

Employee Benefits

2026-2027





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Working together is what makes Allied Power a success, and this teamwork extends to your benefits. We provide options to support your family's overall wellbeing. This guide offers details on your 2026-2027 benefits. Contact the HR Helpline with any questions.

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See page 25 for important information concerning Medicare Part D coverage.

In this Guide, we use the term company to refer to Allied Power Management LLC. This Guide is intended to describe the eligibility requirements, enrollment procedures, and coverage effective dates for the benefits offered by the company. It is not a legal plan document and does not imply a guarantee of employment or a continuation of benefits. While this Guide is a tool to answer most of your questions, full details of the plans are contained in the Summary Plan Descriptions (SPDs), which govern each plan's operation. Whenever an interpretation of a plan benefit is necessary, the actual plan documents will be used.

Welcome

You matter to us. So, the things that are important to you matter to us, too. That's why we offer comprehensive benefits options for you and your family, including medical, dental, vision, life and disability, and additional benefits coverage. We are committed to excellence in our work and in our offerings for 2026-2027.

This guide includes:

- » An overview of your 2026-2027 benefits options
- » Explanations of each offering to help you make the best decisions for you and your family
- » Contact information for all benefits vendors
- » Costs associated with your benefits

Allied Power proudly offers a competitive benefits plan to all full-time eligible employees working at least 30 hours per week. The comprehensive package details are briefly summarized in this guide. Your offerings are funded on a pre-tax basis, including medical, dental, vision, and FSA. Other voluntary benefits are available for purchase via payroll deductions.

Available Benefits

- » Medical Insurance
- » Dental Insurance
- » Vision Insurance
- » Supplemental Health Insurance
- » Flexible Spending Accounts (FSA)
- » Voluntary Life and AD&D Insurance
- » Voluntary Short-Term Disability

Any Questions?

We're here to help. Contact HR Helpline at 225-412-6435.



Eligibility and Enrollment



Allied Power's benefits are designed to support your unique needs.

Eligibility

If you are a full-time employee of Allied Power who is regularly scheduled to work at least 30 hours per week, you are eligible to participate in the Allied Power benefits plan.

Coverage Dates

Your elections are effective July 1, 2026. Benefits cannot be changed until the next enrollment period unless you experience a Qualifying Life Event.

Dependents

Dependents eligible for coverage include:

- » Your legal spouse.
- » Children up to age 26 (includes birth children, stepchildren, legally adopted children, children placed for adoption, foster children, and children for whom you or your spouse have legal guardianship).
- » Dependent children 26 or more years old, unmarried, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a dependent under this plan (periodic certification may be required).

Verification of dependent eligibility may be required upon enrollment.

Active Enrollment

This year, we are conducting an “**Active Enrollment**” for Medical and FSA. You must actively log in and make your elections to have these benefits for the new plan year.

- » Would like to change or decline your current benefits, including who from your family is covered.
- » Would like to purchase voluntary life insurance for yourself, spouse, and/or child.
- » Would like to contribute to an FSA. Spending account elections DO NOT roll over and must be re-elected for 2026-2027.

Any new elections you make or those that roll over will remain in place until the following enrollment period unless you experience a Qualifying Life Event.

Note

Open Enrollment is your annual chance to choose your benefits, unless you have a Qualifying Life Event, such as marriage or the birth/adoption of a child.



Ready for Enrollment?

Allied Power covers a significant amount of your benefit costs. Your contributions for medical, dental, and vision benefits are deducted on a pre-tax basis, lessening your tax liability. Employee contributions vary depending on the level of coverage you select — typically, the more coverage you have, the higher your portion.

You can choose any combination of medical, dental, and/or vision coverage. You could select medical coverage for yourself and your entire family, but dental and vision coverage only for yourself. The only requirement is that as an eligible employee of Allied Power, you must elect coverage for yourself in order to elect coverage for dependents.

Benefits Enrollment Action Items



Update your personal information.

If you've experienced any life changes since the last Open Enrollment period — such as the birth of a child or a move — you may need to change your elections or update your pertinent details.



Double-check covered medications.

If you make any changes to your plan, consider how it affects your prescriptions.



Consider your FSA.

An FSA can help cover healthcare costs, including dental and vision services and prescriptions. Adding one of these accounts to your benefits can help with your long-term financial goals.



Check your networks.

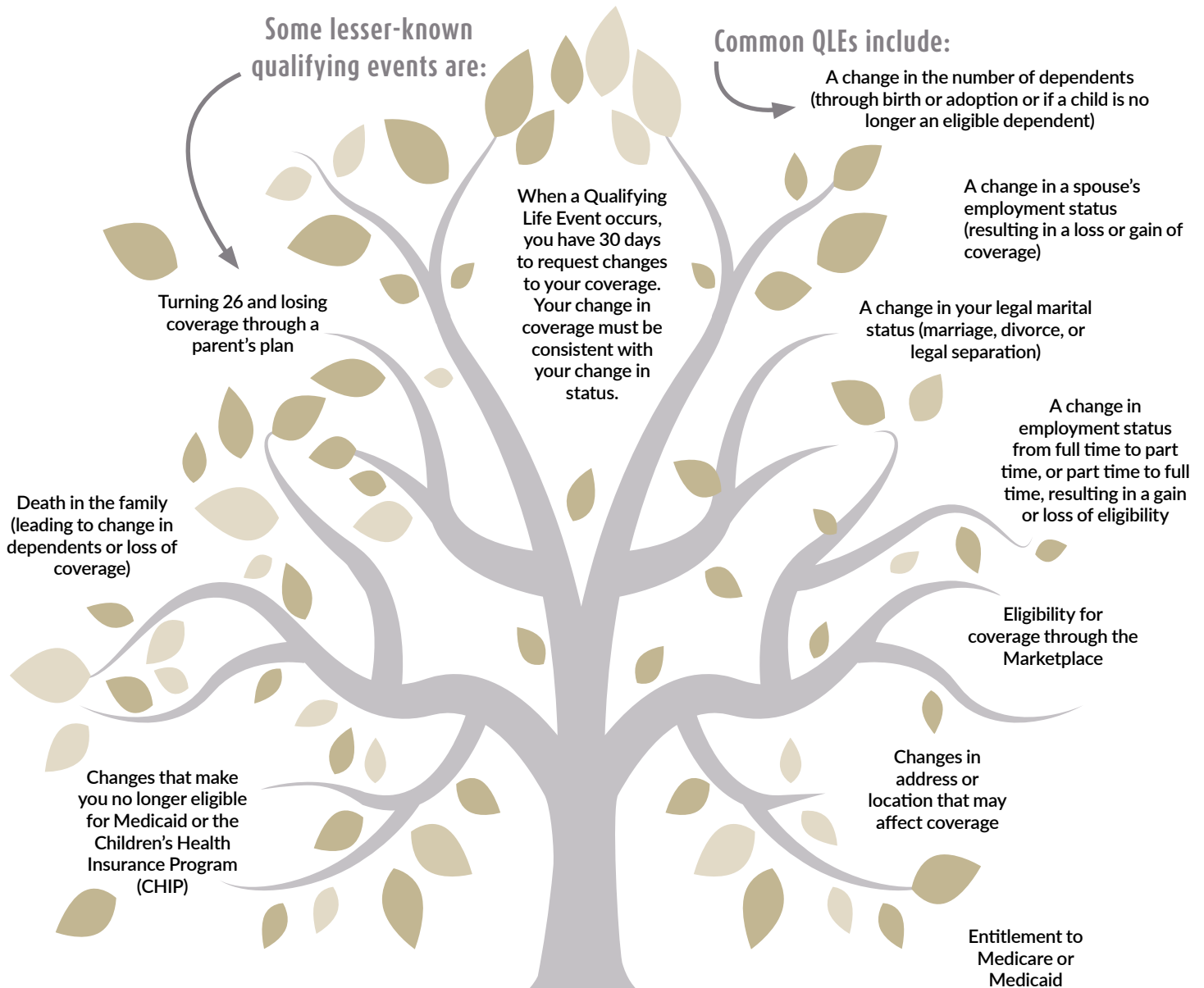
Going in-network often saves you money. Check for any plan changes to make sure your go-to providers and pharmacy are still your best bet.



