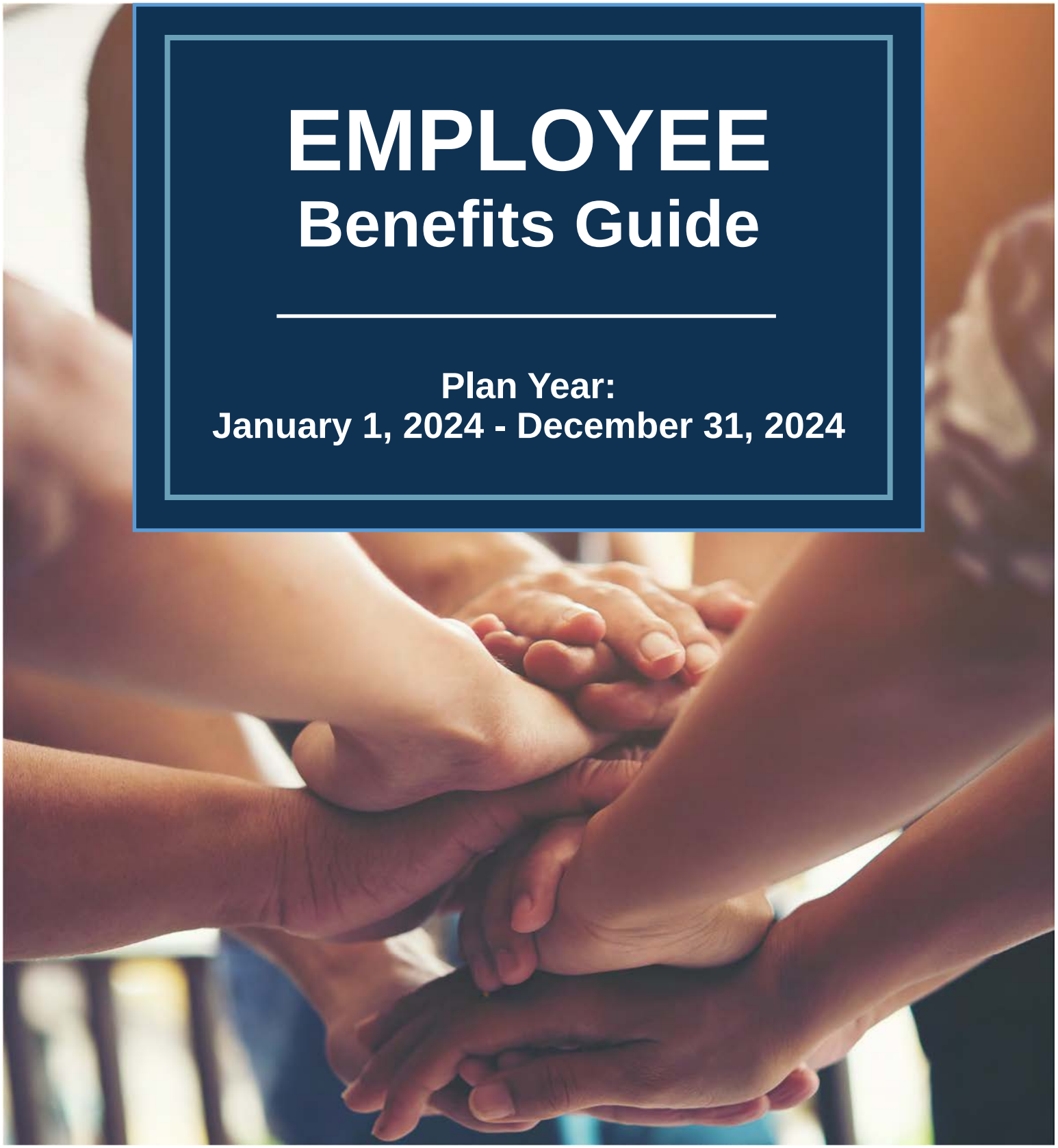


EMPLOYEE
Benefits Guide

Plan Year:
January 1, 2024 - December 31, 2024

GEARHEART COMMUNICATIONS
one source...many resources

Prepared by:

FOUNDATION RISK PARTNERS

Welcome to Gearheart Communications!

On behalf of the management team, let me say that we're glad you're here and we look forward to your contribution to our continued growth. In exchange for your effort, we will always strive to provide you with a safe and pleasant workplace and a competitive compensation package.

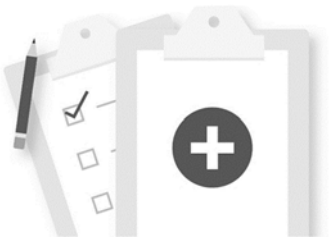
Gearheart Communications knows that our employees have different needs, so we offer employees a wide range of comprehensive benefit plans to let you choose the benefits that best suit your particular situation.

This booklet provides you with a summary of your benefits. Please review it carefully so you can choose the coverage that's right for you and your dependents.

A QUICK LOOK AT THE COST OF YOUR BENEFITS

Gearheart Communications pays the full cost of many of your benefits; you share the cost for others. You pay the full cost for any voluntary benefits you elect.

Benefit	Tax Treatment	Who Pays
Medical Insurance	Pre-tax	Company & You
Health Savings Account (HSA)	Pre-tax	Company & You
Flexible Spending Account (FSA)	Pre-tax	You
Dental Insurance		Company
Vision Insurance		Company
Basic Life and Accidental Death & Dismemberment (AD&D) Insurance		Company
Voluntary Life and Accidental Death & Dismemberment (AD&D) Insurance	After tax	You
Disability Coverage		Company



The following information is a quick overview of the benefits plans currently provided and is not to be interpreted as a complete disclosure of plans entitlement to any of the benefits described. The company reserves the right to adjust, amend and revise benefits plans. In all cases of specific plan interpretations, receipt of benefits or entitlements, the actual plan document shall rule. You can contact your HR department for the actual plan documents.

Table of Contents

Carrier Contact Information

Benefit	Carrier	Phone Number	Carrier Website
Medical Insurance	Anthem	1-888-650-4047	www.anthem.com
Flexible Spending Account (FSA) / Health Savings Account (HSA)	BMS	1-800-919-2674	www.bmsllc.net
Dental Insurance	Delta Dental of KY	1-800-955-2030	www.deltadentalky.com
Vision Insurance	Anthem	1-866-723-0515	www.anthem.com
Basic Life/AD&D and Voluntary Life Insurance	Lincoln Financial Group	1-800-423-2765	www.lfg.com
Short and Long Term Disability Insurance	Lincoln Financial Group	1-800-423-2765	www.lfg.com
Lincoln EAP Lifekeys	Lincoln Financial Group	1-855-891-3684	www.lincoln4benefits.com
Anthem EAP	Anthem EAP	1-800-999-7222	www.anthemeap.com Company Code: Anthem Kentucky

FOUNDATION
RISK PARTNERS

Foundation Risk Partners is a part of your team

Your contacts for employee benefits questions include:

Your Main Contact

Pamela Murphy
Sr. Account Manager
PMurphy@FoundationRP.com
502.371.4039

Your account manager is here to:

- Be your day-to-day contact
- Assist with claims and enrollment
- Answer questions about eligibility and billing

Additional Contacts

Brittany Barnickle
Sr. Account Executive
BBarnickle@FoundationRP.com
812.590.7659

Diane Sousan
Account Advisor, VP
DSousan@FoundationRP.com
502.371.4034

Additional Insurance Services

Insurance can be confusing and stressful. Don't let that keep you from having the appropriate coverage for your family & belongings. Let us help take the stress out of it for you. Our staff is equipped with the tools and knowledge to ensure you have the right coverage options. **Call our main number below or ask your account manager for more information.**

Personal Home & Auto

Medicare Solutions

MEDICARE SOLUTIONS

MEDICARE MADE EASY

We have a resource for individuals who are aging into Medicare.

Our Employee Benefits provider, Foundation Risk Partners, has a Medicare Advisor who can educate you on your Medicare options.

If you're approaching 65, then you've probably been bombarded with Medicare information.

You have a lot of options and it can be unsettling trying to decide which are best for you.

At Foundation Risk Partners, we work with you to build a customized plan that best fits your needs, ensuring you get the attention and care you deserve.

WE ASSIST WITH:

- **Supplemental Plans**
- **Medicare Advantage Plans (Part C)**
- **Part D Prescription Plans**

To set-up an appointment or to further discuss your Medicare needs, please contact:

JESSE GRAY
Medicare Advisor
JGray@FoundationRP.com
502.498.2971

FOUNDATION
RISK PARTNERS

Eligibility & How To Enroll

ELIGIBILITY

The eligibility period for enrollment in medical, dental, vision and life is 1st day following ninety (90) days from date of hire. The eligibility period for enrollment in short & long term disability, and flexible spending is one (1) year from date of hire. Employees working thirty (30) hours a week or more are eligible for all benefits outlined in this summary. Eligible employees may elect to cover a spouse and/or dependents.

You may enroll your eligible dependents for coverage once you are eligible. Your eligible dependents include:

- Your legal spouse
- Your children up to age 26

Once your benefit elections become effective, they remain in effect until the end of the plan year. You may only change coverage within 30 days of a qualified life event. Pre-tax benefits are in effect until the end of the year.

QUALIFIED LIFE EVENT

Generally, you may change your benefit elections only during the annual enrollment period. However, you may change your benefit elections during the year if you experience a qualified life event, including: marriage, divorce, legal separation, birth or adoption of a child, change in child's dependent status, death of spouse, child or other qualified dependent, commencement or termination of adoption proceedings, or change in spouse's benefits.

You must notify Human Resources within 30 days of the qualified life event. Depending on the type of event, you may be asked to provide proof of the event. If you do not contact Human Resources within 30 days of the qualified event, you will have to wait until the next annual enrollment period to make changes (unless you experience another qualified life event).

For more information, please contact **Angela Hall at (606) 479-6355.**

HOW TO ENROLL

Everyone must complete their benefit elections in the Benetrac online enrollment system. Please see Angela Hall, HR Manager, for assistance.

Benefits Plan Apps & Websites

We are very excited about our benefit providers. Each provider, Anthem, Delta Dental, BMS, Lincoln EAP and GoodRx have their own app for your smartphone which gives you access to plan benefits at your fingertips 24/7. We even have access to a website that ho uses all our benefit plan information; plan documents, claim forms, etc.

Anthem
Anthem's Sydney app gives you access to:

- find a doctor or hospital - gives turn by turn directions to get you there;
- view your ID Card - email or fax your card directly to your provider;
- manage prescription benefits - check the cost, get refills, or switch to the home delivery system through Carelon; and
- view your Health Record - share this info with your doctors whenever you go.

Go to **https://www.sydneyhealth.com/** for information on how to download the app. You will need your Anthem ID # and the group number (located on your card) to register online.

Anthem Virtual Visits (formerly Live Health Online)
Anthem Virtual Visits allow you to:

- Talk to a doctor in a few minutes via web, phone or mobile app
- Visit cost will be your PCP Copay OR $59 if covered on an HDHP/HSA Plan
- Choose a board-certified doctor at the time of your visit
- Have your visit 24/7, 365 days a year!

When to use Anthem Virtual Visits:
Always call 911 in an emergency. Otherwise, you can see a doctor online whenever you have concerns and you can't speak to your own doctor. Common visits include: cold and flu symptoms, allergies, rashes, etc..

Sign up for free through the Anthem Sydney App and be ready for your first visit. Please note - if you have used LiveHealth Online App previously, you may continue to do so & it is available on Apple and Google Play devices.

Delta Dental
The Delta Dental app lets you:

- search for a dentist in network (Delta Dental PPO and Delta Dental Premier are our networks);
- see claims and coverage information;
- see your mobile ID card;
- register or log in to your account at **https://www.deltadental.com/Public/index.jsp** (be sure to choose your state at the top of the screen).

Benefits Plan Apps & Websites

Benefit Marketing Solutions -
Flexible Spending Accounts (FSA) / Health Spending Accounts (HSA)
The BMSLLC mobile app can easily be downloaded for FREE from the iTunes Store or Google Play (formerly known as the Android Market) to you iPhone, iPad, iPad Mini, iPod Touch and Android devices.
What can I do with the BMSLLC mobile app?

- Enter new claims
- Upload receipts for debit card claim use verification
- View account balances
- Review the history of mobile app claim submissions

The log in for the Consumer Portal and Mobile App are the same. The participant will need to register their online account before being able to log into the mobile app.

Lincoln Financial (EAP)
Employee Assistance Programs (EAP) provides professional help to full-time employees and their household members who are struggling with issues such as:

- emotional difficulties
- stress
- relationship problems
- parent/child/family conflicts
- marital distress
- alcohol/drug problems
- financial & legal

This benefit is administered by Lincoln Financial, the vendor for Gearhart's Life & Disability Policies. This service is free of charge and completely confidential to all employees of Gearhart and their household members. Call 1-855-891-3684 or visit their website Lincoln4Benefits.com (Web ID = LifeKeys) anytime, 24/7.

GoodRx
GoodRx is a website and mobile app that tracks prescription drug prices and offers drug coupons at over 75,000 US pharmacies. GoodRx even shows the cost variance between different pharmacies. For example, in some cases Walgreens and CVS will be more expensive than a big box store such as Walmart or Costco.

Medical Insurance
Anthem / Policy # L02608

ELIGIBILTY: You are eligible to participate in the Anthem plan, the 1st day following 90 days from your date of hire. Dependent children are covered up to age 26.

YOUR COST FOR SERVICES:	PLATINUM	GOLD	SILVER	BRONZE HDHP
MAJOR MEDICAL*				
Annual Deductible (Individual / Family)	$0 / $0	$0 / $0	$500 / $1,000	$3,000 / $6,000 **non-embedded deductible**
Annual Out-of-Pocket Limit (Individual / Family)	$2,000 / $4,000	$2,500 / $5,000	$3,000 / $6,000	$3,425 / $6,850 **non-embedded out of pocket**
Coinsurance	0%	20%	20%	0%
PHYSICIAN OFFICE VISITS				
Preferred PCP Office Visit (EPHC Providers)	$10 copay	$20 copay	$20 copay	$10 copay after deductible
Primary Care Office Visit	$20 copay	$30 copay	$35 copay	$20 copay after deductible
Specialist Office Visit	$20 copay	$30 copay	$50 copay	$20 copay after deductible
Anthem Virtual Visits/Live Health Online (Telemedicine)	$10 PCP copay $20 Specialist copay	$20 PCP copay $30 Specialist copay	$20 PCP copay $50 Specialist copay	$59 copay before deductible; No charge after deductible
Urgent Care	$50 copay	$50 copay	$75 copay	$20 copay after deductible
Preventive Care	0%	0%	0%	0%
HOSPITAL BENEFITS				
Inpatient Hospitalization	0%	20%	20% after deductible	0% after deductible
Outpatient Surgery / Facility	0%	20%	20% after deductible	0% after deductible
Emergency Room	$100 copay	$200 copay	$150 copay	$200 copay after deductible
ADDITIONAL MEDICAL BENEFITS				
Outpatient Home Health	0%	20%	20% after deductible	0% after deductible
Inpatient Skilled Nursing Facility	0%	20%	20% after deductible	0% after deductible
PRESCRIPTION DRUG CARD				
RX Deductible (Retail & Mail Order)	$200 Individual / $600 Family RX deductible applies to Tier 2, 3 & 4; Deductible must be met before copays apply. Deductible does not apply to Tier 1.			Combined with Medical
Retail (30 Day Supply)	$10 / $20 / $50 / 25% up to $350	$10 / $20 / $50 / 25% up to $350	$10 / $20 / $50 / 25% up to $350	$10 / $35 / $60 / 25% up to $350 after deductible
Mail Order (90 Day Supply)	$25 / $50 / $125 / 25% up to $350	$25 / $50 / $125 / 25% up to $350	$25 / $50 / $125 / 25% up to $350	$25 / $88 / $150 / 25% up to $350 after deductible

* These are in-network benefits. For out-of-network benefits please see the complete benefit summary.

Plan Cost per Pay (26 per Year)	Platinum		Gold		Silver		Bronze HDHP	
	Rate	10%*	Rate	10%*	Rate	10%*	Rate	10%*
Employee Only	$50.26	$45.23	$32.80	$26.52	$20.00	$18.00	$47.49	$42.47
Employee + One Dependent	$100.46	$90.42	$65.60	$59.04	$30.00	$27.00	$94.33	$84.90
Family	$138.32	$124.49	$98.41	$88.56	$40.00	$36.00	$110.00	$99.00

* With completion of biometric screening and health risk assessment

All copays, coinsurance and deductible accumulates toward the out-of-pocket limit.

