therapy partner solutions

BENEFIT GUIDE

JANUARY 1, 2025 – DECEMBER 31, 2025

Dear valued employee,

We are happy to provide you with this Benefit Guide to summarize your employee benefits for the January 1, 2025 – December 31, 2025 plan year.

Therapy Partner Solutions Holdings, LLC recognizes that benefits are an important part of your life as an employee. Our benefits program will help you choose what works best for your needs and your budget.

This document is not just an enrollment guide; it is a resource for you and your family to use throughout the year. Inside you will find a summary of each benefit plan and helpful tips you may not have known about in the past. This guide is designed to break down the insurance benefits to help you make an informed decision regarding the selection and management of the services and benefits provided to you as an employee of Therapy Partner Solutions Holdings, LLC.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see pages 81-82 for more details.

CONTENTS

IMPORTANT NOTICE TO EMPLOYEES:

This Benefit Guide provides a general description of the various benefits available to you through the Therapy Partner Solutions Holdings, LLC Employee Benefits program. The details of these plans and policies are contained in the official plan and policy documents.

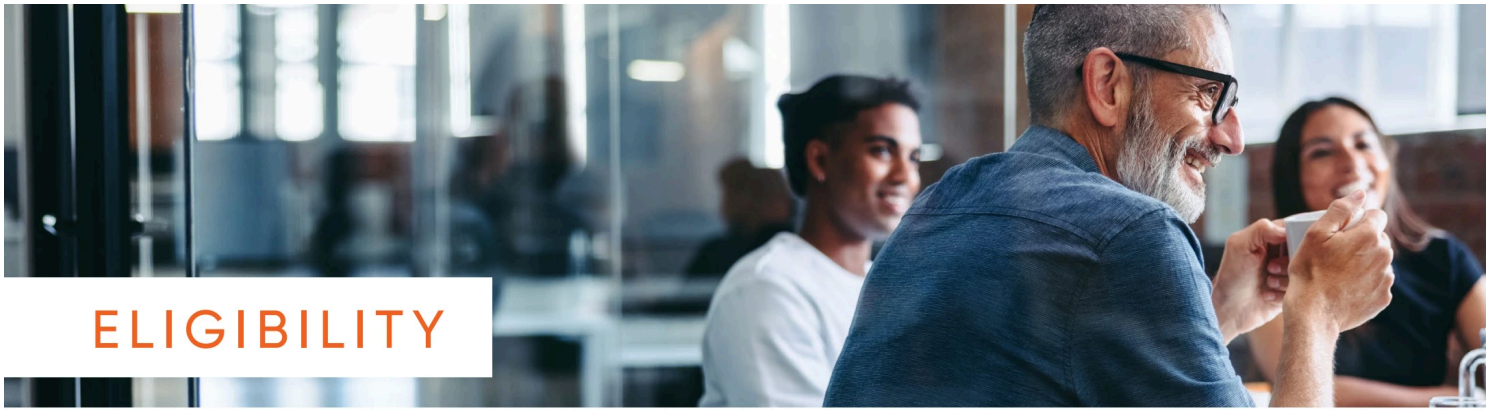
This guide is meant only to cover the major points of each plan or policy, for illustrative purposes only. It does not contain all of the facts regarding coverage, limitations, or exclusions that are contained in the policy documents. In the event of a conflict between the information in this guide and the formal policy documents, the formal documents will govern.

SUMMARY OF BENEFITS & COVERAGE (SBC) NOTICE

Attached are your Federally Mandated Summary of Benefits and Coverage (SBC) documents for all offered medical plan options. In the following pages you will find simpler formatted, easy to understand plan summaries which provide a general description of the various benefits available to you through the Therapy Partner Solutions Holdings, LLC Employee Benefits Program.

To access your SBCs you may scan or click the QR code below with your phone.

If you would prefer a printed copy, please contact your HR department.



ELIGIBILITY

FOR YOU

All full-time employees working an average of **30 hours** per week are eligible to enroll in benefits. For specific details, please refer to the plan documents.

New full-time employees' benefits for all lines of coverage will begin on the **1st of the month following date of hire.**

FOR YOUR FAMILY

Legislation regulates eligibility requirements for dependent coverage on medical insurance plans. It is important for everyone to understand what constitutes eligibility and what the implications could be for not following the eligibility guidelines.

Examples of Eligible Dependents includes:

- Legal spouse
- Dependent children

Healthcare reform legislation restricts a plan or issuer from denying coverage for a child under age 26 based on any of the following factors:

- Financial dependence on the employee
- Residency with the employee
- Student status
- Marital status
- Employment status

DEPENDENT COVERAGE

When you first enroll, and/or if you change coverage mid-year due to a qualifying event, you may be asked to provide the applicable documents from the following list:

Spouse Verification Documentation:

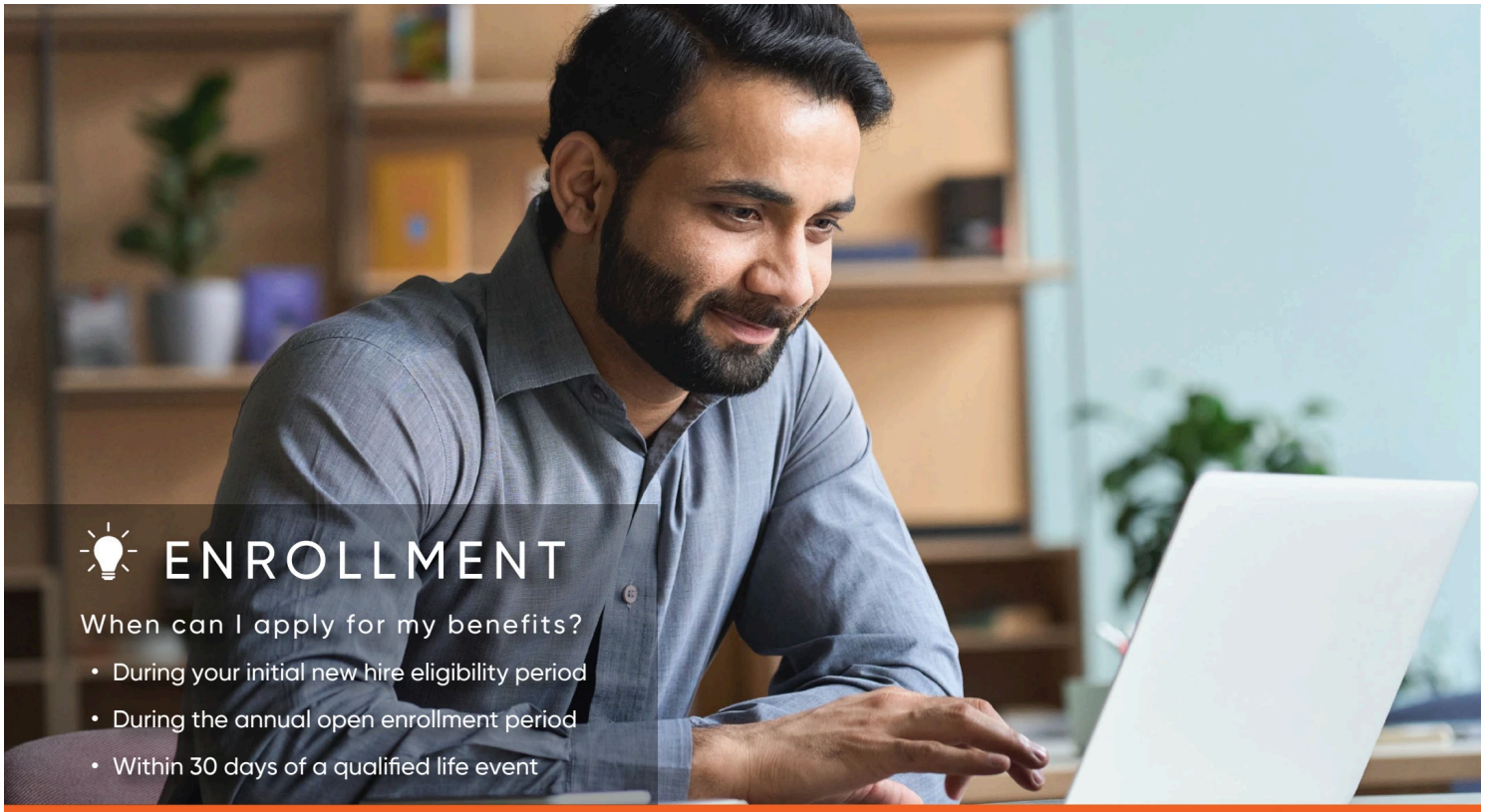
Marriage certificate

Child Verification Documentation:

Birth certificate, court document awarding custody or requiring coverage

You can provide these documents to Human Resources.

The adult child's spouse is not eligible for coverage. In some circumstances and for a limited time period, the newborn of an enrolled adult dependent may be covered. For adult children age 26, the State of Florida has adopted legislation allowing for extended coverage up to age 30, but under more limited conditions such as the child must reside in Florida or be a part-time or full-time student and must be unmarried with no dependent child(ren) of his/her own. In addition, they cannot be covered under another group or franchise plan, student or individual plan, or be Medicare eligible.



ENROLLMENT

When can I apply for my benefits?

- During your initial new hire eligibility period
- During the annual open enrollment period
- Within 30 days of a qualified life event

MID-YEAR ENROLLMENT CHANGES – Section 125 Cafeteria Plan

Employees receive the tax benefits of a Section 125 Cafeteria Plan. This plan allows you to pay for your employee benefits on a pre-tax basis to be deducted from your paycheck.

When you elect to pay for these authorized benefits pre-tax, you save because you are paying less in taxes. You do not pay Federal Income or Social Security taxes on these designated benefit dollars. Therefore, you lower your taxable income. This will allow you to take home more of your paycheck, decreasing the net cost of the benefit you are purchasing.

IRS regulations state that benefit choices cannot be changed in the middle of a plan year unless you experience a qualifying life event.

Changes must be reported within 30 days of the actual event.

Some common qualifying events may include:

- Marriage, divorce or death of spouse
- Birth, adoption or change in legal custody
- Loss of other coverage
- Change in Medicare or Medicaid entitlement
- FMLA or Military Leave

To determine if any of these apply to you, please check with your Human Resources representative.

PLEASE NOTE:

The IRS does not consider financial hardship a qualifying event to drop coverage.

paylocity
Forward Together.

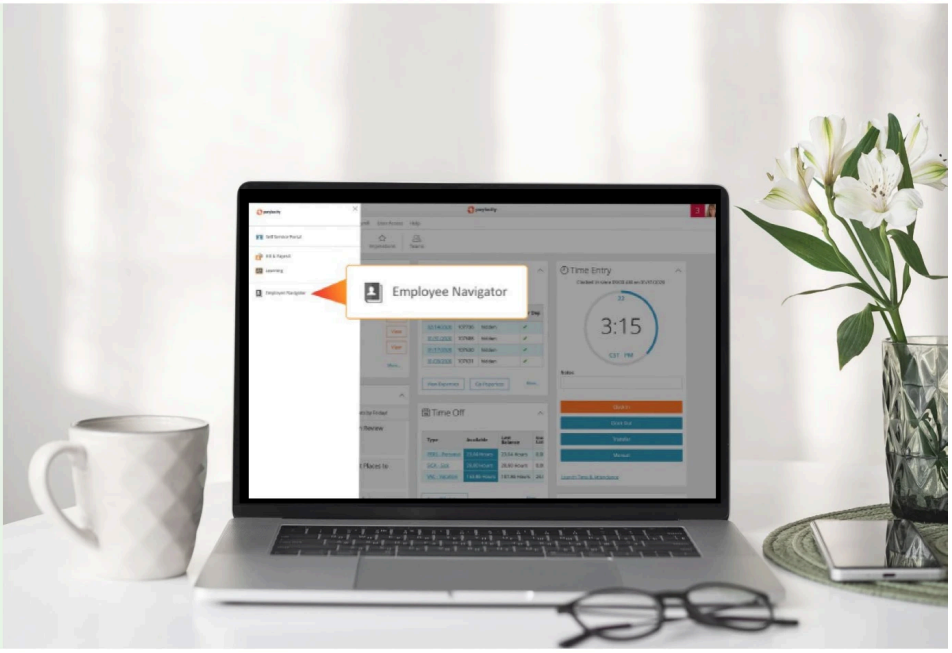
Single Sign-On is available through Paylocity

Employees login to their Paylocity self-service portal

Navigate to the menu on the upper left-hand side of their Paylocity account

Click on the "Employee Navigator" link

NOTE: First time users will be asked to accept a one-time Terms and Conditions page.



employee NAVIGATOR

Therapy Partner Solutions Holdings, LLC utilizes Employee Navigator as our online benefit platform. We encourage all employees to utilize the system to make benefit elections, demographic and address changes, and other qualifying event elections. Below are the instructions on how to register as a new user and how to access Employee Navigator for Returning Users.

COMPANY ID:
TPSH

New Users

1. You will receive a Registration Email
2. Use the link in the email to create your Employee Navigator profile
3. Confirm and update personal information
4. Elect OR waive each line of coverage
5. Review Enrollment Summary
6. Click the Agree button

Returning Users

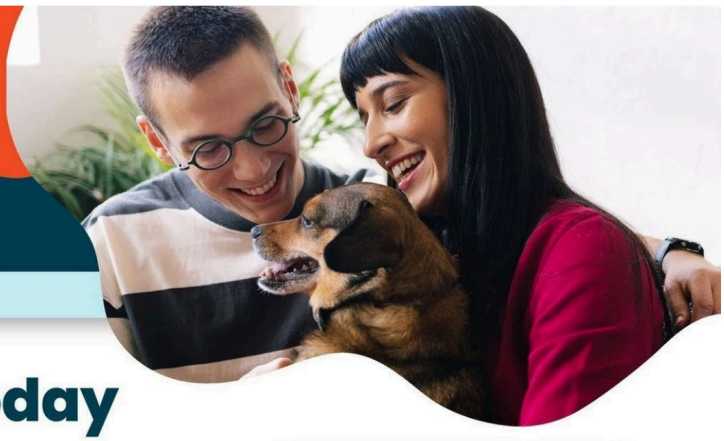
1. You will receive a Welcome Email
2. Login to ioa.employeenavigator.com
3. Confirm and update personal information
4. Elect OR waive each line of coverage
5. Review Enrollment Summary
6. Click the Agree button

PET INSURANCE

SPOT PET INSURANCE

spot pet insurance

America's Favorite Pet Insurance!



Get Peace Of Mind Today With Our Pet Coverage

Accidents

Spot plans help ensure your pet is covered from head-to-tail for unexpected accidents and injuries.

Illnesses

Spot plans cover exams for qualified illnesses and related treatment, including things like surgeries & medications.

Wellness

Spot's **optional** Preventive Care plans focus on routine care and regular check-ups to help ensure their routine wellbeing.

We Take Care of Our Pack

- Vet Exam Fees
- Behavioral Issues
- Dental Illnesses
- Surgery
- Microchip Implantation
- Unexpected Emergencies
- Hereditary Conditions
- Prescription Medications
- Diagnostics
- X-rays & Tests
- Cancer & Growths
- And Much More...

Unleash More with Spot

Spot Perks

Special discounts on pet products and services from your favorite brands.

24/7 Pet Telehealth Line

Get unlimited 24/7 virtual pet care from vet experts for your pet.

Flexible Plans For Any Budget

Customize your annual limit, deductible and reimbursement rate to make your pet and wallet happy.

Simple & Easy Claims Process

1. Visit Any Vet in the U.S or Canada
2. Submit Your Claim Online
3. Get Cash Back for Covered Vet Bills!

therapy partner solutions™

Get Your Special Discount*
spotpet.link/tps

*10% employee discount available on all pets. Not available in HI or TN. Waiting periods, annual deductible, co-insurance, benefit limits and exclusions may apply. For all terms visit spotpetins.com/sample-policy. Products, schedules, discounts, and rates may vary and are subject to change. More information available at checkout. Insurance plans are underwritten by either Independence American Insurance Company (NAIC #26581. A Delaware insurance company located at 11333 N. Scottsdale Rd, Ste. 160, Scottsdale, AZ 85254) or United States Fire Insurance Company (NAIC #21113. Morristown, NJ), and are produced by Spot Pet Insurance Services, LLC. (NPN # 19246385. 990 Biscayne Blvd Suite 603, Miami, FL 33132. CA License #6000188).

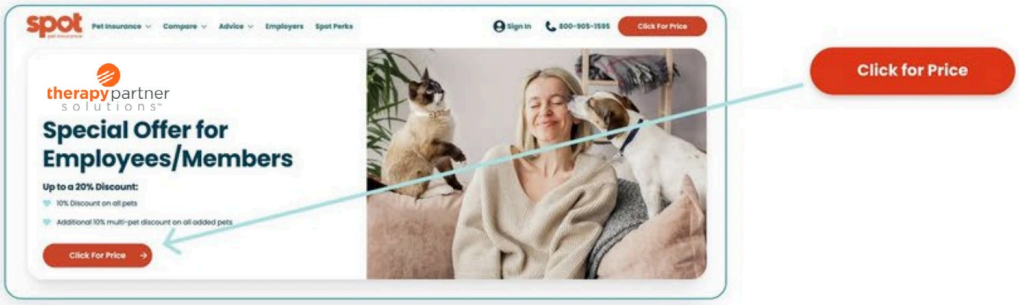
How to Get a Quote & Enroll: A Step-By-Step Guide

spot pet insurance

Whether you're a new pet parent or exploring your options, follow this easy guide to help find the right plan for your BFF today.

1 Start the Quote Process

- Open your browser and go to your company's designated landing page: spotpet.link/tps
- Click on the "**Click for Price**" button.



2 Enter Your Pet's and Your Own Information

- You will be prompted to enter information about your pet. This includes:
  - Pet's **name**, **age**, whether it's a **dog or cat**, **gender**, and **breed**.
- You can also "**Add Another Pet**" and receive a 10% multi-pet discount on each additional pet after the first!

- Finish off the section by entering your own basic information.
  - Your **zip code**, **email address**, **first & last name**, and **mobile number** (optional).

3 Create Your Plan

- After clicking "**Select your coverage**," you'll be presented with two different plan options (accompanied by an overview of what can be covered under each):

Accident + Illness OR **Accident Only**

therapy partner solutions

- Once you choose your plan, customize it even more by adjusting:
  - The **annual limit**
  - The **reimbursement rate**
  - The **annual deductible**

Get Your Special Discount*
spotpet.link/tps

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*10% group discount available on every pet. Not available in HI or TN.
Waiting periods, annual deductible, co-insurance, benefit limits and exclusions may apply. For all terms visit spotpetins.com/sample-policy. Products, schedules, discounts, and rates may vary and are subject to change. More information available at checkout. Insurance plans are underwritten by either Independence American Insurance Company (NAIC #26581. A Delaware insurance company located at 11333 N. Scottsdale Rd, Ste. 160, Scottsdale, AZ 85254) or United States Fire Insurance Company (NAIC #21113. Morristown, NJ), and are produced by Spot Pet Insurance Services, LLC. (NPN # 19246385. 990 Biscayne Blvd Suite 603, Miami, FL 33132. CA License #6000188).

How to Get a Quote & Enroll: A Step-By-Step Guide

spot pet insurance

4 Explore Preventive Coverage Plans

- For an additional fee, you'll have the option to add a wellness plan.
- You can choose between our **Gold Plan** or our more comprehensive **Platinum Plan.**

Gold
Up to $250/yr in benefits

Dental Cleaning	$100	Wellness Exam	$50
Dog DHLPP or Cat FVRCP Vaccine/ Titer	$20	Dog Heartworm or FeLV Screening	$20
Rabies and/or Dog Lyme or Cat FIP Vaccine/Titer	$20	Deworming	$20
Fecal Test	$20		

Platinum Recommended for dogs ages 3-5
More reimbursements · More benefits

Dental Cleaning or Spay/ Neuter	$150	Wellness Exam	$50
Dog DHLPP or Cat FVRCP Vaccine/Titer	$25	Dog Heartworm or FeLV Screening	$25
Rabies and/or Dog Lyme or Cat FIP Vaccine/Titer	$25	Deworming	$25
Fecal Test	$25	Flea/Heartworm Prevention	$25
Health Certificate	$25	Dog Bordetella or Cat FELV Vaccine/Titer	$25
Urinalysis	$25	Blood Test	$25

Note: Preventive care plans can help prevent future illnesses and help support your pet's overall health and longevity.

5 Review and Compare Plans

- Once you've selected and customized your plan, click **"Proceed to Checkout."** You will see a summary of the costs and coverage details.
- Review the details carefully to ensure the plan meets your needs.

6 Choose a Payment Plan and Finalize

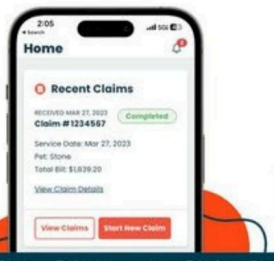
- Choose between being billed **monthly**, or **annually**.
- Provide your payment details and billing information.
- Read and accept the policy terms and conditions, and click **"Complete Purchase."**

That's it! Following these steps should help you get a quote and enroll in a Spot Pet Insurance Plan.

Additional Tips:

- If you need further assistance, please contact our team by calling **800.905.1595**
- Get convenient access to your policy details, claim status, and more by downloading the Spot Pet Insurance app on your smartphone.

Download on the App Store · GET IT ON Google Play



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Get Your Special Discount*
spotpet.link/tps

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DISCOUNT MARKETPLACE

IOA
INSURANCE OFFICE OF AMERICA

IOA is Proud to Bring You...

BENEPLACE

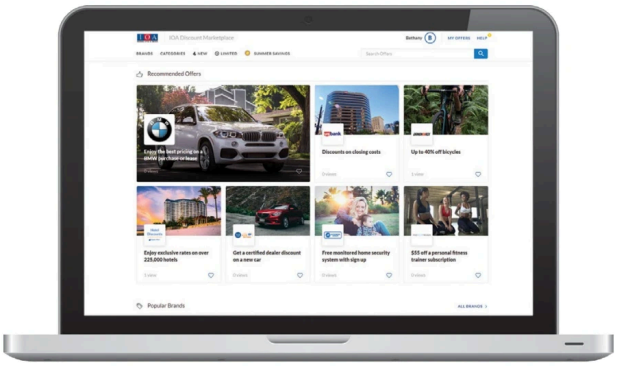
A best-in-class savings platform that's reliable, budget-friendly, and focused on one thing: rewarding you with discounts on products and services from the brands you love.

Fast, Valuable Savings for You!

Familiar Shopping Tools
Simple search and other easy online shopping tools help you save money on the products and services you need.

Trusted Brands
Access to hundreds of offers from well-known brands that you love and trust.

Personalized Experience
Favorite lists and other familiar personalization tools help you rediscover valuable offers quickly.



Easy, Simple Options for You!