Now's the Time to Enroll!

What are Qualifying Life Events?

You can update your benefits when you start a new job or during Open Enrollment. But changes in your life called Qualifying Life Events (QLEs) determined by the IRS can allow you to enroll in health insurance or make changes outside of these times.



Reach out to Allied Power's HR Helpline with questions regarding specific life events and your ability to request changes. Don't miss out on a chance to update your benefits!

Medical Benefits



Medical benefits are provided through Louisiana Blue. Consider the physician networks, premiums, and out-of-pocket costs when choosing for you and your family. Keep in mind your choice is effective for the entire 2026-2027 plan year unless you have a Qualifying Life Event.

Medical Plan Summary

This chart summarizes the 2026-2027 medical coverage provided by Louisiana Blue. All covered services are subject to medical necessity as determined by the plan. Please note that all out-of-network services are subject to Reasonable and Customary (R&C) limitations.

VALUE PPO PLAN	
IN-NETWORK	
CALENDAR YEAR DEDUCTIBLE	
INDIVIDUAL	\$2,500
FAMILY	\$7,500
COINSURANCE (PLAN PAYS)	70%*
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (MAXIMUM INCLUDES DEDUCTIBLE)	
INDIVIDUAL	\$6,350
FAMILY	\$12,700
COPAYS/COINSURANCE	
PREVENTIVE CARE	100% covered
PRIMARY CARE	\$40 copay
SPECIALIST SERVICES	\$55 copay
DIAGNOSTIC CARE	30% coinsurance*
MENTAL HEALTH – INPATIENT	30% coinsurance*
MENTAL HEALTH – OUTPATIENT	\$40 copay
URGENT CARE	\$55 copay
EMERGENCY ROOM	30% coinsurance*

*After deductible

The individual deductible amount must be met by each member enrolled under your medical coverage. If you have several covered dependents, all charges used to apply toward a “per individual” deductible amount will also be applied toward the “per family” deductible amount. When the family deductible amount is reached, no further individual deductibles will have to be met for the remainder of that plan year. No member may contribute more than the individual deductible amount to the “per family” deductible amount. The same typically applies for the out-of-pocket maximum.

Healthcare Cost Transparency

There are so many different providers and varying costs for healthcare services — how do you choose? Online services called healthcare cost transparency tools can help. Available through most health insurance carriers, these tools allow you to compare costs for services, from prescriptions to major surgeries, to make your choices simpler. Visit www.lablue.com to learn more.

Medical Premiums

Premium contributions for medical are deducted from your paycheck on a pre-tax basis. Your level of coverage determines your contributions.

VALUE PPO PLAN

CONTRIBUTIONS		
	WEEKLY	MONTHLY
EMPLOYEE ONLY	\$89.64	\$358.55
EMPLOYEE + SPOUSE	\$380.92	\$1,523.66
EMPLOYEE + CHILD(REN)	\$346.68	\$1,386.72
EMPLOYEE + FAMILY	\$574.93	\$2,299.70

How to Find a Provider

Visit www.lablue.com or call Customer Care at 800-495-2583 for a list of Louisiana Blue network providers.



Pharmacy Benefits

Prescription Drug Coverage for Medical Plans

Our Prescription Drug Program is coordinated through Louisiana Blue. That means you will only have one ID card for both medical care and prescriptions. Information on your benefits coverage and a list of network pharmacies is available online at www.lablue.com or by calling the Customer Care number on your ID card. Your cost is determined by the tier assigned to the prescription drug product. Products are assigned as Tier 1, Tier 2, Tier 3, or Tier 4.

PRESCRIPTION DRUGS

RETAIL RX (30-DAY SUPPLY)	
TIER 1	\$7 copay
TIER 2	\$30 copay
TIER 3	\$70 copay
TIER 4	10%, up to \$150

Generic Drugs

Want to save money on meds? Generic drugs are versions of brand-name drugs with the exact same dosage, intended use, side effects, route of administration, risks, safety, and strength. Because they are the same medicine, generic drugs are just as effective as the brand names, and they undergo the same rigid FDA standards. **But generic versions cost 80% to 85% less on average than the brand-name equivalent.** To find out if there is a generic equivalent for your brand-name drug, visit www.fda.gov.

NOTE: Apps and prescription discount programs such as GoodRx, Amazon Prime Rx Savings, and Optum Perks let you compare prices of prescription drugs and find possible discounts.

How do they work? These discounts can't be combined with your benefit plan's coverage, so make sure to check the price against the cost of using your insurance's prescription drug benefit. Something else to consider: If you choose to use a discount card and are therefore not tapping into your insurance's prescription drug benefit, the cash amount you pay for the prescription will not count toward your deductible or out-of-pocket maximum under the benefit plan.