To locate a network provider in your area, go to: www.anthem.com

Select Blue Access network.

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Sydney™ Health makes healthcare easier

Access personalized health and wellness information wherever you are

The Sydney Health mobile app is the one place to keep track of your health and your benefits. With a few taps, you can quickly access your plan details, Member Services, virtual care, and wellness resources. Sydney Health stays one step ahead — moving your health forward by building a world of wellness around you.

Find Care

Search for doctors, hospitals, and other healthcare professionals in your plan's network and compare costs. You can filter providers by what is most important to you such as gender, languages spoken, or location.

Virtual Care

Connect directly to care from the convenience of home. Assess your symptoms quickly using the Symptom Checker, then consult with a doctor through a video visit or text session.

My Health Dashboard

Use My Health Dashboard to find news on health topics that interest you, health and wellness tips, and personalized action plans that can help you reach your goals.

Community Resources

This resource center helps you connect with organizations offering free and reduced-cost programs to help with challenges such as food, transportation, and child care.

Live Chat

Find answers quickly with the Live Chat tool in Sydney Health. You can use the interactive chat feature or talk to an Anthem representative when you have questions about your benefits or need information.

My Health Records

See a full picture of your family's health in one secure place. Use a single profile to view, download, and share information such as health histories and electronic medical records directly from your smartphone or computer.

Download Sydney Health today

Use the app anytime to:

- Find care and compare costs
- See what's covered and check claims
- View and use digital ID cards

GET IT ON Google Play

Download on the App Store

Use your smartphone camera to scan this QR code

Anthem

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Expanding your virtual care options

Find complete care support, on your time, through the **Sydney Health app**

Visit with a doctor at your convenience

Accessing the care you need, when you need it, matters. That's why our Sydney℠ Health mobile app connects you to a team of doctors ready to help you on your time. There are two secure ways to find low or no-additional cost care through our app:

1. **Chat with a doctor 24/7 without an appointment**
   - Urgent care support for health issues, such as allergies, a cold, or the flu.
   - New prescriptions[1] for concerns such as a cough or a sinus infection.
2. **Schedule a virtual primary care appointment**
   - Routine care, including virtual annual preventive care (wellness) visit and prescription refills.[1,2,3,4]
   - Personalized care plans for chronic conditions, such as asthma or diabetes.

Assess your symptoms with the Symptom Checker

When you're sick, you can use the Symptom Checker on Sydney Health to answer a few questions about how you're feeling. That information is run against millions of medical data points to provide care advice tailored to you.

Save money and time with virtual care

Sydney Health brings care to you anywhere, anytime. The Symptom Checker is always free to use, while virtual primary care visits and on-demand urgent care through the app are available at low or no-additional cost.

▷ Download our Sydney Health mobile app today.

Set up your account right away and it will be ready to use when you need it.

GET IT ON Google Play | Download on the App Store

85% of virtual visits **resolve** the person's need.[5]

1 Virtual annual preventive care (wellness) visits through the Sydney Health app are available starting September 2022. The virtual annual preventive care (wellness) visit is covered in full unless the employer has a limit or cap under their benefit plan.
2 Virtual primary care medical services provided by Preventive Medical Associates P.C. through an arrangement with Hydrogen Health, which provides the virtual care platform.
3 Eligible employees are those who have not yet had an annual preventive care (wellness) visit during the plan year (either virtual or in-person) whose group benefit plan covers a virtual primary care exam. If an employer group has a cap on the number of preventive care (wellness) visits that are covered in full and the employee has exceeded the cap but would like to have another preventive care (wellness) visit, they may be responsible for copays and other out-of-pocket costs for the visit. Employees should consult their benefit plan and/or contact Member Services if they have any questions.
4 Your doctor will determine if a prescription is needed at time of visit.
5 K Health analysis of Q4 2020 visit depositions.

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When you're not feeling well, Sydney Health can help

Check your symptoms and connect with a doctor through the app

The Sydney Health mobile app is a quick and convenient way to assess your symptoms when you're sick and connect with a doctor, wherever you are.

Assess your symptoms

Start with the Symptom Checker and answer a few questions about how you are feeling. You'll receive information and advice tailored to your gender, age, and medical history. The Symptom Checker was built with doctors and medical professionals. It intuitively uses the information you provide to narrow down millions of medical data points and assess your specific symptoms before you even see a doctor.

Connect with a doctor

The app can connect you to a board-certified doctor through a Virtual Text Visit or Video Visit right from your phone or tablet.

Virtual Text Visits offer the convenience and privacy of texting with a qualified doctor anytime, anywhere. Through a Virtual Video Visit, the doctor will be able to see what you're experiencing and diagnose your symptoms. They can talk about your treatment options and order prescriptions and labs, as needed. They can also let you know whether you need an in-person visit as a next step.

Save money

The Sydney Health Symptom Checker is free. Virtual Text Visits cost less than most copays, at $19 or less per visit depending on your plan. Virtual Video Visits through LiveHealth Online are $59 or less, depending on your plan.

Download the free Sydney Health mobile app today. You'll be able to check your symptoms when you're sick and connect to care directly from your mobile device.

GET IT ON Google Play

Download on the App Store

Anthem

Sydney Health is offered through an arrangement with CareMarket, Inc. Sydney and Sydney Health are trademarks of CareMarket, Inc.

LiveHealth Online is the trade name of Health Management Corporation, a separate company, providing telehealth services on behalf of Anthem Blue Cross and Blue Shield.

Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. Copies of Colorado network access plans are available on request from member services or can be obtained by going to anthem.com/co/networkaccess. In Connecticut: Anthem Health Plans, Inc. In Georgia: Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. HMO plans are administered by Anthem Health Plans of New Hampshire, Inc. and underwritten by Matthew Thornton Health Plan, Inc. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWI), underwrites or administers PPO and indemnity policies and underwrites the out of network benefits in POS policies offered by Compcare Health Services Insurance Corporation (Compcare) or Wisconsin Collaborative Insurance Corporation (WCIC). Compcare underwrites or administers HMO or POS policies; WCIC underwrites or administers Well Priority HMO or POS policies. Independent licensees of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

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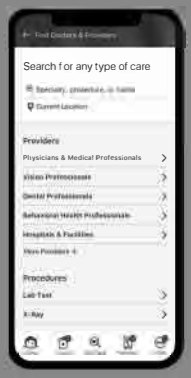
Connect with the care that's right for you

The Find Care tool helps you search for doctors/dentists and compare costs

Choosing a provider you trust is important — and choosing one in your plan's network can help keep your costs down. Finding high-quality, cost-effective care is simple when you use the Find Care tool on the Sydney Health mobile app or **anthem.com.**

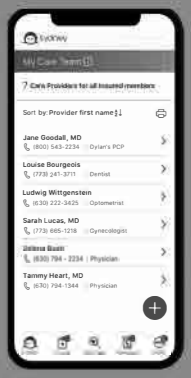
How to use Find Care

The Find Care tool brings together details about doctors, dentists, hospitals, labs, and healthcare facilities in your plan's network. You can easily compare information such as costs, location, and office hours. You can:



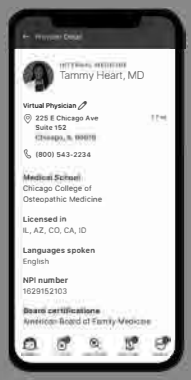
1

Search for providers and facilities in your plan's network by name, specialty, or procedure.



2

Customize the list of providers you see in your search based on factors that are most important to you, such as languages spoken, affiliated hospitals, and location.



3

Review details about doctors/ dentists such as their specialties, gender, educational background, and contact information.

4

Choose a doctor/ dentist from the list to review their patient ratings and compare costs for services.

Choose with confidence

You can start using **Find Care** by downloading the Sydney Health app to your mobile device or logging in to **anthem.com.** Select **Find Care** and the Find Care tool will guide you through the steps.

We're ready to help you

The Find Care tool empowers you to take control of your healthcare by helping you connect with high-quality care options. If you have questions, you can reach us using the interactive chat feature on the Sydney Health app or through the Message Center on **anthem.com.**

Download Sydney Health today to find a provider that's right for you

Use your smartphone camera to scan this QR code.

Anthem

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Anthem

When you need care quickly

Knowing where to go can save you time and money

When you need care right away, the emergency room (ER) might be the first place that comes to your mind. However, the ER may not be the best choice in every situation. You have options when you have a sudden need for care, and knowing what they are can help you save time and money — and feel better sooner.

Where to go for care

Going to the ER or calling 911 is always your best option for emergencies. If it's not an emergency, you can see your primary care physician (PCP), have a virtual visit with a doctor, or go to a retail health clinic or urgent care center. This chart compares those options:[1]

PCP	**Virtual care**	**Retail health clinic**	**Urgent care center**	**Emergency room**
Usually available during normal business hours and may also provide medical advice by phone after hours	24/7 access to doctors through the **Sydney Health**℠ app, no appointment needed	Walk-in care clinics located in certain drugstores and major retailers	Stand-alone facilities, open extended hours	Stand-alone facilities or part of hospitals, open 24/7
				
cost[7] **$$** / average wait[2] **18 min**	cost **$** / average wait[3] **10 min**	cost **$$** / average wait[4] **30 min**	cost **$$$** / average wait[5] **30 min**	cost **$$$$** / average wait[6] **90 min**
Mild asthma, back pain, flu-like symptoms, allergies, fever, sprains, diarrhea, eye or sinus infection, rash, urinary tract infection (UTI), sore throat, earaches, bumps, minor cuts and scrapes, and other nonemergency symptoms	Flu-like symptoms, allergies, fever, sinus pain, diarrhea, eye infection, rash, UTI	They help ensure tests Sore throat, earaches, bumps, minor cuts and scrapes, UTI	Sprain and strains, nausea, diarrhea, ear or sinus pain, minor allergic reactions, cough, sore throat, minor headache, UTI	Signs of a heart attack (chest pain) or stroke (sudden numbness and slurred speech), difficulty breathing, and severe burn or bleeding – and any other symptoms where it is reasonable to think you are having a life-threatening emergency or your health is in serious jeopardy

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How to find the care you need:

1. Go to **anthem.com or download the Sydney Health mobile app from the App Store® or Google Play™.** Then, log in to:
   - Find a doctor if you don't have a PCP.
   - Have a virtual visit with a doctor using the Sydney Health℠ mobile app.
   - Find a retail health clinic, urgent care center, or ER.
2. Choose **Find Care** and follow the steps.

Did you know?

The average total cost of an ER visit can be up to **10 times** more than an urgent care center visit. ER wait time is usually about **three times** more than at an urgent care center.[8]

Learn more about your healthcare options

Use your phone's camera to scan this QR code.

Anthem

Sources:
1 The care options and list of symptoms are not all-inclusive. If possible, consult your PCP for more guidance.
2 Business Wire: *9th Annual Vitals Wait Time Report Released* (accessed July 2021): businesswire.com.
3 LiveHealth Online, internal data 2020.
4 Healthcare Finance: *Patient wait times show notable impact on satisfaction scores, Vitals study shows* (accessed July 2021): healthcarefinancenews.com.
5 Urgent Care Association: *UCA 2019 Benchmarking Report* (accessed July 2021): ucaoa.org.
6 Harvard Business Review: *To Reduce Emergency Room Wait Times, Tie Them to Payments* (accessed July 2021): hbr.org.
7 Costs are ranked according to the member's estimated out-of-pocket costs and average health plan copays. Each plan may have different costs. Nonemergency care outside of your network may cost more out of pocket or may not be covered at all. $ = lower cost, and $$$ = higher cost. Call the Member Services number on your ID card if you have questions about your plan.
8 Healthgrades: *Should You Go to the ER or Urgent Care? How to Decide* (accessed July 2021): healthgrades.com.

Protecting your health and wellness

Discover no-cost programs that can help

Your health plan comes with programs to help you confidently care for your well-being. It doesn't matter what health issues you may be experiencing or even what stage of life you're in — there is a program for everyone.

ConditionCare

Managing chronic conditions, such as asthma, diabetes, chronic obstructive pulmonary disease (COPD), or heart disease requires extra care and attention. To help you be at your best, the ConditionCare program offers free resources, including:

- 24/7 phone access to nurses who can address your health questions and concerns.
- Support from healthcare professionals to help you reach your health goals.
- Educational guides and useful tools to help you learn more about a certain condition.

Connect with the support you need

- 24/7 NurseLine: **800-337-4770**
- ConditionCare: **866-962-1065**
- Find Building Healthy Families in your plan's mobile health app.

Anthem

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Building Healthy Families

Whether trying to conceive, expecting a child, or in the thick of raising young children, Building Healthy Families offers personalized, digital support to help each family navigate their unique journey. You can find Building Healthy Families in your plan's mobile health app to do things like:

- Track baby's feedings, diaper changes, and developmental milestones.
- Monitor prenatal health risks and receive updates on your pregnancy progress.
- Explore a library with thousands of educational articles and videos.
- Connect with one-on-one pregnancy support in the app or over the phone.

24/7 NurseLine

When your allergies flare up on the weekend or your little one spikes a fever at 3 a.m., you can ask a registered nurse for advice by calling 24/7 NurseLine. Nurses are ready any time of the day or night to:

- Answer your questions.
- Recommend where to go for care when your doctor isn't available.
- Help you find healthcare professionals in your area.
- Enroll you and your dependents in health management programs.
- Remind you about important preventive screenings and exams.

Enroll today

1. Visit **anthem.com** or log in to Sydney Health.
2. Find *Featured Programs* at the bottom of the homepage.
3. Select **View All** then choose the **Building Healthy Families** tile.

You can also scan this QR code with your phone's camera to get started.

You can take your benefits with you

with the BlueCard® PPO and Blue Cross Blue Shield Global® Core programs

If you are away from home and you need care right away, you're covered. As an Anthem Blue Cross and Blue Shield (Anthem) member, you have access to care across the country through the **BlueCard® PPO Program.** This includes **95% of doctors and 96% of hospitals in the U.S.**[1]

To access care across the U.S., you can:

Call 911 or **go to the nearest hospital** in an **emergency.***

Go to anthem.com, log in and use the **Find a Doctor** tool to search for a BlueCard PPO Program doctor or hospital.

Use the Sydney Health mobile app to search for a BlueCard PPO Program doctor or hospital. You can receive turn-by-turn directions to the nearest doctor, urgent care center or hospital.

Call Member Services at the number on your ID card. They can help you find a doctor or hospital.

*You or a family member needs to call the Member Services number on your ID card within 24 hours (48 hours for members in Indiana) after going to the hospital or as soon as you can.

General tips for traveling

Here is what you need to know:

- Ask Member Services if your international benefits are different before leaving the country.
- Call Member Services to understand if you need to be preapproved for any type of care. The number is on you ID card.
- Save money by seeing a BlueCard program doctor or hospital. You only pay your usual out-of-pocket amounts (such as a deductible, your percentage of costs or copay). If you go to a doctor or hospital outside the program, you will need to pay the entire bill up front.
- Show your Anthem ID card so the doctor or hospital can check your benefits and send us a claim for processing.

Your member ID card is always with you

The "PPO-in-a-suitcase" symbol shows you can receive care from BlueCard PPO Program doctors and hospitals. You can also carry a digital ID card wherever you go. Find it by logging on to anthem.com or the Sydney Health mobile app.

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Access care around the world

Use the **Blue Cross Blue Shield Global® Core Program.** It gives you access to preferred doctors and hospitals in 190 countries and territories around the world.[2]

To access care outside the U.S.:

Go straight to the nearest hospital in an emergency.

Go to bcbsglobalcore.com to search for a doctor or hospital.

Use the Blue Cross Blue Shield Global Core app to find a doctor or hospital.

Call the Blue Cross Blue Shield Global Core Service Center 24/7 at **1-800-810-2583 (BLUE)** or call collect at **1-804-673-1177.** They can help you set up a doctor visit or hospital stay.

Before you access care outside of the U.S.

Unless it's an emergency, please call the Global Core Service Center before accessing care outside the U.S. Global Core will work with the doctor and Anthem to approve and accept a Guarantee of Payment (GOP). If you receive care from a doctor or hospital that has not accepted a GOP:

1. You will need to pay up front in full for your care.
2. Download an international claim form at **bcbsglobalcore.com** or call Member Services at the number on your ID card for help.
3. Fill out the claim form and send it with the original bills to the Blue Cross Blue Shield Global Core Service Center. You can submit claims through the mobile app, email or postal mail.

Your health benefits are your travel companion. They go where you go, so you will never have to worry about coverage when you're away from home.

You can download the Blue Cross Blue Shield Global Core app today

With the app, you can:

- Search for a doctor or hospital.
- Submit claims.
- Find help with medical terms and phrases for many symptoms translated — and even use an audio feature to play the translation.
- Find a drug's generic name, local brand name and check whether it's available.
- Receive information about how to find and contact a U.S. embassy.