HTTPS://IOAUSA.SAVINGS.BENEPLACE.COM

Here are just a few of the categories the Beneplace platform offers:

- Automotive
- Dining & Grocery
- Education
- Electronics
- Entertainment
- Flowers & Gifts
- Health & Wellness
- Home & Garden
- Retail
- Travel

MEDICAL INSURANCE

BLUE CROSS BLUE SHIELD

Scan or click the QR code to access the carrier's website >>>

Identify Your Network:

***FLORIDA = NETWORK BLUE *GEORGIA = BLUE OPEN ACCESS POO**
***MARYLAND/DC = BlueChoice Advantage *ALL OTHER STATES = BLUE CHOICE PPO**

IN-NETWORK MEDICAL BENEFITS	BASE 4000	HSA 3500	BUY UP 2500
Deductible (Individual / Family)	$4,000/$8,000	$3,500/$7,000	$2,500/$5,000
Is deductible Calendar year or Policy year?	Calendar year	Calendar year	Calendar year
Is deductible Embedded or Non Embedded	Embedded	Embedded	Embedded
Out of pocket maximum (Individual / Family)	$4,700/$12,900	$6,850/$14,000	$3,850/$10,200
Coinsurance	20%	20%	30%
Prescription drugs	$10/$50/$125	Deductible then $10/$50/$80	$10/$50/$80
Mail order drugs (90 day supply)	$30/$150/$375	Deductible then $30/$150/$240	$30/$150/$240
PHYSICIAN OFFICE VISITS			
Primary Care Physician / Virtual PCP	$30	Deductible, then $30	$30
Telehealth	$0	Deductible, then $0	$0
Specialist	$30	Deductible, then $30	$30
Referral needed for specialist?	No	No	No
PREVENTIVE CARE			
Routine adult physical exams Well woman exams Routine mammograms and colonoscopy Well child exam & immunizations	Covered 100%	Covered 100%	Covered 100%
DIAGNOSTIC / LABORATORY			
Independent clinical Lab (Blood work)	$0	Deductible + 20%	$0
Independent diagnostic testing facility (X-rays)	$60	Deductible + 20%	Deductible + 30%
Advanced Imaging (MRI, PET, CT Scan, Nuclear Medicine)	Deductible + 20%	Deductible + 20%	Deductible + 30%
HOSPITALIZATION / OUTPATIENT SERVICES			
Inpatient hospitalization (Facility)	Deductible + 20%	Deductible + 20%	Deductible + 30%
Outpatient surgical care (Hospital facility)	Deductible + 20%	Deductible + 20%	Deductible + 30%
Ambulatory surgical center	Deductible + 20%	Deductible + 20%	Deductible + 30%
Emergency room	Deductible + 20%	Deductible + $350	$300
Urgent care	$100	Deductible + $100	$60
OUT-OF-NETWORK MEDICAL BENEFITS			
Deductible (Individual / Family)	$4,000/$8,000	$3,500/$7,000	$2,500/$5,000
Out of pocket maximum (Individual / Family)	$4,700/$12,900	$6,850/$14,000	$3,850/$10,200
Coinsurance	40%	40%	50%
EMPLOYEE BI-WEEKLY PAYROLL DEDUCTIONS			
Employee only	$62.09	$87.04	$134.64
Employee + Spouse	$220.80	$277.68	$365.94
Employee + Child(ren)	$198.77	$248.66	$334.80
Employee + Family	$364.15	$443.98	$572.91

This information summarizes the Therapy Partner Solutions Holdings, LLC Medical benefits plans and is for illustrative purposes only. In the event of a discrepancy between this illustration and the official plan documents, the official documents will govern.

SMALL STEPS CAN LEAD TO BIG CHANGES

Coming Soon

When it comes to your health, small steps can lead to life-changing results.
That's the idea behind Personify Health, an innovative program offered by your health plan.

What's in it for you?

Personify Health is a digital program, so it's easy to make it part of your life. Brief daily check-ins help you build healthy habits, join fun activities with coworkers and track how you're doing — not just with physical health-related issues but also with your emotional, social and financial well-being.

How does it work?

Daily cards customized to your goals help you explore new ways to get healthier and earn rewards. Interesting challenges offer activities to tackle and perhaps share with coworkers, friends or family members. You can set goals and keep track of your progress, accessing Personify tools easily on your computer or mobile device.

Getting started is easy:

- Log in to your **My Health Toolkit®** account. Select **Wellness and Care Management**, then **Wellness Programs**, then **Personify Health** to enroll.
- Accept the terms and conditions.
- Start with your Personal Health Assessment, a brief, confidential survey.
- Download the Personify Health mobile app from the App Store or Google Play.

Personify Health can help you be the best version of yourself!
Small steps add up to a healthier, happier you.

Personify Health is an independent company that provides a health and wellness platform on behalf of your health plan.
Blue Cross and Blue Shield of Florida, Inc. is an Independent Licensee of the Blue Cross and Blue Shield Association.

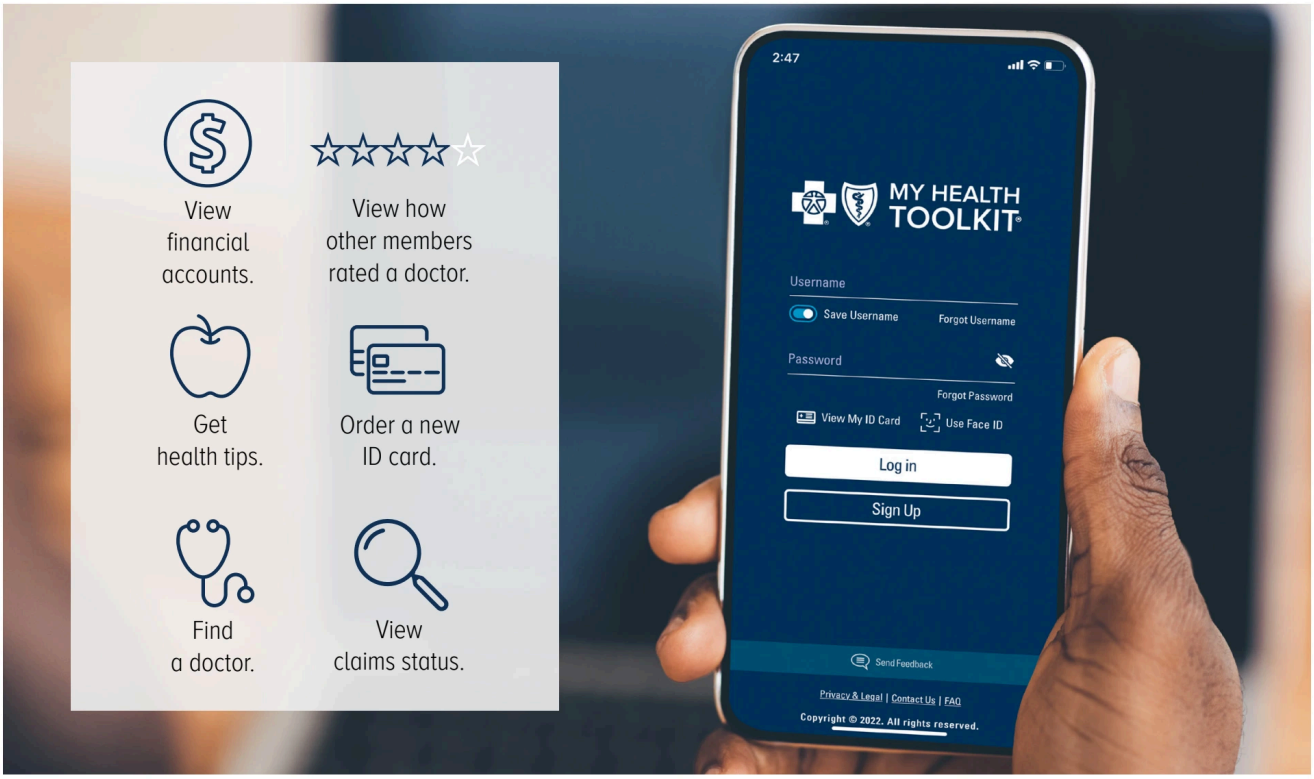
FL-EE-1563-08-2024

My Health Toolkit®

Get easy access to your benefits information by downloading the My Health Toolkit® mobile app today! It's free on the App Store or Google Play.

Download on the App Store | GET IT ON Google Play

Register quickly through the app using your birth date plus your member ID number or Social Security number. Or just log in if you're already a My Health Toolkit user.



Your account homepage will link you to all of the helpful resources included with your health benefits plan.

Now you have anywhere, anytime access to your benefits information, including claims, discounts and how you prefer to be contacted.

Rather get My Health Toolkit from a desktop or laptop computer?

Go to www.MyHealthToolkitFL.com and then:

- Select Create An Account within the Member Login section.
- Enter your member ID (from your ID card).
- Follow the instructions to create your profile, or use the subscriber's Social Security number and your birthdate.

HELP ALONG THE WAY TO BETTER HEALTH

Ready to get on track with your health but not sure where to start? You don't have to figure it out on your own. Your health plan includes free care management programs and resources to help you make positive, meaningful changes at your own pace.

What is care management?

It's a personalized approach that gives you support and lots of options. A care manager can help you reach your health goals, make the most of your benefits and serve as your advocate if you run into obstacles receiving care.

This program is included in your benefits for no additional cost. In some cases, your care manager may help you find ways to lower your medical or pharmacy costs. Connect digitally or by phone!

We offer care management for these conditions:

- Attention-deficit hyperactivity disorder (adults)
- Asthma (adults and children)
- Bipolar disorder
- Heart disease and heart failure
- Chronic obstructive pulmonary disease
- Depression
- Diabetes (adults and children)
- High blood pressure and high cholesterol
- Metabolic health (metabolic syndrome and prediabetes)
- Migraine
- Recovery support for substance use disorder

Case management

If you experience complex or difficult health issues, your nurse care manager will reach out to you to provide support. Things he or she can help with include cancer, transplants, end-stage renal disease, trauma and neonatal intensive care.

Maternity Care

- Personalized digital support during and after your pregnancy
- On-demand access to a maternity nurse

Ready to become a healthier you?

If you qualify for one of our care management programs, we will reach out to you with a phone call, email, text or letter to help you get started. If you have questions, connect with us by phone at **855-838-5897** or through our app, My Health Planner. Just search for **My Health Planner** in the Apple App Store or Google Play and enter access code **ACTNOW** to get started.

ADULT WELLNESS GUIDELINES

Adult health — for ages 18 and over

Preventive care is very important for adults. By making healthier choices, you can improve your overall health and well-being. These healthy choices are a good start:

- Eat a healthy diet.
- Get regular exercise.
- Don't use tobacco products.
- Limit alcohol use.
- Strive for a healthy weight.
- Take medications as prescribed by your doctor.

Adult Recommendations

Screenings	
Physical Exam	Every year or as directed by your doctor
Body Mass Index (BMI)	Every year
Blood Pressure (BP)	At least every two years
Colon Cancer Screening	Beginning at age 45 in consultation with your doctor — You have three options: a colonoscopy every 10 years, a flexible sigmoidoscopy every five years or a blood test annually.
Diabetes Screening	Screening beginning at age 45 — If you have high blood pressure or high cholesterol, are overweight, or have a close family history of diabetes, you should consider being screened earlier.
Lung Cancer Screening	If at high risk, talk with your doctor.

Immunizations	19 – 21 years	22 – 26 years	27 – 49 years	50 – 64 years	65 and older
Influenza (Flu)*	Once each year				
Tetanus, Diphtheria and Pertussis (Tdap)*	One dose with a booster every 10 years				
Herpes Zoster (Shingles) — RZV*					Two doses for those 50 and older
Varicella (Chickenpox)*	Two doses				
Pneumococcal (Pneumonia)*					Two doses
Measles, Mumps and Rubella (MMR)*	One or two doses if no evidence of immunity				
Human Papillomavirus (HPV) — Female*	One or two doses if no evidence of immunity				
Human Papillomavirus (HPV) — Male*	Two or three doses depending on age at series initiation				
Hepatitis A**	Two or three doses for at-risk adults — Discuss with your doctor if this vaccine is right for you.				
Hepatitis B**	Three doses for at-risk adults — Discuss with your doctor if this vaccine is right for you.				
Meningitis**	One to three doses depending on indication — This vaccine is only recommended for specific groups of adults. Discuss the risks and benefits with your doctor.				
Haemophilus Influenzae Type B (Hib)*	One to three doses depending on health risks — This vaccine is only recommended for specific groups of adults. Discuss the risks and benefits with your doctor.				

*Recommended for most adults.

**Recommended for adults with certain health risks.

CHILDREN'S HEALTH

Put your children on the path to wellness by scheduling regular office visits with a doctor. The doctor will watch your child's growth and progress and should talk with you about eating and sleeping habits, safety, and behavior issues.

According to the Bright Futures recommendations from the American Academy of Pediatrics, the doctor should:

- Check your child's body mass index percentile regularly beginning at age 6.
- Conduct a yearly wellness exam beginning at age 3.
- Test vision at least once between the ages of 3 and 5.

Routine Children's Immunization Schedule

Vaccine	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	1.5 – 3 years	4 – 6 years
Hepatitis B (HepB)	●	●			●					
Rotavirus (RV)			●	●	●*					
Diphtheria, Tetanus and Pertussis (DTaP)			●	●	●		●†			●
Haemophilus Influenzae Type B (Hib)			●	●	●*	●				
Pneumococcal Conjugate (PCV)			●	●	●	●				
Inactivated Polio Vaccine (IPV)			●	●	●	●				●
Influenza (Flu)	● Recommended **yearly** starting at age 6 months with two doses given the first year									
Measles, Mumps and Rubella (MMR)						●†				●
Varicella (Chickenpox)						●				●
Hepatitis A (HepA)	● First dose: 12 – 23 months ● Second dose: 6 – 18 months later									

● One dose ▢ Range of recommended dates

*Number of doses needed varies depending on vaccine used. Ask your doctor.

†12 months is minimum age for routine vaccination: two-dose series at 12 – 15 months and 4 – 6 years. Second dose may be given as early as four weeks after the first dose.

Sources: U.S. Department of Health and Human Services, the Centers for Disease Control and Prevention, U.S. Preventive Services Task Force

Some of these recommendations may not be covered by your health plan. Please refer to your summary of benefits to verify which services are covered.

The American Academy of Pediatrics is an independent organization that provides health information you might find helpful.

WOMEN'S HEALTH

Sure, multitasking is your superpower.
But pay attention to your own health, too.

Your ability to keep everything and everyone in order is truly impressive. But remember that your powers have a limit. Before you can save the world, you must first take care of yourself.

Make sure everything is healthy underneath that cape by scheduling regular health screenings. These recommendations are in addition to the standard wellness guidelines for adults.

Women's Recommendations	
Mammogram	Women 40 and up should get checked yearly.
Cholesterol	Ages 30 – 35 should be tested if at high risk. Women 45 and older should be tested.
Pap Test	Every three years for ages 21 – 65. Or, Pap test and HPV test every five years for ages 30-60. Those who've had a hysterectomy or are over age 65 might not need a Pap test.*
Osteoporosis Screening	Screenings should begin at age 65 or at age 60 if risk factors are present.*
Aspirin Use	At ages 50 – 79, talk with your doctor about the benefits and risks of aspirin use.
Pelvic Exam	Ages 21 and over should have an exam every year.*

*Recommendations may vary. Discuss screening options with your doctor, especially if you are at increased risk.

Sources: American Cancer Society, U.S. Department of Health and Human Services, the Centers for Disease Control and Prevention, U.S. Preventive Services Task Force

MEN'S HEALTH

Even the toughest machines depend on regular maintenance

Preventive care is important to men's health. If you're going to keep firing on all cylinders, you need to make time for tuneups. So, let's man up and schedule that appointment!

In addition to the standard wellness guidelines for adults, men should discuss these recommendations with their doctors.

Men's Recommendations	
Cholesterol	Ages 20 – 35 should be tested if at high risk. Men ages 35 and over should be tested.
Abdominal Aortic Aneurysm	Get checked once between ages 65 and 75 if you have ever smoked.
Aspirin Use	At ages 50 – 79, talk with your doctor about the benefits and risks of aspirin use.
Prostate Cancer Screening	Ages 55 and older, discuss benefits and risks with your doctor.*

Sources: American Cancer Society, U.S. Department of Health and Human Services,the Centers for Disease Control and Prevention, U.S. Preventive Services Task Force

*Recommendations may vary. Discuss options with doctor, especially if you are at increased risk.

YOUR PRESCRIPTION DRUG BENEFITS

When you need a prescription medication, your employer's prescription drug plan gives you and your doctor many options. Here's some information to help you make the most of your benefits – and save money at the pharmacy.

Our pharmacy benefits are managed by Optum Rx®. Optum Rx is an independent company that provides pharmacy services on behalf of our health plans.

Log In to My Health Toolkit To Review Your Pharmacy Benefits

Log in to your health plan's My Health Toolkit site to see what your specific plan covers. Under **Benefits**, look for **Prescription Drugs**.

Pharmacy Network

With almost 70,000 network pharmacies to choose from, it's easy to find one near you. All major chains are included in the network, as well as many independent drugstores . Always make sure your pharmacy is part of our network before you have your prescriptions filled.

How do I find a pharmacy?

Log in to My Health Toolkit acount and select the **Benefits** tab. Next, select the **Pharmacy Benefits** link, and then select **View Your Pharmacy Benefits**.

Mail Service

Mail service is convenient and can save you money on prescriptions you take regularly. You'll receive up to a 90-day supply of your prescription drugs at one time with free standard shipping. **Optum Rx Home Delivery** provides this service. Optum Rx Home Delivery is a division of Optum Rx, an independent company that provides pharmacy benefit management services on behalf of your health plan.

Specialty Drug Network

Prescriptions for specialty drugs can be filled at your company's on-site pharmacy only.

Generic Drugs

This program can help you save money on your prescription drugs when a generic equivalent is available for your brand-name drug. If you or your doctor thinks the generic is not right for you, your pharmacist will fill your prescription with the brand-name medication. You will pay the brand drug copayment or coinsurance that applies to your prescription. **You will also pay any difference between the cost of the generic and the brand drug**. You will never pay more than the total cost of the brand drug.

YOUR FORMULARY

Your prescription drug benefit is based on a list of covered drugs called the Premium Formulary. A committee of independent doctors and pharmacists chooses the drugs for our formularies based on their effectiveness, safety and value. If you want to save the most on your drug costs, ask your doctor if a generic or preferred brand-name drug is right for you.

To find information on your formulary and drug management programs, go to your health plan's My Health Toolkit website. Then select **Prescription Drug** from the top menu.

Drug Tiers

Each drug in the formulary is assigned a tier under your benefit plan. Each tier is associated with a copayment or coinsurance amount. This is the amount you pay when you get a prescription. Refer to your benefit document to find the amounts that apply to you.

Tier types include:

- **Generic** — For the lowest out-of-pocket expense, you should always consider generic drugs if you and your doctor decide they are right for you.
- **Preferred Brand** — Consider preferred brand-name drugs if no generic drug is available to treat your condition.
- **Nonpreferred Brand** — These are usually the highest-cost products. When a generic becomes available, most of the time the brand-name version will move to nonpreferred status.
- **Specialty** — Most plans have one or more tiers designated for specialty drugs.

Nonformulary/Excluded Drug List

From time to time, our pharmacy committee may decide to no longer cover some drugs. The committee does this when other safe, effective, less costly alternatives are available. Those drugs are then moved to nonformulary status. Additionally, some plans may exclude coverage for certain categories of drugs, such as those for weight loss, fertility or sexual dysfunction. You and your doctor always have the freedom to choose the medication that works best for you.

If your drug is not on the formulary and you have more questions, please call the customer service number on the back of your membership card.

Specialty Drugs

Specialty drugs are prescription medications that are used to treat complex or chronic medical conditions like cancer, rheumatoid arthritis, multiple sclerosis and hepatitis, just to name a few. Depending on your plan, you may pay a different copayment or coinsurance for specialty drugs under the pharmacy benefit.

SPECIALTY DRUG COVERAGE UNDER YOUR MEDICAL BENEFIT

Your health plan requires prior authorization (PA) for most specialty drugs covered under your medical benefit. This applies to specialty drugs administered and dispensed by a medical professional.

What are specialty drugs?

Specialty drugs treat conditions such as cancer, hepatitis, multiple sclerosis or rheumatoid arthritis, just to name a few. They often require special administration, dosing and monitoring.

How are specialty drugs covered under my medical benefit?

Most specialty drugs covered under the medical benefit require prior authorization through the MBMNow medical prior authorization system.

How do I get prior authorization under the medical benefit?

Your doctor can access the medical Prior Authorization system by going to the Provider area of your health plan's website and signing in to **My Insurance Manager**. Your doctor can also request prior authorization by calling **877-440-0089**.

Site of care

Prior authorization for some specialty drugs may only be granted for administration in certain locations (sites of care), such as an infusion center or in your home.

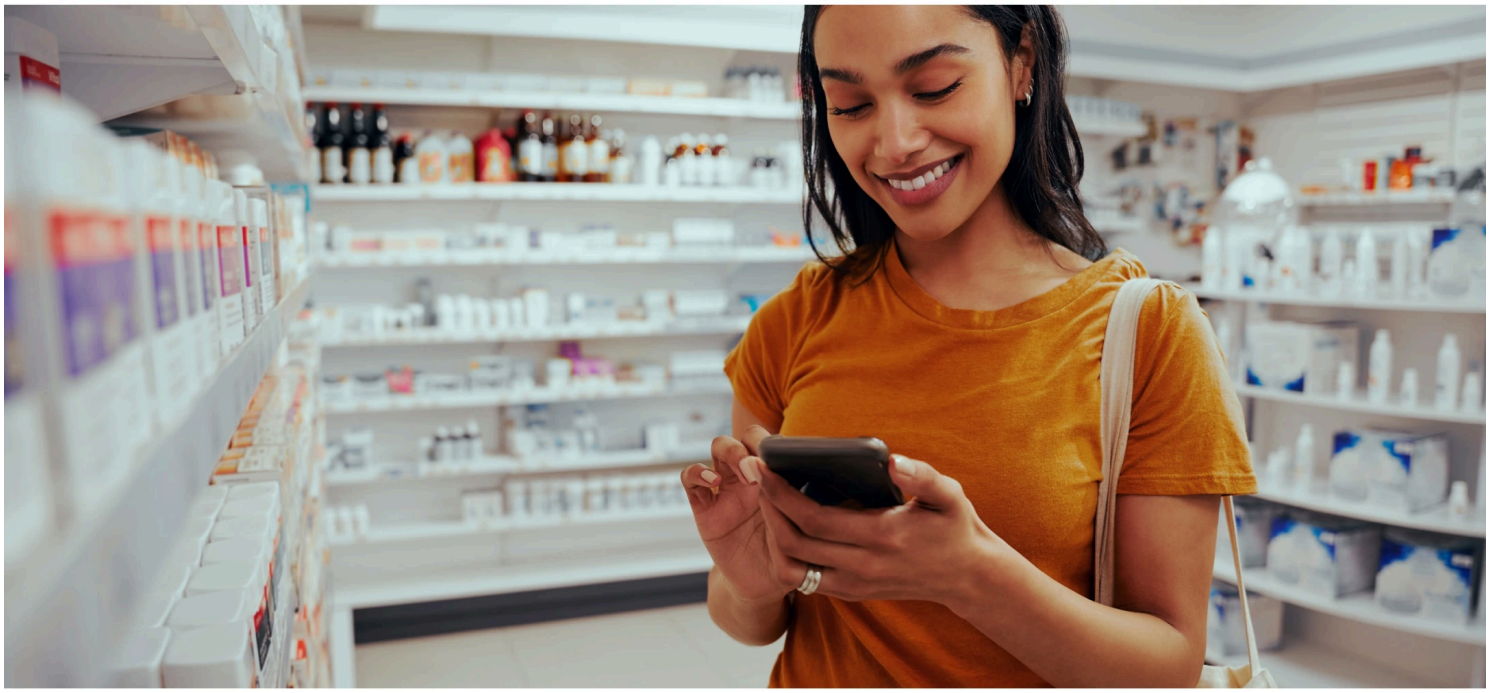
Self-administered drug block

Most specialty drugs that are typically self-administered are "blocked" from coverage under the medical benefit and are covered only under your pharmacy benefit. See the Your Formulary section of this guide for more information on specialty drug coverage under the pharmacy benefit.

