



Your employee benefits – **2023-2024**

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- Medical
 - Aetna
 - Plan 1: \$2,000 Deductible Copay plan
 - Plan 2: \$3,500 Deductible Copay plan
 - Plan 3: \$5,500 Deductible HSA plan
- Dental
 - Aetna
- Vision
 - Aetna
- Basic Life and AD&D
 - Principal
- Short-Term Disability
 - o Principal
- Healthcare FSA
 - Navia
- Limited Purpose FSA
 - o Navia
- Dependent Care FSA
 - o Navia
- HSA
 - o UMB





Medical Benefits	Plan 1	Plan 2	Plan 3 (HSA)	
Member Coinsurance	20%	20%	0%	
Deductible				
Individual	\$2,000	\$3,500	\$5,500	
Family	\$4,000	\$7,000	\$11,000	
Out-of-Pocket Max		<u> </u>		
Individual	\$6,000	\$7,000	\$7,500	
Family	\$12,000	\$14,000	\$15,000	
Physician Services	¢25 Canav	#25 Canav	Doductible	
Primary Care Routine Preventative	\$25 Copay 100% Covered	\$35 Copay 100% Covered	Deductible 100% Covered	
Specialist	\$75 Copay	\$75 Copay	Deductible	
Hospital Services	<i>\$15</i> Сорау	<i>\$15</i> Сорау	Deductible	
Inpatient Hospital	Deductible + 20%	Deductible + 20%	Deductible	
Physician Services	Deductible + 20%	Deductible + 20%	Deductible	
Outpatient Surgery	Deductible + 20%	Deductible + 20%	Deductible	
Outpatient Diagnostics	Deductible + 20%	Deductible + 20%	Deductible	
Urgent Care	\$75 Copay	\$75 Copay	Deductible	
Emergency Room	\$300 Copay + 20%	\$300 Copay + 20%	Deductible + \$500 Copay	
Prescription Card				
Retail				
		\$3 / \$10 / \$50 / \$80 / 20% to \$250	Deductible + \$3 / \$10 / \$50 / \$100	
	/ 40% to \$500	/ 40% to \$500	/ 20% to \$250 / 40% to \$500	
Mail Order (90 Day Supply)	2x Retail Copay	2x Retail Copay	Deductible + 2x Retail Copay	
Employee Cost per Paycheck				
Employee Only	\$91.10	\$59.66	\$51.29	
Employee + Spouse	\$183.29	\$119.70	\$102.37	
Employee + Child(ren)	\$172.23	\$112.49	\$96.24	
Family	\$283.77	\$185.14	\$158.05	
WAIVE MEDICAL COVERAGE				
	DENTAL	VISION		
Employee Cost per Paycheck				
Employee Only	\$3.67	\$0.85		
Employee + Spouse	\$6.99	\$1.62		
Employee + Child(ren)	\$9.43	\$1.70		
Family	\$12.69	\$2.50		
WAIVE COVERAGE	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		
Check the b	ox next to the cost for the plan you wa	ant above, then fill in the information b	elow.	
PRINT NAME				
CICNATUDE		<u>-</u>	DATE	
SIGNATURE			DATE	

Basic Life and AD&D

This is a 100% employer paid benefit.

Plan Benefits	
Basic Life	\$20,000
Accidental Death and Dismemberment	\$20,000

Short-Term Disability

This is a 100% employer paid benefit.

Contact

Nancy Soden CFO 816.483.5100 nsoden@dsdoors.build

Disclaimer: The benefits outlined in this document are intended for summary purposes only and are not intended to be a complete explanation of all plan provisions. Please refer to actual plan documents or plan certificate for detailed provisions of the plan.

Notices

Notice of Special Enrollment Rights

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

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

Notice of Patient Protections

Your plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For children, you can designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Human Resources Department.

You do not need prior authorization from your plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Human Resources Department.

Women's Health and Cancer Rights Act

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator for more information.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than eight hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay in excess of 48 hours (or 96 hours).

HIPAA Privacy

Your employer is required by law to take reasonable steps to ensure the privacy and inform you about the uses of your protected health information (PHI). The use and disclosure of PHI is regulated by the federal law known as HIPAA (the Health Insurance Portability and Accountability Act). A more complete description of your privacy rights and protections is available to you on request. Contact the Human Resources Department with any questions or to request a copy of the full HIPAA privacy notice.



Coverage for: Employee + Family | Plan Type: POS

Coverage Period: 11/01/2023 - 10/31/2024



The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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, www.HealthReformPlanSBC.com or by calling 1-888-982-3862. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-888-982-3862 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In- <u>Network</u> : Individual \$2,000 / Family \$4,000. Out-of-Network: Individual \$4,000 / Family \$12,000.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. Certain office visits, <u>preventive care</u> , <u>urgent care</u> and <u>prescription drugs</u> in- <u>network</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	In-Network: Individual \$6,000 / Family \$12,000. Out-of-Network: Individual \$14,000 / Family \$42,000.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit?</u>	<u>Premiums</u> , <u>balance-billing</u> charges, penalties for failure to obtain <u>pre-authorization</u> for services, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See http://www.aetna.com/docfind or call 1-888-982-3862 for a list of in-network providers.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider before</u> you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the specialist you choose without a referral.



		What You Will Pay		
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Primary care visit to treat an injury or illness	\$25 <u>copay</u> /visit, <u>deductible</u> does not apply	50% coinsurance	No charge for in- <u>network</u> virtual primary care telemedicine <u>provider</u> visits for certain services.
If you visit a health care	Specialist visit	\$75 copay/visit, deductible does not apply	50% coinsurance	None
provider's office or clinic	Preventive care /screening /immunization	No charge	50% coinsurance	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	None
ii you nave a test	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.aetna.com/pharmacy-insu rance/individuals-families	Preferred generic drugs	Tier 1A: \$3 copay/ prescription (retail), \$6 copay/ prescription (mail order); Tier 1: \$10 copay/ prescription (retail), \$20 copay/ prescription (mail order), deductible does not apply	50% <u>coinsurance</u> (retail), <u>deductible</u> does not apply	Covers up to a 30 day supply (retail prescription), 31-90 day supply (mail order prescription). Your cost will be higher for choosing Brand over Generics unless prescribed Dispense as Written; cost difference penalty doesn't apply to out-of-pocket limit. No
	Preferred brand drugs	\$50 copay/ prescription (retail), \$100 copay/ prescription (mail order), deductible does not apply	50% <u>coinsurance</u> (retail), <u>deductible</u> does not apply	charge for preferred generic FDA-approved women's contraceptives in-network. No coverage for mail order prescriptions out-of-network. Maintenance drugs- after two retail fills, you are required to fill a 90-day
	Non-preferred generic/brand drugs	\$80 <u>copay/</u> prescription (retail), \$160 <u>copay/</u> prescription (mail order), <u>deductible</u> does not apply	50% <u>coinsurance</u> (retail), <u>deductible</u> does not apply	supply at CVS Caremark® Mail Service Pharmacy or CVS Pharmacy.
	Specialty drugs	Preferred: 20% coinsurance up to a \$250 maximum/ prescription for up to a 30 day supply; Non-preferred: 40% coinsurance up to a \$500	Not covered	First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred specialty pharmacy <u>network</u> .

	Services You May Need	What You Will Pay		
Common Medical Event		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
		maximum/ prescription for up to a 30 day supply, deductible does not apply		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	None
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	20% <u>coinsurance</u> after \$300 <u>copay</u> /visit	20% <u>coinsurance</u> after \$300 <u>copay</u> /visit	<u>Copay</u> waived if admitted. Out-of-network <u>emergency room care</u> cost-share same as in- <u>network</u> . No coverage for non-emergency care.
medical attention	Emergency medical transportation	20% coinsurance	20% coinsurance	Out-of-network cost-share same as in-network.
	Urgent care	\$75 <u>copay</u> /visit, <u>deductible</u> does not apply	50% coinsurance	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Out-of-network precertification required or \$400 penalty applies per occurrence.
nospital stay	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Outpatient office visits: No charge; All other outpatient services: 20% coinsurance	Office visits and all other outpatient services: 50% coinsurance	None
	Inpatient services	20% coinsurance	50% coinsurance	Out-of-network precertification required or \$400 penalty applies per occurrence.
If you are pregnant	Office visits	No charge	50% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	None
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	Out-of-network precertification required or \$400 penalty applies per occurrence.

	Services You May Need	What You Will Pay		
Common Medical Event		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Home health care	20% coinsurance	50% coinsurance	Coverage is limited to 60 visits per year. Out-of-network precertification required or \$400 penalty applies per occurrence.
	Rehabilitation services	\$75 <u>copay</u> /visit	50% coinsurance	Coverage is limited to 60 visits per year for Physical Therapy, Occupational Therapy, Speech Therapy & Chiropractic care combined.
If you need help	Habilitation services	20% coinsurance	50% coinsurance	None
recovering or have other special health needs	Skilled nursing care	20% coinsurance	50% coinsurance	Coverage is limited to 60 days per year. Out-of-network precertification required or \$400 penalty applies per occurrence.
	Durable medical equipment	50% coinsurance	50% coinsurance	Coverage is limited to 1 <u>durable medical</u> <u>equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	20% coinsurance	50% coinsurance	Out-of-network precertification required or \$400 penalty applies per occurrence.
If your child needs dental or eye care	Children's eye exam	No charge	50% coinsurance	Coverage is limited to 1 exam every 12 months.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

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

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Hearing aids

- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

- Routine foot care
- Weight loss programs

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

- Acupuncture Coverage is limited to 10 visits per year for in-network only.
- Chiropractic care Coverage is limited to 60 visits per year for Physical Therapy, Occupational Therapy, Speech Therapy & Chiropractic care combined.
- Routine eye care (Adult) Coverage is limited to 1 exam every 12 months.

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:

- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For more information on your rights to continue coverage, contact the <u>plan</u> at 1-888-982-3862.
- For non-federal governmental group health <u>plans</u>, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or <u>www.cciio.cms.gov</u>.
- If your coverage is a church <u>plan</u>, church <u>plans</u> are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the <u>Health Insurance</u> <u>Marketplace</u>. 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 <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information on how to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact:

- If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general toll free number at 1-888-982-3862. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental group health <u>plans</u>, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or <u>www.cciio.cms.gov</u>.
- Additionally, a consumer assistance program can help you file your <u>appeal</u>. Contact information is at: http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.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 Minimum Value Standards? Yes.

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

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

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost-sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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	\$75
Hospital (facility) coinsurance	20%
Other coinsurance	20%

well-controlled condition) The plan's overall deductible \$2

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a

The <u>plan's</u> overall <u>deductible</u>	\$2,000
Specialist copayment	\$75
Hospital (facility) coinsurance	20%
Other coinsurance	20%

Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

This EXAMPLE event includes services like:

Total Example Cost	\$12,700	
In this example, Peg would pay:		
<u>Cost Sharing</u>		
<u>Deductibles</u>	\$2,000	
<u>Copayments</u>	\$10	
Coinsurance	\$1,900	
What isn't covered		
Limits or exclusions	\$60	
The total Peg would pay is	\$3,970	

This EXAMPLE event includes services like:

<u>Primary care physician</u> office visits (including disease education)

<u>Diagnostic tests</u> (blood work)

Prescription drugs

Diabetic supplies (glucose meter)

Total Example Cost	\$5,600	
In this example, Joe would pay:		
Cost Sharing		
<u>Deductibles</u>	\$100	
<u>Copayments</u>	\$1,200	
<u>Coinsurance</u>	\$0	
What isn't covered		
Limits or exclusions	\$20	
The total Joe would pay is	\$1,320	

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	\$2,000
Specialist copayment	\$75
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)

<u>Diagnostic test</u> (x-ray)

<u>Durable medical equipment</u> (crutches)

Rehabilitation services (physical therapy)

Total Example Cost	\$2,800	
In this example, Mia would pay:		
Cost Sharing		
<u>Deductibles</u>	\$2,000	
<u>Copayments</u>	\$400	
<u>Coinsurance</u>	\$0	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$2,400	

Note: These numbers assume the patient does not participate in the <u>plan's</u> wellness program. If you participate in the <u>plan's</u> wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-888-982-3862.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-888-982-3862.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, disability, gender identity or sexual orientation.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: P.O. Box 24030, Fresno, CA 93779),

1-800-648-7817, TTY: 711,

Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies, including Aetna Life Insurance Company and its affiliates (Aetna).

AFA CPOSII 2000 80/50 CY V23

Supplemental Information

How is the overall deductible or	Individual deductible and	The family deductible and family out-of-pocket limit are cumulative for all family
out-of-pocket limit met?	out-of-pocket limit	members. The family deductible and out-of-pocket limit can be met by a combination
	payments apply to the	of family members; however no single individual within the family will be subject to
	family deductible and	more than the individual <u>deductible</u> or <u>out-of-pocket limit</u> amount.
	out-of-pocket limit.	

How your out-of-network care is reimbursed:

We cover the cost of services based on whether doctors are "in-network" or "out-of-network." We want to help you understand how much Aetna pays for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

You may choose a **provider** (doctor or hospital) in our **network**. You may choose to visit an out-of-network **provider**. If you choose a doctor who is out-of-network, your Aetna health **plan** may pay some of that doctor's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor or hospital.

When you choose out-of-network care, Aetna limits the amount it will pay. This limit is called the "recognized" or "allowed" amount.