Wellbeing Solutions

Focus on your well-being and earn rewards up to $500

The more activities you complete, the greater your reward

The Wellbeing Solutions program connects you with easy-to-use digital health and wellness tools that can help you stay your best. When you complete any of the activities listed below sponsored by your employer, you'll earn rewards to put toward electronic gift cards for select retailers. You choose the activities you'd like to complete to receive the maximum of $500.

Activity Type	Activities	Amount
Preventive care	Have an annual preventive wellness exam or well-woman exam with your doctor	$20
	Get an annual cholesterol test[1]	$5
	Have a colorectal cancer screening (ages 45 and older)	$25
	Have a routine mammogram (women ages 40 to 74)	$25
	Have an annual eye exam[2]	$20
	Get an annual flu shot	$10

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Activity Type	Activities	Amount
Condition management programs	ConditionCare: Work one on one with your health coach and earn rewards for participating in and completing the program[3]	Up to $100 ($40/$60)
	Building Healthy Families: Support is available through the Sydney℠ Health app wherever you are in your family planning process, such as trying to conceive or raising your toddler[4]	$75 ($15/$20/$20/$20)
	Well-being Coach – Weight Management: Receive one-on-one coaching by phone as you complete your goal to earn a reward[5]	$50
	Well-being Coach – Tobacco Cessation: Receive one-on-one coaching by phone as you complete your goal to earn a reward[6]	$50
	Complete a diabetic foot exam	$25
	Have diabetic lab tests	$30
Digital & wellness activities	Log in to your Anthem account	$5
	Connect a fitness or lifestyle device	$5
	Complete a health assessment and receive tailored health recommendations	$20
	Complete action plans around eating healthy, weight management, and physical activity	Up to $20 ($4 per action)
	Track your steps	Up to $60 ($2 per 50,000 steps tracked)
	Complete Well-being Coach digital daily check-ins[7]	Up to $20 ($4 per milestone)
	Update your contact information	$15
	Participate in the Emotional Wellbeing Resources Program	$5
	Read five articles or watch five videos on Sydney Health or at **anthem.com**	$5

Well-being Coach can help you meet your goals

The Well-being Coach digital coaching app from Lark offers you 24/7 personalized support. Well-being Coach can help you maintain a healthy weight, quit tobacco, and improve your nutrition, exercise habits, mindfulness, and sleep. If you need extra support with weight management or quitting tobacco, talk to a certified health coach.

Access Well-being Coach in the Sydney Health app or at **anthem.com**.

Earn rewards

Here's how and when you'll earn rewards for completing the activities already mentioned.

Preventive care: Simply visit your doctor for any of the screenings or appointments listed in the chart. Your rewards are added to your account after your claim is processed, which may take up to 60 days

Condition management: Rewards are added to your account as you meet certain benchmarks or complete a program. Programs include: ConditionCare (for asthma, diabetes, and heart or lung conditions), Building Healthy Families, and Well-being Coach for weight management and tobacco cessation.

Digital and wellness activities: Log in to the Sydney Health app or **anthem.com** to complete available activities, such as taking a health assessment, participating in the Well-being Coach digital program, and tracking your steps. Rewards are added to your account as activities are completed.

Use your rewards toward electronic gift cards for select retailers.

1 To view your rewards, open the Sydney Health app or go to **anthem.com**. Next, go to *My Health Dashboard*.

2 Select **My Rewards**.

3 Select **Redeem Rewards** to see how much you've earned. Use your rewards toward electronic gift cards from popular retailers, including Amazon, Uber, Gap Options (all brands), Apple, Target, The Home Depot, and TJ Maxx. The minimum gift card amount is set by each individual retailer.

Download the Sydney Health mobile app by scanning this QR code with your phone's camera.

Do you have questions?

Log in at **anthem.com** or open the Sydney Health app. Then go to *My Health Dashboard* and select **My Rewards** to learn more. You can also call Member Services at the number on your ID card.

1 Annual cholesterol test eligibility: men 35 years and older, women 40 years and older with a full cholesterol (lipid) panel.

2 Annual eye exam reward is available if employer provides vision coverage through Anthem.

3 Adult members identified as moderate or high risk are eligible for ConditionCare and may receive a reward for participation in 1 of 5 ConditionCare programs and completion for 1 of 5 ConditionCare programs: (chronic obstructive pulmonary disease (COPD), coronary artery disease (CAD), asthma, diabetes, and congestive heart failure (CHF). Rewards include: $40 for program participation and $60 for program completion.

4 Building Healthy Families milestone completion dates: BHF Pregnancy Screener must be completed in first trimester; at least 1 of 6 mini assessments must be completed by one day prior to delivery; postpartum assessment must be completed by 56 days after delivery. Building Healthy Families rewards include: $15 for profile completion; $20 for a BHF Pregnancy Screener; $20 for completing at least 1 of 6 mini assessments; $20 for a postpartum assessment.

5 Well-being Coach Weight Management program (telephonic) is available for members who are identified as high risk based on a body mass index (BMI) of 30 or higher.

6 Well-being Coach Tobacco Cessation program (telephonic) is available for members who are identified as high risk based on any tobacco usage.

7 Members may earn rewards for completing quarterly Well-being Coach digital milestones while logging daily check-in activities on the app. Daily check-in reward values: first check-in: $4; next 15 check-ins during first quarter: $4; 25 check-ins during second through fourth quarters: $4 each quarter. Log in to Sydney Health or anthem.com to download the Well-being Coach digital app. Well-being Coach is provided by Lark Health.

We encourage you to actively participate in your rewards program. Rewards earned should be redeemed before the end of the current plan year. Unused rewards are forfeited three months after the end of your plan year. Make sure to redeem them before then.

All preventive care activities are claims-based, which means your completion is determined when a claim is processed. Medical waivers apply to claim-based activities.

Rewards eligibility applies only to subscribers and their enrolled spouse/domestic partner. Members must be active on the plan and their activity must take place during the plan year.

A subscriber and spouse/domestic partner may earn rewards when eligible activities are completed and, in some instances, are verified by an Anthem claim.

The reward amount you receive may be considered income to you and subject to state and federal taxes in the tax year it is paid. You should consult a tax expert with any questions regarding tax obligations.

Electronic gift card availability may vary. The list of retailers available for electronic gift card rewards redemption is subject to change. Log on to anthem.com or open the Sydney Health app to explore the electronic gift card options available to you.

A program focused on helping you improve your health

Introducing digital diabetes prevention coaching

Roughly 88 million Americans are living with prediabetes but 84% aren't even aware they have it.[1] Prediabetes often doesn't cause symptoms, but it does increase the risk of developing type 2 diabetes, heart disease, and stroke. That's why Anthem partnered with Lark to offer a diabetes prevention program that can help determine if you're at risk for prediabetes and if needed, take steps to address it.

This program can help you:

- **Lose weight**
- **Eat healthier**
- **Increase activity**
- **Sleep better**
- **Manage stress**

Better health is within reach

Participation in this program is at no extra cost as part of your health plan. Track progress, check in with a personalized coach, and learn more about prediabetes right in Lark's free mobile app. This program is flexible, convenient, and follows guidelines from the Centers for Disease Control and Prevention (CDC) to help make small changes that can improve health and decrease risk over time.

Anthem

Weight loss with Lark

Losing weight can make a difference in lowering risk for type 2 diabetes. Lark members lose an average of 4.2% of their body weight in 12 months on the diabetes prevention program.[2] Participants in the program receive a wireless scale at no extra cost to help track weight loss progress. The scale also syncs with the Lark app so participants can share updates with their coach.

24/7 coaching support

Losing weight and making lifestyle changes can feel intimidating even if it can lead to better health. Coaches can help you stay motivated. If you enroll in the program, you can send a message to a coach anytime from anywhere and receive an immediate response as well as extra support. During the course of the program, coaches will:

- Provide educational information on prediabetes and preventing type 2 diabetes.
- Be available 24/7 through the Lark mobile app to provide personalized coaching.
- Customize a program based on your food preferences and lifestyle.
- Provide information about how stress affects your health and how to cope with it.

You are in control of your health. Prevent diabetes and start improving your overall health and well-being today.

Learn if you are at risk for prediabetes

Scan the QR code to download the Sydney℠ Health mobile app and login using your existing health plan credentials. Once you login, you will find the Lark DPP screen under Programs in My Health Dashboard to take the one-minute survey.

1 Centers for Disease Control and Prevention website: *Prediabetes - Your Chance to Prevent Type 2 Diabetes* (accessed October 2021): cdc.gov.

2 Lark internal data

Diabetes Prevention Program is provided by Lark, an independent company.

Prescriptions made easier

Your health is in your hands

Your prescription drug coverage is important to your health. With pharmacy benefits from Anthem, powered by CarelonRx, you can track and manage all of your prescriptions in one convenient place. Refill and renew prescriptions, find a pharmacy, and check the cost of medications.

To get started, log in to anthem.com, go to My Plans, andthen go to Pharmacy. You can also use the Sydney℠ Health mobile app.

All of your prescription information in one place

Think of this as a digital version of your medicine cabinet at home. It provides real-time information about your prescriptions, including dosage, days' supply, and the last fill date. You can view your prescription history, check the number of refills left, and request to switch eligible prescriptions to CarelonRx Mail.

No-hassle refills and renewals

Refills and renewals are at your fingertips when you choose CarelonRx Mail. You can turn on automatic refills and renewals, check order status, get notices when your order ships or if something needs your attention, and manage your payments and account balance.

Find ways to save

When you need prescriptions, you can check prices before you get them. See if a generic drug will save you money or if home delivery makes more sense than getting prescriptions at your retail pharmacy. We'll help you understand your options so you can make informed choices for you and your family. You can also save on your prescriptions with available refill pharmacy coupons.

Choose how to stay in touch

When it's time for a refill or when you're due for a health screening, you decide if you'd like us to reach you through a call, email, or text. Opt in or out of alerts and set your payment preferences too.

> Log in to **anthem.com** or download the Sydney Health app to find out how to get the most from your benefit plan.

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GoodRx

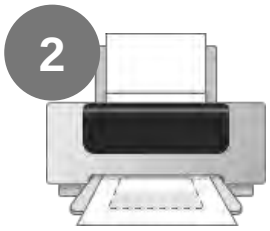
Stop Paying Too Much for Your Prescriptions

Follow these 3 steps for savings:

Compare prices online

GoodRX.com

GoodRx collects prices and discounts from over 70,000 U.S. pharmacies



Print free coupons

Or send coupons to your phone by email or text message

Save up to 80%

Show the coupon to your pharmacist for massive savings on your meds

GoodRx is a great resource to shop for prescriptions and compare pharmacy prices.

GoodRx is **NOT** associated with your company sponsored health insurance program. This is a free, web-based tool anyone can use for potential prescription savings. Your employer does not guarantee any information provided on GoodRx, this is for information purposes only.

How can GoodRx help me?

GoodRx gathers current prices and discounts to help you find the lowest cost pharmacy for your prescriptions. GoodRx is 100% free. No personal information required.

What are GoodRx coupons?

GoodRx coupons will help you pay less than the cash price for your prescription. They're free to use and are accepted at virtually every U.S. pharmacy. Your pharmacist will know how to enter the codes on the coupon to pull up the lowest discount available

How do I use a GoodRx coupon?

It's similar to using a coupon at a grocery store. Simply print the coupon and bring it with you to the pharmacy when you pick up your prescription. The pharmacist will enter the numbers on the coupon into their system to find the discount. If you can't print the coupon, you can download and share from your mobile device

Does GoodRx cost of Prescriptions count towards my Anthem BCBS Out-of-Pocket Annual Limit?

Not automatically! In order for you to obtain credit for money paid for prescriptions obtained through GoodRx, you must complete the **Anthem/Carelon Rx** claim form as instructed and submit directly to **Anthem/Carelon Rx** (mail or fax).

Please note the claim form is specific and will require the Pharmacists signature. Claims will not be processed without a complete form.

Information provided by:

FOUNDATION RISK PARTNERS

Stay on top of your health

Use your preventive care benefits

Regular preventive care can help you stay healthy and catch problems early, when they are easier to treat. Our health plans offer all the preventive care services and immunizations below at no cost to you.[1] As long as you use a doctor, pharmacy, or lab in your plan's network, you won't have to pay anything. If you go to doctors or facilities that are not in your plan, you may have to pay out of pocket.

If you are not sure which exams, tests, or shots make sense for you, talk to your doctor.

Preventive care vs. diagnostic care

What's the difference? Preventive care helps protect you from getting sick. If your doctor recommends you receive services even though you have no symptoms, that's preventive care. Diagnostic care is when you have symptoms, and your doctor recommends services to determine what's causing those symptoms.

Adult preventive care

General preventive physical exams, screenings, and tests (all adults):

- Alcohol misuse: related screening and behavioral counseling
- Aortic aneurysm screening (for men who have smoked)
- Behavioral counseling to promote a healthy diet
- Blood pressure
- Bone density test to screen for osteoporosis
- Cholesterol and lipid (fat) levels screening
- Colorectal cancer screenings, including fecal occult blood test, barium enema, flexible sigmoidoscopy, screening colonoscopy and related prep kit, and computed tomography (CT) colonography (as appropriate)[2, 3]
- Depression screening
- Diabetes screening (type 2)[4]
- Eye chart test for vision[5]
- Hepatitis B virus (HBV) screening for people at increased risk of infection
- Hearing screening
- Height, weight, and body mass index (BMI) measurements
- Hepatitis C virus (HCV) screening
- Human immunodeficiency virus (HIV): screening and counseling
- Interpersonal and domestic violence: screening and counseling
- Lung cancer screening for those ages 50 to 80 who have a history of smoking 20 packs or more per year and still smoke, or who have quit within the past 15 years[2]
- Obesity: related screening and counseling[4]
- Prostate cancer screenings, including digital rectal exam and prostate-specific antigen (PSA) test
- Sexually transmitted infections: related screening and counseling
- Tobacco use: related screening and behavioral counseling
- Tuberculosis screening

Women's preventive care:[6]

- Breast cancer screenings, including exam, mammogram, and genetic testing for BRCA1 and BRCA2 when certain criteria are met[7]
- Breastfeeding: primary care intervention to promote breastfeeding support, supplies, and counseling[8, 9]
- Contraceptive (birth control) counseling
- Counseling related to chemoprevention for those at high risk for breast cancer
- Counseling related to genetic testing for those with a family history of ovarian or breast cancer
- Food and Drug Administration (FDA)-approved contraceptive medical services, including sterilization, provided by a doctor
- Human papillomavirus (HPV) screening[9]
- Interpersonal and domestic violence: screening and counseling
- Pelvic exam and Pap test, including screening for cervical cancer
- Pregnancy screenings, including gestational diabetes, hepatitis B, asymptomatic bacteriuria, Rh incompatibility, syphilis, HIV, and depression[9]
- Well-woman visits

Immunizations:

- Diphtheria, tetanus, and pertussis (whooping cough)
- Hepatitis A and hepatitis B
- Human papillomavirus (HPV)
- Influenza (flu)
- Measles, mumps, and rubella (MMR)
- Meningococcal (meningitis)
- Monkeypox and/or smallpox (at risk)
- Pneumococcal (pneumonia)
- Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (COVID-19)
- Varicella (chickenpox)
- Zoster (shingles)

The preventive care services listed above are recommendations of the Affordable Care Act (ACA) and are subject to change. They may not be right for every person. Ask your doctor what's right for you.

This sheet is not a contract or policy with Anthem Blue Cross and Blue Shield. If there is any difference between this sheet and the group policy, the group policy provisions will rule. Please see your combined *Evidence of Coverage and Disclosure Form* or *Certificate* for exclusions and limitations.

Child preventive care

Preventive physical exams, screenings, and tests:

- Behavioral counseling to promote a healthy diet
- Blood pressure screening
- Cervical dysplasia screening
- Cholesterol and lipid (fat) levels screening
- Depression screening
- Development and behavior screening
- Diabetes screening (type 2)
- Hearing screening
- Height, weight, and BMI measurements
- Hemoglobin or hematocrit (blood count) screening
- Lead testing
- Newborn screening
- Obesity: related screening and counseling
- Oral (dental health) assessment, when done as part of a preventive care visit
- Sexually transmitted infections: related screening and counseling
- Skin cancer counseling for those ages 6 months to 24 years with fair skin
- Tobacco use: related screening and behavioral counseling
- Vision screening, when done as part of a preventive care visit[5]

Immunizations:

- Chickenpox
- Flu
- Haemophilus influenza type B (HIB)
- Hepatitis A and hepatitis B
- Human papillomavirus (HPV)
- Meningitis
- Measles, mumps, and rubella (MMR)
- Pneumonia
- Polio
- Rotavirus
- Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (COVID-19)
- Whooping cough

Coverage for pharmacy items

For 100% coverage of your over-the-counter (OTC) drugs and other pharmacy items listed here, you must:

- Meet certain age requirements and other rules.
- Receive and fill prescriptions from doctors, pharmacies, or other healthcare professionals in your plan's network.
- Have prescriptions, even for OTC items.

