

2026

Employee Benefit Package For: **WIN Network Agents**

Plan Year: 2026

January 1st, 2026 -December 31st, 2026

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BECKS BENEFITS DESIGN
CUSTOMIZING INSURANCE PLANS FOR YOUR UNIQUE NEEDS!

2026 Health Insurance Options

Traditional Plans

H.S.A. Plan

United Healthcare

<u>General Plan Details</u>	Unlimited	Unlimited	Unlimited
Lifetime Medical Maximum	Unlimited	Unlimited	Unlimited
Annual Deductible:			
Individual	\$1,000	\$5,000	\$6,000
Family	\$2,000	\$10,000	\$12,000
Coinsurance	80%	100%	100%
<u>Out-of-Pocket Maximum:</u>			
Individual	\$4,500	\$8,150	\$6,000
Family	\$9,000	\$16,300	\$12,000
<u>Physician Copays</u>			
Office Visits	\$25	\$25	Deductible
Specialists Visits	\$75	\$75	Deductible
Routine Physicals	\$0	\$0	\$0
<u>Hospital Visits</u>			
Hospital Coinsurance	Deductible	Deductible	Deductible
Emergency Room Visit	Ded. + \$300	Ded. + \$300	Deductible
<u>Prescriptions</u>			
Generic/Generic Specialty	\$10	\$15	Deductible
Preferred/Specialty Preferred	\$35	\$50	Deductible
Non-Preferred/Non-Preferred Specialty	\$75	\$150	Deductible
Tier 4	\$250	\$250	Deductible
<u>MONTHLY Cost:</u>			
Employee Only	\$554.81	\$463.97	\$431.09
Employee + Spouse	\$1,110.65	\$919.89	\$850.83
Employee + Child(ren)	\$1,034.86	\$857.73	\$793.61
Family	\$1,590.70	\$1,313.64	\$1,213.35

	NETWORK	NON-NETWORK
Individual Annual Deductible	\$50	\$50
Family Annual Deductible	\$150	\$150
Annual Maximum Benefit <i>(The total benefit payable by the plan will not exceed the highest listed maximum amount for either Network or Non-Network services.)</i>	\$1500 per person per calendar year	\$1500 per person per calendar year
Annual Deductible Applies to Preventive and Diagnostic Services	No	
Waiting Period	No waiting period	

COVERED SERVICES*	NETWORK PLAN PAYS**	NON-NETWORK PLAN PAYS***	BENEFIT GUIDELINES
DIAGNOSTIC SERVICES			
Periodic Oral Evaluation	100%	100%	Limited to 2 times per consecutive 12 months.
PREVENTIVE SERVICES			
Dental Prophylaxis (Cleanings)	100%	100%	Limited to 2 times per consecutive 12 months.
Fluoride Treatments	100%	100%	Limited to covered persons under the age of 16 years and limited to 2 times per consecutive 12 months.
Bitewing Radiographs	100%	100%	Limited to 1 series of films per calendar year.
Sealants	100%	100%	Limited to covered persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.
BASIC DENTAL SERVICES			
Radiographs	80%	80%	Complete/Panorex: Limited to 1 time per consecutive 36 months.
Lab and Other Diagnostic Tests	80%	80%	
Space Maintainers	80%	80%	For covered persons under the age of 16 years, limit 1 per consecutive 60 months.
Restorations <i>(Amalgam or Anterior Composite)*</i>	80%	80%	Multiple restorations on one surface will be treated as a single filling.
Palliative Treatment	80%	80%	Covered as a separate benefit only if no other service was done during the visit other than X-rays.
Simple Extractions	80%	80%	Limited to 1 time per tooth per lifetime.
Periodontal Maintenance	80%	80%	Limited to 2 times per consecutive 12 months following active and adjunctive periodontal therapy, exclusive of gross debridement.
MAJOR DENTAL SERVICES			
Oral Surgery <i>(includes surgical extractions)</i>	50%	50%	
Endodontics	50%	50%	Root Canal Therapy: Limited to 1 time per tooth per lifetime.
Periodontics	50%	50%	Perio Surgery: Limited to 1 quadrant or site per consecutive 36 months per surgical area. Scaling and Root Planing: Limited to 1 time per quadrant per consecutive 24 months.
General Anesthesia	50%	50%	When clinically necessary.
Occlusal Guard	50%	50%	Limited to 1 guard every consecutive 36 months.
Inlays/Onlays/Crowns*	50%	50%	Limited to 1 time per tooth per consecutive 60 months.
Dentures and other Removable Prosthetics	50%	50%	Full Denture/Partial Denture: Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.
Fixed Partial Dentures (Bridges)*	50%	50%	Limited to 1 time per tooth per consecutive 60 months.

