DEVON

1 SOURCE LIFTS & EQUIPMENT

2021-2022

Employee Benefits Guide

Benefits Program

Eligibility & Coverage Information

Enrollment

Electronic enrollment for all eligible employees will begin January 15, 2021. The enrollment process should be completed by both employees that had coverage and wish to continue with enrollment for 2021-22 benefits plan year, as well as those whom are qualified, new enrollees during that same period. **Enrollment must be completed before 5PM on January 30th or employees may lose eligibility and the ability to enroll for the 2021-2022 plan year.**

Plan Eligibility

Eligibility is determined by the requirements stated in the appropriate plan document or insurance policy for the year in question. Since the plans are subject to change, eligibility may also change. If you change coverage from one plan to another, you and your dependent(s) must meet the requirements of the new plan selected. For specific details, please refer to each plan's eligibility requirements.

Employee Eligibility

You are eligible to participate in the Company health and welfare plans if you are classified as a regular, full-time active employee working at least 30 hours per week.

You and your dependents will not be covered until you complete the appropriate paperwork with the Employee Benefits Division, provide the necessary documents to be enrolled (i.e. birth certificates, marriage license, copy of the social security card, etc.), and pay the required premium(s).

Things to Know for 2021

Make Changes

Open enrollment is your opportunity to make changes to your coverage each year. Employees must complete this process to qualify for coverages offered before January 30th at 5PM. Changes during the plan year can only be made due to a qualifying event. Employees must notify the Human Resources department within 31 days of the event to update coverage. Common qualifying events are marriage, divorce, birth of a child, or involuntary loss of other coverage.

Benefits Information

Additional information regarding your benefits can be found by logging in to your employee portal at **www.mydevsource.me**. If you need login assistance, please contact Human Resources.

HIPAA Compliance

The Health Insurance Portability and Accountability Act (HIPAA) requires that your health insurance plan limit the release of your health information to the minimum necessary required for your care. If you have questions about your claims, contact your insurance carrier first. If, after contacting the insurance carrier, you need a representative of the Human Resources Division or NFP, our insurance broker, to assist you with any claim issues, you may be required to provide written authorization to release information related to your claim.

Benefits Eligibility

All active employees who work at least 30 hours per week, and their eligible dependents, qualify for the benefits outlined in this guide.

For new hires, your coverage begins **on the first of the month following 30 days of employment**. After your initial enrollment, you will have the opportunity to enroll again during open enrollment each year. If your employment ends, your coverage will end on the last day of the month of your termination. Depending upon the circumstances of your termination, you may be able to continue coverage under COBRA.

Your eligible dependents include:

- Your spouse (unless legally separated)
- Your children to age 26 (regardless of student, marital, or tax dependent status)
- Your children of any age who have been qualified as disabled and are physically or mentally unable to care for themselves.

Qualifying Events

Outside of Open Enrollment or your initial new hire benefit enrollment, you generally will only be able to change your coverage if you have a qualifying life event.

Qualifying events include, but are not limited to:

- Change in marital status (marriage, divorce, death, legal separation)
- Change in number of dependents (birth, death, adoption, eligibility status, child support order)
- Change in employment status for you or your spouse (commencement, termination, leave of absence, full-time to part-time or vice versa)
- Special enrollment rights under HIPAA
- Lose or gain other coverage for yourself, your spouse, or your qualifying dependents

Generally, elections must be made within **30 days** of the qualifying event. **YOU** are responsible for notifying Human Resources or your Benefits team and providing the necessary documentation of the event.

DON'T FORGET! Newborns will **NOT** be automatically added to coverage. You must take action within **30 days** of the birth.

How to Enroll

This year, **everyone** will be required to enroll or re-enroll in benefits.

- Please follow the instructions on your mydevsource.me profile.
- If you are electing voluntary life for the first time for an amount above the Guarantee Issue, please fill out the Evidence of Insurability (EOI) and electronically sign.

Benefit Plan		Employees
Frequency of Deduction		Weekly
BlueCross BlueShield Gold Medical	Member Only	$45.97
Blue Advantage PPO Platinum P8E1ADT	Member + Child(ren)	$84.15
	Member + Spouse	$84.15
	Member + Family	$104.51
BlueCross BlueShield Silver Medical	Member Only	$31.72
Blue Advantage PPO Gold G746ADT	Member + Child(ren)	$61.41
	Member + Spouse	$61.41
	Member + Family	$84.05
BlueCross BlueShield Bronze Medical	Member Only	$17.37
Blue Advantage PPO Silver S8K1ADT	Member + Child(ren)	$41.71
	Member + Spouse	$41.71
	Member + Family	$47.05
Principal	Member Only	$0.00
Dental	Member + Child(ren)	$7.71
	Member + Spouse	$6.63
	Member + Family	$15.99
Principal	Member Only	$0.00
Vision	Member + Child(ren)	$0.87
	Member + Spouse	$1.69
	Member + Family	$2.73
Principal Basic Life	Coverage $50,000	$0.00
Principal Basic AD&D	Coverage $50,000	$0.00
Principal Voluntary Life & AD&D	Age	Price per $10,000
Purchased in $10,000 Increments to $300,000 maximum.	29 & Under	$0.32
- Proof of Good Health Required over $100,000 for employee	30 - 34	$0.35
- Proof of Good Health Required over $25,000 for spouse	35 - 39	$0.46
	40 - 44	$0.67
	45 - 49	$1.08
	50 - 54	$1.66
	55 - 59	$2.51
	60 - 64	$3.83
	65 - 69	$6.15
	70 & over	$10.13
Principal Voluntary Life - Child(ren)	Incremental Amount	Weekly Cost
	$2,500	$0.12
	$5,000	$0.23
	$7,500	$0.35
	$10,000	$0.46

Benefit Plan (cont.)		Employees
Frequency of Deduction		Weekly
Principal Short Term Disability	60% of income to $1,000/wk	$0.00
Principal Long Term Disability	60% of income to $10,000/mo	$0.00
Principal	Member Only	$0.00
24-hour Accident	Member + Child(ren)	$1.52
	Member + Spouse	$2.54
	Member + Family	$6.04
Principal	Age	Price per $1,000
Critical Illness	24 & Under	$0.12
Employees choose benefit in increments of $5,000 to $50,000 max	25 - 29	$0.14
Spouse choose benefit in increments of $2,500 to $25,000 max	30 - 34	$0.17
*Child(ren) default to $2,500 benefit at $0.17 per week	35 - 39	$0.22
**No Proof of Good health required for Members up to $10,000; Spouse up to $5,000.	40 - 44	$0.30
	45 - 49	$0.50
	50 - 54	$0.79
	55 - 59	$1.19
	60 - 64	$1.90
	65 - 69	$2.49
	70 & over	$3.39

Medical (BlueCross BlueShield of Oklahoma) • 1-800-942-5837 • bcbsok.com

The Company offers Employees three medical plan options, a Platinum Option, a Gold Option, and Silver option, through BCBSOK.

	PLATINUM - P8E1ADT	GOLD - G746ADT	SILVER - S8K1ADT
	Blue Advantage PPO Network	**Blue Advantage PPO Network**	**Blue Advantage PPO Network**
Plan Year Deductible			
Single	$750	$2,000	$7,750
Family	$2,250	$6,000	$15,500
Coinsurance Amounts After Deductible (shared cost after deductible met)			
Insurance %	90%	80%	60%
Member %	10%	20%	40%
Out-of-Pocket Maximum			
Single	$2,000	$6,000	$8,150
Family	$6,000	$17,000	$16,300
Member Costs			
Preventive Care	Covered in full	Covered in full	Covered in full
PCP Office Visits	$25 copay per visit	$30 copay per visit	$50 copay per visit
Specialist Visits	$45 copay per visit	$50 copay per visit	$85 copay per visit
MDLIVE (BCBS Telehealth)	$25 copay per consult	$30 copay per consult	$50 copay per consult
Urgent Care	$50 copay per visit	$50 copay per visit	$50 copay per visit
Emergency Room	$300 per visit, then deductible	$400 per visit, then deductible	$1,000 per visit, then deductible
Inpatient Services/ Outpatient Surgery	$150 inpatient / $100 outpatient facility fee, then deductible	$250 inpatient / $200 outpatient facility fee, then deductible	$250 inpatient / $500 outpatient facility fee, then deductible
Diagnostic, X-Rays, Lab Tests, MRI, CT Scans, PET Scans	10% after deductible	20% after deductible	40% after deductible
Prescription Drugs (Tiers: Pref. Generic / Non-Pref. Generic / Pref. Brand / Non-Pref. Brand / Pref. Specialty / Non-Pref. Specialty)			
30-day supply at Preferred Pharmacy	$0/$10/$35/$75/$150/$250	$0/$10/$50/$100/$150/$250	$0/$10/$50/$100/$150/$250
30-day supply at Non-Pref. Pharmacy	$10/$20/$55/$95/$150/$250	$10/$20/$70/$120/$150/$250	$10/$20/$70/$120/$150/$250
90-day mail-order supply	$0/$30/$105/$225/NA/NA	$0/$30/$150/$300/NA/NA	$0/$30/$150/$300/NA/NA
Employee Contributions	**PLATINUM**	**GOLD**	**SILVER**
Weekly Contributions	Member Only - $45.97; Member + Child(ren) - $84.15; Member + Spouse - $84.15; Member + Family - $104.51	Member Only - $31.72; Member + Child(ren) - $61.41; Member + Spouse - $61.41; Member + Family - $84.05	Member Only - $17.37; Member + Child(ren) - $41.71; Member + Spouse - $41.71; Member + Family - $47.05

NETWORK HIGHLIGHTS

Treatment in Oklahoma - Members seeking treatment within the state of Oklahoma can search the Blue Advantage PPO Network at bcbsok.com under the "Find a Doctor or Hospital" tab, or contact your preferred provider to verify if they accept Blue Advantage PPO Network through BlueCross and BlueShield of Oklahoma.