GoodRx is a web- and app-based platform that allows you to search for prescription drug coupons and compare pharmacy prices. The company claims a savings of up to 80%. **Optum Perks** also provides coupons for medications and a searchable database for drug cost comparison at participating pharmacies near you. The Optum Perks member card, which can be used at more than 64,000 pharmacies, is free to use and requires no personal data. Another discount option is the **Amazon Prime Rx Savings** discount card, which is included with an Amazon Prime membership and is administered by Inside Rx. It provides discounts of up to 80% for generics and up to 40% for brand-name medication at participating pharmacies.

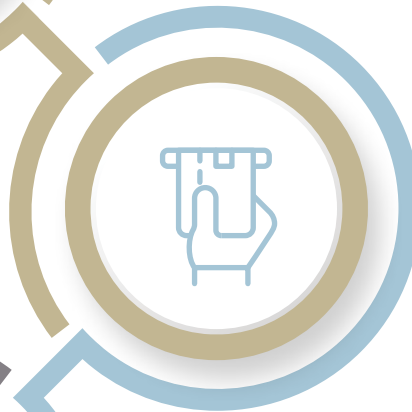
Out-of-Pocket Costs

These are the types of payments you're responsible for:



copay

The fixed amount you pay for healthcare services at the time you receive them.



deductible

The amount you must pay for covered services before your insurance begins paying its portion/coinsurance.



coinsurance

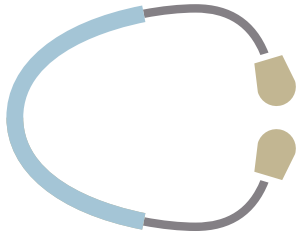
Your percentage of the cost of a covered service. If your office visit is \$100 and your coinsurance is 20% (and you've met your deductible but not your out-of-pocket maximum), your payment would be \$20.



out-of-pocket maximum

The most you will pay during the plan year before your insurance begins to pay 100% of the allowed amount.

Preventive Care



Routine checkups and screenings are considered preventive, so they're often paid at 100% by your insurance.

Keep up to date with your primary care physician to stay on top of your overall health. Under the U.S. Patient Protection and Affordable Care Act (PPACA), some common covered services include:



Wellness visits, physicals, and standard immunizations



Screenings for blood pressure, cancer, cholesterol, depression, obesity, and diabetes



Pediatric screenings for hearing, vision, obesity, and developmental disorders



Anemia screenings, breastfeeding support, and pumps for pregnant and nursing women



Iron supplements (for children ages 6 to 12 months at risk for anemia)

Don't miss out on these covered services. But remember that diagnostic care to identify health risks is covered according to plan benefits, even if done during a preventive care visit. So, if your doctor finds a new condition or potential risk during your appointment, the services may be billed as diagnostic medicine and result in some out-of-pocket costs. Read over your benefit summary to see what specific preventive services are provided to you.



What about the COVID-19 vaccine? The COVID-19 vaccine itself is considered preventive. For the vast majority of individuals who have insurance through an employer, the vaccine will be at no cost.

Where to Go for Care

You're feeling sick, but your primary care physician is booked through the end of the month. You have a question about the side effects of a new prescription, but the pharmacy is closed. Instead of rushing to the emergency room or relying on questionable information from the internet, consider all of your site-of-care options.



Nurse Line

When to Use

You need a quick answer to a health issue that does not require immediate medical treatment or a physician visit.

Types of Care*

Answers to questions regarding:

- » Symptoms
- » Self-care/home treatments
- » Medications and side effects
- » When to seek care

Costs and Time Considerations**

- » Usually available 24 hours a day, 7 days a week
- » Typically free as part of your medical insurance



Telemedicine

When to Use

You need care for minor illnesses and ailments but would prefer not to leave home. These services are available by phone and online (via webcam).

Types of Care*

- » Cold & flu symptoms
- » Allergies
- » Bronchitis
- » Urinary tract infection
- » Sinus problems

Costs and Time Considerations**

- » Usually a first-time consultation fee and a flat fee or copay for any visit thereafter
- » Usually immediate access to care
- » Prescriptions through telemedicine or virtual visits not allowed in all states



Primary Care Center

When to Use

You need routine care or treatment for a current health issue. Your primary doctor knows you and your health history, can access your medical records, provide routine care, and manage your medications.

Types of Care*

- » Routine checkups
- » Immunizations
- » Preventive services
- » Manage your general health

Costs and Time Considerations**

- » Often requires a copay and/or coinsurance
- » Normally requires an appointment
- » Usually little wait time with scheduled appointment



Urgent Care Center

When to Use

You need care quickly, but it is not a true emergency. Urgent care centers offer treatment for non-life-threatening injuries or illnesses.

Types of Care*

- » Strains, sprains
- » Minor infections
- » Minor broken bones (e.g., finger)
- » Minor burns
- » X-rays

Costs and Time Considerations**

- » Often requires a copay and/or coinsurance usually higher than an office visit
- » Walk-in patients welcome, but waiting periods may be longer (urgency decides order)



Emergency Room

When to Use

You need immediate treatment for a serious life-threatening condition. If a situation seems life threatening, call 911 or your local emergency number right away.

Types of Care*

- » Heavy bleeding
- » Spinal injuries
- » Chest pain
- » Severe head injury
- » Major burns
- » Broken bones

Costs and Time Considerations**

- » Often requires a much higher copay and/or coinsurance
- » Open 24/7, but waiting periods may be longer because patients with life-threatening emergencies will be treated first
- » Ambulance charges, if applicable, will be separate and may not be in-network

Do Your Homework

What may seem like an urgent care center could actually be a standalone ER. These facilities come with a higher price tag, so ask for clarification if the word "emergency" appears in the company name.

*This is a sample list of services and may not be all inclusive.

**Costs and time information represent averages only and are not tied to a specific condition or treatment.

Flexible Spending Accounts



Take control of your spending! A Flexible Spending Account (FSA) is a special tax-free account you put money into to pay for certain out-of-pocket expenses.

Healthcare Flexible Spending Account

You can contribute up to \$3,400 annually for qualified medical expenses (deductibles, copays, coinsurance, menstrual products, PPE, over-the-counter medications, etc.) with pre-tax dollars, which reduces your taxable income and increases your take-home pay. You can even pay for eligible expenses with an FSA debit card at the same time you receive them – no waiting for reimbursement.

Dependent Care Flexible Spending Account

In addition to the Healthcare FSA, you may opt to participate in the Dependent Care FSA – even if you don't elect any other benefits. Set aside pre-tax funds into a Dependent Care FSA for expenses associated with caring for elderly or child dependents. Unlike the Healthcare FSA, reimbursement from your Dependent Care FSA is limited to the total amount that is currently deposited in your account.

