EMPOWERING ABILITIES

2026-27 plan year

Employee Benefit Guide

MEDICAL

PRESCRIPTION DRUG

DENTAL

VISION

Questions, Problems or Concerns

Our goal is to make certain that you receive the correct coverage under the benefits plan. We are here to help with any issues that may arise. If you require assistance, have your ID number or Social Security Number available and follow these steps:

- **For claims assistance** call the applicable insurance carrier. Have your ID number, date of service, and provider name available.
- If you require further assistance contact Gallagher. Empowering Abilities has partnered with Gallagher as our benefits administrator for expert assistance with benefit related questions, plan procedures, life events and claim issues.
- **Do you need an ID card?** If you do not have an ID card, please contact the insurance carrier to order your ID card or go online to the carrier's site to download an ID card.

Important Contact Information

Carrier	Group #	Web / Email	Phone
Medical UMR	76414932	www.umr.com	800-826-9781
Prescription Employers' Choice Rx		www.veracity-rx.com https://ecrxpbm.com	800-891-5043
Dental Delta Dental of Iowa	40727	www.deltadentalia.com	800-544-0718
Vision UnitedHealthcare	716641	www.myuhcvision.com	800-638-3120
Basic Life and AD&D Insurance **Voluntary Life Insurance** Equitable	19109	www.equitable.com/employeebenefits	866-274-9887
Short-Term Disability **Long-Term Disability** Assurity STD / Equitable LTD	191090	www.equitable.com/employeebenefits	866-274-9887
Accident and Critical Illness Insurance Assurity		http://bit.ly/empoweringabilitiesassuritybrochures	**Questions:** Matt Rednour 563-265-0122 **Claims:** Jade Wood 855-535-4231 x213
Emergency Travel Assistance Program Equitable | AXA		accounts.travel-eye-axa.com/en/registration/axa-us	855-327-1476
Employee Assistance Program (EAP) Equitable | ComPsych		www.guidanceresources.com	823-256-5115
Empowering Abilities Human Resources Alexis Dykstra		alexisdykstra@empoweringabilities.org	563-391-4834 ext 150
Empowering Abilities Benefits Helpline Gallagher Monday - Friday, 8am - 5:30pm ET		empoweringabilities@assuredpartners.com	888-381-7269, option 2

Visit our Educational Video Library!

Our educational video library is designed to help you navigate the world of insurance with ease. This library features a collection of short, informative videos covering a wide range of insurance-related topics.

Your employer may not offer all benefits shown in video library.

Welcome to your Employee Benefits!

Empowering Abilities takes into consideration our employees' evolving needs, as well as ensuring a level of security and protection when making decisions regarding the benefits program being offered.

We recognize the important role employee benefits play as a critical component of an employee's overall compensation. We also strive to maintain a benefits program that is competitive within our industry.

This benefits guide, together with other enrollment materials, are provided to help you understand your benefit choices and navigate through the Open Enrollment / New Hire process.

Before you enroll, please read this guide to become familiar with the benefit options. Your decisions will impact your benefit selections and what you pay for these benefits.

Empowering Abilities Benefits Helpline

888-381-7269, option 2

empoweringabilities@assuredpartners.com

To help you navigate through this guide and easily find the benefits you need, included is a wayfinding bar at the top of each page. Simply click the icon to go back to the table of contents.

What's Inside

PLEASE NOTE: This booklet provides a summary of the benefits available, but is not your Summary Plan Description (SPD). Empowering Abilities reserves the right to modify, amend, suspend, or terminate any plan at any time, and for any reason without prior notification. The plans described in this book are governed by insurance contracts and plan documents, which are available for examination upon request. We have attempted to make the explanations of the plans in this booklet as accurate as possible. However, should there be a discrepancy between this booklet and the provisions of the insurance contracts or plan documents, the provisions of the insurance contracts or plan documents will govern. In addition, you should not rely on any oral descriptions of these plans, since the written descriptions in the insurance contracts or plan documents will always govern.

Eligibility

Full-time employees with a regular schedule of **30 hours per week** are eligible for the benefits described in this guide, unless otherwise stated.

When Benefits Become Effective

Coverage for most benefit plans are effective on the first day of the month following 60 days from your date of hire. Part-time, seasonal, temporary, internship, and contracted employees are not eligible to participate.

Eligible Dependents

Your dependents are eligible to participate in Empowering Abilities' benefit plans. Your eligible dependents include*:

- A spouse to whom you are legally married.
- A dependent child under age 26. Coverage will terminate at the end of the month of the dependent's 26th birthday. Coverage may be extended past the age of 26 for disabled dependents. Dependent children include natural, adopted children, and stepchildren.

Coverage for eligible dependents generally begins on the same day your coverage is effective. Completed enrollment serves as a request for coverage and authorizes any payroll deductions necessary to pay for that coverage.

**Additional carrier conditions may apply and may vary by state.*

Pre-Tax Benefits: Section 125

Empowering Abilities' benefit plans utilize Section 125. This enables you to elect to pay premiums for health, dental and vision coverage on a pre-tax basis. When you use pre-tax dollars, you will reduce your taxable income and have fewer taxes taken out of your paycheck. Under Section 125, you can actually have more spendable income than if the same deductions were taken on an after-tax basis.

Pre-tax Note: When you pay for your dependent's benefits on a pre-tax basis you are certifying that the dependent meets the IRS definition of a dependent [IRC §§ 152, 21 (b)(1) and 105(b)]. Children/spouses that do not satisfy the IRS definition will result in a tax liability to you, such as changing that dependent's election to a post-tax election, or receiving imputed income on your W-2 for the dependent's coverage that should not have been taken on a pre-tax basis.

