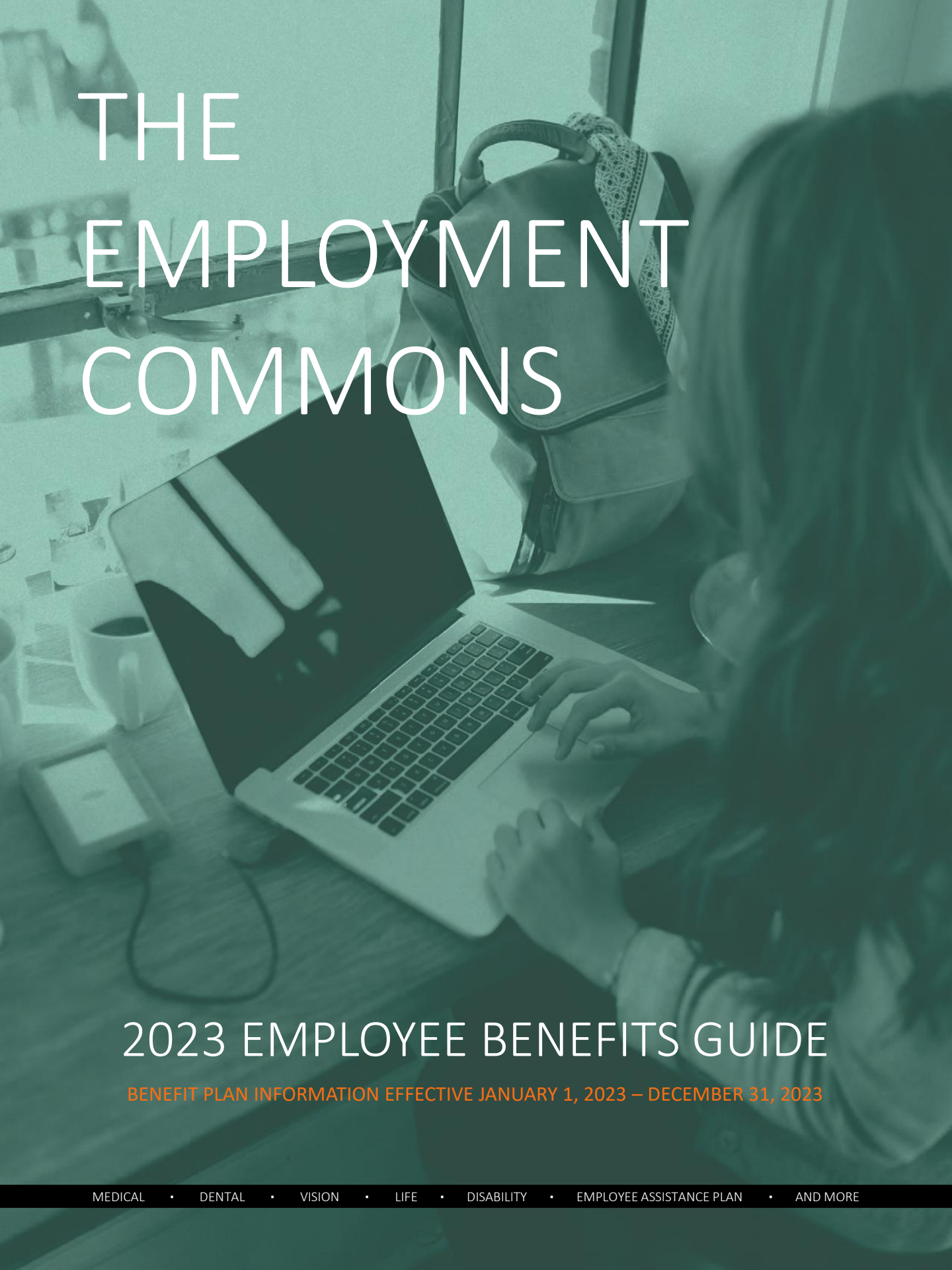


THE EMPLOYMENT COMMONS

2023 EMPLOYEE BENEFITS GUIDE

BENEFIT PLAN INFORMATION EFFECTIVE JANUARY 1, 2023 – DECEMBER 31, 2023

MEDICAL · DENTAL · VISION · LIFE · DISABILITY · EMPLOYEE ASSISTANCE PLAN · AND MORE

WELCOME TO YOUR EMPLOYEE BENEFITS GUIDE

BENEFIT PLAN INFORMATION EFFECTIVE JANUARY 1, 2023 – DECEMBER 31, 2023

The Employment Commons is dedicated in providing a benefits program designed to support the needs of our community employees and their dependents. We understand the importance of a well-rounded benefits package and offer a wide range of comprehensive and affordable plans to help protect you and your family.

The Employee Benefits Guide is your go-to resource for all things benefits and can help to make informed decisions about your employee benefits package. In this Guide you will find:

- ✓ Eligibility Requirements
- ✓ Enrollment Opportunities
- ✓ Benefit Plan Details
- ✓ Employee Plan Costs
- ✓ Vendor Contact Information & Resources
- ✓ and Much More

Please spend some time to review the available options summarized in this Guide and choose your benefits carefully. If you have any questions about our employee benefits program, please contact one of the many resources available on page 3 of this Guide.

TABLE OF CONTENTS

This Guide provides highlights of the benefit plans offered to you by Employment Commons, LCA, and in no way serves as the actual plan description or plan document. Certain restrictions and exclusions apply. For exact terms and conditions, please refer to the Plan Document, Contract or the Summary of Benefits & Coverage (SBC). The plan documents will always govern the benefits that Employment Commons offers. Employment Commons reserves the right to modify any or all of these plans at any time. Please email support@opolis.co for more information.

The information provided in this Guide is advisory and is provided for general informational purposes only. This information should not be considered legal or tax advice or legal or tax opinion on any specific facts or circumstances. Readers and participants are urged to consult their legal counsel and tax advisor concerning any legal or tax questions that may arise.

ELIGIBILITY | ENROLLMENT

CONTACTS & RESOURCES

FOR QUESTIONS ABOUT ELIGIBILITY AND ENROLLMENT

SUPPORT@OPOLIS.CO

FOR QUESTIONS ABOUT BENEFITS, NETWORK PROVIDERS AND FACILITIES, CLAIMS, AND ID CARDS

MEDICAL

Allied – Cigna PPO National Network Access
Group #A21169
800.288.2078 (M-Th 7:30am-7pm CST, F 8am-5pm, Sat 9am-12pm)
alliedbenefit.com
Search for Providers via Allied or at cigna.com = PPO, Choice Fund PPO Network

PRESCRIPTION

CVS Caremark
Group #Rx2129 BIN 004336 PCN ADV
877.860.6415
caremark.com

DENTAL

Principal
Group #1158391
800.247.4695
principal.com

VISION

Principal – VSP Choice Plus Network Access
Group #1158391
800.247.4695 or VSP 800.877.7195
principal.com and vsp.com

FLEXIBLE SPENDING & HEALTH SAVINGS ACCOUNTS

HealthEquity
866.346.5800
healthequity.com

LIFE & DISABILITY

Principal
Group #1158391
800.247.4695
principal.com

EMPLOYEE ASSISTANCE PROGRAM

Principal and Magellan
800.356.7089
magellanascend.com

NEED MEDICARE GUIDANCE?

For those eligible or nearing eligibility for Medicare, we encourage you to reach out to Willamette Valley Benefits to review your options. Willamette Valley Benefits can explain how Medicare works and help you to make an informed decision about your Medicare enrollment.

WWW.WVBENEFITS.COM 888.944.4644

ELIGIBILITY

Regular full-time employees are eligible for benefits beginning on the first of the month following or coinciding with date of hire. This is referred to as your **Initial Eligibility Period**.

Eligible dependents can also enroll in the Medical, Dental, and Vision plans. Eligible dependents include your spouse or domestic partner, your children, and your spouse's or domestic partner's children. Dependent children are eligible through the last day of the month of their 26th birthday.

ENROLLMENT OPPORTUNITIES

You are eligible to enroll and/or make plan changes in the Medical, Dental, and Vision plans as follows:

1. Initial Eligibility Period (above)
2. Qualifying Life Event *
   - Marriage, Divorce or Legal Separation
   - Birth or Adoption
   - Death
   - Loss or Gain of Group Coverage Through Employer, Medicare, Medicaid or State Health Insurance Program

   * If you have a Qualifying Life Event change, you must notify support@opolis.co within 30 days, or you forfeit your opportunity to make changes and must wait until the next Open Enrollment period.
3. Annual Open Enrollment, which is held in November/December for a January 1st effective date.

ENROLLMENT INSTRUCTIONS

Benefit plan enrollment is done through our website, during your Initial Eligibility Period, and confirmed again annually during Open Enrollment:

▶ COMMONS.OPOLIS.CO

From this site you will be able to:

- ✓ Review the available benefit plan options.
- ✓ See how much the plans will cost you.
- ✓ Access benefit plan details and additional member information and resources.
- ✓ Elect your beneficiaries.
- ✓ ENROLL

MEDICAL

Employment Commons Group Medical Plans are administered by Allied, with access to Cigna's National PPO Network. Employees have the option of selecting between 4 medical plans for the coverage that best meets your needs. Included with the medical plans is Prescription Drug coverage, administered by CVS Caremark.

