InspereX Benefits Guide 2024 - 2025

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Life and AD&D

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At InspereX, we strive to provide our employees with a comprehensive, industry-leading benefit package. We appreciate the talented individuals who work here and their extraordinary effort and uncompromised commitment. Just as we ask you to make these commitments to the Company, we are committed to rewarding your hard work and dedication with the quality and flexibility you seek in your benefits.

InspereX

PLAN
BASICS

Eligibility

If you are a full-time employee working 30 hours or more per week, you are eligible for all benefits outlined in this summary. Eligible employees may elect to cover a spouse/domestic partner, dependent child(ren), or their entire family. For medical coverage, dependent child(ren) can be covered until the end of the year in which the adult child reaches the age of 26 (or in accordance with state regulations). Benefits are effective for new employees the first of the month following date of hire and renew for all employees on November 1st of each year.

Open Enrollment

Each year, during Open Enrollment, you may change coverage elections for you and your dependents. Open Enrollment is typically held each October with benefits becoming effective on November 1st.

Life Events and Plan Changes

You may make changes to your coverage elections (outside of your initial eligibility or Open Enrollment period) only if you experience a Qualifying Event such as: the birth/adoption/legal custody of a child; marriage; divorce; death of covered dependent; eligibility change in work hours or location for yourself or your spouse/domestic partner; loss of any other coverage for you or your dependents. Your request for coverage changes must be made within 30 days of the event.

Section 125 Plan

We participate in a Cafeteria Plan under IRS Section 125 which allows any premium portion you pay toward the cost of your medical and dental plans to be deducted on a pre-tax basis. The elections you make at initial eligibility or Open Enrollment may not be changed unless you experience an eligible Qualifying Event.

Insurance Terms

Copay/Copayment

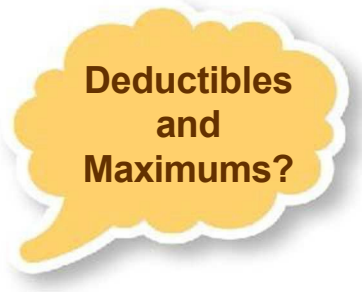
A copay is a fixed dollar amount that a plan member pays to a participating network doctor, caregiver, or other medical provider or pharmacy each time health care services are received.

Coinsurance

Coinsurance is the amount that you are obliged to pay for covered medical services after you've satisfied any co-payment or deductible required by your health insurance plan.
Coinsurance is part of certain health care plans.

Deductible

A deductible is the amount you owe for health care services each year before the insurance company begins to pay. Deductibles are part of certain health care plans and based on a member's specific benefit period. CYD = Calendar Year Deductible



Out of Pocket Maximum

Out of pocket maximum is the highest dollar amount you will need to pay during your benefit period for covered medical services from network providers. See your plan benefit for a list of services included.

Network (or Provider Network)

Network, or Provider Network, speaks to the doctors, hospitals and other health care providers that participate in contract agreements. You will always receive the highest level of benefits when using providers that participate in your specific network. Choosing services from providers that do not participate in your particular provider network will increase the amount that you pay for those services.

InspereX

CORE
PLANS

Medical Plans

InspereX's medical plans offer a great deal of flexibility for you to manage the care for you and your family. The plans are offered through Cigna and the charts below provide a side-by-side comparison of the Cigna plans available to you. All plans are open access, therefore, referrals to specialists are not required. All plans offer national coverage and have out of network coverage available.

Plan Features	OAP	HDHP 1	HDHP 2
	In-Network	In-Network	In-Network
Calendar Year Deductible (CYD)	$750 EE only $1,500 All Others	$2,500 EE only $5,000 All Others	$1,600 EE only $3,200 All Others
Co-Insurance	20%	100%	20%
Physicians Well Visit	No Charge	No Charge	No Charge
Physicians Office Visit	$20 co-pay	Deductible Only	20% after CYD
Specialist Office Visit	$40 co-pay *Open Access*	Deductible Only *Open Access*	20% after CYD *Open Access*
Provider Services at Hospital & ER	20% after CYD	Deductible Only	20% after CYD
Inpatient Hospital	20% after CYD	Deductible Only	20% after CYD
Out-Patient Surgery	20% after CYD	Deductible Only	20% after CYD
Out-Patient Major Diagnostic (e.g. MRI, MRA, PET, CT)	$150 co-pay	Deductible Only	20% after CYD
Emergency Room	$200 co-pay	Deductible Only	20% after CYD
Urgent Care Center	$45 co-pay	Deductible Only	20% after CYD
Prescription Drugs			
Rx Deductible	N/A	Deductible Only	CYD
Retail	$10/$30/$50	Deductible Only	$10/$30/$50
Mail Order	$20/$80/$140	Deductible Only	$25/$75/$125
Out of Pocket Maximum	$2,500 EE only $5,000 All Others	$2,500 EE only $5,000 All Others	$5,000 EE only $10,000 All Others
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Out of Network Deductible	$750 EE only $2,250 All Others	$5,000 EE only $10,000 All Others	$3,000 EE only $6,000 All Others
Out of Network Co-Insurance	40%	20%	40%
Out of Network Out of Pocket maximum	$5,000 EE only $10,000 All Other	$10,000 EE only $20,000 All Other	$10,000 EE only $20,000 All Others

***Please Note: For the HDHP1 and HDHP 2 plans only, employees will receive a corresponding Health Savings Account (HSA) to help offset the cost of medical services. InspereX contributes $1,500 for employee only and $3,000 for all other coverage (EE/Spouse, EE/Child, and Family) levels annually towards members' HSA bank accounts.**

HSA accounts are administered by HealthEquity.

Important Tips for Your Medical Plan

Primary Care Physicians

When beginning the journey of complete healthcare, it is important to have a guide. A guide that knows you, your medical history, your best interests and your need for care. You can look to your primary care physician (PCP) to be your guide.