Treatment Outside of Oklahoma - Members seeking treatment outside the state of Oklahoma can search the National BlueCard PPO/EPO network at bcbs.com under the "Find a Doctor" tab, or contact your preferred provider to verify if they accept BlueCard PPO/EPO through BlueCross and BlueShield.

Dental (Principal) • 800-986-3343 • principal.com/dentist

Offered through Principal, the dental plan is 100% paid for employees by the Company. All employees enrolling in medical coverage are required to enroll in dental coverage.

	High Plan	
	In-Network	**Out-of-Network**
Plan Year Deductible		
Single	**$50**	**$50**
Family	**$150**	**$150**
Plan Year Maximum Benefit	**$2,500**	
Member Costs		
Diagnostic/Preventive Routine exam and cleaning every six months	**Covered in full**	**Covered in full**
Basic Restorative	**100% after deductible**	**80% after deductible**
Major Restorative	**60% after deductible**	**50% after deductible**
Orthodontia (child only)	**50% with a lifetime maximum of $2,000 per child.**	
Employee Contributions		
Weekly Contributions	**Member - $0.00;** **Member + Child(ren) - $7.71;** **Member + Spouse - $6.63;** **Member + Family - $15.99**	

Vision Plan (Principal / VSP Choice) • 800-986-3343 • vsp.com

Offered through Principal using VSP, the vision plan is 100% paid for employees by the Company. All employees enrolling in medical coverage are required to enroll in vision coverage.

	In-Network	**Out-of-Network**
Examination	**$10 copay**	**Up to $45**
Frames	**$25 copay, $150 allowance, 20% off balance over $150**	**Up to $70**
Standard Plastic Lenses		
Single Vision	**$25 copay**	**Up to $30**
Bifocal	**$25 copay**	**Up to $50**
Trifocal	**$25 copay**	**Up to $65**
Contact Lenses		
Elective Contacts	**$60 copay for fitting and evaluation, $150 allowance**	**Up to $105**
Necessary Contacts	**$25 Copay**	**Up to $210**
Frequency	**Exam, Frames, and Lenses/Contact Lenses: Once every 12 months**	
Network Providers	**Visit VSP.com and search "Find an In-Network Doctor" to view network facilities and doctors, or call your optomoterist and ask if they accept VSP Choice Network.**	
Employee Contributions		
Weekly Contributions	**Member - $0.00;** **Member + Child(ren) - $0.87;** **Member + Spouse - $1.69;** **Member + Family - $2.73**	

Disability (Principal) • 800-986-3343 • principal.com

The Company provides Short Term and Long Term Disability coverage at no cost to you. All eligible employees are required to enroll in Disability coverage.

	Short Term Disability	Long Term Disability
Coverage Amount	**60% of salary to max $1,000/week**	**60% of salary to max $10,000/month**
Maximum Payment Period	**Up to 12 weeks after elimination period is satisfied**	**Social Security normal retirement age**
Benefits Begin	**Day 8**	**Day 91**
Premium	**The Company pays 100% of the premium, you may pay taxes on the STD payments you may receive**	**The Company pays 100% of the premium, you may pay taxes on the LTD payments you may receive**

Life Insurance (Principal) • 800-986-3343 • principal.com

The Company provides Basic Life and AD&D insurance at no cost to you, and the option to purchase Voluntary Term Life insurance for you, your spouse, and any eligible children. All eligible employees are required to enroll in Basic Life and AD&D coverage.

	Basic Life and AD&D	Voluntary Term Life
Employee benefit	**$50,000**	**$10,000 increments to a max of $300,000 Amounts above $100,000 requires Proof of Good Health.**
Accidental Death and Dismemberment (AD&D)	**Equal to 1x the employee's basic life benefit**	**Included**
Spouse Benefit	**N/A**	**$5,000 increments to a max of $100,000. Amounts above $25,000 require Proof of Good Health and are subject to approval by Principal**
Child Benefit	**N/A**	**Flat $2,500, $5,000, $7,500, or $10,000**

Accident & Critical Illness (Principal) • 800-986-3343 • principal.com

The company provides accident insurance, which pays cash benefits directly to you for covered accidental injuries and treatment, for employees and offers employees an opportunity to purchase critical illness insurance, which pays cash benefits for diagnosis of cancer, heart attack, major organ failure, or stroke. Both the Accident and Critical Illness plans include a $50 wellness benefit that is paid to the Member one time per year when a covered person takes a preventive screening test, such as an annual physical or mammogram. You can enroll in these plans even if you are not enrolled in other benefit plans. All employees enrolling in medical coverage are required to enroll in Accident & Critical Illness.

	Accident insurance	Critical Illness
Weekly Contributions	**Member Only - $0.00;** **Member + Child(ren) - $1.52;** **Member + Spouse - $2.54** **Member + Family - $6.04**	**See Chart on Rates Page**

***Summaries presented are meant to be helpful in simplifying benefits. If there is any discrepancy between the above summaries and carrier summaries, the carrier summaries are to be assumed correct.**

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.bcbsok.com/member/policy-forms/2021 or by calling 1-800-942-5837. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $750 Individual/$2,250 Family Out-of-Network: $1,500 Individual/$4,500 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-Network Preventive Health, certain services with a copayment, and some prescription drugs are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network: $2,000 Individual/ $6,000 Family Out-of-Network: Unlimited Individual/Unlimited Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bcbsok.com or call 1-800-942-5837 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25/visit; deductible does not apply	30% coinsurance	Virtual Visits are available. See your benefit booklet* for details.
	Specialist visit	$45/visit; deductible does not apply	30% coinsurance	None
	Preventive care/screening/ immunization	No Charge; deductible does not apply	30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	Preauthorization may be required; see your benefit booklet* for details.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	Preauthorization may be required; see your benefit booklet* for details.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsok.com/rx21	Preferred generic drugs	Retail – Preferred Participating – No Charge Participating – $10/prescription Mail - No Charge; deductible does not apply	Retail – $10/prescription; deductible does not apply	Limited to a 30-day supply at retail (or a 90-day supply at a network of select retail pharmacies). Up to a 90-day supply at mail order. Specialty drugs limited to a 30-day supply. Payment of the difference between the cost of a brand name drug and a generic may also be required if a generic drug is available. All Out-of-Network prescriptions are subject to a 50% additional charge after the applicable copayment/coinsurance. Additional Out-of-Network charges will not apply to any deductible or out-of-pocket amounts.
	Non-preferred generic drugs	Retail – Preferred Participating – $10/prescription Participating – $20/prescription Mail - $30/prescription; deductible does not apply	Retail – $20/prescription; deductible does not apply	
	Preferred brand drugs	Retail – Preferred Participating – $35/prescription Participating – $55/prescription Mail - $105/prescription; deductible does not apply	Retail – $55/prescription; deductible does not apply	
	Non-preferred brand drugs	Retail – Preferred Participating – $75/prescription Participating – $95/prescription Mail - $225/prescription; deductible does not apply	Retail – $95/prescription; deductible does not apply	
	Preferred specialty drugs	$150/prescription; deductible does not apply	$150/prescription; deductible does not apply	
	Non-preferred specialty drugs	$250/prescription; deductible does not apply	$250/prescription; deductible does not apply	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100/visit plus 10% coinsurance	$200/visit plus 30% coinsurance	Preauthorization may be required. For Outpatient Infusion Therapy, see your benefit booklet* for details.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	10% coinsurance	30% coinsurance	
If you need immediate medical attention	Emergency room care	$300/visit plus 10% coinsurance	$300/visit plus 10% coinsurance	Copayment waived if admitted.
	Emergency medical transportation	10% coinsurance	10% coinsurance	None
	Urgent care	$50/visit; deductible does not apply	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$150/visit plus 10% coinsurance	$250/visit plus 30% coinsurance	Preauthorization is required. Preauthorization penalty: $500. See your benefit booklet* for details.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25/office visits; 10% coinsurance for other outpatient services	30% coinsurance	Preauthorization is required; see your benefit booklet* for details.
	Inpatient services	$150/visit plus 10% coinsurance	$250/visit plus 30% coinsurance	Preauthorization is required, see your benefit booklet* for details. Preauthorization penalty: $500.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	Primary Care: $25/visit Specialist: $45/initial visit; deductible does not apply	30% coinsurance	Copayment applies to first prenatal visit only (per pregnancy). Cost sharing does not apply for certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	$150/visit plus 10% coinsurance	$250/visit plus 30% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	30 visits/year. Preauthorization may be required.
	Rehabilitation services	10% coinsurance	30% coinsurance	Preauthorization may be required. Outpatient: Separate 25 visit limit per benefit period for Rehabilitation and Habilitation services, which includes physical, speech, occupational therapy, and muscle manipulation. Inpatient: Separate 30 day maximum for Rehabilitation and Habilitation services per benefit period. Preauthorization is required. Preauthorization penalty: $500.
	Habilitation services	10% coinsurance	30% coinsurance	
	Skilled nursing care	10% coinsurance	30% coinsurance	30 days/year. Preauthorization may be required. Inpatient Preauthorization penalty: $500.
	Durable medical equipment	10% coinsurance	30% coinsurance	Preauthorization may be required; see your benefit booklet* for details.
	Hospice services	Inpatient: $150/visit plus 10% coinsurance	Inpatient: $250/visit plus 30% coinsurance	Preauthorization is required. Inpatient Preauthorization penalty: $500.
If your child needs dental or eye care	Children's eye exam	No Charge; deductible does not apply	Up to a $30 reimbursement is available; deductible does not apply	One visit per year. Out-of-Network reimbursement will not exceed the retail cost. See your benefit booklet* (Pediatric Vision Care Benefits) for details.
	Children's glasses	No Charge; deductible does not apply	Reimbursement is available; deductible does not apply	One pair of glasses per year. Reimbursement for frames, lenses, and lens options purchased Out-of-Network is available (not to exceed the retail cost). See your benefit booklet* (Pediatric Vision Care Benefits) for details.
	Children's dental check-up	30% coinsurance	50% coinsurance	None