- » With the Dependent Care FSA, you can set aside up to \$7,500 to pay for child or elder care expenses on a pre-tax basis.
- » Eligible dependents include children under 13 and a spouse or other individual who is physically or mentally incapable of self-care and has the same principal place of residence as the employee for more than half the year.
- » You must provide the tax identification number or Social Security number of the party providing care to be reimbursed.

This account covers dependent daycare expenses that are necessary for you and your spouse to work or attend school full time. Eligible expenses include:

- » In-home babysitting services (not provided by a dependent)
- » Care of a preschool child by a licensed nursery or daycare provider
- » Before- and after-school care
- » Day camp
- » In-house dependent daycare

Due to federal regulations, expenses for your domestic partner and your domestic partner's children may not be reimbursed under the FSA programs. Check with your tax advisor to determine if any exceptions apply.

Using the Account

Use your FSA debit card at doctor and dentist offices, pharmacies, and vision service providers. It cannot be used at locations that do not offer services under the plan, unless the provider has also complied with IRS regulations. The transaction will be denied if you use the card at an ineligible location.

Submit a claim form along with the required documentation. Contact CPI with reimbursement questions. If you need to submit a receipt, CPI will notify you. Always save receipts for your records.

While FSA debit cards allow you to pay for services at point of sale, they do not remove the IRS regulations for substantiation. Always keep receipts and Explanation of Benefits (EOBs) for any debit card charges in case you need to prove an expense was eligible. Without proof an expense was valid, your card could be turned off and the expense deemed taxable.



General Rules

The IRS has the following rules for Healthcare and Dependent Care FSAs:

- » Expenses must occur during the 2026-2027 plan year.
- » Funds cannot be transferred between FSAs.
- » You are not permitted to claim the same expenses on both your federal income taxes and Dependent Care FSA.
- » You must “use it or lose it” – any unused funds will be forfeited.
- » Up to \$680 may be rolled over to the next plan year at the end of 2026-2027 for Healthcare FSAs.
- » You cannot change your FSA election in the middle of the plan year without a Qualifying Life Event.
- » Terminated employees have ninety (90) days following termination to submit FSA claims for reimbursement.
- » Those considered highly compensated employees (family gross earnings were \$160,000 or more last year) may have different FSA contribution limits. Visit www.irs.gov for more info.

Note

The Dependent Care FSA is not to be used for medical expenses, nor is it the same as electing medical coverage for dependents.

Supplemental Health Benefits

 Allied Power offers several ways to supplement your medical plan coverage. This additional insurance can help cover unexpected expenses, regardless of any benefit you may receive from your medical plan. Coverage is available for yourself and your dependents and offered at discounted group rates.

Accident Coverage

You can't always prevent accidents, but you can be prepared for them, including readying for any financial impact. Accident coverage through Lincoln Financial Group provides benefits for you and your covered family member for expenses related to an accidental injury that occurs outside of work. Health insurance helps with medical expenses, but this coverage is an additional layer of protection that can help pay deductibles, copays, and even typical day-to-day expenses such as a mortgage or car payment. Benefits are payable to you to use as you wish.

ACCIDENT COVERAGE

	LOW PLAN	HIGH PLAN
LIFE AND DISMEMBERMENT LOSSES		
ACCIDENTAL DEATH - EMPLOYEE	\$25,000	\$50,000
ACCIDENTAL DEATH - SPOUSE	\$10,000	\$20,000
ACCIDENTAL DEATH - CHILD	\$5,000	\$10,000
COMMON CARRIER DEATH (AD&D)	2x benefit amount	2x benefit amount
CATASTROPHIC LOSS	Up to \$10,000	Up to \$30,000
DISLOCATIONS		
HIP	\$1,500	\$3,375
KNEE (EXCEPT KNEECAP)	\$1,000	\$2,250
ANKLE, COLLARBONE, FOOT (EXCEPT TOES)	\$500	\$1,125
COLLARBONE, ELBOW, HAND (EXCEPT FINGERS), LOWER JAW	\$250	\$575
FRACTURES		
SKULL DEPRESSED	\$2,000	\$4,500
HIP, LEG (HIP TO KNEE)	\$1,500	\$3,375
LEG (KNEE TO ANKLE), PELVIS, SKULL NON-DEPRESSED	\$1,000	\$2,250
ARM (SHOULDER TO ELBOW), FACE BONES, NOSE, UPPER JAW	\$500	\$1,125
COCCYX, COLLARBONE, LOWER JAW, STERNUM	\$300	\$675
ANKLE, ARM (ELBOW TO WRIST) ELBOW, FOOT (EXCEPT TOES)	\$250	\$575
HAND (EXCEPT FINGERS), KNEECAP, RIB, SHOULDER BLADE	\$250	\$575
VERTEBRAL PROCESS, WRIST	\$250	\$575

	LOW PLAN	HIGH PLAN
EMERGENCY CARE		
AMBULANCE	\$150	\$300
AIR AMBULANCE	\$750	\$1,500
EMERGENCY CARE / TREATMENT	\$100	\$200
INITIAL CARE VISIT	\$50	\$100
DIAGNOSTIC EXAM (CT, CAT, EEG, MRI, PET,	\$100	\$200
HOSPITAL SERVICES		
HOSPITAL ADMISSION	\$1,000	\$1,250
INTENSIVE CARE ADMISSION	\$1,500	\$2,000
HOSPITAL DAILY CONFINEMENT	\$200 per day	\$300 per day
INTENSIVE CARE DAILY CONFINEMENT	\$400 per day	\$600 per day
OCCUPATIONAL, PHYSICAL, AND CHIROPRACTIC THERAPY (UP TO 6)	\$35	\$50
SPECIFIC INJURIES		
CONCUSSION	\$100	\$200
2ND DEGREE BURNS	\$50-\$500	\$150-\$1,500
3RD DEGREE BURNS	\$250-\$500	\$500-\$1,500
LACERATION	\$25-\$200	\$50-\$600
TRAUMATIC BRAIN INJURY	\$2,500	\$7,500
WEEKLY CONTRIBUTIONS		
	LOW PLAN	HIGH PLAN
EMPLOYEE ONLY	\$1.46	\$2.62
EMPLOYEE + SPOUSE	\$2.38	\$4.26
EMPLOYEE + CHILD(REN)	\$2.56	\$4.56
EMPLOYEE + FAMILY	\$3.46	\$6.18

Note: Limitations and exclusions may apply.