▶ **See page 8 of this Guide for additional resources, discounts and perks available to our medical plan members.**

EVALUATING YOUR MEDICAL PLAN OPTIONS

It is important to understand the healthcare coverage options that may be available to you: Employment Commons medical plans; coverage through a spouse or parent; Health Insurance Marketplace www.healthcare.gov; Medicaid or other State/Federal Assistance Program; Medicare (age 65+); Individual Plans.

To help in your plan selection, the following pages include details about each of the available medical plans through Employment Commons, with a side-by-side highlight comparison of the plans below, to include monthly pre-tax plan costs.

As you evaluate the medical plan options and your insurance needs, play close attention to plan benefit levels and cost components. Consider the amount of your payroll deduction, as well as other plan expenses, such as member deductible, copays, and the annual out-of-pocket maximum.

MEDICAL PLAN COMPARISON	VALUE COPAY PLAN	PREMIUM COPAY PLAN	VALUE HIGH DEDUCTIBLE HEALTH PLAN	PREMIUM HIGH DEDUCTIBLE HEALTH PLAN
MONTHLY PLAN COSTS	PRE-TAX	PRE-TAX	PRE-TAX	PRE-TAX
Employee Only	**$334.87**	**$694.20**	**$379.01**	**$486.62**
Employee + Spouse	**$923.45**	**$1,618.03**	**$949.82**	**$1,199.98**
Employee + Child(ren)	**$849.72**	**$1,471.69**	**$895.20**	**$1,111.11**
Employee + Family	**$1,337.69**	**$2,299.06**	**$1,415.05**	**$1,748.76**
FSA or HSA Pre-Tax Plans For Eligible Healthcare Expenses	FSA Eligible Plan SEE PAGE 10 FOR MORE INFORMATION ON FSAs	FSA Eligible Plan SEE PAGE 10 FOR MORE INFORMATION ON FSAs	HSA Eligible Plan SEE PAGE 7 FOR MORE INFORMATION ON HSAs	HSA Eligible Plan SEE PAGE 7 FOR MORE INFORMATION ON HSAs
ANNUAL DEDUCTIBLE	IN NETWORK $6,000 Per Member $12,000 Family Maximum	IN NETWORK $750 Per Member $1,500 Family Maximum	IN NETWORK $5,000 Employee Only $10,000 E + Dependent(s)	IN NETWORK $4,900 Employee Only $9,800 E + Dependent(s)
ANNUAL MAXIMUM	IN NETWORK $9,100 Per Member $18,200 Family Maximum	IN NETWORK $6,500 Per Member $13,000 Family Maximum	IN NETWORK $7,500 Employee Only $15,000 E + Dependent(s)	IN NETWORK $4,900 Employee Only $9,800 E + Dependent(s)
PHYSICIAN OFFICE VISITS	IN NETWORK $50 Primary Care Copay $75 Specialist Copay	IN NETWORK $20 Primary Care Copay $40 Specialist Copay	IN NETWORK ALL SERVICES SUBJECT TO ANNUAL MEMBER DEDUCTIBLE	IN NETWORK ALL SERVICES SUBJECT TO ANNUAL MEMBER DEDUCTIBLE
PRESCRIPTION DRUGS	IN NETWORK $10 Generic; 50% Brand; 50% Non-Preferred Brand; 50% Specialty	IN NETWORK $10 Generic; $60 Brand; 50% Non-Preferred Brand; 50% Specialty	IN NETWORK 30% After Deductible	IN NETWORK 0% After Deductible

FIND LOCAL & NATIONAL CIGNA NETWORK PROVIDERS & FACILITIES

▶ **CIGNA.COM**

1. Click on Find a Doctor, Dentist, or Facility
2. How are you Covered? Click on **Employer or School**
3. Enter Address, City or Zip and then search by Doctor Type, Name, or a Health Facility.
4. Select A Plan - I Live In: enter your Zip Code and click Continue.
5. PLAN NETWORK FOR ALL OFFERED PLANS = **PPO, Choice Fund PPO**

FOR ADDITIONAL ASSISTANCE CONTACT ALLIED CUSTOMER SERVICE AT 800.288.2078 (M-Th 7:30am-7pm CST, F 8am-5pm, Sat 9am-12pm)

MEDICAL | PPO COPAY PLANS

We offer 2 **Copay Plans**, which provide access through Cigna's largest National PPO Network. The Copay Plans include physician office visits and prescription drug benefits for an up-front low-cost copay.

The Copay Plans can be paired with a **Flexible Spending Account (FSA)**, which allows members to set aside pre-tax dollars to help pay for eligible out-of-pocket medical, dental, and vision expenses (deductibles, coinsurance, copays). **See page 10 of this Guide for more information about FSAs.**

PER CALENDAR YEAR	VALUE COPAY PLAN		PREMIUM COPAY PLAN	
PLAN HIGHLIGHTS	CIGNA PPO NETWORK	OUT-OF-NETWORK	CIGNA PPO NETWORK	OUT-OF-NETWORK
Annual Deductible	$6,000 Per Member $12,000 Family Maximum	$12,000 Per Member $24,000 Family Maximum	$750 Per Member $1,500 Family Maximum	$6,500 Per Member $13,000 Family Maximum
Annual Out-Of-Pocket Maximum	$9,100 Per Member $18,200 Family Maximum	$25,000 Per Member $50,000 Family Maximum	$6,500 Per Member $13,000 Family Maximum	$13,000 Per Member $26,000 Family Maximum
PREVENTIVE CARE SERVICES	**COVERED IN FULL**	60% After Deductible	**COVERED IN FULL**	50% After Deductible
Physician Visits	$50 Copay Primary Care $75 Copay Specialist	60% After Deductible	$20 Copay Primary Care $40 Copay Specialist	50% After Deductible
Chiropractic & Acupuncture 30 VISITS ANNUALLY	$50 Copay	60% After Deductible	$20 Copay	50% After Deductible
Lab & X-Ray	30% After Deductible	60% After Deductible	30% Coinsurance Basic 30% After Deductible Advanced Imaging	50% After Deductible
Hospital Services	30% After Deductible	60% After Deductible	30% After Deductible	50% After Deductible
Urgent Care SAVE MONEY BY USING URGENT CARE FOR SAME-DAY NON-EMERGENT CARE	$100 Copay	60% After Deductible	$40 Copay	50% After Deductible
Emergency Room	$250 Copay Then 50% After Deductible		$250 Copay Then 30% After Deductible	
PRESCRIPTION DRUGS SEE PAGE 7 FOR MORE INFORMATION	30 DAY SUPPLY RETAIL NETWORK PHARMACIES	90 DAY SUPPLY MAIL ORDER HOME DELIVERY	30 DAY SUPPLY RETAIL NETWORK PHARMACIES	90 DAY SUPPLY MAIL ORDER HOME DELIVERY
CVS caremark® Annual Deductible	None		None	
Tier 1: Generic	$10 Copay	$20 Copay	$10 Copay	$20 Copay
Tier 2: Brand	50% Copay	45% Copay	$60 Copay	$120 Copay
Tier 3: Non-Preferred Brand	50% Copay	45% Copay	50% Copay	45% Copay
Tier 4: Specialty	50% Copay	Specialty Pharmacy Only	50% Copay	Specialty Pharmacy Only

USING A COPAY PLAN

- Access to network and non-network providers and facilities. *A higher amount is covered when obtaining care with network providers and facilities.*
- Self-direct your care, although some services may require pre-authorization. See page 8 for more information about pre-authorizations.
- Physician referrals are not required.
- Preventive Care Services are covered in full with network providers.
- Certain services, such as Physician Office Visits, may require a fixed-dollar payment upfront, referred to as your Copay.
- Certain services, such as hospital-based procedures, may require members to pay a percentage of the cost of care, known as Coinsurance.
- Before the plan will pay certain medical expenses, members may be required to pay a specific dollar amount, referred to as the Annual Deductible.
- Once a member has met the Annual Out-Of-Pocket Maximum limit, most services will be covered in full by the plan for the remainder of the calendar year.
- Benefits and visit limitations accrue on a calendar year basis, resetting annually on January 1st.

MEDICAL | HIGH DEDUCTIBLE HEALTH PLANS

We offer 2 qualified **High Deductible Health Plans (HDHP)**, which provide access through Cigna's largest National PPO Network. With a large upfront deductible for most services, an HDHP encourages members to closely analyze their healthcare decisions.