KEEP UP WITH YOUR PRESCRIPTION DRUG BENEFITS FROM ANYWHERE

The My Rx Toolkit app provides easy access to details you need

Need to know more about your prescription drug benefits? Often, questions come up when you're on the go, such as at the doctor's office or pharmacy. Now there's a mobile app to help you find the answers easily.



The **My Rx Toolkit** app lets you look up coverage information, copays and options for your medications, all with the convenience of using a mobile device. You can use the app to:

- Set up home delivery of medications. Fill, renew or transfer prescriptions for delivery directly to your door, often for less than you'd pay at a retail pharmacy.
- Look up cost information for your medications, including how much you can expect to pay out of pocket.
- See if lower-cost alternatives may be available.
- Find a network pharmacy near you.
- Initiate conversations with your health care providers.

Getting the app

You can download **My Rx Toolkit** from the App Store or Google Play. Log in with the same username and password you use for **My Health Toolkit®** — there's no need to create a new account.

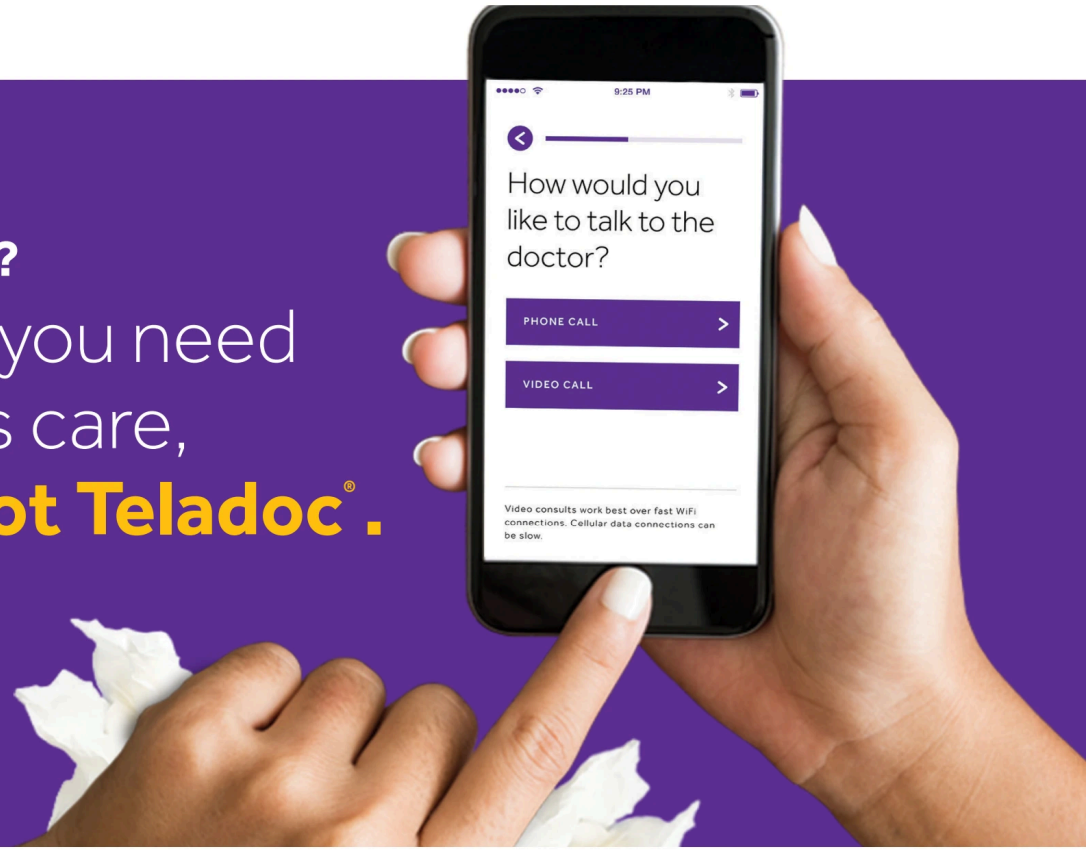
Download on the App Store | GET IT ON Google Play

It's one more way to make the most of your health care benefits.

TELADOC®

Did you know?

Any time you need a doctor's care, you've got Teladoc®.



24/7/365 care
Convenient care for cold and flu, allergies, rash, and much more.

Licensed doctors
U.S. board-certified doctors average 20 years of experience.

In minutes
Connect with a doctor by phone or video.

Get a diagnosis
Our doctors recommend treatment and prescribe medication (when medically necessary).

Register for Teladoc now!

1. **Complete your Teladoc registration at the My Health Toolkit site listed on your member ID card.**
2. **Log in to your My Health Toolkit account.**
3. **Select Providers & Services, then Telehealth.**

From the My Health Toolkit app, select Find Care, then Video Visit.

Download on the App Store | GET IT ON Google Play

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WHERE SHOULD YOU GO WHEN YOU NEED CARE?

Your primary care physician should be your first call for routine medical care. But what if your doctor's office is closed? What if it's an emergency?

Here are tips to help you choose the right type of care for various situations.

Doctor's Office

Your primary care physician, or regular doctor, is the best option for routine medical care:

- Annual checkups and physicals
- Health screenings and immunizations
- Prescription refills

And unexpected health issues, if they can wait a day:

- Sprained muscles
- Minor cuts and bruises
- Cold and flu symptoms, including fever, coughing, sore throat and mild nausea
- Sinus or respiratory infections
- Urinary tract infections
- Seasonal allergies
- Pinkeye
- Migraine
- Rashes, insect bites, sunburn or other skin irritations

Urgent Care Center

If you can't wait for an appointment with your regular doctor, an urgent care center may be your best option for unexpected health issues:

- Minor fractures and sprains, especially if an X-ray is required
- Minor cuts and animal bites, especially if stitches may be required
- Cold and flu symptoms, including fever, coughing, sore throat and mild nausea
- Sinus or respiratory infections
- Urinary tract infections
- Seasonal allergies
- Pinkeye
- Migraine
- Rashes, insect bites, sunburn or other skin irritations

Emergency Room

Go to the emergency room or call 911 for potentially life-threatening conditions:

- Heavy, uncontrolled bleeding
- Signs of a heart attack, like chest pain that lasts more than two minutes
- Signs of stroke, such as numbness or sudden loss of speech or vision
- Loss of consciousness or sudden dizziness
- Major injuries, such as broken bones or head trauma
- Coughing up or vomiting blood
- Severe allergic reactions

MAKE SURE YOU'RE COVERED

Why coordination of benefits is important

Do you have other health insurance?

Coordination of benefits — COB, for short — affects your benefits when you or a family member also is covered under another health insurance plan. COB makes sure the right plan processes your claims first. It prevents overpayments and duplication of services. And that helps keep costs down for everyone.

Examples of other insurance: These may include coverage under a spouse's insurance plan, Medicaid or Medicare.

What you need to do: Be sure we have up-to-date information about your other insurance. That way, we can process your claims correctly and promptly.

- If you receive an Other Health Insurance Questionnaire in the mail, fill it out and return it right away. Even if you do not have coverage with another health plan, we need to know that, too.
- You also can give us this information by logging in to **My Health Toolkit®**. Select **My Plan Benefits**, **Health**, then **Other Health Insurance**.
- Or call the number on the back of your membership card and provide the information to a customer service advocate.

We appreciate your help with this.

Getting benefits after you have declined coverage

Special enrollment rights may apply to you, your spouse or other dependents even after you have declined coverage.

- For example, you might have declined coverage because other health insurance or another group health plan was in effect. Later, you may want to seek coverage with this plan if you or your dependents became ineligible for the other coverage or the employer stopped contributing to the other coverage. You must request our coverage within 30 days after this other coverage ends OR after the employer contribution stops.
- You also may be able to get coverage if you have a new dependent because of marriage, birth, adoption or placement for adoption. Again, you must request enrollment within 30 days of the event.

Please note that you may have been required to provide a written statement when you declined enrollment with us. If you did not provide this written statement, this health plan is not required to grant special enrollment rights to you or your dependents.

For more information, contact your employer's benefit department.

SHOPPING FOR CARE

Find the best health care options just like you check out your choices in cars, hotels or restaurants.

"Know before you go." It's a smart idea before you make any important decision, including finding a new doctor or choosing a location for surgery.

Your health plan makes these decisions easier with Shopping for Care. Find it at your health plan's **My Health Toolkit®** website.

- Find health care providers and services within our vast provider network.
- Check out cost information to make sure you're getting the care you need at the best possible price.*
- See reviews from other patients who have rated a provider you're considering.
- Identify the highest-quality providers in your area, with Total Care and Blue Distinction® Specialty Care designations.
- View a detailed map to help you get where you need to go.

After you've registered with My Health Toolkit®:

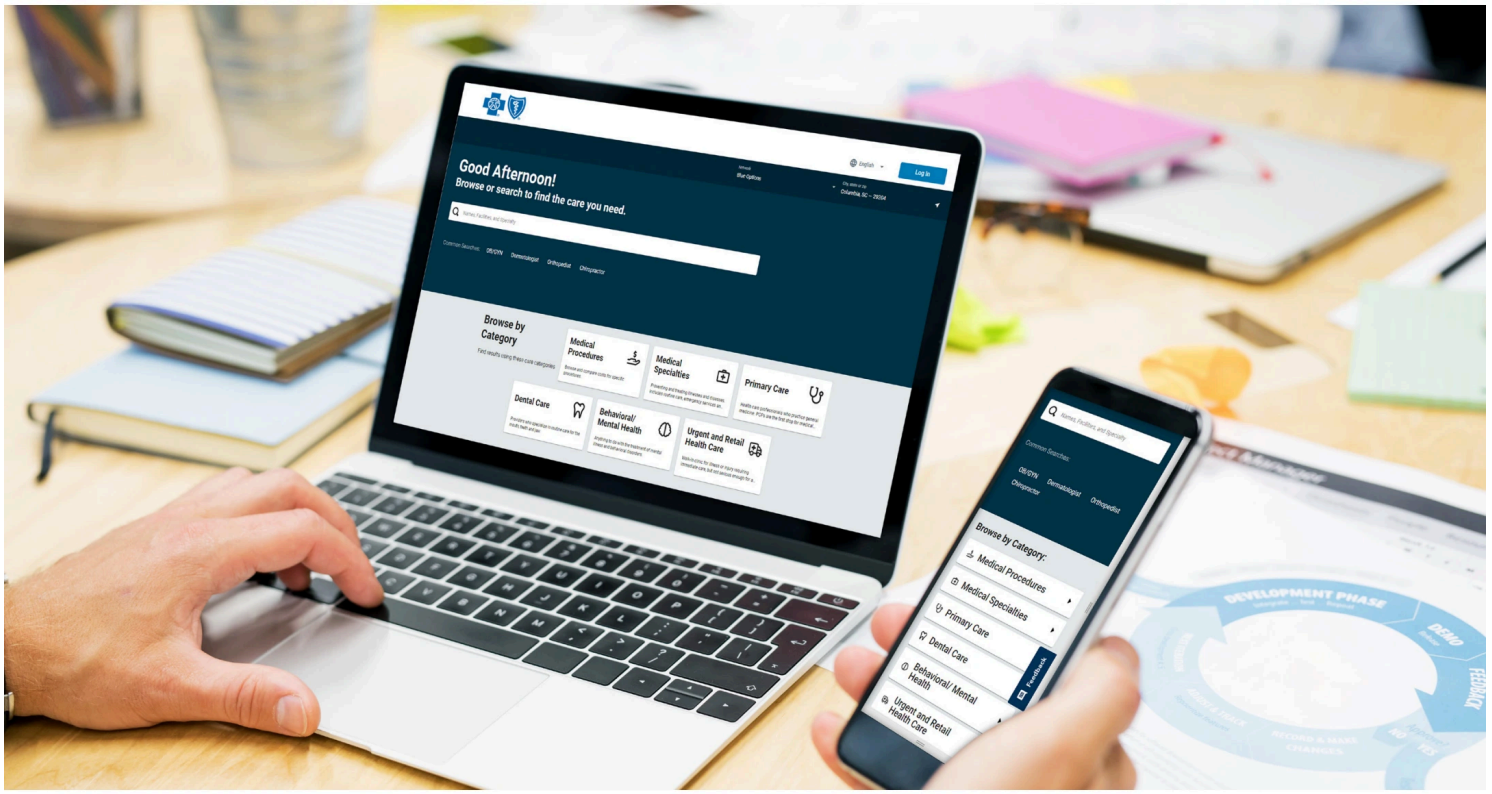
Access Shopping for Care from your computer:

- Visit your health plan's **My Health Toolkit** site.
- Log in to your account, select **Providers and Services**, then **Find Care.**
- We'll walk you through each step!

Or take it with you:

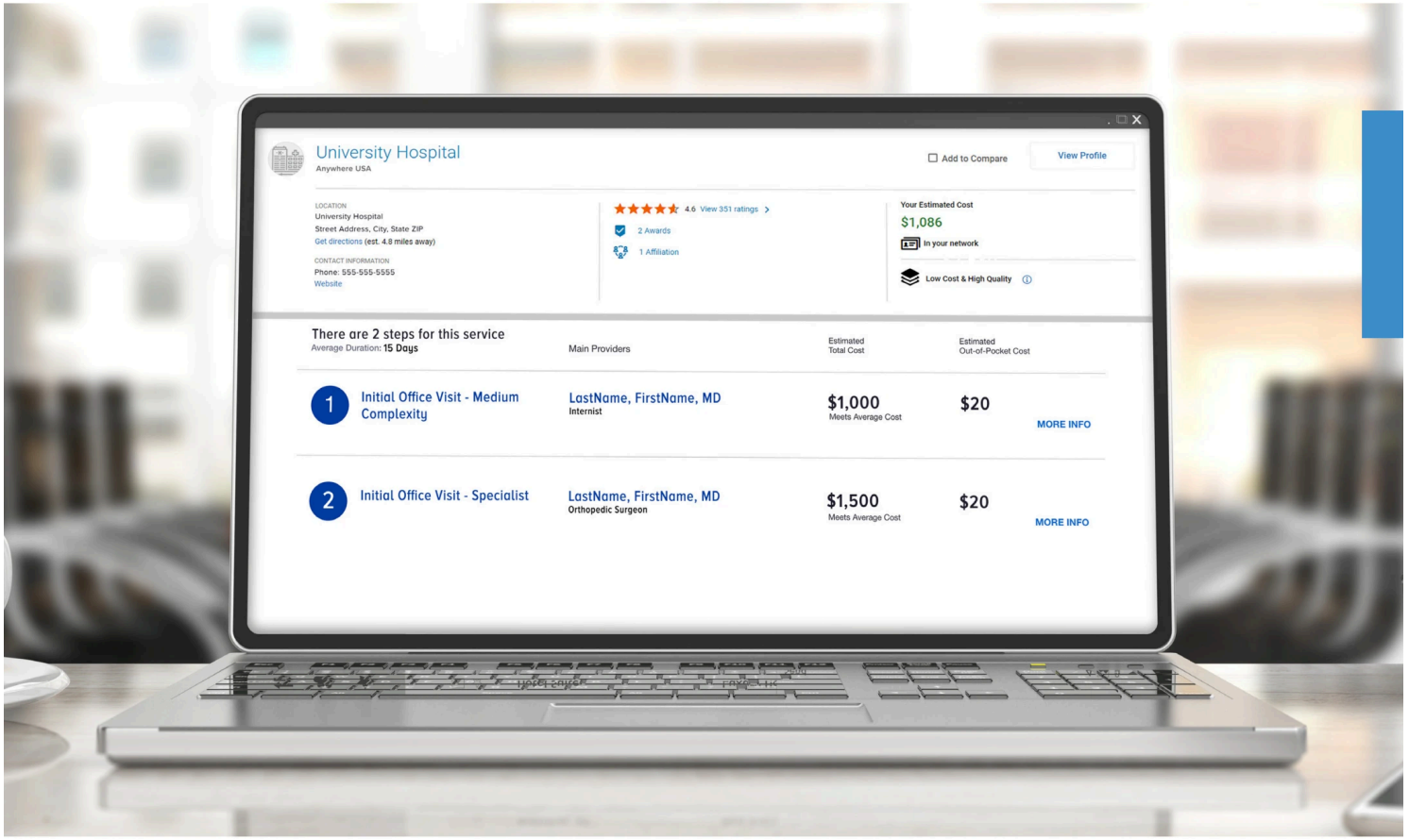
- Log in to the **My Health Toolkit** app from your mobile device.
- Select **Find Care**.

*Cost details might not be included with all plans.



“How much will it cost?”

Estimates help you avoid surprises when the bills come.



Costs for a medical procedure — like an ultrasound, a checkup, X-rays or joint replacement — can vary by hundreds of dollars. Our Shopping for Care feature includes cost estimates to help you find the right care at the right price. (Cost information might not be included for all plans.)

Estimate your out-of-pocket expenses for medical procedures — and compare pricing details that show you the most cost-efficient providers.

- At your health plan’s **My Health Toolkit** website, log in to your **My Health Toolkit** member account.
- Select **Providers and Services**, then **Find Care**.

As you explore the **Find Care** categories further, you’ll see a **Cost Estimates** tab that’s loaded with price information about hundreds of procedures, from mammograms and MRIs to allergy testing, sleep studies, physical therapy and various types of surgery.

TIP: When you get your member ID card, use your ID number to create your My Health Toolkit account. Then you’ll see cost information about copays and other details specific to your health plan.

PRIOR AUTHORIZATION: WHAT YOU NEED TO KNOW

Your health plan requires prior authorization for certain medical tests and treatments. This is an extra step to ensure you receive the appropriate type of care for your condition. If your doctor does not receive authorization before he or she performs the service, it may not be covered by your health insurance.

What types of services require prior authorization?

Generally, prior authorization will be required for these types of services:

- Standard radiology and imaging services, such as magnetic resonance imaging (MRI) and computed tomography (CT) scans
- Radiation therapy for cancer treatment, such as brachytherapy, image-guided radiation and stereotactic therapy
- Spine treatments, such as lumbar decompression or fusion, cervical spine procedures, and spinal epidural injections
- Hips, knees and shoulders treatments, such as arthroplasty and arthroscopy

What should you do?

Most providers will be knowledgeable about services that require prior authorization. You can ask your doctor to visit www.RadMD.com to request authorization for treatment.

What's the status of your prior authorization?

To check the status of your request:

Log in to My Health Toolkit®. Select Claims & Authorizations, then Prior Authorizations. On a mobile device, find Prior Authorizations under the More menu.

You also can sign up for paperless notifications when an authorization request has been submitted or a decision has been made.

Or call the number on the back of your membership card to speak to a customer service advocate.

PRIOR AUTHORIZATION: STANDARD RADIOLOGY SERVICES

Your health plan requires prior authorization for certain radiology and imaging services in an outpatient setting. If you are in the emergency room or an inpatient setting, you don't have to get prior authorization.

What services require prior authorization?

- Magnetic resonance imaging (MRI)
- Magnetic resonance angiogram (MRA)
- Computed tomography (CT) scans
- Positron emission tomography (PET) scans
- Myocardial perfusion imaging — nuclear cardiology study
- Multigated acquisition scan (MUGA)

What should you do?

Ask your doctor to visit **www.RadMD.com** to request authorization for treatment. If your provider does not receive a prior authorization before you receive services, your health plan might not cover the treatment and you could be held liable for the payment.

What's the status of your prior authorization?

To check the status of your request:

Log in to **My Health Toolkit®**. Select **Claims & Authorizations**, then **Prior Authorizations**. On a mobile device, find **Prior Authorizations** under the **More** menu.

You also can sign up for paperless notifications when an authorization request has been submitted or a decision has been made.

Or call the number on the back of your membership card to speak to a customer service advocate.

What is the program designed to do?

The program is designed to:

- Promote patient safety by preventing unnecessary radiation exposure.
- Help you avoid paying unnecessary out-of-pocket expenses.

PRIOR AUTHORIZATION: MUSCULOSKELETAL CARE

Your health plan requires prior authorization for certain spine treatments, including surgeries and pain management services. If you are in an emergency room, prior authorization is not required.

What treatments require prior authorization?

Inpatient and outpatient surgeries:

- Lumbar microdiscectomy
- Lumbar decompression (laminotomy, laminectomy, facetectomy and foraminotomy)
- Lumbar spine fusion (arthrodesis)
- Cervical anterior decompression with fusion: single and multiple levels
- Cervical posterior decompression with fusion: single and multiple levels
- Cervical posterior decompression (without fusion)
- Cervical artificial disc replacement
- Cervical anterior decompression (without fusion)

Outpatient pain management services:

- Spinal epidural injections
- Paravertebral facet joint injections or blocks
- Paravertebral facet joint denervation (radiofrequency [RF] neurolysis)

What should you do?

Ask your doctor to visit **www.RadMD.com** to request authorization for treatment. If your provider does not receive a prior authorization before you receive services, your health plan might not cover the treatment and you might have to pay.

What's the status of your prior authorization?

To check the status of your request:

Log in to **My Health Toolkit®**. Select **Claims & Authorizations**, then **Prior Authorizations**. On a mobile device, find **Prior Authorizations** under the **More** menu.

You also can sign up for paperless notifications when an authorization request has been submitted or a decision has been made.

Or call the number on the back of your membership card to speak to a customer service advocate.

What is the program designed to do?

The program is designed to:

- Promote patient safety by preventing unnecessary surgical procedures.
- Help you avoid paying unnecessary out-of-pocket expenses.

PRIOR AUTHORIZATION: RADIATION ONCOLOGY SERVICES

Your health plan requires prior authorization for certain radiation therapies used during cancer treatment. This is an extra step to make sure you receive the most appropriate treatment for your condition based on current medical guidelines.

Treatments that require prior authorization

These are the types of radiation treatments that require prior authorization if performed in an outpatient setting. If you don't get prior authorization before treatment, we may not cover it and the provider may bill you:

- Low-dose-rate (LDR) brachytherapy
- High-dose-rate (HDR) brachytherapy
- Two-dimensional conventional radiation therapy (2D)
- Three-dimensional conformal radiation therapy (3D-CRT)
- Intensity modulated radiation therapy (IMRT)
- Image-guided radiation therapy (IGRT)
- Stereotactic radiosurgery (SRS)
- Stereotactic body radiation therapy (SBRT)
- Proton beam radiation therapy (PBT)
- Intra-operative radiation therapy (IORT)
- Neutron beam therapy
- Hyperthermia

How to submit the request

Your doctor can visit www.RadMD.com to complete the Radiation Therapy Treatment Form. This form can be used to request prior authorization for your entire treatment plan — it will not be required for each individual procedure.