Professional Services: 105% of Medicare

Facility Services: 140% of Medicare

Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your Aetna <u>plan</u> "recognizes." Your doctor may bill you for the dollar amount that your <u>plan</u> doesn't "recognize." You must also pay any <u>copayments</u>, <u>coinsurance</u> and <u>deductibles</u> under your <u>plan</u>. No dollar amount above the "recognized charge" counts toward your <u>deductible</u> or <u>out-of-pocket limit</u>. To learn more about how we pay out-of-network benefits, visit www.aetna.com. Type "how Aetna pays" in the search box.

You can avoid these extra costs by getting your care from Aetna's <u>network</u> of health care <u>providers</u>. Go to www.aetna.com and click on "Find a Doctor" on the left side of the page. If you are already a member, sign on to your Aetna member site.

This applies when you *choose* to get care out-of-network. When you have no choice (for example: emergency room visit after a car accident or for other **emergency services**), we will pay the bill as if you got care in-network. You pay cost sharing and **deductibles** for your in-network level of benefits. Contact Aetna if your health care **provider** asks you to pay more. You are not responsible for any outstanding **balance billed** by your **providers** for **emergency services** beyond your cost sharing and **deductibles**.

Other important information about your plan:

This <u>plan</u> does not cover all health care expenses and includes exclusions and limitations. Members should refer to their <u>plan</u> documents to determine which

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health care services are covered and to what extent.

Additional information regarding your <u>plan</u> is available in the Disclosure Document on www.aetna.com.

Information includes:

- "Knowing what is covered" which describes how we review a request for coverage for a service or supply
- "Prescription drug benefit" which describes procedures we use to manage prescription drug benefits. These procedures include how to obtain a list of covered drugs and the exception policy for receiving coverage of a drug that is not on a closed formulary

<u>Plans</u> are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits and **health insurance plans** contain exclusions and limitations. Not all health services are covered.

See <u>plan</u> documents for a complete description of benefits, exclusions, limitations and conditions of coverage. <u>Plan</u> features and availability may vary by location and are subject to change. You may be responsible for the health care <u>provider's</u> full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the <u>plan</u>. <u>Providers</u> are independent contractors and are not agents of Aetna. <u>Provider</u> participation may change without notice. We do not provide care or guarantee access to health services.

The following is a partial list of services and supplies that are generally not covered. However, your <u>plan</u> documents may contain exceptions to this list based on state mandates or the <u>plan</u> design or rider(s) purchased by you or your employer.

- All medical and hospital services not specifically covered in, or which are limited or excluded by your **plan** documents
- Donor egg retrieval
- Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial with respect to the treatment of cancer or other life-threatening disease or condition
- Home births
- Immunizations for travel or work except where <u>medically necessary</u> or indicated
- Implantable drugs and certain injectable drugs including injectable infertility drugs

- Long-term rehabilitation therapy
- Non-medically necessary services or supplies
- Orthotics except diabetic orthotics
- Outpatient **prescription drugs** (except for treatment of diabetes), unless covered by a prescription **plan** rider and over-the-counter medications (except as provided in a hospital) and supplies

- Radial keratotomy or related procedures
- Reversal of sterilization
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, counseling or **prescription drugs**
- Therapy or rehabilitation other than those listed as covered

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In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

We consider your personal information to be private. We have policies and procedures in place to protect your personal information from unlawful use and disclosure. For a summary of our policy, go to www.aetna.com. You'll find the Privacy Notices link at the bottom of the page.

<u>Plan</u> features and availability may vary by location and group size.

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Coverage for: Employee + Family | Plan Type: POS

Coverage Period: 11/01/2023 - 10/31/2024



The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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, www.HealthReformPlanSBC.com or by calling 1-888-982-3862. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-888-982-3862 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In- <u>Network</u> : Individual \$3,500 / Family \$7,000. Out-of-Network: Individual \$7,000 / Family \$21,000.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. Certain office visits, <u>preventive care</u> , <u>urgent care</u> and <u>prescription drugs</u> in- <u>network</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	In- <u>Network</u> : Individual \$7,000 / Family \$14,000. Out-of-Network: Individual \$17,000 / Family \$51,000.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit?</u>	<u>Premiums</u> , <u>balance-billing</u> charges, penalties for failure to obtain <u>pre-authorization</u> for services, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See http://www.aetna.com/docfind or call 1-888-982-3862 for a list of in-network providers.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider before</u> you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the specialist you choose without a referral.



	Services You May Need	What You Will Pay		
Common Medical Event		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Primary care visit to treat an injury or illness	\$35 copay/visit, deductible does not apply	50% coinsurance	No charge for in- <u>network</u> virtual primary care telemedicine <u>provider</u> visits for certain services.
If you visit a health care	Specialist visit	\$75 copay/visit, deductible does not apply	50% coinsurance	None
provider's office or clinic	Preventive care /screening /immunization	No charge	50% coinsurance	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	None
ii you nave a test	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	None
If you need drugs to treat	Preferred generic drugs	Tier 1A: \$3 copay/ prescription (retail), \$6 copay/ prescription (mail order); Tier 1: \$10 copay/ prescription (retail), \$20 copay/ prescription (mail order), deductible does not apply	50% <u>coinsurance</u> (retail), <u>deductible</u> does not apply	Covers up to a 30 day supply (retail prescription), 31-90 day supply (mail order prescription). Your cost will be higher for choosing Brand over Generics unless prescribed Dispense as Written; cost difference penalty doesn't apply to out-of-pocket limit. No
your illness or condition More information about prescription drug coverage is available at	Preferred brand drugs	\$50 copay/ prescription (retail), \$100 copay/ prescription (mail order), deductible does not apply	50% <u>coinsurance</u> (retail), <u>deductible</u> does not apply	charge for preferred generic FDA-approved women's contraceptives in-network. No coverage for mail order prescriptions out-of-network. Maintenance drugs- after two retail fills, you are required to fill a 90-day
www.aetna.com/pharmacy-insu rance/individuals-families	Non-preferred generic/brand drugs	\$80 copay/ prescription (retail), \$160 copay/ prescription (mail order), deductible does not apply	50% <u>coinsurance</u> (retail), <u>deductible</u> does not apply	supply at CVS Caremark® Mail Service Pharmacy or CVS Pharmacy.
	Specialty drugs	Preferred: 20% coinsurance up to a \$250 maximum/ prescription for up to a 30 day supply; Non-preferred: 40% coinsurance up to a \$500	Not covered	First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred specialty pharmacy <u>network</u> .

		What You Will Pay		
Common Medical Event			Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
		maximum/ prescription for up to a 30 day supply, deductible does not apply		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	None
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	20% <u>coinsurance</u> after \$300 <u>copay</u> /visit	20% <u>coinsurance</u> after \$300 <u>copay</u> /visit	<u>Copay</u> waived if admitted. Out-of-network <u>emergency room care</u> cost-share same as in- <u>network</u> . No coverage for non-emergency care.
inedical attention	Emergency medical transportation	20% coinsurance	20% coinsurance	Out-of-network cost-share same as in-network.
	Urgent care	\$75 copay/visit, deductible does not apply	50% coinsurance	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Out-of-network precertification required or \$400 penalty applies per occurrence.
1103pital Stay	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or	Outpatient services	Outpatient office visits: No charge; All other outpatient services: 20% coinsurance	Office visits and all other outpatient services: 50% coinsurance	None
substance abuse services	Inpatient services	20% coinsurance	50% coinsurance	Out-of-network precertification required or \$400 penalty applies per occurrence.
lf	Office visits	No charge	50% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
If you are pregnant	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	None
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	Out-of-network precertification required or \$400 penalty applies per occurrence.

		What You Will Pay		
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Home health care	20% coinsurance	50% coinsurance	Coverage is limited to 60 visits per year. Out-of-network precertification required or \$400 penalty applies per occurrence.
	Rehabilitation services	\$75 <u>copay</u> /visit	50% coinsurance	Coverage is limited to 60 visits per year for Physical Therapy, Occupational Therapy, Speech Therapy & Chiropractic care combined.
If you need help	Habilitation services	20% coinsurance	50% coinsurance	None
recovering or have other special health needs	Skilled nursing care	20% coinsurance	50% coinsurance	Coverage is limited to 60 days per year. Out-of-network precertification required or \$400 penalty applies per occurrence.
	Durable medical equipment	50% coinsurance	50% coinsurance	Coverage is limited to 1 <u>durable medical</u> <u>equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	20% coinsurance	50% coinsurance	Out-of-network precertification required or \$400 penalty applies per occurrence.
If your abild peeds destal	Children's eye exam	No charge	50% coinsurance	Coverage is limited to 1 exam every 12 months.
If your child needs dental or eye care	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

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

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- · Hearing aids

- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

- · Routine foot care
- Weight loss programs

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

- Acupuncture Coverage is limited to 10 visits per year.
- Chiropractic care Coverage is limited to 60 visits per year for Physical Therapy, Occupational Therapy, Speech Therapy & Chiropractic care combined.
- Routine eye care (Adult) Coverage is limited to 1 exam every 12 months.

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:

- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For more information on your rights to continue coverage, contact the <u>plan</u> at 1-888-982-3862.
- For non-federal governmental group health <u>plans</u>, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or <u>www.cciio.cms.gov</u>.
- If your coverage is a church <u>plan</u>, church <u>plans</u> are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the <u>Health Insurance</u> <u>Marketplace</u>. 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 <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information on how to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact:

- If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general toll free number at 1-888-982-3862. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental group health <u>plans</u>, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or <u>www.cciio.cms.gov</u>.
- Additionally, a consumer assistance program can help you file your <u>appeal</u>. Contact information is at: http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.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 Minimum Value Standards? Yes.

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

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

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost-sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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	\$3,500
Specialist copayment	\$75
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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

■ T	he <u>plan's</u> overall <u>deductible</u>	\$3,500
<u> </u>	pecialist copayment	\$75
+	lospital (facility) <u>coinsurance</u>	20%
	Other coinsurance	20%

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The <u>plan's</u> overall <u>deductible</u>	\$3,500
Specialist copayment	\$75
Hospital (facility) coinsurance	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		
<u>Deductibles</u>	\$3,500	
<u>Copayments</u>	\$10	
<u>Coinsurance</u>	\$1,600	
What isn't covered		
Limits or exclusions	\$60	
The total Peg would pay is	\$5,170	

This EXAMPLE event includes services like:

<u>Primary care physician</u> office visits (including disease education)

<u>Diagnostic tests</u> (blood work)

Prescription drugs

Diabetic supplies (glucose meter)

Total Example Cost	\$5,600	
In this example, Joe would pay:		
Cost Sharing		
<u>Deductibles</u>	\$100	
<u>Copayments</u>	\$1,300	
<u>Coinsurance</u>	\$0	
What isn't covered		
Limits or exclusions	\$20	
The total Joe would pay is	\$1,420	

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)

<u>Diagnostic test</u> (x-ray)

<u>Durable medical equipment</u> (crutches)

Rehabilitation services (physical therapy)

Total Example Cost	\$2,800	
In this example, Mia would pay:		
Cost Sharing		
<u>Deductibles</u>	\$2,300	
<u>Copayments</u>	\$200	
<u>Coinsurance</u>	\$0	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$2,500	

Note: These numbers assume the patient does not participate in the <u>plan's</u> wellness program. If you participate in the <u>plan's</u> wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-888-982-3862.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-888-982-3862.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, disability, gender identity or sexual orientation.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: P.O. Box 24030, Fresno, CA 93779),

1-800-648-7817, TTY: 711,

Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies, including Aetna Life Insurance Company and its affiliates (Aetna).

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How is the overall deductible or	Individual deductible and	The family deductible and family out-of-pocket limit are cumulative for all family
out-of-pocket limit met?	out-of-pocket limit	members. The family deductible and out-of-pocket limit can be met by a combination
	payments apply to the	of family members; however no single individual within the family will be subject to
	family deductible and	more than the individual <u>deductible</u> or <u>out-of-pocket limit</u> amount.
	out-of-pocket limit.	

How your out-of-network care is reimbursed:

We cover the cost of services based on whether doctors are "in-network" or "out-of-network." We want to help you understand how much Aetna pays for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

You may choose a **provider** (doctor or hospital) in our **network**. You may choose to visit an out-of-network **provider**. If you choose a doctor who is out-of-network, your Aetna health **plan** may pay some of that doctor's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor or hospital.

When you choose out-of-network care, Aetna limits the amount it will pay. This limit is called the "recognized" or "allowed" amount.

Professional Services: 105% of Medicare

Facility Services: 140% of Medicare

Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your Aetna <u>plan</u> "recognizes." Your doctor may bill you for the dollar amount that your <u>plan</u> doesn't "recognize." You must also pay any <u>copayments</u>, <u>coinsurance</u> and <u>deductibles</u> under your <u>plan</u>. No dollar amount above the "recognized charge" counts toward your <u>deductible</u> or <u>out-of-pocket limit</u>. To learn more about how we pay out-of-network benefits, visit www.aetna.com. Type "how Aetna pays" in the search box.

You can avoid these extra costs by getting your care from Aetna's <u>network</u> of health care <u>providers</u>. Go to www.aetna.com and click on "Find a Doctor" on the left side of the page. If you are already a member, sign on to your Aetna member site.

This applies when you *choose* to get care out-of-network. When you have no choice (for example: emergency room visit after a car accident or for other **emergency services**), we will pay the bill as if you got care in-network. You pay cost sharing and **deductibles** for your in-network level of benefits. Contact Aetna if your health care **provider** asks you to pay more. You are not responsible for any outstanding **balance billed** by your **providers** for **emergency services** beyond your cost sharing and **deductibles**.