Critical Illness Coverage

Critical Illness coverage through Lincoln Financial Group pays a lump-sum benefit if you are diagnosed with a covered disease or condition. You can use this money however you like. Examples include helping pay for expenses not covered by your medical plan, lost wages, childcare, travel, home healthcare costs, or any of your regular household expenses.

Plan Highlights

- » **Guaranteed Issue Coverage (no medical questions)**
 - Employee: \$5,000, \$10,000, \$15,000, or \$20,000
 - Spouse: \$2,500, \$5,000, \$7,500, or \$10,000 (up to 50% of EE's amount)
 - Child(ren): \$5,000 (up to 50% of the employee coverage amount)
- » **Pre-Existing Conditions:** A pre-existing condition means a covered condition for which treatment was received during the 12 months prior to the effective date of coverage. Treatment means consultation, care, and services provided or prescribed by a physician. It includes diagnostic measures and the prescription, refill, or taking of prescribed drugs or medicines for which symptoms exist.

Important: As a new hire, EOI is not required when enrolling in coverage up to the guaranteed issue amounts. Future enrollments and changes in coverage will require proof of good health and must go through medical underwriting for approval.

CRITICAL ILLNESS COVERAGE

COVERED CONDITIONS	
HEART ATTACK	100%
STROKE	100%
INVASIVE CANCER	100%
END STAGE RENAL (KIDNEY) FAILURE	100%
MAJOR ORGAN FAILURE	100%
NONINVASIVE CANCER (IN SITU)	25%
SUPPLEMENTAL CONDITIONS	
ADVANCED COPD	100%
AIDS	100%
BENIGN BRAIN TUMOR	100%
ADDITIONAL CHILDHOOD CONDITIONS	
CEREBRAL PALSY	100%
CLEFT LIP, CLEFT PALATE	100%
CYSTIC FIBROSIS	100%
DOWN SYNDROME	100%
MUSCULAR DYSTROPHY	100%
SPINA BIFIDA	100%
TYPE 1 DIABETES	100%
WELLNESS BENEFIT	
EXAM, SCREENING OR IMMUNIZATION	\$50

PER \$1,000 OF COVERAGE (MONTHLY CONTRIBUTION)		
AGE*	NON-TOBACCO	TOBACCO
<25	\$0.362	\$0.378
25-29	\$0.515	\$0.554
30-34	\$0.659	\$0.742
35-39	\$0.829	\$0.999
40-44	\$1.136	\$1.520
45-49	\$1.454	\$2.201
50-54	\$1.962	\$3.345
55-59	\$2.591	\$4.886
60-64	\$3.545	\$7.327
65-69	\$4.771	\$10.601
70-74	\$4.771	\$10.601

Limitations and exclusions may apply.

*Spouse rates based on employee's age.

Hospital Indemnity Coverage

Hospital Indemnity coverage through Lincoln Financial Group pays you cash benefits directly if you are admitted to the Hospital or an Intensive Care Unit (ICU) for a covered stay. You can use the benefits to help pay for your medical expenses such as deductibles and copays, travel cost, food and lodging, or everyday expenses such as groceries and utilities.

Plan Highlights

FIRST DAY BENEFITS — PAYABLE PER BENEFIT YEAR	
HOSPITAL ADMISSION (FOR ONE DAY PER CALENDAR YEAR)	\$1,000
INTENSIVE CARE ADMISSION (FOR ONE DAY PER CALENDAR YEAR)	\$1,000
INTENSIVE CARE ADMISSION (FOR ONE DAY PER CALENDAR YEAR)	
HOSPITAL CONFINEMENT — THIS BENEFIT PAYS FOR EACH DAY OF CONFINEMENT IN A HOSPITAL AS A RESULT OF A SICKNESS/AN INJURY STARTING ON 2ND DAY OF CONFINEMENT.	\$100 per day Up to 30 days
INTENSIVE CARE UNIT (ICU) CONFINEMENT — THIS BENEFIT PAYS FOR EACH FULL OR PARTIAL DAY OF CONFINEMENT IN AN ICU AS A RESULT OF A SICKNESS/AN INJURY STARTING ON 2ND DAY OF CONFINEMENT.	\$100 per day Up to 10 days
COMPLICATIONS OF PREGNANCY	Included
WELLNESS SCREENING BENEFIT	
HEALTH ASSESSMENT BENEFIT – RECEIVE A CASH BENEFIT EVERY YEAR YOU AND ANY OF YOUR COVERED FAMILY MEMBERS, COMPLETE A SINGLE COVERED EXAM, SCREENING OR IMMUNIZATION	\$50

WEEKLY CONTRIBUTIONS	
EMPLOYEE ONLY	\$3.86
EMPLOYEE + SPOUSE	\$8.30
EMPLOYEE + CHILD(REN)	\$6.07
EMPLOYEE + FAMILY	\$10.98

Pre-existing Condition Exclusion

- » A pre-existing condition means a covered condition for which treatment was received during the lookback period prior to the effective date of coverage. Treatment means consultation, care, and services provided or prescribed by a physician. It includes diagnostic measures and the prescription, refill, or taking of prescribed drugs or medicines for which symptoms exist.
- » Look-back period: A pre-existing exclusion applies to conditions for which the employee received treatments during a 12-month period prior to the employee's effective date.
- » Exclusionary period: A pre-existing exclusion applies during the first 12 months of an employee's coverage or increase in coverage. Once this period is satisfied the exclusion no longer applies.

Note: Limitations and exclusions may apply. See plan summary for full details.

Dental Benefits



Like brushing and flossing, visiting your dentist is an essential part of your oral health. Allied Power offers affordable plan options from Lincoln Financial Group for routine care and beyond.

Stay in Network

If your dentist doesn't participate in your plan's network, your out-of-pocket costs will be higher, and you are subject to any charges beyond the Reasonable and Customary (R&C). To find a network dentist, visit Lincoln Financial Group at www.lincolnfinancial.com or call 800-423-2765.

Dental Premiums

Dental premium contributions are deducted from your paycheck on a pre-tax basis. Your tier of coverage determines your premium.

Dental Plan Summary

This chart summarizes the dental coverage provided by Lincoln Financial Group for 2026-2027.