What's the status of your prior authorization?

To check the status of your request:

Log in to My Health Toolkit®. Select Claims & Authorizations, then Prior Authorizations. On a mobile device, find Prior Authorizations under the More menu.

You also can sign up for paperless notifications when an authorization request has been submitted or a decision has been made.

Or call the number on the back of your membership card to speak to a customer service advocate.

What is the program designed to do?

The program is designed to:

- Promote patient safety by preventing unnecessary radiation exposure.
- Help you avoid paying unnecessary out-of-pocket expenses.

PRIOR AUTHORIZATION: HIPS, KNEES AND SHOULDERS MUSCULOSKELETAL CARE

Your health plan requires prior authorization for certain musculoskeletal treatments. For knee, hip and shoulder conditions, those treatments include surgeries and pain management services. If you are in an emergency room, prior authorization is not required.

Treatments that require prior authorization include the following:

Knee:
- Arthroplasty
- Arthroscopy

Hip:
- Arthroplasty
- Arthroscopy

Shoulder:
- Arthroplasty
- Arthroscopy

What should you do?

Ask your doctor to visit www.RadMD.com to request authorization for treatment. If your provider does not receive prior authorization before you receive services, your health plan might not cover the treatment and you might have to pay.

What's the status of your prior authorization?

To check the status of your request:

Log in to My Health Toolkit®. Select Claims & Authorizations, then Prior Authorizations. On a mobile device, find Prior Authorizations under the More menu.

You also can sign up for paperless notifications when an authorization request has been submitted or a decision has been made.

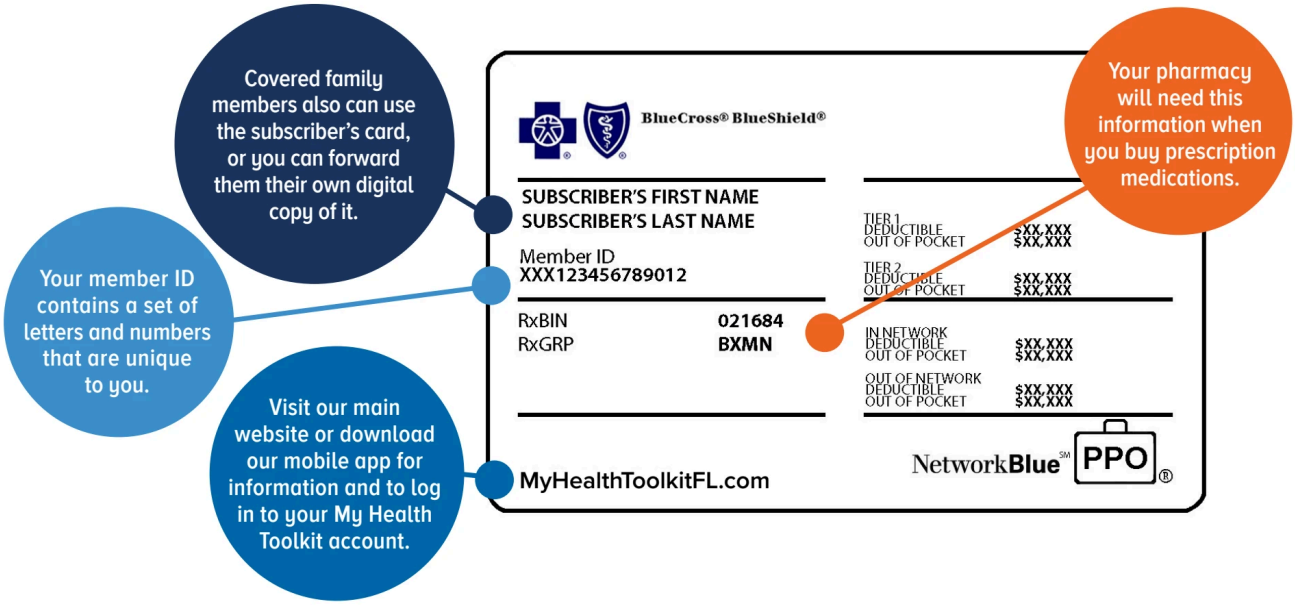
Or call the number on the back of your membership card to speak to a customer service advocate.

What is the program designed to do?

The program is designed to:
- Promote patient safety by preventing unnecessary surgical procedures.
- Help you avoid paying unnecessary out-of-pocket expenses.

WE'VE GOT YOU COVERED WITH YOUR MEMBERSHIP CARD

Your BCBSF membership card contains important information that helps providers and pharmacists apply your benefits correctly. Keep it with you at all times or download a digital ID card to keep on your smartphone. A health care provider usually will ask to see your insurance card at the beginning of your visit.



Convenient option: your digital ID

It's all about convenience! Your digital ID card has the same information as the card you receive in the mail, but you can:

- View the digital ID on a smartphone, tablet or computer.
- Email the card to a spouse, child, doctor's office or pharmacy.
- Print the card from a smartphone, tablet or computer and use the printout just like a plastic card.

Accessing your digital ID

- From a computer or mobile device, log in to My Health Toolkit.
- Follow the prompts to select/view your insurance ID card.

WHEN AN EXPLANATION OF BENEFITS COMES, HERE'S WHAT TO DO WITH IT

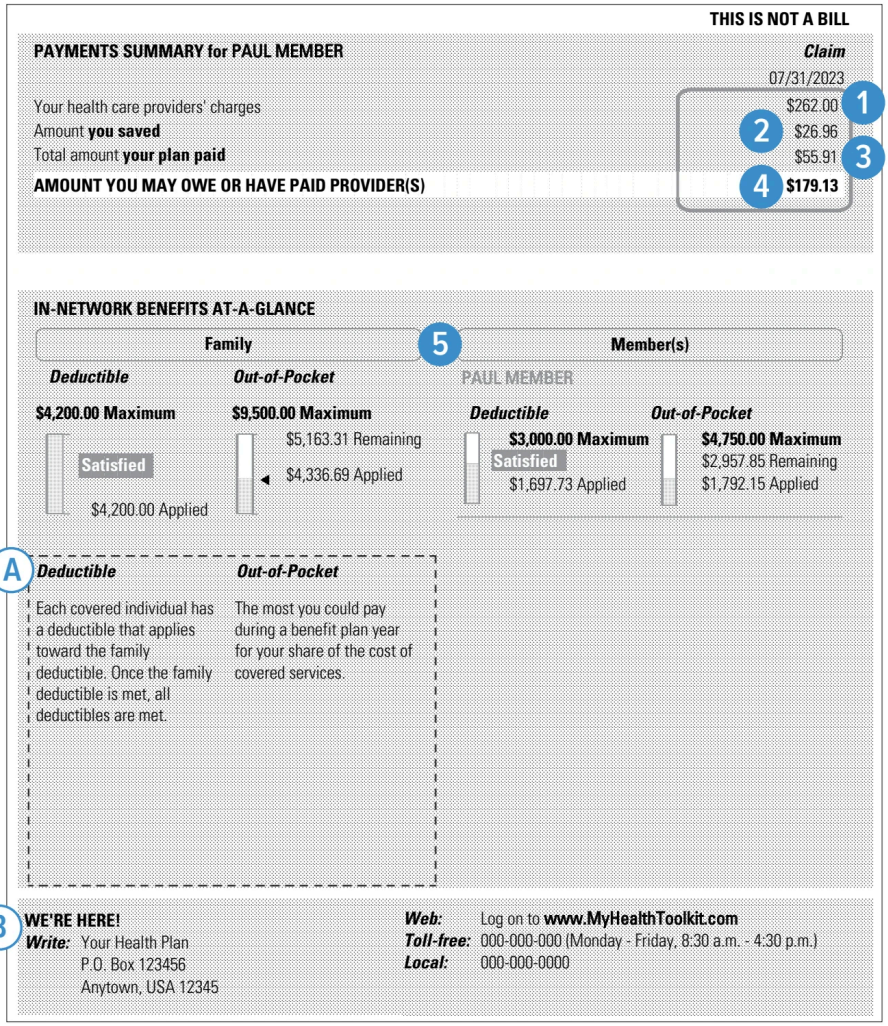
Whenever you use your health insurance, we send you an Explanation of Benefits (EOB). It shows you a breakdown of the services you received, the cost of those services and what you might have to pay your provider. **An EOB is not a bill.**

Your EOB shows you:

1. How much the doctor charged.
2. How much you saved through your health plan.
3. How much your health plan paid.
4. How much you may still owe.
5. How close you are to reaching your deductible and out-of-pocket maximum during this benefit period based on your in-network benefits.

On page 1, you'll find:

- (A) Helpful definitions.
- (B) How to reach us if you have questions.
- (C) Your member ID number.



THIS IS NOT A BILL

PAYMENTS SUMMARY for PAUL MEMBER — ***Claim*** 07/31/2023

Your health care providers' charges	$262.00 (1)
Amount **you saved**	$26.96 (2)
Total amount **your plan paid**	$55.91 (3)
AMOUNT YOU MAY OWE OR HAVE PAID PROVIDER(S)	**$179.13** (4)

IN-NETWORK BENEFITS AT-A-GLANCE

(5) **Family** — ***Deductible*** **$4,200.00 Maximum** — Satisfied — $4,200.00 Applied

Out-of-Pocket **$9,500.00 Maximum** — $5,163.31 Remaining — $4,336.69 Applied

Member(s) — PAUL MEMBER

Deductible **$3,000.00 Maximum** — Satisfied — $1,697.73 Applied

Out-of-Pocket **$4,750.00 Maximum** — $2,957.85 Remaining — $1,792.15 Applied

(A) ***Deductible***

Each covered individual has a deductible that applies toward the family deductible. Once the family deductible is met, all deductibles are met.

Out-of-Pocket

The most you could pay during a benefit plan year for your share of the cost of covered services.

(B) **WE'RE HERE!**

Write: Your Health Plan
P.O. Box 123456
Anytown, USA 12345

Web: Log on to **www.MyHealthToolkit.com**
Toll-free: 000-000-000 (Monday - Friday, 8:30 a.m. - 4:30 p.m.)
Local: 000-000-0000

Individual Claim Report

EXPLANATION OF BENEFITS

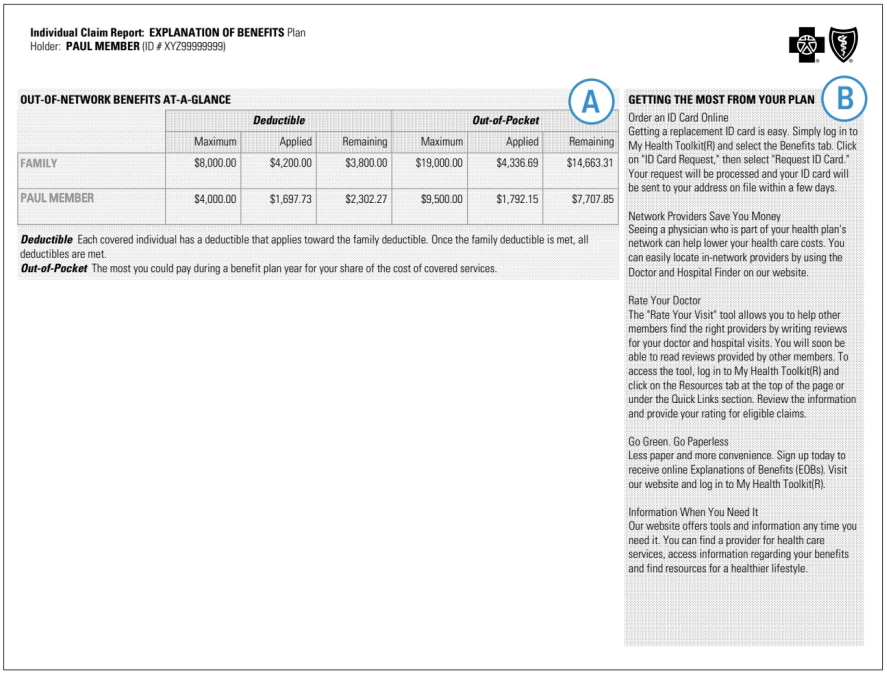
(C) **Plan Holder: PAUL MEMBER**
(ID # XYZ999999999999)
Benefit Plan Year: 01/01/2023 - 01/01/2024
Notice Date: 08/07/2023

On page 2, you'll find:

- (A) How close you are to reaching your deductible and out-of-pocket maximum during this benefit period based on your out-of-network benefits.
- (B) Tips on using and making the most of your benefits.

On page 3, you'll find:

- (A) Details about your claim, including the claim number and provider.
- (B) When the visit took place and if the provider is in or out of network.
- (C) A breakdown of what your health plan paid and how much you might owe your provider. The amount you might owe does not reflect any amount you may have already paid the provider.
- (D) Additional details about your claim, including why a claim may have been denied.



Individual Claim Report: EXPLANATION OF BENEFITS Plan
Holder: **PAUL MEMBER** (ID # XYZ99999999)

OUT-OF-NETWORK BENEFITS AT-A-GLANCE (A)

	Deductible			Out-of-Pocket		
	Maximum	Applied	Remaining	Maximum	Applied	Remaining
FAMILY	$8,000.00	$4,200.00	$3,800.00	$19,000.00	$4,336.69	$14,663.31
PAUL MEMBER	$4,000.00	$1,697.73	$2,302.27	$9,500.00	$1,792.15	$7,707.85

Deductible Each covered individual has a deductible that applies toward the family deductible. Once the family deductible is met, all deductibles are met.
Out-of-Pocket The most you could pay during a benefit plan year for your share of the cost of covered services.

GETTING THE MOST FROM YOUR PLAN (B)

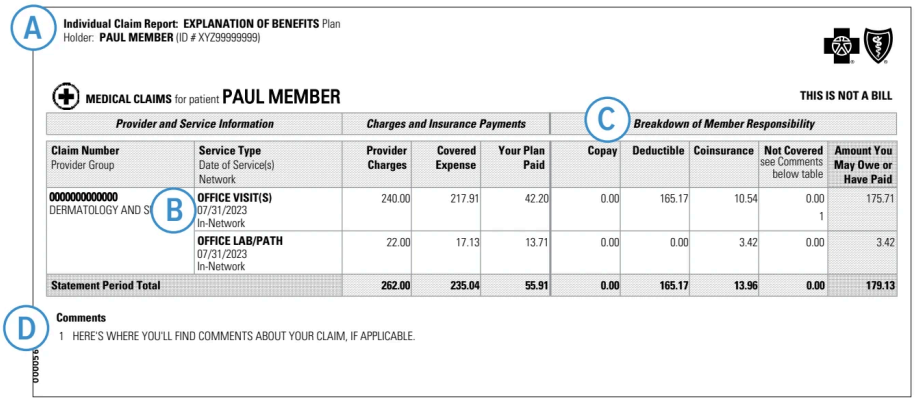
Order an ID Card Online
Getting a replacement ID card is easy. Simply log in to My Health Toolkit(R) and select the Benefits tab. Click on "ID Card Request," then select "Request ID Card." Your request will be processed and your ID card will be sent to your address on file within a few days.

Network Providers Save You Money
Seeing a physician who is part of your health plan's network can help lower your health care costs. You can easily locate in-network providers by using the Doctor and Hospital Finder on our website.

Rate Your Doctor
The "Rate Your Visit" tool allows you to help other members find the right providers by writing reviews for your doctor and hospital visits. You will soon be able to read reviews provided by other members. To access the tool, log in to My Health Toolkit(R) and click on the Resources tab at the top of the page or under the Quick Links section. Review the information and provide your rating for eligible claims.

Go Green. Go Paperless
Less paper and more convenience. Sign up today to receive online Explanations of Benefits (EOBs). Visit our website and log in to My Health Toolkit(R).

Information When You Need It
Our website offers tools and information any time you need it. You can find a provider for health care services, access information regarding your benefits and find resources for a healthier lifestyle.



(A)
Individual Claim Report: EXPLANATION OF BENEFITS Plan
Holder: **PAUL MEMBER** (ID # XYZ99999999)

MEDICAL CLAIMS for patient **PAUL MEMBER** — **THIS IS NOT A BILL**

Provider and Service Information		Charges and Insurance Payments			(C) Breakdown of Member Responsibility				
Claim Number / Provider Group	Service Type / Date of Service(s) / Network	Provider Charges	Covered Expense	Your Plan Paid	Copay	Deductible	Coinsurance	Not Covered see Comments below table	Amount You May Owe or Have Paid
0000000000000 DERMATOLOGY AND S (B)	**OFFICE VISIT(S)** 07/31/2023 In-Network	240.00	217.91	42.20	0.00	165.17	10.54	0.00 1	175.71
	OFFICE LAB/PATH 07/31/2023 In-Network	22.00	17.13	13.71	0.00	0.00	3.42	0.00	3.42
Statement Period Total		**262.00**	**235.04**	**55.91**	**0.00**	**165.17**	**13.96**	**0.00**	**179.13**

(D) **Comments**
1 HERE'S WHERE YOU'LL FIND COMMENTS ABOUT YOUR CLAIM, IF APPLICABLE.

950000

Every EOB includes important information about how to appeal a denial of your claim. This will help you figure out what to do if you disagree with any of the benefits decisions made on this claim.

Check your EOBs through the **My Health Toolkit®** app or by logging in online. Select **Claims & Authorizations**, **Claims**, and then **Health Claims**.

Choose how you want to receive your EOBs — text, email or mail

You can set your contact preferences when you register for **My Health Toolkit**. Log in and select **Profile**, **My Account** and then **Contact Preferences**.

If you get paper EOBs, an EOB will be mailed to you after a claim has been finalized. If you've opted for online delivery, you'll get an email or text when your EOB is ready to view in **My Health Toolkit**.

24-HOUR NURSE ADVISOR

Call anytime for health care advice

You never know when or where illness or injury may happen. Fortunately, 24-hour Nurse Advisor is always here for you.

24-hour Nurse Advisor can help you avoid needless worry, out-of-pocket charges and hours sitting in an emergency room.

When you call, a registered nurse will help you decide:

- If you can take care of the problem at home.
- If you need to see your doctor.
- If it is safe to wait or if you need to get help right away.
- What you should watch for if you don't need care right away.

You can also ask the nurse about:

- Questions you forgot to ask your doctor.
- Health information you heard about.
- Making important health care decisions.
- Your medicines or other treatments.

For immediate health care advice, call: 877-836-0701

MEMBER PERKS

Discounts for you — just for being Blue!

In addition to superior health coverage, your membership provides access to exclusive discounts on a variety of products and services. The member discounts program includes items that generally are not covered byhealth insurance.

Log in to My Health Toolkit, select the **Resources** tab, then **Blue365® Discounts**. On a mobile device, select **Menu**, then **Blue365® Discounts**. You'll find details on discounts for:

Fitness

- Gym memberships
- Wearable fitness devices
- Activewear
- Home fitness equipment
- Vitamins and nutritional supplements

Personal care

(please note that some restrictions may apply for these services.)

- Allergy relief
- Acupuncture
- Chiropractic services
- Massage therapy
- Hair restoration
- Teeth whitening

Healthy eating

- Weight loss programs
- Cookbooks and recipes
- Online cooking classes

Hearing and vision

- Hearing aids
- Eyewear

Lifestyle

- Travel clubs
- Vacation packages
- Pet care

Clarity
BENEFIT SOLUTIONS™

A LIFETIME SAVINGS OPTION FOR **SAVERS**, **SPENDERS** OR **INVESTORS**

If you have a high deductible health plan, the Clarity health savings account (HSA) lets you set aside tax free dollars from your paycheck to cover your deductible. This includes medical expenses that aren't paid for by your insurance, so you're confident you have it covered.

1 HIGH-YIELD INTEREST OPTIONS FOR SAVERS

With the Clarity HSA you have several ways to save and maximize your HSA funds. You have two interest options to choose from: High-Yield, backed by a group annuity product provided by a highly-rated insurance provider and Traditional funds are backed by an FDIC-insured institution. With High-Yield, you can maximize the value of your HSA by **earning up to 10x higher interest** than in the traditional option.

In addition our platform offers built-in predictive analytic tools to guide intelligent long-term funding decisions and our personalized Opportunities feed delivers targeted contribution messages.

2 PERSONALIZED SUGGESTIONS FOR SPENDERS

The **Clarity HSA** empowers you to make the best healthcare spending decisions. With our Find Care feature you can search for in-network procedures, facilities and doctors with associated cost and quality information. And, the Opportunities feed provides personalized suggestions for smarter healthcare spending actions. And, there is a virtual medicine cabinet to help with managing monthly drug cost.

3 THREE MODELS FOR INVESTORS

The **Clarity HSA** is the only HSA in the market with a fully integrated, multi-path investment experience. Powered by an API-driven, cloud-based brokerage platform, Clarity HSA features an impressive investment stack with three distinct investing models – **Managed** (advisor tool), **Self-Directed** and **Brokerage** – provide a tailored investment experience that meets consumers where they are. We also offer exchange-traded funds (ETFs) to give consumers lower costs and diversified market return and fractional trading up to 8 decimal points enables ownership of high-value stocks like Apple or Berkshire Hathaway for as little as a penny. Additional features include auto-rebalancing, real-time account opening and trading, on-demand investment statements, historical performance of available funds, and more.

YOUR **HSA FUNDS** CAN BE USED FOR THE FOLLOWING*:

- ✓ Copays, deductibles, coinsurance
- ✓ Doctors visits and hospital charges
- ✓ Prescription drugs
- ✓ Dental and orthodontia expenses
- ✓ Vision exams, frames, contact lenses
- ✓ Physical therapy and chiropractic care
- ✓ Over-the-counter medications
- ✓ And much more...

EXPENSES THAT DON'T QUALIFY*

- ✓ Expenses incurred prior to opening your HSA
- ✓ Cosmetic procedures or surgery
- ✓ Dental products for general health

*For further guidance refer to the IRS publications 969, 502 and code section 213(d). These publications are available at www.irs.gov.

A SMARTER WAY TO SAVE

Your HSA savings go in tax-free, grow tax-free, and can be spent tax-free, so you're always ready for life.

Tip: For translation to your preferred language, Google translate offers a free service that instantly translates to 100+ languages.

Learn more about us at **claritybenefitsolutions.com**

CONFIDENCE THAT GROWS

If you don't use your HSA funds, don't worry! Every penny you contribute is yours to keep, even if you change plans or employers. Plus, unused funds roll over each year.

Once you've contributed over $1,000, your money can be invested in a suite of mutual funds. As your investment grows, you can grow more confident that your medical costs are covered.

Use your funds to pay for current healthcare expenses, preserve your funds for tax-free growth, or invest your funds for long-term savings.