Other important information about your plan:

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Questions: Call the toll free number on your ID card (1-888-982-3862 for prospective members), TDD 1-800-628-3323 (hearing impaired only), or visit us at www.HealthReformPlanSBC.com

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- Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial with respect to the treatment of cancer or other life-threatening disease or condition
- Home births
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- Implantable drugs and certain injectable drugs including injectable infertility drugs

- Long-term rehabilitation therapy
- Non-medically necessary services or supplies
- Orthotics except diabetic orthotics
- Outpatient <u>prescription drugs</u> (except for treatment of diabetes), unless covered by a prescription <u>plan</u> rider and over-the-counter medications (except as provided in a hospital) and supplies

- Radial keratotomy or related procedures
- Reversal of sterilization
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, counseling or **prescription drugs**
- Therapy or rehabilitation other than those listed as covered

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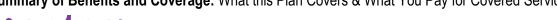
Supplemental Information

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

We consider your personal information to be private. We have policies and procedures in place to protect your personal information from unlawful use and disclosure. For a summary of our policy, go to www.aetna.com. You'll find the Privacy Notices link at the bottom of the page.

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Coverage Period: 11/01/2023 - 10/31/2024

Coverage for: Employee + Family | Plan Type: POS





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, www.HealthReformPlanSBC.com or by calling 1-888-982-3862. 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 https://www.healthcare.gov/sbc-glossary/ or call 1-888-982-3862 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In- <u>Network</u> : Individual \$5,500 / Family \$11,000. Out-of-Network: Individual \$10,000 / Family \$30,000.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> in- <u>network</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	In- <u>Network</u> : Individual \$7,500 / Family \$15,000. Out-of-Network: Individual \$20,000 / Family \$60,000.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> charges, penalties for failure to obtain <u>pre-authorization</u> for services, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See http://www.aetna.com/docfind or call 1-888-982-3862 for a list of in-network providers.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider before</u> you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	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.

		What You Will Pay		
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Primary care visit to treat an injury or illness	0% coinsurance	50% coinsurance	0% <u>coinsurance</u> after <u>deductible</u> for in- <u>network</u> virtual primary care telemedicine <u>provider</u> visits for certain services.
If you visit a health care	Specialist visit	0% coinsurance	50% coinsurance	None
provider's office or clinic	Preventive care /screening /immunization	No charge	50% coinsurance	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	0% coinsurance	50% coinsurance	Applies to services received in office or in outpatient setting.
ii you nave a test	Imaging (CT/PET scans, MRIs)	0% coinsurance	50% coinsurance	Applies to services received in office or in outpatient setting.
If you need drugs to treat	Preferred generic drugs	Tier 1A: \$3 copay/ prescription (retail), \$6 copay/ prescription (mail order); Tier 1: \$10 copay/ prescription (retail), \$20 copay/ prescription (mail order)	50% <u>coinsurance</u> (retail)	Covers up to a 30 day supply (retail prescription), 31-90 day supply (mail order prescription). Your cost will be higher for choosing Brand over Generics unless prescribed Dispense as Written; cost difference penalty doesn't apply to overall deductible or out-of-pocket limit. No charge for preferred
your illness or condition More information about prescription drug coverage is available at	Preferred brand drugs	\$50 copay/ prescription (retail), \$100 copay/ prescription (mail order)	50% <u>coinsurance</u> (retail)	generic FDA-approved women's contraceptives in-network. No coverage for mail order prescriptions out-of-network. Maintenance
www.aetna.com/pharmacy-insu rance/individuals-families	Non-preferred generic/brand drugs	\$100 <u>copay</u> / prescription (retail), \$200 <u>copay</u> / prescription (mail order)	50% <u>coinsurance</u> (retail)	drugs- after two retail fills, you are required to fill a 90-day supply at CVS Caremark® Mail Service Pharmacy or CVS Pharmacy. Deductible doesn't apply to certain preventive medications.
	Specialty drugs	Preferred: 20% coinsurance up to a \$250 maximum/ prescription for up to a 30 day supply; Non-preferred: 40%	Not covered	First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred specialty pharmacy <u>network</u> .

	Services You May Need	What You Will Pay		
Common Medical Event		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
		coinsurance up to a \$500 maximum/ prescription for up to a 30 day supply		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	50% coinsurance	None
J. J. J	Physician/surgeon fees	0% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	\$500 <u>copay</u> /visit	\$500 <u>copay</u> /visit	<u>Copay</u> waived if admitted. Out-of-network <u>emergency room care</u> cost-share same as in- <u>network</u> . No coverage for non-emergency care.
	Emergency medical transportation	0% coinsurance	0% coinsurance	Out-of-network cost-share same as in-network.
	<u>Urgent care</u>	0% coinsurance	50% coinsurance	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	50% coinsurance	Out-of-network precertification required or \$400 penalty applies per occurrence.
noopital otay	Physician/surgeon fees	0% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits and all other outpatient services: 0% coinsurance	Office visits and all other outpatient services: 50% coinsurance	None
	Inpatient services	0% <u>coinsurance</u>	50% coinsurance	Out-of-network precertification required or \$400 penalty applies per occurrence.
If you are pregnant	Office visits	No charge	50% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	0% coinsurance	50% coinsurance	None
	Childbirth/delivery facility services	0% coinsurance	50% coinsurance	Out-of-network precertification required or \$400 penalty applies per occurrence.

		What You Will Pay		
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Home health care	0% coinsurance	50% coinsurance	Coverage is limited to 60 visits per year. Out-of-network precertification required or \$400 penalty applies per occurrence.
	Rehabilitation services	0% coinsurance	50% coinsurance	Coverage is limited to 60 visits per year for Physical Therapy, Occupational Therapy, Speech Therapy & Chiropractic care combined.
If you need help	Habilitation services	0% coinsurance	50% coinsurance	None
recovering or have other special health needs	Skilled nursing care	0% coinsurance	50% coinsurance	Coverage is limited to 60 days per year. Out-of-network precertification required or \$400 penalty applies per occurrence.
	Durable medical equipment	0% coinsurance	50% coinsurance	Coverage is limited to 1 <u>durable medical</u> <u>equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	0% coinsurance	50% coinsurance	Out-of-network precertification required or \$400 penalty applies per occurrence.
If your shild peads dental	Children's eye exam	No charge	50% coinsurance	Coverage is limited to 1 exam every 12 months.
If your child needs dental or eye care	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

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

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- · Hearing aids

- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

- · Routine foot care
- · Weight loss programs

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

- Acupuncture Coverage is limited to 10 visits per year for in-network only.
- Chiropractic care Coverage is limited to 60 visits per year for Physical Therapy, Occupational Therapy, Speech Therapy & Chiropractic care combined.
- Routine eye care (Adult) Coverage is limited to 1 exam every 12 months.

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:

- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For more information on your rights to continue coverage, contact the <u>plan</u> at 1-888-982-3862.
- For non-federal governmental group health <u>plans</u>, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or <u>www.cciio.cms.gov</u>.
- If your coverage is a church <u>plan</u>, church <u>plans</u> are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the <u>Health Insurance Marketplace</u>. For more information about the <u>Marketplace</u>, visit <u>www.HealthCare.gov</u> or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information on how to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact:

- If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general toll free number at 1-888-982-3862. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental group health <u>plans</u>, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or <u>www.cciio.cms.gov</u>.
- Additionally, a consumer assistance program can help you file your <u>appeal</u>. Contact information is at: http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.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 Minimum Value Standards? No.

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

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

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost-sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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 <u>plan's</u> overall <u>deductible</u>	\$5,500
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:

Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

Total Example Cost	\$12,700	
In this example, Peg would pay:		
Cost Sharing		
<u>Deductibles</u>	\$5,500	
<u>Copayments</u>	\$10	
<u>Coinsurance</u>	\$0	
What isn't covered		
Limits or exclusions	\$60	
The total Peg would pay is	\$5,570	

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

well-controlled condition)

The plan's overall deductible \$5,500
Specialist coinsurance 0%
Hospital (facility) coinsurance 0%

0%

This EXAMPLE event includes services like:

<u>Primary care physician</u> office visits (including disease education)

Diagnostic tests (blood work)

Prescription drugs

Diabetic supplies (glucose meter)

Other coinsurance

Total Example Cost	\$5,600	
In this example, Joe would pay:		
Cost Sharing		
<u>Deductibles</u>	\$5,400	
<u>Copayments</u>	\$0	
<u>Coinsurance</u>	\$0	
What isn't covered		
Limits or exclusions	\$20	
The total Joe would pay is	\$5,420	

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$5,500
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)

<u>Diagnostic test</u> (x-ray)

<u>Durable medical equipment</u> (crutches)

Rehabilitation services (physical therapy)

Total Example Cost	\$2,800	
In this example, Mia would pay:		
Cost Sharing		
<u>Deductibles</u>	\$2,800	
<u>Copayments</u>	\$0	
<u>Coinsurance</u>	\$0	
What isn't covered		
Limits or exclusions \$0		
The total Mia would pay is	\$2,800	

Note: These numbers assume the patient does not participate in the <u>plan's</u> wellness program. If you participate in the <u>plan's</u> wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-888-982-3862.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-888-982-3862.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, disability, gender identity or sexual orientation.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: P.O. Box 24030, Fresno, CA 93779),

1-800-648-7817, TTY: 711,

Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies, including Aetna Life Insurance Company and its affiliates (Aetna).

AFA CPOSII 5500 HSA 100/50 E CY V23

Supplemental Information

Is a Health Savings Account (HSA) available under this <u>plan</u> option?	Yes	An HSA is an account that may be set up by you or your employer to help you plan for current and future health care costs. You may make contributions to the HSA up to a maximum amount set by the IRS. Any earnings on your contributions grow tax free and any withdrawals you make for eligible medical expenses are also tax free. Contact your employer or call the Customer Service number on your ID Card for more information.
How is the overall <u>deductible</u> or <u>out-of-pocket limit</u> met?	Individual deductible and out-of-pocket limit payments apply to the family deductible and out-of-pocket limit.	The family <u>deductible</u> and family <u>out-of-pocket limit</u> are cumulative for all family members. The family <u>deductible</u> and <u>out-of-pocket limit</u> can be met by a combination of family members; however no single individual within the family will be subject to more than the individual <u>deductible</u> or <u>out-of-pocket limit</u> amount.

How your out-of-network care is reimbursed:

We cover the cost of services based on whether doctors are "in-network" or "out-of-network." We want to help you understand how much Aetna pays for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

You may choose a **provider** (doctor or hospital) in our **network**. You may choose to visit an out-of-network **provider**. If you choose a doctor who is out-of-network, your Aetna health **plan** may pay some of that doctor's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor or hospital.

When you choose out-of-network care, Aetna limits the amount it will pay. This limit is called the "recognized" or "allowed" amount.

Professional Services: 105% of Medicare

Facility Services: 140% of Medicare

Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your Aetna <u>plan</u> "recognizes." Your doctor may bill you for the dollar amount that your <u>plan</u> doesn't "recognize." You must also pay any <u>copayments</u>, <u>coinsurance</u> and <u>deductibles</u> under your <u>plan</u>. No dollar amount above the "recognized charge" counts toward your <u>deductible</u> or <u>out-of-pocket limit</u>. To learn more about how we pay out-of-network benefits, visit www.aetna.com. Type "how Aetna pays" in the search box.

You can avoid these extra costs by getting your care from Aetna's **network** of health care **providers**. Go to www.aetna.com and click on "Find a Doctor" on the left side of the page. If you are already a member, sign on to your Aetna member site.

This applies when you *choose* to get care out-of-network. When you have no choice (for example: emergency room visit after a car accident or for other **emergency services**), we will pay the bill as if you got care in-network. You pay cost sharing and **deductibles** for your in-network level of benefits.

Questions: Call the toll free number on your ID card (1-888-982-3862 for prospective members), TDD 1-800-628-3323 (hearing impaired only), or visit us at www.HealthReformPlanSBC.com

AFA CPOSII 5500 HSA 100/50 E CY V23

Supplemental Information

Contact Aetna if your health care **provider** asks you to pay more. You are not responsible for any outstanding **balance billed** by your **providers** for **emergency services** beyond your cost sharing and **deductibles**.

Other important information about your plan:

This <u>plan</u> does not cover all health care expenses and includes exclusions and limitations. Members should refer to their <u>plan</u> documents to determine which health care services are covered and to what extent.

Additional information regarding your <u>plan</u> is available in the Disclosure Document on www.aetna.com.

Information includes:

- "Knowing what is covered" which describes how we review a request for coverage for a service or supply
- "Prescription drug benefit" which describes procedures we use to manage prescription drug benefits. These procedures include how to obtain a list of covered drugs and the exception policy for receiving coverage of a drug that is not on a closed formulary

<u>Plans</u> are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.

When offered, investment services are independently offered by the HSA Administrator.

HSAs are currently not available to HMO members in California and Illinois.

Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered.

See <u>plan</u> documents for a complete description of benefits, exclusions, limitations and conditions of coverage. <u>Plan</u> features and availability may vary by location and are subject to change. You may be responsible for the health care <u>provider's</u> full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the <u>plan</u>. <u>Providers</u> are independent contractors and are not agents of Aetna. <u>Provider</u> participation may change without notice. We do not provide care or guarantee access to health services.

The following is a partial list of services and supplies that are generally not covered. However, your <u>plan</u> documents may contain exceptions to this list based on state mandates or the <u>plan</u> design or rider(s) purchased by you or your employer.

