THE EMPLOYMENT COMMONS

2021 BENEFIT ENROLLMENT GUIDE

2021 BENEFITS GUIDE

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EMPLOYMENT COMMONS BENEFITS

The benefit programs offered are designed to support the needs of community employees and their dependents by providing a benefits package that is easy to understand, easy to access and affordable.

This summary will help you choose the type of plan and level of coverage that is right for you and your family.

Do you know all of the options that are available to you?

- Four (4) medical plans for you to choose the best option for you and your family
- A spouse's or domestic partner's plan
- Coverage through your state Health Insurance Marketplace. You can find information about your state's marketplace at www.healthcare.gov (created as part of healthcare reform)
- Medicaid or other federal assistance programs for low-income families
- Medicare if you are age 65 or older
- Individual market

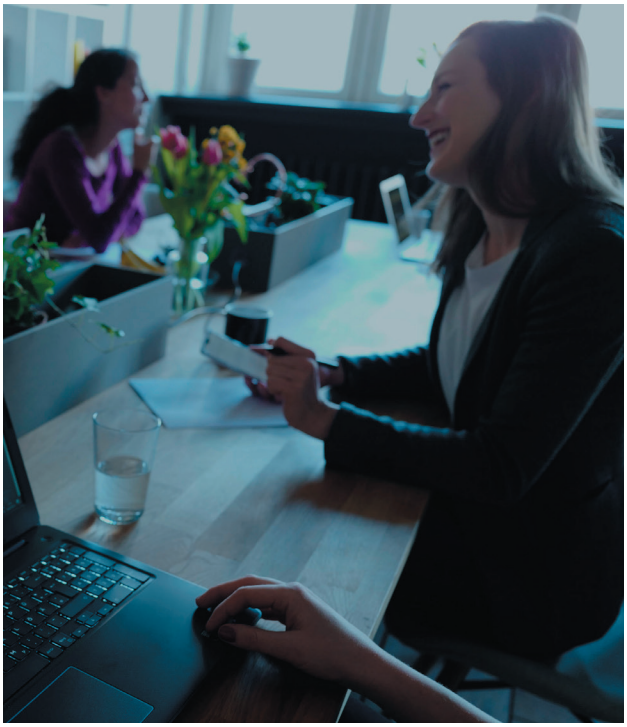
Understanding what might be available to you and if you are eligible to participate can help you make the best choices for you and your family.

Individual Mandate: The Affordable CARE Act requires most individuals to obtain acceptable health insurance coverage for themselves and their family members; in prior years if coverage was not elected a tax penalty was assessed. However, the penalty has been waived starting in 2019.

ELIGIBILITY & ENROLLMENT

WHO IS ELIGIBLE?

We are proud to offer a comprehensive benefits package to all eligible, full-time employees who work 20 hours or more per week. Eligible dependents are your legal spouse, children up to age 26, or disabled dependents of any age.



MAKING CHANGES (QUALIFING EVENTS)

Elections made now will remain until the next annual enrollment unless you or your family members experience a qualifying event. If you experience a qualified event, you must contact The Employment Commons HR within 30 days. With eligibility for Medicaid or CHIP or termination of Medicaid or CHIP, you have 60 days to contact The Employment Commons HR. Written documentation supporting your eligibility to make changes may be required. Qualified events are defined as:

- Marriage, divorce, or legal separation
- Gain or loss of an eligible dependent for reasons such as birth, adoption, court order, disability, death, marriage, or reaching the dependent-child age limit
- Changes in your dependent's employment affecting benefits eligibility
- Changes in your dependent's benefit coverage with another employer that affects benefits eligibility

MEDICAL COVERAGE

Choosing the right health plan is one of the most important decisions you can make for you and your family. It is the objective of the The Employment Commons Community to provide an employee benefits program that makes it easy for you and your dependents to access the medical care you need. Please carefully consider the three medical plans (in partnership with Blue Cross Blue Shield) to make the best medical choices for you and your family.

PLAN OPTIONS

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. The Employment Commons offers you the choice of three medical plans:

1. **Gold 500 FSA**
2. **Silver 4250 HSA**
3. **Bronze 5000 HSA**
4. **Bronze 6000 FSA**

PPO PLANS (GOLD 500 FSA + Bronze 6000 FSA)

A PPO plan provides both in and out of network coverage, however, you save the most money when you seek services from an in-network provider. A PPO plan covers preventive care at 100% resulting in no out-of-pocket costs to you. The most commonly used services, such as office visits, urgent care, and prescription drugs are not subject to the deductible and you are only subject to a copay. Higher costs services, such as imaging, inpatient hospitalization, and outpatient surgery require you to meet your annual deductible before receiving coverage.

HIGH DEDUCTIBLE HEALTH PLAN - HDHP (BRONZE 5000 HSA SILVER 4250 HSA)

A HDHP (High Deductible Health Plan) provides both in-and out-of-network benefits, similar to a PPO plan, however, you must meet your deductible before insurance will begin to pay for covered services, except for preventive care which is covered at 100%. The HDHP option is a qualified plan for a Health Savings Account (HSA). With an HSA, you are able to set aside pre-tax funds into an account to be used for qualified medical, dental, and vision expenses. For more information on how your HSA works, please see the HSA section of this booklet.

TERMS YOU SHOULD KNOW

Deductible: This is the amount you must pay each calendar year before the plan begins to pay for certain benefits.

Co-payment/Copay: This is the fee you must pay under your plan each time you go to a doctor or hospital for certain services. A copay is also required for prescription drugs.

Co-Insurance: This is the percentage of cost that you pay for covered services after you have met the deductable.

Out-of-Pocket Max: The plan limits the amount of money you will have to pay each year for covered expenses. Once you reach this dollar limit, the plan generally pays 100% of eligible expenses for the rest of the calendar year.