PCPs typically work in the fields of family medicine, general internal medicine or general pediatrics. While not required, PCPs provide an efficient way to access care, and having a PCP can help minimize trips to the emergency room and urgent care center. In addition, having a PCP means you have chosen a health care professional with whom you are comfortable. From prevention to diagnosis, to specialty care and rehabilitation, your PCP will advocate your personal needs and coordinate your care.

In-Network Care

Cigna has a strong network of quality providers located in the communities where you live and work. All of the plans are open access so referrals are not required when you want to see a specialist. When you seek medical services from participating provider, you receive a higher level of benefits. This means when you use an in-network provider, you substantially reduce the amount you pay for medical services. Participating providers also take care of filing your claim directly. To find a participating provider for your plans please visit: www.myCigna.com

Out-of-Network Care

Under the Cigna plans, you may choose to receive care from a provider that is not a network provider, however you will receive a lower level of benefits. Your benefits are based on the amount that is considered reasonable and customary and you are responsible for any amount about the allowed charges. For certain services, coverage is limited to in-network only.

Wellness and Healthy Living

InspereX strongly believes in the importance of preventive care and wellness measures. Our medical plans cover many adult and child wellness tests and screenings at 100% when you receive these services from a participating in-network provider.

Make the most of your preventive health coverage:

- Annual physical for early detection and prevention
- Annual screenings for Cancer, Diabetes and Heart Disease
- Routine immunizations for children and flu vaccines for adults

Your doctor will determine the tests that are right for you based on your age, gender and family history.

Important Tips for Your Medical Plan

Choosing the appropriate place of care ensures prompt medical attention and lower costs

Primary Care Doctor

For most illnesses or injuries, the best choice for medical care may be a visit to your general practitioner or primary care physician. Your regular doctor knows you best, has your medical history, and has the expertise to diagnose and treat most conditions. For most illnesses and injuries, and for regular checkups and preventive care, your doctor can provide the most cost-effective care.

Urgent Care or Walk-in Clinic

Many situations require immediate care that you might not be able to receive in your doctor's office, yet these situations might not be serious enough to require the services of a hospital emergency room. In these situations, a walk-in clinic or urgent care center may be an appropriate choice.

Walk-in clinics or convenience care clinics are often located within your neighborhood drug store, and are set up to offer treatment for common, minor cases such as ear infections, and sore throats. These clinics also offer preventive services such as flu shots and vaccines.

Urgent care centers are designed to handle those less serious medical conditions that still require immediate treatment but aren't life-threatening or emergencies. Urgent care clinics have more staff than walk-in clinics, can provide X-rays, administer IVs, and treat minor to moderately severe trauma for non-life-threatening conditions such as broken bones or deep lacerations.

Below are some guidelines for determining when going to an urgent care center is appropriate.

- You have telephoned your doctor or nurse practitioner and he or she recommends that you go to an urgent care center.
- Your symptoms or injury have occurred outside of your physician's regular office hours and are too severe to wait until the next regular office hours, yet they are not severe enough to warrant a visit to the emergency room.
- You do not have a regular doctor or primary care physician.
- You are out of town.
- You are unable to reach your doctor or nurse practitioner by phone.

Remember, care received in an urgent care facility is more costly than a doctor visit, yet it is much less expensive than an emergency room. Your best choice for non-urgent situations, however, is always a scheduled appointment with your doctor.

Emergency Room Care

A visit to the hospital emergency room is the most expensive type of outpatient care. Emergency rooms should only be used for true emergencies, as they are staffed, equipped and best suited for medical emergencies. Going to an emergency room for non-emergency care is a poor use of your health benefits and can be very costly.

Some examples of situations where emergency room care is appropriate are as follows:

- A major injury, such as a broken bone
- A wound that continues to bleed vigorously despite application of pressure
- Decreased mental activity or awareness, or disorientation
- Shortness of breath
- A cold sweat accompanied by chest pain, abdominal pain or lightheadedness
- Severe pain

The next time you are faced with deciding where to go to receive medical care, be sure to evaluate all your options and choose the setting that best suits your illness or injury. Of course, in a true emergency, seek the appropriate care without delay. Choosing the most cost-effective options will go a long way toward ensuring that your employer can continue to provide you and your family with the quality, affordable health benefits you rely on.

Health Savings Account (HSA)

An HSA is a great way to set aside tax-free money for your healthcare expenses. If you have chosen a high deductible health plan (HDHP), you have to pay a certain amount out of your own pocket before your health plan covers your expenses. With an HSA, you can set aside money from each paycheck tax-free to cover your deductible and other out-of-pocket expenses. Besides paying for your healthcare, an HSA has other advantages you will want to consider:

- Reduces your taxable income. You pay no federal taxes on the money you put into your HSA, so you keep more of your paycheck.
- The money always belongs to you. Any money you put into an HSA, earns interest - a lot or a little - depending on the type of account your employer chooses, the investments you choose, and your balance. All the interest earned is tax-free too.
- You control the money. You decide how to invest the funds, including any amounts your employer contributes.
- You can save the money for future needs. Even if you don't use a lot of healthcare services now, your HSA funds will be there if you need them in the future – even retirement. If you never need the money, it goes to your heirs.
- It's easy to use the funds. Further gives you a debit card that lets you take money out of your HSA for medical expenses without the hassle of reimbursement forms.

1. How much can I contribute to an HSA? The maximum amount you, your employer and anyone else can contribute to your HSA in any year is established by the IRS. For 2025 the IRS limits are $4,300 for individual coverage and $8,550 for family coverage.

2. When can I make "catch-up" contributions to an HSA? If you are 55 or older, or turning 55 during the calendar year, you can make additional "catch-up" contributions to your HSA. The "catch-up" contribution is $1,000. If you have high deductible health plan (HDHP) coverage for the full year, you can make the full catch-up contribution regardless of when your 55th birthday falls during the year. If you do not have HDHP coverage for the full year, you must prorate your catch-up contribution for the number of full months you were eligible, i.e., had HDHP coverage. However, if you are covered on December 1, you're treated as an eligible individual for that entire year and can make the full contribution, provided you also elect the HDHP for the following year.