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Supplemental Information

- All medical and hospital services not specifically covered in, or which are limited or excluded by your **plan** documents
- Donor egg retrieval
- Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial with respect to the treatment of cancer or other life-threatening disease or condition
- Home births
- Immunizations for travel or work except where <u>medically necessary</u> or indicated
- Implantable drugs and certain injectable drugs including injectable infertility drugs

Coverage for: Employee + Family | Plan Type: POS

- Long-term rehabilitation therapy
- Non-medically necessary services or supplies
- Orthotics except diabetic orthotics
- Outpatient <u>prescription drugs</u> (except for treatment of diabetes), unless covered by a prescription <u>plan</u> rider and over-the-counter medications (except as provided in a hospital) and supplies
- Radial keratotomy or related procedures
- Reversal of sterilization
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, counseling or **prescription drugs**
- Therapy or rehabilitation other than those listed as covered

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

We consider your personal information to be private. We have policies and procedures in place to protect your personal information from unlawful use and disclosure. For a summary of our policy, go to www.aetna.com. You'll find the Privacy Notices link at the bottom of the page.

<u>Plan</u> features and availability may vary by location and group size.

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Dental Benefits Summary

	Passive PPO MAX With PPOII Network
Annual Deductible*	
Individual	\$50
Family	\$150
Preventive Services	100%
Basic Services	80%
Major Services	50%
Annual Benefit Maximum	\$1,500
Office Visit Copay	N/A
Orthodontic Services**	50%
Orthodontic Deductible	None
Orthodontic Lifetime Maximum	\$1,500
*The deductible applies to: Basic & Major services only	
**Orthodontia is covered only for children (appliance must	be placed prior to age 20).

Partial List of Services	Passive PPO MAX With PPOII Network
Preventive	William Gir Notwork
Oral examinations (a)	100%
Cleanings (a) Adult/Child	100%
Fluoride (a)	100%
Sealants (permanent molars only) (a)	100%
Bitewing X-rays (a)	100%
Full mouth series X-rays (a)	100%
Space Maintainers	100%
Basic	
Root canal therapy	
Anterior teeth / Bicuspid teeth	80%
Root canal therapy, molar teeth	80%
Scaling and root planing (a)	80%
Gingivectomy*	80%
Amalgam (silver) fillings	80%
Composite fillings (anterior teeth only)	80%
Stainless steel crowns	80%
Incision and drainage of abscess*	80%
Uncomplicated extractions	80%
Surgical removal of erupted tooth*	80%
Surgical removal of impacted tooth (soft tissue)*	80%
Osseous surgery (a)*	80%
Surgical removal of impacted tooth (partial bony/ full bony)*	80%
Crown Lengthening	80%
Major	
Inlays	50%
Onlays	50%
Crowns	50%
Full & partial dentures	50%
Pontics	50%
General anesthesia/intravenous sedation*	50%
Denture repairs	50%
Crown Build-Ups	50%
*Certain services may be covered under the Medical Plan. Contact Membe (a) Frequency and/or age limitations may apply to these services. These I booklet/certificate.	



Dental Benefits Summary

Other Important Information

This Aetna Dental® Preferred Provider Organization (PPO) MAX benefits summary is provided by Aetna Life Insurance Company for some of the more frequently performed dental procedures. Under the Dental Preferred Provider Organization (PPO) MAX plan, you may choose at the time of service either a PPO participating dentist or any nonparticipating dentist. With the PPO MAX plan, savings are possible because the participating dentists have agreed to provide care for covered services at negotiated rates. Non-Participating coverage is limited to a maximum allowable charge (MAX) of the plan's payment, which is based on the contracted maximum fee for participating providers in the particular geographic area.

Emergency Dental Care

If you need emergency dental care for the palliative treatment (pain relieving, stabilizing) of a dental emergency, you are covered 24 hours a day, 7 days a week.

When emergency services are provided by a participating PPO dentist, your co-payment/coinsurance amount will be based on a negotiated fee schedule. When emergency services are provided by a non-participating dentist, you will be responsible for the difference between the plan payment and the dentist's usual charge. Refer to your plan documents for details. Subject to state requirements. Out-of-area emergency dental care may be reviewed by our dental consultants to verify appropriateness of treatment.

Partial List of Exclusions and Limitations* - Coverage is not provided for the following:

- 1. Services or supplies that are covered in whole or in part:
 - (a) under any other part of this Dental Care Plan; or
 - (b) under any other plan of group benefits provided by or through your employer.
- 2. Services and supplies to diagnose or treat a disease or injury that is not:
 - (a) a non-occupational disease; or
 - (b) a non-occupational injury.
- 3. Services not listed in the Dental Care Schedule that applies, unless otherwise specified in the Booklet-Certificate.
- 4. Those for replacement of a lost, missing or stolen appliance, and those for replacement of appliances that have been damaged due to abuse, misuse or neglect.
- 5. Those for plastic, reconstructive or cosmetic surgery, or other dental services or supplies, that are primarily intended to improve, alter or enhance appearance. This applies whether or not the services and supplies are for psychological or emotional reasons. Facings on molar crowns and pontics will always be considered cosmetic.
- 6. Those for or in connection with services, procedures, drugs or other supplies that are determined by Aetna to be experimental or still under clinical investigation by health professionals.
- 7. Those for dentures, crowns, inlays, onlays, bridgework, or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or to correct attrition, abrasion or erosion.
- 8. Those for any of the following services (Does not apply to the DMO plan in TX):
 - (a) an appliance or modification of one if an impression for it was made before the person became a covered person;
 - (b) a crown, bridge, or cast or processed restoration if a tooth was prepared for it before the person became a covered person; or
 - (c) root canal therapy if the pulp chamber for it was opened before the person became a covered person.
- 9. Services that Aetna defines as not necessary for the diagnosis, care or treatment of the condition involved. This applies even if they are prescribed, recommended or approved by the attending physician or dentist.
- 10. Those for services intended for treatment of any jaw joint disorder, unless otherwise specified in the Booklet-Certificate.
- 11. Those for space maintainers, except when needed to preserve space resulting from the premature loss of deciduous teeth.
- 12. Those for orthodontic treatment, unless otherwise specified in the Booklet-Certificate.
- 13. Those for general anesthesia and intravenous sedation, unless specifically covered. For plans that cover these services, they will not be eligible for benefits unless done in conjunction with another necessary covered service.
- 14. Those for treatment by other than a dentist, except that scaling or cleaning of teeth and topical application of fluoride may be done by a licensed dental hygienist. In this case, the treatment must be given under the supervision and guidance of a dentist.
- 15. Those in connection with a service given to a person age 5 or older if that person becomes a covered person other than:
 - (a) during the first 31 days the person is eligible for this coverage, or
 - (b) as prescribed for any period of open enrollment agreed to by the employer and Aetna. This does not apply to charges incurred:
 - (i) after the end of the 12-month period starting on the date the person became a covered person; or
 - (ii) as a result of accidental injuries sustained while the person was a covered person; or



Dental Benefits Summary

- (iii) for a primary care service in the Dental Care Schedule that applies as shown under the headings Visits and Exams, and X-rays and Pathology.
- 16. Services given by a nonparticipating dental provider to the extent that the charges exceed the amount payable for the services shown in the Dental Care Schedule that applies.
- 17. Those for a crown, cast or processed restoration unless:
 - (a) it is treatment for decay or traumatic injury, and teeth cannot be restored with a filling material; or
 - (b) the tooth is an abutment to a covered partial denture or fixed bridge.
- 18. Those for pontics, crowns, cast or processed restorations made with high-noble metals, unless otherwise specified in the Booklet-Certificate.
- 19. Those for surgical removal of impacted wisdom teeth only for orthodontic reasons, unless otherwise specified in the Booklet-Certificate.
- 20. Services needed solely in connection with non-covered services.
- 21. Services done where there is no evidence of pathology, dysfunction or disease other than covered preventive services.

Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage.

*This is a partial list of exclusions and limitations, others may apply. Please check your plan booklet for details.

Your Dental Care Plan Coverage Is Subject to the Following Rules:

Replacement Rule

The replacement of; addition to; or modification of: existing dentures; crowns; casts or processed restorations; removable denture; fixed bridgework; or other prosthetic services is covered only if one of the following terms is met:

The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed. This coverage must have been in force for the covered person when the extraction took place.

The existing denture, crown; cast or processed restoration, removable denture, bridgework, or other prosthetic service cannot be made serviceable, and was installed at least 8 years before its replacement.

The existing denture is an immediate temporary one to replace one or more natural teeth extracted while the person is covered, and cannot be made permanent, and replacement by a permanent denture is required. The replacement must take place within 12 months from the date of initial installation of the immediate temporary denture.

The extraction of a third molar does not qualify. Any such appliance or fixed bridge must include the replacement of an extracted tooth or teeth.

Tooth Missing But Not Replaced Rule

Coverage for the first installation of removable dentures; fixed bridgework and other prosthetic services is subject to the requirements that such removable dentures; fixed bridgework and other prosthetic services are (i) needed to replace one or more natural teeth that were removed while this policy was in force for the covered person; and (ii) are not abutments to a partial denture; removable bridge; or fixed bridge installed during the prior 8 years.

<u>Alternate Treatment Rule</u>: If more than one service can be used to treat a covered person's dental condition, Aetna may decide to authorize coverage only for a less costly covered service provided that all of the following terms are met:

- (a) the service must be listed on the Dental Care Schedule;
- (b) the service selected must be deemed by the dental profession to be an appropriate method of treatment; and
- (c) the service selected must meet broadly accepted national standards of dental practice.

If treatment is being given by a participating dental provider and the covered person asks for a more costly covered service than that for which coverage is approved, the specific copayment for such service will consist of:

- (a) the copayment for the approved less costly service; plus
- (b) the difference in cost between the approved less costly service and the more costly covered service.

Finding Participating Providers

Consult Aetna Dentals online provider directory, DocFind®, for the most current provider listings. Participating providers are independent contractors in private practice and are neither employees nor agents of Aetna Dental or its affiliates. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change without notice. For the most current information, please contact the selected provider or Aetna Member Services at the toll-free number on your ID card, or use our Internet-based provider directory (DocFind) available at www.aetna.com.

Specific products may not be available on both a self-funded and insured basis. The information in this document is subject to change without notice. In case of a conflict between your plan documents and this information, the plan documents will govern.

In the event of a problem with coverage, members should contact Member Services at the toll-free number on their ID cards for information on how to utilize the grievance procedure when appropriate.

All member care and related decisions are the sole responsibility of participating providers. Aetna Dental does not provide health care services and, therefore, cannot guarantee any results or outcomes.



Dental Benefits Summary

Dental plans are provided or administered by Aetna Life Insurance Company, Aetna Dental Inc., Aetna Dental of California Inc. and/or Aetna Health Inc.

This material is for informational purposes only and is neither an offer of coverage nor dental advice. It contains only a partial, general description of plan or program benefits and does not constitute a contract. The availability of a plan or program may vary by geographic service area. Certain dental plans are available only for groups of a certain size in accordance with underwriting guidelines. Some benefits are subject to limitations or exclusions. Consult the plan documents (Schedule of Benefits, Certificate/Evidence of Coverage, Booklet, Booklet-Certificate, Group Agreement, Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to your plan.

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call 877-238-6200.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),

1-800-648-7817, TTY: 711,

Fax: 859-425-3379 (CA HMO customers: 860-262-7705),

CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna). TTY: 711

For language assistance in your language call 877-238-6200 at no cost. (English)

Para obtener asistencia lingüística en español, llame sin cargo al 877-238-6200. (Spanish)

欲取得繁體中文語言協助, 請撥打877-238-6200, 無需付費。(Chinese)

Pour une assistance linguistique en français appeler le 877-238-6200 sans frais. (French)

Para sa tulong sa wika na nasa Tagalog, tawagan ang 877-238-6200 nang walang bayad. (Tagalog)



Partial list of Exclusions and Limitations

Exclusions and limitations for vision include: any charges in excess of the benefits, dollar or supply limits listed above; special vision procedures, such as orthoptics, vision therapy or vision training; vision services or supplies that do not meet professionally accepted standards; plano (non-prescription) lenses; non-prescription sunglasses; two pair of glasses in lieu of bifocals; medical and/or surgical treatment of the eyes; cosmetic services; lost or broken lenses, frames, glasses or contact lenses. Other exclusions and limitations may also apply.

*You can choose to receive care outside the network. Simply pay for the services up front and then submit a claim form to receive an amount up to the out of network reimbursement amounts listed above. Reimbursement will not exceed the providers actual charge. Claim forms can be found at www.aetnavision.com or by calling customer service Mon-Sun @ 877-9-SEE-AETNA. Submit completed claim form with receipts to Aetna, PO Box 8504 Mason, OH 45040-7111.

Enrolled members can access our secure member website once their plan becomes effective. Enrolled subscribers will receive a welcome packet with ID card mailed to their home within 15 business days after enrollment is processed.

**Allowances are one-time use benefits. No remaining balances may be used. The plan does not provide a declining balance benefit.

1Premium progressives and premium anti-reflective Brand designations are subject to annual review and change based on market conditions. Ask your eye care provider for more information.

²Additional pair discount applies to purchases made after the plan allowances have been exhausted.

³Non covered discounts may not be available in all states.

⁴Lasik or PRK from the US Laser Network, owned and operated by LCA Vision.

⁵Retinal Imaging available at participating locations. Contact your eyecare provider to verify if available.

Vision insurance plans are underwritten by Aetna Life Insurance Company (Aetna). Certain claims administration services are provided by First American Administrators, Inc. and certain network administration services are provided through EyeMed Vision Care ("EyeMed"), LLC.