IN NETWORK	GOLD 500 FSA	SILVER 4250 HSA	BRONZE 5000 HSA	BRONZE 6000 FSA
Annual Deductible:				
Sole Coverage Only	$500	$4,250	$5,000	$6,000
Individual Member of Family	$500	$4,250	$5,000	$6,000
Combined Family	$1,000	$8,500	$10,000	$12,000
Out-of-Pocket Max:				
Sole Coverage Only	$6,500	$4,250	$6,900	$8,550
Individual Member of Family	$6,500	$4,250	$6,900	$8,550
Combined Family	$13,000	$8,500	$13,800	$17,100
Primary Care Physician	$20 Copay	0% After Ded.	$40 Copay After Ded.	$50 Copay
Specialist	$40 Copay	0% After Ded.	$60 Copay After Ded.	$75 Copay
Preventive Care	Covered In Full	Covered In Full	Covered In Full	Covered In Full
Basic Lab / X-ray services	30% Copay	0% After Ded.	50% After Ded.	30% After Ded.
Advanced Imaging (CT/PET Scans, MRI's)	30% After Ded.	0% After Ded.	50% After Ded.	30% After Ded.
Inpatient	30% After Ded.		30% After Ded.	30% After Ded.
Outpatient	30% After Ded.		30% After Ded.	30% After Ded.
Urgent Care	$40 Copay		$60 Copay After Ded.	$100 Copay
Emergency Room	50% After In-Network Ded.	0% After Ded. for all	50% After Ded.	50% After In-Network Ded.
			$10 Copay After Ded.	
Telehealth	$10 Copay		$40 Copay After Ded.	$10 Copay
Acupuncture & Spinal Manipulation	$20 Copay ($1,000 Annual Limit)	($1,000 Annual Limit)	($1,000 Annual Limit)	$50 Copay ($1,000 Annual Limit)
Prescription Drug Benefits:				
Preferred Generic / Non Preferred Generic / Preferred Brand / Non Preferred Brand / Preferred Specialty / Non Preferred Specialty	Retail: $10 Copay / 25% Copay / $50 Copay / 50% Copay / 20% Copay / 50% Copay	Subject to Medical Plan Ded. 0% After Ded.	Retail: After Ded. 30% / 30% / 30% / 30% / 30% / 30%	Not Subject to Ded. $10 Copay / 25% Copay / 50% Copay / 50% Copay / 50% Copay / 50% Copay

OUT OF NETWORK	GOLD 500 FSA	SILVER 4250 HSA	BRONZE 5000 HSA	BRONZE 6000 FSA
Annual Deductible (Sole-Coverage / Family)	$5,000 / $10,000	$8,000 / $16,000	$10,000 / $20,000	$12,000 / $24,000
Out-of-Pocket Max (Sole-Coverage / Family)	$10,000 / $20,000	$16,000 / $32,000	$15,000 / $30,000	$17,100 / $34,200
Primary Care / Specialty	50% After Ded.	50% After Ded.	50% After Ded.	60% After Ded.
Prescription Drug Benefits: Preferred Generic / Non Preferred Generic / Preferred Brand / Non Preferred Brand / Preferred Specialty / Non Preferred Specialty	No coverage for prescription drugs not on the Drug List. No coverage for prescription drugs from an out-of-network pharmacy.			

HEALTH SAVINGS ACCOUNT (HSA)

WHAT IS A HEALTH SAVING ACCOUNT?

A Health Savings Account (HSA) is an individually-owned, tax-advantaged account that you can use to pay for current or future IRS qualifiedmedical expenses. With an HSA, you'll have the potential to build more savings for healthcare expenses or additional retirement savings through self-directed investment options.

HOW DO HSA ACCOUNTS WORK?

You can contribute to your HSA via payroll deductions, online banking transfer, or send a personal check. Your employer or third party, such as a spouse or parent, may contribute to your account as well.

You can pay for qualified medical expenses with your Health Benefits Debit Card directly to your medical provider or pay our-of-pocket. You can either choose to reimburse yourself or keep the funds in your HSA to grow your savings.

Unused funds will roll over year to year. After age 65, funds may be withdrawn for any purpose without a penalty (subject to ordinary income taxes). Check balances and account information via HealthEquity website at www.healthequity.com or use their mobile app 24/7.

ARE YOU ELIGIBLE FOR AN HSA?

You can open and contribute to an HSA if you meet the following criteria:

1. Are covered by an HSA-qualified health plan (HDHP);
2. Are not covered by other health insurance (with some exceptions);
3. Are not enrolled in Medicare;
4. Are not enrolled in TriCare;
5. Are not eligible to be claimed as a dependent on another person's tax return (unless it's your spouse);
6. Have not received health benefits from the Veterans Administration with the exception of services for a "service related disability" or an Indian Health Services facility within the last three months; and
7. Are not covered by your own or your spouse's general purpose Healthcare.

IRS LIMITS ON ANNUAL DEPOSITS

Any contributions made by all parties can not exceed the IRS annual HSA limit. Below are the IRS limit amounts for the 2021 calendar year.

MAXIMUM CONTRIBUTION:
Individual $3,600 / Family $7,200

HEALTH SAVINGS ACCOUNT (HSA)

CONTRIBUTING TAX FREE EARNINGS INTO YOUR HSA

If you enroll in the High Deductible Health Plan mid-plan year, you may contribute the maximum calendar year amount to your HSA as long you maintain continuous HDHP enrollment for a 12-month period. The 12-month period starts with the last month of the taxable year and ends 12 months later. If you do not remain continuously enrolled in an HDHP for the 12-month period, your maximum contribution will be less than the maximum calendar year amount and you may be subject to additional IRS taxes and penalties. Please consult your tax advisor for information.

Catch-up contributions for employee's age 55 or older, who are not enrolled in Medicare, may contribute an additional $1,000 to their HSA account. Spouses who are 55 or older and covered under the employee's medical insurance may also make a catch-up contribution into a separate HSA account in their own name. If you enroll in Medicare mid-year, your catch-up contribution should be prorated.

SPENDING YOUR HSA DOLLARS, EXAMPLES INCLUDE*:

Alcoholism treatment
Acupuncture
Ambulance service
Artificial limb or prosthesis
Birth control pills (by prescription)
Chiropractor
Childbirth/ delivery
Doctor's fees (copay, etc.)
Dental treatments
Dermatologist
Diagnostic services
Disabled dependent care
Drug addiction therapy
Fertility enhancement
(including in-vitro fertilization)
Gynecologist
Guide dog (or other service animal)
Hearing aids and batteries
Hospital bills
Laboratory fees
Lactation expenses
Lodging (away outpatient care)
Nursing home & Nursing services
Obstetrician
Osteopath
Oxygen
Pregnancy test kit
Podiatrist
Prescription drugs and medicines
Prenatal care & postpartum treatment
Psychiatrist & Psychologist
Smoking cessation programs
Special education tutoring
Equipment to assist hearing or vision impaired
Therapy or counseling
Medical transportation expenses
Transplants
Vaccines
Vision care
Lasik surgery
Weight loss programs
Wheelchair
Retirement

***This is not a comprehensive list of IRS qualified expenses. For more information, please refer to the IRS publication 502 titled "Medical and Dental Expenses".**

DENTAL COVERAGE

UNITED HEALTHCARE DPO

Annual Deductible: Individual $50 / Family $150 Max

100% Preventive / 80% Basic / 50% Major Care
Endo and Perio in Basic
$1,000 Annual Maximum Included
Maximum Rollover In
No Wait for Major Care
Child Orthodontia - $1,000 Lifetime Max

Get rewarded for taking care of your smile:

• Earn award dollars for visiting your dentist at least once a year.
• Your award dollars will help to pay for claims that go beyond your annual maximum.
• Unused award dollars can roll over each year.

