WEST VIRGINIA

CommuniCare
FAMILY OF COMPANIES

Serving with Pride.

2024 Benefits Enrollment Guide

LOOK INSIDE FOR INFORMATION ABOUT:

How Your Benefits Work
Your Insurance Plans
Benefits Enrollment

CHOOSE SIMPLY. LIVE HAPPY.

It's time to enroll in your benefits! This guide will walk you through your choices, and will help you to decide which plans are best for you and your family.

** This communication represents a brief summary of the various benefits available to you and is provided as a reference only. The actual carrier policies determine coverage and contain exclusions, limitations, full coverage terms, conditions and requirements. Any notices included in this document do not replace other potential employer requirements for communication.*

WELCOME

Dear Valued Employee:

CommuniCare recognizes that our employees are the most valuable asset a company can have. We are committed to your wellbeing and realize that each person's needs are unique. Our objective is to provide a benefits package that is comprehensive, affordable, diverse, mindful of our unique corporate culture, and sensitive to our business needs. In consideration of this, we strive to offer a variety of benefits with highly rated carriers and vendors designed to offer you opportunities to mitigate your risks and provide peace of mind to you and your family.

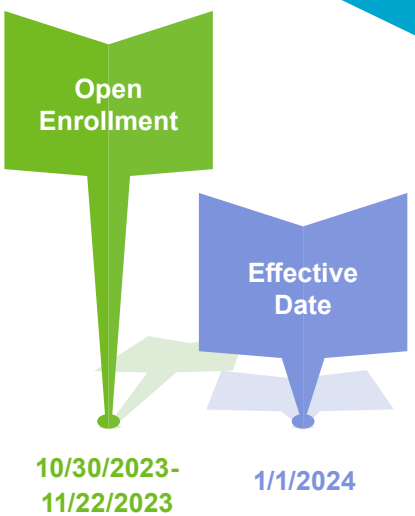
To fulfill these objectives, we are committed to:

- **Continuously evaluating how we choose our healthcare coverage**, how we are using healthcare services and how we can help our employees manage their personal health decisions.
- **Providing affordable opportunities** for our employees to mitigate their financial risks.
- **Communicating with and educating** you about the benefits and resources available to you.

As benefits represent an important component of your total compensation package, we are pleased to provide you with the 2024 benefit offerings included in this guide. Please review this enrollment guide for a summary of the benefits that are available to you and your family for enrollment along with tips and resources that will help you maximize the value of the coverage you elect. This guide will summarize who is eligible to enroll, when you are eligible to enroll, what coverage options are available to you and the cost of coverage. It will also provide you contact information in case you have detailed questions or need more information. Please note, there will be 26 payroll deductions for the 2024 plan year.

Best Regards,
CommuniCare Family of Companies

Mark the dates below on your calendar now so you don't forget! Schedule a time to review your current plan and identify what changes you'd like to make.



CONTACT INFORMATION

Medical
AmeriBen
Anthem PPO/HDHP
1-888-921-0374
www.ameriben.com

Telehealth
PHP Telehealth
1-833-683-2273
PHPTelehealth.com

Balance Bill Support
ELAP
1-800-977-7381
bb@elapservices.com
www.elapservices.com

Pharmacy
Pharmacy Benefits Management Services (PBMS)
1-866-490-3636
Pharmacy@nwpharma.com

Dental
Delta Dental
1-800-524-0149
www.deltadental.com

Vision
EyeMed
1-866-723-0596
www.eyemedvisioncare.com

Short Term Disability
Aflac
1-800-433-3036
www.aflacgroupinsurance.com/customer-service/file-a-claim.aspx

Long Term Disability
Aflac
Claims:1-800-206-8826
Group # GLD0000073
1-800-206-8826
www.mygrouplifedisability.aflac.com/personal

Life and AD&D Insurance Claims
Aflac
Claims:1-800-206-8826
Group # GLD0000073
1-800-206-8826
www.mygrouplifedisability.aflac.com/personal

CHUBB
Claims
1-800-542-2013
www.chubb.com/WorkplaceBenefitsClaims

Lifetime Benefit Term
CHUBB
855-241-9891
Fax: 603-352-1179
Claims@gotoservice.chubb.com
Policy info: 855-241-9891
csmail@gotoservice.chubb.com

Flexible Spending and Health Saving Account
iSolved
1-866-370-3040
fbamail@isolvedhcm.com

COBRA Services
iSolved
1-800-594-6957
crmail@isolvedhcm.com

Worksite Benefits
Aflac
1-800-433-3036
www.aflacgroupinsurance.com/customer-service/file-a-claim.aspx

Identity Theft Protection
Legal Shield/ ID Shield Inc. Group #: 161012
1-516-967-9814
www.legalshield.com

Catilize Health
MERP
1-877-872-4232
Merp@catilizehealth.com

Cancer Advocate Plus (CAP)
CHUBB
1-833-542-2013
www.chubb.com/Workplace Benefits Claims Plan Identifier: The Employee's Social Security Number

ELIGIBILITY

Eligibility for you and your dependents

You are eligible to participate in the group benefit plans if you are an active full-time employee and scheduled to work 30 or more hours per week. Employees are eligible the first of the month following 30 days of employment. Certain dependents of eligible team members can enroll in the medical, dental, vision, dependent life insurance plans and voluntary benefits.

Eligible dependents include:

- Your legal spouse – provide a copy of your marriage certificate and evidence of your current marital status
- Your natural children, legally adopted children, step children and children for whom you assume legal guardianship up to age 26
- Children age 26 or older incapable of self-support due to a mental or physical condition incurred prior to age 26. You may be required to complete a Handicapped/Disabled Certification form prior to the child attaining age 26.
- If Spouse is offered medical coverage through their employer, they cannot be on the CommuniCare medical plan. A spousal affidavit is required during enrollment.

Qualifying Life Events

The choices you make during your New Hire period or Annual Open Enrollment period are irrevocable until either the next Annual Open Enrollment period or unless you experience a qualifying life event. Qualifying life events include changes to your legal marital status, giving birth or adopting a child, a change in you or your spouse's employment status or your entitlement to Medicare.

If you anticipate any of these changes, please see Human Resources in advance of the event to verify your right to change plan coverage(s). You must elect your change in benefits within 30 days of the qualified life event. **If you do not notify Human Resources within 30 days of a qualifying event, you will have to wait until the next annual open enrollment period to make benefit changes unless you have another qualifying event.**

Loss of Essential Coverage

Loss of COBRA Benefits

Marriage or Divorce

Permanent Relocation

Birth, adoption or new dependent

Aged off of Parent's Plan

Change in Citizenship

Change in Employment Status

Death in Family

Change in Government Assistance Eligibility

Q&A

Can you explain the meaning of some of the key terms in this guide?

- *Deductible:* a set dollar amount that a person must pay before insurance coverage for medical expenses can begin. They are usually charged on an annual basis.
- *Coinsurance:* the money that an individual is required to pay for services after the deductible has been met. It is often a specified percentage of the charges.
- *Copayment (aka Copay):* an arrangement where an individual pays a specified amount for various health care services and the health plan or insurance company pays the remainder. The individual must usually pay his/her share when services are rendered. Copayments are usually a set dollar amount.
- *Out-of-pocket Maximum:* the total amount paid each year by the member for the deductible, coinsurance, copayments and other covered health care expenses, excluding the premium. After reaching the out-of-pocket maximum, the plan pays 100% of the allowable charges for covered services the rest of that year.

Will I receive new medical ID cards?

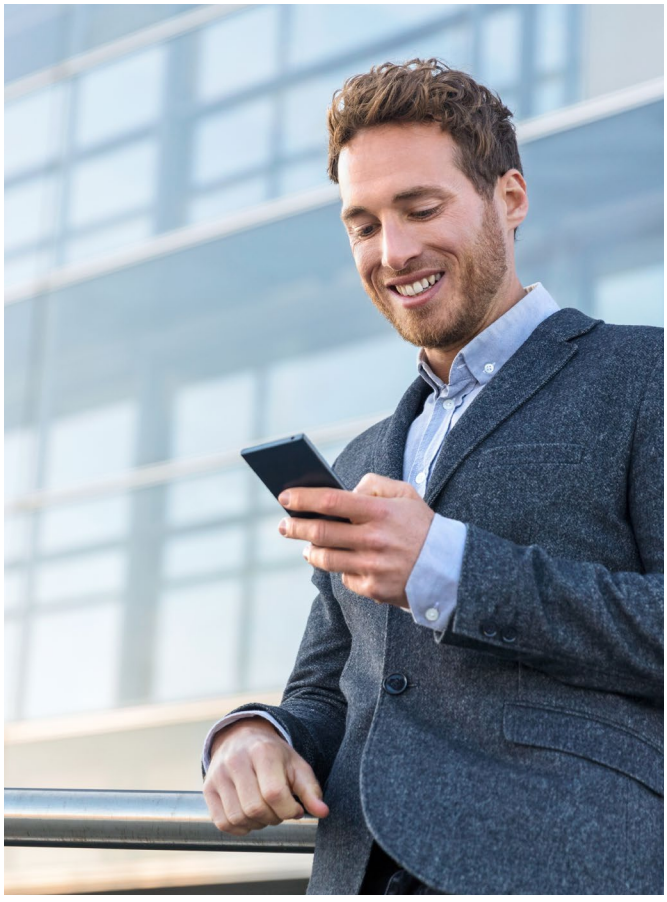
All enrolled employees and their dependents will receive new ID cards for 2024.