Providers participating in the Aetna Vision network are contracted through EyeMed Vision Care, LLC. EyeMed and Aetna are independent contractors and not employees or agents of each other. Participating vision providers are credentialed by and subject to the credentialing requirements of EyeMed. Aetna does not provide medical/vision care or treatment and is not responsible for outcomes. Aetna does not guarantee access to vision care services or access to specific vision care providers and provider network composition is subject to change without notice.

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability. Aetna provides free aids/services to people with disabilities and to people who need language assistance. If you need a qualified interpreter, written information in other formats, translation or other services, call 877-973-3238. If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with Civil Rights Coordinator by contacting: Civil Rights Coordinator, P.O. Box 14462, Lexington, KY 40512. 1-800-648-7817, TTY: 711, Fax: 859-425-3379, CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD). Help for those who speak another language and for the hearing impaired

For language assistance in your language call 877-973-3238. Para obtener asistencia lingüística en español, llame sin cargo al número que figura en su tarjeta de identificación.

Policy forms issued in Idaho include: GR-29/GR-29N, AL HGrpPOL-Vision 01 Policy forms issued in Missouri include: AL HGrpPOL-Vision 01 Policy forms issued in Oklahoma include: AL HGrpPOL-Vision 01

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Policyholder: DESIGN SUPPLY DOORS LLC

Group Term Life Benefit Summary

This chart provides you a brief summary of the key benefits of the life coverage available from Principal Life Insurance Company. Following the chart, you will find additional information to answer questions you may have. For a complete list of all your life coverage benefits and restrictions, please refer to your booklet or contact your employer.

	Eligibility		
Job Class	ALL MEMBERS		
	Benefits Payable		
	Employee Life Benefits		
Benefit Amount	\$20,000		
Proof of Good Health	Proof of good health is required for life insurance amounts greater than:		
	If you are Under 70:		
	\$20,000		
	If you are 70 and older:		
	The lesser of \$20,000 or the amount with the prior carrier		
Age Reductions	35% benefit reduction at age 65, with an additional 15% reduction at age 70.		
	If your employer provides coverage to retired members, please refer to your benefit booklet for possible reductions due to age.		
	Age reductions apply to the benefit amount after proof of good health .		
	Additional Employee Benefits		
Coverage During Disability	If you become disabled before age 60, coverage will continue and premium may be waived.		
Accelerated Death Benefit	If you are terminally ill, you may be able to receive a portion of your life coverage benefit as a lump sum.		
Individual Purchase Rights	If coverage terminates, you may be able to convert coverage to an individual policy.		
	Limitations & Exclusions		
Coverage Outside of the US	Benefits will not be paid if you are outside the United States for certain reasons for more than six months.		

GROUP TERM LIFE

	Accidental Death & Dismemberment (AD&D) Coverage
Benefit Amount	 Your benefit is equal to your group term life benefit amount if loss is due to accident or injury. If loss is due to exposure to the elements or disappearance, your loss may be covered. You may be paid: Full benefit when you lose: your life / both hands / both feet / sight of both eyes / one hand and sight of one eye / one foot and sight of one eye / one hand and one foot. Half of the benefit when you lose: one hand / one foot / sight of one eye. One-fourth of the benefit when you lose the thumb and index finger on the same hand. The loss must occur within 365 days of the accident.
	Additional Benefits
Seatbelt/Airbag	\$10,000 if you are wearing a seatbelt or are protected by an airbag and die in an automobile accident
Education	\$3,000 per year for up to four years for dependent(s) enrolled at an accredited post-secondary school at the time of your death
Repatriation	Up to \$2,000 for preparation and transportation of your body if you die at least 100 miles from your permanent residence
Loss of Use/Paralysis	For total and irrevocable loss of voluntary movement for 12 consecutive months or paralysis that is permanent, complete and irreversible, the benefit is: 100% for quadriplegia; 50% for paraplegia, hemiplegia, loss of use of both hands or both feet, or loss of use of one hand and one foot; or 25% for loss of use of one arm, one leg, one hand or one foot
Loss of Speech and/or Hearing	When loss is irrevocable and continues for 12 consecutive months, the benefit is: 100% for loss of both speech and hearing; 50% for loss of speech or hearing; 25% for loss of hearing in one ear
	Limitations & Exclusions
Other Limitations	The Benefit Summary is a summary only. For a complete list of benefit restrictions, please refer to your booklet.

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Understanding Your Life Coverage Benefits

Am I Eligible For Coverage?

To be eligible for coverage, you must qualify as an eligible member and be considered actively at work or if your employer is providing coverage to you as a retired member, you may also be eligible for coverage.

Spouse and child coverage is not available.

V	What Additional Benefits Are Included?		
Coverage During Disability	If you become totally disabled before age 60, coverage will continue and premium will be waived. You must be totally disabled for 180 days before the waiver begins. Coverage continues without premium payment until you recover or turn age 65, whichever occurs first.		
Accelerated Death Benefit	If you are terminally ill you can receive up to 75% of your benefit amount in a lump sum, not to exceed \$250,000, as long as: Your life expectancy is 12 months or less (as diagnosed by a physician), and Your death benefit is at least \$10,000. If you use the accelerated benefit, your death benefit is reduced by the accelerated benefit payment. There are possible tax consequences to receiving an accelerated		
	benefit payment. You should contact your tax advisor for details. Receipt of accelerated benefits could also affect eligibility for public assistance. The charge for this benefit is included in the premium.		
Individual Purchase Rights	If coverage terminates, you may be able to convert coverage to an individual policy. Your employer is required to inform you of your individual purchase rights to convert to an individual policy without proof of good health. The amount you can purchase varies depending on the termination situation. Contact Principal Life for details.		
Claim Processing	Principal Life makes claim administration easy and convenient for employers by offering an online life claim form. Once the form is complete, employers submit the information directly over a secure, confidential Web site, expediting the claim review process. The employer can choose to use the online form or a printable version that can be faxed or mailed. Along with the online claim form, Principal Life also provides Express Claim Processing for claims that meet certain criteria. Through the Express Claim Process, decisions are reached within five working days without the employer or beneficiary submitting paperwork.		



 $Principal\ Life\ Insurance\ Company,\ Des\ Moines,\ Iowa\ 50392-0002,\ www.principal.com$

This is a summary of life coverage underwritten by or with administrative services provided by Principal Life Insurance Company. This benefit summary is for administrative purposes and is not a complete statement of benefits and restrictions. You'll receive a benefit booklet with details about your coverage. If there is a discrepancy between this summary and your benefit booklet, the benefit booklet prevails. Principal and symbol design and Principal Financial Group are trademarks and service marks of Principal Financial Services, Inc., a member of the Principal Financial Group.

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Policyholder: DESIGN SUPPLY DOORS LLC

Short Term Disability (STD) Benefit Summary

This chart provides you a brief summary of the key benefits of the short-term disability coverage available from Principal Life Insurance Company. Following the chart, you will find additional information to answer questions you may have. For a complete list of all your short-term disability coverage benefits and restrictions, please refer to your booklet or contact your employer.

Eligibility		
Job Class	ALL MEMBERS	
Eligible Members	All active, full time employees (except seasonal, temporary, or contract workers) who work at least 30 hours per week	
Benefits Payable		
Primary Weekly Benefit	60% of your predisability earnings up to \$1,500	
Benefit Amount	Primary Weekly Benefit less other income sources	
Definition of Earnings	Base wage	
Benefit Qualification		
Elimination Period	Benefits begin on the 15th day for accident and 15th day for sickness	
Benefit Payment Period	Up to 11 weeks after the elimination period is satisfied	
Maternity	Treated the same as any other disability	
Additional Benefits		
Survivor Benefit	3 weeks of pre-tax primary weekly benefit to your survivor	
Limitations & Exclusions		
Other Limitations	There are additional limitations to your coverage. A complete list is included in your booklet.	

Understanding Your Short-Term Disability Benefits

Am I Eligible For Coverage?

To be eligible for coverage, you must qualify as an eligible member and be considered actively at work.

You will be considered actively at work if you are able and available for active performance of all of your regular duties. Short-term absence because of a regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off is considered active work provided you are able and available for active performance of all of your regular duties and were working the day immediately prior to the date of your absence.

How Do I Qualify For Benefits?

1) **Meet the Definition of Disability**. Disabilities must be solely and directly caused by sickness, injury, or pregnancy.

During the elimination period and the benefit payment period, one of these situations must apply:

- You cannot perform the majority of the substantial and material duties of your own occupation.
- You are performing the duties of your own occupation on a modified basis and lose at least 20% of the income you earned before becoming disabled.
- You are performing the duties of any other occupation and lose at least 20% of the income you earned before becoming disabled.
- 2) **Satisfy the Elimination Period.** The amount of time you must be disabled before receiving benefits is called the elimination period. Benefits begin on the 15th day when due to injury and begin on the 15th day when due to sickness. The elimination period can be satisfied with days of total or partial disability.

How Much Weekly Benefit Will I Receive?

Your benefits will be determined by using your base wage.

The benefit payment period is the length of time you will receive benefits for a qualifying disability after the elimination period is satisfied. When you are unable to work in any capacity during the benefit payment period, your primary weekly benefit is equal to 60% of your predisability earnings, up to \$1,500. Your primary weekly benefit less income from other sources is the benefit amount you will receive. Your benefit amount will never be less than the \$15 minimum benefit.

SHORT-TERM DISABILITY

Benefits if Working If you are able to work while disabled, you may still be eligible to receive a disability benefit.

If you are working during the benefit payment period, your benefit amount is the lesser of:

- Your primary weekly benefit, less income from other sources, multiplied by your income loss percentage; or
- 100% of your predisability earnings, less income from other sources, less current earnings.

Income you receive from other sources can be deducted from your primary weekly benefit. For a complete list of other sources, please refer to your booklet. Other sources may include: All retirement or disability benefits that you and your dependents receive or could have received from Social Security or other government agencies/ Salary continuance, personal time off or sick pay / Workers' Compensation benefits / Income from state disability plans / Disability or retirement benefits paid by pension plans sponsored by the policyholder / Income received from no-fault auto laws / Severance pay.

How Long Will I Receive My Benefits?

You are eligible to receive short-term disability benefits for 11 weeks after the elimination period is satisfied.

Your disability benefits will end when you: Recover / Cease to be under the regular and appropriate care of a physician / Fail to provide any required proof of disability / Fail to submit to a required medical examination / Fail to report income from other sources, or any other required earnings information / Fail to pursue Social Security disability benefits or Workers' Compensation benefits / Die.

If you recover and return to work for less than 30 continuous days during the benefit duration and then again become disabled from the same or related cause, you are not required to complete a new elimination period.

What Additional Benefits Are Included?

while receiving disability benefits. The benefit payment is equal to 3 weeks of pre-tax primary weekly benefits.
While disabled, you may qualify to participate in a rehabilitation plan. Our rehabilitation staff works with you, your physician(s) and your employer to create an individual rehabilitation plan to assist you in returning to work. If you are not disabled, but have a condition that could prevent you from performing the substantial and material duties of your own occupation, preventive rehabilitation services may be offered.
Your Mandatory Rehabilitation provision indicates that, if appropriate, you may be required to participate in an individual rehabilitation plan.

SHORT-TERM DISABILITY

What Are The Restrictions Of My Coverage?

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



Principal Life Insurance Company, Des Moines, Iowa 50392-0002, www.principal.com

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Benefit Contribution Limits 2023-24

Healthcare FSA \$3,050

Limited Purpose FSA \$3,050

Dependent Care FSA \$5,000

HSA \$3,850 individual \$4,150 - 2024

\$7,750 family \$8,300 - 2024

\$1,000 catch-up





Healthcare

FSA

Save over \$900 a year on health expenses





Hello!

We're **Navia Benefit Solutions** and we administer the Healthcare FSA provided to you by your company. This toolkit will help you understand what a healthcare FSA is, how it works, and the many ways you can save money by participating. It also offers tips and tools for understanding your healthcare finances and becoming a more aware healthcare consumer.



Healthcare Flexible Spending Account (FSA)

A Healthcare FSA is a personal expense account that works with your employer's health plan, allowing you to set aside a portion of your salary pre-tax to pay for qualified medical expenses.

Many ways to use your dollars

Use it for eligible medical, dental, vision, feminine products, over-the-counter and prescription drugs. In fact, there are more than 38,000 ways you can use your FSA funds.

Family coverage

It covers you, your spouse, and eligible dependents!

Easy to use

Pay using your Navia debit card or by submitting a claim online or on the Navia mobile app.

Maximum Contribution

IMPORTANT! The contribution limit varies by employer, but you may be able to contribute up to \$3050 per year. The funds in the account must be used during the plan year, but they are available to you immediately.















An FSA helps you pay for things you already buy

An FSA helps you pay for things you likely already pay for, but now you get to do it tax free.

There are thousands of eligible expenses for tax-free purchases with your FSA funds, including prescriptions, over-the-counter drugs, feminine products like tampons, doctor's office copays, health insurance deductibles, and even things like band-aids, first aid kits, face masks and hand sanitizer.



NOW ELIGIBLE!

Over-the-counter (OTC) Medications

On average, U.S. households spend \$338/year on OTC products like like Tylenol®, Zyrtec®, and cold medicine. With an FSA, you save \$100 each year on those purchases.

Feminine Care Products

The average woman spends \$300/year on feminine care products. With an FSA, you would save \$90 each year.

Personal Protective Equipment (PPE)

Masks, hand sanitizer and sanitizing wipes that are purchased to prevent the spread of COVID-19 are now eligible expenses.