For all benefits you must enroll within 30 days from your date of hire.

Benefit Changes

The benefit elections you make during open enrollment, or as a new hire, will remain in effect for the entire plan year. You will not be able to change or revoke your elections once they have been made unless a life event status change occurs.

For purposes of health, dental and vision, you will be deemed to have a life event status change if:

- your marital status changes through marriage, the death of your spouse, divorce, legal separation, or annulment;
- your number of dependents changes through birth, adoption, placement for adoption, or death of a dependent;
- you, your spouse or dependents terminate or begin employment;
- your dependent is no longer eligible due to attainment of age;
- you, your spouse or dependents experience an increase or reduction in hours of employment (including a switch between part-time and full-time employment; strike or lock-out; commencement of or return from an unpaid leave of absence);
- gain or loss of eligibility under a plan offered by your employer or your spouse's employer;
- a change in residence for you, your spouse or your dependent resulting in a gain or loss of eligibility.

You must notify your Human Resources Department within 30 days from the life event status change in order to make a change in your benefit selections.

In order to be permitted to make a change of election relating to your health, dental or vision coverage due to a life event status change, the change must result in you, your spouse or dependent gaining or losing eligibility for health, dental or vision coverage under this plan or a plan sponsored by another employer by whom you, your spouse or dependent are employed. The election change must correspond with that gain or loss of eligibility.

You may also be permitted to change your elections for health coverage under the following circumstances:

- a court order requires that your child receive accident or health coverage under this plan or a former spouse's plan;
- you, your spouse or dependent become entitled to Medicare or Medicaid;
- you have a Special Enrollment Right;
- there is a significant change in the cost or coverage for you or your spouse attributable to your spouse's employment.

For purposes of all other benefits under the plan, you will be deemed to have a life event status change if the change is on account of and consistent with a change in status, as determined by the plan administrator, in its discretion, under applicable law and the plan provisions.

Benefit Changes continued...

Event	Action Required	Results If Action Not Taken
New Hire:	Make elections within 30 days of hire date. Documentation is required.	You and your dependents are not eligible until the next annual Open Enrollment.
Marriage:	Your new spouse must be added to your elections within 30 days of the marriage date. A copy of the marriage certificate must be presented.	Your spouse is not eligible until the next annual Open Enrollment period.
Divorce:	The former spouse must be removed within 30 days of the divorce. Proof of the divorce will be required. A copy of the divorce decree must be presented.	Benefits are not available for the divorced spouse and will be recouped if paid erroneously.
Birth or adoption of a child:	The new dependent must be enrolled in your elections within 30 days of the birth and adoption, even if you already have family coverage. A copy of the birth certificate, footprints, or hospital discharge papers must be presented. Once you receive the child's Social Security Number, be sure to contact Gallagher to update your child's insurance information record.	The new dependent will not be covered on your health insurance until the next annual Open Enrollment period.
Death of a spouse or dependent:	Remove the dependent from your elections within 30 days from the date of death. Death certificate must be presented.	You could pay a higher premium than required and you may be overpaying for coverage.
Your spouse gains or loses employment that provides health benefits:	Add or drop health benefits from your elections within 30 days of the event date. A letter from the employer or insurance company must be presented.	You need to wait until the next annual Open Enrollment period to make any change.
Loss of coverage with a spouse:	Change your elections within 30 days from the loss of coverage. A letter from the employer must be provided.	You will be unable to enroll in the benefits until the next annual Open Enrollment period.
Changing from full-time to part-time employment (without benefits) or from part-time to full-time (with benefits):	Change your elections within 30 days from the employment status change in order to receive COBRA information or to enroll in benefits as a full-time employee. Documentation from the employer must be provided.	Benefits may not be available to you or your dependents if you wait to enroll in COBRA. Full-time employees will have to wait until the annual Open Enrollment period.

If you Experience a Life Event Status Change

You must update your elections within 30 days of your life event status change or you will not be able to make changes until the next annual open enrollment. If adding or removing dependents, you are required to submit specific documents to your Human Resources Department.

Watch a brief video on changing your elections following life events.

Medical Plan

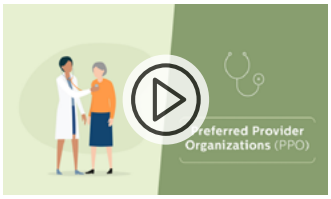
The UMR PPO plan is a Preferred Provider Organization Plans, or PPO for short. Under this plan, both you and your family can see any health care provider in the UMR network, including specialists, without a referral. You are not required to choose a primary care physician.

- ✓ Copays for most services, lower deductible to fulfill
- ✓ Do not have to choose a Primary Care Physician (PCP)
- ✓ No referrals required
- ✓ Offers out-of-network coverage (although at greater cost to you)

	UMR $1,000 Deductible	
	In-Network	Out-of-Network
Network	UHC - Choice Plus & VIP Network	
Deductible Individual / Family	**$1,000 / $2,000**	**$8,000 / $16,000**
Out-of-Pocket Maximum Individual / Family	$2,500 / $5,000	$15,000 / $30,000
Preventive Services Well-Child Care Adult Physical Examination Mammography / Colonoscopy Pap Test	No charge	N/A
Office Visits Primary Care Physician Specialist	 $30 copay $50 copay	 Deductible, then 40% Deductible, then 40%
Urgent Care Centers	$75 copay	Deductible, then 40%
Emergency Room	$500 copay	$500 copay
Inpatient Services	Deductible, then 20%	Deductible, then 40%
Outpatient Services	Deductible, then 20%	Deductible, then 40%
Rehabilitation Services	$30 copay per visit	Deductible, then 40%
Imaging (CT / PET scans, MRIs)	Deductible, then 20%	Deductible, then 40%
Retail Prescriptions (30 day supply) Tier 1: Generic Tier 2: Brand Preferred Tier 3: Brand Non-preferred	*No Walgreens, CVS, & Rite Aid* $10 copay $30 copay $45 copay	N/A
Mail Order Prescriptions (90 day supply) Tier 1: Generic Tier 2: Brand Preferred Tier 3: Brand Non-preferred	 $25 copay $75 copay $112.50 copay	N/A

This summary is for informational purposes only. For specific benefit information, please refer to the applicable insurance contract.