Can the FSA pay for my health insurance premiums?

No.

Why might I want Hospital Indemnity/ Accident/Critical Illness coverage if I am enrolled in a major medical plan?

This plan/these plans are not intended to replace major medical coverage. This plan/these plans complement medical plans by eliminating the concern of having to pay for a high deductible or other out-of-pocket expenses in the event of applicable catastrophic events. This plan/these plans can serve as an affordable way to fill in a gap in coverage and help reduce your financial risks.



HEALTHCARE BENEFITS

MEDICAL | PHARMACY | DENTAL | VISION

MEDICAL

AmeriBen

You have three medical plan options to choose from:

AmeriBen Anthem PPO	Ameriben Anthem HDHP	RBP 5000
Annual Deductible: $4,000 Individual $8,000 Family	**Annual Deductible:** $3,500 Individual $7,000 Family	**Annual Deductible:** $5,000 Individual $10,000 Family
Out-of-Pocket Maximum: $7,000 Individual $14,000 Family	**Out-of-Pocket Maximum:** $6,500 Individual $13,000 Family	**Out-of-Pocket Maximum:** $5,000 Individual $10,000 Family
Office Visits: $30 copay for Primary Care $60 copay for Specialist	**Office Visits:** Deductible then Coinsurance for Primary Care and Specialist Office Visits	**Office Visits:** $25 copay for Primary Care $50 copay for Specialist

Which Plan is Right for You?

When choosing a health plan, you want to know what's available and how various benefit plan options fit your needs. You need to consider costs and benefits and then choose with confidence, knowing you have made the right decision for yourself and family. Please take as much time as necessary to review all your choices before you enroll.

CommuniCare is pleased to offer you a choice of three health plans with different levels of costs and benefits. Before enrolling in a plan, consider what you want and need. Step back and look at how you and your family use health care and how much you pay for it. For example:

- Are you paying for coverage you don't need or use?
- Do you need more coverage than you have?
- How many prescription drugs do you and your family take?
- How much do you pay when you have a prescription?
- Does anyone in your family need ongoing medical care?

When choosing a health benefits plan, the most important question is: Will it provide the right amount of coverage for you and your family? After deciding how much coverage you need, consider the costs – and when you pay them.

TIP

ID cards will be mailed in a plain white unmarked envelope. If you need care before you recieve your card, please call Ameriben at 1-888-921-0374 M-F 7:00AM-6:00PM, MT. You can also access an electronic ID card online at www.myameriben.com.

Medical Summary of Benefits

Medical Plan Highlights	AmeriBen Anthem PPO	Ameriben Anthem HDHP	RBP 5000
In-Network			
Employee Deductible	$4,000	$3,500	$5,000
Family Deductible	$8,000	$7,000	$10,000
Employee Out-of-Pocket	$7,000	$6,500	$5,000
Family Out-of-Pocket	$14,000	$13,000	$10,000
Coinsurance	40%	30%	0%
Preventive Annual Exam	Covered in Full	Covered in Full	Covered in full
Primary Care	$30 copay	Deductible then Coinsurance	$25 copay
Specialist	$60 copay	Deductible then Coinsurance	$50 copay
Inpatient Hospital	$300 copay, deductible then 40% coinsurance	Deductible then Coinsurance	0% coinsurance after deductible
Urgent Care	$50 copay	Deductible then Coinsurance	$50 copay
Emergency Room	$300 copay, deductible then 40% coinsurance	Deductible then Coinsurance	$250 copay, deductible then 0% coinsurance

This page is a summary only. For a complete list of benefit restrictions, limitations and exclusions, please refer to your Certificate of Coverage.

Additional Medical

Boone Memorial Hospital Benefits	
Employee Deductible	$400 - services paid at 100% after deductible
Family Deductible	$700 - services paid at 100% after deductible
Lab and X-Ray	$0 deductible - services paid at 100%
Office Visit	$25 copay
Specialist Visit	$25 copay
Emergency Room Visit	$150 copay – 20% coinsurance applies after deductible, copayment waived if admitted

Medical and Pharmacy Bi-Weekly Payroll Deductions

Bi-Weekly Payroll Deductions			
Plan Type	**AmeriBen Anthem PPO**	**Ameriben Anthem HDHP**	**RBP 5000**
Employee Only	$111.10	$82.27	$30.00
Employee + Spouse	$497.44	$442.20	$165.07
Employee + Child(ren)	$265.04	$236.92	$60.00
Family	$567.95	$503.79	$269.19

php Telehealth

PHP Telehealth has you covered this cold, flu, and back-to-school season with $0 copay virtual visits.*

No need to leave the house when you're under the weather or a non-emergent issues arises. A friendly healthcare provider can assess, treat, diagnose, and even prescribe through video conference.

WHAT IS PHP TELEHEALTH?

- A CommuniCare Family of Companies dedicated telemedicine platform and service company.
- We are a network of healthcare providers dedicated to delivering accessible, cost-effective, personal care in which the patient comes first.
- Patients and healthcare providers see and hear each other through a secure video link in real time.
- Our healthcare providers include physicians and advanced practice providers.

This telehealth service is available at **no additional cost or copay to employees and dependents covered by one of the three CommuniCare health plans.*

Scheduling an appointment is easy:

Already registered? Just scan the QR code to make an appointment.

Need to register? Scan the QR code to set up your personal PHP Telehealth account.

SCAN ME

For non-emergent technical issues, please call **833.683.2273** and leave a detailed message.

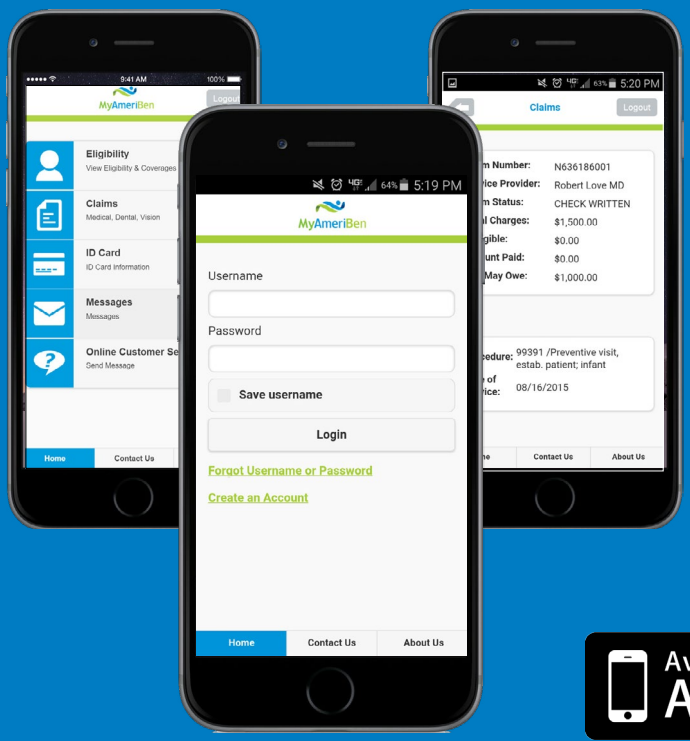
HOW CAN PHP TELEHEALTH SERVE YOU?

- **Complete assessments** to see if a trip to the physician's office or hospital is necessary.
- **Speedier admissions** and less wait time should a visit to the hospital or doctor's office become necessary. Your virtual healthcare provider can even order tests in advance of your arrival.
- **Save time and money** because telemedicine allows you to skip the wait at the doctor's office and see a physician when and where it's convenient for you.
- **24/7 access** to everything you need to stay informed about your health. Even after hours, including nights, weekends, and holidays.
- **Improved quality of life** through continuity of care, medication management, and after-hours care.

PHPTelehealth.com

MyAmeriBen

CommuniCare



How do I Access MyAmeriBen?

1. Log into MyAmeriBen.com on your PC. Enter your user name and password.

How do I Access MyAmeriBen Mobile?

1. Download MyAmeriBen Mobile on your iOS or Android device.

2. Open the app.

3. Enter your username and password.

Available on the App Store

GET IT ON Google play

Electronic ID Card

ID Cards are now available electronically! You can access or e-mail your electronic ID card directly to your healthcare providers.

1. Log in to MyAmeriBen
2. Tap or click on the ID Card icon
3. Tap on 'View ID Card' button. This will provide a downloadable version of the ID card for your records.
4. You can also send the ID card electronically by tapping on the 'Email ID Card' and a new window will open. Enter the destination email address and hit send.

Questions? Please contact AmeriBen Customer Care Monday - Friday 7:00 am - 6:00 pm Mountain Time at 888-921-0374

New to MyAmeriBen?

1. If you have previously logged into MyAmeriBen.com on your PC, use the same username and password for MyAmeriBen Mobile.

2. If you have not previously created a user profile, open MyAmeriBen Mobile and select "Create an Account" on the homepage.