Pay 30% less on medical expenses

Federal, state, and FICA taxes lower your take-home pay by 30% or more, leaving the remaining 70% for your living expenses. When you use an FSA, you set aside money before it is taxed, so you spend the entire 100% of your earned income. This means you save 30% on your out-of-pocket healthcare expenses when you use your FSA. It's like free money!



EXAMPLE: Tanner has worn contacts since she was in college and every year it costs her around \$1000 to buy her contacts. Most of the time she doesn't have \$1000 to spend up front, so she has to buy the contacts in spurts, a couple boxes every month. With her Healthcare FSA, Tanner purchases her contacts and saves \$300 due to her tax-free savings of 30%. Best of all, she can buy a year's worth of contacts all at once because her FSA funds are available immediately and in full.



How does it work?





During your open enrollment use an FSA calculator to estimate your expenses for the plan year and come up with how much your annual election should be.



Monthly paycheck deductions

Your annual election amount will be evenly deducted pre-tax from your paycheck throughout the plan year. You cannot change your annual election amount after the plan start unless you have a qualified change in status.



Funds are available immediately

Once you are enrolled, you have access to your funds immediately. Claims can be submitted online or through Navia's mobile application.



Pay and submit claims!

Claims can be submitted online or through Navia's mobile app. Some Navia plans also offer a debit card, which is your fastest way to pay and avoid a claim.



7 tips to get the most out of your FSA

<u>Download</u>



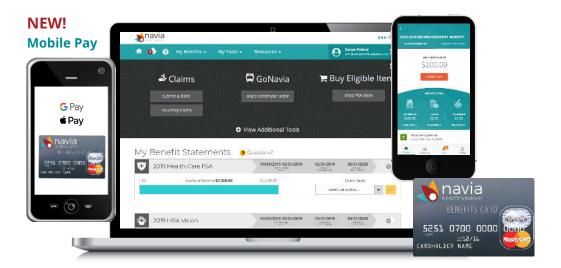
How much should you contribute to your FSA?

Calculate now

Accessing your benefits couldn't be easier!

Just swipe your Navia Benefit Card to pay for eligible healthcare expenses. Funds come directly out of your FSA and are paid to the provider. Some swipes require us to verify the expense, so hang on to your receipts! If we need to see it, we will send you a notification. Navia Mobile Pay is also available for any participant that has the Navia Benefit Card. *Learn more.*

IMPORTANT! Some plans do not include the Navia Debit Card, but that's ok! You can also submit claims through Navia's online portal, mobile app, email, fax, or mail. Claims are processed within a few days and reimbursements are issued according to your employer's reimbursement schedule. Navia also offers it's unique FlexConnect tool where you can get reimbursed for all healthcare claims with one click! **Learn more**.





Navia is here for you!

We're committed to providing you with unparalleled customer service. If you have questions, we're here to answer them!

U.S.

100% US-based, live customer support with offices in every time zone **45 sec**

If you have a question, you wait less than a minute to talk with a live Navia expert

2 days

Claims are turned around within 2 days to ensure you are reimbursed fast



Why should I enroll?

Save enough money to pay for three months of groceries or a gym membership for a year

If you're like the average consumer, you normally spend \$1400/year on out-of-pocket healthcare expenses (e.g. prescriptions, contacts, braces, and even products like Band-Aids). With an FSA, you only pay \$980 for those same expenses—saving \$420 (assuming a tax rate around 30%). If you elect the full \$3050, you save over \$900.

Rest easy knowing you have emergency funds for unexpected costs

An FSA lets you set aside funds for preventative, routine, and unexpected care for not only you but also your family - making it easy to take care of health and wellness needs.

Don't wait to get your son's braces, new glasses, or that laser eye surgery you've always wanted

Depending on your FSA plan design, you have 12 to 14.5 months to spend your money, but the full amount is available to you immediately. **IMPORTANT!** This means you can take care of any pressing healthcare needs at the beginning of your plan year, even if you haven't contributed anything to your account yet.









38,000 ways to spend your FSA!

There are 38,000 products and services you can buy for with tax-free FSA money

Spend your money on anything from medicines and hospital services to acupuncture and training a service dog. Here are just a few to give you an idea:



NEW! Over-the-counter drugs **NEW!** Feminine care products **NEW!** Home Covid-19 tests

NEW! Personal protective

equipment (PPE)

Prescriptions

Copays & Coinsurance

Deductibles

Office Visits

Dental work

Orthodontia

Glasses & Contacts

Chiropractic

Massage

Acupuncture

Capital improvements to your

home, such as ramps, railings

and support bars

Mileage for travel to and from healthcare appointments

Night guards

Bandages and other

medical supplies

Sunscreen

Birth control

Breast pumps

Breast reconstruction

surgery

Childbirth classes

Eye surgery, including laser

eye surgery and Lasik

Fertility treatments and

monitors

Flu shots

Hearing aids and batteries

Insulin

Lab fees

Physical therapy

Prescription sunglasses

Psychologists and

therapy

Stop-smoking programs

Vaccinations and

immunizations

Walking aids like canes,

walkers and crutches

Weight-loss program (if

it's a treatment for a

specific disease

diagnosed by a

physician)

Wheelchairs

X-rays

Nursing services

Prosthesis

Click here for a full list of eligible items



Don't be afraid of use-it-or-lose it

The Healthcare FSA is subject to the "Use-It or Lose-It" rule. This means that **if you do not use all of your annual election within the plan year, the remaining funds are not refundable to you.** Fortunately, very few participants forfeit money in an FSA, and the IRS has relaxed the rules in recent years to make it easier for FSA participants to avoid forfeiture.

Some plans include features that extend deadlines and roll over funds

Run-out Period

The run-out period is how long you have to file a claim for medical costs incurred during the plan year and during the grace period following the plan year. Run-out periods vary by employer and typically last 60 to 90 days after the end of the plan year.

Carryover

The Carryover feature allows participants to roll over up to \$610 from one plan year to the next. Any funds above the threshold would be forfeited. This is an optional feature, so check your employer's plan design to see if the Carryover is included.

Grace Period

The Grace Period gives you an extra 2.5 months at the end of the plan year to incur expenses against your FSA balance. This is an optional feature, so check your employer's plan design to see if the Grace Period is included.



Check your employer's plan design to see if the Grace Period or Carryover feature is part of your plan. Plans can only have either a Grace Period or Carryover, not both.







Bottom line

If you plan on spending even a dollar outof-pocket for healthcare this year, a taxadvantaged benefit account will save you an average of 30% on every expense.

Enroll now!

In order to participate in your company's FSA program you will need to sign up during your open enrollment period. Even if you participated last year, you will still need to re-enroll during this year's open enrollment.

Want to know more?

Below are some additional resource links to help you get the most out of your Healthcare FSA benefit! Click to learn more.



Healthcare FSA Overview



Tax Saving Calculator



FSA Store



Limited Healthcare

FSA

Save over \$900 a year on dental and vision expenses





Hello!

We're **Navia Benefit Solutions** and we administer the Limited Healthcare FSA provided to you by your company. This toolkit will help you understand what a Limited Healthcare FSA is, how it works, and the many ways you can save money by participating. It also offers tips and tools for understanding your healthcare expenses and becoming a more aware healthcare consumer.



Limited Healthcare Flexible Spending Account (FSA)

An Limited Healthcare FSA is a pre-tax benefit account that works with your Health Savings Account (HSA), allowing you to set aside money to pay for qualified dental and vision expenses.

Many ways to use your dollars

Use it for eligible dental and vision expenses to maximize your savings and conserve your HSA dollars for other healthcare that you may need. There are hundreds of ways you can use your limited healthcare FSA funds alongside your HSA.

Family coverage

It covers you, your spouse, and eligible dependents!

Easy to use

Pay using your Navia debit card or by submitting a claim online or on the Navia mobile app.

Maximum Contribution

The contribution limit varies by employer, but you may be able to contribute up to \$3050 per year. The funds in the account must be used during the plan year, but they are available to you immediately.













A Limited Healthcare FSA helps you pay for dental and vision expenses

Alongside your HSA, a Limited Healthcare FSA helps you pay for dental and vision expenses you likely already have to pay for, but now you get to do it tax free.

There are hundreds of eligible expenses for tax-free purchase with your Limited Healthcare FSA funds.



Common eligible expenses

Doctor's office copays, deductibles, routine dental and eye care, glasses and contacts, dental and vision surgeries, and orthodontics.

Pay 30% less on dental and vision expenses

Federal, state, and FICA taxes lower your take-home pay by 30% or more, leaving the remaining 70% for your living expenses. When you use an FSA, you set aside money before it is taxed, so you spend the entire 100% of your earned income. This means you save 30% on your out-of-pocket dental and vision expenses when you use your FSA. It's like free money!



EXAMPLE: Grace accidentally broke her tooth and needs a root canal and crown to restore it. Her share of the dental work is around \$1,500. Without a Limited Healthcare FSA, Grace would either need to delay the services until she can afford the treatment or set up a payment plan with her dentist. With her Limited Healthcare FSA, Grace was able to pay for her treatment upfront and tax-free, saving \$450 (30% off).



How does it work?



Estimate your annual election

During your open enrollment, use the FSA calculator to estimate your out-of-pocket dental and vision expenses for the plan year. This will help you determine your annual election amount.



Monthly paycheck deductions

The amount you elect will be deducted evenly out of each paycheck on a pre-tax basic and put into your Limited Healthcare FSA. You cannot change your annual election amount after the start of the plan year unless you have a qualified change in status.



Funds are available immediately

Once you are enrolled, you have access to your funds immediately. Claims can be submitted online or through Navia's mobile app.



Pay and submit claims!

Claims can be submitted online or through Navia's mobile app. Some Navia plans also offer a debit card, which is your fastest way to pay and avoid a claim.



7 tips to get the most out of your FSA

Download



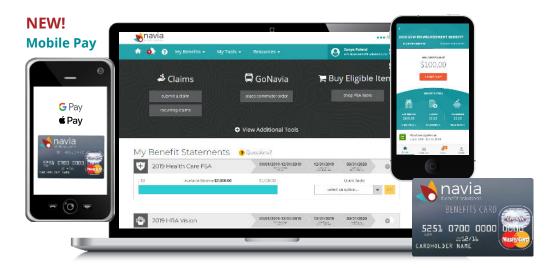
How much should you contribute to your FSA?

Calculate now

Accessing your benefits couldn't be easier!

Just swipe your Navia Debit Card to pay for eligible dental and vision expenses. Funds come directly out of your FSA and are paid to the provider. Some swipes require us to verify the expense, so hang on to your receipts! If we need to see it, we will send you a notification. Navia Mobile Pay is also available for any participant that has the Navia Benefit Card. *Learn more*.

IMPORTANT! Some plans do not include the Navia Debit Card, but that's ok! You can also submit claims through Navia's online portal, mobile app, email, fax, or mail. Claims are processed within a few days and reimbursements are issued according to your employer's reimbursement schedule. Navia also offers it's unique FlexConnect tool where you can get reimbursed for all healthcare claims with one click! **Learn more.**





Navia is here for you!

We're committed to providing you with unparalleled customer service. If you have questions, we're here to answer them!

U.S.

100% US-based, live customer support with offices in every time zone

45 sec

If you have a question, you wait less than a minute to talk with a live Navia expert

2 days

Claims are turned around within 2 days to ensure you are reimbursed fast



Why should I enroll?

Save enough money to pay for three months of groceries or a gym membership for a year

If you're like the average consumer, you normally spend \$1200/year on out-of-pocket dental and vision expenses (e.g. contacts/glasses, braces, dental surgery). With an FSA, you only pay \$840 for those same expenses—saving \$360 (assuming a tax rate around 30%). If you elect the full \$3050, you save over \$900.

Rest easy knowing you have emergency funds for unexpected costs

An FSA lets you set aside funds for preventative, routine, and unexpected dental and vision care for you and your family - making it easy to take care of health and wellness needs.

Don't wait to get your new contacts, daughter's braces, or that laser eye surgery you've always wanted

Depending on your FSA plan design, you have 12 to 14.5 months to spend your money, but the full amount is available to you immediately. **IMPORTANT!** This means you can take care of any pressing healthcare needs at the beginning of your plan year, even if you haven't contributed anything to your account yet.









Ways to spend your FSA!

Most dental and vision products and services you can pay for with tax-free FSA money

There are so many things you can spend your money on! Anything related to dental and vision care - from over-the-counter supplies, diagnostic services, to surgery. Here are just a few to give you an idea:



NEW! Dental pain relievers (over-the-counter)

Copays & Coinsurance

Deductibles

Diagnostic services, including x-rays

Cleanings

Fillings

Root Canals

Crowns

Bridges

Implants

Dentures

Orthodontia

Occlusal guards for grinding



NEW! Reading glasses (over-the-counter)

NEW! Eye drops/treatments (over-the-counter)

Copays & Coinsurance

Deductibles

Diagnostic services & office visits

Optometrist/Ophthalmologist fees

Glasses

Prescription sunglasses

Contact lenses and solutions

Vision correction surgery (laser eye/lasik)

Corneal keratotomy

Radial keratotomy

Click here for a full list of eligible items

Don't be afraid of use-it-or-lose it

The Healthcare FSA is subject to the "Use-It or Lose-It" rule. This means that **if you do not use all of your annual election within the plan year, the remaining funds are not refundable to you.** Fortunately, very few participants forfeit money in an FSA, and the IRS has relaxed the rules in recent years to make it easier for FSA participants to avoid forfeiture.