Plan Cost Per Pay	UMR $1,000 Deductible
Employee Only	$62.50
Employee + Child	$162.50
Family	$330.00



Watch a brief video explaining PPO plans.

Telehealth

Teladoc virtual doctor visits. Care you can count on 24/7.

Health is a top priority and quality care should always be within reach. Virtual Doctor Visits. Save you time. Save you money. Save you stress.

CARE FROM THE SAFETY AND COMFORT OF HOME

Avoid exposure to viruses and germs.

LESS TIME WAITING

Talk with a doctor in less than 15 minutes and feel better faster.

24/7 AVAILABILITY

Teladoc doctors are available nights, weekends, and holidays in all 50 states.

TOP QUALITY PHYSICIANS

Access to one of the largest virtual care networks in the country, with board-certified doctors who are available by phone, web, or the Teladoc mobile app.

DEPENDABLE CARE

Our AI-powered evaluation process and proprietary telemedicine guidelines help us deliver care you can count on.

PRESCRIPTIONS

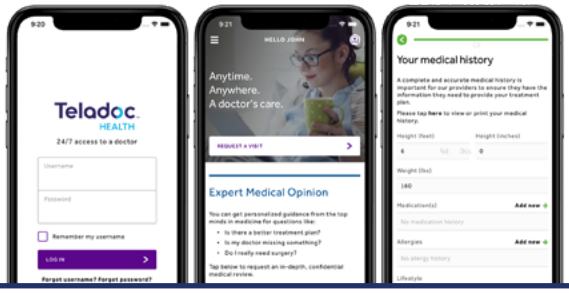
Your provider can send prescriptions to your preferred pharmacy and refill existing medications.

Activate your account today and you'll be ready to see a doctor when you need one!

TeladocHealth.com

1-800-Teladoc (835-2362)

Search for "Teladoc" in the App Store or on Google Play.



PHYSICIANS THAT TREAT MORE THAN 80 ROUTINE MEDICAL CONDITIONS

- Allergies
- Asthma
- Back Pain
- Bronchitis
- Common Cold
- Constipation
- Cough
- COVID-19
- Diarrhea
- Ear Infections
- Flu
- Headache
- Mild Injuries
- Nausea
- Pink Eye
- Rashes
- Respiratory Problems
- Sinus Infections
- Sore Throat
- Strep Throat
- Urinary Tract Infections (females 18+)
- …and more, including medication refills

Visits through Teladoc are at NO COST to Empowering Abilities members!

The Teladoc benefits will be available to all employees and dependents enrolled in the Empowering Abilities medical plans. All employees enrolled in the Empowering Abilities and Affiliates Medical Plans through UMR will be automatically enrolled to have access to Teladoc services.

Watch a brief video on telehealth.

EMPLOYERS' CHOICE Rx

Prescription Coverage

Your prescription drug benefit is part of your medical plan. Employers' Choice Rx (ECRx) will oversee and manage your pharmacy benefits. As your benefits partner, Employers' Choice Rx, with assistance from VeracityRx, will handle all claims and customer service functions including Specialty and Personal Importation pharmacy fulfillment.

Medicare Part D

The prescription drug benefit is creditable coverage. Medicare-eligible participants need not enroll in a separate Medicare D drug plan.

UMR $1,000 Deductible	In-Network
Retail Copay *(up to 34 day supply)*	
Tier 1: Generic	$10
Tier 2: Preferred Brand	$30
Tier 3: Non-Preferred Brand	$45
Mail Order Copay *(up to 90 day supply)*	
Tier 1: Generic	$25
Tier 2: Preferred Brand	$75
Tier 3: Non-Preferred Brand	$112.50
Specialty Drugs	*Specialty Drugs are EXCLUDED.* Enroll at **www.veracity-rx.com** for more information.
Personal Importation Drugs	$0 Copay – Personal Importation drugs are available through STAR-Rx Pharmacy Services. If you choose not to participate, you will be responsible for 50% of the cost of the medication at your local pharmacy. For more information, please go to **www.veracity-rx.com** and complete the "Enrollment Form".

This summary is for informational purposes only. For specific benefit information, please refer to the applicable insurance contract.

Where You Can Fill Prescriptions

- Your plan uses a Select/Non-select pharmacy network. Prescriptions filled at Non-select pharmacies will not be covered by the plan.
- Non-select pharmacies are CVS, Target, Walgreens, and Rite- Aid. All independent pharmacies and grocery stores are considered Select.

90-Day Prescriptions

Any prescriptions greater than a 34-day supply up to 90-days can be filled at all Select pharmacies or mail order. For more information, call 800-662-0586 or register online.

Specialty Medications

Specialty Medications are EXCLUDED from the plan. For more information, please go to **www.veracity-rx.com** and complete the "Enrollment Form". Once completed, a VeracityRx Specialty team member will be in touch.