To help offset large up-front plan costs, we encourage members to sign up for the **HealthEquity Health Savings Account (HSA)**, available with our High Deductible Health Plans. An HSA is a personal bank account that allows members to set aside pre-tax dollars to pay for eligible healthcare expenses. **See page 7 of this Guide for more information about HSAs.**

PER CALENDAR YEAR	VALUE HIGH DEDUCTIBLE HEALTH PLAN		PREMIUM HIGH DEDUCTIBLE HEALTH PLAN	
PLAN HIGHLIGHTS	CIGNA PPO NETWORK	OUT-OF-NETWORK	CIGNA PPO NETWORK	OUT-OF-NETWORK
Annual Deductible	$5,000 Employee $10,000 E + Dependent(s)	$10,000 Employee $20,000 E + Dependent(s)	$4,900 Employee $9,800 E + Dependent(s)	$9,800 Employee $19,600 E + Dependent(s)
Annual Out-Of-Pocket Maximum	$7,500 Employee $15,000 E + Dependents	$25,000 Employee $50,000 E + Dependent(s)	$4,900 Employee $9,800 E + Dependent(s)	$19,600 Employee $39,200 E + Dependent(s)
PREVENTIVE CARE SERVICES	**COVERED IN FULL**	50% After Deductible	**COVERED IN FULL**	50% After Deductible
Physician Visits	$40 After Deductible Primary Care $60 After Deductible Specialist	50% After Deductible	0% After Deductible	50% After Deductible
Chiropractic & Acupuncture 30 VISITS ANNUALLY	$40 After Deductible	50% After Deductible	0% After Deductible	50% After Deductible
Lab & X-Ray	30% After Deductible	50% After Deductible	0% After Deductible	50% After Deductible
Hospital Services	30% After Deductible	50% After Deductible	0% After Deductible	50% After Deductible
Urgent Care SAVE MONEY BY USING URGENT CARE FOR SAME-DAY NON-EMERGENT CARE	$60 After Deductible	50% After Deductible	0% After Deductible	50% After Deductible
Emergency Room	50% After In-Network Deductible		0% After Deductible After In-Network Deductible	
PRESCRIPTION DRUGS SEE PAGE 7 FOR MORE INFORMATION	30 DAY SUPPLY RETAIL NETWORK PHARMACIES	90 DAY SUPPLY MAIL ORDER HOME DELIVERY	30 DAY SUPPLY RETAIL NETWORK PHARMACIES	90 DAY SUPPLY MAIL ORDER HOME DELIVERY
CVS caremark Annual Deductible	Subject To Medical Plan Deductible		Subject To Medical Plan Deductible	
Tier 1: Generic	30% After Deductible	25% After Deductible	0% After Deductible	0% After Deductible
Tiers 2 & 3: Brand	30% After Deductible	25% After Deductible	0% After Deductible	0% After Deductible
Tier 4: Specialty	30% After Deductible	Specialty Pharmacy Only	0% After Deductible	Specialty Pharmacy Only

USING A HIGH DEDUCTIBLE HEALTH PLAN

- Access to network and non-network providers and facilities. *A higher amount is covered when obtaining care with network providers and facilities.*
- Self-direct your care, although some services may require a pre-authorization. See page 7 for more information about pre-authorizations.
- Physician referrals are not required.
- Preventive Care Services are covered in full with network providers.
- For all covered non-preventive care services, members are required to pay a specific dollar amount up front, referred to as the Annual Deductible.
- Once the Annual Deductible has been met, most services will continue to require the member to pay a percentage of the cost, known as Coinsurance, or a dollar amount, known as a Copay.
- Once a member has met the Annual Out-Of-Pocket Maximum limit, most services will be covered in full by the plan for the remainder of the calendar year.
- Under HDHPs, the Deductible and Annual Maximum amounts are based on enrollment. If enrolled with dependents, all members are subject to the Employee + Dependent(s) amounts.

MEDICAL | HEALTH SAVINGS ACCOUNT

By enrolling in a Qualified High Deductible Health Plan, you are eligible to contribute tax-free* money into a Health Savings Account (HSA). An HSA is a personal bank account, administered by an authorized financial institution, which accumulates funds that can be used to pay healthcare costs, particularly those associated with the deductible under your High Deductible Health Plan, also known as an HDHP.

ADVANTAGES OF A HIGH DEDUCTIBLE HEALTH PLAN w/HSA

- Lower medical plan premiums than traditional PPO medical plans.

  Use the monthly premium savings to contribute to your HSA. Contributions can be set up to be automatically deducted from each paycheck and deposited directly into your HSA.

- HSA pre-tax contributions may reduce your taxable income.
- HSA funds accumulate tax-free* interest, subject to state law.
- You own your HSA. The monies in the account are yours, and will remain with you, even if you leave the company.
- Withdrawals are tax-free* when paying for qualified expenses.
- Post-tax contributions you make to your HSA may be tax-deductible on your tax return (excluding AL, CA and NJ up to the applicable maximum contribution).
- Your HSA is a vehicle to save for future health needs, such as COBRA premiums, long-term care or healthcare after retirement.

HSA ELIGIBILITY QUALIFICATIONS

To make tax-free* deposits to an HSA, the IRS requires that:

- you are covered by an HSA Qualified High Deductible Health Plan (HDHP);
- you have no other health coverage - such as other non-HDHP health plan (spouse's plan), Medicare, Tricare, military health benefits;
- you have not received any health or prescription benefits from the Veteran's Administration, or one of their facilities, in the last 3 months. Exception for those enrolled in VA benefits and use the plan solely for "service-related injuries".
- you are not covered by, or eligible to make claims for, a non-limited Healthcare Flexible Spending Account (FSA);
  - **For employees with an existing FSA for 2022** and newly enroll in a High Deductible Health Plan on June 1st, you will not be eligible to open or contribute to an HSA until January 1st, 2023, and you must exhaust all FSA monies prior to December 31st, 2022.
- your spouse is not enrolled in a general-purpose FSA through their employer;
- you are not claimed as a dependent on another individual's tax return.

ANNUAL HSA CONTRIBUTION LIMITS

Contributions cannot exceed $3,850 for employee only enrollment, and $7,750 for employee + dependent(s) enrollment in 2023. Individuals age 55 or older may also contribute an additional $1,000 in "catch-up" contributions.

USING YOUR HSA FUNDS

You can use your money tax-free* at any time for HSA eligible expenses. If you use the money for non-eligible HSA expenses, you will be subject to income tax and a 20% tax penalty. See separate rules/taxation for those over age 65.

To use your HSA, the most convenient way to pay for qualified HSA expenses is to utilize your HSA Debit Card. You can also use your own funds and reimburse yourself by making a withdrawal from your HSA. *It is recommended that you keep all receipts for HSA purchases should you ever be audited by the IRS.*

HealthEquity™

ACTIVATE YOUR HSA

The High Deductible Health Plans come with an HSA administered through HealthEquity. To activate your personal HealthEquity HSA:

1. Enroll in one of the HSA eligible High Deductible Health Plans through our website.
2. Enter you pre-tax contribution. Your elected contribution will then automatically be deducted from each paycheck and deposited directly into your HSA.
3. Once you confirm your HSA election, your HealthEquity Health Savings Account will be opened on your behalf.

ACCESSING YOUR HSA

Once your account has been set up by HealthEquity, you will receive a packet of information, mailed to your home, with details about your HealthEquity HSA, including your **HSA Debit Card**.

Manage your account at any time, online at healthequity.com or via HealthEquity's mobile app:

- ✓ Make payments to providers.
- ✓ View your account balance, transactions, and contributions.
- $ Easy to use investment features to maximum tax-free earning potential on your HSA funds.

FOR MORE INFORMATION
HEALTHEQUITY.COM/HSALEARN
866.346.5800

THE INFORMATION PROVIDED IS INTENDED FOR GENERAL GUIDANCE ONLY. WE RECOMMEND THAT YOU CONSULT WITH A TAX ADVISOR FOR SPECIFIC TAXATION INFORMATION AND ADVICE BEFORE ENROLLING IN A HIGH DEDUCTIBLE HEALTH PLAN.

* HSA's are never taxed at a federal income tax level when used appropriately for qualified medical expenses. Most states recognize HSA funds as tax-free with very few exceptions. Consult a tax advisor regarding your state's specific rules.

ALLIEDBENEFIT.COM

Get the most out of your medical plan membership - connect to your personal plan information online through our Allied Member Portal.

TRACK YOUR BENEFITS & COVERAGE Review claims, see your deductible, and more.

FIND A DOCTOR Connect to CIGNA.COM to find providers in the Cigna PPO Network.

PRESCRIPTION INFO Link to CAREMARK.COM for details about our prescription benefits.

REACH FOR BETTER HEALTH & SAVINGS Access additional resources available to members to assist with healthy living and out-of-pocket savings.

GET THE RIGHT CARE AT THE RIGHT TIME FOR THE RIGHT PRICE

PRIMARY CARE ($)

Want to see someone who knows your health, but it's not urgent? Have a chronic problem, need preventive care or follow-up? Contact your Primary Care Provider to schedule an appointment.

URGENT CARE ($$)

Know you need help right away, but don't think you are in immediate danger? Urgent care can deal with things like minor cuts and burns, infections and more. Visit an urgent care facility near you.

EMERGENCY ($$$)

Think your life may be in danger? Maybe you have signs of heart attack, stroke, uncontrolled bleeding or unbearable pain? Go immediately to the nearest emergency room.

SERVICES REQUIRING PRE-AUTHORIZATION

THE FOLLOWING NON-EMERGENT SERVICES REQUIRE PRE-AUTHORIZATION FOR COVERAGE BEFORE SERVICES ARE PROVIDED. Failure to obtain pre-authorization prior to receiving these services will result in higher out-of-pocket costs to the member. Contact Cigna's Pre-Authorization Team for more information, 800.288.2078.

- Hospital Admissions and Inpatient Confinements
- Select Outpatient Procedures and Surgeries:
  - Any Potentially Cosmetic Service (Breast, Eyes/Nose, Head/Ear, Skin, Trunk/Body or Vein Therapy/Treatment)
  - Any Potentially Investigational/Experimental Service
  - Maxillo-Facial orthopedics and Mandibular Surgical Procedures
  - Spinal Surgeries and Procedures of the Spine
- Skilled Nursing and Sub-Acute Facility Admissions and Confinements
- Durable medical equipment (DME)
- Home Health Care and In-Home Services (including IV therapy)
- Transplant Related Services (including Initial Consultation and Evaluation)
- Sleep Management Programs, including but not limited to:
  - Obstructive Sleep Apnea, Diagnostic or Therapeutic Sleep Studies.
  - Oral Pharynx Procedures (Uvulectomy, and LAUP Procedures)
- Inpatient Mental/Nervous and Substance Use Disorder Services: Pre-Authorization through Allied Care Solutions, 800.288.2078.
- Specialty and High-Cost Prescription Drugs: Pre-Authorization through Caremark, 877.860.6415.