3. Read and accept the licensing agreement.

4. Confirm your identity.

INTRODUCING RBP BILL SUPPORT – ELAP

ELAP – Your Health Plan's Partner for Fairness and Affordability

Overinflated hospital bills cause health plans to raise rates and members to pay more. ELAP eliminates this problem so that everyone pays only what's fair.

When life takes you here…

- Hospital
- Emergency Room
- Outpatient Surgery

ELAP eases the financial pain…

- **Supporting claim limits:** ELAP helps your plan set fair limits on what it will pay for healthcare services to avoid wasteful spending.
- **Reviewing every hospital and facility bill:** ELAP examines every bill line-by-line to catch overcharging.
- **Resolving billing issues:** After ELAP reviews claims, your TPA will send you an EOB stating any member responsibility. If you receive a bill from your provider stating you owe more, that is what is known as a balance bill.

ELAP Services is your health plan's affordability partner, and ELAPulse is your online portal.

Stay Connected | 24/7

Balance Bill Support

- Submit hospital and facility bills
- Check the status of claims
- Contact a Member Services Advocate

KNOW WHAT YOU OWE

Make sure your EXPLANATION OF BENEFITS (EOB)...

From your health plan (not a bill)

Shows you what your plan covered and what you'll owe. If you owe money, you'll get a bill from the hospital/provider.

...matches your BILL

From the hospital/facility

If this does not match your EOB, simply contact ELAP. They will take care of it.

Most of the time, you'll never have a reason to contact ELAP about a bill. But if you do, their advocacy team is here to support you.

RBP Plan – ELAP Frequently Asked Questions

How does ELAP make my health plan better? Overinflated hospital bills cause health plans to raise rates and members to pay more. ELAP eliminates this problem so that everyone pays only what's fair and reasonable.

What exactly does ELAP do? ELAP partners with your company to ensure hospital and facility payments do not exceed your health plan's limits and that they are for services rendered and nothing more. They do this by auditing all hospital and facility claims. ELAP Services will ensure the hospital makes a fair and reasonable profit on all services provided, but they greatly reduce excessive markups that are often seen on facility bills.

What types of medical bills does ELAP review? Their focus is on expenses from facilities including hospitals, outpatient surgery centers and skilled nursing facilities.

How do I know ELAP reviewed my claim? You will receive a notice from your Third Party Administrator (TPA) notifying you that ELAP has audited a claim for services rendered to you. The letter will list the date of service and facility. If you receive a bill for money outside of your member responsibility, this is called "balance billing" and you must submit the bill to ELAP.

What should I do if a facility requests payment up front? The only out-of-pocket expense that you should pay to the facility in advance of or at the time of service is a copay (if applicable). You can contact your plan to confirm copay and/or deductible amounts. Since ELAP will often reduce the amount you owe after auditing a bill, you could overpay by paying up front and the facility will not reimburse you.

What if the facility denies care due to an outstanding billing issue? If the facility will not perform treatment without additional funds outside of your normal copay, then you should contact your Third Party Administrator (TPA) immediately and request to speak with a representative.

When do I have to contact ELAP? Sometimes a hospital or other facility does not accept the payment that ELAP approves as fair and reasonable. In this case, they may bill you for the balance. This is called "balance billing" and when it happens, you need to contact ELAP and send ELAP your bill via fax, email or mail.

- *Email*: bb@elapservices.com
- *Fax*: 888-560-2447
  ATTN Balance Bill Response Team
- *Mail*: 1550 Liberty Ridge Drive,
  Suite 330 Wayne, PA 19087

What happens when I contact ELAP about balance billing? You will receive assistance from a Member Services Advocate throughout the balance billing process. ELAP's legal team will also go to work right away to handle the billing issue with healthcare facilities and collection agencies. It is very important that you send ELAP any bills or notices as you receive them.

QUESTIONS about a hospital, surgery or skilled nursing facility bill?

TEL 1-800-977-7381 9 a.m. - 7 p.m. ET
FAX 1-888-560-2447 • bb@elapservices.com

MAKING THE MOST OF YOUR ANTHEM BENEFITS

Staying In-Network for PPO

Anthem has contracted with a network of providers, including physicians, hospitals and other types of providers. In order to receive the highest level of benefits and pay the least amount out-of-pocket, you need to access care from the providers who have elected to be part of the network. This plan does allow you to seek care from a provider who is not in the network. Just remember that if you make this choice, you will be required to pay a larger portion of the expenses out of your pocket, and the expenses may be subject to the Reasonable and Customary charging pattern for the area. This could also result in a greater out-of-pocket expense for you. We want you to get the most from your healthcare plan.

Your medical network is made up of:

- convenience care (quick) clinics
- physicians
- facilities (urgent care, emergency room)
- nurse practitioners
- specialists

When you see an in-network provider, you will:

- Have lower health care costs for medical services.
- Not need to obtain pre-authorization before a procedure such as surgery, your in-network provider will handle this on your behalf.
- Not have to worry about paying for balance-billed charges and charges above the usual, reasonable, and customary.
- Not have to fill out forms to send to the insurance carrier in order to receive reimbursement, your in-network provider will handle this on your behalf.

How to find an in-network provider:

- Visit Anthem website at www.anthem.com
- **All States:** National PPO (BlueCard PPO)
- **MO:** Blue Access Choice (St Louis) (Select Network)
- **DC/NVA/MD:** BlueChoice Adv Open Access (Select Network)

Pharmacy Benefits Management Services

powered by Northwind Pharmaceuticals

Welcome to Pharmacy Benefits Management Services, your PBM provider effective January 1, 2024.

MEMBER ID CARD

Your Member Identification Card has important information for your pharmacy. After January 1st, show your new ID card when you fill a prescription to ensure that you take full advantage of your pharmacy benefit plan.

Pharmacy Benefit Information

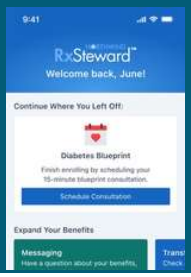
Rx BIN :012528
Rx PCN :VENTEG
Rx Group # :VRX0237
Member ID : Same as your Medical Plan ID

Download the RxSteward Mobile App

All the power of your pharmacy benefit – all the convenience of your phone.

- Schedule time with the Northwind Clinical Team to answer any questions you may have about your benefit or medications.
- Check the formulary to see what is available with your Northwind plan.
- Navigate your pharmacy benefits

To download the mobile app, search for **RxSteward** in your app store.



Available on the App Store
GET IT ON Google Play

PBM Services Key Highlights

Northwind Pharmacy Home Delivery

Our goal is to make medication access simple. Through our partner, Northwind Pharmacy Home Delivery, you can have your medications delivered to your home.

Generic and Brand medications have lower copays when you use home delivery.

Clinical Team

To best support members, the Clinical Team can help you manage your prescriptions and supplies, and maximize your benefit. Call or schedule time via RxSteward mobile app with the Clinical Team today for assistance with any questions you may have.

Pharmacy Concierge for High-Cost Specialty Medications

If you are starting or taking a high-cost specialty medication, you will have a dedicated Pharmacy Concierge to support you:

- Assist with Prior Authorizations
- Check for manufacturer coupons
- Access to free or reduced cost medications

1-866-490-3636 | pbmservices.com

Pharmacy Benefits Management Services

PBM SERVICES

PHARMACY BENEFIT COVERAGE

Your health and well-being are very important to us. The following tips are provided to help ensure you get the most value from your pharmacy benefit.

Understanding Your Coverage

1 CommuniCare RBP

Pharmacy	Generic / Brand / Non-Formulary / Specialty
Retail (30-day supply)	**$15 / $40 / $120 / 25% max $300**
Northwind Home Delivery (90-day supply, specialty has 30-day supply limit)	**$30 / $80 / $240 / 25% max $300**

2 CommuniCare HDHP

Start after deductible is met

Pharmacy	Generic / Brand / Non-Formulary / Specialty
Retail (30-day supply)	**30% Co-insurance**
Northwind Home Delivery (90-day supply, specialty has 30-day supply limit)	**30% Co-insurance**

3 CommuniCare PPO

Pharmacy	Generic / Brand / Non-Formulary / Specialty
Retail (30-day supply)	**$20 / $50 / $150 / 25% max $300**
Northwind Home Delivery (90-day supply, specialty has 30-day supply limit)	**$40 / $100 / $300 / 25% max $300**

Pro Tip:

For most plans, Northwind Pharmacy Home Delivery reduces your cost and provides the equivalent of one free month of medications.

Check your benefit plan and formulary to see if your medications are included.

Weight Loss Medications are not covered by the CommuniCare plan.

1-866-490-3636 | pbmservices.com

Pharmacy Benefits Management Services

SPECIALTY MEDICATION

Specialty Medication Cost Reduction Strategies

When filling your high-cost specialty medication, you will encounter several options to help you manage the cost of the medication:

1. Prior Authorization: Ensures the medication is clinically appropriate for you and there are no other lower cost alternatives available to try first.
2. Manufacturer Coupons: We can assist you with accessing available manufacturer coupons to help lower your out of pocket costs.
3. High-Cost Manufacturer-Covered Medications: Based on unique qualifiers such as household income, you or a family member may qualify for FREE specialty medications through our Pharmacy Concierge Program.