Adult preventive drugs and other pharmacy items (age appropriate):

- Aspirin use (81 mg and 325 mg) for the prevention of cardiovascular disease (CVD), preeclampsia, and colorectal cancer in adults younger than age 70
- Colonoscopy prep kit (generic or OTC only) when prescribed for preventive colon screening for individuals ages 45 to 75
- Generic low-to-moderate dose statins for individuals ages 40 to 75 who have one or more CVD risk factors (dyslipidemia, diabetes, hypertension, or smoking)
- Metformin (850 mg) to prevent or delay progression of diabetes in individuals ages 35 to 70
- Preexposure prophylaxis (PrEP) for the prevention of HIV
- Tobacco cessation products, including all FDA-approved brand-name and generic OTC and prescription products, for individuals ages 18 and older

Child preventive drugs and other pharmacy items (age appropriate):

- Dental fluoride varnish to prevent tooth decay in children ages 5 and younger
- Fluoride supplements for children ages 6 and younger

Women's preventive drugs and other pharmacy items (age appropriate):[6]

- Breast cancer risk-reducing medications, such as tamoxifen, raloxifene, and aromatase inhibitors, that follow the U.S. Preventive Services Task Force criteria[2]
- Contraceptives, including generic prescription drugs, brand name drugs with no generic equivalent, and OTC items like condoms and spermicides[9,11]
- Folic acid for women ages 55 or younger who are planning to become pregnant
- Low-dose aspirin (81 mg) for pregnant women who have an increased risk of preeclampsia

If you'd like more help understanding your preventive care benefits, call the number on the back of your member ID card. For a complete list of covered preventive drugs under the Affordable Care Act, view the *Preventive ACA Drug List* flyer, available at anthem.com/pharmacyinformation.

1 The range of preventive care services covered at 100% when provided by plan doctors is designed to meet state and federal requirements. The Department of Health and Human Services decided which services to include for full coverage based on U.S. Preventive Services Task Force A and B recommendations, the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), and certain guidelines for infants, children, adolescents, and women supported by Health Resources and Services Administration (HRSA) guidelines.You may have additional coverage under your insurance policy. To learn more about what your plan covers, see your Certificate of Coverage or call the Member Services number on your ID card.

2 You may be required to receive preapproval for these services.

3 The follow-up colonoscopy after a positive stool-based or direct visualization (such as a CT colonography or flexible sigmoidoscopy) colorectal cancer screening is considered a screening colonoscopy, meaning it is paid at 100% (so you pay no share of the cost) when provided by a doctor in the plan's network.

4 The Centers for Disease Control and Prevention (CDC)-recognized diabetes prevention programs are available for overweight or obese adults with abnormal blood glucose or who have abnormal CVD risk factors.

5 Some plans cover additional vision services. Please see your contract or Certificate of Coverage for details.

6 Keep in mind, these recommendations are categorized by "men" and "women," and are driven by biological sex (male and female) rather than gender identity. Meet with your doctor to determine which recommendations best apply to you based on individual factors, such as your sex assigned at birth and current anatomy.

7 Check your medical policy for details.

8 Breast pumps and supplies must be purchased from suppliers or retailers in your plan's network for 100% coverage. We recommend using plan durable medical equipment (DME) suppliers.

9 This benefit also applies to those younger than age 19.

10 Counseling services for breastfeeding (lactation) can be provided or supported by a doctor or facility in your plan's network, such as a pediatrician, OB-GYN, or family medicine doctor, and hospitals with no share of the cost (deductible, copay, or coinsurance) for you. Contact the provider to see if such services are available.

11 You may pay a share of the cost for other prescription contraceptives, based on your drug benefits. Your share of the cost may be waived if your doctor decides that using the multisource brand or brand name is medically necessary.

Save money
with SpecialOffers and discounts

As part of your health plan, you qualify for discounts on products and services that help promote better health and well-being. These discounts are available through SpecialOffers to help you save money while taking care of your health.

Dental, hearing, and vision

Dental

ProClear™ Aligners

You can improve your smile without metal braces and dental visits. These clear, teeth-straightening aligners, which you buy online, are an excellent lower-cost option to the regular wire braces or aligner treatments you receive through an orthodontist.

RefreshaDent

Save on premium dentures from the comfort of your home with a lifetime warranty.

Hearing

NationsHearing®

Receive hearing screenings and in-home service at no additional cost. You can also receive hearing aids at a discounted rate.

Hearing Care Solutions

Receive no-cost hearing exams and discounts on hearing aids. Hearing Care Solutions has 3,100 locations and eight manufacturers, and offers a three-year warranty, batteries for two years, and unlimited visits for one year.

Amplifon

Save on top-quality care and ongoing service and support for your hearing aids.

Eyewear

Glasses.com® and 1-800 CONTACTS®

Shop for the latest brand-name frames at a fraction of the cost for similar frames at other retailers. You can also receive additional savings on orders of $100 or more, plus no-cost shipping and returns.

EyeMed

Take advantage of discounts on new glasses, nonprescription sunglasses, and eyewear accessories.

LASIK

Premier LASIK Network

Save on LASIK when you choose any featured Premier LASIK Network provider.

TruVision

Save on LASIK eye surgery at over 1,000 locations.

Health and fitness

Health

BREVENA

Enjoy a discount on BREVENA skin care creams and balms for smooth, rejuvenated skin from head to toe.

ChooseHealthy®

Discounts are available on acupuncture, chiropractic, massage, podiatry, physical therapy, and nutritional services. You also have discounts on fitness equipment, wearable trackers, and health products such as vitamins and nutrition bars.

Jenny Craig®

Receive everything you need to make it easier to reach your health goals. In addition to no-cost coaching, you can also save on food purchases.

LifeMart®

Deals on beauty and skin care, diet plans, fitness club memberships and plans, personal care, spa services, yoga classes, sports gear, and vision care.

Fitness

Active&Fit Direct™

Choose from more than 11,900 participating fitness centers nationwide at a discounted rate. This program is offered through American Specialty Health Fitness, Inc.

Fitbit®

Work toward your fitness goals with Fitbit trackers and smartwatches that go with your lifestyle and budget.

Garmin®

Discounts are available on select Garmin wellness devices.

GlobalFit®

Discounts are available for gym memberships, fitness equipment, coaching, and other services.

Family and home

Family

WINFertility®

Save up to 40% on infertility treatment. WINFertility helps make quality treatment more affordable.

Safe Beginnings®

Babyproof your home while saving on everything from safety gates to outlet covers.

23andMe®

Save on health and ancestry kits to learn about your wellness, ancestry, and more.

Home

Nationwide® pet insurance

Receive discounts when you enroll through your company or organization. Additional savings are available when you enroll multiple pets.

ASPCA® Pet Health Insurance

Find reduced rates on pet insurance and choose from three levels of care, including flexible deductibles and custom reimbursements.

Medicine and treatment

Medicine

Puritan's Pride®

Choose from a large selection of discounted vitamins, minerals, and supplements.

Allergy Control Products and National Allergy Supply™

Save on select doctor-recommended products such as allergy-friendly bedding, air purifiers and filters, and asthma products. Some orders qualify for no-cost ground shipping within the contiguous U.S.

Treatment

The Living Well Course Series

Choose one of the online living programs and save on coaching to help you lose weight, stop smoking, manage stress or diabetes, restore sound sleep, or face an alcohol problem.

▷ **Learn more about SpecialOffers**
Log in to **anthem.com**, choose **Care**, and select **Discounts.**

Health Savings Account (HSA)
BMS, LLC

A Health Savings Account (HSA) is an account that can be funded by you, your employer, or both, with tax-exempt dollars. Funds from the account can help pay for eligible medical expenses that are not covered by your insurance plan including deductible, coinsurance, and even dental and vision services.

ADVANTAGES OF AN HSA:

- Money can be invested much like 401(k) funds
- You can change your HSA contribution amount during any payroll period
- Unused money is not forfeited at the end of the year and is carried forward
- The account is yours to keep so that you can take it with you if you change jobs or retire
- If you have any money remaining after your retirement, you may withdraw it as cash without penalty

Keep in mind, an HSA can only be used in conjunction with a High-Deductible Health Plan, which for Gearheart Communications is the Bronze Health Plan.

Any funds used on non-qualified expenses or subject to taxation and a 20% penalty from the IRS.

INELIGIBLE FOR AN HSA:

- Enrolled in Medicare or Tricare
- Enrolled in another PPO plan.
- Enrolled in an FSA.
- Claimed as a dependent on someone else's tax return.

CONTRIBUTIONS

- The maximum amount that can be contributed in 2024 is $4,150 for a single contract and $8,300 for a family.
- Individuals 55 and over can make an additional $1,000 catch-up contribution annually.

These annual contribution maximums include the employer contribution. **Gearheart Communications contributes $3,000 for single or $6,000 for any plan that includes dependents.** These contributions will be distributed on a quarterly basis in 2024. BMS, LLC is the administrator of the HSA Accounts. Please keep in mind the total annual contribution to your HSA cannot exceed the IRS limits listed above.

To see a list of eligible HSA expenses, please visit **https://hsastore.com/HSA-Eligibility-List.aspx**

How It Works

When visiting a physician, hospital, or other facility:

- When arriving for your appointment, provide them with your health insurance card.
- After your visit, your claim will be submitted to your insurance carrier for processing
- After the health care provider has received notification from your insurance carrier that the claim has been processed, you will receive a billing statement outlining the balance for which you are responsible.
- You then use your HSA card to pay for these expenses.

When going to the Pharmacy:

- When picking up your medication, provide them with your health insurance card.
- The pharmacy will run it through their system and provide you with a balance due.
- You then use your HSA card to pay for these expenses at that time.

YOU SAVE…

One option for employee contributions is via pre-tax payroll deduction through a Section 125 plan. One advantage of this plan is your contributions are not subject to individual or employment taxes. This means if you contribute $1,000 of your gross pay into the HSA, the impact on your net pay is about $700 since you did not have to pay tax on your HSA contributions. In this example, you would save about $300.

The following information is a quick overview of the benefits plans currently provided and is not to be interpreted as a complete disclosure of plans entitlement to any of the benefits described. The company reserves the right to adjust, amend and revise benefits plans. In all cases of specific plan interpretations, receipt of benefits or entitlements, the actual plan document shall rule. You can contact your HR department for the actual plan documents.

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Mailing: P.O. Box 43653 Louisville, KY 40253-0653
(502) 244-1161 * (800) 919-BMSI
FAX (502) 244-1162
www.bmsllc.net

Health Savings Account (HSA) - Q&A

What is a Health Savings Account?

A Health Savings Account (HSA) is a tax deferred account created to allow the account holder covered under a qualified High-Deductible Health Plan (HDHP), to use pre-taxed money toward qualified medical expenses (*section 213d*). The BMS LLC HSA is similar to a personal savings/checking account, with many of the features of a traditional checking account. The money is used for qualified medical expenses under the IRS code *(section 213d)* for expenses you incurred under your HDHP.

Who is eligible to contribute to an HSA?

Participants must be enrolled in a qualified High Deductible Health Plan (HDHP), regardless of whether or not the insurance is provided to the participant by an employer or if purchased as an individual insurance policy. In order to be eligible to contribute to the HSA account, participants cannot be covered by any other health plan that is not an HDHP (i.e. limitations include, but are not limited to the following; *participants cannot be covered by a spouse's insurance that is not a qualified HDHP, cannot be enrolled under Medicare, cannot participate in a Flexible Spending Account and cannot be claimed as a dependent on another person's tax return.)*

What is a Qualified High Deductible Health Plan (HDHP)?

A **2024** HDHP is an insurance plan that has a **minimum deductible of $1,600 annually for individual coverage ($3,200 minimum for family coverage). Plans with co-pays are ineligible. Maximum annual out-of-pocket cannot exceed $8,000 individual/ $16,100 family.** (Participants will want to verify with the insurance provider and/ or with the employer to see if the insurance plan qualifies for contributions to an HSA.) Keep in Mind: **IRS Regulations are subject to change each calendar year**.

How much can employees contribute (deposit) into an HSA?

Annual contributions that are permitted to be made into an HSA account are limited to the federal maximum **(indexed annually, for 2024, the maximum is $4,150 for individual and $8,300 for family policies).** Individuals that will be at least 55 years of age by the end of a tax year may also be eligible to make **"Catch Up"** contributions into the HSA, above the maximum; **$1,000** is the catch-up limit**.**

How is the money moved into an HSA Account on a pre-taxed basis?

The employer will set up pre-taxed payroll deductions and forward them to BMS LLC for deposit in the employee's bank Account. The money will be available within approximately 1-3 business days from the payroll deduction date. If employer contributions are included as well, this will be deposited as a separate contribution.

Do employer contributions into an HSA impact what I am allowed to contribute in 2024?*

Yes; for example, if an employee has Single coverage on the qualified HDHP insurance plan, they are allowed to contribute up to $4,150 into their HSA account in 2024. If the employer contributes $200 into this employee's HSA account, then the employee would only be permitted to contribute an additional $3,950 to their HSA. Another example: if an employee has Family coverage on the qualified HDHP insurance plan, they are allowed to contribute up to $8,300 into their HSA account in 2024. If the employer contributes $600 into this employee's HSA account, then the employee would only be permitted to contribute an additional $7,700 to their HSA.

Employer contributions are optional; check with your Employer for details of HSA contributions for your company.

What is a Qualified Medical Expense?
Qualified medical expenses are defined by the IRS under the Section 213(d) code. Using funds from an HSA for non-qualified medical expenses can result in IRS penalties. For further information one can also visit the IRS website. http://www.irs.gov/publications/p502/index.html.

How do employees pay for qualified medical expenses out of an HSA?
It is recommended that they use the HSA Debit Card to pay for all of their qualified medical expenses, whenever possible. You will find that most service providers accept Debit Cards. Transaction descriptions should show on the employees account statement or receipt. Ask for more details.

What if the medical provider does not accept a debit card?
Account Holders can pay their provider with another method of payment (cash or another debit card/credit card.) Then they can simply request a reimbursement of funds from their HSA Account to re-pay themselves for the qualified expenses.

Does the HSA account need to have enough money before they can pay for a qualified medical expense?
Yes, this is a personal HSA account for the employees. So, the funds must be in the account before they can pay for an expense. We encourage you to watch your balances closely prior to using your account for expenses.

If there is not enough money in the HSA account to pay for a qualified medical expense, they will need to pay for the expense by some other means. Once contributions are made to the HSA account, they can request a withdraw for the amount that was paid for the expense to reimburse themselves. Requests can be made by completing an HSA Distribution Form and submitting to BMS LLC. The form be found at www.bmsllc.net. BMS will send your distribution directly to you via check (or ACH Direct Deposit, if you've signed up).

When employees make a withdrawal from the HSA account to pay for a qualified medical expense, do they have to pay taxes on it?
No, as long as employees use their HSA account only for qualified medical expenses, they should never have to pay taxes on the money. Remember – every dollar you deduct from your payroll and contribute to your HSA is tax free to you if you qualify for the 125 Plan!

Who is responsible for ensuring that employees are only using the HSA account for qualified medical expenses?
How employees use the HSA account is solely between the employee and the IRS. Employees will need to save all invoices, statements and receipts that will support the withdrawals out of the HSA account. HSA usage is subject to IRS audit and individual employees do not have to submit receipts for review by BMS, but must keep them for possible review by the IRS.

What if employees do not use their HSA account for qualified medical expenses?
If employees use the HSA account for expenses other than qualified medical expenses, employees can subject themselves to tax and IRS penalties (currently 20%.) Also, inappropriate use of HSA accounts may leave employees without the money to pay for their qualified medical expenses should it be needed.

What other information is readily available to employees on the HSA account?
The IRS has provided a list of Question and Answers on their website (see below). You can also contact BMS LLC and ask questions of our qualified staff members or access our website at www.bmsllc.net.

Are employees required to have a minimum balance before they have the option of Investing funds from the HSA account?
Yes, you must have a $2,000 or more in balance in your HSA. Remember to maintain a minimum balance in the HSA savings account portion so one can continue to use the account for qualified medical expenses and to avoid any overdrafts if the account holder fails to diversify funds from investments to the savings account portal.