How your dollars add up:
This year's annual maximum is $1,000
If your total claims are less than $500
You'll earn a reward of $250

Plus, if you have a Dental PPO plan and all claims are with network dentists, you'll earn an extra $100. Your award dollars will be added to next year's annual maximum to pay for qualifying claims.

Good oral care enhances overall physical health, appearance and mental well-being.

We offer competitive benefits designed to provide high quality dental care. Problems with the teeth and gums are common and many of these issues are easily treated health problems. You and your family members may visit any licensed dentist and will receive the greatest out-of-pocket savings if you see an in-network dentist.

If you choose to see an out-of-network dentist, you can incur additional out-of pocket expenses due to lower plan reimbursement levels and if your provider balance bills you for the difference between what the plan pays and their submitted fee. When you see an in-network Dentist, you are protected from balance billing. Ask your dentist if they are "In-Network" or go to the carrier website and search for in-network providers.

Our Consumer MaxMultiplier® program rewards you for keeping up with your dental care by adding dollars to next year's annual maximum. And it's included as part of your dental plan.

Program rules:

1. $1,000 is the most award dollars that can be rolled over to the annual maximum. The total annual maximum cannot go above $2,000.
2. If your plan has different annual network and out-of-network maximums, the award dollars will be based on the annual out-of-network maximum.
3. Award dollars can be used for claims filed up to 180 days after your benefit period ends.
4. Award dollars can be used for both network and out-of-network claims.
5. Award dollars do not apply to orthodontic services.
6. If you sign up for a UnitedHealthcare Dental PPO or Dental In-Network Only (INO) plan in the last three months of a benefit period, you will have to wait until the end of the first full month of the next benefit period to participate in this program.
7. If you end your coverage, but sign up again within six months with the same employer, you can keep your award balance as long as your employer still offers a dental plan with Consumer MaxMultiplier. If six months or more pass, you will lose the award balance.
8. If your employer decides to change your dental plan, your award balance will move with you as long as the new plan includes Consumer MaxMultiplier.

View your annual maximum balance on www.myuhc.com. You will not actually earn cash that you can access or withdraw. UnitedHealthcare adds the award dollars to your annual maximum for the following year and applies them to qualifying claims.

PEDIATRIC DENTAL COVERAGE ALREADY INCLUDED UNDER ALL THREE MEDICAL PLANS	
Covered for members up to age 19 **Member's coinsurance amounts apply to in-network medical out-of-pocket maximum** **Various limits apply**	
Preventive and Diagnostic Services	• X-rays: —Routine radiology: 1 (set) per calendar year —Bitewing x-ray series: 1 (set) per calendar year —Panoramic or intra-oral complete series: Once every 5 calendar years • Cleanings: 2 per calendar year • Preventive and diagnostic oral examinations: 2 per calendar year • Topical fluoride application: 2 treatments per calendar year • Sealants (permanent molars): Once per molar during a 5-year period • Space maintainers
Basic Services	• Fillings: Consisting of composite and amalgam restorations • Oral Surgery: Uncomplicated and complex oral surgery procedures • General dental anesthesia or intravenous sedation: Subject to necessity • Emergency treatment for pain relief • Periodontal Maintenance: 2 per calendar year • Periodontal debridement: Once in a 2-year period • Scaling and Root Planing: Once in a 2-year period • Endodontic services including root canal treatment, pulpotomy and apicoectomy
Major Services	• Crowns, inlays and onlays: —Permanent crowns limited to 4 (including replacement crowns) in a 7-year period —Permanent crown replacement limited to once within a 7-year period after placement • Dentures (full or partial) • Bridges (fixed partial denture) • Orthodontia: Covered when medically necessary

VISION COVERAGE

Your eyes can provide a window to your overall health. Through routine exams your provider may be able to detect general health problems in their early stages along with determining if you need corrective lenses.

ANNUAL COPAYMENT	
Examination $10 Copay / Materials $25 Copay	**Examinations: 12 months** **Lenses: 12 months** **Contact Lenses in Lieu of Frames & Lenses: 12 months** **Frames: 12 months / $130 In-Network Allowance**

FLEXIBLE SPENDING ACCOUNTS (FSA)

WHAT IS A FLEXIBLE SPENDING ACCOUNT?

Flexible Spending Accounts (FSAs) allow employees to use pretax dollars for healthcare and/or child and dependent care expenses not covered by insurance plans. Employees contribute a portion of each paycheck to an FSA and save on taxes. Money in an FSA can be used to pay for out-of pocket medical, dental and vision expenses or dependent care expenses. The FSA Plan Year is January 1st through December 31st. The funds are subject to the "use it or lose it" rule. The Employment Commons offers two Health Flexible Spending Accounts: Healthcare FSA and Limited Purpose FSA, and also a third type called Dependent Care FSA. All three types are defined below.

HEALTHCARE FSA

is a pre-tax benefit account used to pay for eligible medical, dental, and care expenses that aren't covered by your insurance plan or elsewhere. It's a smart, simple way to save money while keeping you and your family healthy and protected. The IRS sets a limit on how much you can contribute to this account each year. For 2021, the spending limit is $2,750.

LIMITED PURPOSE HEALTHCARE FSA (LPFSA)

is a flexible spending account that only reimburses you for eligible dental and vision expenses. A LPFSA is available to employees who are enrolled in a high deductible health plan (HDHP) and you may enroll in both the LPFSA and the HSA. By establishing a LPFSA, you can save money on taxes by using your LPFSA dollars for your dental and vision expenses while preserving your HSA funds for other purposes, including simply saving those funds for the future. The IRS sets a limit on how much you can contribute to this account each year. For 2021, the spending limit is $2,750.

DEPENDANT CARE FSA

is a pre-tax benefit account used to pay for dependent care services, such as preschool, summer day camp, before or after school programs, and child or elder daycare. A Dependent Care FSA is a smart, simple way to save money while taking care of your loved ones so that you can continue to work. The IRS sets a limit on how much you can contribute to this account each year. For 2021, the spending limit is $5,000 if married and filing jointly or head of household or $2,500 if married and filing separately.