About PHARMACY CONCIERGE

The Pharmacy Concierge is a team of healthcare providers who will work with you, your doctor, pharmacy, and specialty drug manufacturer to locate alternative funding for expensive specialty medications and ensure timely delivery.

Our concierge team can help you with:

- Eliminating drug cost through alternative funding
- Quoting prescription pricing
- Expediting prescription fulfillment
- Confidential and quick delivery
- Annual renewal process
- Addressing questions

Pharmacy Copay Structure for Specialty Plans

Pharmacy	You Pay | Specialty (30-day supply limit)
CommuniCare RBP	25% copay with a maximum of $300/Rx
CommuniCare HDHP	After deductible is met 30% Coinsurance
CommuniCare PPO	25% copay with a maximum of $300/Rx

1-866-490-3636 | pbmservices.com

DENTAL

Delta Dental

You have two dental plan options through Delta Dental. Although you can use an out-of-network dentist, you will save the most money out of your pocket by using Delta Dental dentists who have agreed to give you negotiated rates. To see what dentists are in the network, call 1-800-524-0149 or visit www.deltadental.com.

When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. This amount may be less than what the Dentist charges or Delta Dental approves and you are responsible for that difference.

Dental Summary of Benefits	Low Option Plan		High Option Plan	
	PPO or Premier Dentists	Non Participating Dentist	PPO or Premier Dentists	Non Participating Dentist
Calendar Year Benefit Maximum	$1,000		$1,000	
Calendar Year Deductible *(applies to Basic & Major Only)*	$50/$150		$50/$150	
Plan pays				
Preventive Services	100%	100%	100%	100%
Basic Services	50%	50%	80%	80%
Major Services	25%	25%	50%	50%
Orthodontics *(for children up to age 19)*	50%	50%	50%	50%
Orthodontic Lifetime Maximum	$500		$1,000	

Dental Bi-Weekly Payroll Deductions		
Plan Type	**Low Option Plan**	**High Option Plan**
Employee Only	$6.67	$8.33
Employee + Spouse	$12.55	$15.66
Employee + Child(ren)	$15.62	$19.32
Family	$25.38	$31.65

TIP

Minimize your out-of-pocket expenses for dental care by asking your dentist for a pre-treatment estimate before you agree to receive any prescribed major treatment. Your dentist may be able to present alternative treatment options that will lower your share of the bill while still meeting your basic dental care needs.

This page is a summary only. For a complete list of benefit restrictions, limitations and exclusions, please refer to your Certificate of Coverage.

VISION

EyeMed

Whether you have glasses, contacts, or even 20/20 vision, CommuniCare offers two comprehensive vision benefit plans provided by EyeMed. Vision insurance is the key to maintaining good eye health, as annual exams may detect early warning signs of various health conditions.

Discovering Your Provider Network

For your convenience, this plan utilizes the EyeMed. When looking for a provider, please make sure they participate in the EyeMed network.

Additional Discounts

Additional discounts may be available for Laser Surgery and additional materials. Please refer to the plan summary for a complete listing.

Vision Summary of Benefits	Plan 1 – Base Plan	Plan 2 – Buy Up Plan
Routine Eye Exam *(once every 12 months)*	$10	$0
Lenses		
Single	$10 copay every 24 months	$10 copay every 12 months
Bifocal	$10 copay every 24 months	$10 copay every 12 months
Trifocal	$10 copay every 24 months	$10 copay every 12 months
Frames	$0 copay; $110 Allowance; 20% off balance over $110; Allowed every 24 months	$0 copay; $150 Allowance; 20% off balance over $150; Allowed every 12 months
Conventional Contact Lenses *(in lieu of glasses)*	$0 copay; $110 Allowance; 15% off balance over $110	$0 copay; $150 Allowance; 15% off balance over $150
Standard Contact Fitting & Evaluation	Up to $40	Up to $40

Vision Bi-Weekly Payroll Deductions	Plan 1 – Base Plan	Plan 2 – Buy Up Plan
Employee Only	$2.07	$6.08
Employee + One Dependent	$3.89	$11.43
Family	$5.69	$16.73

This page is a summary only. For a complete list of benefit restrictions, limitations and exclusions, please refer to your Certificate of Coverage.

HSA & FSA

HEALTH SAVINGS ACCOUNT

iSolved

A Health Savings Account (HSA) allows you to set aside money on a pretax basis to pay for qualified expenses, such as doctor visits, prescriptions, braces, or even Lasik eye surgery, with tax-free dollars.

There is no use it or lose it rule with HSAs. Any remaining balance at the end of the year will roll over into the next plan year. HSAs are also portable. This means that if you were to change jobs or health plans, the money in your account stays with you.

One of the best parts of the HSA is its triple-tax advantage: tax-free deductions when you contribute to your account, tax-free investment earnings, and tax-free withdrawals for qualified medical expenses. You earn tax-free interest on the money in your HSA account. You may also have the option to invest the money in your HSA.

You will receive a card linked to your account to pay for qualified expenses. You may be penalized or taxed if you use your HSA funds to pay for ineligible expenses. A full list of qualified expenses can be found on the IRS website at www.irs.gov (section 213(d)).

Eligibility

- You are enrolled in the High Deductible Health Plan (HDHP); and,
- Are not covered under another medical plan such as Medicare, Tricare or a spouse's medical plan (not an HDHP) which provides similar coverage; and,
- Cannot be claimed as a dependent on another person's insurance policy or tax return.

Just a few examples of HSA eligible expenses:

- Acupuncture
- Alcoholism
- Ambulance
- Annual Physical Examination
- Artificial Limb
- Bandages
- Birth Control Pills
- Breast Pumps and Supplies
- Breast Reconstruction Surgery
- Contact Lenses
- Crutches
- Dental Treatment
- Diagnostic Devices
- Eye Exam
- Eyeglasses
- Hearing Aids
- Home Care
- Hospital Services
- Learning Disability
- Legal Fees
- Nursing Home
- Optometrist

2024 IRS Calendar Year Contribution Limits

$4,150
INDIVIDUAL

$8,300
FAMILY

$1,000
AGE 55+ CATCH UP

COMMUNICARE WILL MATCH YOUR DEPOSITS UP TO $250 FOR SINGLE COVERAGE AND UP TO $500 FOR FAMILY COVERAGE.

If you elect a Medical HDHP and an HSA account you are eligible to elect the Limited FSA. You may not elect the FSA with the Medical HDHP.

FLEXIBLE SPENDING ACCOUNT

iSolved

A Flexible Spending Account, or FSA, is an account set-up by your employer that allows you to pay for medical and dependent care expenses on a pre-tax basis. Pre-tax means before federal, state, and social security taxes are deducted from your paycheck. Refer to the IRS website for a full list of qualified and unqualified expenses. Our FSA Administrator is iSolved.

Eligibility

You do not need to participate in medical, dental, or vision plans sponsored by CommuniCare to contribute to a Flexible Spending Account.

2024 IRS Calendar Year Contribution Limits

$3,200
HEALTH CARE FSA

$5,000
DEPENDENT CARE FSA

$3,200
LIMITED PURPOSE FSA

There are 3 types of FSA's:

Health Care FSA

A Health Care Spending Account can be established to help you pay for unreimbursed medical expenses for you and your dependents with pre-tax dollars. Eligible expenses may include deductibles, copays, orthodontics, glasses, contact lenses, and dental copays. The IRS has also authorized expenses for over-the-counter medications if prescribed by a physician. Eligible expenses may be incurred during the plan year. Up to $610 in unused funds in your HCFSA can "roll over" for use in the next plan year. Funds in excess of $610 that are left in the account at the end of the plan year will be forfeited. You must enroll in the Health Care Spending account again in order to claim your rollover funds. Minimum Contributions - $130/year or $5 bi-weekly.

Dependent Care FSA

A Dependent Care Spending Account can be used to help pay for expenses you incur with Child and Elder Care in order for you to work. Eligible expenses include the amount you pay for a babysitter, day-care, senior-care or other service inside or outside of your home for the care of your dependent parent. Eligible expenses must be incurred during the plan year.

Limited Purpose FSA

- For dental and vision expenses only
- If you elect a Medical HDHP and an HSA account you are eligible to elect the Limited FSA. You may not elect the FSA with the Medical HDHP.

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Introducing a Medical Expense Reimbursement Plan ("MERP") as part of your benefits package.

The MERP offers employees who have access to alternate group medical and prescription drug coverage through their spouse, **100% coverage with $0 out of pocket**. You will be reimbursed for ALL eligible co-pays, co-insurance and deductibles incurred through your alternate medical plan up to the maximum out of pocket limits under the Affordable Care Act ($9,450/single and $18,900/family per year).