Excluded Services & Other Covered Services:

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

- Abortion (unless the life of the mother is endangered)
- Acupuncture
- Bariatric surgery (for treatment of obesity/weight reduction)
- Cosmetic surgery (with exception of accidental injury repair and some instances for physiological functioning improvement of a malformed body member)
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care (except for diabetic subscribers)
- Weight loss programs

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

- Chiropractic care (limited to 25 visits per calendar year)
- Hearing aids (limited to one each ear every 48 months)
- Private-duty nursing (limited to 85 visits per year)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the plan at Blue Cross and Blue Shield of Oklahoma at 1-800-942-5837 or visit www.bcbsok.com. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: For group health coverage subject to ERISA: the plan at 1-800-942-5837 or visit www.bcbsok.com, the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, and the Oklahoma Department of Insurance, Consumer Protection at 1-405-521-2991 or www.oid.ok.gov. For non-federal governmental group health plans and church plans that are group health plans, the plan at 1-800-942-5837 or www.bcbsok.com or contact the Oklahoma Department of Insurance, Consumer Protection at 1-405-521-2991 or www.oid.ok.gov. Additionally, a consumer assistance program can help you file your appeal. Contact the Oklahoma Department of Insurance's Consumer Health Assistance Program at 1-405-521-2991 or visit www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/ok.html.

Does this plan provide Minimum Essential Coverage? **Yes**

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

Does this plan meet the Minimum Value Standards? **Yes**

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

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-942-5837.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-942-5837.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-942-5837.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-942-5837.

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

About these Coverage Examples:

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

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

The plan's overall deductible	$750
Specialist copayment	$45
Hospital (facility) copay/coins	$150+10%
Other coinsurance	10%

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$750
Copayments	$200
Coinsurance	$100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,110**

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

The plan's overall deductible	$750
Specialist copayment	$45
Hospital (facility) copay/coins	$150+10%
Other coinsurance	10%

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$750
Copayments	$700
Coinsurance	$20
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,490**

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

The plan's overall deductible	$750
Specialist copayment	$45
Hospital (facility) copay/coins	$150+10%
Other coinsurance	10%

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$750
Copayments	$400
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,250**

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

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.bcbsok.com/member/policy-forms/2021 or by calling 1-800-942-5837. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $2,000 Individual/$6,000 Family Out-of-Network: $4,000 Individual/$12,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-Network Preventive Health, certain services with a copayment, and some prescription drugs are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network: $6,000 Individual/ $17,100 Family Out-of-Network: Unlimited Individual/Unlimited Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bcbsok.com or call 1-800-942-5837 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30/visit; deductible does not apply	30% coinsurance	Virtual Visits are available. See your benefit booklet* for details.
	Specialist visit	$50/visit; deductible does not apply	30% coinsurance	None
	Preventive care/screening/ immunization	No Charge; deductible does not apply	30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Preauthorization may be required; see your benefit booklet* for details.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Preauthorization may be required; see your benefit booklet* for details.

*For more information about limitations and exceptions, see the plan or policy document at www.bcbsok.com/member/policy-forms/2021.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsok.com/rx21	Preferred generic drugs	Retail – Preferred Participating – No Charge Participating – $10/prescription Mail - No Charge; deductible does not apply	Retail – $10/prescription; deductible does not apply	Limited to a 30-day supply at retail (or a 90-day supply at a network of select retail pharmacies). Up to a 90-day supply at mail order. Specialty drugs limited to a 30-day supply. Payment of the difference between the cost of a brand name drug and a generic may also be required if a generic drug is available. All Out-of-Network prescriptions are subject to a 50% additional charge after the applicable copayment/coinsurance. Additional Out-of-Network charges will not apply to any deductible or out-of-pocket amounts.
	Non-preferred generic drugs	Retail – Preferred Participating – $10/prescription Participating – $20/prescription Mail - $30/prescription; deductible does not apply	Retail – $20/prescription; deductible does not apply	
	Preferred brand drugs	Retail – Preferred Participating – $50/prescription Participating – $70/prescription Mail - $150/prescription; deductible does not apply	Retail – $70/prescription; deductible does not apply	
	Non-preferred brand drugs	Retail – Preferred Participating – $100/prescription Participating – $120/prescription Mail - $300/prescription; deductible does not apply	Retail – $120/prescription; deductible does not apply	
	Preferred specialty drugs	$150/prescription; deductible does not apply	$150/prescription; deductible does not apply	
	Non-preferred specialty drugs	$250/prescription; deductible does not apply	$250/prescription; deductible does not apply	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$200/visit plus 20% coinsurance	$300/visit plus 40% coinsurance	Preauthorization may be required. For Outpatient Infusion Therapy, see your benefit booklet* for details.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	$400/visit plus 20% coinsurance	$400/visit plus 20% coinsurance	Copayment waived if admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None

*For more information about limitations and exceptions, see the plan or policy document at www.bcbsok.com/member/policy-forms/2021.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Urgent care	$50/visit; deductible does not apply	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$250/visit plus 20% coinsurance	$350/visit plus 40% coinsurance	Preauthorization is required. Preauthorization penalty: $500. See your benefit booklet* for details.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30/office visits; 20% coinsurance for other outpatient services	30% coinsurance for office visits or 40% coinsurance for other outpatient services	Preauthorization is required; see your benefit booklet* for details.
	Inpatient services	$250/visit plus 20% coinsurance	$350/visit plus 40% coinsurance	Preauthorization is required, see your benefit booklet* for details. Preauthorization penalty: $500.