Can a person have both an HSA and a Flexible Spending Account (FSA)?

If a person elects an HSA, they cannot participate in a health FSA. They can enroll into a Limited FSA which allows for only dental and vision expenses to be reimbursed. Remember – if you elect to submit claims during the 2 ½ month grace period provided by some employers, you cannot make contributions to your HSA until your health FSA balance is zero. If you have carryover funds in a medical FSA from a prior year, you cannot contribute to an HSA unless your FSA is changed to a Limited FSA. Ask for more details.

What tax forms will employees receive with the HSA account?

Employees will be receiving two annual tax forms from the bank on an annual basis. The 1099-SA will provide a summary of the distributions (withdrawals) out of the HSA and the 5498-SA will provide a summary of the contributions (deposits) that employees have made into the HSA account. Employees will need to complete Form 8889-SA when they do taxes. This form can be obtained from the IRS website (www.IRS.gov) or from a tax consultant.

US Government HSA websites:

http://www.treas.gov/offices/public-affairs/hsa/
http://www.irs.gov/publications/p969/index.html

Disclaimer - This document is for educational purposes only. Information as presented may vary based on your unique situations. Contracted banking relationships assume no liability regarding the accuracy or application of the materials contained herein.

Flexible Spending Account (FSA)
BMS, LLC

The Flexible Spending Account (FSA) is available to all full-time employees. If you are enrolled and contributing or receiving contributions into your HSA, you are only eligible for the Dependent Care Reimbursement. There is no employer contribution to the Flexible Spending Account. An FSA enables employees to set aside money, on a pre-tax basis via salary redirection, to pay for certain qualified expenses.

The two types of plans permitted under Section 125 are:

- Healthcare Reimbursement
- Dependent Daycare Assistance Plan

Unlike with an HSA, you cannot stockpile money in the FSA from year to year, and ***you will lose leftover money in the account at the end of the plan year. Your FSA is set up that $640 of unused healthcare funds may roll over to be used during subsequent plan years.***

ADVANTAGES OF AN FSA:

- Funds in your FSA become available to you at the beginning of the year, even if the amount has not yet been deposited in your account, as long as the amount is no more than your elected annual deferral amount less any amount already used. However, this applies to the individual's medical only, not to dependent care.
- Funds will be deposited into your FSA through salary deferral.

CONTRIBUTIONS

Company pays all expenses associated with administering the plan. **The maximum allowable contribution for the calendar year for the Health FSA is $3,200.** For the Dependent Daycare Assistance Plan, the maximum allowable contribution is $5,000 for married filing jointly or filing single, and $2,500 for married filing separately.

HEALTH FSA

Under a Health FSA, employees are reimbursed for eligible health care expenses that are not covered or reimbursed under the employer's health plan. Typically, these include deductibles, prescription copays, doctor visit copays, dental care, braces, eyeglasses, etc. A Take Care Debit Card is available to all participants in the Health FSA for their convenience in paying qualified expenses.

You may only change your FSA election and contribution amount if you have a qualified changed in status. A qualified change in status would include change in marital status, change in number of dependents, or change in employment status. If you believe you qualify, please contact your employer.

DEPENDENT DAYCARE ASSISTANCE PLAN

The Dependent Daycare Assistance Plan allows for an employee to be reimbursed for qualified dependent daycare expenses. This can be a licensed daycare provider or an individual who provides a social security number per IRS guidelines.

Ways to Submit Claims

- Use your Take Care debit card.
- Submit through BMS app.
- Complete paper reimbursement. You will need a completed FSA Reimbursement form found on the BMS website at www.bmsllc.net. With the form include a copy of the detailed receipt or Explanation of Benefits (EOB) from the carrier showing type of service, date of service and amount of services. You may submit through fax or email below.

If further documentation is required on a debit transaction, you will be notified and requested to mail, fax 502-244-1162 or email to claims@bmsllc.net a copy of the your receipt (EOB).

Reimbursement requests are processed daily with a 48-72 hour turnaround. Payments may be made to you in the form of a reimbursement check or direct deposit to your designated account.

To see a list of eligible FSA expenses, please **visit https://fsastore.com/FSA-Eligibility-List.aspx**

The following information is a quick overview of the benefits plans currently provided and is not to be interpreted as a complete disclosure of plans entitlement to any of the benefits described. The company reserves the right to adjust, amend and revise benefits plans. In all cases of specific plan interpretations, receipt of benefits or entitlements, the actual plan document shall rule. You can contact your HR department for the actual plan documents.

Qualified Medical Expense List - Healthcare FSA

Acid reducing gum, liquid & tablets
Acne Medications
Acupuncture fees
Airplane ear protection
Alcoholism & drug treatment
All prescriptions drugs dispensed in US
Allergy medications
Ambulance expense
Anti-diarrhea medications Antifungal treatments
Anti-itch lotion
Antiseptic or ointment for cuts
Arches & orthopedic shoes
Arthritis pain reliever
Artificial limbs & braces
Bedpans & ring cushions
Benzocaine swabs
Body scans
Boric acid powder
Braille Books, & magazines
Bronchial asthma inhalers
Bronchodilator/expectorant tablets
Bunion & blister medications
Chiropractor & Podiatrist fees
Cholesterol tests & monitors Christian Science practitioner's fees Co-Insurance expenses
Cold relief syrup, tablets & drops
Cold sore & fever blister medications
Colorectal cancer screening tests
Contact lenses and solution
Contraceptives
Co-payments
Corn & callus removal
Crutches & canes
Deductible expenses
Dental fillings, crowns & bridges
Dental sealants
Denture adhesive
Dentures
Diabetic supplies - test strips, lancets, insulin, etc.
Diagnostic services or treatment
Diaper rash ointments
Diuretics & water pills
Doctor's office co-pays
Eye watering/drying aid
Ear Wax removal drops
Eardrops for swimmers
Eczema cream
Elevated toilet seats
Emergency room co-pays
Endodontist Fees
Eye exams
First aid bandages, gloves & masks
First Aid wipes
Flu relief syrup, tablets & drops
Flu shots
Gas prevention tablets or drops
Gastric bypass surgery
Glucose meters and tablets
Hearing devices & batteries
Hemorrhoid relief
Home blood or drug tests
Homeopathic earache tablets
Homeopathic sinus medications
Hot & cold compress packs & wraps
Humidifiers & Vaporizers
Hydrogen peroxide
Incontinence supplies
Inpatient admission co-pays
Iodine tincture
Ipecac syrup
Itch relief
Lab Fees
Laxatives
Lice treatment and control products
Medical alert bracelets & fees
Medicated bandages
Medicated bath products
Medicated chest rub
Menstrual care products - tampons, pads, liners, cups, sponges, etc.
Motion sickness tablets
Nasal decongestant spray/drops/inhaler
Needles
Obstetrics & Fertility
Office visits
Orthodontist & Dentist
Ovulation indicators
Oxygen
Pain relievers, aspirin, non-aspirin
Panty liners and napkins
Periodontist & Endodontist fees
Physical & speech therapy
Physician & Osteopath fees
Physiologist & Psychiatrist
Pill Boxes
Pinworm treatment
Pregnancy test
Prescribed medicines
Prescription Glasses & Contacts
Radiology
Reconstructive bypass surgery associated with birth defect, disease or accident
Reconstructive Surgery in connection with birth defect, disease, or accident
Respiratory stimulant ammonia
Routine check-ups
Shower bars & safety handles
Shower protection for casts, prostheses. Etc.
Sinus & allergy nasal spray
Sleeping Aids
Smoking Cessation programs, patches & gums
Special schooling for a disabled child
Surgical fees
Syringes
Tampons
Therapeutic support gloves
Throat pain medications
Travel to doctor or healthcare facilities
Upset stomach medications
Vapor patch cough suppressant
Wart removal medications
Weight-loss programs & fees pertaining to a specific disease (with physicians note)
Wheelchairs, walkers & shower chairs
Wigs for hair loss caused by disease
X-rays & MRI

Visit our website for valuable resources including access to a searchable list of eligible FSA expenses!

BMS LLC
BENEFIT MARKETING SOLUTIONS LLC

Benefit Marketing Solutions LLC (BMS LLC)

WEBSITE: www.bmsllc.net PHONE: (502)244-1161 FAX :(502)244-1162

Delta Dental of Kentucky
Delta Dental PPO plus Premier
Summary of Dental Plan Benefits

Group Name: Gearheart Communications
Group Number: 712910

Covered Services –

	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Non-participating Dentist
	Plan Pays	**Plan Pays**	**Plan Pays***
Diagnostic & Preventive			
Diagnostic and Preventive Services – exams, cleanings, fluoride, and space maintainers	100%	100%	100%
Emergency Palliative Treatment – to temporarily relieve pain	100%	100%	100%
Sealants – to prevent decay of permanent teeth	100%	100%	100%
Brush Biopsy – to detect oral cancer	100%	100%	100%
Radiographs – X-rays	100%	100%	100%
Basic Services			
Minor Restorative Services – fillings and crown repair	80%	80%	80%
Endodontic Services – root canals	80%	80%	80%
Periodontic Services – to treat gum disease	80%	80%	80%
Oral Surgery Services – extractions and dental surgery	80%	80%	80%
Other Basic Services – misc. services	80%	80%	80%
Denture Repair – repairs to complete or partial dentures	80%	80%	80%
Major Services			
Major Restorative Services – crowns	80%	80%	80%
Fixed Prosthodontic Repair – to bridges	80%	80%	80%
Implant Repair – implant maintenance, repair, and removal	80%	80%	80%
Relines and Rebase – to dentures	80%	80%	80%
Adjustments to Dentures – adjustments to complete or partial dentures	80%	80%	80%
Prosthodontic Services – bridges, implants, and dentures	80%	80%	80%
Orthodontic Services			
Orthodontic Services – braces	80%	80%	80%
Orthodontic Age Limit –	No Age Limit		

* 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. The Nonparticipating Dentist Fee may be less than what your dentist charges and you are responsible for that difference.

- Oral exams (including evaluations by a specialist) are payable twice per calendar year. Limited oral evaluations for a specific problem or complaint are also payable twice in the same calendar year.
- Prophylaxes (cleanings) are payable twice per calendar year. Two additional periodontal maintenance procedures are payable per calendar year for individuals with a documented history of periodontal disease. Full mouth debridement is payable once in a lifetime.
- Fluoride treatments are payable once per calendar year for people up to age 19.
- Bitewing X-rays are payable once per calendar year and full mouth X-rays (which include bitewing X-rays) are payable once in any five-year period.
- Sealants are payable once per tooth per five-year period for the occlusal surface of first and second permanent molars up to age 14. The surface must be free from decay and restorations.
- Composite resin (white) restorations are Covered Services on posterior teeth.
- Porcelain and resin facings on bridges are Covered Services on posterior teeth.
- Implants and implant related services are payable once per tooth in any five-year period.

Deductible – $75 Deductible per person total per Benefit Year limited to a maximum Deductible of $150 per family per Benefit Year. The Deductible does not apply to diagnostic and preventive services, emergency palliative treatment, brush biopsy, X-rays, sealants, cephalometric films, photos, diagnostic casts and orthodontic services (including surgical repositioning of teeth).

Maximum Payment – $2,000 per person total per Benefit Year on all services, except cephalometric films, photos, diagnostic casts and orthodontic services (including surgical repositioning of teeth). $1,500 per person total per lifetime on cephalometric films, photos, diagnostic casts and orthodontic services (including surgical repositioning of teeth).

Dependent Age Limit – Unmarried dependent children are eligible to the end of the month in which they attain the age of 26.

Eligible People – The subscriber (you) is eligible for dental benefits when your employer or organization notifies Delta Dental.

Also eligible at your option are your legal spouse and your children who meet the age requirements noted above. You and your eligible dependents must enroll for a minimum of 12 months. If coverage is terminated after 12 months, you may not re-enroll prior to the open enrollment that occurs at least 12 months from the date of termination. Your dependents may only enroll if you are enrolled (except under COBRA) and must be enrolled in the same plan as you. Plan changes are only allowed during open enrollment periods, except that an election may be revoked or changed at any time if the change is the result of a qualifying event as defined under Internal Revenue Code Section 125.

If you and your spouse are both eligible under this Contract, you may be enrolled as both a Subscriber on your own application and as a dependent on your spouse's application. Your dependent children may be enrolled on both applications as well. Delta Dental will coordinate benefits.

Benefits will cease on the last day of the month in which the employee is terminated.

This Summary of Dental Plan Benefits should be read along with your Certificate. Your Certificate provides additional information about your Delta Dental plan, including information about plan exclusions and limitations. If a statement in this Summary conflict with a statement in the Certificate, the statement in this Summary applies to you and you should ignore the conflicting statement in the Certificate. The percentages above are applied to Delta Dental's allowance for each service and it may vary due to the dentist's network participation.*

VSP® Vision Savings Pass™

VSP Vision Savings Pass is a discount vision program that offers immediate savings on eye care and eyewear. This is not an insurance plan.

See the Savings
- Access to discounts through a trusted, private-practice VSP doctor
- One rate of $50 for an eye exam[1]
- Special pricing on complete pairs of glasses and sunglasses
- 15% savings on a contact lens exam[2]
- Unlimited use on materials throughout the year
- Exclusive Member Extras, like rebates and special offers

Unlimited Annual Material Use[3]
Your VSP Vision Savings Pass can be used as often as you like throughout the year. With the best choices in eyewear, we make it easy to find the perfect frame that's right for you, your family, and your budget. Choose from great brands like Anne Klein, bebe®, Calvin Klein, Flexon®, Lacoste, Nike, Nine West, and more.[4]

How to Use Your VSP Vision Savings Pass

1. Find a VSP doctor at **vsp.com** or call **800.877.7915**.
2. Save immediately on eye exam[1] and eyewear at the time of service.
3. Take advantage of your VSP Vision Savings Pass over and over - use is unlimited on materials.[3]

Service	Reduced prices and savings
Wellvision Exam®	• $50 with purchase of a complete pair of prescription glasses. • 20% off without purchase. • Once every calendar year.
Retinal Screening	• Guaranteed pricing with Wellvision Exam, not to exceed $39.
Lenses	With purchase of a complete pair of prescription glasses: • Single Vision $40 • Lined trifocals $75 • Lined bifocals $60 • Polycarbonate for children $0
Lens Enhancements	• Average savings of 20-25% on lens enhancements such as progressive, scratch-resistant and anti-reflective coating.
Frames	• 25% savings when a complete pair of prescription glasses is purchased.
Sunglasses	• 20% savings on unlimited non-prescription sunglasses from any VSP doctor within 12 months of your last Wellvison Exam.
Contact Lenses	• 15% savings on contact lens exam (fitting and evaluation).
Laser Vision Correction	• Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities.

SEE WHY WE'RE CONSUMERS' #1 CHOICE IN VISION CARE[5]

Contact us.
vsp.com | 800.877.7195

1. This cost is only available with the purchase of a complete pair of prescription glasses; otherwise, you'll receive 20% off an eye exam only.
2. Applies only to contact lens exam, not materials. You are responsible for 100% of the contact lens material cost.
3. Unlimited use is for materials only. An eye exam is limited to once a year per member.
4. Brands subject to change.
5. Blueocean Market Intelligence National Vision Plan Member Research, 2014.

THIS PLAN IS NOT INSURANCE and is not intended to replace health insurance. This plan is not a Qualified Health Plan under the Affordable Care Act. THIS IS NOT A MEDICARE PRESCRIPTION DRUG PLAN. There is no cost to join this discount program. The plan provides discounts at certain health care providers for services. The range of discounts will vary depending on the type of provider and service. Plan members are obligated to pay for all health care services but will receive a discount from those health care providers who have agreed to provide discounts. The plan and its administrators have no liability for providing or guaranteeing service by providers or the quality of service rendered by providers. This plan is not available in Washington. Void where prohibited.

Delta Dental of Kentucky
ky.deltadental.com | 800-955-2030

Rev. 7/19

Hearing Health Care Program Brought to you by Delta Dental of Kentucky

Listen Up! 1 in 9 Americans are affected by hearing loss. If you think you may have hearing loss, rest easy. Delta Dental Of Kentucky has teamed up with Amplifon to offer you quality hearing health care.

AMPLIFON HEARING HEALTH CARE PROGRAM

Your Program	Benefit Description	Benefit Plan
Diagnostic Services	Hearing Exam	Up to $125*
Hearing Devices	Includes all major brands and technology levels	Up to $2,995* Per Device
Other Services**	1 year of free follow-up care 2 years of free batteries 3-year warranty for loss, repairs, or damage	Included

†The cost of a hearing exam may be as low as $45. The cost per hearing aid through the Essential Plan may be as low as $695.