ACCESS YOUR FUNDS, YOUR WAY

Clarity BENEFIT SOLUTIONS™

A NEXT-GENERATION INVESTMENT EXPERIENCE

Clarity Benefit Solutions delivers a new and modern approach to HSA investing that allows you to personalize your investment journey to fit your unique needs and experience level. Choose from three different investment models – **Managed**, **Self-Directed** and a first-of-its-kind **Brokerage** option – all of which are designed to help you work toward your long-term investing goals. Best of all, you can manage all aspects of your HSA, including investments, from a single portal.*

WELCOME TO **YOUR HSA**

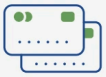
HSA-eligible health plans typically have lower monthly premiums, giving you an opportunity to contribute those savings into an HSA.

TWO INTEREST OPTIONS TO CHOOSE FROM!

Unlike an FSA, unused funds stay in your account from year to year and earn interest tax-free – you can choose the interest rate option to meet your needs: **High-Yield**, backed by a group annuity product provided by a highly-rated insurance provider and Traditional funds are backed by an FDIC-insured institution. With High-Yield, employees can maximize the value of their HSA by **earning up to 10x higher interest** than in the traditional option.

USE YOUR FUNDS

Money is added to your account through a payroll deduction, online banking transfer, or a direct contribution. Once your account is funded, you can use the money to pay for expenses now or let it grow for the future.



SWIPE, PAY, AND GO

The Clarity Benefit Card is a quick and easy way to pay a provider like a doctor, dentist, or pharmacy. The amount is deducted right from your HSA account.

PAYMENT AT YOUR FINGERTIPS

With Clarity's online bill payment, you can request for a payment to be sent from your HSA to your provider. If you've already paid the provider, you can reimburse yourself for the out-of-pocket expense.

YOUR ACCOUNT GOES WHERE YOU DO

On your online employee portal, you can view your balance and transaction history, invest HSA funds, pay providers, reimburse yourself, as well as much more. You can also download the Clarity mobile app to have access on any mobile device!

To maximize savings, all HSA will be automatically opted into the high-yield interest option. You have the ability to switch between high-yield and traditional at any time. Simply log into the Clarity Portal or Mobile app, navigate to your HSA account summary, and click on 'interest options'.

*The balance in your HSA Investment Account is subject to investment risks, including fluctuations in value and the possible loss of the principal amount invested. Investing through the WealthCare Saver investment platform is subject to the terms and conditions of the Health Savings Account Custodial Agreement and any applicable investment supplement(s). For information regarding underlying investment expenses, earnings, and distributions, see the applicable investment prospectus and other publicly available information. WealthCare Saver, a dba of Alegeus Technologies, LLC, is a licensed Non-Bank Custodian of HSA cash accounts. CapFinancial Partners, LLC ("CAPTRUST") is an investment adviser registered under the Investment Advisers Act of 1940. CAPTRUST acts as investment advisor with respect to the investments available in your HSA. In addition, you may choose to have CAPTRUST manage your HSA account on a discretionary basis. DriveWealth, LLC a registered broker dealer and member of FINRA and SIPC. SOC 2 Type 2, GDPR, CCPA compliant. Registered in all 50 U.S. states.

Learn more about us at **claritybenefitsolutions.com**

HOW YOUR **HEALTH SAVINGS ACCOUNT** WORKS FOR YOU: **FAQS**

QUESTION	ANSWER
What is a health savings account (HSA)?	An HSA is a tax-advantaged personal savings account that can be used to pay for medical, dental, vision and other qualified expenses now or later in life. To contribute to an HSA, you must be enrolled in a qualified high-deductible health plan (HDHP) and your contributions are limited annually. The funds can even be invested, making it a great addition to your retirement portfolio.
Why should I participate in an HSA?	High-deductible health plans typically have lower monthly premiums and greater out-of-pocket costs. An HSA helps offset those costs and ensure you have money set aside to pay for out-of-pocket healthcare expenses. HSA contributions can be made pre-tax via payroll contributions, or post-tax – which simply means you can reap the tax benefit when you file your income taxes. Either way, you're saving an average of 30% and making your healthcare dollars stretch further. But an HSA is also a powerful investment vehicle and can be a smart addition to your retirement strategy. You will never be taxed when you use HSA dollars for qualified medical expenses. No other investment account offers this benefit!
What expenses are eligible for reimbursement?	You can check what expenses are eligible by logging into your Clarity portal, click "Learn", then click "Eligible Healthcare Expense List" where you can filter to the HSA option.
Am I eligible to participate?	In order to contribute, you must be enrolled in a qualified HDHP, not covered under a secondary health insurance plan, not enrolled in Medicare, and not another person's dependent. There are no eligibility requirements to spend previously-contributed HSA funds.
How do I contribute money to my HSA?	Payroll deduction is most likely offered by your employer. Your annual contribution will be divided into equal amounts and deducted from your payroll before taxes. Direct contributions can also be made from your personal checking account and can be deducted on your personal income tax return.

HOW YOUR **HEALTH SAVINGS ACCOUNT** WORKS FOR YOU: **FAQS**

QUESTION	ANSWER
How much can I contribute to my HSA?	Contributions can be made by the eligible employee, their employer, or any other individual. For contribution limits please visit: claritybenefitsolutions.com/resources/plan-limits.
Can I change my contributions to my HSA during the year?	Yes. You can set aside up to the maximum amount determined by the IRS each year and it can be changed at any time. For more information on the maximum amount you can contribute this year, please visit claritybenefitsolutions.com.
Do I have to spend all my contributions by the end of the plan year?	No. HSA money is yours to keep. Unlike a flexible spending account (FSA), unused money in your HSA isn't forfeited at the end of the year; it continues to grow, tax-deferred.
What happens if my employment is terminated?	HSAs are portable and move with you if you change employment. Your HSA belongs to you, not your employer, just like your personal checking account.
How do I access the funds in my HSA?	Use your Clarity Benefit Card for eligible healthcare expenses or pay with your personal funds and reimburse yourself with money from your HSA. Your HSA is similar to a checking account. You are responsible for ensuring the money is spent on qualified purchases only and maintaining records to withstand IRS scrutiny. Payments can be made via check, ACH, online bill-pay, or debit card, depending on what is available to you.
Do I have to spend all my contributions by the end of the plan year?	Unlike a flexible spending account (FSA), unused money in your HSA isn't forfeited at the end of the year; it continues to grow, tax-free.
What happens if my employment is terminated?	If you get laid off, furloughed from your job or chose to leave, your account and funds stay with you and you can always use your HSA dollars to help pay for qualified medical costs.

QUESTION	ANSWER
When must contributions be made to an HSA for a taxable year?	Contributions for the taxable year can be made in one or more payments at any time after the year has begun and prior to the individual's deadline (without extensions) for filing the eligible individual's federal income tax return for that year. For most taxpayers, the deadline is April 15 of the year following the year for which contributions are made.
What happens to the money in my HSA if I no longer have HDHP coverage?	Once you discontinue coverage under an HDHP and/or get secondary health insurance coverage that disqualifies you from an HSA, you can no longer make contributions to your HSA. However, since you own the HSA, you can continue to use the remaining funds for future healthcare expenses.
Is tax reporting required for an HSA?	Yes. IRS form 8889 must be completed with your tax return each year to report total deposits and withdrawals from your account. You do not have to itemize to complete this form.
Can I still deduct healthcare expenses on my tax return?	Yes, but not the same expenses for which you have already been reimbursed from your HSA.
Can I withdraw the money for non-healthcare purchases?	Yes. If you withdraw the money for an unqualified expense prior to age 65, you'll be subject to your ordinary income tax, in addition to a 20% tax penalty. You can withdraw the money for any reason without penalty after age 65, but are subject to applicable income taxes.
Can I roll over or transfer funds from my HSA or Medical Savings Account (or Archer MSA) into an HSA?	Yes. Pre-existing HSA funds or MSA monies may be rolled into an HSA and will continue their tax-free status.
Can I invest my HSA funds for growth?	Yes. Once your HSA cash account balance reaches $1,000, you can invest your funds like a 401(k). But unlike a 401(k), you will never pay taxes on withdrawals for qualified expenses, making your HSA a powerful investment vehicle to help you prepare for future healthcare expenses, even into retirement.

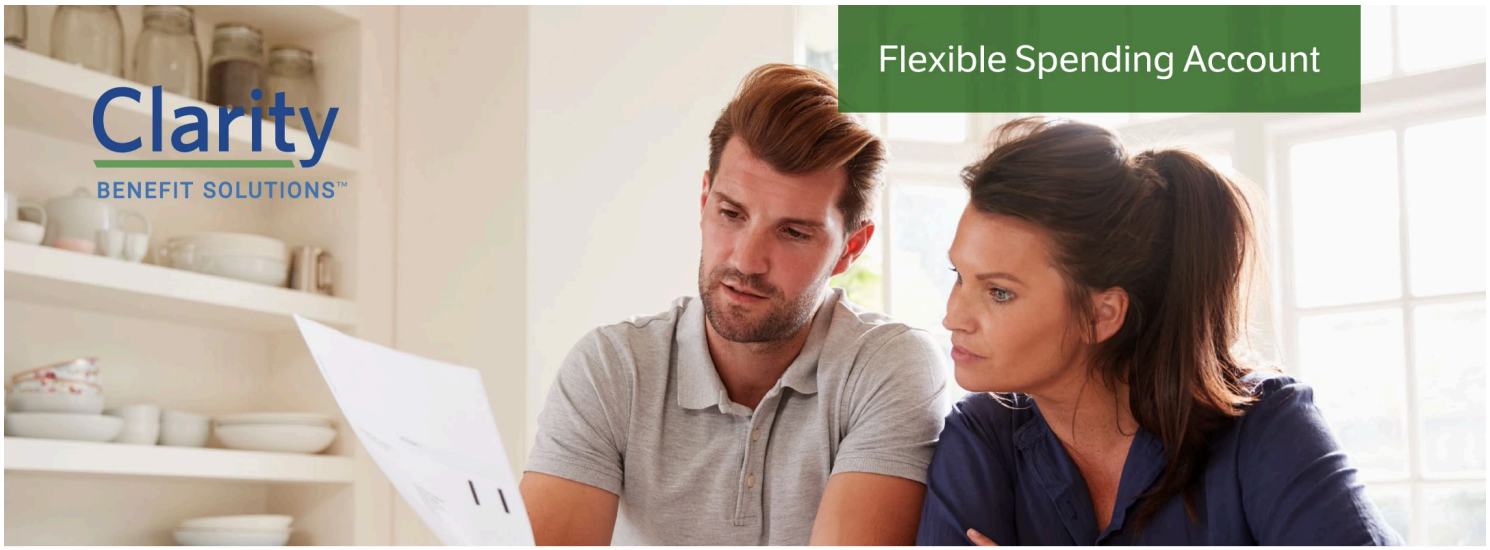
Learn more about us at **claritybenefitsolutions.com**

Clarity BENEFIT SOLUTIONS™

QUESTION	ANSWER
What type of investment options are provided?	Your Clarity HSA gives you access to WealthCare Investments - a modern investment experience with features and functionality new to HSAs. You can manage all aspects of your HSA, including your investments, from a single platform. You can choose from three investment paths to suite your needs and experience level: Managed, Self- Directed, and Brokerage.
Is investing my HSA the only way to maximize my contributions?	No, unused funds in your HSA cash account will earn interest and grow tax-free. You can choose the interest option to meet your needs: High-Yield or Traditional. The High-Yield interest option can help you earn up to 10x higher interest on your HSA cash balance.
What is the difference in high-yield versus traditional interest rates	1. **Interest earning potential:** The high-yield interest options offers employees the potential to earn a higher interest rate on their cash balance, up to 10 times higher. 2. **Where the HSA balance is held:** With the high-yield interest option, instead of being held by a bank, HSA cash account funds are held in a deposit account that is backed by a highly rated insurance company, Pacific Life. In the **traditional option**, deposits are insured by the FDIC for up to $250k. In the **high-yield option**, deposits are not insured by the FDIC but rather by the stability of the insurance partner supporting the deposit account. Insurance companies are highly regulated by each state to ensure they can cover all their obligations to account holders.
Can I choose which type of interest rate schedule I want to be in?	Yes. Upon opening your HSA, your funds will be placed in the high-yield option. You can switch to Traditional at any time by logging into the Clarity portal or mobile all going to your HSA account summary, and clicking on 'interest options'. You have ability to switch between the high-yield interest option and the traditional interest option at any time,
Can I transfer funds between the cash and investment accounts?	Yes. You can transfer money between your HSA cash and HSA investment account at any time.

Learn more about us at **claritybenefitsolutions.com**

Clarity BENEFIT SOLUTIONS™



HEALTHCARE SAVINGS WITHOUT THE HASSLE

A flexible spending account (FSA) makes healthcare affordable by better preparing you for health-related costs not covered by insurance. Clarity FSA gives you the tax savings you expect -- plus a simply smarter experience. Our program is simple to use, easy to manage, and automated for efficiency. You can even check what expenses are eligible by logging into your Clarity portal, click "Learn", then click "Eligible Healthcare Expense List" where you can filter to the HSA option.

A **SIMPLY SMARTER** FSA

We connect to your benefits administration platform to automatically update all enrollments, terminations, and deposits. Our platform also connects to your insurance carriers, automatically substantiating card swipes and eliminating the need for receipts or EOB statements.

CUSTOMER SERVICE THAT REALLY SUPPORTS

Every employee receives dedicated support from a Client Relationship Manager with an average of 5-10 years of benefit experience and a world-class service rating. You can always get the help you need, with service available in over 230 languages.

BENEFIT TECHNOLOGY THAT TRANSFORMS

Easily connect with insurance carriers and benefit administration platforms, while streamlining access for your online enrollment, our Clarity Benefit card, and an intuitive online portal that's mobile-friendly.

EVERYONE SAVES WITH A FLEXIBLE SPENDING ACCOUNT (FSA)

An FSA lets you set aside pre-tax dollars to cover routine out-of-pocket healthcare expenses, saving you about 30% on average.

Learn more about us at **claritybenefitsolutions.com**

Tip: For translation to your preferred language, Google translate offers a free service that instantly translates to 100+ languages.

WE MAKE IT EASY FOR YOU TO GET THE MOST OUT OF CLARITY FSA

Clarity BENEFIT SOLUTIONS™

CLARITY BENEFIT CARD

Pay providers for qualifying healthcare expenses by swiping the Clarity Benefit card at the point of sale. The card can be used at any qualified service provider that accepts MasterCard.

CLARITY BENEFITCONNECT

Enroll to track deductible spend, substantiate card transactions or automatically reimburse eligible expenses.

ONLINE PORTAL AND MOBILE APP

Participants will have access to account information, be able to submit claims and supporting documentation, or sign up for e-claims reimbursement in our online portal. You can also download the Clarity mobile app to have access on any mobile device.

Learn more about us at **claritybenefitsolutions.com**

CLARITY FSA | FREQUENTLY ASKED QUESTIONS

QUESTION	ANSWER
How do you contribute money to your FSA?	Your annual election will be divided by the number of pay periods in their plan year. This amount will be deducted from your paycheck before taxes are assessed.
How much can you contribute to your FSA?	Annual contributions are determined each year by the IRS. Please visit claritybenefitsolutions.com for more information.
Who is eligible under an FSA?	An FSA covers eligible expenses for yourself and your dependents, even if they are not covered under your primary health plan.
What expenses are eligible for reimbursement?	Health plan co-pays, deductibles, co-insurance, eyeglasses, dental care, medications, and certain medical supplies are covered. The IRS provides specific guidance regarding eligible expenses. (See IRS Publication 502).
How do you determine the date your expenses were incurred?	Expenses are incurred at the time the medical care was provided, not when you are invoiced or pay the bill.
How do you get the funds out of your FSA?	If you have a Clarity Benefit Card, you can simply swipe it at the register. Otherwise, you can file a claim including the receipt, documenting the type, amount, and date. Once approved, your reimbursement check will be mailed or deposited directly into your bank account.
What happens if you don't spend all of your FSA by the end of the plan year?	Be sure to only allocate dollars for predictable medical expenses. Any unused funds at the end of the plan year are typically forfeited, which is known as the "use-it-or-lose-it rule".
How soon can you start spending your FSA funds?	With a healthcare FSA, your entire annual election amount is available on the first day of the plan year, even though you have not yet contributed that amount.
Can you change your election amount mid-year?	Elections can only be altered if you experience a change in status as defined by IRS regulations, such as marriage, divorce, birth, or death in your immediate family.

Learn more about us at **claritybenefitsolutions.com**

Clarity BENEFIT SOLUTIONS™

CLARITY FSA | FREQUENTLY ASKED QUESTIONS

QUESTION	ANSWER
What happens to the FSA if employment is terminated?	Participation in their FSA is also terminated. This means that only expenses that were incurred prior to their termination date are eligible for reimbursement.
What is the deadline for submitting claims?	You can submit claims for reimbursement at any time during the same plan year that you incur the expense. You may also have a grace period at the end of the plan year. Check the summary plan document provided by your employer for additional information. Check the summary plan document provided by your employer for additional information.
Can you still deduct healthcare expenses from your tax return?	Yes, but not the same expenses for which you have already been reimbursed from your FSA.
Are over-the-counter (OTC) medications eligible for reimbursement?	Yes, OTC medications are FSA-eligible.
What is a Letter of Medical Necessity?	The IRS mandates that eligible expenses be primarily for the diagnosis, treatment, or prevention of disease; this also includes treatment of conditions affecting any functional part of the body. For example, vitamins are not typically covered because they are used for general wellness, but a doctor may prescribe a vitamin to treat a medical condition. The vitamin would then become eligible in this instance.

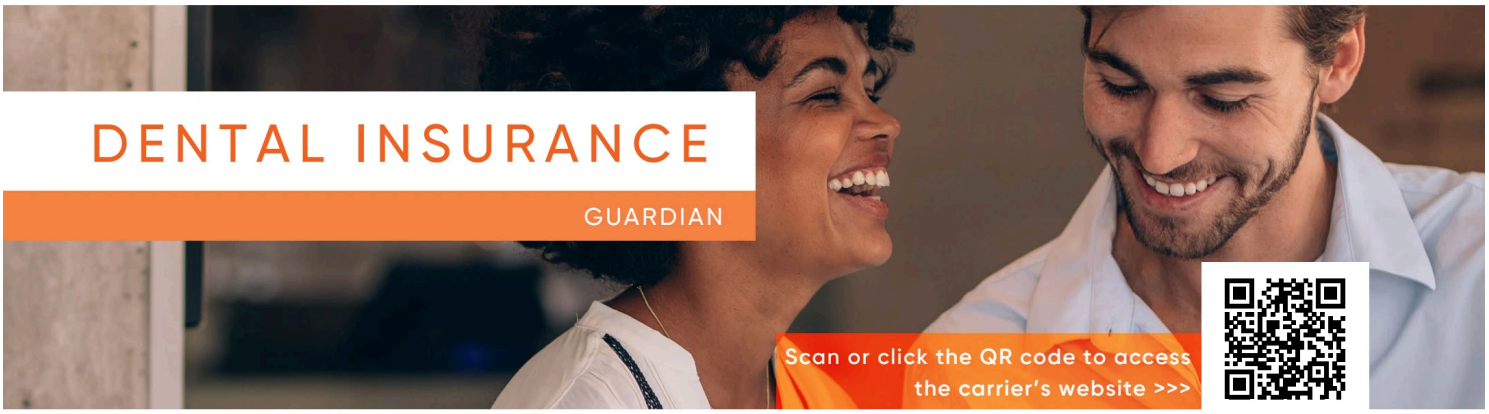
A SIMPLY SMARTER APPROACH
TO EMPLOYEE BENEFITS

Today, the benefits landscape is more confusing than ever, but it's also never been so essential. At Clarity, we believe life is a journey; one that should be lived well. So, we'll stop at nothing to bring clarity, and ensure you are ready for life. With state-of-the-art technology and world-class customer service, we'll handle the day-to-day so you can focus on what matters: your health.

VOTED ONE OF THE 30 FASTEST GROWING TECH COMPANIES IN 2020

Learn more about us at **claritybenefitsolutions.com**

Clarity BENEFIT SOLUTIONS™



DENTAL INSURANCE

GUARDIAN

BENEFITS SUMMARY	BASE PLAN RECOMMENDED WHEN USING IN-NETWORK PROVIDERS ONLY		BUY UP PLAN RECOMMENDED WHEN USING OUT-OF-NETWORK PROVIDERS	
Annual Deductible(Individual/Family)	$75/$225		$75/$225	
Annual Benefit Maximum	$1,000		$1,200	
Orthodontia Lifetime Maximum	$1,000		$1,000	
Waiting Period	None		None	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
PREVENTATIVE SERVICES-DEDUCTIBLE WAIVED				
Oral Evaluations Prophylaxis: Cleanings Fluoride Treatment (child only) Bitewing X-rays, Full Mouth X-rays Sealants Space Maintainers	Plan pays 100%	Plan pays 100% of a negotiated Fee Schedule	Plan pays 100%	Plan pays 100% of the 90th% UCR
BASIC SERVICES				
Amalgam Restorations (Silver Fillings) Resin Based Restorations (anterior and posterior) Extractions (routine and surgical) Endodontic Treatments Periodontic Treatments	Plan pays 60% after Deductible	Plan pays 60% of a negotiated Fee Schedule	Plan pays 80% after Deductible	Plan pays 80% of the 90th% UCR
MAJOR SERVICES				
Crowns Dentures Bridges	Plan pays 50% after Deductible	Plan pays 50% of a negotiated Fee Schedule	Plan pays 50% after Deductible	Plan pays 50% of the 90th% UCR
ORTHODONTIA SERVICES				
Diagnostics and Treatments (child to age 19)	50%	Plan pays 50% of a negotiated Fee Schedule	50%	Plan pays 50% of the 90th% UCR

EMPLOYEE BI-WEEKLY PAYROLL DEDUCTIONS		
Employee Only	$9.61	$18.61
Employee + Spouse	$21.96	$37.92
Employee + Child(ren)	$24.88	$42.97
Employee + Family	$37.85	$65.36

* UCR = Usual, Customary, and Reasonable

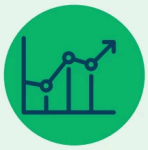
This information summarizes the Therapy Partner Solutions Holdings, LLC Dental benefits plans and is for illustrative purposes only. In the event of a discrepancy between this illustration and the official plan documents, the official documents will govern.

Guardian®

Oral Health Rewards Program

Regular visits to the dentist can help prevent and detect the early signs of serious diseases.

That's why Guardian's Maximum Rollover Oral Health Rewards Program encourages and rewards members who visit the dentist, by rolling over part of your unused annual maximum into a Maximum Rollover Account (MRA). This can be used in future years if your plan's annual maximum is reached.



Automatic rollover

Submit a claim (without exceeding the paid claims threshold of a benefit year), and Guardian will roll over a portion of your unused annual dental maximum.

How maximum rollover works*

Depending on a plan's annual maximum, if claims made for a certain year don't reach a specified threshold, then the set maximum rollover amount can be rolled over.

Plan annual maximum**	Threshold	Maximum rollover amount	Maximum rollover account limit
$1,000 Maximum claims	**$500** Claims amount that determines rollover eligibility	**$250** Additional dollars added to a plan's annual maximum for future years	**$1,000** The limit that cannot be exceeded within the maximum rollover account

Plan annual maximum**	Threshold	Maximum rollover amount	Maximum rollover account limit
$1,200 Maximum claims	**$600** Claims amount that determines rollover eligibility	**$300** Additional dollars added to a plan's annual maximum for future years	**$1,200** The limit that cannot be exceeded within the maximum rollover account

* This example has been created for illustrative purposes only.