No premium contribution will be deducted from your paycheck. PLUS, your employer will reimburse you for any additional premium contribution paid for the Alternate Coverage. If it exceeds the premium contribution that you would have paid to remain on CommuniCare's Medical Plan you will be reimbursed up to a maximum of $300 per month up to $3,600 per year/single, $400 per month up to $4,800 per year/employee + spouse, $375 per month up to $4,500 per year/employee + child(ren) and $550 per month up to $6,600 per year/family. If your spouse is currently enrolled in his/her medical plan, you will be reimbursed for any increase in premium to add you and/or your dependents up to the above monthly maximums. If the cost of Alternate Coverage is less than what the employee would have paid for CommuniCare's Medical Plan, then the premium contribution reimbursement is $0.

Eligibility

- **Current employees**: must be enrolled in a CommuniCare medical plan as of December 31, 2023.
- **New employees** must satisfy CommuniCare's benefit eligibility requirements.
- **Qualifying event or newly eligible:** marriage, birth of child, part time to full time, etc.
- **Employees currently enrolled in the MERP:** You must Attest to Alternate Coverage during open enrollment through Workday and provide updated premium contribution information for your Alternate Coverage each year.

Opportunities for Enrollment

- CommuniCare's annual open enrollment window
- Qualifying event: marriage, spouse's change in employment status, birth of child, part time to full time, etc.
- Spouse's Employer's annual open enrollment window
- New employees: may enroll during their new hire enrollment period.

Enrollment

- Enroll in Alternate Coverage and waive coverage on your CommuniCare Medical Plan.
- Complete MERP enrollment in Workday.
- Check the Attestation box in Workday.
- Provide proof of premium contribution paid for Alternate Coverage.

Catilize Health®
2605 NICHOLSON ROAD
SUITE 1140
SEWICKLEY PA 15143

Catilize.com/MERP-info
PHONE: 877-872-4232
MERP@CATILIZEHEALTH.COM

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IRS Rules

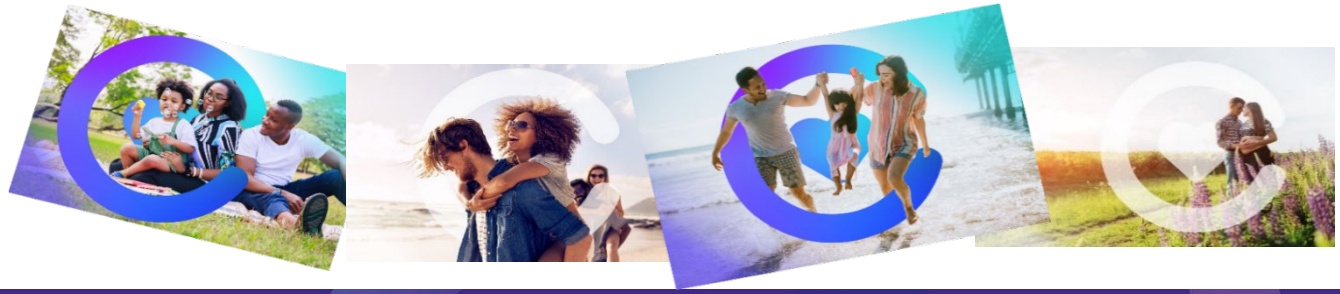
- You may be enrolled in an HRA or FSA. You **CANNOT** be reimbursed from both the MERP and your HRA or FSA.
- Employees are NOT eligible for the MERP if their Alternate Coverage is:
  - A High Deductible Health Plan (HDHP) **with** active contributions to a health savings account (HSA); however, **it is acceptable alternate coverage** if contributions can be waived. A spouse who is not enrolled in the MERP may contribute to an HSA and use the HSA funds. The HSA funds CANNOT be used for medical expenses for members enrolled in the MERP
  - Medicare, Tricare, VA health care or Medicaid
  - Healthcare Exchange Policy made available thru the Affordable Care Act
  - Individual policy or Limited Benefit Health Plan

Premium Contribution Reimbursements Proof Required

- Paystub showing premium contribution amount, pre-tax or post-tax, frequency (other pay information may be blacked out)
- If the entire family is not enrolling in the MERP, then you must provide the tiers of coverage indicating the cost for each tier.

Claims

- How do I use the MERP ID Card?
  - First, present your alternate coverage ID card.
  - Then, present your MERP ID card. Let the provider know that the MERP will pay the provider directly for eligible co-pays, co-insurance, and deductibles.
  - You pay nothing; your provider may file the claim with both your alternate coverage and with the MERP.
- Electronic Claims:
  - To claim reimbursement under the plan electronically, go to portal.catilize.com
  - Here you will simply need to upload the required documentation:
    - Co-pay, co-insurance or deductible: Explanation of Benefits (EOB) from alternate coverage
    - Prescriptions: "Tab" from pharmacy that includes name of drug, date filled, patient's name and patient responsibility amount
- Paper Claims:
  - Send completed and signed claim form to Catilize Health with the required documentation



Catilize Health®

2605 NICHOLSON ROAD
SUITE 1140
SEWICKLEY PA 15143

Catilize.com/MERP-info
PHONE: 877-872-4232
MERP@CATILIZEHEALTH.COM

SUPPLEMENTAL BENEFITS

ACCIDENT | CANCER ADVOCATE | CRITICAL ILLNESS
SHORT-TERM DISABILITY | LONG-TERM DISABILITY
LIFETIME BENEFIT TERM | SUPPLIMENTAL LIFE
TELUS HEALTH

ACCIDENT

Accidents happen and treatment can be vital to recovery, but also expensive. Most major medical insurance only pays a portion of the bills. We help pick up where other insurance leaves off by providing cash to help cover expenses.

Understanding Accident Insurance: https://learn.aflac.com/communicare?products=Accident%20Insurance

Key Features

- Guaranteed Issue coverage, meaning no medical questions to answer
- Protection for accidental injuries on- or off-the-job, 24-hours a day
- Coverage available for spouse and child(ren)
- Premiums are affordable and are conveniently payroll deducted
- Coverage can be continued, as long as premiums are paid to Aflac.
- $100 Wellness Benefit for employees and their spouses.

Benefits Specifications

Hospital Confinement
Per day, Maximum 365 days of confinement per covered accident

Intensive Care
Per day, max. 15 days/injury.

Outpatient Physician's Treatment
1 visit/year, Hospital or Ambulatory Surgical Center 2 visits/year, Dr's Office, UC or ER

Accidental Death & Dismemberment, Dislocation, or Fracture
Multiple dismemberments, dislocations, and fractures from the same accident are limited to amount shown in Base Accident Benefits

Benefit Amounts*

Base Accident Benefits		Low	High
Accidental Death and Dismemberment	Employee Spouse Children	$50,000 $50,000 $25,000	$50,000 $50,000 $25,000
Common Carrier Accidental Death (fare-paying passenger)	Employee Spouse Children	$100,000 $100,000 $50,000	$100,000 $100,000 $50,000
Paralysis	Paraplegia Quadriplegia	$8,000 $16,000	$12,500 $24,000
Prosthesis (Up to 2 devices per accident)		$500	$750
Initial Hospital Admission (Pays once)		$1,000	$1,250
Hospital Confinement (Pays daily)		$300	$375
Intensive Care (Pays daily)		$175	$225
Family Member Lodging (Pays daily)		$125	$185
Ambulance	Ground Air	$240 $1,000	$400 $1,500

Benefit Enhancement Rider		Low	High
Initial Treatment	ER/Urgent Care ER/Urgent Care with X-Ray Doctor's Office Doctor's Office with X-Ray	$150 $200 $60 $110	$225 $275 $100 $150
Major Diagnostic Testing		$150	$200
Prescriptions		$10	$5
Pain Management		$75	$100
Blood/Plasma/Platelets		$300	$375
Traumatic Brain Injury		$250	$500
Coma		$11,500	$17,000
Burns	Second Degree Burns Third Degree Burns	$500 $10,000	$750 $15,000
Eye Injury - removal of a foreign body		$225	$300
Lacerations		$320	$480
Outpatient Surgery and Anesthesia (per day)** Performed in a Hospital or Ambulatory Surgical Center		$300	$400
Outpatient Surgery and Anesthesia (per day) Performed in a Doctor's Office, Urgent Care Facility or ER		$50	$50
Inpatient Surgery and Anesthesia (per day) **		$750	$1,000
Transportation	Plane Any ground transportation	$500 $200	$750 $300
Appliances		$500	$300
Accident Follow-Up Treatment		$60	$90
Rehabilitation Unit (per day)		$125	$200
Therapy		$30	$45
Chiropractic or Alternative Therapy		$30	$45

ACCIDENT

Benefits Enhancement Rider Specifications

Hospital Admission
Once per accident, within six months of the accident year. Not paid if Rehabilitation Unit benefit paid.

Lacerations
Within 7 days after accident.

Accident Follow-Up Treatment
2 visits within 6 months of the accident.
Initial treatment is received within 7 days of the accident. Follow-up treatments may not include physical, occupational, or speech therapy, chiropractic and/or acupuncture procedures.

Brain Injury Diagnosis
Must be diagnosed within 6 months after accident.

Rehabilitation Unit
Per day, max. 15 days confinement,max. 30 days/ year. Not paid if Daily Hospital Confinement benefit paid.

General Anesthesia
Within 1 year after accident.

Appliance
Within 6 months after accident.

Prosthesis
Maximum of 2 devices per covered accident.