Personal Importation Medications

Medications that can be obtained internationally (from Canada) can also be acquired through VeracityRx Pharmacy Services. When the medications are obtained this way, the cost to you is $0 Copay. If you choose not to participate, a 50% coinsurance will apply at retail. For more information, please go to **www.veracity-rx.com** and complete the "Enrollment Form".

How to Connect

- You can reach ECRx 24 hours a day, 7 days a week – they're always available to take your call, even on holidays.

Phone: **800-891-5043**

Member Portal: **https://ecrxpbm.com**

Email: **support@employerschoicerx.org**

Mobile App:

Where Should I get Medical Care?

If you need emergency care, call 911, or seek help from any doctor or hospital immediately.

When should you go to the emergency room? You should go to the emergency room for life-threatening conditions, severe injuries, sudden severe symptoms, or serious health issues. For less severe issues, consider visiting an urgent care clinic or contacting your primary care physician. It's always better to err on the side of caution when it comes to your health.

Watch a brief video comparing primary care, urgent care, and the ER.

Telehealth

- Available 24:7, 365 days a year.
- Secure video chat with board-certified doctor.
- Download the Telehealth app to access.

Doctor's Office

- Office hours vary.
- Generally the best place to go for non-emergencies.
- Doctor to patient relationship established; able to treat based on medical history.

Urgent Care Center

- Generally includes evenings, weekends, and holidays.
- Used when your doctor's office is closed, and it's not an emergency.
- Convenient access to medical care.

Hospital Emergency Room (ER)

- Available 24:7, 365 days a year.
- Best option for a medical emergency.
- Highest out-of-pocket cost to you.
- Potentially longer wait times.

	Telehealth	Doctor's Office	Urgent Care Center	Hospital Emergency Room (ER)
Who usually provides care	**Board-Certified Doctors**	**Primary Care Doctor**	**Nurse Practitioners**	**ER Doctors, Internal Medicine, Specialists**
Minor Animal bites	✓	✓	✓	
Minor headaches	✓	✓	✓	• Any life-threatening or disabling conditions
Back pain	✓	✓	✓	• Sudden or unexplained loss of consciousness
Nausea, vomiting, diarrhea	✓	✓	✓	• Major injuries
Minor allergic reactions	✓	✓	✓	• Chest pain; numbness in the face, arm or leg; difficulty speaking
Coughs, sore throat	✓	✓	✓	• Severe shortness of breath
Bumps, cuts, scrapes	✓	✓	✓	• High fever with stiff neck, mental confusion or difficulty breathing
Rashes, minor burns	✓	✓	✓	• Coughing up or vomiting blood
Minor fevers, colds	✓	✓	✓	
Ear or sinus pain	✓	✓	✓	
Burning with urination	✓	✓	✓	
Eye swelling, irritation, redness or pain	✓	✓	✓	
Vaccinations	✓	✓	✓	

DELTA DENTAL®

Dental Coverage

Delta Dental of Iowa DPPO

The Delta Dental PPO program gives you access to two Delta Dental dentist networks and different levels of savings. You can choose a dentist from Delta Dental Premier® network or you can take advantage of the lower allowances and out-of-pocket costs associated with dentists who participate in the Delta Dental PPO network. In addition, you can choose a dentist who does not participate and still receive applicable benefits. You can find a network dentist online at **www.deltadentalia.com**, or by calling 800-544-0718.

	PPO Plan Pays	Premier Plan Pays	Nonparticipating Plan Pays
Calendar Year Maximum		$1,000 per person	
Calendar Year Deductible* per individual / per family	$25 / $75	$50 / $150	$50 / $150
Diagnostic and Preventive Services			
routine check-ups, cleanings, full mouth x-rays, fluoride, sealants, and space maintainers	No charge	No charge	No charge
Basic Routine & Restorative Care			
cavity repair, tooth extractions, general anesthesia / sedation, routine oral surgery, emergency treatment	60%	50%	50%
Posterior Composites - tooth-colored filling on back teeth	50%	50%	50%
Endodontic Services - root canals and thereapy	50%	50%	50%
Periodontal Services - non-surgical procedures, gum and bone diseases, surgical procedures, perio maintenance therapy	50%	50%	50%
Major Restorative Care			
High Cost Restorations - repair crowns, crowns, recementing crowns	50%	50%	50%
Prosthetics - bridges, dentures, repairs and adjustments	50%	50%	50%
Implants - endosteal implants to replace missing teeth	50%	50%	50%
Orthodontia Services			
Corrective Orthodontia Benefit - coverage for children to age 19 only	50%	50%	50%
Orthodontia Lifetime Maximum		$1,000 per person	

This summary is for informational purposes only. For specific benefit information, please refer to the applicable insurance contract.

**Deductible is waived for diagnostic and preventive care.*

OUT-OF-NETWORK PROVIDERS & BALANCE BILLING

Under the Dental PPO, the plan pays the same amount to out-of-network providers as it would for in-network providers. Please note that providers that do not participate with your insurance plan can "balance bill" you for any difference between their charge and what the plan pays. Therefore, using non-participating providers may result in significant patient liability.

Plan Cost Per Pay	Dental DPPO
Employee Only	$14.50
Employee + Spouse	$28.00
Employee + Child(ren)	$31.50
Family	$47.00

UnitedHealthcare

Vision Coverage

UnitedHealthcare Vision Plan

As a vision care member, you'll receive access to great eye doctors, quality eyewear and lower out-of-pocket costs. To find an in network provider, visit **www.myuhcvision.com** or call 800-638-3120. At your appointment, tell them you have coverage with the carrier.