CVS caremark®

Prescription Drug Benefits provided with our Allied Medical Plans are managed by CVS Caremark. There are many prescription resources and cost saving features available through our plans.

REGISTER FOR YOUR CVS CAREMARK MEMBER PORTAL AT CAREMARK.COM

- Locate CVS Caremark Network Pharmacies
- View the Performance Drug List: CVS Caremark Performance Drug List – Standard Control is a guide within select therapeutic categories, assigning a Drug Tier, to identify the member cost share. The Performance Drug List includes common FDA-approved generic (Tier 1) and brand preferred (Tier 2) drugs within select therapeutic categories. Brand drugs not identified on this list as generic or brand preferred are designated as non-preferred brands (Tier 3). This Drug List is not a complete list of medications, and some medications listed may not be covered. See the Performance Drug List posted at Caremark.com for the most up to date information.
- Compare Drug Costs and Effectiveness
- Save time and money by ordering up to a 90-day supply of maintenance medications through CVS Caremark Rx Delivery by Mail program.
- Research Medication Usage and Safety
- Access CVS Specialty for Specialty medications and support for members with complex conditions. https://www.caremark.com/manage-prescriptions/specialty.html

DENTAL

We offer 2 dental plan options with varying levels of coverage for members to select the plan that best meets your needs. Both plans allow members to access services from any licensed dentist, up to an Annual Maximum Benefit. By utilizing Principal national network of providers, your out-of-pocket costs will be less, and your Annual Maximum Benefit will go further.

PRINCIPAL.COM

- ✓ Find Principal Network Providers
- ✓ Estimate Costs For Procedures
- ✓ View Claims Status and Details
- ✓ Check Deductible and Maximum Status
- ✓ Download Your Member ID Card

MONTHLY PRE-TAX COST	VALUE PLAN	PREMIUM PLAN
Employee Only	$24.55	$38.66
Employee + Spouse	$49.69	$78.27
Employee + Child(ren)	$61.28	$113.96
Employee + Family	$90.65	$162.59

DENTAL PLAN HIGHLIGHTS Principal Network Benefits	VALUE PLAN	PREMIUM PLAN
Annual Deductible PER CALENDAR YEAR	$50 Per Member $150 Family Maximum	$50 Per Member $150 Family Maximum
Diagnostic & Preventive Care Exam, Cleaning, X-ray, Fluoride, Sealants	COVERED IN FULL Deductible Waived	COVERED IN FULL Deductible Waived
Basic Services Fillings, Extractions, Root Canal, Periodontics, Endodontics	20% After Deductible	20% After Deductible
Major Services Crowns, Bridges, Inlays/Onlays, Dentures	50% After Deductible	50% After Deductible
Annual Maximum Benefit PER CALENDAR YEAR Maximum Rollover: For members who receive services under the annual threshold, additional dollars will be rolled over to next year's Maximum Benefit.	**$1,000 Per Member Per Calendar Year** **+ MAXIMUM ACCUMULATION ROLLOVER**	**$3,000 Per Member Per Calendar Year** **+ MAXIMUM ACCUMULATION ROLLOVER**
Orthodontia Adults & Dependent Children/Age 26	Not Covered	50% Coinsurance $3,000 Lifetime Maximum Benefit

ASK YOUR DENTIST FOR A PRE-TREATMENT ESTIMATE PRIOR TO OBTAINING ANY NON-PREVENTIVE CARE SERVICES. The dentist will verify benefits with Principal and confirm what your total out-of-pocket cost will be prior to the service. This is particularly important when seeing non-network providers, as these providers have not agreed to Principal's contracted rates and may balance bill members for additional amounts.

VISION

The VSP Choice Vision Plan offered through Principal provides up front coverage from VSP Choice Network Providers. To find a VSP Choice Network Provider go to principal.com or vsp.com.

VSP Vision care for life

MAXIMIZE YOUR VISION BENEFITS BY USING VSP CHOICE NETWORK PROVIDERS.

Using your VSP Vision benefit is easy!

- Create an account at vsp.com. Once your plan is effective, review your benefit information.
- Find an eye doctor who's right for you. Visit vsp.com or call 800.877.7195.
- At your appointment, tell them you have VSP through Principal. No ID card necessary.

MONTHLY PRE-TAX COST	
Employee Only	$6.10
Employee + Spouse	$13.51
Employee + Child(ren)	$14.10
Employee + Family	$23.11

VISION PLAN HIGHLIGHTS	VSP CHOICE NETWORK BENEFITS
WELLVISION Exam ONCE PER CALENDAR YEAR	$10 Copay
HARDWARE	$25 Copay
Lenses ONCE PER CALENDAR YEAR	○ Single Vision, Lined Bifocal, Lined Trifocal, Lenticular ○ Lens Enhancements Available - See Applicable Copays and Additional Discounts
Frames ONCE PER CALENDAR YEAR	○ $200 Allowance + 20% Discount For Cost Above Allowance
Contacts *In Lieu of Glasses* ONCE PER CALENDAR YEAR	○ $200 Allowance for Elective Contact Lenses ○ Up To $60 Copay for Fitting/Evaluation

See the Plan Documents for allowances when seeing non-VSP Choice Network Providers. You may have to pay out-of-pocket when seeing non-VSP providers. Go to vsp.com for details on submitting claim reimbursement requests for services received from non-VSP providers.

ADDITIONAL VSP VISION SAVINGS @ VSP.COM/OFFERS

- **GLASSES & SUNGLASSES** 20% savings on additional glasses and sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam.
- **LASER VISION CORRECTION** Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities After surgery, use your frame allowance (if eligible) or discounts for sunglasses from any VSP doctor.

FOR C-CORPs ONLY (S-CORPs NOT ELIGIBLE)

FLEXIBLE SPENDING ACCOUNT

The Healthcare and Dependent Care Flexible Spending Accounts (FSA's) are administered by HealthEquity. An FSA allows you to use pre-tax dollars to reimburse yourself for a wide variety of health and/or dependent care expenses that are not covered through your other benefit plans.

The annual amount you elect to contribute to each account will be divided into equal amounts and deducted from your paycheck before federal, state and local income taxes are withdrawn, therefore reducing your taxable income.

► **FOR MORE INFORMATION ABOUT FSA'S GO TO HEALTHEQUITY.COM/LEARN/FLEXIBLE-SPENDING-ACCOUNT**

HEALTHCARE FSA

Out-of-pocket healthcare expenses for yourself and your dependents – such as medical, dental and/or vision deductibles, coinsurance, and copays – are eligible for reimbursement from your Healthcare FSA. For a detailed list of eligible expenses go to learn.healthequity.com/qme/.

THE ANNUAL MAXIMUM HEALTHCARE FSA CONTRIBUTION ALLOWED IS $3,050.

MAXIMUM CONTRIBUTION FOLLOWS IRS POSTED LIMIT

DEPENDENT CARE FSA

Expenses for dependent care services for children, a disabled spouse, or incapacitated parent are eligible for reimbursement from your Dependent Care FSA as long as you incur these expenses while you and your spouse work or attend school full-time.

THE ANNUAL MAXIMUM DEPENDENT CARE FSA CONTRIBUTION ALLOWED IS $5,000.

$2,500 IF MARRIED AND FILING A SEPARATE TAX RETURN

HIGH DEDUCTIBLE HEALTH PLAN ENROLLEES are eligible for the Limited Healthcare FSA, allowing reimbursement for eligible dental and vision care expenses only. Go to HEALTHEQUITY.COM/LEARN/LPFSA for more information.

RULES AND REGULATIONS

Plan your annual FSA contribution amounts carefully; the election you make when you enroll is binding for the entire plan year unless you have a qualifying status change. Additionally, the IRS imposes some rules and restrictions on the way you can use FSA funds:

- You must re-enroll in the FSA annually.
- Eligible expenses must be incurred during the plan year, which runs January 1st – December 31st.
- You have 90 days from the end of the plan year to submit your expenses for reimbursement (no later than March 31st).
- **At the end of the plan year, you may roll over up to $610 in unused Healthcare FSA deductions for use in the following contract year. You will forfeit any remaining Healthcare FSA balance over $610. Monies in the Dependent Care FSA are not eligible for rollover. REMAINING BALANCES AFTER MARCH 31st WILL BE FORFEITED.**
- Money in your Healthcare FSA cannot be used for dependent care expenses, and money in your Dependent Care FSA cannot be used for healthcare expenses.
- You may only make changes to your contribution amounts with a qualifying life event: marriage, divorce or legal separation, death of a spouse or dependent, change from part-time to full-time or full-time to part-time employment, termination or commencement of spouse's employment, significant change in health coverage due to spouse's employment.

ACCESSING YOUR FSA DOLLARS

1. Be sure that you have necessary claims documentation, to include date of service, provider, type of expense and out-of-pocket cost, such as the Explanation of Benefits from the insurance company or a detailed receipt from your provider.
2. Select from the following EASY ways to access your FSA dollars:

   HEALTHEQUITY BENEFITS FSA DEBIT CARD

   A HealthEquity Benefits FSA Debit Card will automatically be sent to you when you sign up for the Healthcare FSA. Use your FSA Debit Card to pay for FSA eligible healthcare expenses at point of sale. Remember when using the debit card feature to keep all claim documentation on file as it may be requested by HealthEquity and/or the IRS.