*For more information about limitations and exceptions, see the plan or policy document at www.bcbsok.com/member/policy-forms/2021.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	Primary Care: $30/visit Specialist: $50/initial visit; deductible does not apply	30% coinsurance	Copayment applies to first prenatal visit only (per pregnancy). Cost sharing does not apply for certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	$250/visit plus 20% coinsurance	$350/visit plus 40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	30 visits/year. Preauthorization may be required.
	Rehabilitation services	20% coinsurance	40% coinsurance	Preauthorization may be required. Outpatient: Separate 25 visit limit per benefit period for Rehabilitation and Habilitation services, which includes physical, speech, occupational therapy, and muscle manipulation. Inpatient: Separate 30 day maximum for Rehabilitation and Habilitation services per benefit period. Preauthorization is required. Preauthorization penalty: $500.
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	30 days/year. Preauthorization may be required. Inpatient Preauthorization penalty: $500.
	Durable medical equipment	20% coinsurance	40% coinsurance	Preauthorization may be required; see your benefit booklet* for details.
	Hospice services	Inpatient: $250/visit plus 20% coinsurance	Inpatient: $350/visit plus 40% coinsurance	Preauthorization is required. Inpatient Preauthorization penalty: $500.
If your child needs dental or eye care	Children's eye exam	No Charge; deductible does not apply	Up to a $30 reimbursement is available; deductible does not apply	One visit per year. Out-of-Network reimbursement will not exceed the retail cost. See your benefit booklet* (Pediatric Vision Care Benefits) for details.
	Children's glasses	No Charge; deductible does not apply	Reimbursement is available; deductible does not apply	One pair of glasses per year. Reimbursement for frames, lenses, and lens options purchased Out-of-Network is available (not to exceed the retail cost). See your benefit booklet* (Pediatric Vision Care Benefits) for details.
	Children's dental check-up	30% coinsurance	50% coinsurance	None

*For more information about limitations and exceptions, see the plan or policy document at www.bcbsok.com/member/policy-forms/2021.

Excluded Services & Other Covered Services:

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

- Abortion (unless the life of the mother is endangered)
- Acupuncture
- Bariatric surgery (for treatment of obesity/weight reduction)
- Cosmetic surgery (with exception of accidental injury repair and some instances for physiological functioning improvement of a malformed body member)
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care (except for diabetic subscribers)
- Weight loss programs

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

- Chiropractic care (limited to 25 visits per calendar year)
- Hearing aids (limited to one each ear every 48 months)
- Private-duty nursing (limited to 85 visits per year)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the plan at Blue Cross and Blue Shield of Oklahoma at 1-800-942-5837 or visit www.bcbsok.com. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: For group health coverage subject to ERISA: the plan at 1-800-942-5837 or visit www.bcbsok.com, the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, and the Oklahoma Department of Insurance, Consumer Protection at 1-405-521-2991 or www.oid.ok.gov. For non-federal governmental group health plans and church plans that are group health plans, the plan at 1-800-942-5837 or www.bcbsok.com or contact the Oklahoma Department of Insurance, Consumer Protection at 1-405-521-2991 or www.oid.ok.gov. Additionally, a consumer assistance program can help you file your appeal. Contact the Oklahoma Department of Insurance's Consumer Health Assistance Program at 1-405-521-2991 or visit www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/ok.html.

Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet the Minimum Value Standards? Yes

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

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-942-5837.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-942-5837.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-942-5837.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-942-5837.

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

About these Coverage Examples:

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

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

The plan's overall deductible	$2,000
Specialist copayment	$50
Hospital (facility) copay/coins	$250+20%
Other coinsurance	20%

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$300
Coinsurance	$700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,060**

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

The plan's overall deductible	$2,000
Specialist copayment	$50
Hospital (facility) copay/coins	$250+20%
Other coinsurance	20%

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$900
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,920**

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

The plan's overall deductible	$2,000
Specialist copayment	$50
Hospital (facility) copay/coins	$250+20%
Other coinsurance	20%

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$500
Coinsurance	$20
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,520**

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

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.bcbsok.com/member/policy-forms/2021 or by calling 1-800-942-5837. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $7,750 Individual/$15,500 Family Out-of-Network: $15,500 Individual/$31,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-Network Preventive Health, certain services with a copayment, and some prescription drugs are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network: $8,150 Individual/ $16,300 Family Out-of-Network: Unlimited Individual/Unlimited Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bcbsok.com or call 1-800-942-5837 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$50/visit; deductible does not apply	30% coinsurance	Virtual Visits are available. See your benefit booklet* for details.
	Specialist visit	$85/visit; deductible does not apply	30% coinsurance	None
	Preventive care/screening/ immunization	No Charge; deductible does not apply	30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	40% coinsurance	50% coinsurance	Preauthorization may be required; see your benefit booklet* for details.
	Imaging (CT/PET scans, MRIs)	40% coinsurance	50% coinsurance	Preauthorization may be required; see your benefit booklet* for details.

*For more information about limitations and exceptions, see the plan or policy document at www.bcbsok.com/member/policy-forms/2021.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsok.com/rx21	Preferred generic drugs	Retail – Preferred Participating – No Charge Participating – $10/prescription Mail - No Charge; deductible does not apply	Retail – $10/prescription; deductible does not apply	Limited to a 30-day supply at retail (or a 90-day supply at a network of select retail pharmacies). Up to a 90-day supply at mail order. Specialty drugs limited to a 30-day supply. Payment of the difference between the cost of a brand name drug and a generic may also be required if a generic drug is available. All Out-of-Network prescriptions are subject to a 50% additional charge after the applicable copayment/coinsurance. Additional Out-of-Network charges will not apply to any deductible or out-of-pocket amounts.
	Non-preferred generic drugs	Retail – Preferred Participating – $10/prescription Participating – $20/prescription Mail - $30/prescription; deductible does not apply	Retail – $20/prescription; deductible does not apply	
	Preferred brand drugs	Retail – Preferred Participating – $50/prescription Participating – $70/prescription Mail - $150/prescription; deductible does not apply	Retail – $70/prescription; deductible does not apply	
	Non-preferred brand drugs	Retail – Preferred Participating – $100/prescription Participating – $120/prescription Mail - $300/prescription; deductible does not apply	Retail – $120/prescription; deductible does not apply	
	Preferred specialty drugs	$150/prescription; deductible does not apply	$150/prescription; deductible does not apply	
	Non-preferred specialty drugs	$250/prescription; deductible does not apply	$250/prescription; deductible does not apply	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$500/visit plus 40% coinsurance	$600/visit plus 50% coinsurance	Preauthorization may be required. For Outpatient Infusion Therapy, see your benefit booklet* for details.
	Physician/surgeon fees	40% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	$1,000/visit plus 40% coinsurance	$1,000/visit plus 40% coinsurance	Copayment waived if admitted.
	Emergency medical transportation	40% coinsurance	40% coinsurance	None

*For more information about limitations and exceptions, see the plan or policy document at www.bcbsok.com/member/policy-forms/2021.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Urgent care	$50/visit; deductible does not apply	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$250/visit plus 40% coinsurance	$350/visit plus 50% coinsurance	Preauthorization is required. Preauthorization penalty: $500. See your benefit booklet* for details.
	Physician/surgeon fees	40% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$50/office visits; 40% coinsurance for other outpatient services	30% coinsurance for office visits or 50% coinsurance for other outpatient services	Preauthorization is required; see your benefit booklet* for details.
	Inpatient services	$250/visit plus 40% coinsurance	$350/visit plus 50% coinsurance	Preauthorization is required, see your benefit booklet* for details. Preauthorization penalty: $500.

*For more information about limitations and exceptions, see the plan or policy document at www.bcbsok.com/member/policy-forms/2021.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	Primary Care: $50/visit Specialist: $85/initial visit; deductible does not apply	30% coinsurance	Copayment applies to first prenatal visit only (per pregnancy). Cost sharing does not apply for certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	40% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	$250/visit plus 40% coinsurance	$350/visit plus 50% coinsurance	
If you need help recovering or have other special health needs	Home health care	40% coinsurance	50% coinsurance	30 visits/year. Preauthorization may be required.
	Rehabilitation services	40% coinsurance	50% coinsurance	Preauthorization may be required. Outpatient: Separate 25 visit limit per benefit period for Rehabilitation and Habilitation services, which includes physical, speech, occupational therapy, and muscle manipulation. Inpatient: Separate 30 day maximum for Rehabilitation and Habilitation services per benefit period. Preauthorization is required. Preauthorization penalty: $500.
	Habilitation services	40% coinsurance	50% coinsurance	
	Skilled nursing care	40% coinsurance	50% coinsurance	30 days/year. Preauthorization may be required. Inpatient Preauthorization penalty: $500.
	Durable medical equipment	40% coinsurance	50% coinsurance	Preauthorization may be required; see your benefit booklet* for details.
	Hospice services	Inpatient: $250/visit plus 40% coinsurance	Inpatient: $350/visit plus 50% coinsurance	Preauthorization is required. Inpatient Preauthorization penalty: $500.
If your child needs dental or eye care	Children's eye exam	No Charge; deductible does not apply	Up to a $30 reimbursement is available; deductible does not apply	One visit per year. Out-of-Network reimbursement will not exceed the retail cost. See your benefit booklet* (Pediatric Vision Care Benefits) for details.
	Children's glasses	No Charge; deductible does not apply	Reimbursement is available; deductible does not apply	One pair of glasses per year. Reimbursement for frames, lenses, and lens options purchased Out-of-Network is available (not to exceed the retail cost). See your benefit booklet* (Pediatric Vision Care Benefits) for details.
	Children's dental check-up	30% coinsurance	50% coinsurance	None

*For more information about limitations and exceptions, see the plan or policy document at www.bcbsok.com/member/policy-forms/2021.