	WEEKLY	MONTHLY
CONTRIBUTIONS		
EMPLOYEE ONLY	\$4.63	\$18.53
EMPLOYEE + SPOUSE	\$9.57	\$38.29
EMPLOYEE + CHILD(REN)	\$12.30	\$49.19
EMPLOYEE + FAMILY	\$18.65	\$74.60
CALENDAR YEAR DEDUCTIBLE		
INDIVIDUAL	\$50	
FAMILY	\$150	
CALENDAR YEAR MAXIMUM		
PER PERSON	\$1,500	
COVERED SERVICES		
PREVENTIVE SERVICES Oral Exams, Routine Cleanings, Bitewing X-rays, Panoramic X-rays	100% covered	
BASIC SERVICES Fillings, Oral Surgery, Root Canal Therapy	20% coinsurance*	
MAJOR SERVICES Crowns, Dentures, Bridges, Inlays, Onlays	50% coinsurance*	
ORTHODONTICS Dependent Child(ren) Only, up to age 26	50% coinsurance*	
ORTHODONTIC LIFETIME MAXIMUM	\$1,500 per person	

*After deductible

Note

Oral health is linked to your overall health — keeping your mouth healthy can protect you from cardiovascular disease, pregnancy complications, and pneumonia.

Limitations and Exclusions apply.

Benefit percentages are based on maximum allowable charge (MAC).

Vision Benefits



Getting your eyes checked regularly is important even if you don't wear glasses or contacts. We provide quality vision care for you and your family through Lincoln Financial Group.

Vision Premiums

Vision premium contributions are deducted from your paycheck on a pre-tax basis. Your tier of coverage determines your premium.

Vision Plan Summary

This chart summarizes the vision coverage provided by Lincoln Financial Group for 2026-2027.

WEEKLY

MONTHLY

CONTRIBUTIONS				
EMPLOYEE ONLY		\$1.53		\$6.10
EMPLOYEE + SPOUSE		\$2.89		\$11.54
EMPLOYEE + CHILD(REN)		\$3.38		\$13.53
EMPLOYEE + FAMILY		\$4.76		\$19.03
		IN-NETWORK	OUT-OF-NETWORK	FREQUENCY
EXAMS				
	COPAY	\$10 copay	Up to \$40	Once in 12 months
LENSES				
	SINGLE VISION	\$25 copay	Up to \$40	Once in 12 months
	BIFOCAL	\$25 copay	Up to \$60	
	TRIFOCAL	\$25 copay	Up to \$80	
	LENTICULAR	\$25 copay	Up to \$80	
CONTACTS (IN LIEU OF LENSES AND FRAMES)				
	ELECTIVE	Up to \$125 allowance	Up to \$125	Once in 12 months
FRAMES				
	COPAY	\$130 allowance, 30% discount over allowance	Up to \$45	Once in 12 months
	ALLOWANCE	\$130	\$45	
OTHER SERVICES				
	LASER VISION CORRECTION DISCOUNT	Free LASIK consult with in-network providers. Convenient access to experienced LASIK surgeons. For more information, call 855-250-2020.	Not covered	One per eye per lifetime

Note: Fitting and Evaluation fee applied to contact lens allowance.

Limitations and Exclusions apply.

Survivor Benefits



It's hard to think about, but it's important to have a plan in place to provide for your family if something were to happen to you. Survivor benefits provide financial protection in the event of an unexpected event.

Voluntary Life and AD&D Insurance*

Eligible employees may purchase Voluntary Life and AD&D insurance. Premiums are paid through payroll deductions.

VOLUNTARY EMPLOYEE LIFE	
COVERAGE AMOUNT	Increments of \$10,000
WHO PAYS	Employee
MAXIMUM BENEFIT	5x annual salary, max \$500,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	Yes
GUARANTEED ISSUE	New hires under age 70: \$200,000 New hires age 70 or over: \$50,000, subject to any applicable age reductions
AGE REDUCTIONS	33% when you reach age 70; Additional 17% of original amount when you reach age 75
VOLUNTARY SPOUSE LIFE	
COVERAGE AMOUNT	Increments of \$5,000
WHO PAYS	Employee
MAXIMUM BENEFIT	2.5x annual salary, max 100% of employee's amount
EVIDENCE OF INSURABILITY (EOI) REQUIRED	Yes
GUARANTEED ISSUE	When employee is a new hire: \$50,000
COVERAGE TERMINATION	Spouse coverage terminates at age 70
VOLUNTARY CHILD LIFE	
COVERAGE AMOUNT	\$10,000
WHO PAYS	Employee
MAXIMUM BENEFIT	\$10,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	No
COVERAGE AMOUNT	Day 1 to age 14 days: \$500 14 days but less than 25 years: \$10,000
VOLUNTARY EMPLOYEE AD&D	
COVERAGE AMOUNT	Increments of \$10,000
WHO PAYS	Employee
MAXIMUM BENEFIT	5x annual salary, max \$500,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	Yes

Evidence of Insurability

You must submit EOI each time any of the following occur:

- » You enroll for Voluntary Life insurance as a late entrant.
- » You apply for an increase in your amount of Voluntary Life insurance or
- » Your amount of Voluntary Life insurance is in excess of the Guaranteed Issue amount.

*Limitations and exclusions may apply.

VOLUNTARY LIFE INSURANCE	
RATES/\$1,000	
AGE (AS OF 07/01/2026)	EMPLOYEE*
< 20	\$0.167
20-24	\$0.137
25-29	\$0.114
30-34	\$0.123
35-39	\$0.168
40-44	\$0.226
45-49	\$0.337
50-54	\$0.514
55-59	\$0.825
60-64	\$1.037
65-69	\$1.714
70-74	\$2.800

*Spouse rates based on spouse's age
 Note: Benefits subject to age reduction schedule

VOLUNTARY CHILD LIFE INSURANCE
PREMIUM RATES - PER \$1,000
\$0.270

TO CALCULATE HOW MUCH YOUR VOLUNTARY LIFE COVERAGE WILL COST:

\$ <input style="width: 80%;" type="text"/>	÷ 1,000 =	\$ <input style="width: 80%;" type="text"/>	x Age Based Rate =	\$ <input style="width: 80%;" type="text"/>
Benefit Elected				Monthly Premium

Naming a Beneficiary*

Your beneficiary is the person you designate to receive your Life insurance benefits in the event of your death. This includes any benefits payable under Basic Life. You receive the benefit payment for a dependent's death under the Lincoln Financial Group insurance.

Name a primary and contingent beneficiary to make your intentions clear. Indicate their full name, address, Social Security number, relationship, date of birth, and distribution percentage. Please note that in most states, benefit payments cannot be made to a minor. If you elect to designate a minor as beneficiary, all proceeds may be held under the beneficiary's name and will earn interest until the minor reaches age 18. Contact the HR Helpline or your own legal counsel with any questions.