* Your dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exist, your plan bases reimbursement on the least costly treatment alternative. If you and your dentist have agreed on a treatment which is more costly than the treatment on which the plan benefit is based, you will be responsible for the difference between the fee for service rendered and the fee covered by the plan. In addition, a pre-treatment estimate is recommended for any service estimated to cost over \$500; please consult your dentist.

** The network percentage of benefits is based on the discounted fee negotiated with the provider.

*** The non-network percentage of benefits is based on the allowable amount applicable for the same service that would have been rendered by a network provider.

In accordance with the Illinois state requirement, a partner in a Civil Union is included in the definition of Dependent. For a complete description of Dependent Coverage, please refer to your Certificate of Coverage.

The Prenatal Dental Care (not available in WA) and Oral Cancer Screening programs are covered under this plan. The material contained in the above table is for informational purposes only and is not an offer of coverage. Please note that the above provides only a brief, general description of coverage and does not constitute a contract. For a complete listing of your coverage, including exclusions and limitations relating to your coverage, please refer to your Certificate of Coverage or contact your benefits administrator. If differences exist between this Summary Benefits and your Certificate of Coverage/benefits administrator, the Certificate/benefits administrator will govern. All terms and conditions of coverage are subject to applicable state and federal laws. State mandates regarding benefit levels and age limitations may supersede plan design features.

UnitedHealthcare Dental® Options PPO Plan is either underwritten or provided by: UnitedHealthcare Insurance Company, Hartford, Connecticut; UnitedHealthcare Insurance Company of New York, Hauppauge, New York; Unimerica Insurance Company, Milwaukee, Wisconsin; Unimerica Life Insurance Company of New York, New York, New York; or United HealthCare Services, Inc.



Vision Benefit Summary
Powered by UnitedHealthcare Vision Network
Customer Service and Provider Locator: (800) 638-3120
myuhcvision.com

Plan S1006

UnitedHealthcare Vision has been trusted for more than 50 years to deliver affordable, innovative vision care solutions to the nation's leading employers through experienced, customer-focused people and the nation's most accessible, diversified vision care network.

Exam with Materials

Benefit Frequency	
Comprehensive Exam(s)	Once every 12 months
Comprehensive Exam(s) for persons with diabetes	Twice every 12 months
Eyeglass Lenses	Once every 12 months
Frames	Once every 12 months
Contact Lenses instead of Eyeglasses	Once every 12 months

In-Network Services

Copays

Exam(s)	\$10
Eyeglasses (lenses and frame) - includes basic single vision, lined bifocal, lined trifocal or lenticular lenses	\$25
Contact lenses instead of Eyeglasses	\$25
Retinal Screening for persons with diabetes	\$0

Frame Benefit - for frames that exceed the allowance, an additional 30% discount may be applied to the overage¹

Frame Allowance	\$130
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Lens Options - this list highlights the discounted cost on our most popular lens options. Exact pricing may vary; confirm cost with your provider prior to purchase.

Standard Scratch Coating	\$0
Scratch Warranty	\$10
Tint	\$14
UV Coating	\$16
Photochromic	\$67
Anti-Reflective Tier I	\$30
Anti-Reflective Tier II	\$50
Anti-Reflective Tier III	\$75
Anti-Reflective Tier IV	\$95
Roll and Polish Edges	\$13
Progressive Tier I	\$55
Progressive Tier II	\$100
Progressive Tier III	\$150
Progressive Tier IV	\$200
Progressive Tier V	\$250
High Index (<1.66)	\$53
High Index (1.66-1.73)	\$63
Polycarbonate for Adults	\$33
Polycarbonate for Dependent Children	\$0

Contact Lens Benefit²

Elective contact lenses Allowance is applied toward the purchase of contact lenses. Contact lens copay is waived.	\$105
Elective contact lens fitting and evaluation Allowance is applied toward the contact lens fitting/evaluation fees.	\$30
Necessary contact lenses³	Covered in full after copay (if applicable).