Excluded Services & Other Covered Services:

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

- Abortion (unless the life of the mother is endangered)
- Acupuncture
- Bariatric surgery (for treatment of obesity/weight reduction)
- Cosmetic surgery (with exception of accidental injury repair and some instances for physiological functioning improvement of a malformed body member)
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care (except for diabetic subscribers)
- Weight loss programs

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

- Chiropractic care (limited to 25 visits per calendar year)
- Hearing aids (limited to one each ear every 48 months)
- Private-duty nursing (limited to 85 visits per year)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the plan at Blue Cross and Blue Shield of Oklahoma at 1-800-942-5837 or visit www.bcbsok.com. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: For group health coverage subject to ERISA: the plan at 1-800-942-5837 or visit www.bcbsok.com, the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, and the Oklahoma Department of Insurance, Consumer Protection at 1-405-521-2991 or www.oid.ok.gov. For non-federal governmental group health plans and church plans that are group health plans, the plan at 1-800-942-5837 or www.bcbsok.com or contact the Oklahoma Department of Insurance, Consumer Protection at 1-405-521-2991 or www.oid.ok.gov. Additionally, a consumer assistance program can help you file your appeal. Contact the Oklahoma Department of Insurance's Consumer Health Assistance Program at 1-405-521-2991 or visit www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/ok.html.

Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet the Minimum Value Standards? Yes

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

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-942-5837.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-942-5837.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-942-5837.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-942-5837.

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

About these Coverage Examples:

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

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

The plan's overall deductible	$7,750
Specialist copayment	$85
Hospital (facility) copay/coins	$250+40%
Other coinsurance	40%

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$7,750
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$8,110**

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

The plan's overall deductible	$7,750
Specialist copayment	$85
Hospital (facility) copay/coins	$250+40%
Other coinsurance	40%

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$900
Copayments	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,120**

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

The plan's overall deductible	$7,750
Specialist copayment	$85
Hospital (facility) copay/coins	$250+40%
Other coinsurance	40%

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,100
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,700**

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

Policyholder: DEVON INDUSTRIES INC

Group dental insurance benefit summary for

active members

Effective date: 03/01/2021

What's available to me?

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

Combined annual benefit maximum

This is the total amount your insurance will cover annually for all services combined.

Combined annual benefit maximum - all	
In-network	Out-of-network
$2,500	$2,500

Preventive

Calendar year deductible		Coinsurance your policy pays	
In-network	Out-of-network	In-network	Out-of-network
$0	$0	100%	100%

- Routine exams - once per six months
- Routine cleanings - once per six months
- Bitewing X-rays - once per calendar year
- Full mouth X-rays – once every 60 months
- Fluoride – once per calendar year (covered only for dependent children under age 14)

Basic

Calendar year deductible		Coinsurance your policy pays	
In-network	Out-of-network	In-network	Out-of-network
$50	$50	100%	80%

- Sealants – covered only for dependent children under age 14 once per tooth each 36 months
- Emergency exams – subject to Routine exam frequency limit
- Periodontal maintenance - if three months have passed since active surgical periodontal treatment; subject to Routine cleaning frequency limit
- Fillings - covered once every 24 months
- Composite (tooth colored) fillings covered on posterior teeth
- Simple oral surgery (simple extractions)
- Complex oral surgical procedures (impacted teeth)
- Simple endodontics (root canal therapy for anterior teeth)
- Complex endodontics (root canal therapy for molar teeth)
- Non-surgical periodontics, including scaling and root planing - once per quadrant per 24 months
- Periodontal surgical procedures - once per quadrant per 36 months

Major

Calendar year deductible		Coinsurance your policy pays	
In-network	Out-of-network	In-network	Out-of-network
$50	$50	60%	50%

- General anesthesia / IV sedation (covered only for specific procedures)
- Crowns – each 120 months per tooth
- Core buildup - each 120 months per tooth
- Bridges (initial placement / replacement) - 120 months old
- Dentures (initial placement / replacement) - 60 months old

Orthodontia

Calendar year deductible		Coinsurance your policy pays		Lifetime maximum	
In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
$0	$0	50%	50%	$2,000	$2,000

- Child coverage
- Bands that are placed on a dependent child's teeth before age 19 may be covered.

Additional benefits

- Family deductible - 3 times the per person deductible amount
- Combined deductible - Your deductibles that are in-network for basic and major services are combined. Your deductibles that are out-of-network for basic and major services are combined.
- Prevailing charge - When you receive care from an out-of-network-provider, benefits will be based on the 90th percentile of the usual and customary charges.

- Periodontal program - If you're pregnant or have diabetes or heart disease, you may receive scaling and root planing covered at 100% (if dentally necessary), or one additional cleaning (routine or periodontal) subject to deductible and coinsurance.
- Second opinion program - You may be eligible for second opinions from dental providers at 100%. This program makes sure you get the best advice to make an informed decision about your care.
- Cancer treatment oral health program - If you have cancer and are undergoing chemotherapy or head/neck radiation therapy, you may receive up to three fluoride treatments every 12 months covered at 100% plus one additional routine cleaning.

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

Who can buy coverage?

- You may buy coverage if you're an active, full-time employee working at least 30 hours a week. Seasonal, temporary, or contract employees aren't eligible.
  - o If you're on regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off, you're still considered actively at work, as long as you're fulfilling your regular duties and were working the day immediately prior to your time off.
  - o You must enroll within 31 days of being eligible. If you don't, you'll have to wait until the next open enrollment period, or qualifying event.

Additional eligibility requirements may apply.

How do I find a network dentist?

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

What if my dentist isn't in the network?

You can refer your dentist to our network. Please submit the dentist's name and information by calling 800-832-4450, or submitting a form at principal.com/refer-dental-provider.

What are the limitations and exclusions of my coverage?

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

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

What are the restrictions of my coverage?

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

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

Policyholder: DEVON INDUSTRIES INC

Group vision
Benefit summary for active members
Effective date: 03/01/2021

What's available to me?

Vision insurance is offered through Principal® and VSP® Vision Care. It provides choice, flexibility and savings through a VSP doctor.

If you buy this coverage, an established network of VSP doctors will provide quality care for you and your dependents.

Exams	Every 12 months, one exam is covered in full after $10 copay
Prescription glasses Lenses - 1 pair covered every 12 months Frames - covered up to $150 every 12 months; 20% off amount over allowance[1]	$25 copay • Single lenses • Lined bifocal lenses • Lined trifocal lenses • Lenticular lenses
Lens enhancements	Standard progressive lenses covered once every 12 months with a $0 copay[1] Most other popular lens enhancements are covered after a copay, saving our members an average of 20-25%[1]
Elective contacts	Covered up to $150 every 12 months. Contact lenses can be chosen instead of glasses.
Contact fitting and evaluation	$60 copay
Necessary contacts	Covered in full after $25 copay every 12 months

[1]This can vary based on state laws and provider location Savings may not apply at participating retail chains.

Who can buy coverage?

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

Additional eligibility requirements may apply.

What's the difference between elective and necessary contacts?

- Elective - when vision can be corrected by glasses, but contacts are worn.
- Necessary - when vision can't be corrected with glasses due to extreme vision problems.

Why am I charged an additional copay for contact fitting and evaluation?

- Contact lens wearers require an additional evaluation of the eyes' measurements, and possible follow-up appointments, for fitting and training on proper use of contact lenses.
- For these additional services, you won't pay more than $60 at in-network providers.

Are benefits the same for all VSP doctors?

- Yes, with the exception of Costco®, Walmart®, and Sam's Club®. The frame allowance at these locations is $80 which is equivalent to a $150 allowance at other VSP doctor locations. Not all providers at participating retail chains are in-network for exam services.
- Benefits may also vary by location due to state law.

How do I find a VSP doctor?

- Visit vsp.com to locate VSP doctors close to you -- or to see if your current eye care professional is in the VSP network.
  - You'll need to choose the "Choice" doctor network to view the VSP doctors for your coverage.
- Call 800-877-7195.

Will I get an ID card?

- Yes, your card will have a unique member ID that your doctor will use to verify benefits.

Will my doctor submit my claim?

- If you're seeing a VSP doctor, they'll submit the claim for you.
- If you're seeing someone outside the VSP network, you're responsible for submitting your own claim. You can get that form from vsp.com after logging in as a member using your member ID. Or call 800-877-7195.

Are there any additional savings with VSP?

- Glasses and sunglasses - you can save an average of 20-25% off glasses or sunglasses from any VSP doctor within 12 months of your last covered vision exam.
- Laser vision correction - you pay an average of 15% off the regular price and 5% off the promotional price. You'll only receive these discounts from contracted clinics.

These savings can vary based on state laws and provider location.

What benefits do I receive if my doctor is outside VSP's network?