Some plans include features that extend deadlines and roll over funds

Run-out Period

The run-out period is how long you have to file a claim for medical costs incurred during the plan year and during the grace period following the plan year. Run-out periods vary by employer and typically last 60 to 90 days after the end of the plan year.

Carryover

The Carryover feature allows participants to roll over up to \$610 from one plan year to the next. Any funds above the threshold would be forfeited. This is an optional feature, so check your employer's plan design to see if the Carryover is included.

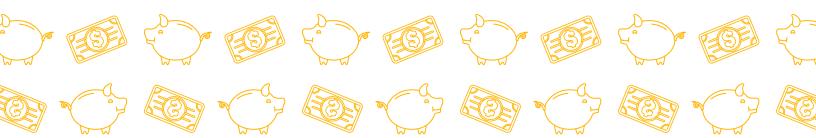
Grace Period

The Grace Period gives you an extra 2.5 months at the end of the plan year to incur expenses against your FSA balance. This is an optional feature, so check your employer's plan design to see if the Grace Period is included.



Check your employer's plan design to see if the Grace Period or Carryover feature is part of your plan. Plans can only have either a Grace Period or Carryover, not both.







Bottom line

If you plan on spending even a dollar out-of-pocket for dental or vision expenses this year, a tax-advantaged benefit account will save you an average of 30% on every expense.

Enroll now!

In order to participate in your company's FSA program you will need to sign up during your open enrollment period. Even if you participated last year, you will still need to re-enroll during this year's open enrollment.

Want to know more?

Below are some additional resource links to help you get the most out of your Limited Healthcare FSA. Click to learn more.



Limited Healthcare FSA Overview



Tax savings calculator



FSA Store



Day Care

Save up to \$1,500 a year on day care expenses



Hello!

We're **Navia Benefit Solutions** and we administer the Day Care FSA provided to you by your company. This toolkit will help you understand what a Day Care FSA is, how it works, and the many ways you can save money by participating. It also offers tips and tools for understanding your day care expenses and becoming a more aware day care consumer.



Day Care Flexible Spending Account (FSA)

A Day Care FSA is a pre-tax benefit account that enables you to set aside money to pay for your out-of-pocket daycare or dependent care expenses.

Save on day care expenses you already pay for

This FSA covers child care for dependents age 12 and under and dependents who cannot care for themselves while you're working.

Pay your provider or a family member for child care

With a Day Care FSA, participants can use their account to pay your licensed day care provider for child care services. You can also use your Day Care FSA to pay a family member to watch your child, as long as the family member is not your spouse and age 19 or older.

Easy to use

Pay using your Navia debit card or by submitting a claim online or on the Navia mobile app.

Maximum contribution

The contribution limit varies by employer, but you may be able to contribute up to \$5000 per year. The funds in the account must be used during the plan year. Much like your banking account, you cannot spend more than what is in your account each month.



















Day Care FSA works like a bank account and saves you money

A Day Care FSA helps you pay for day care expenses that you already pay, using taxfree dollars. This account works like a bank account, meaning you cannot be reimbursed for more than what is in your account at any given time.

With a Day Care FSA you can provide care for any dependent children age 12 and under. You can also provide care for your spouse or relative --13 years or older -- that is physically or mentally incapable of self-care and lives in your home 50% of the year.

Common eligible day care expenses are preschool, day care, day camps, a nanny or au pair, before and after school care, elder care, and adult day care. *Learn more*.



Pay 30% less on day care expenses

Federal, state, and FICA taxes lower your take-home pay by 30% or more, leaving the remaining 70% for your living expenses When you use an FSA, you set aside money before it is taxed, so you spend the entire 100% of your earned income. This means you save 30% on your out-of-pocket day care expenses when you use your FSA. It's like free money!

EXAMPLE: Michael and his spouse work full-time and need after school care for their twin boys. Last year they spent over \$4,200 in after school care and paid the provider monthly. This year they decide to elect that same amount into a Day Care FSA. With his election of \$4,000 into his Day Care FSA, Michael can pay their after school care provider the same way, but he saves \$1,200 (30% off). With those savings, Michael and his spouse were able to afford a family vacation during summer break!



How does it work?



Estimate your annual election

During your open enrollment, use the FSA calculator to estimate your out-of-pocket day care expenses for the plan year. This will help you determine your annual election amount.



Monthly paycheck deductions

The amount you elect will be deducted evenly out of each paycheck on a pre-tax basis and put into your Daycare FSA. You cannot change your annual election amount after the start of the plan year unless you have a qualified change in status.



Funds are available after contribution

After your monthly contribution is made to your account you will be able to submit claims for expenses. Much like your banking account, you cannot spend more than what is in your account each month.



Pay and submit claims!

Claims can be submitted online or through Navia's mobile app. Some Navia plans also offer a debit card, which is your fastest way to pay and avoid a claim.



Check out our video about the Day Care FSA benefit!

Watch



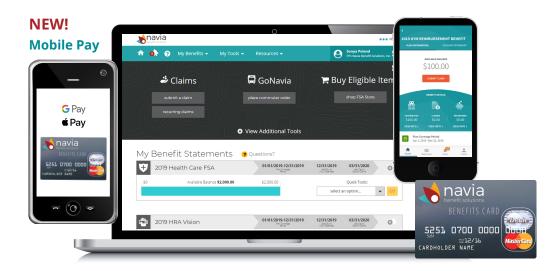
How much should you contribute to your Day Care FSA?

Calculate now

Accessing your benefits couldn't be easier!

Just swipe your Navia Debit Card to pay for eligible day care expenses. Funds come directly out of your FSA and are paid to the provider. Some swipes require us to verify the expense, so hang on to your receipts! If we need to see it, we will send you a notification. *Learn more*.

IMPORTANT! Some plans do not include the Navia Debit Card, but that's ok! You can also submit claims through Navia's online portal, mobile app, email, fax, or mail. Claims are processed within a few days and reimbursements are issued according to your employer's reimbursement schedule. Navia also offers recurring claims with one click!





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We're committed to providing you with unparalleled customer service. If you have questions, we're here to answer them!

U.S.

100% US-based, live customer support with offices in every time zone

45 sec

If you have a question, you wait less than a minute to talk with a live Navia expert

2 days

Claims are turned around within 2 days to ensure you are reimbursed fast



Why should I enroll?

Save enough money to pay for a family vacation or catch up on bills

Child care expenses (e.g. day care, camps, preschool, etc) add up quickly and are expensive. If you contribute the maximum annual election of \$5,000 into a Day Care FSA, you only pay \$3,500 for those same expenses—saving \$1,500 (assuming a tax rate around 30%).

Rest easy knowing you have set aside funds for day care

A Day Care FSA lets you set aside funds for child and elder care expenses - making it easy to take care of those you love.

Pay a relative for child care service

With many schools and daycare facilities closed, working parents are struggling to find a provider who can watch their children during working hours. With the Day Care FSA, participants can use day care FSA funds to pay eligible family members to watch dependents.









Don't be afraid of use-it-or-lose it

The Day Care FSA is subject to the "Use-It or Lose-It" rule. This means that **if you do not use all of your annual election within the plan year, the remaining funds are not refundable to you.** Fortunately, very few participants forfeit money in an FSA, and the IRS has relaxed the rules in recent years to make it easier for FSA participants to avoid forfeiture.

Some plans include a feature that extends deadlines

Run-out Period

The run-out period is how long you have to file a claim for medical costs incurred during the plan year and during the grace period following the plan year. Run-out periods vary by employer and typically last 60 to 90 days after the end of the plan year.

Grace Period

The Grace Period gives you an extra 2.5 months at the end of the plan year to incur expenses against your FSA balance. This is an optional feature, so check your employer's plan design to see if the Grace Period is included.



Check your employer's plan design to see if the Grace Period feature is part of your plan.



Meet our day care partner!



Navia and Kinside have partnered to provide our Day Care FSA participants with a resource for finding affordable child care. Kinside is free for all Day Care FSA participants and can be accessed both through your Participant portal and on the Kinside website.

With Kinside's network you can...

20%

Save up to 20% on child care on daycares and preschools near you. Other savings include waived application fees.



Have access to child care nationwide. Kinside's database can be searched by program type, availability, area code, and more.



Pay online! Connect your Navia debit card to your Kinside account to pay your child care provider. *Learn more.*



Access to full licensing and inspection reports for every daycare and preschool in Kinside's network.

Learn more about Kinside!







Bottom line

If you plan on spending even a dollar outof-pocket for child or elder care this year, a tax-advantaged benefit account will save you an average of 30% on every expense.

Enroll now!

In order to participate in your company's FSA program you will need to sign up during your open enrollment period. Even if you participated last year, you will still need to re-enroll during this year's open enrollment.

Want to know more?

Below are some additional resource links to help you get the most out of your Day Care FSA benefit! Click to learn more.



Day Care FSA Overview



Tax Saving Calculator



FSA Store



Kinside







Four Things You Should Know about Health Savings Accounts

Whether you're juggling a lot of health care expenses every year or you have just a few, a health savings account can help you manage your expenses today and in

the future. To help you decide whether an HSA is right for you, take a closer look at these important facts.



1. You Own It

The money in a UMB Health Savings Account (HSA) is always yours, even if you change jobs, switch your health plan, become unemployed, retire or move to another state. And you start earning interest on the balance in your account from day one. No waiting or vesting periods.

If you've ever put money into a flexible spending account, you know that there's a use-it-or-lose-it rule—spend your balance each year or lose it forever. However, with an HSA, your unused balance rolls over from year to year so you never lose the money. And the longer you save it, the longer it accrues interest.

Your account is yours, even if you're not eligible to contribute.

If you are no longer in an HSA-qualified high-deductible health plan or other circumstances change, your HSA is still yours. You aren't allowed to make new contributions, but you can keep the account as long as you like. Withdrawals for eligible expenses are always tax-free!

2. You Save on Taxes in Three Ways

- Tax-free deposits. The money you contribute to your HSA isn't taxed. Whether or not you itemize deductions on your income tax return, your HSA contributions are deductible. You can keep contributing for the current tax year until the tax deadline, generally April 15 of the following year—up to the IRS annual limit—to maximize your tax savings. (Look up the current IRS maximum at HSA.UMB.com.)
- **2. Tax-free earnings.** Your interest and any investment earnings grow tax-free.

3. Tax-free withdrawals. The money you withdraw—today or in the future—isn't taxed, as long as you use it to pay for eligible medical expenses. That's different from a 401(k) or similar retirement plans, which are taxed when you withdraw funds.

Note: States can choose to follow the federal tax-treatment guidelines for HSAs or establish their own; some states tax HSA contributions. If you have questions about your tax implications, consult your tax advisor. HSA funds used to pay for non-qualified medical expenses are subject to income taxes on the amount and a possible additional 20% penalty, if you're under age 65.

3. You Choose How to Spend the Money—Now or Later

An HSA is a great place to build up savings for expenses you have today or will have in the future. Injuries or a new diagnosis might mean you need to pay a lot of bills at one time. Or you may need to cover expenses that count toward your deductible like doctor visits or prescription drugs. If your budget isn't flexible, use your HSA to pay bills this year.

But if you can afford to pay bills out of pocket and save the money in your HSA for the future, then your HSA balance may grow through interest and investment earnings. That way you'll have more money for expenses when you need it most—whether in a year, 10 years or in retirement.

4. You Must Be Eligible to Open the Account

To take advantage of such great tax breaks, the IRS says that only eligible individuals can save in an HSA. To open and contribute to an HSA, you:

- Must participate in an HSA-qualified high-deductible health plan (HDHP);
- Can't participate in another health plan that's not a highdeductible health plan (for example, a spouse's plan).
 Some exceptions may apply (get more details in IRS publication 969 at www.irs.gov);
- · Can't be enrolled in Medicare benefits; and
- Can't be claimed as a dependent on anyone else's tax return.

Partial-year participation:

If you open your account mid-year or become ineligible midyear, your contribution limits may be impacted. If you are married, your spouse's participation in a health care flexible spending account or other family health insurance coverage may change your eligibility.

Visit **HSA.UMB.com** for more details.

Remember: Opening Your UMB HSA is Easy!

Once you've chosen a high-deductible health plan, you need to take the next step and open your HSA. If you don't, you won't be able to contribute to the account and enjoy all the tax benefits. And you may miss out on free money from your employer. Follow the instructions provided by your employer, or go to **HSA.UMB.com** and look for the "Open an HSA" button.

Money Comes In...

You build your HSA balance in three ways:

1. PAYROLL CONTRIBUTIONS

Most people prefer to make regular contributions through payroll deductions. Sign up through your employer, and your contributions will be deducted from every paycheck on a pretax or after-tax basis, or both— depending on what your employer allows. You can change your contribution rate at any time— when your monthly budget changes or you expect more bills. If you haven't already received instructions from your employer on how to get started, contact HR. If your employer does not support payroll contributions, see Direct Contributions for other ways you can contribute to your account.

2. DIRECT CONTRIBUTIONS

These are after-tax contributions made by you or on your behalf. To make a direct contribution, you can:

- Electronically transfer the funds from a personal account. Log into your account at HSA.UMB.com and select "Make a Contribution."
- Write a personal check. Mail your check along with a
 contribution form to UMB (get it from the Documents
 & Forms section of HSA.UMB.com). Contribution
 deposits are credited on the date of receipt. Lumpsum contributions can also be deducted from your
 gross income on your annual tax return so that you
 won't owe income taxes—whether you itemize your
 expenses or not.