Custom hearing solutions
We find the solution that best fits your lifestyle and your budget from one of our 10 manufacturers.

Risk-free 60-day Trial
100% money-back guarantee.

Continuous Care
One year free follow-up care, two years free batteries, and a three-year warranty.

Hearing aid low price guarantee
If you find the same product at a lower price, bring us the local quote and we'll not only match it, we'll beat it by 5%!

HEARING LOSS AFFECTS PEOPLE OF ALL AGES

Percentage of hearing loss by age

Age 75+	**50%**	Age 45-60	**18%**	School Age	**3%**
Age 65-74	**33%**	Age 18-44	**6.5%**	Newborn	**.3%**

WHAT CAUSES HEARING LOSS

- Excessive noise exposure is the leading cause of hearing loss in the United States in adults
- Ototoxic drugs can cause hearing loss, tinnitus or balance disorders. There are over 200 known medications including: NSAIDS, antibiotics, diuretics, some cardiac medicine, and more.
- Aging is also a cause of hearing loss. Over time, our ears change and the tiny hair cells that help us hear become damaged and cannot re-grow.
- Various illnesses and diseases can be associated with hearing loss. Some include Meningitis, Heart Disease, Diabetes, Ménière's disease and Alzheimer's, among others.
- Other factors can lead to a higher risk of hearing loss as well, such as obesity, birth defects, head injuries, family history, smoking, and more

HOW CAN I PREVENT HEARING LOSS

- Wear hearing protection and limit the time you're exposed to noise
- Turn down the volume – keep music and TV volume at 50% or less
- Maintain a healthy lifestyle to avoid conditions such as high blood pressure and diabetes which contribute to hearing loss
- Avoid ototoxic medications – talk to your healthcare professional when drugs are prescribed

WHEN SHOULD I GET MY HEARING CHECKED

Hearing loss can come on gradually. You may not even notice it's happening. As a rule of thumb, if your hearing test reports your hearing is OK, stick to once every three to five years. You should test your hearing annually if you are 55 or older or are experiencing any of the following:

- Consistent exposure to loud noises
- Difficulty understanding in noisy environments or in groups
- Hearing mumbling or feeling as though people are not speaking clearly
- Ringing in your ears

DO I REALLY NEED HEARING AIDS?

My hearing isn't THAT bad...

Even mild hearing loss can negatively affect key areas of your life, including: mental health, physical health and income. Additionally, untreated hearing loss is usually more noticeable to other people than the actual hearing aids.

ARE HEARING AIDS AFFORDABLE?

Hearing aids are an investment, but don't let the price tag scare you away from getting the treatment you deserve. A few ways to find cost savings while purchasing hearing aids, including:

The Amplifon Program
With Amplifon, you have access to substantial savings on hearing devices and services.

Financing
Amplifon offers interest free financing to those who qualify.

HSA, HRA, FSA
You can use your pre-tax dollars from your health savings account to help pay for hearing aids.

www.amplifonusa.com/deltadentalky

**Batteries - Maximum of 80 cells/ear per year. Risk-free trial - 100% money-back guarantee if not completely satisfied. No restocking or return fees. Warranty - Some exclusions apply. Limited to one-time claim for loss and damage. Manufacturer deductible may apply.

1 Source: https://www.asha.org/articles/untreated-hearing-loss-in-adults/

Amplifon Hearing Health Care is solely responsible for the administration of hearing health care services, and its own financial and contractual obligations. Delta Dental Of Kentucky and Amplifon are independent, unaffiliated companies.T he Amplifon Hearing Health Care discount program is not approved for use with any 3rd party payor program, including government and private third-party payor programs. Hearing services are administered by Amplifon Hearing Health Care, Corp.

Blue View Vision℠
FS.A.0.0.150.150

Anthem

Welcome to your Blue View Vision plan!

You have many choices when it comes to using your benefits. As a Blue View Vision plan member, you have access to one of the nation's largest vision networks. You may choose from many private practice doctors, local optical stores, and national retail stores including LensCrafters®, Target Optical®, and most Pearle Vision® locations. You may also use your in-network benefits to order eyewear online at Glasses.com and ContactsDirect.com. To locate a participating network eye care doctor or location, log in at anthem.com, or from the home page menu under Care, select Find a Doctor. You may also call member services for assistance at 1-866-723-0515.

Out-of-Network – If you choose to, you may instead receive covered benefits outside of the Blue View Vision network. Just pay in full at the time of service, obtain an itemized receipt, and file a claim for reimbursement up to your maximum out-of-network allowance.

YOUR BLUE VIEW VISION PLAN BENEFITS	IN-NETWORK	OUT-OF-NETWORK	FREQUENCY
Routine Eye Exam			
A comprehensive eye examination	$0 Copay	Reimbursed Up To $42	Once every calendar year
Eyeglass Frames			
One pair of eyeglass frames	$150 Allowance, then 20% off any remaining balance	Reimbursed Up To $45	Once every calendar year
Eyeglass Lenses *(instead of contact lenses)*			
One pair of standard plastic prescription lenses • Single vision lenses • Bifocal lenses • Trifocal lenses	 $0 Copay $0 Copay $0 Copay	 Reimbursed Up To $40 Reimbursed Up To $60 Reimbursed Up To $80	Once every calendar year
Eyeglass Lens Enhancements *When obtaining covered eyewear from a Blue View Vision provider, you may choose to add any of the following lens enhancements at no extra cost*			
• Transitions Lenses (for a child under age 21) • Standard polycarbonate (for a child under age 21) • Factory Scratch Coating	$0 Copay $0 Copay $0 Copay	No allowance when obtained out-of-network	Same as covered eyeglass lenses
Contact Lenses *(instead of eyeglass lenses)* *Contact lens allowance will only be applied toward the first purchase of contacts made during a benefit period. Any unused amount remaining cannot be used for subsequent purchases in the same benefit period, nor can any unused amount be carried over to the following benefit period.*			
• Elective conventional (non-disposable) OR	$150 Allowance, then 15% off any remaining balance	Reimbursed Up To $105	Once every calendar year
• Elective disposable OR	$150 Allowance *(no additional discount)*	Reimbursed Up To $105	
• Non-elective (medically necessary)	Covered in full	Reimbursed Up To $210	

This is a primary vision care benefit intended to cover only routine eye examinations and corrective eyewear. Blue View Vision is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care doctor from your medical network. Benefits are payable only for expenses incurred while the group and insured person's coverage is in force. This information is intended to be a brief outline of coverage. All terms and conditions of coverage, including benefits and exclusions, are contained in the member's policy, which shall control in the event of a conflict with this overview. This benefit overview is only one piece of your entire enrollment package.

EXCLUSIONS & LIMITATIONS (not a comprehensive list – please refer to the member Certificate of Coverage for a complete list)

Combined Offers. Not to be combined with any offer, coupon, or in-store advertisement.
Excess Amounts. Amounts in excess of covered vision expense.
Sunglasses. Plano sunglasses and accompanying frames.
Safety Glasses. Safety glasses and accompanying frames.
Not Specifically Listed. Services not specifically listed in this plan as covered services.
Lost or Broken Lenses or Frames. Any lost or broken lenses or frames are not eligible for replacement unless the insured person has reached his or her normal service interval as indicated in the plan design.
Non-Prescription Lenses. Any non-prescription lenses, eyeglasses or contacts. Plano lenses or lenses that have no refractive power.
Orthoptics. Orthoptics or vision training and any associated supplemental testing

Contract code: 4NQW

OPTIONAL SAVINGS AVAILABLE FROM BLUE VIEW VISION IN-NETWORK PROVIDERS ONLY		In-Network Member Cost (after any applicable copay)
Retinal Imaging – at member's option, can be performed a time of eye exam		Not more than $39

Eyeglass lens upgrades
When obtaining eyewear from a Blue View Vision provider, you may choose to upgrade your new eyeglass lenses at a discounted cost. Eyeglass lens copayment applies.
	• Transitions lenses (Adults)
	• Standard Polycarbonate (Adults)
	• Tint (Solid and Gradient)
	• UV Coating
	• Progressive Lenses[1]
	  • Standard
	  • Premium Tier 1
	  • Premium Tier 2
	  • Premium Tier 3
	  • Premium Tier 4
	• Anti-Reflective Coating[2]
	  • Standard
	  • Premium Tier 1
	  • Premium Tier 2
	  • Premium Tier 3
	• Other Add-ons
		$75
		$40
		$15
		$15
		
		$55
		$85
		$95
		$110
		$175
		
		$45
		$57
		$68
		$85
		20% off retail price

Additional Pairs of Eyeglasses Anytime from any Blue View Vision network provider	• Complete Pair • Eyeglass materials purchased separately	40% off retail price 20% off retail price
Eyewear Accessories	Items such as non-prescription sunglasses, lens cleaning supplies, contact lens solutions, eyeglass cases, etc.	20% off retail
Contact lens fit and follow-up A contact lens fitting and up to two follow-up visits are available to you once a comprehensive eye exam has been completed.	• Standard contact lens fitting[3] • Premium contact lens fitting[4]	Up to $55 10% off retail price
Conventional Contact Lenses	• Discount applies to materials only	15% off retail price

[1] Please ask your provider for his/her recommendation as well as the available progressive brands by tier.

[2] Please ask your provider for his/her recommendation as well as the available anti-reflective brands by tier.

[3] Standard fitting includes spherical clear lenses for conventional wear and planned replacement. Examples include but are not limited to disposable and frequent replacement.

[4] Premium fitting includes all lens designs, materials and specialty fittings other than standard contact lenses. Examples include but are not limited to toric and multifocal.

Cannot be combined with any other offer. Discounts are subject to change without notice. Discounts are not covered benefits under your vision plan and will not be listed in your certificate of coverage. Discounts will be offered from in-network providers except where State law prevents discounting of products and services that are not covered benefits under this plan. Discounts on frames will not apply if the manufacturer has imposed a no discount on sales at retail and independent provider locations.

Some of our in-network providers include:

ADDITIONAL SAVINGS AVAILABLE THROUGH ANTHEM'S SPECIAL OFFERS PROGRAM
Savings on items like additional eyewear after your benefits have been used, non-prescription sunglasses, hearing aids and even LASIK laser vision correction surgery are available through a variety of vendors. Just log in at anthem.com, select discounts, then Vision, Hearing & Dental.

* Discounts cannot be used in conjunction with your covered benefits.

OUT-OF-NETWORK

If you choose to receive covered services or purchase covered eyewear from an out-of-network provider, network discounts will not apply and you will be responsible for payment of services and/or eyewear materials at the time of service. Please complete an out-of-network claim form and submit it along with your itemized receipt to the fax number, email address, or mailing address below. To download a claim form, log in at anthem.com, or from the home page menu under Support select Forms, click Change State to choose your state, and then scroll down to Claims and select the Blue View Vision Out-of-Network Claim Form. You may instead call member services at 1-866-723-0515 .to request a claim form.

TO FAX: 866-293-7373
TO EMAIL: oonclaims@eyewearspecialoffers.com
TO MAIL: Blue View Vision
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

Basic Life and AD&D Insurance

Lincoln Financial / Policy # 000010184876

Life insurance is an important part of your financial security, especially if others depend on your for support. Accidental Death & Dismemberment (AD&D) insurance is designed to provide a benefit in the event of accidental death or dismemberment. Our company provides Basic Life and AD&D insurance to all eligible employees at no cost to you.

This benefit includes:

- **Basic Life:** 300% of Annual Salary rounded to the next higher $1,000 up to a maximum of $500,000.
- **AD&D:** 100% of annual salary rounded to the next higher $1,000, plus an additional $50,000 up to $200,000.
- **Guarantee Issue:** Insurance amounts in excess of $425,000, including any increases more then $25,000 over the GI, over a 12-month period based on the month of the policy anniversary date will require the submission and the approval of satisfactory evidence of insurability.
- **Basic Dependent Life:** Spouse: $1,000, Children (14 days but less than 6 months): $500, Children (6 months to age 26): $1,000
- **REDUCTION SCHEDULE:** 35% at age 65; additional 25% of original amount at age 70; an additional 15% of the original amount at age 75; benefits terminate at retirement. Spouse benefits ends at age 70.
- **Conversion of basic life is available after leaving. Contact Lincoln within 31 days of term date at 1-800-423-2765.**

Voluntary Life and Accidental Death & Dismemberment Insurance Coverage

Lincoln Financial / Policy # GL 000400001000-17833

Employees may purchase additional Life and AD&D insurance. Any amounts elected over the guaranteed issue require evidence of insurability.

- Employees may elect $10,000 - $300,000.
- The guaranteed issue for employees under age 65 is $150,000.
- Employees may elect Spousal Life at $5,000 - $150,000 up to 50% of the employee amount.
- The guaranteed issue for spouses under age 65 is $30,000.
- Employees may elect up to $10,000 for each dependent child.
- Employee and spouse rates are based on the insurance you choose and the applicable age band **(these premiums will be reflected in your online enrollment system).**
- **REDUCTION SCHEDULE:** Employee 35% at age 65; additional 25% at age 70, additional 15% at age 75, additional 15% at age 80. Benefits terminate at employee retirement. Spouse: 35% at age 65, ends at age 70 or retirement whichever occurs first.
- **Conversion/Portability is available after leaving. Contact Lincoln within 31 days of term date at 1-800-423-2765.**
- **NOTE:** You must be an active employee to elect coverage for a spouse and/or dependent children. To be eligible for coverage, a spouse or dependent child cannot be confined to a health care facility or unable to perform the typical activities or a health person of the same age or gender.

Disability Insurance Coverage

Lincoln Financial / Policy # 10195891 / # 10184877

The goal of the company's Disability Insurance Plan is to provide you with income replacement should you become disabled and unable to work due to a non-work-related illness or injury. Our company provides eligible employees with disability income at no cost to you.

Short-Term Disability (STD):

- 70% of covered weekly earnings, up to $1500
- Elimination period before benefits begin: 7 days accident / 7 days illness
- Payable to 13 weeks
- Pre-existing - None

Long-Term Disability (LTD):

- 70% of base monthly earnings up to $10,000 less other income sources.
- Elimination period before benefits begin: 90 days
- Payable the later of age 65 or your Social Security Normal Retirement Age.
- Pre-existing-3/12.This means you may not be eligible for benefits if you have received treatment for a condition within 3 months prior to your effective date under this policy until you have been covered under the policy for 12 months.

The following information is a quick overview of the benefits plans currently provided and is not to be interpreted as a complete disclosure of plans entitlement to any of the benefits described. The company reserves the right to adjust, amend and revise benefits plans. In all cases of specific plan interpretations, receipt of benefits or entitlements, the actual plan document shall rule. You can contact your HR department for the actual plan documents.

Voluntary Life Only Rates

Lincoln Financial Group / Policy # 000400001000-17833

Voluntary Term Life Coverage Selection and Premium Calculation
Please note that the premium amounts presented below may vary slightly from amounts provided on your enrollment form, due to rounding.

Employee Bi-Weekly Premium
Life Premium for sample benefit amounts

Employee and Spouse Premiums are calculated separately.
Refer to Program Specifications for your maximum benefit amounts.

Employee Premium Table (26 Payroll Deductions Per Year)											
	Bi-weekly Rate	**$10,000**	**$20,000**	**$30,000**	**$40,000**	**$50,000**	**$60,000**	**$70,000**	**$80,000**	**$90,000**	**$100,000**
0 - 29	$0.0323	$0.32	$0.65	$0.97	$1.29	$1.62	$1.94	$2.26	$2.58	$2.91	$3.23
30 - 34	$0.0369	$0.37	$0.74	$1.11	$1.48	$1.85	$2.22	$2.58	$2.95	$3.32	$3.69
35 - 39	$0.0462	$0.46	$0.92	$1.38	$1.85	$2.31	$2.77	$3.23	$3.69	$4.15	$4.62
40 - 44	$0.0738	$0.74	$1.48	$2.22	$2.95	$3.69	$4.43	$5.17	$5.91	$6.65	$7.38
45 - 49	$0.1200	$1.20	$2.40	$3.60	$4.80	$6.00	$7.20	$8.40	$9.60	$10.80	$12.00
50 - 54	$0.2040	$2.04	$4.08	$6.12	$8.16	$10.20	$12.24	$14.28	$16.32	$18.36	$20.40
55 - 59	$0.3295	$3.30	$6.59	$9.89	$13.18	$16.48	$19.77	$23.07	$26.36	$29.66	$32.95
60 - 64	$0.4200	$4.20	$8.40	$12.60	$16.80	$21.00	$25.20	$29.40	$33.60	$37.80	$42.00
Age Reduction		**$6,500**	**$13,000**	**$19,500**	**$26,000**	**$32,500**	**$39,000**	**$45,500**	**$52,000**	**$58,500**	**$65,000**
65 - 69	$0.7569	$4.92	$9.84	$14.76	$19.68	$24.60	$29.52	$34.44	$39.36	$44.28	$49.20
Age Reduction		**$4,000**	**$8,000**	**$12,000**	**$16,000**	**$20,000**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
70 - 74	$1.4211	$5.68	$11.37	$17.05	$22.74	$28.42	N/A	N/A	N/A	N/A	N/A
Age Reduction		**$2,500**	**$5,000**	**$7,500**	**$10,000**	**$12,500**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
75 - 79	$2.4863	$6.22	$12.43	$18.65	$24.86	$31.08	N/A	N/A	N/A	N/A	N/A
Age Reduction		**$1,000**	**$2,000**	**$3,000**	**$4,000**	**$5,000**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
80+	$4.7635	$4.76	$9.53	$14.29	$19.05	$23.82	N/A	N/A	N/A	N/A	N/A

Your spouse's rate is based on your age.