Covered charges	Benefit	Frequency
Exams	Up to $45	Once every 12 months
Single lenses	Up to $30	One pair every 12 months
Lined bifocal lenses	Up to $50	One pair every 12 months
Lined trifocal lenses	Up to $65	One pair every 12 months
Lenticular lenses	Up to $100	One pair every 12 months
Frames	Up to $70	One set every 12 months
Elective contacts	Up to $105	Contacts are instead of frames and lenses
Necessary contacts	Up to $210	Contacts are instead of frames and lenses

What are the limitations of my benefits?

- Visual analysis or vision aids that aren't medically necessary aren't covered.
- No benefits will be paid for:
  - Non-prescription glasses
  - Medical or surgical treatment of the eyes
  - Claims submitted by a doctor who is part of your family

Once enrolled, you'll receive a booklet with more details regarding your plan limitations and exclusions.

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Insurance issued by Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392

This is a summary of vision coverage insured by or with administrative services provided by Principal Life Insurance Company. This outline is a brief description of your coverage. It is not an insurance contract or a complete statement of the rights, benefits, limitations and exclusions of the coverage. If there is a discrepancy between the policy and this document, the actual policy provision prevails. For complete coverage details, refer to the booklet.

Insurance issued by Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392

Policyholder: DEVON INDUSTRIES INC

Group term life insurance
Benefit summary for active members

Effective date: 03/01/2021

What's available to me?

Protect what means the most to you – the people you love. If something were to happen to you, your life insurance proceeds would go to the people you've designated as your beneficiaries.

	Benefit	Guaranteed issue[1]	Benefit reduction[2]
You	$50,000	If you're under 70: $50,000 If you're 70 or older: The lesser of $50,000 or the amount with the prior carrier	35% reduction at age 65, with an additional 15% reduction at age 70

[1]Amount of coverage you may buy without answering medical questions.
[2]As you get older, your life insurance benefit amount decreases. Age reductions apply to the benefit amount after providing health information.

Who receives coverage?

- You'll receive coverage if you're an active, full-time employee. Seasonal, temporary, or contract employees aren't eligible.
  - If you're on a regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off, you're still considered actively at work, as long as you're fulfilling your regular duties and were working the day immediately prior to your time off.
- If you were covered as an employee, you may be eligible as a retiree.

Additional eligibility requirements may apply.

Do I need to provide health information?

Benefit amounts over the guaranteed issue shown in the table above will require health information.

What benefits does Accidental Death and Dismemberment (AD&D) provide?

If you're accidentally injured on or off the job, you may receive a benefit equal to your life benefit.

Loss	AD&D Benefit
Loss of life, loss of both hands or both feet or one hand and one foot, or loss of sight of both eyes	100%
Loss of one hand, or one foot, or sight of one eye	50%
Loss of thumb and index finger on the same hand	25%
Seatbelt / airbag - If you die in a car accident while wearing a seat belt or protected by an airbag	$10,000

Repatriation - If you die at least 100 miles from your home	Up to $2,000
Education - If your children are enrolled in an accredited post-secondary school at the time of your death	$3,000/year for up to 4 years
Loss of use or paralysis - total loss of movement for 12 consecutive months or permanent paralysis	
Quadriplegia	100%
Paraplegia, hemiplegia, or loss of use of both hands or both feet or one hand and one foot.	50%
Loss of use of one arm, one leg, one hand or one foot	25%
Loss of speech and/or hearing - total loss for 12 consecutive months	
Loss of speech and hearing in both ears	100%
Loss of speech or hearing in both ears	50%
Loss of hearing in one ear	25%

Additional benefits:

Accelerated death benefit	If you're terminally ill, you may be able to receive a portion of your life benefit.
Conversion of terminated coverage	If coverage terminates, you may be able to convert coverage to an individual policy.

The benefit summary is a summary only. For a complete list of benefit restrictions, please refer to your booklet.

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Insurance issued by Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392

Policyholder: DEVON INDUSTRIES INC

Group voluntary term life insurance
Benefit summary for active members

Effective date: 03/01/2021

What's available to me?

Protect what means the most to you – the people you love. If something were to happen to you, your life insurance proceeds would go to the people you've designated as your beneficiaries.

	Benefit	Minimum	Guaranteed issue[1]	Maximum	Benefit reduction[2]
You	Select a benefit in increments of $10,000	$10,000	If you're under 70: $100,000 If you're 70 or older: $10,000	$300,000	35% reduction at age 65, with an additional 15% reduction at age 70
Your spouse[3]	Select a benefit in increments of $5,000	$5,000	If your spouse is under 70: $25,000 If your spouse is 70 or older: $10,000	$100,000	35% reduction at age 65, with an additional 15% reduction at age 70
Your child(ren)[3]	Options[4]: • $2,500, or • $5,000, or • $7,500, or • $10,000				

[1]Amount of coverage you may buy without providing health information.
[2]As you get older, your life insurance benefit amount decreases.
[3]Amount of coverage may not exceed 100% of your benefit.
[4]Dependent children under 14 days old receive a $1,000 benefit.

Who can buy coverage?

- You may buy coverage if you're an active, full-time employee working 30 hours a week. Seasonal, temporary, or contract employees can't purchase.
  - If you're on a regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off, you're still considered actively at work, as long as you're fulfilling your regular duties and were working the day immediately prior to your time off.
  - You must enroll within 31 days of being eligible. If you don't, you may need to provide health information for review, or if you have a qualifying event.
- If you're covered, you may buy coverage for your dependents, if they're not confined at home, in a hospital or skilled nursing facility (this is referred to as Period of Limited Activity).

Additional eligibility requirements may apply.

Do I need to provide health information?

Benefit amounts over the guaranteed issue shown in the table above for you and your spouse will require you to provide health information.

May I increase my benefit later?

- You may be able to increase your benefit and your dependent's benefit two increments per year during your open enrollment period without providing health information.
- If you have a qualifying life event (marriage, birth of a child, etc.), you may enroll or increase your benefit up to the guaranteed issue amount within 31 days without having to provide health information.

What benefits does Accidental Death and Dismemberment (AD&D) provide?

If you're accidentally injured on or off the job, you may receive a benefit equal to your life benefit. Your spouse may receive a benefit if they are injured off the job.

Loss	AD&D Benefit
Loss of life, loss of both hands or both feet or one hand and one foot, or loss of sight of both eyes	100%
Loss of one hand, or one foot, or sight of one eye	50%
Loss of thumb and index finger on the same hand	25%
Seatbelt / airbag - If you die in a car accident while wearing a seat belt or protected by an airbag	$10,000
Repatriation - If you die at least 100 miles from your home	Up to $2,000
Education - If your children are enrolled in an accredited post-secondary school at the time of your death	$3,000/year for up to 4 years
Loss of use or paralysis - total loss of movement for 12 consecutive months or permanent paralysis	
Quadriplegia	100%
Paraplegia, hemiplegia, or loss of use of both hands or both feet or one hand and one foot.	50%
Loss of use of one arm, one leg, one hand or one foot	25%
Loss of speech and/or hearing - total loss for 12 consecutive months	
Loss of speech and hearing in both ears	100%
Loss of speech or hearing in both ears	50%
Loss of hearing in one ear	25%

Occupational coverage	For your covered spouse, benefits will not be paid for an injury arising from or during employment for wage or profit.

Additional benefits:

Accelerated death benefit	If you're terminally ill, you may be able to receive a portion of your life benefit.
Coverage during disability	If you're disabled, you may be able to continue your coverage and not pay premium.
Portability	If you no longer qualify for coverage, you may be able to continue coverage for yourself and your covered dependents.
Conversion of terminated coverage	If coverage terminates, you may be able to convert coverage to an individual policy.

What are the limitations and exclusions of my coverage?

This benefit summary is a summary only. For a complete list of benefit restrictions, please refer to your booklet.

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Insurance issued by Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392

Policyholder: DEVON INDUSTRIES INC

Group short-term disability insurance
Benefit summary for active members

Effective date: 03/01/2021

Eligibility	
Eligible employees	All active, full-time employees working at least 30 hours a week
Benefits	
Primary weekly benefit	60% of your earnings up to $1,000
Benefit amount	Your primary weekly benefit minus other income sources
Elimination period	8th day for accidents and 8th day for sickness
Benefit payment period	Up to 12 weeks
Maternity	Pregnancy and childbirth are treated the same as any other disability

What's available to me?

Help protect one of your most valuable assets - the ability to earn an income. If you're temporarily disabled and can't work for a short amount of time, you can rely on short-term disability insurance to replace a portion of your weekly income.

Your primary weekly benefit is 60% of your earnings prior to your disability up to $1,000 minus other income sources. Other income sources could include but aren't limited to Social Security, other earnings, worker's compensation, state disability (if applicable), and salary continuance.