   HEALTHEQUITY MOBILE APP

   Access your benefits on the go 24/7 – submit claims, review balance and more. Direct deposit available.

   ONLINE CLAIMS SUBMISSION HEALTHEQUITY.COM

   Log in, upload your claim documentation, complete the online wizard, and reimbursement will be sent to you within days.

LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

Life and AD&D benefits are provided through Principal. The Life Insurance benefit pays your designated beneficiary(ies) $50,000 in the event of your death. This benefit is doubled if your death is the result of an accident. Benefits are also payable in the case of dismemberment.

MONTHLY COST: $6.35

IMPORTANT

YOUR LIFE BENEFITS ARE PAID TO THE INDIVIDUAL(S) OR ENTITY(IES) YOU HAVE SELECTED AS YOUR BENEFICIARY.

UPDATE YOUR BENEFICIARY DESIGNATION AT COMMONS.OPOLIS.CO.

WILL & LEGAL DOCUMENT CENTER provided by ARAG®

Create legal documents with this FREE online resource through Principal.
ARAGWILLS.COM/PRINCIPAL

DISABILITY

Your ability to earn an income may be your most important asset. No one expects to get sick or injured, however, life can change in an instant. When the unexpected becomes reality, Disability Insurance can provide income protection and peace of mind while you are unable to work. Short and Long Term Disability Insurance is provided through Principal.

SHORT TERM DISABILITY BENEFIT HIGHLIGHTS

Short Term Disability (STD) Insurance can help you replace a portion of your income during the initial weeks of a disability.

Elimination Period: If you are disabled due to an injury or sickness, your elimination period, which is 7 days, will need to be satisfied before benefits begin.

Weekly Benefit: Once you have satisfied your elimination period, a weekly benefit may be paid, up to 60% of your pre-disability earnings, to a weekly maximum of $1,500. Applicable State Disability offsets apply.

Benefit Duration: Benefits can be paid for a maximum duration of 12 weeks.

MONTHLY COST PER $10 OF WEEKLY BENEFIT: $0.11

LONG TERM DISABILITY BENEFIT HIGHLIGHTS

Long Term Disability (LTD) Insurance helps replace a portion of your income during an extended disability.

Elimination Period: If you are disabled due to an injury or sickness, your elimination period, which is 90 days, will need to be satisfied before benefits begin.

Monthly Benefit: Once you have satisfied your elimination period, monthly benefits may be paid at 60% of your pre-disability earnings, up to $5,000 maximum per month. Applicable State Disability offsets apply.

Benefit Duration: Benefits may be paid for a maximum duration up to your Social Security Normal Retirement Age (SSNRA).

MONTHLY COST PER $100 OF COVERED EARNINGS:

Age < 25	$0.080	Age 50 - 54	$0.510
Age 25 - 29	$0.070	Age 55 - 59	$0.580
Age 30 - 34	$0.100	Age 60 - 64	$0.590
Age 35 - 39	$0.170	Age 65 - 69	$0.440
Age 40 - 44	$0.300	Age 70 +	$0.220
Age 45 - 49	$0.350		

INCLUDED FREE WITH THE PRINCIPAL DISABILITY PLANS

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Magellan Ascend

Your life's journey – made easier. The EAP is a **FREE** and **CONFIDENTIAL** resource provided by Employment Commons, through Principal and Magellan, to help assist you and your immediate family members manage life's daily challenges.

THE EAP PROVIDES 3 FREE COUNSELING SESSIONS WITH PROFESSIONALS, AVAILABLE 24/7/365.

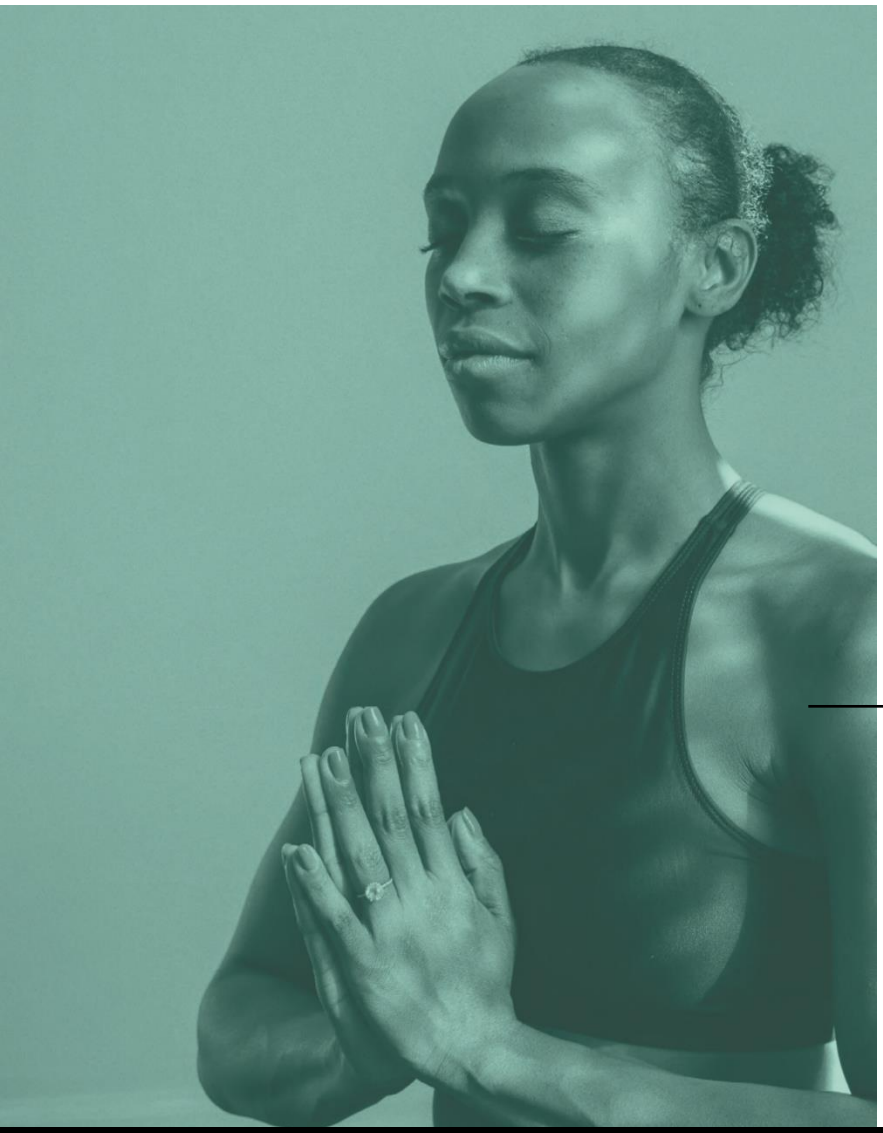
- WELL-BEING COACHING – When you have a goal to achieve, coaches help you create a plan of action and stay on track.
- WELL-BEING COUNSELING – For more difficult issues like grief or stress, counselors can provide support tailored to your unique situation.
- ONLINE PROGRAMS – Self-Guided, interactive programs to help improve emotional well-being for issues like depression and anxiety.

800.356.7089
MAGELLANASCEND.COM

FREE RESOURCES INCLUDED WITH OUR PRINCIPAL PLANS

For more information about these great resources go to principal.com.

- **Laser Vision Correction** discounts through National Lasik Network.
- **Hearing Aid** discounts up to 48% off through American Hearing Benefits.
- **Identity Theft** Protection & Restoration Resources Kit
- **Will & Legal Document Center**
- **Beneficiary Support** through Magellan Healthcare EAP



TRAVEL ASSISTANCE PLAN

provided by AXA Assistance USA

Whether you're traveling in the United States or leaving the country, you can rely on AXA, a comprehensive program that can bring help, comfort and reassurance if you face a medical emergency while traveling 100 or more miles from home.

▶ PRINCIPAL.COM/TRAVELASSISTANCE

- Pre-Trip Planning – Visa, Vaccinations, Exchange Rate, Travel Advisories, Customs Information, Embassy and Consulate Locations and Referrals
- ID Recovery Assistance
- Lost or Stolen Travel Documents
- Emergency Medical Transportation
- Language Translation Services
- Medical and Dental Facility/Provider Referrals
- Assistance with Medications, Vaccines, Corrective Lens, and Medical Device Replacement
- Evacuation Coordination For Emergency Security or Political Event
- Legal Concerns / Assistance

THE COMMONS RETIREMENT PLAN

SLAVIC401K

▶ SLAVIC401K.COM

Contact support@opolis.co for more information.

HEALTHCARE NOTICES

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

PART A: General Information

When key parts of the health care law took effect in 2014, a new way to buy health insurance was introduced: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October for coverage that starts as early as January 1st.

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.86% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. [1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution - as well as your employee contribution to employer-offered coverage - is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?
For more information about your coverage offered by your employer, please check your summary plan description or contact support@opolis.co.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **www.healthcare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer Name Employment Commons, LLC	4. Employer Identification Number (EIN) 85.1138180		5. Employer Address 1624 Market Street Suite 226 #93720
6. Employer phone number 720.689.1521	7. City Denver	8. State CO	9. ZIP Code 80202
10. Contact: The Support Team	11. Phone Number 720.689.1521		12. Email address support@opolis.co

Here is some basic information about health coverage offered:

As your employer, we offer a health plan to: ☐ All employees.