3. Can I also put money in a Medical Flexible Spending Account (FSA)? No. The general medical FSA plan offered does not allow you to have both an HSA and medical FSA account for medical expenses.

4. Does all the money I contribute need to be in my HSA before I can use it? Yes, you can only withdraw funds that have accrued in the account. You may also choose to reimburse yourself from the account for qualifying expenses once funds have been deposited.

5. What qualifies as an HSA expense? Some IRS-approved expenses are: diabetic supplies, eye exams, eyeglasses, contact lenses and solution, hearing aids, orthodontia, dental cleanings and fillings, physical therapy, speech therapy and chiropractic expanses. For a sample list of IRS-approved expenses click here. Over the counter medications such as pain relievers, cough syrup and allergy medications are also eligible without a prescription for reimbursement. Be sure to save all receipts and prescriptions for your records.

Flexible Spending Account (FSA)

An FSA is a great way to set aside tax-free money for your healthcare expenses or dependent care. With an FSA, you can set aside money from each paycheck tax-free to cover your deductible and other out-of-pocket expenses including co-pays, prescriptions, glasses, contacts and dental expenses.

Besides paying for your healthcare, an FSA has other advantages you will want to consider:

- Reduces your taxable income. You pay no federal taxes on the money you put into your FSA, so you keep more of your paycheck.
- It's easy to use the funds. Chard Snyder gives you a debit card that lets you take money out of your FSA for qualified expenses without the hassle of reimbursement forms.
- Not just for medical expenses. You also have the option to put funds aside for eligible dependent care expenses throughout the year.
- **Don't let your funds expire.** Unused funds in your FSA Medical and Dependent Care accounts can expire. See the plan summary for terms and conditions.

1. How much can I contribute to an FSA? The maximum amount you, your employer and anyone else can contribute to your FSA in any year is established by the IRS. The IRS contribution limits for 2024 are $3,200 for medical expenses and up to $5,000 for dependent care, with limits for 2025 pending final announcement.

2. Who is eligible for a Dependent Care Account? Employees who have a dependent under age 12 and the care is necessary to allow the parents to work or attend school Full Time, or if they are unable to care for their children.

3. Can I also put money in a Health Savings Account (HSA)? No. The general FSA plan offered does not allow you to have both an FSA and HSA account for medical expenses. You can enroll for a dependent care account if you are enrolled into a HSA; refer to the plan documents for specific information.

4. What qualifies as an FSA expense? Some IRS-approved expenses are: diabetic supplies, eye exams, eyeglasses, contact lenses and solution, hearing aids, orthodontia, dental cleanings and fillings, physical therapy, speech therapy and chiropractic expanses. For a sample list of IRS-approved expenses visit the IRS website. Over the counter medications such as pain relievers, cough syrup and allergy medications are also eligible without a prescription for reimbursement.. Be sure to save all receipts and prescriptions for your records. Dependent care qualified expenses: daycare, after school activities, nursery school, summer day camp and elder care are some examples.

Dental

Staying healthy includes quality routine dental care for you and your family. InspereX's dental plan is through Principal Financial Group. The plan provides coverage for services ranging from routine check-ups to more serious dental work. With your PPO dental plan you have the flexibility to choose in-network and out-of-network dental providers. If you choose an in-network provider from Principal's network, you will see savings based on contracted negotiated rates with these providers.

Plan Features	PPO	
	In-Network	Out-Network
Calendar Year Deductible	$0 EE Only $0 All Other	$25 EE Only $50 All Other
Office visit co-pay	N/A	N/A
Sample of Services:		
Type 1 – Preventative		
Cleaning	No Charge	100%
Frequency	Once every 6 months	Once every 6 months
Oral Exams	No Charge	No Charge
Sealants (per tooth)	No Charge	No Charge
X-rays	No Charge	No Charge
Type 2 – Basic		
Fillings	No Charge	20%
Perio Surgery	No Charge	20%
Periodontal Maintenance	No Charge	20%
Frequency	Once every 24 months	Once every 6 months
Root Canal	No Charge	20%
Scaling & Root Planing (per quadrant)	No Charge	20%
Simple Extractions (per tooth)	No Charge	20%
Surgical Extractions (per tooth)	No Charge	20%
Type 3 – Major		
Bridges and Dentures	40%	50%
Inlays, Onlays, Veneers	40%	50%
Repair & Maintenance of Crowns, Bridges& Dentures	40%	50%
Single Crowns	40%	50%
Orthodontia	Children 50%; $1,000 lifetime maximum benefit	
Calendar Year Maximum	$1,500	

InspereX Holdings LLC

40% OFF
additional complete pair of prescription eyeglasses

20% OFF
non-covered items, including non-prescription sunglasses

Find an eye doctor
(Select Network)

- 866.299.1358
- eyemed.com
- EyeMed Members App
- For LASIK, call 1.800.988.4221

Heads Up
You may have additional benefits. Log into **eyemed.com/member** to see all plans included with your benefits.