Therapy
Maximum of 6 visits if initial treatment is received within 7 days of the accident.

Non-Local Transportation
Per trip 100 miles or more from your home, max. Once/accident within 6 months of the accident

$100 Wellness Benefit
Payable for wellness tests performed as the result of preventative care, including tests and diagnostic procedures ordered in connection with routine examinations.

Organized Athletic Activity Rider
An additional 25% of the payable benefit if injured while participating in an organized athletic event.

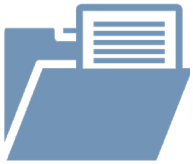
INJURY BENEFIT SCHEDULE*
Benefit amounts given are for Open Reduction Closed Reduction amount is 50%

DISLOCATION	Low	High
Hip	$5,000	$7,700
Knee	$3,250	$5,005
Shoulder	$2,500	$3,850
Foot/Ankle	$2,000	$3,080
Hand	$1,750	$2,695
Lower Jaw	$1,500	$2,310
Wrist	$1,250	$1,925
Elbow	$1,000	$1,540
Finger/Toe	$400	$616
FRACTURE	**Low**	**High**
Hip/Thigh	$5,000	$7,000
Vertebrae/Sternum	$4,500	$6,300
Pelvis	$4,000	$5,600
Skull (Depressed)	$3,750	$5,250
Leg	$3,000	$4,200
Forearm/Hand/Wrist	$2,500	$3,500
Foot/Ankle/Kneecap	$2,500	$3,500
Shoulder Blade/Collar Bone	$2,000	$2,800
Lower Jaw	$2,000	$2,800
Skull (Simple)	$1,750	$2,450
Upper Arm/Upper Jaw	$1,750	$2,450
Facial Bones (except teeth)	$1,500	$2,100
Vertebral Processes/Sacrum	$1,000	$1,400
Coccyx/Rib/Finger/Toe	$400	$560

* Benefit dollar amounts shown are maximum amounts payable amount paid may vary based on severity of injury, benefits subject to limitations on a per accident basis. See plan design from Aflac for more details.

** Surgical procedures may include, but are not limited to, surgical repair of: ruptured disc, tendons/ligaments, hernia, rotator cuff, torn knee cartilage, skin grafts, joint replacement, internal injuries requiring open abdominal or thoracic surgery, exploratory surgery (with or without repair), etc., unless otherwise noted due to an accidental injury.

Accident Disability Plan Summary:
https://communicarebenefits.com/ACC



CANCER ADVOCATE

Cancer Advocate Plus combines Financial Protection and Cancer Care and includes Genetic Cancer Screening to help you determine you risk for cancer and Pharmacogenomic Testing to determine their best treatment based on your own DNA.

Understanding Cancer Advocate Plus:
https://players.brightcove.net/818971943001/default_default/index.html?videoId=6319507660112

Key Features

Active employees 18 or older & spouces are eligible.

- Proactive Cancer Screening
- Cancer Management
- Cancer Recovery
- Cancer Recurrency Monitoring
- Cancer Education & Empowerment

Service Benefits

Heritable Cancer Screening
If an employee understands their genes known to increase the risk of cancer helps them reduce their risk and diagnose cancer early.

Pharmacogenomic Testing (PGx)
PGx indicates how employee will respond to medications and identifies optimal dosages to avoid adverse reactions and medical trial and error.

Genetic Counseling & Action Plan
Nurse oncologists explain results & empower employees to take control of their health.

Oncology Nurse Advocate
Explain diagnosis, advocate on employee's behalf, and partner with doctors to act on genetic information.

Expert Medical Review
Review of relevant medical records be cancer experts.

Genetic Tumor Testing
Molecular diagnostic tests are used to define personalized medicines

Clinical Trial Enrollment
Comprehensive clinical trial search and enrollment support.

Precision Treatment Report
Shares actionable insights to treating physician and access to the experts who created it.

Genetic-based Recurrence Monitoring
A breakthrough in identifying cancer early before it progresses and becomes more difficult to treat.

healthŌme Portal
A collection of videos and reference materials about genetics & cancer.

Financial Protection

Diagnosis of Cancer On or After Effective Date	
Upon Cancer Diagnosis	**$5,000**
6 Months After Diagnosis	**$5,000**
12 Months After Diagnosis	**$5,000**
Total Cash Payment	**$15,000**
Recurrence	**25%**

Once Chubb pays a Cancer benefit, if there is a recurrence, we will pay a Recurrence Benefit as long as the insured was treatment free for 12 months and is in Complete Remission. Complete Remission is defined as having no signs or symptoms that can be identified to indicate the presence of Cancer.

Featuring

Confidentiality
Genetic information is not shared with the employer, Chubb, or healthŌme. Only the prescribing physician, genetic counselor and the testing laboratory will see the genetic tests results. healthŌme will not see genetic information unless the insured is diagnosed with cancer and utilizes cancer support services.

Conditional Renewability
Coverage is automatically renewed as long as the insured is an eligible employee, premiums are paid as due, and the Policy is in force.

Portability
Employees can keep their coverage if they change jobs or retire while the Policy is in force. Once ported, coverage cannot be canceled as long as premiums are paid as due. Employees may not port coverage while they are actively employed by the Policyholder.

Attained Age Premium
Rates increase on the Policy Anniversary as employees move into new age brackets.

HSA Compliant
Cancer Advocate Plus benefits do not disqualify employees from having a Health Savings Account HSA.

CRITICAL ILLNESS

Understanding Critical Illness Insurance:
https://learn.aflac.com/communicare?products=Critical%20Illness%20Insurance

Financial support in the event that you are diagnosed with a serious illness, such as cancer, heart attack, stroke, or kidney failure. These types of illnesses can be devastating not just emotionally and physically, but also financially.

By purchasing critical illness insurance, you can have peace of mind knowing that you'll have financial support to help cover these expenses if you're ever faced with a serious illness. This can help alleviate some of the stress and anxiety that often comes with a diagnosis and allow you to focus on your recovery.

Plan Highlights

Guaranteed Issue Coverage (no medical questions)
Employee: $30,000
Spouse: 50% of employee benefit

- Dependant Children covered 50% at no additional cost.
- $50 annual Wellness Benefit is payable for employees and their spouses completing wellness screenings such as a pap test, cholesterol test, mammogram, colonoscopy or stress test.
- Coverage may be continued; refer to your certificate for details.

Benefits of Critical Illness:

Maintain your lifestyle: If you're unable to work due to a serious illness, critical illness insurance can help cover your living expenses so you can maintain your lifestyle and avoid dipping into your savings or retirement funds.

1. Provide additional support: Even if you have health insurance, the out-of-pocket expenses associated with a serious illness can be substantial. Critical illness insurance can provide financial support to help cover these costs.
2. Customized to your needs: Choose the level of coverage that best meets your needs and budget, have peace of mind knowing that you're covered in the event of a serious illness.

Critical illness insurance is a valuable investment for anyone who wants to protect themselves and their finances from the unexpected. While nobody likes to think about the possibility of being diagnosed with a serious illness, critical illness insurance provides a sense of security and peace of mind.

*Autism benefit not payable if the DSM severity specifier is less than level 1. Diagnosis must occure AFTER effective date of this policy.

Plan Benefits

Base Benefits	
Heart Attack (Myocardial Infarction)	100%
Coronary Artery Bypass Surgery	50%
Major Organ Transplant*	100%
Bone Marrow Transplant (Stem Cell Transplant)	100%
Kidney Failure (End-Stage Renal Failure)	100%
Stroke (Ischemic or Hemorrhagic)	100%
Coma	100%
Loss of Hearing	100%
Loss of Sight	100%
Loss of Speech	100%
Paralysis	100%
Cancer Benefits	
Cancer (Internal or Invasive)	100%
Non-Invasive Cancer	25%
Skin Cancer (per calendar year)	$250
Metastatic Cancer	25%
Health Screening Benefit	
Health Screening (Once per calendar year)	$50
Additional Benefits	
Benign Brain Tumor	100%
Occupational HIV (max 1 payment)	100%
Occupational Hepatitis B or C (max 1 payment per disease)	100%
Advanced Alzheimer's Disease	100%
Advanced Parkinson's Disease	100%
Autism Spectrum Disorders*	$3,000

Critical Illness Plan Summary:
https://communicarebenefits.com/CI

HOSPITAL INDEMNITY

Hospital Indemnity Insurance:
https://learn.aflac.com/communicare?products=Hospital%20Indemnity%20Insurance

Expenses associated with a hospital stay can be financially difficult if money is tight and you are not prepared.

Having hospital indemnity coverage in place before you experience a sickness or injury can help eliminate your financial concerns and provide support at a time when it is needed most by paying a cash benefit to you if you are stuck in admitted to the hospital.