Spouse Premium Table (26 Payroll Deductions Per Year)											
	Bi-weekly Rate	**$5,000**	**$10,000**	**$15,000**	**$20,000**	**$25,000**	**$30,000**	**$35,000**	**$40,000**	**$45,000**	**$50,000**
0 - 29	$0.0323	$0.16	$0.32	$0.48	$0.65	$0.81	$0.97	$1.13	$1.29	$1.45	$1.62
30 - 34	$0.0369	$0.18	$0.37	$0.55	$0.74	$0.92	$1.11	$1.29	$1.48	$1.66	$1.85
35 - 39	$0.0462	$0.23	$0.46	$0.69	$0.92	$1.15	$1.38	$1.62	$1.85	$2.08	$2.31
40 - 44	$0.0738	$0.37	$0.74	$1.11	$1.48	$1.85	$2.22	$2.58	$2.95	$3.32	$3.69
45 - 49	$0.1200	$0.60	$1.20	$1.80	$2.40	$3.00	$3.60	$4.20	$4.80	$5.40	$6.00
50 - 54	$0.2040	$1.02	$2.04	$3.06	$4.08	$5.10	$6.12	$7.14	$8.16	$9.18	$10.20
55 - 59	$0.3295	$1.65	$3.30	$4.94	$6.59	$8.24	$9.89	$11.53	$13.18	$14.83	$16.48
60 - 64	$0.4200	$2.10	$4.20	$6.30	$8.40	$10.50	$12.60	$14.70	$16.80	$18.90	$21.00
Age Reduction		**$3,250**	**$6,500**	**$9,750**	**$13,000**	**$16,250**	**$19,500**	**$22,750**	**$26,000**	**$29,250**	**$32,500**
65 - 69	$0.7569	$2.46	$4.92	$7.38	$9.84	$12.30	$14.76	$17.22	$19.68	$22.14	$24.60
70+		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Example: Use this formula to calculate premium for benefit amounts over $100,000.

Age	Bi-Weekly Rate Per $1,000	X	Benefit In $1,000's	=	Bi-Weekly Cost
35	**$0.0462**	**X**	**150**	**=**	**$6.93**

This is an estimate of premium cost. Actual deductions may vary slightly due to rounding and payroll frequency.

The following information is a quick overview of the benefits plans currently provided and is not to be interpreted as a complete disclosure of plans entitlement to any of the benefits described. The company reserves the right to adjust, amend and revise benefits plans. In all cases of specific plan interpretations, receipt of benefits or entitlements, the actual plan document shall rule. You can contact your HR department for the actual plan documents.

Voluntary Life and Accidental Death & Dismemberment Insurance Rates

Lincoln Financial Group / Policy # 000400001000-17833

AD&D Coverage Selection and Premium Calculation
Please note that the premium amounts presented below may vary slightly from amounts provided on your enrollment form, due to rounding. You have the ability to select the amount of AD&D coverage you feel is appropriate for yourself and your eligible dependents. However, there are some guidelines you need to consider when choosing this coverage.

Employee Bi-Weekly Premium
Life and Accidental Death and Dismemberment Premium for sample benefit amounts

Employee and Spouse Premiums are calculated separately.
Refer to Program Specifications for your maximum benefit amounts.

Employee Premium Table (26 Payroll Deductions Per Year)

	Bi-weekly Rate	$10,000	$20,000	$30,000	$40,000	$50,000	$60,000	$70,000	$80,000	$90,000	$100,000
0 - 29	$0.0462	$0.46	$0.92	$1.38	$1.85	$2.31	$2.77	$3.23	$3.69	$4.15	$4.62
30 - 34	$0.0508	$0.51	$1.02	$1.52	$2.03	$2.54	$3.05	$3.55	$4.06	$4.57	$5.08
35 - 39	$0.0600	$0.60	$1.20	$1.80	$2.40	$3.00	$3.60	$4.20	$4.80	$5.40	$6.00
40 - 44	$0.0877	$0.88	$1.75	$2.63	$3.51	$4.38	$5.26	$6.14	$7.02	$7.89	$8.77
45 - 49	$0.1338	$1.34	$2.68	$4.02	$5.35	$6.69	$8.03	$9.37	$10.71	$12.05	$13.38
50 - 54	$0.2178	$2.18	$4.36	$6.54	$8.71	$10.89	$13.07	$15.25	$17.43	$19.61	$21.78
55 - 59	$0.3434	$3.43	$6.87	$10.30	$13.74	$17.17	$20.60	$24.04	$27.47	$30.90	$34.34
60 - 64	$0.4338	$4.34	$8.68	$13.02	$17.35	$21.69	$26.03	$30.37	$34.71	$39.05	$43.38
Age Reduction		**$6,500**	**$13,000**	**$19,500**	**$26,000**	**$32,500**	**$39,000**	**$45,500**	**$52,000**	**$58,500**	**$65,000**
65 - 69	$0.7708	$5.01	$10.02	$15.03	$20.04	$25.05	$30.06	$35.07	$40.08	$45.09	$50.10
Age Reduction		**$4,000**	**$8,000**	**$12,000**	**$16,000**	**$20,000**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
70 - 74	$1.4349	$5.74	$11.48	$17.22	$22.96	$28.70	N/A	N/A	N/A	N/A	N/A
Age Reduction		**$2,500**	**$5,000**	**$7,500**	**$10,000**	**$12,500**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
75 - 79	$2.5002	$6.25	$12.50	$18.75	$25.00	$31.25	N/A	N/A	N/A	N/A	N/A
Age Reduction		**$1,000**	**$2,000**	**$3,000**	**$4,000**	**$5,000**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
80+	$4.7774	$4.78	$9.55	$14.33	$19.11	$23.89	N/A	N/A	N/A	N/A	N/A

Follow the method described above to select a benefit amount and calculate premiums for optional dependent spouse and/or child(ren) coverage. Your spouse's benefit amount must be in an increment of $1,000. Dependent benefit amounts cannot be more than 100% of the employee benefit amount.

Spouse Premium Table (26 Payroll Deductions Per Year)

	Bi-weekly Rate	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
0 - 29	$0.0462	$0.23	$0.46	$0.69	$0.92	$1.15	$1.38	$1.62	$1.85	$2.08	$2.31
30 - 34	$0.0508	$0.25	$0.51	$0.76	$1.02	$1.27	$1.52	$1.78	$2.03	$2.28	$2.54
35 - 39	$0.0600	$0.30	$0.60	$0.90	$1.20	$1.50	$1.80	$2.10	$2.40	$2.70	$3.00
40 - 44	$0.0877	$0.44	$0.88	$1.32	$1.75	$2.19	$2.63	$3.07	$3.51	$3.95	$4.38
45 - 49	$0.1338	$0.67	$1.34	$2.01	$2.68	$3.35	$4.02	$4.68	$5.35	$6.02	$6.69
50 - 54	$0.2178	$1.09	$2.18	$3.27	$4.36	$5.45	$6.54	$7.62	$8.71	$9.80	$10.89
55 - 59	$0.3434	$1.72	$3.43	$5.15	$6.87	$8.58	$10.30	$12.02	$13.74	$15.45	$17.17
60 - 64	$0.4338	$2.17	$4.34	$6.51	$8.68	$10.85	$13.02	$15.18	$17.35	$19.52	$21.69
Age Reduction		**$3,250**	**$6,500**	**$9,750**	**$13,000**	**$16,250**	**$19,500**	**$22,750**	**$26,000**	**$29,250**	**$32,500**
65 - 69	$0.7708	$2.51	$5.01	$7.52	$10.02	$12.53	$15.03	$17.54	$20.04	$22.55	$25.05
70+		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Example: Use this formula to calculate premium for benefit amounts over $100,000.

Age	Bi-Weekly Rate Per $1,000	X	Benefit In $1,000's	=	Bi-Weekly Cost
35	**$0.0600**	**X**	**150**	**=**	**$9.00**

Dependent Children Rate = $0.92 Bi-Weekly
Premium covers all dependent children regardless of the number of children.

The following information is a quick overview of the benefits plans currently provided and is not to be interpreted as a complete disclosure of plans entitlement to any of the benefits described. The company reserves the right to adjust, amend and revise benefits plans. In all cases of specific plan interpretations, receipt of benefits or entitlements, the actual plan document shall rule. You can contact your HR department for the actual plan documents.

Lincoln Financial Group®

Evidence of insurability

Instructions for online submission

What is EOI and when is it needed?

EOI is the information we use to verify your good health when you're purchasing life, disability, or critical illness insurance. We require EOI if you are:

- Buying an insurance amount higher than the guaranteed amount for your plan
- Already enrolled and want to increase coverage

Get started now

1. Log in to my MyLincolnPortal.com. First time user? Register using: PMRCO
2. Click "Complete Evidence of Insurability."
3. Answer the questions about you and other applicants. You'll be asked:
   - General applicant information, such as date of birth, height, and weight
   - Qualifying questions, including if you or other applicants have been diagnosed with a disease or are prescribed medications for a condition
   - Medical questions—if you or other applicants have a condition, we may need to know a little more about it, such as the name, diagnosis date, and treatments
4. Review your responses, then electronically sign and submit your application.
5. Save your confirmation report.

Submitting EOI made easy

Minimal questions
The online questionnaire adjusts to your responses, so you only answer questions that are relevant to you.

Guided support
Quick tips and search-as-you-type features help you provide quick and appropriate responses.

Instant confirmation
You'll receive email acknowledgment that we've received your application. In some cases, you may be automatically approved.

What happens next?

In some cases, you may be auto-approved for coverage. If not, we'll review your application and contact you if more information is required. In all cases, we'll notify you of your application outcome.

Questions
For more information, contact your human resources department.

LCN-3543154-041221 Order code: DIS-EOIIS-FLI001_Z04
DIS-EOIIS-FLI001_Z04

GROUP BENEFITS

HANDLING LIFE, HANDLING LOSS

Lincoln Financial Group®

You're In Charge®

LifeKeys℠ services help you meet life's challenges

When you choose life insurance, you're planning for your family's future—assuring their comfort and securing their plans. With Lincoln Term Life Insurance, you can also access services that make a real difference now as well as in the future. *LifeKeys* services, included at no additional cost with all Lincoln Term Life and Accidental Death and Dismemberment Insurance policies, provide assistance to you, your family and your beneficiaries.

FOR YOU AND YOUR FAMILY...

EstateGuidance® will preparation

Create your will online—easily and economically. Follow a step-by-step guide through the entire process, and then use online instructions to execute your will. You can:

- Name an executor to manage your estate
- Choose a guardian for your children
- Specify wishes for your property
- Provide funeral and burial instructions

GuidanceResources® Online

GuidanceResources® Online is the place to go for articles, tutorials, streaming videos and "Ask the Expert" personal responses on topics such as:

- Law and regulations
- Money and investments
- Family and relationships
- Health and wellness
- Work and education
- Leisure and home

Insurance products issued by:
The Lincoln National Life Insurance Company
Lincoln Life & Annuity Company of New York

Identity theft

Identity theft is one of the fastest-growing crimes in the U.S. Be sure you have the information you need to recognize and prevent it. Our online resource helps you:

- Spot the warning signs
- Take steps to protect your cell phone, computer and tax records from fraud
- Lessen the damage and repair your credit if identity theft occurs
- Link to essential resources such as credit reporting bureaus, the FBI Internet Crime Complaint Center, ID Theft Resource Center, and more.

You may also be eligible for beneficiary services

If you develop a terminal illness and access your Accelerated Death Benefit, you will be able to use beneficiary services shown on the other side of this flier.

To access *LifeKeys* services: Call 1-855-891-3684 or visit Lincoln4Benefits.com (Web ID = LifeKeys)

FOR YOUR BENEFICIARIES...

Services are available for up to one year after a loss, and include:

A combination totaling six in-person sessions for grief counseling, or legal or financial information

and

Unlimited phone counseling

Assistance at a difficult time

Make sure your loved ones have the support they need, should you pass away. Unlimited phone contact with master's-level grief counselors lets your beneficiaries access information, advice and referrals for topics such as:

Grief and loss

Stress, anxiety and depression

Memorial planning information

Concerns about children and teens

Financial services

Your beneficiaries can call one of our certified financial specialists or use online tools and resources whenever they need help with essential topics such as:

- Estate planning
- Budgeting
- Debt
- Bankruptcy
- Investments

Legal support

If your beneficiaries need quick legal information, they can call one of our in-house attorneys. Or, if they need in-depth information, guidance or representation, we'll refer them to a qualified attorney in their area. They will be eligible for a free 30-minute consultation as well as a 25% reduction in customary legal fees thereafter. They'll get expert guidance on areas such as:

- Estate and probate law
- Real estate transactions
- Social Security survivor and child benefits
- Important documents beneficiaries need

Support with day-to-day concerns

Through good times and bad, everyone can use assistance. *LifeKeys*℠ services provide in-depth information and guidance—on virtually any topic you can name. Your beneficiaries can call for a quick answer or take advantage of specialists who will do the research for them and provide a comprehensive, customized booklet of information. Topics include:

- Planning a memorial service
- Finding child care or elder care
- Selecting a mortgage
- Moving and relocation
- Making major purchases

To access *LifeKeys* beneficiary services: Call 1-855-891-3684 or visit guidanceresources.com (First-time user: Web ID = LifeKeys)

LincolnFinancial.com

BP 3/13 **Z01**
Order code: LFE-SERV-FLI002

Lincoln Financial Group®

You're In Charge®

Employee Assistance Program
Service Summary
Kentucky EAP

Anthem

Available 24/7, 365 days a year

Everything you share is confidential*

Life can be full of challenges. Your Anthem Employee Assistance Program (EAP) is here to help you and your household members. EAP offers a wide range of **no-cost** support services and resources, including:

Counseling

- Up to 3 visits per issue
- In-person or online visits
- Call EAP or use the online Member Center to initiate services

Legal consultation

- 30-minute phone or in-person meeting
- Discounted fees to retain a lawyer
- Free legal resources, forms, and seminars online

Financial consultation

- Phone meeting with financial professionals
- Regular business hours; no appointment required
- Free financial resources and budgeting tools online

ID recovery

- Help reporting to consumer credit agencies
- Assistance with paperwork and creditor negotiations

Dependent care and daily living resources

- Online information about child care, adoption, elder care, and assisted living
- Phone consultation with a work-life specialist
- Help with pet sitting, moving, and other common needs

Other anthemEAP.com resources

- Well-being articles, podcasts, and monthly webinars
- Self-assessment tools for emotional health issues

Crisis consultation

- Toll-free emergency number; 24/7 support
- Online critical event support during crises

We are ready to support you

You can call us at **800-999-7222**, or go to **anthemEAP.com** and enter your company code: Anthem Kentucky

When something unexpected happens, EAP can help you figure out your next steps. Contact us today.

* In accordance with federal and state law, and professional ethical standards.
This document is for general informational purposes. Check with your employer for specific information on the services available to you.

Language Access Services – (TTY/TDD: 711)
Spanish – Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda.
Chinese – **您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。**

Anthem complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

108413MUMENABS VPOD BV Rev. 12/20

Exchange Notice

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 8-31-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year (9.12% adjusted for 2023), or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?
For more information about your coverage offered by your employer, please check your summary plan description or contact: **Angela Hall, HR Manager.**

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and Contact Information for a Health Insurance Marketplace in your area.