SUMMARY OF BENEFITS

VISION CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
EXAM SERVICES		
Exam	$10 copay	Up to $35
CONTACT LENS FIT AND FOLLOW-UP		
Fit and Follow-up - Standard	Up to $40	Not covered
Fit and Follow-up - Premium	10% off retail price	Not covered
FRAME		
Frame	$0 copay; 20% off balance over $120 allowance	Up to $48
LENSES		
Single Vision	$25 copay	Up to $25
Bifocal	$25 copay	Up to $40
Trifocal	$25 copay	Up to $60
Lenticular	20% off retail price	Not covered
Progressive - Standard	$25 copay; 20% off retail price less $55 allowance	Up to $40
Progressive - Premium	$25 copay; 20% off retail price less $55 allowance	Up to $40
LENS OPTIONS		
Anti Reflective Coating - Standard	20% off retail price	Not covered
Anti Reflective Coating - Premium	20% off retail price	Not covered
All Other Lens Options	20% off retail price	Not covered
CONTACT LENSES		
Contacts - Conventional	$0 copay; 15% off balance over $135 allowance	Up to $95
Contacts - Disposable	$0 copay; 100% of balance over $135 allowance	Up to $95
Contacts - Medically Necessary	$0 copay	Up to $200
OTHER		
Hearing Care from Amplifon Network	Up to 66% off hearing aids; call 1-877-203-0675	Not covered
LASIK or PRK from U.S. Laser Network	15% off retail or 5% off promo price; call 1.800.988.4221	Not covered
FREQUENCY	**ALLOWED FREQUENCY - ADULTS**	**ALLOWED FREQUENCY - KIDS**
Exam	Once every 12 months from the date of service	Once every 12 months from the date of service
Lenses	Once every 12 months from the date of service	Once every 12 months from the date of service
Frame	Once every 24 months from the date of service	Once every 24 months from the date of service
Contact Lenses	Once every 12 months from the date of service	Once every 12 months from the date of service

(Plan allows the member to receive either contacts and frame, or frame and lens services.)

Fees charged by a Provider for services other than a covered benefit and any local, state or Federal taxes must be paid in full by the Insured Person to the Provider. Such fees, taxes or materials are not covered under the Policy. Allowances provide no remaining balance for future use within the same Benefit Frequency. Some provisions, benefits, exclusions or limitations listed herein may vary by state. No benefits will be paid for services or materials connected with or charges arising from: medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures; Refraction, when not provided as part of a Comprehensive Eye Examination; services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; any Vision Examination or any corrective Vision Materials required by a Policyholder as a condition of employment; safety eyewear; solutions, cleaning products or frame cases; non-prescription sunglasses; plano (non-prescription) lenses; plano (non-prescription) contact lenses; two pair of glasses in lieu of bifocals; electronic vision devices; services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer. Member receives a 20% discount on items not covered by the plan at In-Network locations. Discount does not apply to Provider's professional services or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see the online provider locator to determine which participating providers have agreed to the discounted rate. Discounts on vision materials may not be applicable to certain manufacturers' products. The Plan reserves the right to make changes to the products on each tier and to the member out-of-pocket costs. Fixed tier pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. Services and amounts listed above are subject to change at any time. Discounts are not insured benefits. Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, Policy number VC-19, form number M-9083, or Policy number VC-146, form number M-9184, in New York underwritten by Fidelity Security Life Insurance Company of New York, Policy Number VCN-1, form number MN-1, or Policy Number VCN-19, form number MN-28.

Ready to live your best EyeMed life?

There's so much more to your vision benefits than copays and coverage. Get ready to see the good stuff for yourself.

Your network is the place to start

See who you want, when you want. You have thousands of providers to choose from – independent eye doctors, your favorite retail stores, even online options.

Keep your eyes open for extra discounts*

Members already save an average 76% off retail using their EyeMed benefits,[1] but our long list of special offers takes benefits even further.

Remember, you're never alone

We're always here to help you use your benefits like a pro. Stay in-the-know with text alerts or healthy vision resources from the experts. If it can make benefits easier for you, we do it.

*Discounts are not insurance. Available at participating providers.

[1] Based on weighted average of sample transactions: EyeMed Insight network/$10 exam copay/$10 materials copay/$150 frame or contact lens allowance. 2021 EyeMed Commercial BOB stats.

Create a member account at eyemed.com/member

Everything is right there in one spot. Check claims and benefits, see special offers, estimate costs and find an eye doctor – search for one with the hours, location and brands you want. For maximum mobility, try the EyeMed App (Google Play or App Store).

This information is available broadly and is not plan or state specific.

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION EST. 1961 TARGET OPTICAL

PDF-2301-M-651

Life and Accidental Death and Dismemberment (AD&D) Insurance

These plans are offered through Mutual of Omaha

Group Life and AD&D

Life and AD&D insurance is an important part of your financial well-being, especially if others depend on you for support. For that reason, InspereX provides each employee two times your basic annual salary/draw up to $500,000 of both Group Life and Accidental Death and Dismemberment (AD&D) at no cost to you. Please refer to your plan documents for complete details of this coverage.

Voluntary Life and AD&D

You also have the option to purchase additional Voluntary Term Life Insurance and AD&D in $10,000 increments for you up to a maximum amount that is the lesser of five times your base salary/draw or $500,000. Upon initial employment, guaranteed issue on this coverage is $150,000, meaning that election above this amount will be subject to medical underwriting.

Additional coverage is available in $5,000 increments for your spouse up to a maximum amount that is the lesser of 50% of your voluntary elected coverage amount or $150,000. Upon initial employment, guaranteed issue on this coverage is $30,000; any election above this amount will be subject to medical underwriting. You may also purchase coverage for your dependent child(ren); the guaranteed issue and maximum coverage per child is $10,000. Please refer to the plan documents for complete details for this coverage. Rates for each type of coverage are detailed in the Payroll Deductions section of this guide.

Disability Insurance

These plans are offered through Mutual of Omaha

Short Term Disability Coverage

Temporary loss of income due to an illness or injury can take a financial toll. For this reason, InspereX provides each employee Short Term Disability protection. This coverage will replace 60% of your weekly salary/draw to a maximum of $2,500 per week. This benefit begins immediately following an injury or on the 8th day of an illness and continues for 13 weeks. Please refer to the plan documents for complete details for this coverage.

Long Term Disability Coverage

Employees often do not consider the financial hardship that can occur as a result of being disabled. With this in mind, InspereX provides Long Term Disability protection to each employee. This plan will replace 60% of your base salary/draw up to $10,000 per month and continue until 65 or normal social security retirement age. Please refer to the plan documents for complete details for this coverage.

Payroll Deductions

Below is the cost per pay period.