*Limitations and exclusions may apply.

Income Protection



You and your loved ones depend on your regular income. That's why Allied Power offers disability coverage to protect you financially in the event you cannot work as a result of a debilitating injury or illness. A portion of your income is protected until you can return to work or you reach retirement age.

Short-Term Disability (STD) Insurance*

STD benefits are available for purchase. This insurance replaces 60% of your income if you become partially or totally disabled for a short time. See your plan documents or contact the HR Helpline for details.

ALLIED POWER RESOURCES & ALLIED POWER RESOURCES MICHIGAN EMPLOYEES	
WEEKLY MAXIMUM BENEFIT	\$2,500
ELIMINATION PERIOD	15 days
MAXIMUM BENEFIT PERIOD	24 weeks
WHO PAYS FOR THIS BENEFIT	Employee
COST	\$0.478 per \$10 of weekly benefit
PRE-EXISTING CONDITION LIMITS	3/12 - Conditions for which you have received medical treatment for in the 3 months prior to your effective date are not covered for the first 12 months of continuous coverage.



*Limitations and exclusions may apply.



Glossary

Balance Billing – When you are billed by a provider for the difference between the provider’s charge and the allowed amount. For example, if the provider’s charge is \$100 and the allowed amount is \$60, you may be billed by the provider for the remaining \$40.

Coinsurance – Your share of the cost of a covered healthcare service, calculated as a percent of the allowed amount for the service, typically after you meet your deductible.

Copay – The fixed amount you pay for healthcare services received, as determined by your insurance plan.

Deductible – The amount you owe for healthcare services before your insurance begins to pay its portion. For example, if your deductible is \$1,000, your plan does not pay anything until you’ve paid \$1,000 for covered services. This deductible may not apply to all services, including preventive care.

Explanation of Benefits (EOB) – A statement from your insurance carrier that explains which services were provided, their cost, what portion of the claim was paid by the plan, and what portion is your liability, in addition to how you can appeal the insurer’s decision.

Flexible Spending Accounts (FSAs) – A special tax-free account you put money into that you use to pay for certain out-of-pocket healthcare costs. You’ll save an amount equal to the taxes you would have paid on the money you set aside. FSAs are “use it or lose it,” so funds not used by the end of the plan year will be lost. Some Healthcare FSAs do allow for a grace period or rollover into the next plan year.

- » **Healthcare FSA** – A pre-tax benefit account used to pay for eligible medical, dental, and vision care expenses that aren’t covered by your insurance plan. All expenses must be qualified as defined in Section 213(d) of the Internal Revenue Code.
- » **Dependent Care FSA** – A pre-tax benefit account used to pay for dependent care services. For additional information on eligible expenses, refer to Publication 503 on the IRS website.

Healthcare Cost Transparency – Also known as market transparency or medical transparency. Online cost transparency tools, available through health insurance carriers, allow you to search an extensive national database to compare varying costs for services.

Network – A group of physicians, hospitals, and healthcare providers that have agreed to provide medical services to a health insurance plan’s members at discounted costs.

- » **In-Network** – Providers that contract with your insurance company to provide healthcare services at the negotiated carrier discounted rates.
- » **Out-of-Network** – Providers that are not contracted with your insurance company. If you choose an out-of-network provider, services will not be covered at the in-network negotiated carrier discounted rates.
- » **Non-Participating** – Providers that have declined entering into a contract with your insurance provider. They may not accept any insurance and you could pay for all costs out of pocket.

Open Enrollment – The period set by the employer during which employees and dependents may enroll for coverage.

Out-of-Pocket Maximum – The most you pay during the plan year before your health insurance begins to pay 100% of the allowed amount. This does not include your premium, out-of-network provider charges beyond the Reasonable & Customary, or healthcare your plan doesn’t cover. Check with your carrier to confirm what applies to the maximum.

Over-the-Counter (OTC) Medications – Medications available without a prescription.

Prescription Medications – Medications prescribed by a doctor. Cost of these medications is determined by their assigned tier: generic, preferred, non-preferred, or specialty.

- » **Generic Drugs** – Drugs approved by the U.S. Food and Drug Administration (FDA) to be chemically identical to corresponding preferred or non-preferred versions. Usually the most cost-effective version of any medication.
- » **Preferred Drugs** – Brand-name drugs on your provider’s approved list (available online).
- » **Non-Preferred Drugs** – Brand-name drugs not on your provider’s list of approved drugs. These drugs are typically newer and have higher copayments.
- » **Specialty Drugs** – Prescription medications used to treat complex, chronic, and often costly conditions. Because of the high cost, many insurers require that specific criteria be met before a drug is covered.
- » **Prior Authorization** – A requirement that your physician obtain approval from your health insurance plan to prescribe a specific medication for you.
- » **Step Therapy** – The goal of a Step Therapy Program is to steer employees to less expensive, yet equally effective, medications while keeping member and physician disruption to a minimum. You must typically try a generic or preferred-brand medication before “stepping up” to a non-preferred brand.

Reasonable and Customary Allowance (R&C) – The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The R&C amount is sometimes used to determine the allowed amount. Also known as the UCR (Usual, Customary, and Reasonable) amount.

Summary of Benefits and Coverage (SBC) – Mandated by healthcare reform, you are provided with a summary of your benefits and plan coverage.

Summary Plan Description (SPD) – The document(s) that outline the rights, obligations, and material provisions of the plan(s) to all participants and their beneficiaries.



Required Notices

Important Notice From Allied Power Management LLC About Your Prescription Drug Coverage and Medicare Under the Louisiana Blue Medical Plan(s)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Allied Power Management 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. Allied Power Management LLC has determined that the prescription drug coverage offered by the Louisiana Blue Medical plan(s) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current Allied Power Management LLC coverage may not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed herein.

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

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

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

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

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

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

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	July 1, 2026
Name of Entity/Sender:	Allied Power Management LLC
Contact—Position/Office:	HR Helpline
Address:	4171 Essen Lane, Suite 525 Baton Rouge, LA 70809
Phone Number:	225-412-6435

Women's Health and Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. For deductibles and coinsurance information applicable to the plan in which you enroll, please refer to the summary plan description. If you would like more information on WHCRA benefits, please contact HR Helpline at 225-412-6435.