HERES HOW AN FSA WORKS:

1. Decide the annual amount you want to contribute based on your expected health care and/or dependent childcare/elder care expenses.
2. Elections are deducted from each paycheck before income and Social Security taxes, and deposited into your FSA. Your entire annual election is available immediately after the beginning of the plan year for the Health Care FSA and LPFSA. For the Dependent Care FSA you can only receive the amount that is in your account when your claim is paid.
3. For eligible Health Care FSA or LPFSA expenses you submit a claim form for reimbursement or file the claim online. For dependent care you pay for eligible expenses when incurred and then submit a reimbursement claim form or file the claim online.
4. You are reimbursed from your FSA so you actually pay your expenses with tax-free dollars.
5. You can use the LPFSA only for dental and vision expenses.
6. Any Healthcare FSA, LPFSA and Dependent Care FSA funds not used by the end of the calendar year will be forfeited.

LIFE & DISABILITY INSURANCE

BASIC LIFE & AD&D

Life/Accidental Death & Dismemberment protects employees and their families from financial hardship in the event of death or dismemberment. It provides the peace of mind you get when you know your loved ones will be protected if anything happens to you.

LIFE/ACCIDENTAL DEATH AND DISMEMBERMENT	
Employee Benefit Amount	$50,000
Spouse Child(ren)	Not Covered Not Covered

SHORT AND LONG TERM DISABILITY

One of the most important assets to you as an employee is the ability to earn an income. The disability program is designed to continue providing you with income if you're unable to work due to sickness or injury. Disability insurance can help you continue to pay your bills by replacing a portion of your income until you are able to return to work.

SERVICES	SHORT TERM DISABILITY	LONG TERM DISABILITY
Benefit Percentage	60%	60%
Benefit Maximum	$750 per week	$5,000 per month
Elimination Period	7 days accident / 7 days sickness	90 days (13 weeks)
Benefit Duration	90 days (13 weeks)	5 years
Pre-Existing Clause	12 months prior / 12 months insured	3 months prior / 12 months insured

THE COMMONS RETIREMENT PLAN

The Commons' 401(K) PLAN IS ADMINISTERED BY SLAVIC 401K: www.slavic401k.com . Please contact the The Employment Commons HR team for further enrollment details.

2021 PREMIUMS - MONTHLY

MEDICAL (CIGNA)	GOLD 500 FSA - PPO	SILVER 4250 HSA - HDHP	BRONZE 5000 HSA - HDHP	BRONZE 6000 FSA - PPO
Employee Only	$508.41	$362.15	$275.14	$265.43
Employee + Spouse	$1,138.88	$846.34	$672.33	$634.51
Employee + Child(ren)	$1,044.31	$773.71	$612.76	$577.76
Employee + Family	$1,674.77	$1,257.91	$1,009.95	$956.04

DENTAL (UNITED)	
Employee Only	$42.46
Employee + Spouse	$84.92
Employee + Child(ren)	$99.28
Employee + Family	$149.32

VISION (UNITED) New Separate Policy	
Employee Only	$5.58
Employee + Spouse	$11.74
Employee + Child(ren)	$13.77
Employee + Family	$20.33

SHORT TERM DISABILITY (UNITED)	LONG TERM DISABILITY (UNITED)	
$0.20 per $10 of Weekly Benefit	Age-Banded Rates per $100 of Covered Payroll	
	Age 0-24	$0.04
	Age 25-29	$0.05
	Age 30-34	$0.07
	Age 35-39	$0.09
	Age 40-44	$0.12
	Age 45-49	$0.17
	Age 50-54	$0.23
	Age 55-59	$0.33
	Age 60-64	$0.40
	Age 65-150	$0.40

LIFE & AD&D (UNITED)
$7.50 / month

LEGAL NOTICE

WOMENS HEALTH AND CANCER RIGHTS ACT

The Women's Health Act of 1998 requires us to notify you that our plans provide benefits for certain breast reconstruction procedures related to a mastectomy. If you elect coverage under the medical plan and you or any covered family member require breast reconstruction related to a mastectomy,
benefits will be provided for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Any deductible, copayments or other plan requirements that normally apply to surgical procedures covered by your health plan will also apply to these procedures.

If you have questions pertaining to this notice, please feel free to contact Human Resources at hr@opolis.co.

NEWBORNS ACT NOTICE

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

HIPAA SPECIAL ENROLLMENT RIGHTS

Loss of Other Coverage — If you are declining enrollment for yourself and/ or your dependents (including your spouse) because of other health insurance coverage or group health plan coverage, you may be able to enroll yourself and/or your dependents in this plan if you or your dependents lose eligibility for that other coverage or if the employer stops contributing towards your or your dependents' coverage. To be eligible for this special enrollment opportunity
you must request enrollment within 30 days after your other coverage ends or after the employer stops contributing towards the other coverage.

New Dependent as a Result of Marriage, Birth, Adoption or Placement for Adoption — If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and/ or your dependent(s). To be eligible for this special enrollment opportunity you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. Our health health plan will allow an employee or dependent who is eligible, but not enrolled for coverage, to enroll for coverage if either of the following events occur:

1. TERMINATION OF MEDICAID OR SCHIP COVERAGE. If the employee or dependent is covered under a Medicaid plan or under a State child health plan
2. (SCHIP) and coverage of the employee or dependent under such a plan is terminated as a result of loss of eligibility.
3. ELIGIBILITY FOR EMPLOYMENT ASSISTANCE UNDER MEDICAID OR SCHIP. If the employee or dependent becomes eligible for premium assistance under
4. Medicaid or SCHIP, including under any waiver or demonstration project conducted under or in relation to such a plan. This is usually a program where
5. the State assists employed individuals with premium payment assistance for their employer's group health plan rather than direct enrollment in a State Medicaid program.

To be eligible for this special enrollment opportunity, you must request coverage under the group health plan within 60 days after the date the employee or dependent becomes eligible for premium assistance under Medicaid or SCHIP or the date your or your dependents' Medicaid or State sponsored CHIP coverage ends. To request special enrollment or obtain more information, please contact Human Resources at hr@opolis.co.

LEGAL NOTICE

IMPORTANT NOTICE FROM THE EMPLOYMENT COMMONS COMMUNITY 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 The Employment Commons Community 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 highermonthly premium.
2. Prescription drug coverage offered by a group 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 Credible 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 The Employment Commons Community coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current The Employment Commons Community coverage, be aware that you and your dependents may not be able to get this coverage back.

When will you pay a higher premium (penalty) to join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with The Employment Commons Community 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.

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 The Employment Commons changes. You also may request a copy of this notice at any time or if you have questions pertaining to this notice, please feel free to contact Human Resources at hr@opolis.co.