[1]An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer Name		4. Employer Identification Number (EIN)
Gearheart Communications		61-0513429
5. Employer Address		6. Employer Phone Number
20 Laynesville Rd		606-479-6355
7. City	8. State	9. Zip Code
Harold	KY	41635
10. Who can we contact about employee health coverage at this job?		
Angela Hall, HR Manager		
11. Phone Number (if different from above)	12. Email Address	
	angelahall@gearheart.com	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

  ☐ All employees. Eligible employees are:

  ☑ Some employees. Eligible employees are:

  Any employee who works 30 hours or more per week

- With respect to dependents:

  ☑ We do offer coverage. Eligible dependents are:

  Spouse and dependent children

  ☐ We do not offer coverage.

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit Healthcare.gov to find out if you can get a tax credit to lower your monthly premiums.

This information is an abbreviation of the compliance notices currently in place by the Department of Labor and should not to be interpreted as a complete disclosure of notices. Contact your HR department for questions pertaining to any notices.

Exchange Notice, continued

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 8-31-2023)

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

☐ **Yes** (continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)

☐ **No** (Stop and return this form to the employee)

14. Does the employer offer a health plan that meets the minimum value standard*?

☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans):
If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $_____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? $_____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If you believe you are eligible and decide to shop for coverage in the Marketplace, please refer to your employer.

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –

INDIANA - Medicaid	KENTUCKY - Medicaid
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement
According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

This information is an abbreviation of the compliance notices currently in place by the Department of Labor and should not to be interpreted as a complete disclosure of notices. Contact your HR department for questions pertaining to any notices.

FEDERAL REQUIREMENT NOTICES

Women's Health and Cancer Rights Act

As required by the Women's Health and Cancer Rights Act of 1998, the Plan provides Benefits for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

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

The amount you must pay for such Covered Health Services are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

Women's Preventive Care

The Affordable Care Act requires insurance companies to cover additional preventive health benefits for women. Health plans must cover the guidelines on women's preventive services with no cost sharing in plan years starting on or after August 1, 2012. The eight additional services for women that will be covered are:

- Annual Well-Woman Preventive Care Visit
- Gestational Diabetes Screening
- High-Risk Human Papillomavirus DNA Testing
- Sexually Transmitted Infections Counseling
- HIV Screening and Counseling
- Contraception and Contraceptive Counseling
- Breastfeeding Support, Supplies and Counseling
- Interpersonal and Domestic Violence Screening and Counseling

The Newborns' and Mothers' Health Protection Act of 1996

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 48 hours following a vaginal delivery, or less than 96 hour 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 not in excess of 48 hours (or 96 hours).

Your Rights Under the Uniformed Services Employment and Reemployment Act (USERRA)

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.

Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

Qualified Medical Support Order (QMCSO)

Federal law requires that medical coverage be provided to an Alternate Recipient in accordance with the requirements of a QMCSO. You are responsible for making sure that any medical child support order relating to your child meets the requirements of a QMCSO. The written requirements and procedures governing QMCSOs may be obtained from the Plan Administrator upon request at no charge.

The Health Insurance Portability and Accountability Act of 1996 HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was signed into law on August 21, 1996. The focus of this law was to facilitate the portability of health coverage when employees move from one job to another. HIPAA addresses portability, access and renewability of health coverage and affects all group health plan sponsors. The Act also addresses significant benefit areas including long term care, medical savings accounts and COBRA. The following information focuses on the portability, access and renewability provisions of HIPAA.

A major feature of HIPAA is that it limits the length of pre-existing condition exclusions for coverage to 12 months after enrollment (or 18 months for a late enrollee) for conditions for which medical advice, diagnosis, care or treatment was recommended or received within the 6 month period ending on the enrollment date in any new health plan. If an individual had a medical condition in the past, but has not received any medical advice, diagnosis, care or treatment within 6 months prior to enrolling in the plan, the old condition is not a "pre-existing condition" for which an exclusion can be applied.

Pre-existing condition exclusions cannot be applied to pregnancy, regardless of whether the individual had previous coverage. In addition, a pre-existing condition exclusion cannot be applied to a newborn or adopted child under age 18 as long as the child became 21 covered under the health plan within 30 days of birth or adoption, provided the individual does not incur a subsequent 63 day or longer break in coverage. To prove creditable coverage to offset the exclusion period, each participant is entitled to receive a certificate indicating the period of creditable coverage. Coverage under a health plan that occurs before a 63 consecutive day break in coverage is not counted, unless the state insurance laws require otherwise.

The certification of creditable coverage must be in writing and must specify the period of creditable coverage under the group health plan, including periods of COBRA continuation coverage. Group health plans must provide the written certification: 1) at the time a participant's coverage under the plan ends; 2) at the time COBRA continuation coverage ends; and 3) upon request of the individual within two years after coverage ceases.

Patient Protection and Affordable Care Act ("PPACA") - Patient Protection Notices

The Claims Administrator generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Claims Administrator's Network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator at the number on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from the Claims Administrator 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 the Claims Administrator's 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 Claims Administrator at the number on the back of your ID card.

This information is an abbreviation of the compliance notices currently in place by the Department of Labor and should not to be interpreted as a complete disclosure of notices. Contact your HR department for questions pertaining to any notices.

FEDERAL REQUIREMENT NOTICES

Important Notice from Gearheart Communications About Your Creditable Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Gearheart Communications and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **Gearheart Communications has determined that the prescription drug coverage offered by all four Anthem PPO and High Deductible Plans are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7.

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you are an active employee with Gearheart Communications and you decide to join a Medicare drug plan, your current coverage with Gearheart will not be affected.

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

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with Gearheart Communications and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact the Entity/Sender listed below for further information or contact your Human Resources Department. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Gearheart Communications changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

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

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

Date: 01/01/2024
Name of Entity/Sender: Gearheart Communications

This information is an abbreviation of the compliance notices currently in place by the Department of Labor and should not to be interpreted as a complete disclosure of notices. Contact your HR department for questions pertaining to any notices.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

The Plan is required to provide this Notice to you by the privacy rules (the "Privacy Rules") issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The Notice describes the practices of the group health plan components of the Gearheart Communications's Group Benefit Plan (the "Plan") which is a hybrid entity. The Plan can revise this Notice at any time. If the Plan makes any material change to this Notice, you will be provided with a revised Notice. If you have any questions, please contact: Angela Hall.

Your Protected Health Information - The Privacy Rules only protect certain medical information, which is known as "protected health information" (or "PHI"). Generally, PHI is individually identifiable health information created or received in connection with the Plan that relates to: (1) your past, present or future physical or mental health; (2) providing you with health care; or (3) the past, present or future payment for your care. This Notice only applies to the Plan's PHI.

Our Pledge Regarding Medical Information - The Plan understands that medical information about you and your health is personal. The Plan is committed to protecting medical information about you. A record of the health care claims reimbursed under the Plan is created for purposes of the administration of the Plan. This notice applies to all of the medical records maintained by the Plan. Your personal doctor or health care provider may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic.

This notice will tell you about the ways in which your medical information may be used or disclosed. It also describes the Plan's obligations and your rights regarding the use and disclosure of medical information.

The Plan is required by law to make sure that medical information that identifies you is kept private; give you this notice of the Plan's legal duties and privacy practices with respect to medical information about you; and follow the terms of this notice.

The Plan's Use and Disclosure of PHI - In certain circumstances, the Plan can use or disclose your PHI without your permission. However, most uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI, require an authorization. The following categories describe the different ways that your PHI can be used.

For Payment. The Plan can use or disclose your PHI in connection with: (1) determining your eligibility benefits; (2) facilitating payment for treatment and services that you received from health care providers; (3) determining the Plan's benefit responsibility; and (4) coordinating coverage. For example, the Plan may tell your health care provider about your medical history so he or she can determine whether a treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. The Plan can also disclose your PHI to a utilization review provider, precertification provider, or to another entity (or health plan) to assist with the adjudication, subrogation or coordination of payment for health claims.

For Health Care Operations. The Plan can use or disclose your PHI in connection with other operations that are necessary to run the Plan. For example, PHI may be used in connection with: (1) quality assessment and improvement activities; (2) underwriting, premium rating and other similar activities (however, genetic information cannot be used or disclosed for underwriting purposes); (3) submitting stop-loss (or excess loss) claims; (4) conducting medical review, legal services, audit services, and fraud and abuse detection; (4) business planning, management, and development; and (5) the Plan's general administrative activities.

For Treatment. The Plan can use or disclose your PHI to facilitate medical treatment or services by health care providers, including doctors, nurses, technicians, medical students, or other medical personnel who are taking care of you. For example, information about your prior prescriptions can be disclosed to a pharmacist to determine if a pending prescription is contraindicative with prior prescriptions.

To Business Associates. The Plan can contract with individuals or entities known as "Business Associates" to perform various functions or services on its behalf. To perform these functions or services, a Business Associate will have access to, and may use and disclose, your PHI, but only after they enter into an agreement with the Plan to implement appropriate safeguards intended to protect your PHI (i.e., a "Business Associate Agreement"). For example, after entering into a Business Associate Agreement the Plan may disclose your PHI to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation.

As Required by Law. The Plan can disclose your PHI when it is required by federal, state or local law. For example, the Plan can disclose your PHI when required to do so by federal or public health disclosure laws.

To Avert a Serious Threat to Health or Safety. The Plan can use or disclose your PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. However, disclosures can only be made to those able to help prevent the threat.

To the Company. For the purposes of administering the Plan, your PHI may be disclosed to certain employees who will generally only use or disclose your PHI to perform administration functions for the Plan or as required by the Privacy Rules. Your PHI cannot be used for employment purposes without your authorization.

More Stringent State Laws. In certain situations, the Plan may be required to comply with state laws that have requirements that are more stringent than those described in this Notice.

Special Situations

Organ and Tissue Donation. If you are an organ donor, the Plan can disclose your PHI to organizations that handle organ procurement or organ, eye or tissue transplantation, or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the U.S., armed forces or a foreign military, the Plan may disclose your PHI as required by military authorities.

Workers' Compensation. The Plan can disclose your PHI in connection with workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Public Health Risks. The Plan can disclose your PHI for public health activities, such as those which involve: (1) preventing or controlling disease, injury or disability; (2) reporting births and deaths; (3) reporting child abuse or neglect; (4) reporting reactions to medications or problems with products; (5) notifying people of recalls of products; (6) notifying people who may have been exposed to a disease or may be at risk for contracting or spreading a disease; and (7) notifying the appropriate government authority if it is believed you have been the victim of abuse, neglect or domestic violence, and if you agree to the disclosure or it is required or authorized by law.

Health Oversight Activities. The Plan can disclose your PHI to a health oversight agency for activities, authorized by law, that are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws. These activities include audits, investigations, inspections, and licensure.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, the Plan can disclose your PHI in response to a court or administrative order, subpoena, discovery request, or other lawful process by someone else involved in the dispute. However, efforts must have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. The Plan can disclose your PHI if requested by a law enforcement official: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime if, under certain limited circumstances, the Plan are unable to obtain the victim's authorization; (4) about a death that is believed to be the result of criminal conduct; or (5) about certain criminal conduct.

Coroners, Medical Examiners and Funeral Directors. The Plan can disclose your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. The Plan can also disclose your PHI to a funeral director if necessary to carry out his or her duties.

National Security and Intelligence Activities. The Plan can disclose your PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Plan can disclose your PHI to the correctional institution or law enforcement official if necessary for the institution: (1) to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research. The Plan can disclose your PHI to researchers when: (1) the individual identifiers have been removed; or (2) when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information, and approves the research.

This information is an abbreviation of the compliance notices currently in place by the Department of Labor and should not to be interpreted as a complete disclosure of notices. Contact your HR department for questions pertaining to any notices.

NOTICE OF PRIVACY PRACTICES

Other Disclosures

Legal Representatives. The Plan will generally disclose your PHI to individuals authorized by you, or to your legal representative if you provide the Plan with written notice/authorization and supporting documents (e.g., power of attorney). However, the Plan is not required to disclose your PHI to your legal representative if the Plan reasonably believes that: (1) you have been, or may be, subjected to domestic violence, abuse or neglect by this person, or treating this person as your legal representative could endanger you; and (2) in the Plan's professional judgment, it is not in your best interest to treat this person as your legal representative.

Spouses/Family Members. The Plan will generally send all mail to the employee covered under the Plan, including mail relating to his or her family members covered under the Plan (e.g. use and denial of benefits). If someone covered under the Plan requested restrictions or confidential Communications (described later in this Notice), and if the HIPAA Privacy Officer agreed to the request, the Plan will send mail as provided by the request.

Authorizations. Uses or disclosures of your PHI that are not described in this Notice will only be made with your written authorization. You can revoke a written authorization at any time if the revocation is in writing. Written revocations are only effective for future uses and disclosures and will not be effective for PHI that may have been used or disclosed (in reliance upon your written authorization) prior to receiving your revocation.

Your Rights

Inspecting and Copying PHI. You have the right to inspect and copy certain PHI that may be used to make decisions about your benefits under the Plans. To inspect and copy this PHI, you must submit your request in writing to the HIPAA Privacy Officer. If you request a copy of the information, you may be charged a fee for the costs of copying, mailing or other supplies associated with your request. The Plan can deny your request to inspect and copy PHI in certain limited circumstances. If you are denied access to your PHI, you can request that the denial be reviewed by submitting a request in writing to the HIPAA Privacy Officer.

Amending PHI. If you believe that certain PHI that is maintained by the Plan is incorrect or incomplete, you have the right to request an amendment as long as the PHI is maintained by the Plan. You can request an amendment, by submitting a written request in writing (along with the reason for your request) to the HIPAA Privacy Officer. Your request may be denied if: (1) it is not in writing; (2) it does not include a valid reason to support the request; (3) it requests an amendment to PHI that is not maintained by the Plan, was not created by the Plan (unless the person or entity that created the PHI is no longer available to make the amendment, or is not PHI that you are permitted to inspect and copy; or (4) it requests an amendment to PHI that is accurate and complete. If your request is denied, you can file a statement of disagreement in writing with the HIPAA Privacy Officer, and then any future disclosures of the disputed PHI will include your statement.

Right to an Accounting of Disclosures. You have the right to request an "accounting" of certain disclosures of your PHI. However, an accounting will not include: (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures that you authorized; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures. To request an accounting of disclosures, you must submit your request in writing to the HIPAA Privacy Officer. Your request must provide for a time period for the disclosures of not longer than 6 years and may not request disclosures made more than six years before the date you make your request. Your request must indicate the form in which you would like to receive the disclosures (e.g., paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, you may be charged for the costs of providing the disclosures to you. You will be notified of the cost involved and may choose to withdraw or modify your request at that time before any costs are incurred.

Requesting Restrictions. You have the right to request a restriction on uses and disclosures of your PHI that the Plan normally would use or disclose for treatment, payment, or health care operations, or would disclose to someone involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that the Plan not to disclose PHI about a surgery. The Plan is generally not required to agree to your request. However, if your request is denied, the Plan will honor the restriction until you revoke your request or you are notified of the denial. You must send a written request for restrictions to the HIPAA Privacy Officer. Your request must contain: (1) the PHI you want to limit; (2) whether you want to limit the Plan use, disclosure, or both; and (3) to whom you want the limits to apply (e.g., disclosures should not be made to your spouse).

Requesting Confidential Communications. You have the right to request that the Plan communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that the Plan only contact you at work or by mail. The Plan will accommodate reasonable requests if you provide clear information that the disclosure of all or part of your PHI could endanger you. You must send a written request for confidential communications to the HIPAA Privacy Officer. Your request must specify how or where you wish to be contacted. You will not be asked the reason for your request.

Breach Notification. You have the right to be notified in the event that we (or a Business Associate) discover a breach of your "unsecured" PHI.

Paper Copy of This Notice. You can ask the Plan for a paper copy of this Notice any time.

Complaints. If you believe your privacy rights have been violated, you can file a complaint with the Plan or the Secretary of the Department of Health and Human Services by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201.You will not be penalized for filing a complaint.

Changes to This Notice

The Plan reserves the right to change this notice. The Plan reserves the right to make the revised or changed notice effective for medical information the Plan already has about you, as well as any information the Plan receives in the future. A copy of the current notice will be posted on the website where other information about the Plan is located. The notice will contain on the first page, in the title section, the effective date.

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this notice or the laws that apply to the Plan will be made only with your written permission. If you provide permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, the Plan will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that the Plan is unable to take back any disclosures already made with your permission, and that the Plan is required to retain our records of the care that the Plan provided to you.

Conclusion

The use and disclosure of medical information by the Plans is regulated by a federal law known as HIPAA and the Privacy Rules under HIPAA. You may find these rules at 45 Code of Federal Regulations Parts 160 and 164. This notice attempts to summarize the Privacy Rules. The Privacy Rules will supersede any discrepancy between the information in this notice and the Privacy Rules.

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Offices in:

Kentucky | Indiana | Ohio

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