Plan Cost Per Pay	Vision Plan
Employee Only	$3.30
Employee + Spouse	$6.90
Employee + Child(ren)	$7.20
Family	$10.95

Benefit	In-Network	Out-of-Network	Frequency
Exam	$10 copay	up to $40	12 months
Frames Retail Allowance	up to $130, 30% off remaining balance	up to $45	24 months
Eyeglass Lenses			12 months
Single Vision	$25 copay	up to $40	
Lined Bifocal Lenses	$25 copay	up to $60	
Lined Trifocal Lenses	$25 copay	up to $80	
Lenticular	$25 copay	up to $80	
Contact Lenses Allowance *(In lieu of glasses)*			12 months
Elective	$25 copay, up to 4 boxes	up to $125	
Medically Necessary	up to $125	up to $210	

This summary is for informational purposes only. For specific benefit information, please refer to the applicable insurance contract.

EQUITABLE

Basic Life | AD&D Insurance

Basic Life | AD&D Insurance

Life insurance provides financial protection for your family in the event of your passing. Empowering Abilities offers all employees life and accidental death and dismemberment insurance through Equitable. Empowering Abilities covers the full cost of this benefit.

Basic Life Benefit Amount: 2x basic annual earnings up to $200,000

AD&D Benefit Amount: Equal to Life amount

Your benefit amount will reduce to 65% at age 65; 50% at age 70 and above. Benefits terminate upon retirement.

Plan Cost: 100% Employer Paid

Voluntary Life | AD&D Insurance

Increase Your Coverage

You may elect to increase your life insurance coverage for yourself, your spouse and your dependent children – all at an affordable group rate provided by Equitable.

Voluntary Life | AD&D Insurance Increments

	Employee	Spouse	Dependent Child
Benefit Amount:	increments of $10,000	increments of $5,000	$10,000
Guaranteed Issue:	$150,000	$30,000	$10,000
Maximum Benefit:	the lesser of 5x Annual Base Earnings or $300,000	$150,000	$10,000

Spouse amount cannot exceed 50% of the employee's Supplemental Life benefit.
Child amount cannot exceed spouse amount.

Portability Options for Basic & Voluntary Life

Portability is available when an Insured Person's employment terminates for a reason other than sickness or injury or retirement at the Social Security Normal Retirement Age (SSNRA). The Insured Person's coverage must be in force for at least 12 months in a row just prior to the date employment ends.

This person has the option to continue all or part of his or her insurance enforce when employment ends without Evidence of Insurability. To continue insurance, application and the first premium payment must be made within the time period specified in the policy. Coverage can continue until the earlier of the date the master policy terminates or up to 36 Months.

For information on Portability, please contact Empowering Abilities Benefits Helpline.

Disability

EQUITABLE

Voluntary Short-Term Disability

To ensure your income will continue if you are unable to work due to a disability, Empowering Abilities provides short-term disability (STD). Benefits are payable for a non-occupational injury or illness that keep you from performing the normal duties of your job. If a medical condition is job-related, it is considered Workers' Compensation rather than STD.

Benefits Start After:	7 days
Benefit Amount:	$100 - $1,000 in units of $50 not to exceed 60% of pre-disability weekly earnings
Maximum Benefit:	$1,000 / week
Benefit Duration:	13 weeks
Plan Cost:	**100% Employee Paid**

Long-Term Disability

Long-Term Disability (LTD) insurance helps replace a portion of your income if you are disabled for an extended period of time. Eligibility for long-term benefits are generally defined as, due to sickness or accidental injury which you are receiving appropriate care and treatment; are complying with your treatment requirements and unable to earn more than 80% of your predisability earnings.

Benefits Start After:	90 days
Benefit Amount:	60% of predisability monthly earnings
Maximum Benefit:	$5,000 / month
Benefit Duration:	**age > 64:** SSNRA or 42 months whichever is greater. **age 64:** 36 months **age 67:** 24 months **age 65:** 30 months **age 68:** 21 months **age 66:** 27 months **age 69+:** 18 months
Plan Cost:	**100% Employer Paid**

**SSNRA means the Social Security Normal Retirement Age in effect under the Social Security Act on the Policy Effective Date.*

Pre-Existing Condition Limitations

The carrier will not pay benefits for any period of Disability caused or contributed to by, or resulting from, a Pre-existing Condition. A "Pre-existing Condition" means any Injury or Sickness for which you incurred expenses, received medical treatment, care or services including diagnostic measures, took prescribed drugs or medicines, or for which a reasonable person would have consulted a Physician within 3 months before your most recent effective date of insurance.

The Pre-existing Condition Limitation will apply to any added benefits or increases in benefits. This limitation will not apply to a period of Disability that begins after you are covered for at least 12 months after your most recent effective date of insurance, or the effective date of any added or increased benefits.

Watch a brief video on Disability Insurance and how it works.

Need to take extended leave? Watch a brief video on FMLA leave.

Assurity

Voluntary Benefits

The following Voluntary Benefits can complement existing medical coverage and help fill financial gaps caused by out-of-pocket expenses such as deductibles, co-payments, and non-covered medical services. Benefits are paid regardless of what is covered by medical insurance. Payments are made directly to you, to spend as you choose.

Both plans are portable (you can continue coverage if you leave the company) and each plan includes a wellness benefit of $50.

Accident (On/Off the Job)

Accident Insurance is designed to help covered individuals meet the out-of-pocket expenses and extra bills that can follow an accidental injury, whether minor or catastrophic. Lump sum benefits are paid directly to you based on the amount of coverage listed in the schedule of benefits. The coverage is guaranteed issue so no health questions are required.