Plan Highlights

- Guaranteed Issue coverage without a Pre-Existing Condition Limitation
- **No** 9-month pregnancy exclusion
- Coverage also available for your dependents
- Premiums are affordable and are conveniently payroll deducted
- Coverage may be continued; refer to your certificate for details

BENEFITS OVERVIEW:

HOSPITAL ADMISSION BENEFIT per confinement (once per covered sickness or accident per calendar year for each insured) Payable when an insured is admitted to a hospital and confined as an inpatient because of a covered accidental injury or covered sickness. We will not pay benefits for confinement to an observation unit, or for emergency room treatment or outpatient treatment. We will not pay benefits for admission of a newborn child following his birth; however, we will pay for a newborn's admission to a Hospital Intensive Care Unit if, following birth, he is confined as an inpatient as a result of a covered accidental injury or covered sickness (including congenital defects, birth abnormalities, and/or premature birth).	$1,500
HOSPITAL CONFINEMENT per day (maximum of 31 days per confinement for each covered sickness or accident for each insured) Payable for each day that an insured is confined to a hospital as an inpatient as the result of a covered accidental injury or covered sickness. If we pay benefits for confinement and the insured becomes confined again within six months because of the same or related condition, we will treat this confinement as the same period of confinement. This benefit is payable for only one hospital confinement at a time even if caused by more than one covered accidental injury, more than one covered sickness, or a covered accidental injury and a covered sickness.	$300
HOSPITAL INTENSIVE CARE BENEFIT per day (maximum of 15 days per confinement for each covered sickness or accident for each insured) Payable for each day when an insured is confined in a Hospital Intensive Care Unit because of a covered accidental injury or covered sickness. We will pay benefits for only one confinement in a Hospital's Intensive Care Unit at a time. Once benefits are paid, if an insured becomes confined to a Hospital's Intensive Care Unit again within six months because of the same or related condition, we will treat this confinement as the same period of confinement. This benefit is payable in addition to the Hospital Confinement Benefit.	$300
REHABILITATION FACILITY per day (maximum of 30 days per confinement, no more than 30 days total per calendar year for each insured) We will pay the amount shown for each day that, due to a covered accidental injury or a covered sickness, an insured receives treatment as an inpatient at a rehabilitation facility. For this benefit to be payable, the insured must be transferred to the rehabilitation facility for treatment following an inpatient hospital confinement. We will not pay the rehabilitation facility benefit for the same days that the hospital confinement benefit is paid.	$150

Hospital Indemnity Plan Summary:
https://communicarebenefits.com/HI

LONG TERM DISABILITY

Understanding LTD Insurance:
https://learn.aflac.com/demo?products=Long-term%20Disability

BENEFITS SPECIFICATIONS

Class Description	All Active Full Time Employees (30 Hours)
Monthly Benefit	60% of Predisability Earnings
Maximum Monthly Benefit	$5,000
Minimum Monthly Benefit*	$100
Elimination Period	180 Days or until the end of the STD Max Benefit Period.
Own Occupation Period	24 months
Pre-Existing Condition	3/12
Social Security Integration	Family Social Security
Benefit Duration	SSNRA

*The minimum monthly benefit is subject to overpayment situations and any applicable rehabilitation incentives.

Guarantee Issue

The 'guarantee' means you are not required to answer health questions to qualify for coverage up to and including the specified amount, when applicant signs up for coverage during the initial enrollment period.

Pre-Existing Condition Limitation

A pre-existing condition includes any condition/symptom for which you, in the 3 months period prior to coverage in this plan, consulted with a physician, received treatment, or took prescribed drugs.
If a pre-existing condition limitation is determined to exist you will not receive claim payments during the first 12 months that you are covered under this policy.

Over 1 in 4 of today's 20 year-olds will become disabled before they retire and among the most common reasons for disability claims include cancer, pregnancy and mental health issues. That's why long term disability insurance is a vital protection that helps ensure an illness or injury won't permanently damage your financial confidence.

Sometimes referred to as income replacement, it pays you benefits to replace a portion of the income you lose if you're unable to work due to a prolonged illness or injury. You continue to receive benefits until you're able to work or until you reach the end of your benefit period.

Understanding Your Benefits

For first two years of disability, you will receive benefit payments while you are unable to work inyour own occupation. After two years, you will continue to receive benefits if you cannot work in any occupation based ontraining, experience and education.

Earnings definition: Your covered salary excludes bonuses and commissions.

Special limitations: Provides a 24-month benefit limit for specific conditions including mental health and substance abuse.Other conditions such as chronic fatigue are also included in this limitation. Refer to contract for details.

Work incentive: Plan benefit will not be reduced for a specified amount of months so that you have part-time earnings whileyou remain disabled, unless the combined benefit and earnings exceed 100% of your previous earnings.

Long-Term Disability Summary:
https://learn.aflac.com/communicare/document-view/assets/documents/2173

SHORT-TERM DISABILITY

Too often when we hear the words disability and insurance together, it conjures up an image of a catastrophic condition that has left an individual in an incapacitated state. Be it an accident or a sickness, that's the stereotype of a disabling injury that most of us have come to expect.

Expenses such as house and car payments, or even daily expenses such as groceries and gas, will still need to be paid. Disability insurance can help replace your lost income and help ensure your finances are not depleted.

Plan Details

- Off job injury or illness coverage
- 6-month benefit duration period
- 14 day elimination period for injury & illness
- No "other income" offsets
- No pre-existing condition exclusions
- No 9 month pregnancy exclusion

Key Features

- Benefits are paid when you are sick or hurt and unable to work, up to 60% of your salary (up to 40% in states with state disability).
- Flexible Monthly Benefit – $300 to $4,000
- Pays 50% of the monthly benefit when a covered employee is partially disabled and returns to work earning less than 80%of base income due to sickness or injury.
- Benefits are paid directly to you unless otherwise assigned.
- Coverage is portable. That means you can take it with you if you change jobs (with certain stipulations).
- Payroll Deduction – Premiums are paid through convenient payroll deduction.

Understanding Short-Term Disability Insurance: https://learn.aflac.com/communicare?products=Group%20Short-term%20Disability%20Insurance

BENEFITS SPECIFICATIONS

Total Disability - Monthly benefit starts after the elimination period has been met. Benefits will not continue beyond the maximum benefit period.

Partial Disability - Pays 50% of the monthly benefit after at least one month of total disability. Payments continue while partially disabled for up to 3 months, but not beyond the maximum benefit period.

Organ Donor - Pays a benefit when disabled from donating an organ.

Waiver of Premium - Pays the premium after monthly disability benefits are payable for 30 days in a row, for as long as monthly benefits are payable.

Concurrent Disability - Being disabled from more than one cause does not extend the payment of benefits under the maximum benefit period.

Recurrent Disability - Pays a benefit when disabled from the same or related cause within 6 months without a new waiting period or maximum benefit period.

Certificate Exclusions and Limitations

Benefits are not paid for:

We will not pay benefits whenever fraud is committed in making a claim under this coverage or any prior claim under any other Aflac coverage for which you received benefits that were not lawfully due and that fraudulently induced payment.

We will not pay benefits for a Disability that is caused by or occurs as a result of:

1. Any act of war, declared or undeclared; insurrection; rebellion; or act of participation in a riot;
2. Actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Reserve;
3. An intentionally self-inflicted Injury;
4. A commission of a crime for which the Insured has been convicted; we will not pay a benefit for any Period of Disability during which the Insured is incarcerated;
5. Travel in, or jumping or descent from any aircraft, except when a fare-paying passenger in a licensed passenger aircraft;
6. Mental Illness as defined;
7. Alcoholism or drug addiction;
8. An Injury that arises from any employment;
9. Injury or Sickness that is covered by Worker's Compensation.

Short-Term Disability Plan Summary: https://communicarebenefits.com/STDI

LIFETIME BENEFIT TERM

LifeTime Benefit Term Insurance:
https://www.youtube.com/watch?v=YnrM41NFVV0

CHUBB's Lifetime Benefit Term's innovative design provides lifetime guarantees at a fraction of the cost. And flexibility allows employees to customize benefits for LTC and double the benefit amount.

Issue Type	Issue Age	Max Benefit Amount	Initial Eligibility
Employee Coverage			
Guaranteed Issue	19 through 70	$150,000	Actively employed working at least 30 hours per week aged 19 through 80. 90 day wait period for benefit eligibility
Conditional Guaranteed Issue	19 through 70	$150,000	
Simplified Issue	19 through 70	$225,000	
Simplified Issue	71 through 80	$50,000	
Spouse Coverage			
Conditional Guaranteed Issue	19 through 70	$75,000	Legally married spouse, domestic partner and civil union partner aged 19 - 70.
Simplified Issue	19 through 70	$112,500	
Dependent Child Coverage			
Child Term Rider	15 days through 25 years	$25,000	Ages 15 days - 25 years
LifeTime Benefit Term Certificate	15 days through 18 years 19 through 25 years	$25,000 Amount $3/week will purchase	

Permanent and Guaranteed Renewable with Guaranteed Premiums

Premiums will never increase and are guaranteed through age 100 and coverage cannot be cancelled as long as premiums are paid as due. After age 100, no premium is due.

Guaranteed Issue

The first time this benefit is available to you, to the amounts listed, you and your family automatically qualify for this benefit without having to answer health questions. You will continue to carry this for as long as you maintain the policy.

Benefits for Long Term Care

Long Term Care is expensive, and LifeTime Benefit Term can help. It pays death benefits in advance for home health care, assisted living, adult day care and nursing home care. Early payments equal 4% of the death benefit per month for up to 50 months. Premiums are waived while this benefit is being paid.