LEGAL NOTICE: CONTINUED

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 visitwww.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).

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE:

Contact: HR@Opolis.co

LEGAL NOTICE

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 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 or call www.askebsa.dol.gov or call 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 July 31, 2019. Contact your state for more information on eligibility.

ALABAMA - Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447
ALASKA - Medicaid
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
ARKANSAS - Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)
COLORADO - Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
HFC Website: www.healthfirstcolorado.com/ HFC Member Contact Center: 1-800-221-3943 / State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-planplus CHP+ Customer Service: 1-800-359-1991/ State Relay 711

FLORIDA - Medicaid
Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
GEORGIA - Medicaid
Website: https://medicaid.georgia.gov/health-insurance-premiumpayment-program-hipp Phone: 678-564-1162 ext 2131
INDIANA - Medicaid
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: http://www.indianamedicaid.com Phone 1-800-403-0864
IOWA - Medicaid
Website: http://dhs.iowa.gov/Hawki Phone: 1-800-257-8563
KANSAS - Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512

LEGAL NOTICE: CONTINUED

KENTUCKY - Medicaid
Website: https://chfs.ky.gov Phone: 1-800-635-2570
LOUISIANA - Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447
MAINE - Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840
MINNESOTA - Medicaid
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
MISSOURI - Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA - Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
NEBRASKA - Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178
NEVADA - Medicaid
Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE - Medicaid
Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP
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
NEW YORK - Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA - Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
NORTH DAKOTA - Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA - Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid
Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
RHODE ISLAND– Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059

LEGAL NOTICE: CONTINUED

TEXAS - Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493
UTAH - Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT - Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
WASHINGTON - Medicaid
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022 ext. 15473
WEST VIRGINIA - Medicaid
Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN - Medicaid
Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
WYOMING - Medicaid
Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
866.444.EBSA (3272)

U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877.267.2323, Menu Option 4, Ext. 61565

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

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

IMPORTANT CONTACTS

BENEFIT	CARRIER	CONTACT INFORMATION
Medical	Cigna (Allied)	1-800-288-2078 www.alliedbenefit.com
Vision	United Healthcare	1-800-683-3120 www.myuhcvision.com
Dental	United Healthcare	1-800-357-0978 www.uhc.com
Basic Life, Voluntary Life, STD & LTD	United Healthcare	1-800-357-0978 www.uhc.com

GOLD 500 FSA

2021 BENEFIT ENROLLMENT GUIDE

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-312-906-8080 or go to www.alliedbenefit.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. www.alliedbenefit.com or call 1-312-906-8080 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers $500 person / $1,000 family; for out-of-network providers $5,000 person / $10,000 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Prescription drugs, in-network preventive care, breast pumps and supplies, in-network physician exam charges (including specialists), in-network urgent care exam charges, second surgical opinions, in-network physical/occupational/speech therapy, in-network chiropractic care and acupuncture services, in-network outpatient/office/independent laboratory diagnostic tests, radiology and pathology administration and interpretation services, and renal dialysis are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	There are no other specific deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers $6,500 individual / $13,000 family; for out- of-network providers $10,000 individual / $20,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Penalties for failure to obtain precertification/preauthorization, services in excess of Plan maximums or limits, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.alliedbenefit.com or call 1-312-906-8080 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most) *Payment of all Out-Of-Network professional services will be limited to 135% of the Medicare fee schedule. Payment of all Out-Of-Network facility services will be limited to 175% of the Medicare fee schedule	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/office visit, deductible does not apply, and 30% coinsurance for other physician services	50%* coinsurance	Limited to general practice, family practice, OB/GYN, internal medicine, osteopaths, pediatricians, nurse practitioners, physician assistants, and mental health providers. Chiropractic care and acupuncture services are limited to a combined maximum of 30 visits per person per calendar year. See Plan Document for other services.
	Specialist visit	$40 copay/visit, deductible does not apply	50%* coinsurance	See Plan Document for other services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most) *Payment of all Out-Of-Network professional services will be limited to 135% of the Medicare fee schedule. Payment of all Out-Of-Network facility services will be limited to 175% of the Medicare fee schedule	
	Preventive care/screening/ immunization	No charge, deductible does not apply	50%* coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance, deductible does not apply	50%* coinsurance	Does not include emergency room diagnostic services.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50%* coinsurance	None.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs (Tier 1)	$10 copay/prescription (retail) $20 copay/prescription (extended retail and mail-order)		Covers up to a 30-day supply (retail prescription); 90-day supply (extended retail and mail order prescription). Deductible does not apply. Once the out-of-pocket maximum has been met, prescription drugs shall be covered at 100% for the remainder of the calendar year.
	Preferred brand drugs (Tier 2)	$50 copay/prescription (retail) $100 copay/prescription (extended retail and mail-order)		
	Non-preferred brand drugs (Tier 3)	50% copay/prescription (retail) 45% copay/prescription (extended retail and mail-order)		
	Specialty drugs (Tier 4)	50% copay/prescription		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50%* coinsurance	Preauthorization is required for certain procedures & surgeries. Services must be pre-certified in order to avoid $250 penalty per occurrence.
	Physician/surgeon fees	30% coinsurance	50%* coinsurance	None.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most) *Payment of all Out-Of-Network professional services will be limited to 135% of the Medicare fee schedule. Payment of all Out-Of-Network facility services will be limited to 175% of the Medicare fee schedule	
If you need immediate medical attention	Emergency room care	30% coinsurance		None.
	Emergency medical transportation	30% coinsurance	30%* coinsurance	
	Urgent care	$40 copay/visit, deductible does not apply	50%* coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50%* coinsurance	Preauthorization is required. Services must be pre-certified in order to avoid $250 penalty per occurrence.
	Physician/surgeon fees	30% coinsurance	50%* coinsurance	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/office visit, deductible does not apply, and 30% coinsurance for other outpatient services	50%* coinsurance	Preauthorization is required for inpatient services. Services must be pre-certified in order to avoid $250 penalty per occurrence.
	Inpatient services	30% coinsurance	50%* coinsurance	
If you are pregnant	Office visits	$20 copay/office visit, deductible does not apply	50%* coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most) *Payment of all Out-Of-Network professional services will be limited to 135% of the Medicare fee schedule. Payment of all Out-Of-Network facility services will be limited to 175% of the Medicare fee schedule	
	Childbirth/delivery professional services	30% coinsurance	50%* coinsurance	include tests and services described elsewhere in the SBC (i.e., ultrasound). Services must be pre-certified for vaginal deliveries requiring more than a 48 hour stay and for cesarean section deliveries requiring more than a 96 hour stay in order to avoid $250 penalty.
	Childbirth/delivery facility services	30% coinsurance	50%* coinsurance	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50%* coinsurance	Limited to 100 visits per person per calendar year. Preauthorization is required. Services must be pre-certified in order to avoid $250 penalty per occurrence.
	Rehabilitation services	$20 copay/office visit, deductible does not apply	50%* coinsurance	Physical and occupational therapy: limited to a combined maximum of 30 visits of office and outpatient facility services per calendar year. Speech therapy: limited to 30 visits maximum per calendar year.
	Habilitation services	$20 copay/office visit, deductible does not apply	50%* coinsurance	
	Skilled nursing care	30% coinsurance	50%* coinsurance	Limited to 60 days per person per calendar year. Preauthorization is required. Services must be pre-certified in order to avoid $250 penalty per occurrence.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most) *Payment of all Out-Of-Network professional services will be limited to 135% of the Medicare fee schedule. Payment of all Out-Of-Network facility services will be limited to 175% of the Medicare fee schedule	
	Durable medical equipment	30% coinsurance	50%* coinsurance	Preauthorization is required. Services must be pre-certified in order to avoid $250 penalty per occurrence.
	Hospice services	30% coinsurance	50%* coinsurance	None.
If your child needs dental or eye care	Children's eye exam	No charge, deductible does not apply	50%* coinsurance	Applies from birth through age 5.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Dental check-ups (Child)
- Glasses (Child)
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (limited to 30 visits, combined with chiropractic services, per person per calendar year)
- Chiropractic Care (limited to 30 visits, combined with acupuncture services, per person per calendar year)
- Hearing Aids (limited to 1 hearing aid per ear every 3 calendar years)
- Infertility treatment (except promotion of conception)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the Plan Administrator at (720) 689-1521 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes.**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes.**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