☑ Some employees: Active employees working a minimum of 20 hours per week.

With respect to dependents: ☐ We do not offer coverage. ☑ We do offer coverage. Eligible dependents are:

- ✓ An eligible employee's legal spouse/domestic partner and/or children.
- ✓ Children are considered eligible if they are:
  - An eligible employee's or their spouse's / domestic partner's biological children, stepchildren, adopted child or foster child up to age 26.
  - An eligible employee's or their spouse's / domestic partner's children of any age if they are incapable of self-support due to a physical or mental disability.

☑ **IF CHECKED, HEALTH PLAN COVERAGE MEETS THE MINIMUM VALUE STANDARD, AND THE COST OF THIS COVERAGE TO YOU IS INTENDED TO BE AFFORDABLE, BASED ON EMPLOYEE WAGES.**

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

HEALTHCARE NOTICES

NOTICE OF SPECIAL ENROLLMENT RIGHTS

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

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you or your dependent(s) lose coverage under a state Children's Health Insurance Program (CHIP) or Medicaid, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the loss of CHIP or Medicaid coverage. If you or your dependent(s) become eligible to receive premium assistance under a state CHIP or Medicaid, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days of the determination of eligibility for premium assistance from state CHIP or Medicaid.

To request special enrollment or obtain more information please contact support@opolis.co.

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

WHAT IS "BALANCE BILLING" (SOMETIMES CALLED "SURPRISE BILLING")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network. "Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay, and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit. "Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

YOU ARE PROTECTED FROM BALANCE BILLING FOR:

EMERGENCY SERVICES If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

CERTAIN SERVICES AT AN IN-NETWORK HOSPITAL OR AMBULATORY SURGICAL CENTER When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

YOU'RE NEVER REQUIRED TO GIVE UP YOUR PROTECTIONS FROM BALANCE BILLING. YOU ALSO AREN'T REQUIRED TO GET CARE OUT-OF-NETWORK. YOU CAN CHOOSE A PROVIDER OR FACILITY IN YOUR PLAN'S NETWORK.

WHEN BALANCE BILLING ISN'T ALLOWED, YOU ALSO HAVE THE FOLLOWING PROTECTIONS:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

IF YOU BELIEVE YOU'VE BEEN WRONGLY BILLED, you can file an appeal with your insurance company, then ask for an external review of the company's decision after the initial appeal is completed with your plan. You can also contact the No Surprises Helpdesk, operated by the U.S. Department of Health and Human Services, at 1-800-985-3059, or visit https://www.cms.gov/files/document/memo-no-surprises-act-phone-number-and-website-url-clean-508-mm2.pdf for more information about your rights under federal law.

HEALTHCARE NOTICES

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA) DISCLOSURE

The Mental Health Parity and Addiction Equity Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For information regarding the criteria for medical necessity determinations with respect to mental health or substance use disorder benefits, please contact support@opolis.co.

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA) NOTICES

ENROLLMENT NOTICE

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

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

ANNUAL NOTICE

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? If you would like more information on WHCRA benefits, please contact support@opolis.co.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION 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).

HEALTHCARE NOTICES

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

If you or your children are eligible for Medicaid or CHIP and you are 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 are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs, but you may be eligible 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, you can 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, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the 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 permit you to enroll in your employer plan if you are not 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, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3272).

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. Contact your State for more information on eligibility. The following list of States is current as of July 31, 2022:

ALABAMA – Medicaid
http://myalhipp.com
1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
http://myakhipp.com
1-866-251-4861 customerservice@myakhipp.com
Medicaid Eligibility https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid
https://myarhipp.com
1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid
HIPP Program https://dhcs.ca.gov/hipp
1-916-445-8322 hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Medicaid) & CHP+
Health First www.healthfirstcolorado.com
1-800-221-3943 / State relay 711
CHP+ https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
1-800-359-1991 / State Relay 711
Health Insurance Buy-In Program (HIB)
https://www.Colorado.gov/pacific/hcpf/health-insurance-buy-program
1-855-692-6442

FLORIDA – Medicaid
www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
1-877-357-3268

GEORGIA – Medicaid
HIPP https://Medicaid.Georgia.gov/health-insurance-premium-payment-program-hipp
678-564-1162 Press 1
GA CHIPRA https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
678-564-1162 Press 2

INDIANA – Medicaid
Healthy Indiana Plan for Low-Income Adults 19-64
www.in.gov/fssa/hip/ 1-877-438-4479
All Other Medicaid
www.in.gov/Medicaid/ 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
https://dhs.iowa.gov/ime/members 1-800-338-8366
http://dhs.iowa.gov/hawki 1-800-257-8563
https://dhs.iowa.gov/ime/members/Medicaid-a-to-z/hipp 1-888-346-9562

KANSAS – Medicaid
https://ww.kancare.ks.gov/
1-800-792-4884

KENTUCKY – Medicaid
KI-HIPP http://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
1-855-459-6328 kihipp.program@ky.gov
KCHIP https://kidshealth.ky.gov/Pages/index.aspx 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA – Medicaid
www.Medicaid.la.gov or www.ldh.la.gov/lahipp
Medicaid 1-888-342-6207
LaHIPP 1-855-618-5488

MAINE – Medicaid
Enrollment www.maine.gov/dhhs/ofi/applications-forms
1-800-442-6003 TTY: Maine Relay 711
https://www.maine.gov/dhhs/ofi/applications-forms
1-800-977-6740 TTY: Maine Relay 711

MASSACHUSETTS – Medicaid & CHIP
www.mass.gov/masshealth/pa
1-800-862-4840

MINNESOTA – Medicaid
http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp
1-800-657-3739

MISSOURI – Medicaid
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
573-751-2005

MONTANA – Medicaid
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
1-800-694-3084

NEBRASKA – Medicaid
http://www.ACCESSNebraska.ne.gov
1-855-632-7633 Lincoln 402-473-7000 Omaha 402-595-1178

NEVADA – Medicaid
http://dhcfp.nv.gov
1-800-992-0900

NEW HAMPSHIRE – Medicaid
https://www.dhhs.nh.gov/oii/hipp.htm
603-271-5218
HIPP Program 800-852-3345 x-5218

NEW JERSEY – Medicaid & CHIP
Medicaid www.state.nj.us/humanservices/dmahs/clients/medicaid/
609-631-2392
CHIP www.njfamilycare.org/index.html
1-800-701-0710

NEW YORK – Medicaid
https://www.health.ny.gov/health_care/medicaid/
1-800-541-2831

NORTH CAROLINA – Medicaid
https://medicaid.ncdhhs.gov/
919-855-4100

NORTH DAKOTA – Medicaid
http://www.nd.gov/dhs/services/medicalserv/medicaid/
1-844-854-4825

OKLAHOMA – Medicaid & CHIP
http://www.insureoklahoma.org
1-888-365-3742

OREGON – Medicaid
http://healthcare.oregon.gov/Pages/index.aspx
www.oregonhealthcare.gov/index-es.html
1-800-699-9075

PENNSYLVANIA – Medicaid
https://www.dhs.pa.gov/providers/Pages/Medical/HIPP-Program.aspx
1-800-692-7462

RHODE ISLAND – Medicaid
http://www.eohhs.ri.gov
855-697-4347
Direct Rite Share Line 401-462-0311

SOUTH CAROLINA – Medicaid
http://www.scdhhs.gov
1-888-549-0820

SOUTH DAKOTA – Medicaid
http://dss.sd.gov
1-888-828-0059

TEXAS – Medicaid
http://gethipptexas.com
1-800-440-0493

UTAH – Medicaid & CHIP
Medicaid https://medicaid.utah.gov
CHIP http://health.utah.gov/chip
1-877-543-7669

VERMONT – Medicaid
http://www.greenmountaincare.org
1-800-250-8427

VIRGINIA – Medicaid & CHIP
https://www.covera.org/en/famis-select
https://www.coverva.org/en/hipp
1-800-432-5924

WASHINGTON – Medicaid
http://www.hca.wa.gov/
1-800-562-3022

WEST VIRGINIA – Medicaid & CHIP
https://dhhr.wv.gov/bms/ http://mywvhipp.com/
Medicaid 304-558-1700
CHIP 1-855-MyWVHIPP (699-8447)

WISCONSIN – Medicaid & CHIP
https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
1-800-362-3002

WYOMING – Medicaid
https://health.wyo.gov/healthcarefin/Medicaid/programs-and-eligibility/
1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

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

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

HEALTHCARE NOTICES

THIS IS AN IMPORTANT NOTICE ABOUT YOUR CREDITABLE PRESCRIPTION DRUG COVERAGE AND MEDICARE

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

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

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

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare prescription drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Prescription Drug Plan?

If you decide to join a Medicare drug plan, the prescription coverage through your employer's group health plan will not be affected. Plan participants can keep their prescription drug coverage under their employer's group health plan if they select Medicare Part D prescription drug coverage. If they select Medicare Part D prescription drug coverage, the employer's health plan prescription drug coverage will coordinate with the Medicare Part D prescription drug coverage.

If you are eligible for Medicare and do decide to enroll in a Medicare prescription drug plan and drop your employer's group health prescription drug coverage, be aware that you and your dependents can re-enroll in your employer's group plan, but you may have to wait for the annual open enrollment period.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with your employer and don't join a Medicare prescription drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage

Contact support@opolis.co for further information NOTE: You will receive this notice annually, and again if the coverage through your employer changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

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

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1.800.633.4227). TTY users should call 1.877.486.2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit the Social Security Administration (SSA) online at www.socialsecurity.gov, or call SSA at 1.800.772.1213 (TTY 1.800.325.0778).