** If a plan has a different annual maximum for PPO benefits vs. non-PPO benefits, ($1500 PPO/$1000 non-PPO for example) the non-PPO maximum determines the Maximum Rollover plan. May not be available in all states.

Guardian's Dental Insurance is underwritten and issued by The Guardian Life Insurance Company of America, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage. Information provided in this communication is for informational purposes only. Dental Policy Form No. GP-1-DEN-16. GUARDIAN® is a registered service mark of The Guardian Life Insurance Company of America ® ©Copyright 2019 The Guardian Life Insurance Company of America.

VISION INSURANCE

GUARDIAN-VSP

Scan or click the QR code to access the carrier's website >>>

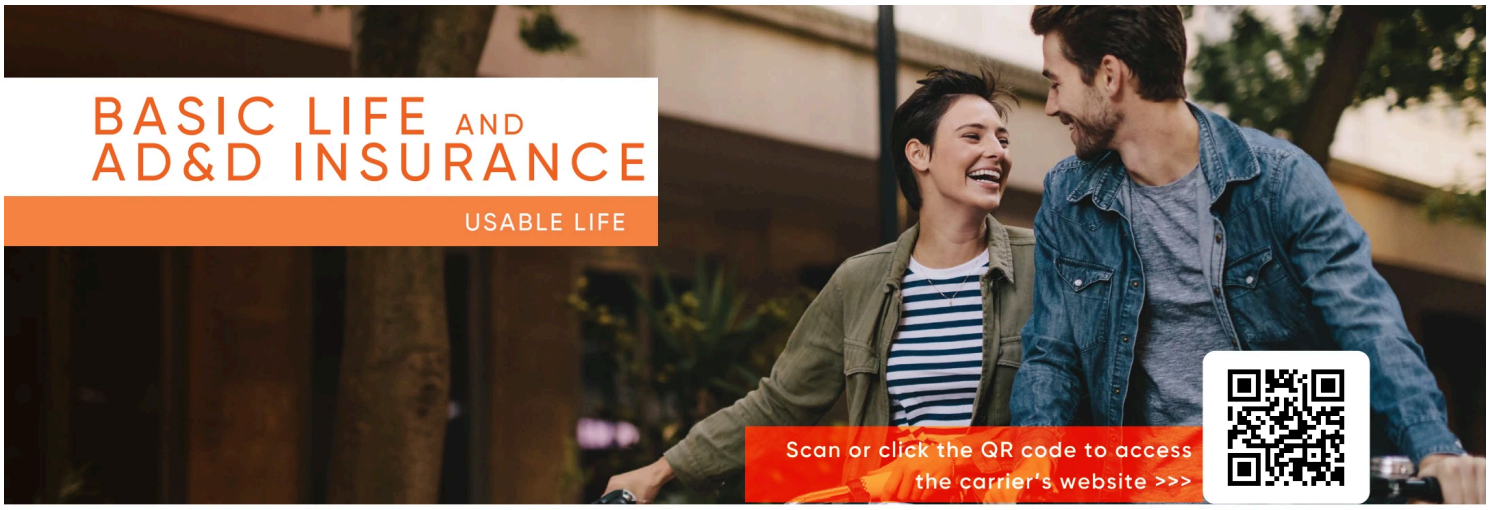
BENEFIT SUMMARY	IN-NETWORK	OUT-OF-NETWORK	FREQUENCY
Eye Examination	$10	Up to $39 Reimbursement	12 Months
Materials Copay	$25	--	
Eyeglass Frames	$130 Retail Allowance; 20% off amount over allowance	Up to $46 Reimbursement	24 Months
STANDARD EYEGLASS LENSES			
Single Vision	Covered 100% after $25 Copay	Up to $23 Reimbursement	12 Months
Bifocal		Up to $37 Reimbursement	
Trifocal		Up to $49 Reimbursement	
Lenticular	$55	Up to $64 Reimbursement	
CONTACT LENSES (IN LIEU OF EYEGLASSES)			
Elective	$130 Allowance	Up to $100 Reimbursement	12 Months
Medically Necessary	Covered 100% after $25 Copay	Up to $210 Reimbursement	

EMPLOYEE BI-WEEKLY PAYROLL DEDUCTIONS	
Employee Only	$2.84
Employee + Spouse	$5.81
Employee + Child(ren)	$5.92
Employee + Family	$9.13

*This information summarizes the Therapy Partner Solutions Holdings, LLC Vision benefits plans and is for illustrative purposes only. In the event of a discrepancy between this illustration and the official plan documents, the official documents will govern.

Elective Contact Lenses are in lieu of glasses (lenses & frames). You are not eligible for glasses under our plan until 12 months after you receive contacts and vice versa.

This information summarizes the Therapy Partner Solutions Holdings, LLC Vision benefits plans and is for illustrative purposes only. In the event of a discrepancy between this illustration and the official plan documents, the official documents will govern.



BASIC LIFE AND AD&D INSURANCE

USABLE LIFE

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100% Employer-Paid!

BENEFITS SUMMARY

LIFE BENEFIT AMOUNT
$25,000

AD&D BENEFIT AMOUNT
$25,000

BENEFITS WILL REDUCE BY:
65% at age 70 50% at age 70

- Group Basic Life insurance helps protect your loved ones from financial hardships related to an untimely death
- Cash benefit paid to your beneficiary in the event of your death
- Cash benefit if you suffer a covered loss in an accident, such as losing a limb or eyesight
- You **MUST** designate your beneficiary(ies) in Employee Navigator, your online benefits portal
- Designating your beneficiary ensures your beneficiary will receive the benefit instead of it going into probate

This information summarizes the Therapy Partner Solutions Holdings, LLC Basic Life and AD&D benefits plans and is for illustrative purposes only. In the event of a discrepancy between this illustration and the official plan documents, the official documents will govern.

VOLUNTARY LIFE AND AD&D INSURANCE

USABLE LIFE

Scan or click the QR code to access the carrier's website >>>

BENEFITS SUMMARY

EMPLOYEE LIFE BENEFIT	SPOUSE LIFE BENEFIT	CHILD LIFE BENEFIT
Benefit Increment: $10,000	Benefit Increment: $5,000	Benefit Increment: $2,000
Minimum Benefit: $10,000	Minimum Benefit: $5,000	Minimum Benefit: $2,000
Maximum Benefit: 10x annual salary not to exceed $500,000	Maximum Benefit: $250,000 not to exceed 100% of Employee amount	Maximum Benefit: $10,000
Guarantee Issue Amount: $100,000	Guarantee Issue Amount: $25,000	Guarantee Issue Amount: $10,000

BENEFIT REDUCTION
35% at age 70 50% at age 75

Spouse rate is based on Employee's age.

Employee Age Band	Employee & Spouse Rate per $1,000
< 25	$0.074
25-29	$0.074
30-34	$0.090
35-39	$0.118
40-44	$0.156
45-49	$0.230
50-54	$0.348
55-59	$0.520
60-64	$0.670
65-69	$1.356
70+ **(EOI Required)**	$2.396

Child Voluntary Term Life and AD&D Rate
$0.150 per $1,000

- Voluntary Life insurance helps protect you and your loved ones from financial hardships related to an untimely death.
- Cash benefit paid to your designated beneficiary in the event of your death or a cash benefit paid to you upon the death of a covered dependent
- Cash benefit if you or your covered dependent suffers a covered loss in an accident, such as losing a limb or eyesight
- You MUST designate your beneficiary(ies) in Employee Navigator, your online benefits portal
- Designating your beneficiary ensures your beneficiary will receive the benefit instead of it going into probate
- if an elected amount is above the guaranteed issue, an Evidence of Insurability (EOI) Form is required to be completed, submitted, and approved.

This information summarizes the Therapy Partner Solutions Holdings, LLC Voluntary Life benefits and AD&D plans and is for illustrative purposes only. In the event of a discrepancy between this illustration and the official plan documents, the official documents will govern.

SHORT-TERM DISABILITY INSURANCE (STD)

USABLE LIFE

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BENEFIT SUMMARY	
Elimination Period for Accident	14 days
Elimination Period for Illness	14 days
Benefit Duration	Up to 11 weeks
Benefit Percent	60% of weekly salary
Benefit Maximum	up to $1,000 per week

3 / 12 Pre-Existing Condition is an illness or injury for which you have received treatment for a condition within 3 months before your effective date under this policy until you have been covered under the policy for 12 months

How to Calculate Your Short-Term Disability Premium

Lindsay is 24 years old working at a marketing company. For someone who is less than age 30, the rate is $0.780 per $10 of covered benefit. She earns $25,000 a year.

How much is deducted per her bi-weekly paycheck?

Employee Age Band	Rate per $10 of Weekly Payroll
<25	$0.780
25-29	$0.860
30-34	$0.720
35-39	$0.600
40-44	$0.580
45-49	$0.560
50-54	$0.660
55-59	$0.840
60+	$1.020

1. Weekly Benefit Calculation:

Equals Annual Salary divided by 52 multiplied by 60% ($25,000/52 weeks) x .60 = $288.46

2. Monthly Premium Calculation:

Equals Weekly Benefit Times Rate, divided by 10 ($288.46 x $0.780) / 10 = $22.50

3. Bi-Weekly Payroll Deduction:

Equals monthly premium times 12, divided by 26 ($22.50 x 12) / 26 = $10.38 per bi-weekly paycheck

This information summarizes the Therapy Partner Solutions Holdings, LLC STD benefits plans and is for illustrative purposes only. In the event of a discrepancy between this illustration and the official plan documents, the official documents will govern.

LONG-TERM DISABILITY INSURANCE (LTD)

USABLE LIFE

Scan or click the QR code to access the carrier's website >>>

BENEFIT SUMMARY

Elimination Period	90 days
Benefit Amount	60% of monthly salary
Benefit Maximum	Up to $6,000 per month
Duration of Benefits	Social Security Normal Retirement Age
Definition of Disability	24 Months Own Occupation
Pre-Existing Conditions	12 Months Prior / 12 Months Exclusion 12 / 12 Pre-Existing Condition is an illness or injury for which you have received treatment for a condition within 12 months before your effective date under this policy until you have been covered under the policy for 12 months

How to Calculate Your Long-Term Disability Premium

Rupert is 63 and works half-time from home for an accounting firm. He loves cooking with his wife, Lucy. For someone who is between ages 60+, the rate is $2.530 per $100 of monthly payroll. Rupert earns $25,000 a year.

How much is deducted per his bi-weekly paycheck?

Employee Age Band	Rate per $100 of Monthly Payroll
<25	$0.230
25-29	$0.340
30-34	$0.530
35-39	$0.750
40-44	$0.960
45-49	$1.350
50-54	$1.840
55-59	$2.360
60+	$2.530

1. Monthly Benefit Calculation:

Equals Annual Salary divided by 12 Months

$25,000 / 12 = $2,083.33

2. Monthly Premium Calculation:

Equals Weekly Benefit Times Rate, divided by 100

($2083.33 x $2.530) / 100 = $52.70

3. Bi-Weekly Payroll Deduction:

Equals monthly premium times 12, divided by 26 ($52.70 x 12) / 26 = $24.32 per bi-weekly paycheck

This information summarizes the Therapy Partner Solutions Holdings, LLC LTD benefits plans and is for illustrative purposes only. In the event of a discrepancy between this illustration and the official plan documents, the official documents will govern.

WE OFFER A UNIQUE SOLUTION FOR LONG-TERM CARE

Click Here to Watch Video

PLEASE SCAN THE QR CODE TO WATCH A SHORT INFORMATIONAL VIDEO THAT WILL OUTLINE MORE DETAILS ABOUT THIS UNIQUE SOLUTION AND TO SCHEDULE AN APPOINTMENT WITH A BENEFIT COUNSELOR.

Guaranteed Employee Coverage

That means NO MEDICAL QUESTIONS! New Hire guaranteed employee coverage of up to $150,000 for life insurance and up to $300,000 for long-term care coverage. If employees have waived coverage previously, they are eligible up to $100,000 for life insurance and up to $200,000 long-term care.

Portable and Affordable

This policy belongs to you and you can take it with you into retirement, or to another job. This is a universal life policy and the premiums are determined at the time of purchase.

Guaranteed Family Coverage

Spousal coverage guaranteed up to $35,000. Children can be covered up to $20,000.

Financial Payments for LTC

If you are not able to perform just 2 activities of daily living, you can receive the guaranteed issue amount of $4,000 per month of long-term care coverage.

Pays You Cash

Pays you, or whomever you see fit to take care of you. Be it a family member, registered care taker, or an assisted living facility.

Builds Cash Value

Guaranteed minimum interest rate of 2%. Currently 4.75%.

Monica Hayes
(256) 679-6599
monica@vbwork.com

Let our Benefits Work For You

VB @WORK

Guardian
ACCIDENT INSURANCE

GUARDIAN

Watch our video
How accident insurance can get you back on your feet.

Please log in to www.employeenavigator.com to download the claim form.

Accident insurance

Accidents happen. With accident insurance, you can help them hurt a bit less.

Accident insurance is an extra layer of protection that gives you a cash payment to help cover out-of-pocket expenses when you suffer an unexpected, qualifying accident.

Who is it for?

Nobody can predict when an accident might happen. That's why accident insurance is an important add-on policy for people who want to supplement the health and disability insurance coverage they already have individually or through an employer.

What does it cover?

Accident insurance pays you lump sum benefits after an accident happens. This could be a severe burn, broken bone or emergency room visit. Our accident insurance policies also offer an increased benefit that pays extra for children injured while playing an organized sport like soccer, baseball, lacrosse, or football.

The child must be covered at the time the accident occurred and be 18 years of age or younger.

Why should I consider it?

Health coverage may become more expensive, with higher co-pays, premiums, and deductibles. Accident insurance can be a simple, affordable way to help supplement and cover additional expenses your health and disability insurance may not cover, including x-rays, ambulance services, deductibles, and even things like rent or groceries.

Plus, accident insurance is portable and payments are made directly to you.

You will receive these benefits if you meet the conditions listed in the policy.

Added support during recovery

Amanda breaks her leg falling off her bike and needs emergency treatment.

Average non-surgical broken leg treatment expense: **$2,500**

Average Major Medical deductible: **$1,500**

Major Medical covers 80% of the surgical cost after the deductible is met, but Amanda's still responsible for 20%: **$200**

Total out-of-pocket amount for Amanda (deductible + coinsurance): **$1,700**

Amanda's Guardian Accident policy pays her a benefit of **$1,700,** which covers all of her out-of-pocket expenses.

This example is for illustrative purposes only. Your plan's coverage may vary. See your plan's information on the following pages for specific amounts and details.

Guardian

Your accident coverage

	ACCIDENT
COVERAGE - DETAILS	
Your Bi-weekly premium	$7.80
You and Spouse/Domestic Partner	$12.42
You and Child(ren)	$12.88
You, Spouse/Domestic Partner and Child(ren)	$17.49
Accident Coverage Type	On and Off Job
Portability - Allows you to take your Accident coverage with you if you terminate employment.	Included
ACCIDENTAL DEATH AND DISMEMBERMENT	
Benefit Amount(s)	Employee $25,000 Spouse $25,000 Child $5,000
Catastrophic Loss	Quadriplegia, Loss of speech & hearing (both ears), Loss of Cognitive function: 100% of AD&D Hemiplegia & Paraplegia: 50% of AD&D
Common Carrier	200% of AD&D benefit
Common Disaster	200% of Spouse AD&D benefit
Dismemberment - Hand, Foot, Sight	Single: 50% of AD&D benefit Multiple: 100% of AD&D benefit
Dismemberment - Thumb/Index Finger Same Hand, Four Fingers Same Hand, All Toes Same Foot	25% of AD&D benefit
Seatbelts and Airbags	Seatbelts: $10,000 & Airbags: $15,000
Reasonable Accommodation to Home or Vehicle	$2,500
Child(ren) Age Limits	Children age birth to 26 years
RAINY DAY FUND	Benefit Amount: $400 Rollover Maximum: $200 Fund Maximum: $800
FEATURES	
Air Ambulance	$1,000
Ambulance	$200
Blood/Plasma/Platelets	$300
Burns (2nd Degree/3rd Degree)	9 sq inches To 18 sq inches: $0/$2,000 18 sq inches To 35 sq inches: $1,000/$4,000 Over 35 sq inches: $3,000/$12,000
Burns - Skin Graft	50% of burn benefit
Child Organized Sport - Benefit is paid if the covered accident occurred while your covered child, age 18 years or younger, is participating in an organized sport that is governed by an organization and requires formal registration to participate.	25% increase to child benefits
Chiropractic Visits	$50/visit, up to 6 visits

Guardian

Your accident coverage

FEATURES (Cont.)	
Coma	$10,000
Concussion Baseline Study	$25
Concussions	$200
Diagnostic Exam (Major)	$200
Dislocations	Schedule up to $5,000
Doctor Follow-Up Visits	$50, up to 6 treatments
Emergency Dental Work	$300/Crown, $75/Extraction
Emergency Room Treatment	$200
Epidural Anesthesia Pain Management	$100, 2 times per accident
Eye Injury	$300
Family Care—Benefit is payable for each child attending a Child Care center while the insured is confined to a hospital, ICU or Alternate Care or Rehabilitative facility due to injuries sustained in a covered accident.	$20/day, up to 30 days
Fractures	Schedule up to $6,000
Gun Shot Wound	$750
Hospital Admission	$1,000
Hospital Confinement	$250/day - up to 1 year
Hospital ICU Admission	$2,000
Hospital ICU Confinement	$500/day - up to 15 days
Initial Dr. Office/Urgent Care Facility Treatment	$100
Joint Replacement (Hip/Knee/Shoulder)	$2,500/$1,250/$1,250
Knee Cartilage	$500
Laceration	Schedule up to $400
Lodging - The hospital stay must be more than 50 miles from the insured's residence.	$125/day, up to 30 days for companion hotel stay
Medical Appliance—Wheelchair, motorized scooter, leg or back brace, cane, crutches, walker, walking boot that extends above the ankle or brace for the neck.	Schedule up to $500
Outpatient Therapies	$35/day, up to 10 days
Post-Traumatic Stress Disorder	$400
Prosthetic Device/Artificial Limb	1: $500 2 or more: $1,000
Rehabilitation Unit Confinement	$100/day, up to 15 days
Ruptured Disc With Surgical Repair	$500
Surgery (Cranial, Open Abdominal, Thoracic, Hernia) Max	Schedule up to $1,250 Hernia: $250
Surgery (Exploratory or Arthroscopic)	$400
Tendon/Ligament/Rotator Cuff	1: $500 2 or more: $1,000
Transportation - Benefit is paid if you have to travel more than 50 miles one way to receive special treatment at a hospital or facility due to a covered accident.	$0.50 per mile, limited to $500/round trip, up to 3 times per accident
Traumatic Brain Injury — A nondegenerative, noncongenital Injury to the brain from an external nonbiological force, requiring Hospital Confinement for 48 hours or more and resulting in a permanent neurological deficit with significant loss of muscle function and persistent clinical symptoms.	$4,000

Guardian

Your accident coverage

FEATURES (Cont.)	
X - Ray	$40

UNDERSTANDING YOUR BENEFITS:

- **Common Carrier** – Benefit is paid if an insured's death occurs due to an accident while riding as a fare-paying passanger in a public conveyance. If this is paid, we do not pay the Accidental Death benefit.
- **Common Disaster** – Benefit is paid if both you & your spouse die in a covered accident or separate covered accidents within the same 24 hour period.
- **Reasonable Accomodation** – Benefit is payable if a modification is required to an insured's place of residence or vehicle due to an Accidental Dismemberment or Catastrophic loss.
- **Emergency Room Treatment** – Benefit is paid only when an insured is examined or treated within 72 hours of a covered accident.
- **Rainy Day Fund** – Can pay benefits when a claimant has exhausted a frequency limitation that applies to a particular benefit. Rainy Day Fund will apply to the following benefits Air Ambulance, Ambulance, Blood/Plasma/Platelets, Chiropractic visits, Diagnostic Exam (Major), Doctor Follow-Up visits, Emergency Dental Work, Epidural Anesthesia Pain Management, Eye Injury, Family Care, Fractures, Gun Shot Wound, Hospital Confinement, Hospital ICU Confinement, Joint Replacement, Knee Cartilage, Lodging, Outpatient Therapies, Rehabilitation Unit Confinement, Ruptured Disc with Surgical Repair, Surgery (Cranial, Open Abdominal, Thoracic, Hernia), Surgery (Exploratory and Arthroscopic), Transportation and X-Ray, if they are included on your plan.

LIMITATIONS AND EXCLUSIONS:

A SUMMARY OF ACCIDENT LIMITATIONS AND EXCLUSIONS:

Employees must be working in the United States in order to be eligible for coverage. Underwriting must approve coverage for employees on temporary assignment: (a) exceeding 1 year; or (b) in an area under travel warning by the US Department of State, subject to state specific variations.

This proposal summarizes the major features of the Guardian Accident benefit plan. It is not intended to be a complete representation of the proposed plan. For full plan features, including exclusions and limitations, please refer to your Policy.

This proposal is hedged subject to satisfactory financial evaluation.

We don't pay benefits for any Injury caused by or related to directly or indirectly: Sickness, disease, mental infirmity or medical or surgical treatment; the covered person being legally intoxicated; declared or undeclared war, act of war, or armed aggression; service in the armed forces, National Guard, or military reserves of any state or country; taking part in a riot or civil disorder; commission of, or attempt to commit a felony; intentionally self-inflicted Injury, while sane or insane; suicide or attempted suicide, while sane or insane; travel or flight in any kind of aircraft, including any aircraft owned by or for the policyholder, except as a fare-paying passenger on a common carrier; participation in any kind of sporting activity for compensation or profit, including coaching or officiating; riding in or driving any motor-driven vehicle in a race, stunt show or speed test; participation in hang gliding, bungee jumping, sail gliding, parasailing, parakiting, ballooning, parachuting, zorbing or skydiving; an accident that occurred before the covered person is covered by this plan; injuries to a dependent child received during birth; voluntary use of any poison, chemical, prescription or non-prescription drug or controlled substance unless: (1) it was prescribed for a covered person by a doctor, and (2) it was used as prescribed. In the case of a non-prescription drug, this Plan does not pay for any Accident resulting from or contributed to by use in a manner inconsistent with package instructions. "Controlled substance" means anything called a controlled substance in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended from time to time. Job related or on the job injuries for the employee are excluded if Accident coverage is off job only.

Contract # GP-1-ACC-18

If Accident insurance premium is paid for on a pre tax basis, the benefit may be taxable. Please contact your tax or legal advisor regarding the tax treatment of your policy benefits.

Guardian®

CRITICAL ILLNESS INSURANCE

GUARDIAN

Critical illness insurance

Critical illness insurance may help you cover expenses not covered by your health insurance.

It's a cash payment you receive if you ever experience a serious illness like cancer, a heart attack, or a stroke, giving you the financial support to focus on recovery.

Who is it for?