HIPAA Privacy and Security

The Health Insurance Portability and Accountability Act of 1996 deals with how an employer can enforce eligibility and enrollment for healthcare benefits, as well as ensuring that protected health information which identifies you is kept private. You have the right to inspect and copy protected health information that is maintained by and for the plan for enrollment, payment, claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask your benefits administrator to amend the information. For a full copy of the Notice of Privacy Practices, describing how protected health information about you may be used and disclosed and how you can get access to the information, contact HR Helpline at 225-412-6435.

HIPAA 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 later 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 towards your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

- » Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (i.e. legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- » Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- » Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- » Failing to return from an FMLA leave of absence; and
- » Loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment within 30 days after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or the CHIP, you may request enrollment under this plan within 60 days of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy towards this plan, you may request enrollment under this plan within 60 days after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

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.

To request special enrollment or obtain more information, contact HR Helpline at 225-412-6435.

Illinois Essential Health Benefit (EHB) Listing

Employer Name: Allied Power Management LLC
Employer State of Situs: Louisiana
Name of Issuer: Louisiana Blue
Plan Marketing Name: Value PPO
Plan Year: 2026-2027

Ten (10) Essential Health Benefit (EHB) Categories:

- » Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- » Emergency services
- » Hospitalization (like surgery and overnight stays)
- » Laboratory services
- » Mental health and substance use disorder (MH/SUD) services, including behavioral health treatment (this includes counseling and psychotherapy)
- » Pediatric services, including oral and vision care (but adult dental and vision coverage aren't essential health benefits)
- » Pregnancy, maternity, and newborn care (both before and after birth)
- » Prescription drugs
- » Preventive and wellness services and chronic disease management
- » Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)

2020-2026 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)				Employer Plan Covered Benefit?
Item	EHB Benefit	EHB Category	Benchmark Page # Reference	
1	Accidental Injury – Dental	Ambulatory	Pgs. 10 & 17	Yes
2	Allergy Injections and Testing		Pg. 11	Yes
3	Bone Anchored Hearing Aids		Pgs. 17 & 35	Yes
4	Durable Medical Equipment		Pg. 13	Yes
5	Hospice		Pg. 28	Yes
6	Infertility (Fertility) Treatment		Pgs. 23 - 24	Yes
7	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)		Pg. 21	Yes
8	Outpatient Surgery Physician/Surgical Services (Ambulatory Patient Services)		Pgs. 15 - 16	Yes
9	Private-Duty Nursing		Pgs. 17 & 34	Yes
10	Prosthetics/Orthotics		Pg. 13	Yes
11	Sterilization (Vasectomy Men)		Pg. 10	Yes
12	Temporomandibular Joint Disorder (TMJ)		Pgs. 13 & 24	Yes
13	Emergency Room Services (Includes MH/SUD Emergency)	Emergency Services	Pg. 7	Yes
14	Emergency Transportation/Ambulance		Pgs. 4 & 17	Yes
15	Bariatric Surgery (Obesity)	Hospitalization	Pg. 21	Yes
16	Breast Reconstruction After Mastectomy		Pgs. 24 – 25	Yes
17	Reconstructive Surgery		Pgs. 25 – 26, & 35	Yes
18	Inpatient Hospital Services (e.g., Hospital Stay)		Pg. 15	Yes
19	Skilled Nursing Facility		Pg. 21	Yes
20	Transplants – Human Organ Transplants (Including Transportation & Lodging)		Pgs. 18 & 31	Yes

2020-2026 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)				Employer Plan Covered Benefit?
Item	EHB Benefit	EHB Category	Benchmark Page # Reference	
21	Diagnostic Services	Laboratory Services	Pgs. 6 & 12	Yes
22	Intranasal Opioid Reversal Agent Associated with Opioid Prescriptions	MH/SUD	Pg. 32	Yes
23	Mental (Behavioral) Health Treatment (Including Inpatient Treatment)		Pgs. 8 – 9, 21	Yes
24	Opioid Medically Assisted Treatment (MAT)		Pg. 21	Yes
25	Substance Use Disorders (Including Inpatient Treatment)		Pgs. 9 & 21	Yes
26	Tele-Psychiatry		Pg. 11	Yes
27	Topical Anti-Inflammatory Acute and Chronic Pain Medication		Pg. 32	Yes
28	Pediatric Dental Care	Pediatric Oral and Vision Care	See All Kids Pediatric Dental Document	Yes
29	Pediatric Vision Coverage		Pgs. 26 – 27	Yes
30	Maternity Service	Pregnancy, Maternity, and Newborn Care	Pgs. 8 & 22	Yes
31	Outpatient Prescription Drugs	Prescription Drugs	Pgs. 29 – 34	Yes
32	Colorectal Cancer Examination and Screening	Preventive and Wellness Services	Pgs. 12 & 16	Yes
33	Contraceptive/Birth Control Services		Pgs. 13 & 16	Yes
34	Diabetes Self-Management Training and Education		Pgs. 11 & 35	Yes
35	Diabetic Supplies for Treatment of Diabetes		Pgs. 31– 32	Yes
36	Mammography – Screening		Pgs. 12, 15, & 24	Yes
37	Osteoporosis – Bone Mass Measurement		Pgs. 12 & 16	Yes
38	Pap Tests/Prostate-Specific Antigen Tests/Ovarian Cancer Surveillance Test		Pg. 16	Yes
39	Preventive Care Services		Pg. 18	Yes
40	Sterilization (Women)		Pgs. 10 & 19	Yes
41	Chiropractic & Osteopathic Manipulation	Rehabilitative and Habilitative Services and Devices	Pgs. 12 – 13	Yes
42	Habilitative and Rehabilitative Services		Pgs. 8, 9, 11, 12, 22, & 35	Yes

Special Note: Under Pub. Act 102-0104, eff. July 22, 2021, any EHBs listed above that are clinically appropriate and medically necessary to deliver via telehealth services must be covered in the same manner as when those EHBs are delivered in person.

Important Contacts

Medical and Pharmacy

Louisiana Blue
800-495-2583
www.lablue.com

Supplemental Health (Accident, Critical Illness, Hospital Indemnity)

Lincoln Financial Group
800-423-2765
claim@lfg.com

Dental

Lincoln Financial Group
800-423-2765
www.lincolnfinancial.com

Vision

Lincoln Financial Group
800-440-8453
www.lvc.lfg.com

Flexible Spending Accounts

CPI
225-215-2203
www.mycpitem.com

Life and AD&D

Lincoln Financial Group
800-423-2765
lifecclaims@lfg.com

Disability

Lincoln Financial Group
800-423-2765
www.lincolnfinancial.com

Allied Power HR Helpline

4171 Essen Lane, Suite 525
Baton Rouge, LA 70809
225-412-6435