Medical:

	OAP	HDHP 1	HDHP 2
Employee	$92.50	$80.00	$72.50
Employee + Spouse	$305.00	$300.00	$250.00
Employee + Child(ren)	$230.00	$220.00	$182.50
Employee + Family	$392.50	$372.50	$317.50

Dental:

	DPPO
Employee	$5.00
Employee + Spouse	$15.00
Employee + Child(ren)	$17.50
Employee + Family	$25.00

Vision:

	Vision
Employee	$1.50
Employee + Spouse	$3.00
Employee + Child(ren)	$3.00
Employee + Family	$4.00

Payroll Deductions

Below is the formula to calculate your cost per pay period.

Voluntary Life Insurance - Employee (semi-monthly cost)

1 Unit = $10,000

The maximum number of units is 50 ($500,000).

Rates = Cost per Unit x Number of Units

Employee – Uni-Smoker	Cost Per Unit
<25	$0.34
25-29	$0.34
30-34	$0.34
35-39	$0.44
40-44	$0.69
45-49	$0.99
50-54	$1.79
55-59	$2.93
60-64	$3.19
65-69*	$5.89
70-74*	$12.14
75-79*	$34.34
80+*	$76.29

*35% reduction of benefits at age 70 and an additional 15% reduction at age 75

Payroll Deductions

Below is your cost per pay period.

Voluntary Life Insurance - Spouse (semi-monthly cost)

1 Unit = $5,000

The maximum number of units is 30 ($150,000).

Rates = Cost per Unit x Number of Unit. Spouse rates are based on EMPLOYEE age and smoking status.

Spouse Uni-Smoker	Cost Per Unit
<25	$0.17
25-29	$0.17
30-34	$0.17
35-39	$0.22
40-44	$0.35
45-49	$0.50
50-54	$0.90
55-59	$1.47
60-64	$1.60
65-69*	$2.95
70-74*	$6.07
75-79*	$17.17

* See benefit summary for benefit reduction schedule

Voluntary Life Insurance – Dependent Child (semi-monthly cost)

1 Unit = $2500

The maximum number of units is 4 ($10,000).

Coverage Amount	$10,000
Per Pay Period Cost	$1.00

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SUPPLEMENTAL **PLANS**

CIGNA SUPPLEMENTAL HEALTH BENEFITS

Benefit Guide Template

All eligible employees will have the opportunity to enroll in Cigna's Supplemental Health plans. An unexpected illness or injury can disrupt every facet of your life, including your physical, emotional and financial well-being. Regular expenses, big and small, can add up. These voluntary benefits are designed to help strengthen your overall benefits package and provide additional protection for you and your family through **fixed benefits paid directly to YOU**.

Key Features to Consider:

- **Flexible.** Use the money however you want. Pay for anything you need – medical deductibles, child care, groceries, etc.
- **Supplement your medical plan.** Benefits are paid in addition to other coverage you may have.
- **Cost effective.** Your premium is conveniently deducted from your paycheck at a low group rate.

ACCIDENTAL INJURY INSURANCE

Pays a fixed cash benefit directly to you[1] when you have a covered accident-related injury, like an ankle sprain or arm fracture.

Accidental Injury Benefit Example

Situation: Chloe broke her leg playing soccer.[2]

Chloe's covered benefits:

- Doctor's office visit
- Diagnostic exam (X-ray)
- Broken leg
- Physical therapy sessions

Accidental Injury benefit paid directly to Chloe: $1,200

CRITICAL ILLNESS INSURANCE

Pays a fixed, lump-sum cash benefit directly to you[1] when you are diagnosed with a covered health condition, such as a heart attack or stroke.

Critical Illness Benefit Example

Situation: Marco had a heart attack while raking leaves.[2]

Marco's covered benefits:

- Heart attack diagnosis

Critical Illness benefit paid directly to Marco: $10,000

HOSPITAL CARE INSURANCE

Pays a fixed cash benefit directly to you[1] when you experience a covered hospital[3] stay, for events like an in-patient procedure or childbirth.

Hospital Care Benefit Example

Situation: Susan was hospitalized[2] following a car accident.

Susan's covered benefits:

- Hospital admission
- Hospital ICU stay
- Hospital stay

Hospital Care benefit paid directly to Susan: $2,000

- **Please refer to the plan overviews below for more details:**
- Accidental Injury Insurance
- Critical Illness Insurance
- Hospital Care Insurance

Together, all the way.®

Cigna®

Accident Plan: Payroll Deductions

Employee's Semi-Monthly Cost of Coverage:

Tier	Plan 1	Plan 2
Employee	$2.48	$4.29
Employee and spouse	$4.51	$7.89
Employee and child(ren)	$5.88	$10.45
Family	$7.91	$14.05

Costs are subject to change. Actual per pay period premiums may differ slightly due to rounding.

Critical Illness Plan: Payroll Deductions

Employee's Semi-Monthly Cost of Coverage:

Benefit Amount: $10,000

Age	Employee	Employee + Spouse	Employee + Children	Employee + Family
<25	$1.79	$3.71	$3.94	$5.86
25 to 29	$1.99	$4.14	$4.14	$6.29
30 to 34	$2.34	$4.88	$4.48	$7.03
35 to 39	$3.16	$6.66	$5.31	$8.81
40 to 44	$4.10	$8.68	$6.25	$10.83
45 to 49	$5.70	$12.11	$7.85	$14.27
50 to 54	$7.60	$16.21	$9.75	$18.36
55 to 59	$10.69	$22.84	$12.84	$24.98
60 to 64	$13.52	$28.93	$15.67	$31.07
65 to 69	$17.65	$37.80	$19.80	$39.95
70 to 74	$23.01	$49.32	$25.15	$51.47
75 to 79	$29.94	$64.23	$32.09	$66.38
80 to 84	$35.44	$76.06	$37.59	$78.21
85 to 89	$46.65	$100.16	$48.80	$102.31
90 to 94	$46.65	$100.16	$48.80	$102.31
95+	$46.65	$100.16	$48.80	$102.31