Your benefits are determined by your base wage. This is your definition of earnings and is outlined further in the booklet you'll receive following enrollment.

Compensation for business owners covers business profits plus salaries averaged over the prior two years.

Who receives coverage?

- You'll receive coverage if you're an active, full-time employee working at least 30 hours a week. Seasonal, temporary, or contract employees aren't eligible.
  - If you're on regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off, you're still considered actively at work, as long as you're fulfilling your regular duties and were working the day immediately prior to your time off.
  - You must enroll within 31 days of being eligible. If you don't, you'll need to provide health information for us to review for approval, or if you have a qualifying event.

Additional eligibility requirements may apply.

When do I begin receiving disability benefits?

Your elimination period is completed on the 8th day for accidents and the 8th day for sickness. The elimination period is the amount of time before you start receiving benefits.

Once I start receiving benefits, how long will they continue?

Short-term disability benefits can continue up to 12 weeks.

What types of conditions may qualify as a disability?

You'll be considered disabled due to sickness or injury, or pregnancy.

During your elimination period and your benefit payment period (how long benefit is paid), one of the following must apply:

- You're unable to perform the majority of substantial duties of your own job; or
- You're unable to earn 80% of your income prior to your disability while working in a modified capacity.

Additional benefits:

Work incentive benefit	If you're working on a limited or part-time basis, you can keep your work earnings and may still receive your disability benefit. You can't receive more than 100% of your earnings prior to your disability.
Rehabilitation plan	If you're disabled, our staff may work with you, your physician and employer to create an individual rehabilitation plan to help you return to work. You may also receive this benefit if you're not disabled but have a condition that prevents you from working.
Rehabilitation incentive benefit	If you're totally disabled and satisfy the requirements of an individual rehabilitation plan, your benefit percentage may increase by 5%.

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This is a summary of short-term disability coverage insured by or with administrative services provided by Principal Life Insurance Company. This outline is a brief description of your coverage. It is not an insurance contract or a complete statement of the rights, benefits, limitations and exclusions of the coverage. If there is a discrepancy between the policy and this document, the actual policy provision prevails. For complete coverage details, refer to the booklet.

Insurance issued by Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392

Policyholder: DEVON INDUSTRIES INC

Group long-term disability insurance
Benefit summary for active members

Effective date: 03/01/2021

Eligibility	
Eligible employees	All active, full-time employees working at least 30 hours a week
Benefits	
Primary monthly benefit	60% of your earnings up to $10,000
Benefit amount	Your primary monthly benefit minus other income sources
Elimination period	90 days
Own occupation period	2 year
Benefit payment period	Varies based on your age when you become disabled, see chart below
Limitations & exclusions	
Pre-existing conditions	3 months prior / 12 months insured
Other limitations	A complete list is included in your booklet

What's available to me?

Your income is important - you depend on it for almost everything. If you're too sick or hurt to work for a long period of time, you can rely on long-term disability insurance to replace a portion of your monthly income.

Your primary monthly benefit is 60% of your earnings prior to your disability up to $10,000 minus other income sources. Other income sources could include but aren't limited to Social Security for you and your dependents, other earnings, worker's compensation, state disability (if applicable) and salary continuance.

Your benefits are determined by your base wage. This is your definition of earnings and is outlined further in the booklet you'll receive following enrollment.

Compensation for business owners covers business profits plus salaries averaged over the prior two years.

Who receives coverage?

- You'll receive coverage if you're an active, full-time employee working at least 30 hours a week. Seasonal, temporary, or contract employees aren't eligible.
  - If you're on regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off, you're still considered actively at work, as long as you're fulfilling your regular duties and were working the day immediately prior to your time off.
  - You must enroll within 31 days of being eligible. If you don't, you'll need to provide health information for us to review for approval, or if you have a qualifying event.

Additional eligibility requirements may apply.

When do I begin receiving disability benefits?

Your elimination period is 90 days. The elimination period is the amount of time before you start receiving benefits.

If you recover and return to work during your elimination period and become disabled again, you may not have to satisfy a new elimination period. If you qualify for this, your elimination period will pick up at the point where it was left off when you recovered.

Once I start receiving benefits, how long will they continue?

Age disability occurs	Benefits are payable until the later of:
Under age 65	Social Security Normal Retirement Age (SSNRA) or 36 months
Age 65-67	SSNRA or 24 months
Age 68-69	SSNRA or 18 months
Age 70-71	SSNRA or 15 months
Age 72 and over	SSNRA or 12 months

What types of conditions may qualify as a disability?

You'll be considered disabled due to sickness or injury, or pregnancy.

During the first 2 years of receiving benefits, your disability is based on your own occupation, known as the own occupation period. This is the occupation you're routinely performing at the time of disability. After 2 years, we'll evaluate for any occupation based on education, training or experience.

During your elimination period and your own occupation period, one of the following must apply:

- You're unable to perform the majority of the substantial and material duties of your own occupation; or
- You're unable to earn 80% of your indexed income prior to your disability while working in a modified capacity.

After completing the own occupation period, one of the following must apply:

- You're unable to perform the majority of the substantial and material duties of any occupation for which you are or may reasonably become qualified based on education, training, or experience.
- You're performing the substantial and material duties of your own occupation or any occupation on a modified basis and are unable to earn more than 60% of your indexed income prior to your disability.

Do I qualify if I have a preexisting condition?

- You may. If you haven't been seen by a doctor or prescribed medication for an injury or sickness in the last 3 months or if your disability happens after 12 consecutive months of coverage, you may qualify.

Are mental nervous, drug/alcohol and special conditions covered?

- It'll be considered a disability if it's caused by:
  - A mental health condition for up to a lifetime maximum of 24 months
  - Abuse, dependency, or addiction to alcohol, drug, or chemicals for up to a lifetime maximum of 24 months
  - A special condition such as (but not limited to) chronic fatigue syndrome, musculoskeletal or connective tissue disorders for up to a lifetime maximum of 24 months
- The amount of time you receive benefits for these covered conditions will be limited to a combined lifetime maximum of 24 months.

Additional benefits:

Work incentive benefit	If you're working on a limited or part-time basis, you can keep your work earnings and may still receive your disability benefit for 12 months. You can't receive more than 100% of your earnings prior to your disability.
Rehabilitation plan	If you're disabled, our staff may work with you, your physician and employer to create an individual rehabilitation plan to help you return to work. You may also receive this benefit if you're not disabled but have a condition that prevents you from working.
Rehabilitation incentive benefit	If you're totally disabled and satisfy the requirements of an individual rehabilitation plan, your benefit percentage may increase by 5%.
Mandatory rehabilitation	You may be paid for any expenses associated with an approved rehabilitation plan.
Survivor benefit	If you haven't been paid an accelerated survivor benefit, your survivors will receive 3 times your primary monthly benefit minus other income sources, which includes but is not limited to Social Security.

What are the limitations and exclusions of my coverage?

Preexisting conditions	A preexisting condition is an injury or sickness (including pregnancy) and all related conditions and complications, in the three months prior to your effective date under this policy, for which you: • Received medical treatment, consultation, care or service; or • Were prescribed or took prescription medications Benefits will not be paid for disabilities resulting from preexisting conditions unless, when you become disabled, you have been actively at work for one full day after being covered under the policy for 12 consecutive months. Preexisting condition exclusions also apply to benefit increases due to policy amendments and changes in earnings of 25% or greater.
Treatment of mental health conditions, drug and alcohol abuse conditions and special conditions	A disability is considered due to alcohol, drug or chemical abuse, dependency or addiction or a mental health condition or a special condition if the disability is caused by one of these condition(s) and not by other disabling conditions. Maximum benefit payment periods for: Mental health conditions – 24 months Alcohol, drug or chemical abuse conditions – 24 months Special conditions – 24 months The benefit payment period listed above is a lifetime maximum for all periods of disability. All disabilities from conditions with the same maximum benefit payment period contribute towards one lifetime maximum. However, if at the end of the benefit payment period, you are confined in a hospital or any other type of facility providing treatment for any of these conditions, the benefit payment period may be extended to include the time period you are confined for treatment. Special conditions are considered to be Thoracic outlet syndrome / Headaches, such as functional, migraine, organic, sinus and tension / Chronic fatigue syndrome / Fibromyalgia/ Temporomandibular joint (TMJ) / Cumulative trauma disorder, overuse syndrome, or repetitive stress disorder including carpal tunnel and ulnar tunnel syndrome / Environmental allergies and multiple chemical sensitivity / Musculoskeletal and connective tissue disorders of the neck and back, including any disease or disorder of the cervical, thoracic and lumbosacral back and surrounding soft tissue, including sprains and strains of joints and adjacent muscles.