Critical illness insurance is a supplemental policy for people who already have health insurance. It provides you with an additional payment to cover expenses like deductibles, treatments, and living costs.

What does it cover?

Critical illnesses include strokes, heart attacks, Parkinson's disease and cancer. Our policies can cover over 30 major illnesses, helping you stay financially stable by paying you a lump sum if you're diagnosed with one of them.

Why should I consider it?

Health coverage is becoming more expensive, with higher co-pays, premiums, and deductibles. Critical illness insurance is an affordable way to supplement and pay for additional expenses that your health insurance doesn't cover. Our policies typically provide payments for the first and second time you're diagnosed with a covered illness.

Plus, critical illness insurance is portable and payments are made directly to you.

You will receive these benefits if you meet the conditions listed in the policy.

Watch our video
How critical illness insurance helps cover the costs of treatment.

Please log in to www.employeenavigator.com to download the claim form.

Critical costs

John is hospitalized after a heart attack, and has to cover the cost of five days as an inpatient.

Average heart attack hospitalization expense: **$53,000**

Average Major Medical deductible: **$1,500**

Major Medical covers 80% of the cost after the deductible is met, but John's still responsible for 20%: **$10,300**.

Total out-of-pocket amount for John (deductible + coinsurance): **$11,800**.

John has a **$10,000** Guardian Critical Illness policy, which covers the majority of these out-of-pocket expenses.

This example is for illustrative purposes only. Your plan's coverage may vary. See your plan's information on the following pages for specific amounts and details.

Guardian

Your critical illness coverage

	CRITICAL ILLNESS	
Benefit Amount(s)	Employee may choose a lump sum benefit of $5,000 to $30,000 in $5,000 increments.	
CONDITIONS		
Cancer	**1st OCCURRENCE**	**2nd OCCURRENCE**
Invasive Cancer	100%	50%
Carcinoma In Situ	30%	0%
Benign Brain Tumor	75%	0%
Skin Cancer	$250 per lifetime	Not Covered
Vascular		
Heart Attack	100%	50%
Stroke	100%	50%
Heart Failure	100%	50%
Coronary Arteriosclerosis	30%	0%
Other		
Organ Failure	100%	50%
Kidney Failure	100%	50%
ADDITIONAL CONDITIONS	**1st OCCURRENCE ONLY**	
Addison's Disease	30%	
ALS (Lou Gehrig's Disease)	100%	
Alzheimer's Disease	50%	
Coma	100%	
Huntington's Disease	30%	
Loss of Hearing	100%	
Loss of Sight	100%	
Loss of Speech	100%	
Multiple Sclerosis	30%	
Parkinson's Disease	100%	
Permanent Paralysis	50% for 1 limb, 100% for 2 limbs	
Severe Burns	100%	
Childhood Conditions	**1st OCCURRENCE ONLY**	
Cerebral Palsy	100%	
Cleft Lip/Palate	100%	
Club Foot	100%	
Cystic Fibrosis	100%	
Down's Syndrome	100%	
Muscular Dystrophy	100%	
Spina Bifida	100%	
Type 1 Diabetes	100%	

Your critical illness coverage

	CRITICAL ILLNESS
Spouse/Domestic Partner Benefit	May choose a lump sum benefit of $2,500 to $15,000 in $2,500 increments up to 50% of the employee's lump sum benefit.
Child Benefit- children age Birth to 26 years	25% of employee's lump sum benefit
Benefit Reductions: Benefits are reduced by a certain percentage as an employee ages	50% at age 70
Guarantee Issue: The 'guarantee' means you are not required to answer health questions to qualify for coverage up to and including the specified amount, when you sign up for coverage during the initial enrollment period.	For a child: All Amounts **Health questions are required if the elected amount exceeds the Guarantee Issue.**
Portability: Allows you to take your Critical Illness coverage with you if you terminate employment.	Included
Pre-Existing Condition Limitation: A pre-existing condition includes any condition for which you, in the specified time period prior to coverage in this plan, consulted with a physician, received treatment, or took prescribed drugs.	12 months prior, 12 months after
Cancer Vaccine Benefit	$50 per lifetime for receiving a cancer vaccine

Condition Definitions

- Stroke: Stroke must be severe enough to cause neurological deficits at least 30 days after the event.
- Heart Failure: An insured must be placed on an organ transplant list in order to be eligible for the Heart failure benefits.
- Coronary Arteriosclerosis: Coronary Arteriosclerosis must be severe enough to require a coronary artery bypass graft.
- Organ Failure: Organ failure includes both lungs, liver, pancreas or bone marrow and requires the insured to be placed on an organ transplant list.
- Kidney Failure: An insured must be placed on an organ transplant list in order to be eligible for the Kidney failure benefits.

Critical Illness Cost Illustration

To determine the most appropriate level of coverage, you should consider your current basic monthly expenses and expected financial needs during a Critical Illness.

Spouse/DP coverage premium is based on Employee age

Child cost is included with employee election.

	Bi-weekly Premiums Displayed *Election Cost Per Age Bracket*					
	< 30	*30-39*	*40-49*	*50-59*	*60-69*	*70+†*
Employee						
$5,000	$1.09	$1.78	$3.35	$6.16	$10.87	$18.23
$10,000	$2.17	$3.55	$6.69	$12.32	$21.74	$36.46
$15,000	$3.25	$5.33	$10.04	$18.49	$32.61	$54.69
$20,000	$4.34	$7.11	$13.39	$24.65	$43.48	$72.92
$25,000	$5.42	$8.89	$16.73	$30.81	$54.35	$91.15
$30,000	$6.51	$10.66	$20.08	$36.97	$65.22	$109.39
Benefit Amount Up To 50% of Employee Amount to a Maximum of $15,000						
Spouse						
$2,500	$0.55	$0.89	$1.68	$3.08	$5.44	$9.12
$5,000	$1.09	$1.78	$3.35	$6.16	$10.87	$18.23
$7,500	$1.63	$2.67	$5.02	$9.24	$16.31	$27.35
$10,000	$2.17	$3.55	$6.69	$12.32	$21.74	$36.46
$12,500	$2.71	$4.45	$8.37	$15.41	$27.18	$45.58
$15,000	$3.25	$5.33	$10.04	$18.49	$32.61	$54.69

†Benefit reductions may apply. See plan details.

EXCLUSIONS AND LIMITATIONS

A SUMMARY OF PLAN LIMITATIONS AND EXCLUSIONS FOR CRITICAL ILLNESS:

We will not pay benefits for the First Occurrence of a Critical Illness if it occurs less than 3 months after the First Occurrence of a related Critical Illness for which this Plan paid benefits. By related we mean either: (a) both Critical Illnesses are contained within the Cancer Related Conditions category; or (b) both Critical Illnesses are contained within the Vascular Conditions category. We will not pay benefits for a Second occurrence (recurrence) of a Critical Illness unless the Covered Person has not exhibited symptoms or received care or treatment for that Critical Illness for at least 12 months in a row prior to the recurrence. For purposes of this exclusion, care or treatment does not include: (1) preventive medications in the absence of disease; and (2) routine scheduled follow-up visits to a Doctor.

We do not pay benefits for claims relating to a covered person: taking part in any war or act of war (including service in the armed forces) committing a felony or taking part in any riot or other civil disorder or intentionally injuring themselves or attempting suicide while sane or insane.

Employees must be legally working in the United States in order to be eligible for coverage. Underwriting must approve coverage for employees on temporary assignment: (a) exceeding 1 year; or (b) in an area under travel warning by the US Department of State, subject to state specific variations.

If the plan is new (not transferred): During the exclusion period, this Critical Illness plan does not pay charges relating to a pre-existing condition. If this plan is transferred from another insurance carrier, the time an insured is covered under that plan will count toward satisfying Guardian's pre-existing condition limitation period. A pre-existing condition includes any condition for which an employee, in a specified time period prior to coverage in this plan, consults with a physician, receives treatment, or takes prescribed drugs. Please refer to the plan documents for specific time periods. State variations may apply.

Guardian's Critical Illness plan does not provide comprehensive medical coverage. It is a basic or limited benefit and is not intended to cover all medical expenses. It does not provide "basic hospital," "basic medical," or " medical" insurance as defined by the New York State Insurance Department.

Health questions are required on late enrollees. This coverage will not be effective until approved by a Guardian underwriter.

This policy will not pay for a diagnosis of a listed critical illness that is made before the insured's Critical Illness effective date with Guardian.

The policy has exclusions and limitations that may impact the eligibility for or entitlement to benefits under each covered condition. See your certificate booklet for a full listing of exclusions & limitations..

If Critical Illness insurance premium is paid for on a pre tax basis, the benefit may be taxable. Please contact your tax or legal advisor regarding the tax treatment of your policy benefits..

Contract # GP-1-CI-14

Guardian's Critical Illness Insurance is underwritten and issued by The Guardian Life Insurance Company of America, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage. This policy provides limited benefits health insurance only. It does not provide basic hospital, basic medical or major medical insurance as defined by the New York State Department of Financial Services.
Policy Form # GP-1-LAH-12R; GP-1-CI-14

Guardian

CANCER INSURANCE

GUARDIAN

Cancer insurance

If you're diagnosed with cancer, the last thing you need to think about is the cost. Cancer insurance helps ease the financial burden.

Every year, more and more people are diagnosed with cancer. Unfortunately, in addition to bearing the physical and emotional toll of this disease, patients are often saddled with added financial expenses.

Who is it for?

Cancer insurance is for people who want added financial protection, in addition to their regular health insurance. It comes into play if you are diagnosed with cancer—providing additional financial support to help keep the focus on your cancer treatment and recovery.

What does it cover?

Cancer insurance benefits can help you handle medical plan deductibles, co-pays and other out-of-pocket costs by providing benefits when you receive radiation or chemotherapy treatment, or are hospitalized for surgery to treat cancer. These benefits can be used for non-medical expenses such as transportation to treatment facilities, and even everyday living expenses like groceries, rent, and mortgage payments.

Why should I consider it?

Health coverage may become more expensive, with higher co-pays, premiums, and deductibles. The unexpected out-of-pocket expenses of cancer recovery, including transportation, co-pays, and deductibles, can add up fast. What's more, some of the costs you may incur during recovery are non-medical, such as covering a mortgage, childcare, and household expenses. Cancer insurance can help you pay for all of them.

Plus, cancer insurance is portable and payments are made directly to you.

You will receive these benefits if you meet the conditions listed in the policy.

Watch our video
How cancer insurance can ease the financial burden of a cancer diagnosis.

Please log in to www.employeenavigator.com to download the claim form.

Extra support

Sarah's diagnosed with kidney cancer after a screening test and decides to undergo kidney removal surgery.

Average surgical expense: **$25,000**

Average Major Medical deductible: **$1,500**

Major Medical covers 80% of the surgical cost after the deductible is met, but Sarah's still responsible for 20%: **$4,700**

Total out-of-pocket amount for Sarah (deductible + coinsurance): **$6,200**

Sarah has Guardian's Cancer Advantage policy, which pays her **$2,500** as an initial diagnosis benefit and **$2,100** for a 7-day hospital stay.

This gives her a total of **$4,600** to help cover a portion of her out-of-pocket amount.

This example is for illustrative purposes only. Your plan's coverage may vary. See your plan's information on the following pages for specific amounts and details.

Guardian

Your cancer coverage

	CANCER
COVERAGE - DETAILS	
CANCER SCREENING	
Benefit Amount	$50; $50 for Follow-Up screening
RADIATION THERAPY OR CHEMOTHERAPY	
Benefit	Schedule amounts up to a $5,000 benefit year maximum.
Pre-Existing Conditions Limitation: A pre-existing condition includes any condition for which you, in the specified time period prior to coverage in this plan, consulted with a physician, received treatment, or took prescribed drugs.	12 month look back period, 12 month exclusion period.
Portability: Allows you to take your Cancer coverage with you if you terminate employment. Ported Cancer plan terminates at age 70.	Included
Child(ren) Age Limits	Children age birth to 26 years
FEATURES	
Air Ambulance	$250/trip, limit 2 trips per hospital confinement
Ambulance	$200/trip, limit 2 trips per hospital confinement
Anesthesia	25% of surgery benefit
Attending Physician	$25/day while hospital confined. Limit 75 visits.
Blood/Plasma/Platelets	$50/day up to $5,000 per year
Extended Care Facility/Skilled Nursing care	$100/day up to 90 days per year
Hormone Therapy	$25/treatment up to 12 treatments per year
Hospice	$50/day up to 100 days/lifetime
Hospital Confinement	$300/day for first 30 days; $600/day for 31st day thereafter per confinement
ICU Confinement	$400/day for first 30 days; $600/day for 31st day thereafter per confinement
Immunotherapy	$500 per month, $2,500 lifetime max
Prosthetic	Surgically Implanted: $2,000/device, $4,000 lifetime max Non-Surgically: $200/device, $400 lifetime max
Second Surgical Opinion	$200/surgical procedure
Skin Cancer	Biopsy Only: $100 Reconstructive Surgery: $250 Excision of a skin cancer: $375 Excision of a skin cancer with flap or graft: $600
Surgical Benefit	Schedule amount up to $2,750
Waiver of Premium - If you become disabled due to cancer that is diagnosed after the employee's effective date, and you remain disabled for 90 days, we will waive the premium due after such 90 days for as long as you remain disabled.	Included

Guardian

Your cancer coverage

Your Bi-weekly premium		
You	<30	$1.15
	30-39	$2.11
	40-49	$4.46
	50-59	$8.29
	60-64	$13.36
	65+	$19.71
You and Spouse	<30	$2.17
	30-39	$3.89
	40-49	$8.31
	50-59	$16.43
	60-64	$27.66
	65+	$42.27
You and Child(ren)	<30	$2.36
	30-39	$3.32
	40-49	$5.67
	50-59	$9.50
	60-64	$14.57
	65+	$20.92
You, Spouse and Child(ren)	<30	$3.37
	30-39	$5.10
	40-49	$9.51
	50-59	$17.63
	60-64	$28.87
	65+	$43.47

UNDERSTANDING YOUR BENEFITS :

- **Cancer** – Cancer means you have been diagnosed with a disease manifested by the presence of a malignant tumor characterized by the uncontrolled growth and spread of malignant cells in any part of the body. This includes leukemia, Hodgkin's disease, lymphoma, sarcoma, malignant tumors and melanoma. Cancer includes carcinomas in-situ (in the natural or normal place, confined to the site of origin, without having invaded neighboring tissue). Pre-malignant conditions or conditions with malignant potential, such as myelodyplastic and myeloproliferative disorders, carcinoid, leukoplakia, hyperplasia, actinic keratosis, polycythemia, and nonmalignant melanoma, moles or similar diseases or lesions will not be considered cancer. Cancer must be diagnosed while insured under the Guardian cancer plan.

LIMITATIONS AND EXCLUSIONS:

A SUMMARY OF CANCER LIMITATIONS AND EXCLUSIONS:

Conditional Issue underwriting is required on those enrolling outside of the initial enrollment period or annual open enrollment period.

This plan will not pay benefits for: Services or treatment not included in the Features. Services or treatment provided by a family member. Services or treatment rendered for hospital confinement outside the United States. Any cancer diagnosed solely outside of the United States. Services or treatment provided primarily for cosmetic purposes. Services or treatment for premalignant conditions. Services or treatment for conditions with malignant potential. Services or treatment for non-cancer sicknesses.

Cancer caused by, contributed to by, or resulting from: participating in a felony, riot or insurrection; intentionally causing a self-inflicted injury; committing or attempting to commit suicide while sane or insane; a covered person's mental or emotional disorder, alcoholism or drug addiction; engaging in any illegal activity; or serving in the armed forces or any auxiliary unit of the armed forces of any country.

If Cancer insurance premium is paid for on a pre tax basis, the benefit may be taxable. Please contact your tax or legal advisor regarding the tax treatment of your policy benefits.

Contract # GP-1-CAN-IC-12

Guardian

HOSPITAL INDEMNITY

GUARDIAN

Hospital indemnity insurance

Hospital indemnity insurance can cover some of the cost associated with a hospital stay, letting you focus on recovery.

Being hospitalized for illness or injury can happen to anyone, at any time. While medical insurance may cover hospital bills, it may not cover all the costs associated with a hospital stay. That's where hospital indemnity coverage can help.

Who is it for?

Hospital indemnity insurance is for people who need help covering the costs associated with a hospital stay if they suddenly become sick or injured.

What does it cover?

If you are admitted to a hospital for a covered sickness or injury, you'll receive payments that can be used to cover all sorts of costs, including:

- Deductibles and co-pays.
- Travel to and from the hospital for treatment.
- Childcare service assistance while recovering.

Why should I consider it?

Health coverage is becoming more expensive, with higher co-pays, premiums, and deductibles. Hospital indemnity insurance can help pay for out-of-pocket costs associated with being hospitalized, giving you more of a financial safety net for unplanned expenses brought on by a hospital stay.

Plus, hospital indemnity insurance is portable and payments are made directly to you – even if you didn't incur any out-of-pocket expenses.

You will receive these benefits if you meet the conditions listed in the policy.

Watch our video
How hospital indemnity insurance can give you a comfortable stay.

Please log in to www.employeenavigator.com to download the claim form.

Be prepared

John is hospitalized after a heart attack, and has to cover the cost of five days as an inpatient.

Average heart attack hospitalization expense: **$53,000**

Average Major Medical deductible: **$1,500**

Major Medical covers 80% of the cost after the deductible is met, but John's still responsible for 20%: **$10,300**.

Total out-of-pocket amount for John (deductible + coinsurance): **$11,800**.

John's Guardian Hospital Indemnity policy pays him **$1,000** for hospital admission.

The policy gives him a total payment of **$1,000** to help cover the out-of-pocket amount.

This example is for illustrative purposes only. Your plan's coverage may vary. See your plan's information on the following pages for specific amounts and details.

Guardian

Your hospital indemnity coverage

	Hospital Indemnity	
	Option 1	
Benefits		
Hospital/ICU Admission	$1,000 per admission, limited to 1 admission(s) per insured and 3 admission(s) per covered family per benefit year.	
Pre-Existing Conditions Limitation - A pre-existing condition includes any condition for which you, in the specified time period prior to coverage in this plan, consulted with a physician, received treatment, or took prescribed drugs.	3 months prior, 12 months after	
Portability - Allows you to take your Hospital Indemnity coverage with you if you terminate employment.	Included	
Child(ren) Age Limits	Children age birth to 26 years	
Coverage Details		
Your Bi-weekly premium		
You	<50 50-59 60-64 65-69	$7.25 $6.73 $10.04 $18.32
You and Spouse/Domestic Partner	<50 50-59 60-64 65-69	$13.03 $13.59 $20.99 $39.30
You and Child(ren)	<50 50-59 60-64 65-69	$11.70 $11.06 $14.37 $22.95
You, Spouse/Domestic Partner and Child(ren)	<50 50-59 60-64 65-69	$17.70 $17.91 $25.32 $43.63
Applicants over the age of 69 are not eligible to enroll in the Hospital Indemnity coverage.		
Spouse rate is based on employee's age bracket.		

UNDERSTANDING YOUR BENEFITS – HOSPITAL INDEMNITY

Hospital Admission & Hospital ICU Admission benefits are not payable on the same day.

Premium will be waived if you are hospitalized for more than 30 days.

Hospital admission or confinement benefits are not payable for a newborn unless the child is admitted to the Neonatal ICU.

After initial enrollment, Hospital Indemnity coverage will continue as long as an insured is actively at work.

Guardian

Your hospital indemnity coverage

LIMITATIONS AND EXCLUSIONS:

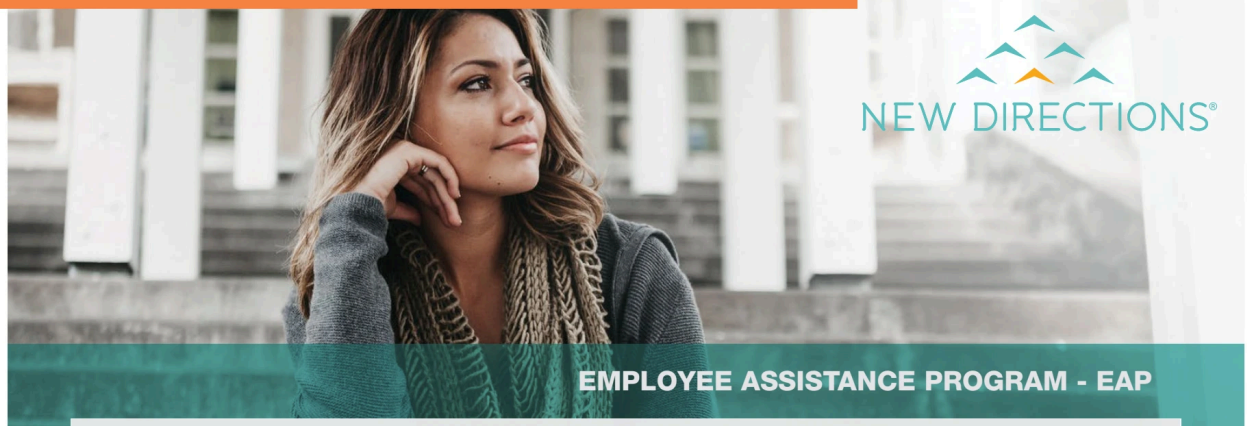
In order to be eligible for coverage: Employees must be legally working: (a) in the United States or (b) outside the United States, for a US based employer, in a country or region approved by Guardian.
An applicant must enroll within 31 days of the coverage effective date. An open enrollment will occur each year during a 30 day time period specified by the policyholder. If an applicant does not enroll during their initial enrollment period, he/she may not enroll until the next open enrollment period.
This Plan will not pay benefits for:
• Treatment relating to a covered person: taking part in any war or act of war (including service in the armed forces), commission of or attempt to commit a felony, an act of terrorism, or participating in an illegal occupation, riot or insurrection.
.• Suicide or any intentionally self-inflicted injury
Elective surgery;
Surgery to correct vision or hearing, unless medically necessary surgery for glaucoma, cataracts or other sickness or injury;
Dental care, dental xrays, or dental treatment;
Gastric or intestinal bypass services including lap banding, gastric stapling, and other similar procedures to facilitate weight loss; the reversal, or revision of such procedures; or services required for the treatment of complications from such procedures. This exclusion does not apply to completion of a weight reduction program that may be payable under the Health Screening benefit ;
Rest cures or custodial care, or treatment of sleep disorders;
Cosmetic surgery. This Exclusion does not apply to reconstructive surgery:
(a) on an injured part of the body following infection or disease of the involved part;
(b) of a congenital disease or anomaly of a covered dependent newborn or adopted infant; or
(c) on a nondiseased breast to restore and achieve symmetry between two breasts following a covered Mastectomy;
Treatment or removal of warts, moles, boils, skin blemishes or birthmarks, bunions, acne, corns, calluses, the cutting and trimming of toenails, care for flat feet, fallen arches or chronic foot strain;
Service, treatment or loss related to alcoholism or drug addiction, except for drugs prescribed by the Covered Person's Doctor and taken as prescribed;
Care or treatment for mental or nervous disorders;
Services, treatment or loss rendered in any Veterans Administration or Federal Hospital, except if there is a legal obligation to pay;
Services or treatment Provided by a Doctor, Nurse or any other person who is employed or retained by a Covered Person or who is a Covered Person's Spouse, parent, brother, sister, child, Domestic Partner or partner in a civil union.
Surgery and treatment, procedures, products or services that are experimental or investigative.