Benefit Amount: $20,000

Age	Employee	Employee + Spouse	Employee + Children	Employee + Family
<25	$3.58	$7.42	$7.88	$11.72
25 to 29	$3.98	$8.27	$8.28	$12.57
30 to 34	$4.67	$9.76	$8.96	$14.05
35 to 39	$6.32	$13.31	$10.62	$17.61
40 to 44	$8.20	$17.36	$12.50	$21.66
45 to 49	$11.39	$24.22	$15.70	$28.53
50 to 54	$15.20	$32.41	$19.50	$36.71
55 to 59	$21.38	$45.67	$25.67	$49.96
60 to 64	$27.04	$57.85	$31.33	$62.14
65 to 69	$35.29	$75.60	$39.59	$79.90
70 to 74	$46.01	$98.64	$50.30	$102.93
75 to 79	$59.88	$128.46	$64.18	$132.76
80 to 84	$70.88	$152.11	$75.18	$156.41
85 to 89	$93.30	$200.32	$97.60	$204.62
90 to 94	$93.30	$200.32	$97.60	$204.62
95+	$93.30	$200.32	$97.60	$204.62

Costs are subject to change. Actual per pay period premiums may differ slightly due to rounding.
The policy's rate structure is based on attained age, which means the premium can increase due to the increase in your age.

cigna healthcare

Hospital Plan: Payroll Deductions

Employee's Semi-Monthly Cost of Coverage:

Tier	Plan 1
Employee Only	
0-49	$6.39
50-59	$6.12
60-69	$8.43
70+	$52.05
Employee & Spouse	
0-49	$15.87
50-59	$14.78
60-69	$22.38
70+	$108.62
Employee & Child(ren)	
0-49	$11.33
50-59	$11.06
60-69	$13.38
70+	$57.00
Employee & Family	
0-49	$20.81
50-59	$19.73
60-69	$27.33
70+	$113.57

Costs are subject to change. Actual per pay period premiums may differ slightly due to rounding. The policy's rate structure is based on attained age, which means the premium can increase due to the increase in Your age.

cigna healthcare

InspereX

ANCILLARY **PLANS**

Sam℠

On-demand, virtual care designed for you.

Sam by UCM Digital Health

Convenient care where and when you need it...

Your health always deserves the best.

24/7 On-Demand Access

Our integrated care team, including medical providers, mental health providers, and care coordinators, works together to treat your physical and mental health needs.

We take a holistic view of your health to ensure that you are getting high-quality, coordinated care.

Virtual Care For

- Urgent care
- Emergency care
- Primary care
- Mental health care

Download the "Sam by UCM" Mobile App

www.sambyucm.com
1-844-4-VIP-DOC

Board-certified providers ready to care for you.

Sam℠

Primary Care

Ongoing care to address a range of primary care needs to help you **get well and stay well.**

- Wellness visits
- **Routine Screenings for H**ypertension, Diabetes, & more
- Age-appropriate screenings, e.g. mammograms, colonoscopies, and more
- **Labs** for cholesterol, blood sugar, & more
- Smoking cessation
- Chronic disease management

Urgent & Emergency Care

A convenient, cost-effective alternative to going to urgent care or to the emergency room. Get treated within minutes, not hours.

UCM does not turn any patients away. We are proud to treat a wide range of complex conditions and injuries, including, but not limited to:

- Upper respiratory infection
- Urinary tract infection
- Cough, sore throat, or flu
- Abdominal pain
- Rashes or Pink eye
- Nausea, vomiting, or diarrhea
- Headaches
- COVID-19
- Ear problems

Mental Health Care

Unlimited, confidential consults with Masters and Ph.D. level trained counselors.

- Anxiety and Depression
- Alcohol or drug abuse
- Child or family issues
- Caring for the Caregiver
- Marital or relationship issues
- Parenting
- Grief
- Sexual, physical, or mental abuse

Our Benefits

- Easy to access via phone, mobile app, or online.
- Cost-effective and convenient.
- Concierge service from a care coordinator to handle follow-ups like prescriptions, labs, and referrals when needed. We even follow up with each patient after a consult to see how they are doing!
- Access to "Up to Date", evidence-based clinical information to learn more about health topics directly on the app.

www.sambyucm.com
1-844-4-VIP-DOC

Sam

Download the "Sam by UCM" Mobile App

Thank you for trusting us with your health!

UCM DIGITAL HEALTH

MAKE UCM DIGITAL HEALTH YOUR FIRST STOP FOR *ALL* OF YOUR HEALTHCARE NEEDS.

PRIMARY CARE

- Wellness visits
- Routine preventive screenings
- Labs and imaging
- Smoking cessation
- Weight management
- Nutrition counseling
- Chronic disease management

AND MORE!

- Emergencies, injuries, and illnesses*
- Urinary tract infections
- COVID-19, the flu, and upper respiratory infections
- Dermatology
- School or work notes
- Prescription refills and referrals

**Treatment provided for any emergencies deemed as non-life threatening.*

1-844-4-VIP-DOC

WWW.GOSEESAM.COM

We hope that you continue to see us for your ongoing primary care needs, and more!

Benefits of virtual primary care with UCM Digital Health:

- **Fast:** Appointments available within days, not weeks
- **High quality:** Dedicated time with a board-certified provider
- **Saves time:** Connect with a provider within minutes from the comfort of your home
- **Saves money:** Lower cost than an in-person office visit
- **Simplifies follow-up:** Care coordinators handle follow-ups for you, including referrals and more

DOWNLOAD THE "SAM BY UCM" MOBILE APP!

GET IT ON Google Play

Download on the App Store

TELEHEALTH FOR YOU.

Physical and mental health go hand in hand. Sam is here to help.

Access to mental health counseling is in the palm of your hand with Sam, the telehealth app from UCM Digital Health.

You now have access to confidential mental health counseling and care coordination through UCM's telehealth service.