Children's and Maternity Eye Care Benefit

Members up to age 19 and members pregnant or breastfeeding are eligible for a 2nd exam 60 days after the initial exam. These members are also eligible for a replacement frame and lenses if they have a prescription change of 0.5 diopter or more. The 2nd exam and replacement benefits are the same as the initial exam, frame and lens benefits.

Out-of-Network Reimbursements (Copays do not apply)

Exam(s)	Up To \$40.00
Frames	Up To \$45.00
Single Vision Lenses	Up To \$40.00
Lined Bifocal and Progressive Lenses	Up To \$60.00
Lined Trifocal Lenses	Up To \$80.00
Lenticular Lenses	Up To \$80.00
Elective Contacts instead of Eyeglasses ²	Up To \$80.00
Contact Lens Fitting and Evaluation	Up To \$0.00
Necessary Contacts instead of Eyeglasses ³	Up To \$210.00

Discounts

Laser vision

UnitedHealthcare has partnered with QualSight LASIK, the largest LASIK manager in the United States, to provide our members with access to discounted laser vision correction services. Member savings represent up to 35% off the national average price of Traditional LASIK. Contracted prices start at \$945 per eye for Traditional LASIK and \$1,395 per eye for Custom LASIK. Discounts are also provided on newer technologies such as Custom Bladeless (all laser) LASIK. For more information, visit myuhcvision.com.

Additional Material

At a participating in-network provider you will receive up to a 20% discount on an additional pair of eyeglasses or contact lenses. This program is available after your vision benefits have been exhausted. Please note that this discount shall not be considered insurance, and that UnitedHealthcare shall neither pay nor reimburse the provider or member for any funds owed or spent. Additional materials do not have to be purchased at the time of initial material purchase.

Contact Lens

Order extra contact lenses at uhcglasses.com for 10% off.

Hearing Aids

As a UnitedHealthcare Vision plan member, you can save on custom-programmed hearing aids when you buy them from UnitedHealthcare Hearing. To find out more go to UHChearing.com. When placing your order use promo code MYVISION to get the special price discount.

Blue Light Protection Discount

UnitedHealthcare Vision has collaborated with industry partners to provide members with discounts off the retail price on blue-light screen filters for their devices. Members can learn more and access discount information by visiting their plan website.

¹30% discount available at most participating in-network provider locations. May exclude certain frame manufacturers. Please verify discounts with your provider.

²Contact lenses are instead of eyeglass lenses and/or eyeglass frames.

³Necessary contact lenses are determined at the provider's discretion for certain conditions. If your provider considers your contacts necessary, you should ask your provider to contact UnitedHealthcare Vision confirming the reimbursement that UnitedHealthcare will make before you purchase such contacts.

Important to Remember:

In-Network

- Always identify yourself as a UnitedHealthcare Vision member when making your appointment. This will assist the provider in obtaining your benefit information.
- Patient lens options are subject to change.

Choice and Access of Vision Care Providers

UnitedHealthcare offers its vision program through a national network including both private practice and retail chain providers. To access the Provider Locator service or for a printed directory, visit our website myuhcvision.com or call (800) 638-3120, 24 hours a day, seven days a week. You may also view your benefits, search for a provider or print an ID card online at myuhcvision.com.

In-Network Provider - Copays and non-covered patient options are paid to provider by program participant at the time of service.

Out-of-Network Provider - Participant pays all billed charges to the provider, and UnitedHealthcare reimburses the participant for services rendered up to the maximum allowance. Copays do not apply to out-of-network benefits. Receipts for payments should be submitted within 90 days after the date of service to the following address: UnitedHealthcare Vision, Attn. Claims Department, P.O. Box 30978, Salt Lake City, UT 84130, or electronically through the online submission form on the plan website. If it was not reasonably possible to give written proof in the time required, the Company will not reduce or deny the claim for this reason. However, proof must be filed as soon as reasonably possible, but no later than 1 year after the date of service unless the Covered Person was legally incapacitated.