Treatment of a Covered Dependent Child's Children;

Sickness or Injury sustained while on active duty in the armed forces of any country. This does not include Reserve or National Guard duty for training.

GP-1-HI-15

EMPLOYEE ASSISTANCE PROGRAM (EAP)



NEW DIRECTIONS®

EMPLOYEE ASSISTANCE PROGRAM - EAP

When life's a little much,
your EAP has you covered.

Life can be challenging. When your responsibilities start to feel overwhelming and showing up each day seems difficult, it's important to reach out for help. You can lean on your confidential Employee Assistance Program (EAP) for support.

Real support for real life.

A no-cost-to-you benefit from your workplace, your EAP can help you or anyone in your household:

- Receive support when you don't feel like yourself
- Get help with responsibilities that are distracting or stressful
- Improve personal relationships
- Receive care after a traumatic event or diagnosis
- Make healthy lifestyle choices
- Improve and inspire daily life
- Be more present and productive at work
- Grow personal and career skills
- With legal advice or questions
- Assistance with budget or financial concerns

We're always here for you.

Life happens regardless of day or time. We are available 24 hours a day, 365 days a year. Whenever you need to reach out, we are here for you.

Your EAP can help you:

Reduce stress | Cope after crisis | Focus at work | Lead others
Navigate the legal system | Reduce debt | Live a healthier life
Support and improve relationships | Be resilient

How to reach your EAP

Support Line
800-624-5544

Online
eap.ndbh.com

Mobile app
Search for
New Directions
EAP

EAP services are 100% confidential and no-cost to you.

eap.ndbh.com
Code: TPS
800-624-5544

> “EAP has been beneficial in so many ways I don’t know how I would have gotten through without it.”

Download our app.

Search for **New Directions EAP** in your app store.

Available on Google Play | Available on the App Store

Whatever life throws your way, we’re here to help.

Stress, relationships, work and money. These are the most common reasons people reach out to EAP every year. No matter what issues you’re facing, EAP is the perfect first step for you or your household members.

Counseling

Depending on your situation, your preference for help may change. That’s why we offer several different ways for you to get what you need. Counseling is available in a variety of ways:

- Face-to-face
- Online
- Over the phone
- In-the-moment

Legal and financial resources

Navigating finances and/or the legal system can be overwhelming and confusing. Luckily, your EAP can help with services like:

- A no-cost-to-you, 30-minute consultation with a certified financial expert or attorney
- Online tools including budget templates, financial calculators, tax preparation documents, will builder, business agreements and other legal documents
- Emotional support and referrals to help you better manage your legal and financial challenges

Work/Life

Work/Life services can help you tackle your to-do list with specialists who can locate providers, get referrals and find resources for almost anything you and your household needs. You have free access to:

- Personalized consultation with a highly-trained specialist over the phone or through online chat
- Referrals to local providers and resources
- Tip sheets, checklists and other helpful tools

Work/Life topics may include family and caregiving, education, legal and financial, career and work, and health and wellness.

Coaching

Life coaching services are designed to promote self-awareness, clarify visions, values, intentions and goals. This service builds on strengths that you already have to help you set and achieve your goals. With coaching you can:

- Schedule telephonic sessions with one of our coaches
- Work with your coach to establish and meet goals
- Identify resources to keep you on track

Coaching topics may include managing stress, work/life balance, time management, personal challenges, setting and organizing priorities.

Online Services

Our comprehensive website, as well as our New Directions EAP mobile app, make it easy to access information regarding EAP benefits and requesting services. The website and app offer:

- Referrals via online intake
- Mental health toolkits
- Monthly live webinars and other training resources
- Substance use resources
- Resource Library includes webinars, calculators, videos, articles and much more.

Take your first step and call today.

eap.ndbh.com
Code: TPS
800-624-5544

EAPM1037-20210915

TRAVEL ASSISTANCE

USAble Life℠

AXA TRAVEL ASSISTANCE PROGRAM

Support before, during, and after travel

Live life. You're covered.®

Congratulations! You and your dependents now have access to the Travel Assistance Program provided by AXA Assistance USA, Inc. This program offers you a broad range of valuable travel and medical support services **24 hours a day, 365 days a year**. With one simple phone call to our response center, you will be connected to a global network of providers to assist you when you travel 100 miles or more from home.

Travel assistance services

- **Travel assistance**
  - Lost document and luggage assistance
  - Emergency cash/bail assistance
  - Emergency message transmission
  - Telephone interpretation
  - Legal referrals
  - Pre-trip and cultural information
  - Vaccination recommendations
  - General travel information
  - Vehicle return[1]

Medical assistance services

- **Medical transportation assistance**[1]
  - Emergency medical evacuation
  - Medical repatriation
  - Return of mortal remains
  - Return of traveling companion
  - Visit of a family member or friend
  - Return of minor children
  - Dispatch of physician
- **Medical assistance**
  - Medical and dental referrals
  - Coordination of hospital admission
  - Critical care monitoring
  - Dispatch of prescription medication

AXA

Do you need assistance?

If you have any questions about the services or require assistance, please contact us at:

1 (866) 384.2786 OR +1 (630) 616.4536 (collect) OR medassist-usa@axa-assistance.us

Just a phone call away

Travel information and medical assistance services can be accessed worldwide **24 hours a day, 7 days a week, 365 days a year**.

Travel web portal

Our web portal, WebCorp, offers travel information at your fingertips. Information available includes practical travel information, medical and security alerts, and our global medical provider search tool to help you before, during, and after your trip. Use the credentials below to log in today. Visit **https://webcorpsf.secure.force.com:**

- **Username: travel@usablelife.com**
- **Password: LIFE#**

AXA

USAble Life℠

TRAVEL ASSISTANCE PROGRAM

Carry this card with you when you travel.

DID: 630.616.4536 | TFN: 866.384.2786

CALL AXA ASSISTANCE IF YOU REQUIRE:

- Medical and dental referrals
- Medical evacuation or repatriation
- Hospital admission and critical care monitoring
- Return of mortal remains
- Dispatch of prescription medication
- Lost document and luggage assistance
- Emergency cash and bail assistance
- General travel information

This is not a medical insurance card. All services must be authorized and provided by AXA Assistance USA, Inc. No reimbursements will be accepted.

Program guidelines

Services will not be provided or available for any loss or injury that is caused by, or a result of:

- A mental nervous condition or diagnosis
- Traveling against the advice of a physician
- Traveling for medical treatment
- Pregnancy and childbirth (exception: complications of pregnancy) or voluntary-induced abortion

[1]***Program Terms:*** *When traveling 100 miles or more away from home for up to 120 days, medical emergency transportation services include the arrangement and payment for any reasonable and customary charges determined by AXA Assistance USA, Inc. Vehicle return service is applicable upon activation of medical emergency transportation.*

No reimbursements for out-of-pocket expenses will be accepted.

All additional costs are the responsibility of the member. Services will be provided as permitted under applicable law. Services must be authorized and arranged by AXA Assistance. Travel assistance services are not insurance.

AXA

USAble Life℠

THE DIGNITY PLANNER™

FUNERAL PLANNING MADE PERSONAL

The Dignity Planner allows you to create a personalized funeral plan for yourself or a loved one. We all have unique passions and personal stories, and whether you're planning a memorial for yourself or for a loved one, The Dignity Planner allows you to create a plan simply by answering a few questions. Dignity will take care of the rest of the details.

THE DIGNITY PLANNER:

- allows you to choose a location for your memorial and specify your desire for burial, cremation, memorial services, charitable donations, flowers, obituaries and death notices...you can build a complete plan.
- is part of The Dignity Memorial Network of funeral homes and cemetery providers.
- allows you to save or share your plan once it's complete. You can also update your plan at any time.

When you preplan your funeral and cemetery services, you'll help alleviate your family's burden of making difficult decisions at what will be an already difficult time. With your wishes recorded, they won't be left to guess what you would have wanted. Making your final arrangements in advance allows you to influence all elements of your services, including songs, readings or other personal details that are important to you. It's your funeral - it should celebrate your life, your way. By communicating exactly which merchandise and services you want, you can keep your family from purchasing unnecessary additions to your services.

VISIT USABLELIFE.COM/DIGNITYPLANNER TO LEARN MORE.

DIGPLAN-FLY-EE (01-17)

TERMS TO KNOW

SCAN OR CLICK THE QR CODE TO WATCH A SHORT VIDEO ON THE TERM YOU WOULD LIKE TO KNOW

AD&D: Accidental Death & Dismemberment

ANNUAL ENROLLMENT: Designated period of time during which an employee may enroll in group health coverage. Also, designated period of time during the year when individuals without group coverage may enroll in health coverage without needing medical underwriting.

CARRIER: The insurance company.

CLAIM: The request for payment for benefits received in accordance with an insurance policy.

COINSURANCE: A payment made by the covered person in addition to the payment made by the health plan on covered charges, shared on a percentage basis. For example, the health plan may pay 80% of the allowable charge, with the covered person responsible for the remaining 20%. The 20% amount is then referred to as the coinsurance amount.

COPAY: A co-payment, or copay, is a capped contribution defined in the policy and paid by an insured person each time a medical service is accessed. It must be paid before any policy benefit is payable by an insurance company.

CREDITABLE: Is the prescription drug coverage offered by an employer plan that pays, on average, the same amount as Medicare pays.

DEDUCTIBLE: A deductible is the amount you must pay each year before your carrier begins to pay for services. If you have a PPO plan, there is usually a separate higher deductible for using out of network providers.

ELIMINATION PERIOD: This is the time period between injury or illness and the receipt of benefit payments.

EMBEDDED DEDUCTIBLE: An embedded deductible is a system that combines individual and family deductibles in a family health insurance policy. When a health plan has embedded deductibles, it just means that a single member of a family doesn't have to meet the full family deductible in order for after-deductible benefits to kick in, each individual only needs to meet the individual deductible in order for after-deductible benefits to kick in.

EOB (Explanation of Benefits): EOB stands for Explanation of Benefits. This is a document produced by your medical insurance carrier that explains their response and action (whether it is payment, denial, or pending) to a medical claim processed on your behalf.

EVIDENCE OF INSURABILITY (EOI): This is the medical information you must provide that requires review and approval by the insurance company BEFORE coverage becomes effective. This may include medical records and a physical exam.

HMO: Health Maintenance Organization, this type of medical plan is Network exclusive. A participant must receive services from in-network providers except in a case of medical emergency.

IN-NETWORK: Refers to the use of providers who participate in the health plan's provider network. Many benefit plans encourage members to use participating in-network providers to reduce out-of-pocket expenses.

MAC: Maximum allowable charge

MAIL ORDER PRESCRIPTIONS: Used for maintenance drugs, members can order and refill their prescriptions via postal mail, Internet, fax, or telephone. Once filled, the prescriptions are mailed directly to the member's home.

MAINTENANCE DRUGS: A medication that is anticipated to be taken regularly for several months to treat a chronic condition such as diabetes, high blood pressure and asthma, this also includes birth control.

NON-EMBEDDED DEDUCTIBLE: A non-embedded deductible is also referred to as an aggregate deductible. Under an aggregate deductible, the total family deductible must be paid out-of-pocket before after-deductible benefits kick in for the health care services incurred by any family member.

OUT-OF-NETWORK: The use of health care providers who have not contracted with the health plan to provide services. HMO members are generally not covered for out-of-network services except in emergency situations. Members enrolled in Preferred Provider Organizations (PPO) and Point-of-Service (POS) coverage can go out-of-network, but will pay higher out-of-pocket costs.

OUT-OF-POCKET MAXIMUM: The total amount a covered person must pay before his or her benefits are paid at 100%. Deductible, copayments, and coinsurance may apply towards the maximum out of pocket, depending on the plan.

PARTICIPATING PROVIDER: Individual physicians, hospitals and professional health care providers who have a contract to provide services to its members at a discounted rate and to be paid directly for covered services.

PCP (PRIMARY CARE PHYSICIAN): A physician selected by the member, who is part of the plan network, who provides routine care and coordinates other specialized care. The PCP should be selected from the network that corresponds to the plan in which you are a member. The physician you choose as your PCP may be a family or general practitioner, internist, gynecologist or pediatrician.

PPO: Benefits paid for both in and out of a network of doctors. Member makes choice with knowledge that better benefits are available in network. Plans feature office visit copays, deductibles at a variety of levels and then coinsurance to a maximum out of pocket expense. Usually includes copays for prescription drugs.

PREVENTIVE CARE: Care rendered by a physician to promote health and prevent future health problems for a member who does not exhibit any symptoms. Examples are routine physical examinations and immunizations.

REFERRAL: A written recommendation by a physician that a member may receive care from a specialty physician or facility.

SPECIALIST: A participating physician who provides non-routine care, such as a dermatologist or orthopedist.

UCR: Usual, customary, reasonable

MANDATORY NOTICES

IMPORTANT NOTICE ABOUT THIS GUIDE AND THE LEGISLATIVE NOTICES INCLUDED

A Plan Sponsor's responsibilities include making sure the health plan complies with ERISA, ACA and other federal and state regulations. Various federal notices are set forth below. Even if employers use third-party service providers to manage the plan, there are still certain functions that may make the employer responsible as a fiduciary. Plan Sponsors are recommended to maintain comprehensive record-keeping documents for up to seven years.

Insurance Office of America does not intend for you to use this guide as a substitute for legal counsel. Should you have any questions or concerns, you should contact your legal counsel for further guidance on all matters pertaining to compliance. Importantly, since this information is intended as a brief overview, please refer to the applicable federal regulations for more specific and detailed information. In addition, please note that States may have additional laws, restrictions and benefits that are more protective of individuals. You should always consult your State's benefits and insurance laws for further guidance.

Important Notice:
Medicare Part D Creditable Coverage Disclosure

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. **Therapy Partner Solutions Holdings, LLC** has determined that the prescription drug coverage offered by the **Base 4000; HSA 3500; Buy Up 2500 plan** is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your group plan coverage as an employee, or dependent or spouse of an active employee will not be affected. There is coordination of benefits and Medicare will be your primary coverage and the group plan will become your secondary coverage. However, if you drop current coverage under the group plan and enroll in a Medicare prescription drug plan, you will not be able to re-enroll for medical and prescription drug coverage until the next annual enrollment period, or upon a qualifying life event for which enrollment is permitted, if earlier (and only if you are eligible for coverage at the time your reenrollment would be effective). In addition, your current coverage pays for medical expenses, in addition to prescription drugs, and if you choose to drop prescription drug coverage, you must also drop your medical coverage as well.

If you (or a dependent/spouse) are covered under the group plan through COBRA and later are covered by Medicare, the medical and prescription drug coverage under the group plan will be cancelled, if permitted by law. Once you cease to be covered under COBRA, you may not reinstate your COBRA coverage under the group plan.

Therefore, before deciding whether to join a Medicare drug plan, you should carefully compare your current coverage, including which drugs are covered, with the coverage and cost of the Medicare drug plans in your area. Please refer to group plan's summary plan description for information about coverage, how the group plan coordinates with Medicare and when coverage terminates under the group plan.

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 under the group plan and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

Important Notice:
Medicare Part D Creditable Coverage Disclosure

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 your Human Resources for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if the group plan coverage changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

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

For more information about Medicare prescription drug coverage:

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

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

Contact Human Resources for more information:

Human Resources Department

519 Broad St, Ste 300, Rome, GA 30161

hr@therapypartnersolutions.com

706-397-5429

For questions about Medicare prescription drug coverage, Grace Agency is here to help.

800-791-4840 | info@graceagency.org

Mandatory Notices

HIPAA 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.

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

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

To request special enrollment or obtain more information, please contact Human Resources.

Health Insurance Portability and Accountability Act (HIPAA) Privacy Rights

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that we maintain the privacy of protected health information, give notice of our legal duties and privacy practices regarding health information about you and follow the terms of our notice currently in effect.

If not attached to this document, you may request a copy of the current Privacy Practices, explaining how medical information about you may be used and disclosed and how you can get access to this information.

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

You have the right to inspect and copy, right to an electronic copy of electronic medical records, right to get notice of a breach, right to amend, right to an accounting of disclosures, right to request restrictions, right to request confidential communications, right to a paper copy of this notice and the right to file a complaint if you believe your privacy rights have been violated.

Model General Notice of COBRA Continuation of Coverage Rights

INTRODUCTION

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

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

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

WHAT IS COBRA CONTINUATION COVERAGE?

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

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

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

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

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

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

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

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WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

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

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

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

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

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

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.
There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

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

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

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

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?

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

CAN I ENROLL IN MEDICARE INSTEAD OF COBRA CONTINUATION COVERAGE AFTER MY GROUP HEALTH PLAN COVERAGE ENDS?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit
https://www.medicare.gov/medicare-and-you

IF YOU HAVE QUESTIONS

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

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

To protect your family's rights, let the Plan Administrator know

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about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

PLAN CONTACT INFORMATION

Plan and COBRA continuation coverage can be obtained on request:

Human Resources Department

519 Broad St, Ste 300, Rome, GA 30161

hr@therapypartnersolutions.com

706-397-5429

Health Insurance Marketplace Coverage Options and Your Health Coverage

Beginning in 2014, there is a new way to buy health insurance: 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.

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.
Each year, the open enrollment period for health insurance coverage through the Marketplace runs from Nov. 1 through Dec. 15 of the previous year. After Dec. 15, you can get coverage through the Marketplace only if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP).

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 9.5 percent (as adjusted each year after 2014) 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. (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 percent of such costs.)

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.

For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources.

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, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Women's Health and Cancer Rights Act of 1998

If you are enrolled in a health plan that covers the medical and surgical costs of a mastectomy, the WHCRA states that your plan must also cover the costs of certain reconstructive surgery and other post-mastectomy benefits.

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 (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. Therefore, the deductibles and coinsurance of your enrolled plan will apply.

If you would like more information on WHCRA benefits, contact your plan administrator or Human Resources.

Newborns' and Mothers' Health Protection Act

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).

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Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility (see next page).

State Contacts

ALABAMA – Medicaid

Website: myalhipp.com | Phone: 1-855-692-5447

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program Website: myakhipp.com
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid

Website: myarhipp.com
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid

Website: Health Insurance Premium Payment (HIPP) Program - dhcs.ca.gov/hipp
Phone: 916-445-8322 | Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website: www.healthfirstcolorado.com
Health First Colorado Member Contact Center:
1-800-221-3943/State Relay 711
CHP+: hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI): www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

Website: www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid

GA HIPP Website: medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, Press 2

INDIANA – Medicaid

Health Insurance Premium Payment Program
All other Medicaid
Website: www.in.gov/medicaid
www.in.gov/fssa/dfr
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website:
Iowa Medicaid | Health & Human Services
Medicaid Phone: 1-800-338-8366
Hawki Website: hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki
Hawki Phone: 1-800-257-8563
HIPP Website: hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: www.kancare.ks.gov
Phone: 1-800-792-4884 | HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website: chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or
1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website:
www.mymaineconnection.gov/benefits/s/?language=e n_US
Phone: 1-800-442-6003 TTY: Maine relay 711
Private Health Insurance Premium Webpage:
www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740 | TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: www.mass.gov/masshealth/pa
Phone: 1-800-862-4840 | TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid

Website: mn.gov/dhs/health-care-coverage
Phone: 1-800-657-3672

MISSOURI – Medicaid

Website: www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid

Website:
dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid

Website: www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE - Medicaid

Website: www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

State Contacts

NEW JERSEY - Medicaid and CHIP

Medicaid Website: www.state.nj.us/humanservices/dmahs/clients/medicaid
Phone: 1-800-356-1561
CHIP Premium Assistance Phone: 609-631-2392
CHIP Website: www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710 (TTY: 711)

NEW YORK - Medicaid

Website: www.health.ny.gov/health_care/medicaid
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: medicaid.ncdhhs.gov
Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid

Website: healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid & CHIP

Website: www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP

Website: www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid

Website: www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid

Website: dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid

Website: www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Utah's Premium Partnership for Health Insurance (UPP)
Website: medicaid.utah.gov/upp
Email: upp@utah.gov
Phone: 1-888-222-2542
Adult Expansion Website: medicaid.utah.gov/expansion
Utah Medicaid Buyout Program Website: medicaid.utah.gov/buyout-program CHIP Website: chip.utah.gov

VERMONT– Medicaid

Website: www.greenmountaincare.org
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Website: coverva.dmas.virginia.gov/learn/premium-assistance/famis-select coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid

Website: www.hca.wa.gov
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP

Website: dhhr.wv.gov/bms/Pages/default.aspx mywvhipp.com
Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN - Medicaid and CHIP

Website: www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING - Medicaid

Website: health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2026)

CONTACTS

LINE OF COVERAGE	CARRIER	CUSTOMER SERVICE
Medical	BLUE CROSS BLUE SHIELD	800-830-1501 www.MyHealthToolkitFL.com
Wellness	PERSONIFY HEALTH	www.MyHealthToolkitFL.com
Prescriptions	BLUE CROSS BLUE SHIELD	Download My Rx Toolkit in the App Store
Telehealth	TELADOC	www.MyHealthToolkitFL.com > Providers & Services > Telehealth > Find Care > Video Visit
24-Hour Nurse Advisor	BLUE CROSS BLUE SHIELD	877-836-0701 www.MyHealthToolkitFL.com
Flexible Spending Account (FSA)	CLARITY BENEFIT SOLUTIONS	888-423-6359 claritybenefitsolutions.com
Health Savings Account (HSA)	CLARITY BENEFIT SOLUTIONS	888-423-6359 claritybenefitsolutions.com
Dental	GUARDIAN	800-541-7846 www.guardiananytime.com
Vision	GUARDIAN - VSP	800-877-7195 www.vsp.com
Employer-Paid Basic Life and AD&D	USABLE LIFE	800-370-5856 www.usablelife.com
Voluntary Life & AD&D	USABLE LIFE	800-370-5856 www.usablelife.com
Short Term Disability (STD)	USABLE LIFE	800-370-5856 www.usablelife.com
Long Term Disability (LTD)	USABLE LIFE	800-370-5856 www.usablelife.com
Accident, Critical Illness, Cancer, Hospital Indemnity	GUARDIAN	800-541-7846 www.guardiananytime.com
Employee Assistance Program (EAP)	NEW DIRECTIONS	800-624-5544 www.ndbh.com Company Code: FCL
Pet Insurance	SPOT PET INSURANCE	800-905-1595 spotpet.link/tps Code: EB_TPS

INSURANCE OFFICE OF AMERICA

For assistance with benefits questions, membership card issues, claims, and billing inquiries please contact one of your IOA service team members per the contact information below:

NAME - TITLE	PHONE	EMAIL
Lindsey Malotte Sr. Account Associate	904-596-2850	Lindsey.Malotte@ioausa.com
Christina Summerell Account Executive	904-596-2844	Christina.Summerell@ioausa.com

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THERAPY PARTNER SOLUTIONS HOLDINGS, LLC BENEFIT GUIDE

JANUARY 1, 2025 - DECEMBER 31, 2025

INSURANCE OFFICE OF AMERICA