Portability of Coverage

You may be able to keep your insurance if you later become ineligible such as by leaving the group.

Guaranteed Benefits – During the Working Years

While the policy is in force, the death benefit is guaranteed for the longer of 25 years or through age 70. Even after age 70, the death benefit is guaranteed to never be less than 50% of the original death benefit.

SUPPLIMENTAL LIFE

Understanding Life Insurance:
https://learn.aflac.com/demo?products=Life%20Insurance

Protect those you love from financial hardship. Life insurance pays a benefit directly to any beneficiaries you choose, such as your spouse, partner, children or other loved ones. Life insurance may help provide replacement income for your family.

Group Supplemental & Dependent Life

	Benefit Amount	Guaranteed Issue
Employee Life	Maximum of $300,000 in $10,000 increments	$200,000
Spouse	Maximum of $50,000 in $12,500 increments Not to exceed 100% of employee amount.	$25,000
Child(ren)	Maximum of $10,000 in $2,500 increments	$10,000

Employer Paid Life

Your employer cares about you and wants to make sure your loved ones are taken care of in the event that you die. All full time employees are provided Basic Term Life and AD&D insurance coverage in the amount of 1.5 times your base annual earnings to a maximum benefit of $50,000.

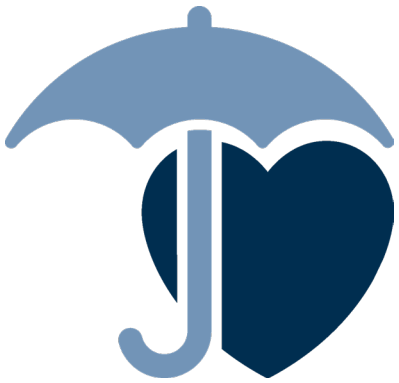
Guaranteed Issue
The first time this benefit is available to you, to the amounts listed, you and your family automatically qualify for this benefit without having to answer health questions. You will continue to carry this for as long as you maintain the policy.

Waiver of Premium
Premiums may be waived if you should become disabled and are unable to work.

Portability of Coverage
You may be able to keep your insurance if you later become ineligible such as by leaving the group.

Convertible
You may be able to convert your coverage to an individual insurance policy, without having to furnish proof of good health.

Age Reduction
Your Life and AD&D insurance will reduce by 65% of the original amount on your 65th birthday and 50% of the original amount on your 70th birthday.



Supplimental Life Plan Summary:
https://learn.aflac.com/communicare/document-view/assets/documents/2178

TELUS HEALTH EAP

Learn about Telus Health:
https://www.youtube.com/watch?v=uAxfOUYYzIk

Life presents us with challenges at work and at home on a daily basis. You do not have to face these challenges alone. Our Employee Assistance Program (EAP), available through Guardian, offers confidential services for a variety of important needs – all to support your well-being and help you think, feel, and perform your best.

What is TELUS Health EAP?

TELUS Health EAP is a full-service employee assistance program (EAP) and resource that provides confidential consultations, information and resources, connections to community agencies, and referrals to counseling.

Why would I contact TELUS Health EAP?

TELUS Health can provide support and resources to help you find answers to questions related to work, life, health, family, or money. You can contact TELUS Health for support with any issue, challenge, or concern. The service is available 24/7.

Up to 3 face to face visits per issue

How do I contact the EAP?

Toll-free by phone, 24 hours a day, seven days a week, 365 days of the year, Connect with a professional consultant for support, strategies, tools, and referrals.

Online at one.telushealth.com. Access hundreds of articles, e-books, audio recordings, assessments, toolkits, & more.
Username: CommuniCare
Password: eap

By free mobile app (for iOS & Android). Download the TELUS Health One app on your mobile device.

Who pays for TELUS Health EAP?

The EAP is available at no additional cost to you, as defined by your benefits plan. Your employer provides this program as a benefit to support your wellbeing.

What are the qualifications of EAP counselors?

Every one of our counseling professionals has either a master or doctorate in psychology, clinical social work, marriage and family therapy, or a related mental health field. They must have a minimum of three years post-master level clinical experience, preferably with EAP experience, and at least 2,500 hours of professional counseling experience.

Potential candidates undergo an intensive recruitment and screening process, which includes several interviews. Candidates must provide proof of degree and liability insurance, which are primary source verified. All candidates are licensed to practice independently. Clinicians are bound by the code of ethics, complaint investigation process and disciplinary sanctions within their own associations and licensing boards.

Is TELUS Health EAP confidential?

Yes. We take the utmost care to protect the identity of anyone who uses TELUS Health. The only exceptions to confidentiality include those governed by law, i.e., we are required to release documents under court subpoena, and we have a duty to intervene and report if a consultant or counselor deems an individual to be at imminent risk of harm to self or others.

Who can use the EAP?

TELUS Health is available to you as an employee of your organization, as well as to your spouse/partner, and to your immediate family members/dependents.

Online: one.telushealth.com
Phone: (844) 246-7674
Mobile App: Search for TELUS Health One app
24 hour crisis help available.

EAP Summary:
https://communicarebenefits.com/EAP

All rates given in this guide are calculated as bi-weekly deductions. If you have any questions about the benefits or your rates contained here, please reach out to the benefit enrollment callcenter and an enrollment counselor will be happy to assist you.

The call center can be reached at
(937) 249-5396
Monday - Friday
8AM - 5PM

Accident

	Low	High
Employee	$4.79	$6.05
Employee and Spouse	$8.00	$10.30
Employee and Child(ren)	$9.24	$12.03
Family	$12.45	$16.28

Hospital Indemnity

Employee	$13.53
Employee and Spouse	$27.17
Employee and Child(ren)	$21.15
Family	$34.79

Short-Term Disability

	Rate is per $10 of Monthly Benefit
18-74 (All Age Bands)	$0.96

Long Term Disability

	Rate is per $100 of Covered Monthly Earnings
< 24	$0.1195
25-34	$0.1735
35-39	$0.2843
40-44	$0.3346
45-49	$0.4648
50-54	$0.5931
55-59	$0.7523
60-64	$0.8409
65+	$0.6858

Critical Illness

Employee Age	$10,000	$20,000	$30,000
18-29	$2.31	$4.62	$6.93
30-39	$3.24	$6.48	$9.72
40-49	$4.84	$9.67	$14.51
50-59	$11.38	$22.75	$34.13
60-64	$16.49	$32.98	$49.47
65-69	$22.46	$44.91	$67.37
70+	$33.30	$66.60	$99.90
Spouse Age	**$5,000**	**$10,000**	**$15,000**
18-29	$1.47	$2.95	$4.42
30-39	$1.93	$3.86	$5.79
40-49	$3.51	$7.02	$10.53
50-59	$6.51	$13.02	$19.53
60-64	$10.17	$20.34	$30.51
65-69	$14.55	$29.09	$43.64
70+	$19.45	$38.91	$58.36

Cancer Advocate Plus

Age	Employee Only		Employee and Spouse	
	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco
18-25	$14.04	$24.96	$27.72	$49.56
26-30	$14.64	$25.92	$28.92	$51.60
31-35	$16.20	$28.80	$32.04	$57.00
36-40	$18.24	$32.28	$35.88	$63.84
41-45	$21.84	$38.64	$42.48	$75.60
46-50	$25.08	$43.80	$48.60	$85.44
51-55	$30.72	$54.36	$59.04	$105.00
56-60	$36.48	$64.92	$70.08	$124.92
61-65	$45.84	$80.64	$86.28	$152.40
66-70	$53.28	$91.32	$99.12	$171.48
71-75	$58.32	$105.96	$107.88	$195.60
76-80	$74.52	$130.32	$133.20	$233.88
81+	$82.80	$146.40	$146.16	$258.96

Supplemental Life and AD&D Per $1,000 of Coverage

Age	Employee		Spouse	
	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco
< 20	$0.0295	$0.0420	$0.0618	$0.0711
20-24	$0.0295	$0.0420	$0.0618	$0.0711
25-29	$0.0342	$0.0420	$0.0618	$0.0711
30-34	$0.0392	$0.0452	$0.0665	$0.0757
35-39	$0.0420	$0.0508	$0.0711	$0.0849
40-44	$0.0508	$0.0702	$0.0849	$0.1172
45-49	$0.0711	$0.1075	$0.1172	$0.1772
50-54	$0.1020	$0.1615	$0.1680	$0.2649
55-59	$0.1555	$0.2492	$0.2557	$0.4080
60-64	$0.2382	$0.3660	$0.3895	$0.5972
65-69	$0.4085	$0.6014	$0.6665	$0.9803
70-74	$0.7375	$1.0071	$1.2018	$1.6403
75+	$0.9572	$2.1628	$2.7942	$3.5188

NOTES

NOTES

CommuniCare
FAMILY OF COMPANIES

Serving with Pride.

**This communication represents a brief summary of the various benefits available to you and is provided as a reference only. The actual carrier policies determine coverage and contain exclusions, limitations, full coverage terms, conditions and requirements. Any notices included in this document do not replace other potential employer requirements for communication.*