Customer Service is available toll-free at (800) 638-3120 from 8:00 a.m. to 11:00 p.m. Eastern Time Monday through Friday, and 9:00 a.m. to 6:30 p.m. Eastern Time on Saturday.

READ YOUR PLAN CAREFULLY - THIS BENEFIT SUMMARY PROVIDES A VERY BRIEF DESCRIPTION OF THE IMPORTANT FEATURES OF YOUR PLAN. THIS IS NOT THE INSURANCE CONTRACT. YOUR FULL RIGHTS AND BENEFITS ARE EXPRESSED IN THE ACTUAL PLAN DOCUMENTS THAT ARE AVAILABLE TO YOU UPON YOUR REQUEST TO US.

UnitedHealthcare vision coverage provided by or through UnitedHealthcare Insurance Company, located in Hartford, Connecticut, UnitedHealthcare Insurance Company of New York, located in Islandia, New York, or its affiliates. Administrative services provided by Spectera, Inc., United HealthCare Services, Inc. or their affiliates. Plans sold in Texas use policy form number VPOL.06.TX, VPOL.13.TX or VPOL.18.TX and associated COC form number VCOC.INT.06.TX, VCOC.CER.13.TX or VCOC.18.TX. Plans sold in Virginia use policy form number VPOL.06.VA, VPOL.13.VA or VPOL.18.VA and associated COC form number VCOC.INT.06.VA, VCOC.CER.13.VA or VCOC.18.VA. If you opt to receive vision care services or vision care materials that are not covered benefits under this plan, a participating vision care provider may charge you their normal fee for such services or materials. Prior to providing you with vision care services or vision care materials that are not covered benefits, the vision care provider will provide you with an estimated cost for each service or material upon your request. This cost may be higher than if you had received only covered vision services and you may incur additional out-of-pocket expenses. Eyewear materials may be ordered through our national lab network. You may receive discounts off the retail price of non-covered products and services from providers who have agreed to offer those discounts to you. These discount offers are not part of your insurance benefit and are offered at the discretion of participating providers. You are responsible for the full cost of these non-covered products and services. These discount offers are not guaranteed and may be ended at any time. Depending upon UnitedHealthcare Vision's agreement with these vendors and providers, UnitedHealthcare Vision may receive a portion of the fees paid for non-covered products and services.



WIN NETWORK AGENTS

WIN NETWORK AGENTS Plan Year January 1st, 2026-December 31st, 2026

Agent Information

Name: last Name, first name, middle initial Open enrollment New Hire
 Change (qualifying event) _____

Home Address / City / State / Zip Code Gender:

Date of Birth Date of Hire N/A Hours worked/week N/A

SSN: Occupation: Agent Annual Earnings: N/A

Dependent name:	Gender:	Relationship:	SSN:	DOB:

Please mark your selection:

Monthly Cost:	Employee only	Employee/Spouse	Employee/Child(ren)	Family	Waive
Medical- UHC H.S.A. \$6,000 ded	<input type="checkbox"/> \$431.09	<input type="checkbox"/> \$850.83	<input type="checkbox"/> \$793.61	<input type="checkbox"/> \$1,213.35	<input type="checkbox"/>
Medical- UHC \$5,000 ded	<input type="checkbox"/> \$463.97	<input type="checkbox"/> \$919.89	<input type="checkbox"/> \$857.73	<input type="checkbox"/> \$1,313.64	<input type="checkbox"/>
Medical – UHC \$1,000 ded	<input type="checkbox"/> \$554.81	<input type="checkbox"/> \$1,110.65	<input type="checkbox"/> 1,034.86	<input type="checkbox"/> \$1,590.70	<input type="checkbox"/>
Dental - UHC	<input type="checkbox"/> \$27.85	<input type="checkbox"/> \$55.71	<input type="checkbox"/> \$64.21	<input type="checkbox"/> \$96.91	<input type="checkbox"/>
Vision - UHC	<input type="checkbox"/> \$8.17	<input type="checkbox"/> \$15.51	<input type="checkbox"/> \$18.19	<input type="checkbox"/> \$25.60	<input type="checkbox"/>

Employee Signature

I hereby authorize WIN Network to deduct the appropriate premium contributions from commissions based on my benefit election choices.

Agent Signature: _____
Date: _____