3. EMPLOYER CONTRIBUTIONS

Check to see whether your employer will provide funding to your account. When the contributions are made can vary as well. Keep in mind that any contributions your employer makes cannot be deducted on your tax return—they are not considered taxable income, so you don't pay taxes on them.

NOTE: States can choose to follow the federal tax-treatment guidelines for HSAs or establish their own; some states tax HSA contributions. If you have questions about your tax implications, consult your tax advisor.



DID YOU KNOW?

Friends and family members are allowed to make contributions to your HSA on your behalf All contributions—yours, your employer's, family or friends'—count toward the annual maximum set by the Internal Revenue Service. Go to **HSA. UMB.com** for current annual limits. Any contributions made on an after-tax basis can be claimed on your tax return.

And Grows...

Need a little incentive to build your balance?

YOUR MONEY WORKS FOR YOU IN THREE WAYS WHEN YOU'RE NOT SPENDING IT.

- 1. For starters, you earn interest—accrued daily and paid monthly—on your balance.
- When your balance reaches \$1,000 (also known as the "peg balance"), you can invest your HSA funds into the UMB HSA Saver® investment portfolio.¹ Visit HSA.UMB.com for more details about available investment options.
- 3. Finally, you are never taxed on the growth of your account—in the year that you earn it or when you take money out to pay for qualified medical expenses.

¹See page 8 for disclosure information.

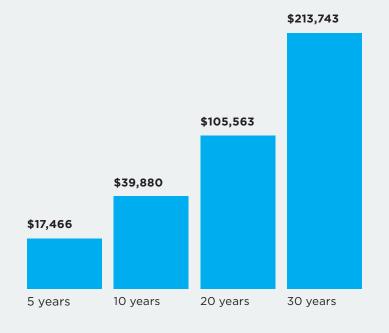
Saving for the Future

The sooner you start saving, the better. Why? Because the impact of compound returns grows your money exponentially over time. Compound returns are generated from your investment gains and interest both on the original amount invested and your reinvested earnings.

AN EXAMPLE OF HOW COMPOUNDING WORKS:

If you saved \$3,000 per year, compounded at a 5% rate of return, after 30 years, you could potentially have \$213,743 tax-free dollars to use when you need it. For example, to pay for qualified medical expenses, Medicare premiums, or to supplement your retirement income.

NOTE: This example is a hypothetical illustration of compounding returns over time and is not intended to represent any particular investment or savings vehicle. The rates of return are constant nominal rates, compounded monthly. Actual investments will fluctuate in value. Contributions are assumed to be made at the beginning of the month. It does not take into consideration taxes or other applicable deductions, which will lower returns.



Money Comes Out...

Pay now or reimburse later.

PAYING FOR EXPENSES

When you have a medical bill, you have a decision to make. Spend your HSA funds? Or let your balance keep growing? Since your HSA is like a personal banking account, check that you have enough money in your account to cover a bill before you pay it. Don't have enough saved up? Pay your bill out of pocket. Then, if you still want to use your HSA funds, you can **reimburse** yourself no matter when you incurred the expense.

When ready to pay a bill, follow these three steps:

- 1. Check if it's eligible. Since your health savings account is supposed to work together with your high-deductible plan, qualified eligible expenses for your HSA are typically the same bills that count toward your deductible, plus some vision and dental costs. A full list of qualified expenses can be found in IRS Publication 502 at www.irs.gov.
- **2.** Choose a payment method. See table below for guidelines.
- **3. Save your receipts.** The IRS may request that you show proof of how you used your tax-free money.

LOWER YOUR BILLS

So you can save more, try to:

- 1. Get regular preventive care.
- 2. Visit urgent care clinics for non-emergencies.
- 3. Ask for generic prescription drugs.
- 4. Get a second opinion for new diagnoses.
- 5. Use online web tools to comparison-shop and plan for non-emergency services.

NOTE: States can choose to follow the federal tax-treatment guidelines for HSAs or establish their own; some states tax HSA contributions. If you have questions about your tax implications, consult your tax advisor.

PAYMENT METHOD

When?

At the pharmacy. Swipe your debit card like any other credit card or access your card using your digital wallet, when you purchase prescription drugs at a network pharmacy. Your pharmacist can typically calculate your cost, including whether or not you've met your deductible, right at the time of your purchase. Also use for vision or dental care.

After you get a bill from a network provider. Wait for your claim to be processed so that you get the network savings and deductible credit applied to your doctor or hospital bill before you pay. Then you can give your HSA debit card number. If your provider won't accept a debit card payment, log into your account on HSA.UMB.com to have a check sent directly to your provider. Pay for your long-term care premiums this way, too.

After you've paid in full to see an out-of-network provider.

Some providers may require payment at the time of service.

And your total bill may vary depending on whether or not you've met your deductible. Once you are logged into your account on
HSA.UMB.com, follow the instructions to "Request a Reimbursement."

Pay your bill with:

Debit Card/Digital Wallet (ApplePay, Samsung Pay, Garmin Pay, FitBit Pay)



Debit Card or Via Online Bill Pay



Online Reimbursement





FILING YOUR TAX RETURN

With such great tax breaks, it's probably not a surprise you'll need to do some tax work. We'll help you by supplying key IRS forms. But it's up to you to file your annual federal and state income tax returns and save your itemized receipts in case you need to prove to the IRS that distributions from your HSA were for qualified medical expenses.

You'll receive up to two forms from us and one you'll need to complete on your own:

IRS Form 5498-SA: This form documents all the contributions made to your HSA in a tax year. You can find information about your total contributions prior to tax day by logging into your account at **HSA.UMB.com**.

NOTE: If you use your HSA funds to pay for goods or services that aren't qualified medical expenses, you are responsible for reporting that to the IRS, paying income taxes on the amount and a 20% penalty if you are under age 65.

IRS Form 1099-SA: This form provides you with the total distributions that were made from your HSA. You will receive a separate 1099-SA for any HSA distributions you had in that tax year. If you did not have distributions during the tax year, you will not receive a 1099-SA.

IRS Form 8889: This is the HSA form for you to complete and attach to your IRS 1040 Form. This form will allow you to calculate and report any deductible contributions, report distributions you took to pay qualified medical expenses, and calculate any tax you owe on withdrawals you made for non-medical-related purposes.

For detailed information about tax reporting with your HSA, visit the U.S. Internal Revenue Service website at **www.irs.gov.**

ACCOUNT FEES

Just like any other bank account, certain fees may be deducted from your balance. UMB uses a simple fee schedule. (For a full list of fees please consult the Accountholder Fee Schedule.)

DID YOU KNOW?

Even if your spouse or dependents you claim on your tax return are not covered by your high-deductible health plan, you may use your HSA dollars to pay for their qualified medical expenses.

Online Account Access

There's only one thing easier than opening your HSA and that's managing your account online. Once you register for online account access, here are just some of the things you can do:

- Pay qualified medical expenses online or reimburse yourself.
- Contribute on a one-time or regular basis.
- **Update** your personal contact information and beneficiaries.
- Review your statements or important tax information, including your total contributions and the fair market value of your HSA.
- Access HSA Future Value and Tax Savings Calculators, detailed FAQs, and other helpful resources.
- Enroll in and manage investment options.
- Track and Manage health care receipts with ReceiptVault

Questions? More details?

Online at **HSA.UMB.com**. Log in to see your account balance, pay bills, invest your balance, try out calculators, get tips and more!

By phone at **866.520.4HSA (4472)**: Automated balance and recent activity available 24-hours from your home phone. Or representatives are available Monday through Friday from 7:00 a.m. to 7:30 p.m. CT and Saturday from 8:00 a.m. through 5:00 p.m. CT.



This material is provided for informational purposes only and contains no investment advice or recommendations to buy or sell any specific securities.

Investors should carefully consider the fund's investment objectives risks, charges and expenses before investing. You may obtain a summary prospectus or prospectus containing this and other information, by clicking on the applicable prospectus link provided on the "HSA Saver Marketplace" located in the "HSA Investment Options" page or to have a copy mailed to you, contact the fund directly. Please carefully read the summary prospectus or prospectus before investing.

INVESTMENTS IN SECURITIES THROUGH UMB HSA SAVER ARE: NOT FDIC-INSURED | MAY LOSE VALUE | NO BANK GUARANTEE

¹UMB Investment Management selects mutual funds in various asset classes for inclusion in the UMB HSA Saver Investment Program. UMB Custody Services provides safekeeping and settlement of the mutual fund investments in the UMB HSA Saver® investment program. UMB Investment Management and UMB Custody Services are departments of UMB Bank, n.a. UMB Bank, n.a. is a wholly owned subsidiary of UMB Financial Corporation. UMB Custody Services provides safekeeping and settlement of the mutual fund investments in the UMB HSA Saver® investment program.

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Funds in an HSA Deposit Account are held at UMB Bank, n.a., Member FDIC.

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Invest Your Way

Invest Simply

Invest from Anywhere

Invest in Real Benefits

Invest with Confidence



Invest Confidently Invest Easily

UMB HSA Saver® is backed by decades of investment experience led by UMB's Chief Investment Officer.¹ HSA Saver pairs that knowledge and experience with an intuitive design to create a powerful yet simple investment tool.

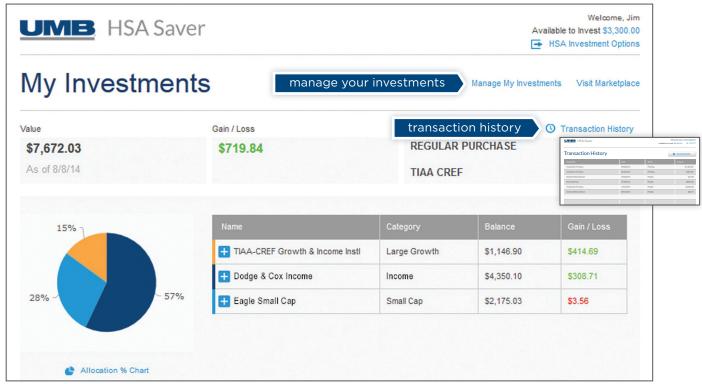
After you have reached the required account balance, you can log on to your HSA, open an HSA Saver investment portfolio² and start investing.

Below is an introduction to our user-friendly features to help you navigate this powerful platform.

Dashboard

Stay on top of your investments.

This is your personalized home page, providing an overview of your investments at a glance. From here, you can view your transaction history, manage your investments or customize your reporting tools, all with the click of a button.



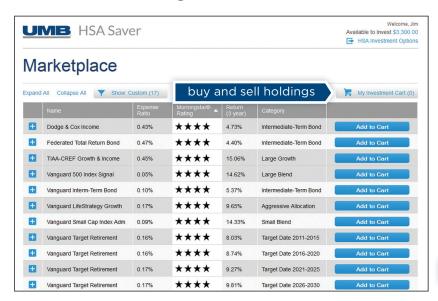
^{1,2}See back page for disclosures.

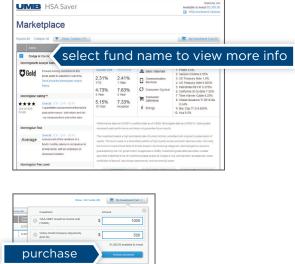
Marketplace

Find quality investment opportunities.

Marketplace makes it easy to navigate and break down your investment options. Invest with confidence knowing the list has been prescreened by UMB for quality. To help make an informed investment decision, Marketplace also provides you with data and performance stats from Morningstar* (an independent financial research firm).³

Once you've made a decision, add that investment to your cart then specify the amount you want to invest in that fund before checking out.

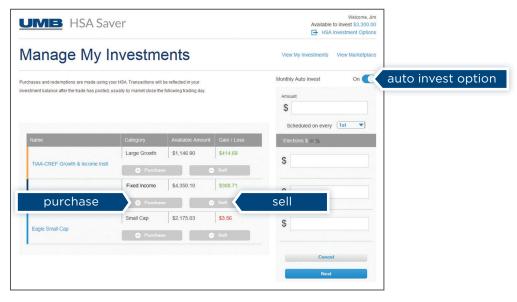




Manage

Take control of your portfolio.

On the Manage page, we've made maintaining and managing your investments a streamlined process, putting you in control of your portfolio. From here, you can purchase more of a specific holding, sell holdings or even schedule monthly auto investments.



³See back page for disclosures.

For more information on the UMB HSA Saver® site or investment strategies, visit

hsa.umb.com/Individuals or call 866.520.4HSA (4472)

This material is provided for informational purposes only and contains no investment advice or recommendations to buy or sell any specific securities

Investors should carefully consider the fund's investment objectives risks, charges and expenses before investing. To obtain a summary prospectus or prospectus containing this and other information, contact UMB Healthcare Services at 866.520.4472 or view the prospectus provided during enrollment. Please carefully read the summary prospectus or prospectus before investing.

¹ UMB Investment Management selects mutual funds in various asset classes for inclusion in the UMB HSA Saver Investment Program. UMB Investment Management is a department of UMB Bank, n.a. UMB Bank, n.a. is a wholly owned subsidiary of UMB Financial Corporation.

Investments in securities through HSA investment account are:

Not FDIC Insured • May Lose Value • No Bank Guarantee

²UMB Custody Services provides safekeeping and settlement of the mutual fund investments in the UMB HSA Saver® investment program. UMB Custody Services is a division of UMB Bank, n.a.

³Generally, data on mutual funds is provided by Morningstar, Inc. Although UMB believes the data gathered from these third party sources is reliable, it does not review such information and cannot warrant it to be accurate complete or timely. UMB is not responsible for any damages or losses arising from any use of this third-party information.

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Find all your Benefit Stuff at

https://benefitstuff.com/designsupply