Spouses and dependent children to age 26 are covered.

The following list are some examples of covered accidents and the Benefit Amount that you will be paid.

Benefit Amount	
Basic Accidental Death:	Employee $40,000 Spouse $20,000 Child $10,000
Ground Ambulance:	$300
Rehabilitation Unit:	$200
Dislocations:	$2,250
Chiropractic / Acupuncture:	$60 per visit
Diagnostic Exams:	$150
Hospital Admission:	$1,000
Hospital Confinement:	$200 per day

Critical Illness

Critical Illness Insurance is designed to help you offset the financial effects of a catastrophic illness with a lump sum benefit if you are diagnosed with a covered critical illness. The benefit is based on the amount of coverage in effect on the date of diagnosis or the date treatment is received according to the terms and provisions of the policy.

You have the choice of electing coverage of $10,000, $20,000 or $30,000.

Your Spouse may choose a lump sum benefit of $10,000, $20,000 or $30,000 in $10,000 increments up to 100% of the employee's lump sum benefit. The child benefit is a lump sum benefit of $2,500 or $5,000.

Below are some examples of covered critical illnesses:

- Heart Attack
- Stroke
- Major Organ Failure
- Cancer
- Alzheimer's Disease
- Parkinson's Disease
- Severe Burns
- Arterial / Vascular Disease

Childhood Covered Conditions:

- Cerebral Palsy
- Cleft lip / palate
- Cystic Fibrosis
- Down Syndrome
- Muscular Dystrophy
- Spina Bifida
- Type 1 Diabetes

For a full list of coverages for each plan and specific benefit information, please refer to the applicable insurance contract.

ComPsych

Employee Assistance Program

Life doesn't always go as planned. And while you can't always avoid the twists and turns, you can get help to keep moving forward. Get professional support and guidance to make life a little easier through Equitable | ComPsych **at NO COST to you.**

EAP staff members are highly trained, master's level professionals who will assess your situation, provide support and, if needed, refer you to other helpful resources. Strict confidentiality will be maintained during any phase of EAP services. No personal information will be shared with your employer. Convenient and confidential help when you want it, how you want it.

Available Services:

- **Family**: Going through a divorce, caring for an elderly family member, returning to work after having a baby
- **Work:** Job relocation, building relationships with co-workers and managers, navigating through reorganization
- **Money:** Budgeting, financial guidance, retirement planning, buying or selling a home, tax issues
- **Legal Services:** Issues relating to civil, personal and family law, financial matters, real estate and estate planning
- **Identity Theft Recovery:** ID theft prevention tips and help from a financial counselor if you are victimized
- **Health:** Coping with anxiety or depression, getting the proper amount of sleep, how to kick a bad habit like smoking
- **Everyday Life:** Moving and adjusting to a new community, grieving over the loss of a loved one, military family matters, training a new pet

Don't delay if you need help!

Visit **www.guidanceresources.com** or call **823-256-5115** for confidential consultation and resource services.

Mobile App available in the Apple App Store or Google Play.

Watch a brief video on Employee Assistance Programs (EAPs).

Watch a brief video on Managing Stress & Mental Health.

EQUITABLE | AXA

Emergency Travel Assistance

You and your dependents now have access to the Emergency Travel EAP provided by AXA. This program offers you a broad range of worldwide travel, emergency medical transportation and concierge services 24 hours a day, 365 days a year. Wherever you are, one simple phone call to the response center will connect you to a global network of providers who can support you while you are away from home.

Services include:

- Medical and dental referrals
- Emergency medical evacuation or repatriation
- Hospital admission and critical care monitoring
- Return of mortal remains
- Dispatch of prescription medication
- Lost document and luggage assistance
- Emergency cash and bail assistance
- ID theft assistance
- General travel information
- Concierge services

Medical Assistance Services:

Emergency Medical Transportation:

- Emergency Medical Evacuation
- Medical Repatriation
- Return of Mortal Remains
- Transportation of Travel Companion
- Transportation of Family Member to Accompany Patient
- Escort of Dependent Children

Medical Assistance:

- Medical and Dental Referrals
- Coordination of Hospital Admission
- Critical Care Monitoring
- Dispatch of Physician
- Dispatch of Prescription Medication

International Medical Teleconsultation:

24/7 virtual medical care while abroad

- Medical Advice
- Treatment Options
- Prescription Refills and Provider Referrals

Register Before Your Next Trip Abroad

Prior to your trip, download the Doctor Please! app via Google Play or Apple Store. Access code US1020.

Travel Assistance Services:

- Lost Document and Luggage Assistance
- Emergency Cash/Bail Assistance
- Emergency Message Transmission
- Legal Referrals
- General Travel Information

Identity Theft:

- **Awareness and Education:** Providing you with a guide on identity theft
- **Recovery and Resolution:** Guidance in taking the necessary steps if your identity is compromised

Concierge Services:

Concierge services are designed to fulfill various travel and entertainment requests, including restaurant and entertainment recommendations, locating available business services, airfare and car rental, and much more.

Travel Assistance Program

Visit **accounts.travel-eye-axa.com/en/registration/axa-us**

Within the United States

1-855-327-1476

Outside the United States
1-312-356-5980

Frequently Asked Questions

IT Issues

Why can't I login into my benefits?

It's recommended that you login using a desktop or laptop computer instead of a mobile device. Click the weblink in your guide or **TYPE the EXACT URL** into your top browser bar. Do not type into Google search bar.

How can I tell if my computer has the Minimal Requirements?

If your computer has the latest browser updates you should be able to login. For most computers you can find the version being used by going to "Help > About" menu selection.