*To see examples of how this **plan** might cover costs for a sample medical situation, see the next section.*

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$500
Specialist copayment	$40
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$10
Coinsurance	$3,600
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,170**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$500
Specialist copayment	$40
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$1,000
Coinsurance	$100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,620**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$500
Specialist copayment	$40
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$200
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,200**

The plan would be responsible for the other costs of these EXAMPLE covered services.

SILVER 4250 HSA

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Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers $4,250 person / $8,500 family; for out- of-network providers $8,000 person / $16,000 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network preventive care and breast pumps and supplies are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	There are no other specific deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers $4,250 individual / $8,500 family; for out- of-network providers $16,000 individual / $32,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Penalties for failure to obtain precertification/preauthorization, services in excess of Plan maximums or limits, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.alliedbenefit.com or call 1-312-906-8080 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

 All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most) *Payment of all Out-Of-Network professional services will be limited to 135% of the Medicare fee schedule. Payment of all Out-Of-Network facility services will be limited to 175% of the Medicare fee schedule	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% coinsurance	50%* coinsurance	Limited to general practice, family practice, OB/GYN, internal medicine, osteopaths, pediatricians, nurse practitioners, physician assistants, and mental health providers. Chiropractic care and acupuncture services are limited to a combined maximum of 30 visits per person per calendar year. See Plan Document for other services.
	Specialist visit	0% coinsurance	50%* coinsurance	See Plan Document for other services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most) *Payment of all Out-Of-Network professional services will be limited to 135% of the Medicare fee schedule. Payment of all Out-Of-Network facility services will be limited to 175% of the Medicare fee schedule	
	Preventive care/screening/ immunization	No charge, deductible does not apply	50%* coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	50%* coinsurance	Does not include emergency room diagnostic services.
	Imaging (CT/PET scans, MRIs)	0% coinsurance	50%* coinsurance	None.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs (Tier 1)	Prescription Drugs purchased at a participating pharmacy (or through the mail order program) will be dispensed at a discounted rate provided You show Your member ID card at the time of purchase. Charges incurred for prescription drugs apply toward Your Deductible and Out-of-Pocket Maximum. After Your Out-of-Pocket Maximum is met, the Plan will pay 100% of Your prescription costs.		Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription). Deductible applies. Once the out-of-pocket maximum has been met, prescription drugs shall be covered at 100% for the remainder of the calendar year.
	Preferred brand drugs (Tier 2)			
	Non-preferred brand drugs (Tier 3)			
	Specialty drugs (Tier 4)	0% copay/prescription		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	50%* coinsurance	Preauthorization is required for certain procedures & surgeries. Services must be pre-certified in order to avoid $250 penalty per occurrence.
	Physician/surgeon fees	0% coinsurance	50%* coinsurance	None.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most) *Payment of all Out-Of-Network professional services will be limited to 135% of the Medicare fee schedule. Payment of all Out-Of-Network facility services will be limited to 175% of the Medicare fee schedule	
If you need immediate medical attention	Emergency room care	0% coinsurance		None.
	Emergency medical transportation	0% coinsurance	0%* coinsurance	
	Urgent care	0% coinsurance	50%* coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	50%* coinsurance	Preauthorization is required. Services must be pre-certified in order to avoid $250 penalty per occurrence.
	Physician/surgeon fees	0% coinsurance	50%* coinsurance	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance	50%* coinsurance	Preauthorization is required for inpatient services. Services must be pre-certified in order to avoid $250 penalty per occurrence.
	Inpatient services	0% coinsurance	50%* coinsurance	
If you are pregnant	Office visits	0% coinsurance	50%* coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Services must be pre-certified for vaginal deliveries requiring more than a 48 hour stay and for cesarean section deliveries requiring more than a 96 hour stay in order to avoid $250 penalty.
	Childbirth/delivery professional services	0% coinsurance	50%* coinsurance	
	Childbirth/delivery facility services	0% coinsurance	50%* coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most) *Payment of all Out-Of-Network professional services will be limited to 135% of the Medicare fee schedule. Payment of all Out-Of-Network facility services will be limited to 175% of the Medicare fee schedule	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	50%* coinsurance	Limited to 100 visits per person per calendar year. Preauthorization is required. Services must be pre-certified in order to avoid $250 penalty per occurrence.
	Rehabilitation services	0% coinsurance	50%* coinsurance	Physical and occupational therapy: limited to a combined maximum of 30 visits of office and outpatient facility services per calendar year. Speech therapy: limited to 30 visits maximum per calendar year.
	Habilitation services	0% coinsurance	50%* coinsurance	
	Skilled nursing care	0% coinsurance	50%* coinsurance	Limited to 60 days per person per calendar year. Preauthorization is required. Services must be pre-certified in order to avoid $250 penalty per occurrence.
	Durable medical equipment	0% coinsurance	50%* coinsurance	Preauthorization is required. Services must be pre-certified in order to avoid $250 penalty per occurrence.
	Hospice services	0% coinsurance	50%* coinsurance	None.
If your child needs dental or eye care	Children's eye exam	No charge, deductible does not apply	50%* coinsurance	Applies from birth through age 5.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Dental check-ups (Child)
- Glasses (Child)
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (limited to 30 visits, combined with chiropractic services, per person per calendar year)
- Chiropractic Care (limited to 30 visits, combined with acupuncture services, per person per calendar year)
- Hearing Aids (limited to 1 hearing aid per ear every 3 calendar years)
- Infertility treatment (except promotion of conception)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the Plan Administrator at (720) 689-1521 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes.**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes.**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

*To see examples of how this **plan** might cover costs for a sample medical situation, see the next section.*

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$4,250
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$4,250
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,310**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$4,250
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$4,250
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$4,270**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$4,250
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

The plan would be responsible for the other costs of these EXAMPLE covered services.