KEEP THIS CREDITABLE COVERAGE NOTICE. If you decide to join one of the Medicare prescription 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). You may disregard this notice if you are NOT eligible for Medicare Part D or will not become eligible for Medicare within the next 12 months.

NAME OF ENTITY/SENDER: Employment Commons, LLC DATE: 11/16/2022

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VALUE COPAY PLAN

2023 Summary of Benefits and Coverage (SBC)

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 $9,100 individual / $18,200 family; for out- of-network providers $25,000 individual / $50,000 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) **Generally, payment of all Out-Of-Network professional services will be limited to 135% of the Medicare fee schedule, and payment of all Out-Of-Network facility services will be limited to 175% of the Medicare fee schedule. Some exceptions may apply. See the "Out-of-Network Benefits" section of the SPD for more information.*	
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) *Generally, payment of all Out-Of-Network professional services will be limited to 135% of the Medicare fee schedule, and payment of all Out-Of-Network facility services will be limited to 175% of the Medicare fee schedule. Some exceptions may apply. See the "Out-of-Network Benefits" section of the SPD for more information.*	
	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.

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) *Generally, payment of all Out-Of-Network professional services will be limited to 135% of the Medicare fee schedule, and payment of all Out-Of-Network facility services will be limited to 175% of the Medicare fee schedule. Some exceptions may apply. See the "Out-of-Network Benefits" section of the SPD for more information.*	
	Physician/surgeon fees	30% coinsurance	60%* coinsurance	None.
If you need immediate medical attention	Emergency room care	$250 copay/visit, then 50% coinsurance		Copay waived if admitted to the hospital directly from emergency room.
	Emergency medical transportation	30% coinsurance	30%* coinsurance	None.
	Urgent care	$100 copay/visit, deductible does not apply	60%* coinsurance	Excludes labs, x-rays, and imaging services.
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	

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) *Generally, payment of all Out-Of-Network professional services will be limited to 135% of the Medicare fee schedule, and payment of all Out-Of-Network facility services will be limited to 175% of the Medicare fee schedule. Some exceptions may apply. See the "Out-of-Network Benefits" section of the SPD for more information.*	
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 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	60%* coinsurance	
	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	

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) *Generally, payment of all Out-Of-Network professional services will be limited to 135% of the Medicare fee schedule, and payment of all Out-Of-Network facility services will be limited to 175% of the Medicare fee schedule. Some exceptions may apply. See the "Out-of-Network Benefits" section of the SPD for more information.*	
	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.
	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	$700
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.

PREMIUM COPAY PLAN

2023 Summary of Benefits and Coverage (SBC)

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Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers $750 person / $1,500 family; for out-of-network providers $6,500 person / $13,000 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 $13,000 individual / $26,000 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) **Generally, payment of all Out-Of-Network professional services will be limited to 135% of the Medicare fee schedule, and payment of all Out-Of-Network facility services will be limited to 175% of the Medicare fee schedule. Some exceptions may apply. See the "Out-of-Network Benefits" section of the SPD for more information.*	
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.

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	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)	$60 copay/prescription (retail) $120 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.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
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	Physician/surgeon fees	30% coinsurance	50%* coinsurance	None.
If you need immediate medical attention	Emergency room care	$250 copay/visit, then 30% coinsurance		Copay waived if admitted to the hospital directly from emergency room.
	Emergency medical transportation	30% coinsurance	30%* coinsurance	None.
	Urgent care	$40 copay/visit, deductible does not apply	50%* coinsurance	Excludes labs, x-rays, and imaging services.
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	

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) *Generally, payment of all Out-Of-Network professional services will be limited to 135% of the Medicare fee schedule, and payment of all Out-Of-Network facility services will be limited to 175% of the Medicare fee schedule. Some exceptions may apply. See the "Out-of-Network Benefits" section of the SPD for more information.*	
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 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	
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	

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) *Generally, payment of all Out-Of-Network professional services will be limited to 135% of the Medicare fee schedule, and payment of all Out-Of-Network facility services will be limited to 175% of the Medicare fee schedule. Some exceptions may apply. See the "Out-of-Network Benefits" section of the SPD for more information.*	
	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	**$750**
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	$750
Copayments	$10
Coinsurance	$3,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,320**

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

The plan's overall deductible	**$750**
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	$750
Copayments	$1,200
Coinsurance	$50
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,020**

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

The plan's overall deductible	**$750**
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	$750
Copayments	$500
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,650**

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

VALUE HIGH DEDUCTIBLE HEALTH PLAN

2023 Summary of Benefits and Coverage (SBC)

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 $7,500 individual / $15,000 family; for out- of-network providers $25,000 individual / $50,000 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) **Generally, payment of all Out-Of-Network professional services will be limited to 135% of the Medicare fee schedule, and payment of all Out-Of-Network facility services will be limited to 175% of the Medicare fee schedule. Some exceptions may apply. See the "Out-of-Network Benefits" section of the SPD for more information.*	
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) *Generally, payment of all Out-Of-Network professional services will be limited to 135% of the Medicare fee schedule, and payment of all Out-Of-Network facility services will be limited to 175% of the Medicare fee schedule. Some exceptions may apply. See the "Out-of-Network Benefits" section of the SPD for more information.*	
	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.

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) *Generally, payment of all Out-Of-Network professional services will be limited to 135% of the Medicare fee schedule, and payment of all Out-Of-Network facility services will be limited to 175% of the Medicare fee schedule. Some exceptions may apply. See the "Out-of-Network Benefits" section of the SPD for more information.*	
	Physician/surgeon fees	30% coinsurance	50%* coinsurance	None.
If you need immediate medical attention	Emergency room care	50% coinsurance		None.
	Emergency medical transportation	30% coinsurance	30%* coinsurance	None.
	Urgent care	$60 copay/visit	50%* coinsurance	Excludes labs, x-rays, and imaging services.
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-
	Childbirth/delivery professional 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) *Generally, payment of all Out-Of-Network professional services will be limited to 135% of the Medicare fee schedule, and payment of all Out-Of-Network facility services will be limited to 175% of the Medicare fee schedule. Some exceptions may apply. See the "Out-of-Network Benefits" section of the SPD for more information.*	
	Childbirth/delivery facility services	30% coinsurance	50%* coinsurance	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.
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.

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) *Generally, payment of all Out-Of-Network professional services will be limited to 135% of the Medicare fee schedule, and payment of all Out-Of-Network facility services will be limited to 175% of the Medicare fee schedule. Some exceptions may apply. See the "Out-of-Network Benefits" section of the SPD for more information.*	
	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.

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Does this plan provide Minimum Essential Coverage? **Yes.**
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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	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$7,010**

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.

PREMIUM HIGH DEDUCTIBLE HEALTH PLAN

2023 Summary of Benefits and Coverage (SBC)

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 $4,900 person / $9,800 family; for out- of-network providers $9,800 person / $19,600 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 $4,900 individual / $9,800 family; for out- of-network providers $19,600 individual / $39,200 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) **Generally, payment of all Out-Of-Network professional services will be limited to 135% of the Medicare fee schedule, and payment of all Out-Of-Network facility services will be limited to 175% of the Medicare fee schedule. Some exceptions may apply. See the "Out-of-Network Benefits" section of the SPD for more information.*	
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) *Generally, payment of all Out-Of-Network professional services will be limited to 135% of the Medicare fee schedule, and payment of all Out-Of-Network facility services will be limited to 175% of the Medicare fee schedule. Some exceptions may apply. See the "Out-of-Network Benefits" section of the SPD for more information.*	
	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.

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) *Generally, payment of all Out-Of-Network professional services will be limited to 135% of the Medicare fee schedule, and payment of all Out-Of-Network facility services will be limited to 175% of the Medicare fee schedule. Some exceptions may apply. See the "Out-of-Network Benefits" section of the SPD for more information.*	
	Physician/surgeon fees	0% coinsurance	50%* coinsurance	None.
If you need immediate medical attention	Emergency room care	0% coinsurance		None.
	Emergency medical transportation	0% coinsurance	0%* coinsurance	None.
	Urgent care	0% coinsurance	50%* coinsurance	Excludes labs, x-rays, and imaging services.
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-
	Childbirth/delivery professional 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) *Generally, payment of all Out-Of-Network professional services will be limited to 135% of the Medicare fee schedule, and payment of all Out-Of-Network facility services will be limited to 175% of the Medicare fee schedule. Some exceptions may apply. See the "Out-of-Network Benefits" section of the SPD for more information.*	
	Childbirth/delivery facility services	0% coinsurance	50%* coinsurance	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.
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.

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) *Generally, payment of all Out-Of-Network professional services will be limited to 135% of the Medicare fee schedule, and payment of all Out-Of-Network facility services will be limited to 175% of the Medicare fee schedule. Some exceptions may apply. See the "Out-of-Network Benefits" section of the SPD for more information.*	
	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	$4,900
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	$4,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,960**

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

The plan's overall deductible	$4,900
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	$4,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$4,920**

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

The plan's overall deductible	$4,900
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.

DENTAL INSURANCE

2023 Summary of Benefits and Coverage (SBC)

Policyholder: EMPLOYMENT COMMONS LCA

Group dental insurance
Benefit Summary

Effective date: 01/01/2023

What's available to me?
You have two dental choices.

Dental insurance helps pay for all, or a portion, of the costs associated with dental care, from routine cleanings to root canals.