ID Cards

How do I get ID cards for my plans?

If you do not have an ID card, contact the carrier to order your ID card or go online to the carrier's website to download an ID card.

I have not received my member ID card but need to see my doctor. What should I do?

For most plans, you can go to your Carrier's website to view a digital version of your member ID card.

If you are unable to view on the Carrier's website, then contact your Benefit Helpline or HR Department. If your application has been processed they will be able to give you your unique member ID number.

Preventive Care

What is considered preventive care and 100% covered at no cost?

Medical services that defend against health emergencies, illnesses, and diseases—like annual check-ups, immunizations and screening tests—are considered preventive. If you are enrolled in a medical plan, in-network preventive services are covered at 100%, with no payment needed from you.

Do I need a referral for my annual GYN exam?

No, this is considered preventive care. Female members may schedule an appointment for a routine annual exam with any OB/GYN in-network.

Enrolling or Life Event Status Change

Can I get health coverage outside Open Enrollment?

Outside Open Enrollment, you can only get health insurance 3 ways:

- With a life event status change, you qualify if you lose job-based coverage, have a baby, get married, or have certain other life changes, or based on estimated household income.
- Through Medicaid or the Children's Health Insurance Program (CHIP). Go to healthcare.gov for more information.
- HIPAA Special Enrollment due to loss of eligibility for other coverage and upon certain life events.

Can I enroll my spouse or dependent on one plan and myself on another?

No. All covered dependents, including spouse, must be on the same plan as the employee.

What do I do for a life event status change?

You must notify the Benefits Helpline or HR Department within a limited number of days from the life event, in order to make a status change to your benefit selections.

If adding or removing dependents, you are required to submit specific documents, such as marriage license or birth certificate. The change will be inactive until proper documentation is received and approved.

See the full list of life event status changes listed on the Benefit Changes page in your benefit guide or defer to the plan documents.

What happens if I do not enroll within 30 days?

Benefits are subject to regulatory rules and if you do not enroll within the 30 days you will not be able to enroll again until next benefits open enrollment.

Explanation of Benefits (EOB)

What is an EOB?

EOB stands for Explanation of Benefits. This is a document sent to you to let you know a claim has been processed describing what costs it will cover for medical care or products received. The most important thing for you to remember is an EOB is NOT a bill.

To view the full FAQ list, click the link below or scan the QR code.
https://www.flipsnack.com/ajggbs/faqs

Glossary of Terms

Watch a brief video reviewing key benefit-related terms.

This glossary has many commonly used terms, but it isn't a full list. These are not contract terms. Those can be found in your insurance policy or certificate.

Allowed Amount: Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Balance Billing: When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you.

Co-insurance: Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount. (Jane pays 20%, her plan pays 80%.)

Co-payment: A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible: The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services. (Jane pays 100%, her plan pays 0%.)

Emergency Room Care: Emergency services received in an emergency room.

Emergency Services: Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

Home Health Care: Health care services a person receives at home.

Hospitalization: Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Medically Necessary: Health care services or supplies needed to prevent, diagnose or treat an illness, injury, disease or its symptoms and that meet accepted standards of medicine.

Network: The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Non-Preferred Provider: A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.

Out-of-Pocket Limit: The most you pay during policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit. (Jane pays 0%, her plan pays 100%.)

Preauthorization: A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Preferred Provider: A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Primary Care Provider: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

UCR (Usual, Customary and Reasonable): The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care: Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Annual Notices

Health Insurance Portability and Accountability Act (HIPAA)

For purposes of the health benefits offered under the Plan, the Plan uses and discloses health information about you and any covered dependents only as needed to administer the Plan. To protect the privacy of health information, access to your health information is limited to such purposes. The health plan options offered under the Plan will comply with the applicable health information privacy requirements of federal regulations issued by the Department of Health and Human Services. The Plan's privacy policies are described in more detail in the Plan's Notice of Health Information Privacy Practices or Privacy Notice. Plan participants in Empowering Abilities-sponsored health and welfare benefit plan are reminded that Empowering Abilities' Notice of Privacy Practices may be obtained by submitting a written request to the Human Resources Department. For any insured health coverage, the insurance issuer is responsible for providing its own Privacy Notice, so you should contact the insurer if you need a copy of the insurer's Privacy Notice.

Newborns' and Mothers' Health Protection Act

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

Notice Regarding Special Enrollment

If you are waiving enrollment in the Medical plan for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in the Medical plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

States with Individual Mandate

Taxpayers in CA, DC, MA, NJ, RI, and VT (this list is neither complete nor exhaustive) are reminded that your state imposes an individual mandate penalty (tax) should you, your spouse, and children choose to not have (and keep) medical/rx coverage for each tax year. Please consult your tax advisor for how a non-election for health coverage may affect your tax situation.

Special Enrollment Rights CHIPRA – Children's Health Insurance Plan

You and your dependents who are eligible for coverage, but who have not enrolled, have the right to elect coverage during the plan year under two circumstances:

- You or your dependent's state Medicaid or CHIP (Children's Health Insurance Program) coverage terminated because you ceased to be eligible.
- You become eligible for a CHIP premium assistance subsidy under state Medicaid or CHIP (Children's Health Insurance Program).
- You must request special enrollment within 60 days of the loss of coverage and/or within 60 days of when eligibility is determined for the premium subsidy.

Genetic Nondiscrimination

The Genetic Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting, or requiring, genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, Empowering Abilities asks Employees not to provide any genetic information when providing or responding to a request for medical information. Genetic information, as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Qualified Medical Child Support Order

QMCSO is a medical child support order issued under State law that creates or recognizes the existence of an "alternate recipient's" right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An "alternate recipient" is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified, and to administer benefits in accordance with the applicable terms of each order that is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer on the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.