BRONZE 5000 HSA

2021 BENEFIT ENROLLMENT GUIDE

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-312-906-8080 or go to www.alliedbenefit.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. www.alliedbenefit.com or call 1-312-906-8080 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers $5,000 person / $10,000 family; for out- of-network providers $10,000 person / $20,000 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network preventive care and breast pumps and supplies are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	There are no other specific deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers $6,900 individual / $13,800 family; for out- of-network providers $15,000 individual / $30,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Penalties for failure to obtain precertification/preauthorization, services in excess of Plan maximums or limits, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.alliedbenefit.com or call 1-312-906-8080 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

 All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most) *Payment of all Out-Of-Network professional services will be limited to 135% of the Medicare fee schedule. Payment of all Out-Of-Network facility services will be limited to 175% of the Medicare fee schedule	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$40 copay/office visit, and 30% coinsurance for other physician services	50%* coinsurance	Limited to general practice, family practice, OB/GYN, internal medicine, osteopaths, pediatricians, nurse practitioners, physician assistants, and mental health providers. Chiropractic care and acupuncture services are limited to a combined maximum of 30 visits per person per calendar year. See Plan Document for other services.
	Specialist visit	$60 copay/visit	50%* coinsurance	See Plan Document for other services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most) *Payment of all Out-Of-Network professional services will be limited to 135% of the Medicare fee schedule. Payment of all Out-Of-Network facility services will be limited to 175% of the Medicare fee schedule	
	Preventive care/screening/ immunization	No charge, deductible does not apply	50%* coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	50%* coinsurance	Does not include emergency room diagnostic services.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50%* coinsurance	None.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs (Tier 1)	Prescription drugs to be purchased from pharmacy (or through the mail order program) at a reduced cost and applied toward the calendar year deductible. Once the deductible is met, you pay 30% coinsurance (25% coinsurance for mail order) at the point of sale. Coinsurance for prescription drugs applies toward Your Deductible and Out-of-Pocket Maximum. After Your Out-of-Pocket Maximum is met, the Plan will pay 100% of Your prescription costs		Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription). Deductible applies. Once the out-of-pocket maximum has been met, prescription drugs shall be covered at 100% for the remainder of the calendar year.
	Preferred brand drugs (Tier 2)			
	Non-preferred brand drugs (Tier 3)			
	Specialty drugs (Tier 4)	30% copay/prescription		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50%* coinsurance	Preauthorization is required for certain procedures & surgeries. Services must be pre-certified in order to avoid $250 penalty per occurrence.
	Physician/surgeon fees	30% coinsurance	50%* coinsurance	None.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most) *Payment of all Out-Of-Network professional services will be limited to 135% of the Medicare fee schedule. Payment of all Out-Of-Network facility services will be limited to 175% of the Medicare fee schedule	
If you need immediate medical attention	Emergency room care	50% coinsurance		None.
	Emergency medical transportation	30% coinsurance	30%* coinsurance	
	Urgent care	$60 copay/visit	50%* coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50%* coinsurance	Preauthorization is required. Services must be pre-certified in order to avoid $250 penalty per occurrence.
	Physician/surgeon fees	30% coinsurance	50%* coinsurance	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$40 copay/office visit, and 30% coinsurance for other outpatient services	50%* coinsurance	Preauthorization is required for inpatient services. Services must be pre-certified in order to avoid $250 penalty per occurrence.
	Inpatient services	30% coinsurance	50%* coinsurance	
If you are pregnant	Office visits	$40 copay/office visit	50%* coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Services must be pre-certified for vaginal deliveries requiring more than a 48 hour stay and for cesarean section deliveries requiring more than a 96 hour stay in order to avoid $250 penalty.
	Childbirth/delivery professional services	30% coinsurance	50%* coinsurance	
	Childbirth/delivery facility services	30% coinsurance	50%* coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most) *Payment of all Out-Of-Network professional services will be limited to 135% of the Medicare fee schedule. Payment of all Out-Of-Network facility services will be limited to 175% of the Medicare fee schedule	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50%* coinsurance	Limited to 100 visits per person per calendar year. Preauthorization is required. Services must be pre-certified in order to avoid $250 penalty per occurrence.
	Rehabilitation services	$40 copay/office visit	50%* coinsurance	Physical and occupational therapy: limited to a combined maximum of 30 visits of office and outpatient facility services per calendar year. Speech therapy: limited to 30 visits maximum per calendar year.
	Habilitation services	$40 copay/office visit	50%* coinsurance	
	Skilled nursing care	30% coinsurance	50%* coinsurance	Limited to 60 days per person per calendar year. Preauthorization is required. Services must be pre-certified in order to avoid $250 penalty per occurrence.
	Durable medical equipment	30% coinsurance	50%* coinsurance	Preauthorization is required. Services must be pre-certified in order to avoid $250 penalty per occurrence.
	Hospice services	30% coinsurance	50%* coinsurance	None.
If your child needs dental or eye care	Children's eye exam	No charge, deductible does not apply	50%* coinsurance	Applies from birth through age 5.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Dental check-ups (Child)
- Glasses (Child)
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (limited to 30 visits, combined with chiropractic services, per person per calendar year)
- Chiropractic Care (limited to 30 visits, combined with acupuncture services, per person per calendar year)
- Hearing Aids (limited to 1 hearing aid per ear every 3 calendar years)
- Infertility treatment (except promotion of conception)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the Plan Administrator at (720) 689-1521 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes.**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes.**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

*To see examples of how this **plan** might cover costs for a sample medical situation, see the next section.*

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$5,000
Specialist copayment	$60
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$5,000
Copayments	$0
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,960**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$5,000
Specialist copayment	$60
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$5,000
Copayments	$0
Coinsurance	$100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$5,120**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$5,000
Specialist copayment	$60
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

The plan would be responsible for the other costs of these EXAMPLE covered services.