This service is to help you manage your overall well-being and is available to you and your immediate family members for help with:

- Alcohol and drug abuse
- Anxiety and depression
- Child and family issues
- Dealing with change
- Parenting and elder care
- Healthy living practices
- PTSD
- And more.

Available 24/7 via phone, mobile app or website

Confidential, treated by mental health clinicians

Paid for by employer, no co-pay or out-of-pocket cost.*

Ongoing care, direct referrals for further levels of care

Convenient access on mobile device via mobile app

Remember, mental health is part of overall well-being. Download the Sam app today, and have access to mental health counseling in the palm of your hand, anytime you need it.

A

SAM BY UCM MOBILE APP

GET IT ON Google Play

Download on the App Store

B

VISIT WWW.GOSEESAM.COM

SCAN CODE

C

CALL US BY PHONE

844-4-VIP-DOC

(844-484-7362)

* HDHP/HSA qualified plans have a $10 consult fee

For life-threatening situations, or if you believe you or another individual is suffering a mental health crisis or other medical emergency, call 9-1-1

09/21

IDX The Privacy Platform

InspereX

Complete Identity Theft and Privacy Protection

Don't sweat identity and privacy risks.

You're busy enough, the last thing you need to worry about is protecting your identity and your privacy. That's why we're here. More than 40 million Americans trust IDX™ for identity theft and privacy protection. Use IDX — so you can focus on what really matters.

IDX Protection

Select IDX for best-in-class identity theft and privacy protection. Protect you or your family and get peace of mind.

IDX MONITORING

- Tri-bureau credit monitoring
- CyberScan™ dark web monitoring
- Social Security Number trace
- Change in address
- Court records
- Payday loans
- Instant Inquiry Alerts
- VantageScore® 3.0 credit score
- Credit Lock

PRIVACY PROTECTION

- Safe WiFi VPN
- Tracking Blocker
- ForgetMe
- Private Search
- SocialSentry social media protection
- Password Detective
- Lost wallet protection

Expertise and Premier Service

With unlimited access to our team of trained experts, you can rest assured that you'll have the information you need, when you need it.

COMPLETE IDENTITY RECOVERY

With limited power of attorney our care team can act on your behalf, saving you stress and time.

$1 MILLION INSURANCE

Backed by $1 million insurance, our members can rest easy knowing that they will be reimbursed for any out-of-pocket expenses related to addressing the restoration of their identity.

	Individual Plan	Family Plan
IDX Privacy	**$5.80** /month	**$11.25** /month
IDX Complete	**$11.60** /month	**$22.50** /month

Sign-up during Open Enrollment & **SAVE up to 50%** on IDX*!

*Based on IDX™ retail pricing. Information accurate at time of publication. Subject to Terms of Service.

IDX The Privacy Platform

InspereX

		IDX Privacy	IDX Complete
MONITORING	3B Credit Monitoring		●
	3B Credit report		●
	CyberScan Dark Web	●	●
	Vantage Score		●
	Credit Lock		●
	Instant Inquiry		
	Court Record		●
	Payday Loans		●
	Bank Account & Credit Card Takeover		●
	Change of address		●
	Social Security Trace		●
	MIDAS Medical Claims Monitoring*		●
PRIVACY PROTECTION	Social Media	●	●
	Password Detective	●	●
	Privacy Score	●	●
	Private Search	●	●
	Tracking Blocker	●	●
	ForgetMe	●	●
	Safe WiFi	●	●
INSURANCE**	Personal Expenses		$1M
	Lawyer Expert Coverage		$1M
RECOVERY**	Unlimited Assistance from Recovery Specialists	●	●
	Complete Recovery	●	●
	Limited Power of Attorney	●	●
	Dedicated Recovery Specialist	●	●
	Pre-Existing Conditions Covered	●	●
	Lost Wallet	●	●
SERVICE	Concierge Support	●	●
	Alerts	●	●
	Mobile App	●	●

*Monitoring availability dependent on employer's health plan configuration. ** Identity theft event coverage

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InspereX

InspereX is offering Total Pet Plan to employees.

Your pets are part of your family, and you'll do anything to keep them happy and healthy. But with the cost of pet care on the rise, it isn't always easy.

That's why we're offering **Total Pet Plan**, which makes pet care more affordable. Enroll in Total Pet and get the same high-quality products and services your pets are used to, just at a lower price!

$11.75/month for one pet or
$18.50/month for a family plan

For more details and how to enroll, visit petbenefits.com/land/insperex .

TOTAL PET PLAN INCLUDES:

PETplus

DISCOUNTS ON PRODUCTS & RX

- Up to 40% off on products like prescriptions, preventatives, food, toys and more
- Shipping is always free and same-day pickup is available for most human-grade prescriptions

View available products and pricing at petplusbenefit.com.

Pet Assure

DISCOUNTS ON VETERINARY CARE

- Instant 25% savings on all of your pet's in-house medical services at participating vets
- No exclusions due to age, health, pre-existing conditions or type of pet

Visit petbenefits.com/search to locate a participating vet.

AskVet

24/7 PET TELEHEALTH

- Access real-time vet support, even when your vet's office is closed
- Unlimited support on your pet's health, wellness, behavior and more

PetTag

LOST PET RECOVERY SERVICE

- Durable tag can be scanned from any smart phone to access your contact information, helping lost pets return home quicker than a microchip
- Easily update your information online with no need to request a new tag

TOTAL PET PLAN

FREQUENTLY ASKED QUESTIONS

What is Total Pet Plan?

Total Pet Plan brings the best brands in pet care together to create a bundle that covers everything your pets need. Receive benefits from **PetPlus**, **Pet Assure**, **AskVet**, **ThePetTag**, and **PBS Perks** at one low payroll deduct rate.

What does Total Pet cover?