Annual Notices continued...

Notice of Required Coverage Following Mastectomies

In compliance with the Women's Health and Cancer Rights Act of 1998, the plan provides the following benefits to all participants who elect breast reconstruction in connection with a mastectomy, to the extent that the benefits otherwise meet the requirements for coverage under the plan:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- coverage for prostheses and physical complications of all stages of the mastectomy, including lymphedemas. The benefits shall be provided in a manner determined in consultation with the attending physician and the patient. Plan terms such as deductibles or coinsurance apply to these benefits

Women's Preventive Health Benefits

The following women's health services are considered preventive. These services generally will be covered at no cost share, when provided in network:

- Well-woman visits (annually and now including prenatal visits)
- Screening for gestational diabetes
- Human papilloma virus (HPV) DNA testing
- Counseling for sexually transmitted infections
- Counseling and screening for human immunodeficiency virus (HIV)
- Screening and counseling for interpersonal and domestic violence
- Breast-feeding support, supplies and counseling
- Generic formulary contraceptives are covered without member cost-share (for example, no copayment). Certain religious organizations or religious employers may be exempt from offering contraceptive services.

Uniformed Services Employment and Reemployment Rights 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 (including spouse) for up to 24 months while in the military. Even if you do not 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 for pre-existing conditions except for service-connected injuries or illnesses.

Mental Health Parity and Addiction Equity Act of 2008

This act expands the mental health parity requirements in the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Services Act by imposing new mandates on group health plans that provide both medical and surgical benefits and mental health or substance abuse disorder benefits. Among the new requirements, such plans (or the health insurance coverage offered in connection with such plans) must ensure that: the financial requirements applicable to mental health or substance abuse disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance abuse disorder benefits.

Notice to Covered Members

The plans you have selected through your employer-provided employee benefits program are insured by the carrier listed on the confirmation statement or are self-funded plans and the listed carriers is the Plan's claims payer. Administrative services for the billing and collection of premiums from your plan sponsor for the insurance coverages are provided by AP Benefit Advisors, LLC, a licensed Third Party Administrator, pursuant to the agreement previously entered into by AP Benefit Advisors, LLC and the insurer/claims payer. The insurer/claims payer is responsible for eligibility and benefit determination, payment of claims, and all other services associated with your coverage.

COBRA

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, COBRA qualified beneficiaries (QBs) generally are eligible for group coverage during a maximum of 18 months for qualifying events due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

COBRA coverage is not extended for those terminated for gross misconduct. Upon termination, or other COBRA qualifying event, the former employee and any other QBs will receive COBRA enrollment information.

Qualifying events for employees include voluntary/involuntary termination of employment, and the reduction in the number of hours of employment. Qualifying events for spouses or dependent children include those events above, plus, the covered employee becoming entitled to Medicare; divorce or legal separation of the covered employee; death of the covered employee; and the loss of dependent status under the plan rules.

If a QB chooses to continue group benefits under COBRA, they must complete an enrollment form and return it to the Plan Administrator with the appropriate premium due. Upon receipt of premium payment and enrollment form, the coverage will be reinstated. Thereafter, premiums are due on the 1st of the month. If premium payments are not received in a timely manner, Federal law stipulates that your coverage will be canceled after a 30-day grace period. If you have any questions about COBRA or the Plan, please contact the Plan Administrator.

Please note, if the terms of the Plan and any response you receive from the Plan Administrator's representatives conflict, the Plan document will control.

Health Insurance Marketplace

The Patient Protection Affordability Care Act ("PPACA") was signed into law on March 23, 2010. Under PPACA, individuals are required to have creditable health insurance coverage or pay a penalty (if applicable) to the Internal Revenue Service. This is known as the Individual Mandate. For more information on the details of PPACA please visit https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-workers-and-families.

PPACA created a new way to buy health insurance which is called the Health Insurance Marketplace ("Marketplace"), also known as Exchanges. These Marketplaces are established by each individual state, the federal government or as a partnership between the state and the federal government. Through the Marketplaces, individuals can compare and purchase coverage (with a possible premium subsidy for those qualifying as low income); subsidies are made available as a federal tax credit through the Marketplace for individuals that are not eligible for coverage through their employer.

If you are enrolled in Empowering Abilities' medical plan, then PPACA may have little effect on you. Empowering Abilities' medical plans meet or exceed the minimum coverage requirements set by PPACA. If you are eligible for our plans, you will not be eligible for federal tax credits. You still have the option to visit the Marketplace to see the coverage options available. If you purchase a health plan through the Marketplace instead of purchasing health coverage offered by Empowering Abilities, you will lose any contribution your employer makes for your health coverage, and your payments for coverage through the Marketplace will be made on an after-tax basis.
(See https://www.healthcare.gov/have-job-based-coverage/).

If you are not eligible to enroll in Empowering Abilities' medical plan, you may have a few options to purchase medical coverage. These options, if applicable, may include but are not limited to: your spouse's medical plan, your parent's medical insurance plan (if you are under age 26), or from several insurance companies offered though the Marketplace. If you shop for coverage through the Marketplace, you may be eligible for a federal tax credit and/or subsidy if you qualify as low income. (See also: healthcare.gov).

How Can I Get More Information?

For more information about purchasing medical coverage through the Marketplace please visit healthcare.gov or call 1-800-318-2596.

EMPOWERING ABILITIES

Your Benefits Helpline:

888-381-7269, option 2

empoweringabilities@assuredpartners.com