BRONZE 6000 FSA

2021 BENEFIT ENROLLMENT GUIDE

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-312-906-8080 or go to www.alliedbenefit.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. www.alliedbenefit.com or call 1-312-906-8080 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers $6,000 person / $12,000 family; for out- of-network providers $12,000 person / $24,000 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Prescription drugs, in-network preventive care, breast pumps and supplies, in-network physician exam charges (including specialists), in-network urgent care exam charges, second surgical opinions, in-network physical/occupational/speech therapy, in-network chiropractic care and acupuncture services, and renal dialysis are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	There are no other specific deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers $8,550 individual / $17,100 family; for out- of-network providers $17,100 individual / $34,200 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Penalties for failure to obtain precertification/preauthorization, services in excess of Plan maximums or limits, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.alliedbenefit.com or call 1-312-906-8080 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most) *Payment of all Out-Of-Network professional services will be limited to 135% of the Medicare fee schedule. Payment of all Out-Of-Network facility services will be limited to 175% of the Medicare fee schedule	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$50 copay/office visit, deductible does not apply, and 30% coinsurance for other physician services	60%* coinsurance	Limited to general practice, family practice, OB/GYN, internal medicine, osteopaths, pediatricians, nurse practitioners, physician assistants, and mental health providers. Chiropractic care and acupuncture services are limited to a combined maximum of 30 visits per person per calendar year. See Plan Document for other services.
	Specialist visit	$75 copay/visit, deductible does not apply	60%* coinsurance	See Plan Document for other services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most) *Payment of all Out-Of-Network professional services will be limited to 135% of the Medicare fee schedule. Payment of all Out-Of-Network facility services will be limited to 175% of the Medicare fee schedule	
	Preventive care/screening/ immunization	No charge, deductible does not apply	60%* coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	60%* coinsurance	Does not include emergency room diagnostic services.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	60%* coinsurance	None.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs (Tier 1)	$10 copay/prescription (retail) $20 copay/prescription (extended retail and mail-order)		Covers up to a 30-day supply (retail prescription); 90-day supply (extended retail and mail order prescription). Deductible does not apply. Once the out-of-pocket maximum has been met, prescription drugs shall be covered at 100% for the remainder of the calendar year.
	Preferred brand drugs (Tier 2)	50% copay/prescription (retail) 45% copay/prescription (extended retail and mail-order)		
	Non-preferred brand drugs (Tier 3)	50% copay/prescription (retail) 45% copay/prescription (extended retail and mail-order)		
	Specialty drugs (Tier 4)	50% copay/prescription		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	60%* coinsurance	Preauthorization is required for certain procedures & surgeries. Services must be pre-certified in order to avoid $250 penalty per occurrence.
	Physician/surgeon fees	30% coinsurance	60%* coinsurance	None.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most) *Payment of all Out-Of-Network professional services will be limited to 135% of the Medicare fee schedule. Payment of all Out-Of-Network facility services will be limited to 175% of the Medicare fee schedule	
If you need immediate medical attention	Emergency room care	50% coinsurance		None.
	Emergency medical transportation	30% coinsurance	30%* coinsurance	
	Urgent care	$100 copay/visit, deductible does not apply	60%* coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	60%* coinsurance	Preauthorization is required. Services must be pre-certified in order to avoid $250 penalty per occurrence.
	Physician/surgeon fees	30% coinsurance	60%* coinsurance	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$50 copay/office visit, deductible does not apply, and 30% coinsurance for other outpatient services	60%* coinsurance	Preauthorization is required for inpatient services. Services must be pre-certified in order to avoid $250 penalty per occurrence.
	Inpatient services	30% coinsurance	60%* coinsurance	
If you are pregnant	Office visits	$50 copay/office visit, deductible does not apply	60%* coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most) *Payment of all Out-Of-Network professional services will be limited to 135% of the Medicare fee schedule. Payment of all Out-Of-Network facility services will be limited to 175% of the Medicare fee schedule	
	Childbirth/delivery professional services	30% coinsurance	60%* coinsurance	include tests and services described elsewhere in the SBC (i.e., ultrasound). Services must be pre-certified for vaginal deliveries requiring more than a 48 hour stay and for cesarean section deliveries requiring more than a 96 hour stay in order to avoid $250 penalty.
	Childbirth/delivery facility services	30% coinsurance	60%* coinsurance	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	60%* coinsurance	Limited to 100 visits per person per calendar year. Preauthorization is required. Services must be pre-certified in order to avoid $250 penalty per occurrence.
	Rehabilitation services	$50 copay/office visit, deductible does not apply	60%* coinsurance	Physical and occupational therapy: limited to a combined maximum of 30 visits of office and outpatient facility services per calendar year. Speech therapy: limited to 30 visits maximum per calendar year.
	Habilitation services	$50 copay/office visit, deductible does not apply	60%* coinsurance	
	Skilled nursing care	30% coinsurance	60%* coinsurance	Limited to 60 days per person per calendar year. Preauthorization is required. Services must be pre-certified in order to avoid $250 penalty per occurrence.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most) *Payment of all Out-Of-Network professional services will be limited to 135% of the Medicare fee schedule. Payment of all Out-Of-Network facility services will be limited to 175% of the Medicare fee schedule	
	Durable medical equipment	30% coinsurance	60%* coinsurance	Preauthorization is required. Services must be pre-certified in order to avoid $250 penalty per occurrence.
	Hospice services	30% coinsurance	60%* coinsurance	None.
If your child needs dental or eye care	Children's eye exam	No charge, deductible does not apply	60%* coinsurance	Applies from birth through age 5.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Dental check-ups (Child)
- Glasses (Child)
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (limited to 30 visits, combined with chiropractic services, per person per calendar year)
- Chiropractic Care (limited to 30 visits, combined with acupuncture services, per person per calendar year)
- Hearing Aids (limited to 1 hearing aid per ear every 3 calendar years)
- Infertility treatment (except promotion of conception)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the Plan Administrator at (720) 689-1521 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes.**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes.**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

*To see examples of how this **plan** might cover costs for a sample medical situation, see the next section.*

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$6,000
Specialist copayment	$75
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$6,000
Copayments	$10
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$8,070**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$6,000
Specialist copayment	$75
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$900
Copayments	$700
Coinsurance	$1,600
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,220**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$6,000
Specialist copayment	$75
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,100
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,500**

The plan would be responsible for the other costs of these EXAMPLE covered services.