Policyholder: DEVON INDUSTRIES INC

Group accident insurance
Benefit summary for active members

Effective date: 03/01/2021

Eligibility	
Eligible employees	All active, full-time employees working at least 30 hours a week

Benefits if you're accidentally injured on or off the job or your spouse is injured off the job

Injury[1]	Benefit	
Burn		
2nd degree up to 25% of body	$500	
2nd degree over 25% of body	$1,500	
3rd degree up to 25% of body	$2,500	
3rd degree over 25% of body	$5,000	
Coma	$15,000	
Concussion	$500	
Dental injury	$500	
Dislocation[2]	Open reduction (surgical)	Closed reduction (non-surgical)
Hip	$7,500	$3,750
Knee	$5,000	$2,500
Ankle, collarbone, elbow, foot (excluding toes), hand (excluding fingers), lower jaw, shoulder, wrist	$3,000	$1,500
Eye injury with surgical repair	$500	
Fracture[2]	Open reduction (surgical)	Closed reduction (non-surgical)
Hip, skull (depressed), thigh (femur)	$10,000	$5,000
Lower leg (fibula, tibia), pelvis, skull (non-depressed), vertebrae	$5,000	$2,500
Ankle, arm, collarbone, elbow, facial bones, foot (excluding toes), hand (excluding fingers), jaw, knee cap, shoulder blade, wrist	$3,000	$1,500
Sternum, vertebral processes	$2,000	$1,000
Rib, tailbone (coccyx)	$1,000	$500
Injuries not specifically listed	$100	
Internal injury	$1,500	
Knee cartilage injury with surgical repair	$1,500	
Ruptured disc with surgical repair	$1,500	
Tendon / ligament / rotator cuff injury with surgical repair[3]	$1,500	

[1]One benefit per injury type is payable per accident, unless noted.
[2]If you suffer multiple dislocations and/or fractures, your benefit will be up to 200% of the benefit amount for the dislocation/fracture with the highest benefit.
[3]Up to two benefits are payable per accident.

Once enrolled, you'll receive a booklet with more details regarding each of these injuries.

What benefits does Accidental Death and Dismemberment (AD&D) provide?

AD&D	
You	$25,000
Your spouse	$12,500
Your child(ren)	$6,250
Loss	
Loss of life, or loss of both hands or both feet or one hand and one foot	100%
Loss of one hand or one foot	50%
Loss of thumb and index finger on the same hand	25%
Common carrier - If you die while a passenger on public or commercial transportation	additional 200%
Seat belt / airbag - If you die in a car accident while wearing a seat belt or protected by an airbag	additional 25%
Loss of use / paralysis - total loss of movement for 12 consecutive months or permanent paralysis	
Quadriplegia	100%
Paraplegia, hemiplegia, or loss of use of both hands or both feet or one hand and one foot	50%
Loss of use of one arm, one leg, one hand, or one foot	25%
Loss of sight, speech and/or hearing - total loss for 12 consecutive months	
Loss of speech and hearing in both ears, or loss of sight in both eyes	100%
Loss of speech or hearing in both ears, or loss of sight in one eye	50%
Loss of hearing in one ear	25%

Additional benefits:

Wellness	If you or your covered dependent has a covered screening test performed, you each may receive a $50 benefit, once per calendar year. Make sure to file your claim within a year of the date of service.
Portability	If you no longer qualify for coverage, you may be able to continue coverage for yourself and your covered dependents.

What's available to me?

Be better prepared financially for accidents before they happen. This coverage pays a lump-sum benefit for injuries received from an accident.

Who can buy coverage?

- You may buy coverage if you're an active, full-time employee working at least 30 hours a week. Seasonal, temporary, or contract employees can't purchase.
  - If you're on a regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off, you're still considered actively at work, as long as you're fulfilling your regular duties and were working the day immediately prior to your time off.
  - You must enroll within 31 days of being eligible. If you don't, you'll have to wait until the next open enrollment period.
- If you're covered, you may buy coverage for your dependents, if they're not confined at home, in a hospital or skilled nursing facility (this is referred to as Period of Limited Activity) ..

Additional eligibility requirements may apply.

What are the limitations and exclusions of my coverage?

For your covered spouse, benefits will not be paid for an injury arising from or during employment for wage or profit. There are limitations and exclusions to your coverage. A complete list is included in your booklet.

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ACCIDENT INSURANCE PROVIDES LIMITED BENEFITS.
This is a summary of accident coverage insured by or with administrative services provided by Principal Life Insurance Company. This outline is a brief description of your coverage. It is not an insurance contract or a complete statement of the rights, benefits, limitations and exclusions of the coverage. If there is a discrepancy between the policy and this document, the actual policy provision prevails. For complete coverage details, refer to the booklet.

Insurance issued by Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392

Policyholder: DEVON INDUSTRIES INC

Group critical illness insurance
Benefit summary for active members

Effective date: 03/01/2021

What's available to me?

Help cover some of the expenses associated with a serious illness with critical illness coverage. If you're diagnosed with a specific critical illness, you'll receive a lump-sum benefit you can use however you need to.

	Benefit	Minimum	Guaranteed issue[1]	Maximum
You	Select a benefit in increments of $5,000	$5,000	$10,000	$50,000
Your spouse	Select a benefit in increments of $2,500	$2,500	$5,000	$25,000 up to 50% of your benefit
Your child(ren)	Automatically covered for 25% of your benefit			

[1]Amount of coverage you may buy without providing health information.

Who can buy coverage?

- You may buy coverage if you're an active, full-time employee working at least 30 hours a week. Seasonal, temporary, or contract employees can't purchase.
  - If you're on a regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off, you're still considered actively at work, as long as you're fulfilling your regular duties and were working the day immediately prior to your time off.
  - You must enroll within 31 days of being eligible. If you don't, you'll need to provide health information for us to review for approval, or if you have a qualifying event.
- If you're covered, you may buy coverage for your dependents, if they're not confined at home, in a hospital or skilled nursing facility (this is referred to as Period of Limited Activity).

Additional eligibility requirements may apply.

Do I need to provide health information?

Benefit amounts over the guaranteed issue shown in the table above for you and your spouse will require health information.

May I increase my benefit later?

- If you have a qualifying life event (marriage, birth of a child, etc.), you may enroll or increase coverage up to the guaranteed issue amount within 31 days without having to provide health information.
- You may enroll or increase coverage at any time, but you may have to provide health information for yourself or your dependents if it's more than 31 days after becoming eligible for coverage.

Which illnesses are covered?

Covered illnesses	% of scheduled benefit for first occurrence	% of scheduled benefit for additional occurrences
Alzheimer's disease	100%	0%
Amyotrophic lateral sclerosis	100%	0%
Benign brain tumor	100%	0%
Carcinoma in situ	25%	25%
Coma	100%	0%
Coronary artery disease	25%	25%
Heart attack	100%	100%
Invasive cancer	100%	100%
Loss of hearing	100%	0%
Loss of sight	100%	0%
Loss of speech	100%	0%
Major organ failure	100%	100%
Multiple sclerosis	100%	0%
Occupational infectious disease	100%	0%
Paralysis	100%	0%
Parkinson's disease	100%	0%
Skin cancer	$250	$0
Stroke	100%	100%
Childhood conditions		
Cerebral palsy	100%	0%
Cleft lip / palate	100%	0%
Cystic fibrosis	100%	0%
Down syndrome	100%	0%
Muscular dystrophy	100%	0%
Spina bifida	100%	0%

Once enrolled, you'll receive a booklet with more details regarding each of these illnesses.

What if I've already had a covered illness (referred to as a preexisting condition)?

You may qualify for a benefit if you haven't been treated for this illness (including being seen by a doctor or taking medication) in the 6 months prior to your coverage effective date or you've had coverage for 12 consecutive months.

I've already received a benefit. Can I receive another benefit?

- Is it a different illness? You may receive a benefit if you're diagnosed more than 12 months after your prior illness.
- Is it an additional occurrence of the same illness? You may receive an additional benefit for carcinoma in situ, coronary artery disease, heart attack, invasive cancer, major organ failure and stroke if you're diagnosed more than 12 months after your prior illness and you've been treatment-free for 12 consecutive months.

Additional benefits:

Health screening	You may receive a $50 benefit for each covered person who has an eligible health screening test performed, once per calendar year. Make sure to file your claim within a year of the date of service.
Portability	If you no longer qualify for coverage, you may be able to continue coverage for yourself and your covered dependents.

What are the limitations and exclusions of my coverage?

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

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CRITICAL ILLNESS INSURANCE PROVIDES LIMITED BENEFITS.

This is a summary of critical illness coverage insured by or with administrative services provided by Principal Life Insurance Company. This outline is a brief description of your coverage. It is not an insurance contract or a complete statement of the rights, benefits, limitations and exclusions of the coverage. If there is a discrepancy between the policy and this document, the actual policy provision prevails. For complete coverage details, refer to the booklet.

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