- Respond to court orders

In all these circumstances, we must protect your information and limit how we use and share it.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Provide consent when we use or share your information for most purposes

- You may provide a single consent for all future uses or disclosures for treatment, payment, and health care operations purposes.
- You may provide consent for more limited purposes (for example, to only disclose information to another health care provider for your treatment); however, doing so may affect the services we can provide you or how you pay for services.
- You may provide a general consent to share your information through certain third parties, such as a health information network or a research institution, where your treating health care providers can access it.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our health care operations after you have provided consent for all those purposes. We are not required to agree to your request, and we may say “no” if, for example, it could affect your care. If we agree to your request, we may still share this information in the event that you need emergency treatment.

- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our health care operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Discuss this notice with someone in our program

You can ask questions or obtain more information about this notice and our privacy practices by calling or emailing the contact person at the top of this notice.

Choose in advance about fundraising

You have the right to a clear and obvious notice in advance of, and a choice about whether to receive, fundraising communications for our program.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services’ Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting <https://www.hhs.gov/hipaa/filing-a-complaint/index.html>.
- We will not retaliate against you for filing a complaint.

Your Choices

How do we typically use or share your health information?

With your consent, we typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for a chronic condition asks a doctor at our program about your health condition and medications you are taking, for example, to avoid complications.

Run our organization

We can use and share your health information to run our program, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

With your consent, we may also use and share your information in the following ways:

- To whomever you name in a consent to share your information
- To prevent multiple enrollments in withdrawal management or maintenance treatment programs
- To report participation in treatment required by the criminal justice system
- To report prescribed substance use disorder treatment medications to a state prescription drug monitoring program when required by law

You can choose someone to act for you.

- If someone has authority to act as your personal representative, such as if someone has your medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

Our Uses and Disclosures

How else can we use or share your health information?

We are allowed or required to share your information in certain ways without your consent – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

To communicate within our program and with contractors

We can share your information within our program, with an organization that has administrative control over our program, and with contractors who help us run our program.

For medical emergencies

We can share your information during a bona fide medical emergency with the personnel and health care providers responding to your emergency, even when you are unable to consent because of the emergency.

We can also share your identifying information to assist the federal Food and Drug Administration in notifying you or your doctor about unsafe products you may be using.

Help with public health

We can share health information that does not identify you for certain situations such as:

- Preventing disease
- Reporting adverse reactions to medications

Aid scientific research

We can use or share your information to conduct or help with health research. Researchers cannot include any patient identifying information in their reports about the research.

Respond to management and financial audits and program evaluations

We can use or share your information to improve the quality of our services, obtain needed credentials, and cooperate with oversight agencies for activities authorized by law, as long as those who view or receive the information agree to destroy or return the information when they are finished and agree not to use it against you.

Assist with cause of death inquiries

We can share patient identifying information about a deceased patient as required or allowed by laws that collect information relating to cause of death.

Report suspected child abuse and neglect

We will only report the information required by law.

Prevent or reduce crime in our program

We may report to law enforcement when a patient commits or threatens to commit a crime within our program or against our staff.

Redisclosure According to HIPAA

When you consent to uses and disclosures for all future treatment and payment purposes and to run our business, we may share your information with other substance use disorder treatment programs, doctors' offices, and health care businesses for those activities. If the person who receives it is subject to HIPAA, then they are allowed to use and share your information again without your consent for the purposes that HIPAA allows. Your information still cannot be used in legal proceedings against you unless (1) you consent or (2) based on a Part 2 court order and a subpoena (or similar legal requirement).

Legal Proceedings and Court Orders

We must follow certain procedures before using or sharing your information for investigations and legal proceedings.

- We will not use or share your information or provide testimony about your information in any civil, administrative, criminal, or legislative proceedings against you without your written consent or a court order.
- We will only respond to a court order to use or share your health information if it is accompanied by a subpoena or other similar legal mandate requiring us to comply.
- We will only use or share your information in proceedings against you based on a court order after we have received notice and an opportunity to be heard or you tell us that you have received notice.
- We may use or share your information to respond to legal proceedings against our program based on a court order and you may not be notified in advance. You have the right to seek to overturn or change the court order after you learn about it.

Our Responsibilities

- We are required to obtain your consent for most uses and sharing of your information.
- We are required by law to maintain the privacy and security of your information.
- We must let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described in this notice unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Changes to the Terms of this Notice

We are required to follow the terms of this notice that are currently in effect. We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request in our office and on our web site.

Effective Date

This notice is effective as of 2/16/2026.

Additional Information

- We do not use or share any of your information for marketing purposes.
- This notice applies to Pinnacle/On the Spot Management Group Health Plans.
- Contact Information for questions regarding this notice: Pinnacle/On the Spot Management/Solve HR, Benefits Department, benefits@pinnaclepeo.com, 866-344-4477.

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.

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. (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.

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.

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

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

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

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

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

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

<p align="center">MAINE-Medicaid</p> <p>Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711</p> <p>Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711</p>	<p align="center">NEW HAMPSHIRE-Medicaid</p> <p>Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218</p>
<p align="center">NEW JERSEY-Medicaid and CHIP</p> <p>Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710</p>	<p align="center">SOUTH DAKOTA-Medicaid</p> <p>Website: http://dss.sd.gov Phone: 1-888-828-0059</p>
<p align="center">NEW YORK-Medicaid</p> <p>Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831</p>	<p align="center">TEXAS-Medicaid</p> <p>Website: http://gethipptexas.com/ Phone: 1-800-440-0493</p>
<p align="center">NORTH CAROLINA-Medicaid</p> <p>Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100</p>	<p align="center">UTAH-Medicaid and CHIP</p> <p>Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669</p>
<p align="center">NORTH DAKOTA-Medicaid</p> <p>Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825</p>	<p align="center">VERMONT-Medicaid</p> <p>Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427</p>
<p align="center">OKLAHOMA-Medicaid and CHIP</p> <p>Website: http://www.insureoklahoma.org Phone: 1-888-365-3742</p>	<p align="center">VIRGINIA-Medicaid and CHIP</p> <p>Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282</p>
<p align="center">OREGON-Medicaid</p> <p>Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075</p>	<p align="center">WASHINGTON-Medicaid</p> <p>Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022</p>
<p align="center">PENNSYLVANIA-Medicaid</p> <p>Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medicaid/HIPP-Program.aspx Phone: 1-800-692-7462</p>	<p align="center">WEST VIRGINIA-Medicaid</p> <p>Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)</p>

RHODE ISLAND-Medicaid and CHIP	WISCONSIN-Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA-Medicaid	WYOMING-Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since 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
 1-866-444-EBSA (3272)

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

Medicare Part D Creditable Coverage Notice

Important Notice from Your Employer About Your Prescription Drug Coverage and Medicare

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Your Employer has determined that the prescription drug coverage offered by the Humana Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan? If you decide to join a Medicare drug plan, your current Humana coverage will not be affected. Covered employees and dependents can keep this coverage if they elect Part D and this plan will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current Humana coverage, be aware that you and your dependents will not be able to get this coverage back unless you have a special enrollment right or at the next open enrollment.

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

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

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

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

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

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: 6/9/2026
Name of Entity: Pinnacle/Solve HR
Contact: Benefits Department