Eligibility				
Eligible employees	All active, full-time employees			
	Calendar-year deductible		Coinsurance your policy pays	
Option 1: VALUE DENTAL PLAN				
	In-network	Out-of-network	In-network	Out-of-network
Preventive	$0	$0	100%	80%
Basic	$50	$50	80%	80%
Major	$50	$50	50%	50%
Additional provisions				
Family deductible	3 times the per person deductible amount			
Combined deductible	Your deductibles that are in and out-of-network for basic and major services are combined.			
Combined maximum	Maximums for preventive, basic, and major procedures are combined. In-network calendar year maximums are $1,000 per person or non-network calendar year maximums are $1,000 per person.			
Maximum accumulation	Included			
Plan type	Unscheduled			

	Calendar-year deductible		Coinsurance your policy pays	
Option 2: PREMIUM PLAN				
	In-network	Out-of-network	In-network	Out-of-network
Preventive	$0	$0	100%	100%
Basic	$50	$50	80%	80%
Major	$50	$50	50%	50%
Orthodontia	$0	$0	50%	50%

Additional provisions	
Family deductible	3 times the per person deductible amount
Combined deductible	Your deductibles that are in and out-of-network for services are combined.
Combined maximum	Maximums for preventive, basic, and major procedures are combined. In-network calendar year maximums are $3,000 per person or non-network calendar year maximums are $3,000 per person.
Orthodontia lifetime maximum	$3,000 PPO in-network maximum / $3,000 PPO out-of-network maximum
Maximum accumulation	Included
Plan type	Unscheduled

Who can buy coverage?

- You may buy coverage if you're an active, full-time employee. Seasonal, temporary, or contract employees aren't eligible.
  - o If you're on regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off, you're still considered actively at work, as long as you're fulfilling your regular duties and were working the day immediately prior to your time off.
  - o You must enroll within 31 days of being eligible. If you don't, you'll have to wait until the next open enrollment period, or qualifying event.

Additional eligibility requirements may apply.

Which procedures are covered, and how often?

Option 1

Preventive	
Routine exams	Twice per calendar year
Routine cleanings	Twice per calendar year
Bitewing X-rays	Once per calendar year
Full mouth X-rays	Once every 36 months
Fluoride	Twice per calendar year (covered only for dependent children under age 16)
Sealants	Covered only for dependent children under age 16; once per tooth each 36 months

Basic	
Emergency exams	Subject to routine exam frequency limit
Periodontal maintenance	If three months have passed since active surgical periodontal treatment; subject to routine cleaning frequency limit

Fillings	Replacement fillings every 24 months
Oral surgery	Simple and complex
General anesthesia / IV sedation	Covered only for specific procedures
Simple endodontics	Root canal therapy for anterior teeth
Complex endodontics	Root canal therapy for molar teeth
Non-surgical periodontics, including scaling and root planing	Once per quadrant per 24 months
Periodontal surgical procedures	Once per quadrant per 36 months
Occlusal guards (night guards)	One guard per 36 months
Harmful habit appliance	Covered only for dependent children under age 16

Major	
Crowns	Each 60 months per tooth if tooth cannot be restored by a filling
Core buildup	Each 60 months per tooth
Bridges	60 months old (initial placement / replacement)
Dentures	60 months old (initial placement / replacement)
Repairs	Partial denture, bridge, crown, relines, rebasing, tissue conditioning and adjustment to bridge/denture, within policy limitations

Additional benefits

Prevailing charge	When you receive care from an out-of-network-provider, benefits will be based on the 90th percentile of the usual and customary charges.
Maximum accumulation	Some of your unused annual benefit maximum can be carried over to the next year. To qualify, you must have had a dental service performed within the calendar year and used less than the maximum threshold. The threshold is equal to the lesser of 50% of the out-of-network maximum benefit or $1,000. If the qualification is met, 50% of the threshold is carried over to next year's maximum benefit. Individuals with fourth quarter effective dates will start qualifying for rollover at the beginning of the next calendar year. You can accumulate no more than four times the carry over amount. The entire accumulation amount will be forfeited if no dental service is submitted within a calendar year
Emergency services	If you have a dental emergency and you can't see an in-network provider in a reasonable amount of time, your claim may be paid if you see an out-of-network provider.

Participating provider services	If you require treatment and you can't see an in-network provider in a reasonable amount of time, your claim may be paid if you see an out-of-network provider.
Periodontal program	If you're pregnant or have diabetes or heart disease, you may receive scaling and root planing covered at 100% (if dentally necessary), or one additional cleaning (routine or periodontal) subject to deductible and coinsurance.
Second opinion program	You may be eligible for second opinions from dental providers at 100%. This program makes sure you get the best advice to make an informed decision about your care.
Cancer treatment oral health program	If you have cancer and are undergoing chemotherapy or head/neck radiation therapy, you may receive up to three fluoride treatments every 12 months covered at 100% plus one additional routine cleaning.

Option 2

Preventive	
Routine exams	Twice per calendar year
Routine cleanings	Twice per calendar year
Bitewing X-rays	Once per calendar year
Full mouth X-rays	Once every 36 months
Fluoride	Twice per calendar year (covered only for dependent children under age 16)
Sealants	Covered only for dependent children under age 16; once per tooth each 36 months

Basic	
Emergency exams	Subject to routine exam frequency limit
Periodontal maintenance	If three months have passed since active surgical periodontal treatment; subject to Routine cleaning frequency limit
Fillings	Replacement fillings every 24 months
Oral surgery	Simple and complex
General anesthesia / IV sedation	Covered for only specific procedures
Simple endodontics	Root canal therapy for anterior teeth
Complex endodontics	Root canal therapy for molar teeth
Non-surgical periodontics, including scaling and root planing	Once per quadrant per 24 months
Periodontal surgical procedures	Once per quadrant per 36 months

Occlusal guards (night guards)	One guard per 36 months
Harmful habit appliance	Covered only for dependent children under age 16

Major	
Crowns	Each 60 months per tooth if tooth cannot be replaced by a filling
Core buildup	Each 60 months
Bridges	60 months old (initial placement / replacement)
Dentures	60 months old (initial placement / replacement)
Repairs	Partial denture, bridge, crown, relines, rebasing, tissue conditioning and adjustment to bridge/denture, within policy limitations

Orthodontia	
Coverage	For you and your dependents.

Additional benefits

Prevailing charge	When you receive care from an out-of-network-provider, benefits will be based on the 90th percentile of the usual and customary charges.
Maximum accumulation	Some of your unused annual benefit maximum can be carried over to the next year. To qualify, you must have had a dental service performed within the calendar year and used less than the maximum threshold. The threshold is equal to the lesser of 50% of the out-of-network maximum benefit or $1,000. If the qualification is met, 50% of the threshold is carried over to next year's maximum benefit. Individuals with fourth quarter effective dates will start qualifying for rollover at the beginning of the next calendar year. You can accumulate no more than four times the carry over amount. The entire accumulation amount will be forfeited if no dental service is submitted within a calendar year
Emergency services	If you have a dental emergency and you can't see an in-network provider in a reasonable amount of time, your claim may be paid if you see an out-of-network provider.
Participating provider services	If you require treatment and you can't see an in-network provider in a reasonable amount of time, your claim may be paid if you see an out-of-network provider.
Periodontal program	If you're pregnant or have diabetes or heart disease, you may receive scaling and root planing covered at 100% (if dentally necessary), or one additional cleaning (routine or periodontal) subject to deductible and coinsurance.

Second opinion program	You may be eligible for second opinions from dental providers at 100%. This program makes sure you get the best advice to make an informed decision about your care.
Cancer treatment oral health program	If you have cancer and are undergoing chemotherapy or head/neck radiation therapy, you may receive up to three fluoride treatments every 12 months covered at 100% plus one additional routine cleaning.

How do I find a network dentist?

When you receive services from a dentist in our network, your cost may be lower. Network dentists agree to lower their fees for dental services and not charge you the difference. You'll have access to the Principal Plan Dental network, with more than 117,000 dentists nationwide. Visit principal.com/dentist to find a dentist or call 800-247-4695.

What if my dentist isn't in the network?

You can refer your dentist to our network. Please submit the dentist's name and information by calling 800-247-4695, or submitting a form at principal.com/refer-dental-provider.

What are the limitations and exclusions of my coverage?

- Missing tooth –The initial placement of bridges, partials, and dentures to replace teeth missing before this coverage starts won't be covered. If this policy replaces coverage with another carrier, continuous coverage under the prior plan may be applied to the missing tooth provision requirement. This doesn't apply to pediatric essential benefits.
- Frequency limitations for services are calculated to the month and exact date from the last date of service or placement date.

There are additional limitations to your coverage. Please review your booklet for more information.

What are the restrictions of my coverage?

Orthodontia	If there is orthodontia (ortho) treatment in progress on the coverage effective date and you are covered under any prior group coverage for ortho, there will be immediate coverage for treatment if proof is submitted that shows: 1) The lifetime maximum under any prior group coverage has not been exceeded, 2) Ortho treatment was started and bands or appliances were inserted while insured under any prior group coverage, and 3) Ortho treatment has been continued while insured under this policy. Principal Life will credit payments made by the prior carrier toward the Principal Life lifetime ortho payment limit. You will not be covered if ortho treatment is in progress prior to the effective date with Principal Life and you are not covered under any prior group coverage for ortho.

There are additional limitations to your coverage. A complete list is included in your booklet.