As a Total Pet Plan member, you'll receive:

- PetPlus: Up to 40% off and free shipping on all orders from **PetCareRx.com**
- Pet Assure: 25% savings on in-house veterinary care at participating vets
- AskVet: Chat with a US-based Veterinarian for questions on your pet's health, wellness, behavior and more
- ThePetTag: Durable ID tag that can be scanned if your pet goes missing, bringing them home faster than a microchip
- PBS Perks: exclusive members-only discounts at pet retailers and service providers

Which pets can I enroll?

You can enroll any dog and cat in Total Pet Plan. There are no restrictions due to age, breed or health of your pet. Pet Assure Veterinary Discounts also cover exotic pets.

How do I access my Total Pet benefits?

Log in to your account at **www.petbenefits.com** to access all of your plan benefits.

Is this insurance?

No, with the Total Pet Plan you receive instant savings and pet care services without any paperwork.

Are there any additional fees?

No, your membership cost gives you access to all of your benefits without any additional fees.

Are there usage limitations?

No, Total Pet Plan benefits have unlimited usage for the pets enrolled.*

What happens to my membership if I'm no longer eligible for benefits?

Members who are no longer payroll deduct eligible or are leaving the company can port coverage at the same group rate within 28 days of termination.

The following pages include FAQs on each individual component of Total Pet Plan.

*PBS Perks may have exclusions or limitations based on the individual provider.

PetPlus

What is PetPlus?

Receive members-only pricing (up to 40% off) on products you're already buying for your pets. Products include prescriptions, preventatives, food, treats, toys and more! Shipping is always free and same-day pickup is available for most human-grade prescriptions.

How do I access my PetPlus account after enrolling?

After you enroll, you will receive instructions via mail and email on how to activate your online account. You can start shopping online as soon as you activate your account.

How do I place an order for delivery?

Shop online using your PetPlus membership at **PetCareRx.com**. Savings are automatically applied at checkout and shipping is always free.

How do I pick up my pet's prescription at a pharmacy?

If your pet is prescribed a human-grade medication, ask the vet for a written prescription for your pet's medication. Take your pet's prescription and PetPlus Rx card to any participating pharmacy.

The pharmacist will fill your pet's prescription and PetPlus will charge your credit card on file at the listed member rate. You should NOT be charged at the pharmacy for your purchase.

When do I receive my PetPlus card?

Your PetPlus card is available on your PetPlus dashboard as soon as you activate your account. You can either print out your card at home or show it to the pharmacy right from your mobile device.

Pet Assure

What is Pet Assure?

Pet Assure is a veterinary discount plan that saves you 25% at participating veterinarians on all in-house medical services, no exclusions. Even pre-existing conditions are covered!

How do I use Pet Assure?

When you visit a participating vet, present your Pet Assure member ID card from the Pet Assure app at checkout, and the veterinary staff will apply a 25% discount to all in-house medical services. There is no paperwork or forms to fill out. You can use your savings immediately on your benefit start date.

What procedures are discounted?

Participating veterinarians discount all in-house medical services. This includes the office visit, vaccinations, surgery, dental cleaning, spay and neuter surgery, x-rays and any other procedures the vet performs. Even procedures related to pre-existing conditions are discounted.

Are there any exclusions?

No, there are absolutely no exclusions. All in-house medical services are covered, including wellness, sick and emergency care. You can enroll any type of pet, regardless of type, breed, age or health.

Can I use this together with pet insurance?

Yes. Pet insurance typically only covers major medical claims and often excludes wellness exams or pre-existing conditions. Pet Assure does not have any exclusions and will save you money on the procedures not covered by pet insurance. The Pet Assure savings are instant and can help you save on veterinary care prior to meeting your insurance deductible and while you wait for insurance reimbursement.

Where can I find a list of participating vets in my area?

You can search for participating practices by visiting **www.petbenefits.com/search**. Mention that you're a Pet Assure member when you call to make an appointment.

If a veterinarian you would like to visit does not participate, you can invite them to join by clicking the "Invite to Pet Assure" button. With a few details, you'll have a custom-generated email to send to your vet inviting them to join and providing instructions for them to contact Pet Assure for further details.

AskVet

What is AskVet?

AskVet is 24/7 pet telehealth service that gives you direct access to a veterinarian via live chat.

How do I access AskVet?

Log in to your PetPlus account. Click Connect Now on your PetPlus dashboard to chat with an AskVet Veterinarian.

Can AskVet replace my primary veterinarian?

No, AskVet does not diagnose or prescribe, and is not intended to be used as a replacement for your primary veterinarian.

Who are the veterinarians at AskVet?

AskVet veterinary telehealth specialists are US-based licensed veterinarians trained to help you make the best decisions for your pet.

What can an AskVet veterinarian help me with?

AskVet offers 24/7 decision support on all of your pet care questions and concerns. While AskVet cannot provide a diagnosis or prescribe medication, they can help you decide the best course of action or learn more about managing your pet's existing condition.

ThePetTag

What is ThePetTag?

ThePetTag is a lost pet recovery service that provides your pets with a durable ID tag that's directly linked to your contact information.

How do I request a pet tag?

Once enrolled, log in to your Pet Benefits account and register your pet(s) with Pet Assure. Request a tag for your registered pet(s), and ThePetTag will mail your pet's ID tag in 1-2 weeks.

How does ThePetTag Work?

Scanning your pet's tag with a smartphone provides your public contact information to the individual that finds your pet, getting them home quicker than a microchip! Link main and emergency contacts to your pet's tag without the limits of engraving or fear of illegible ID tags.

ThePetTag's 24/7 pet locator helpline is also available for help contacting a lost pet's family.

How do I update my emergency contact information?

Your address, phone number, and additional emergency contacts can be updated from your Pet Benefit Solutions account or in the Pet Assure app at any time – even after your pet goes missing

PBS Perks

What is PBS Perks?

PBS Perks gives you exclusive discounts at pet retailers and service providers, including subscription boxes, high-end pet products, pet sitting, and more.

How do I access PBS Perks?

Simply log in to your Pet Benefits account, where you'll find details on redeeming members-only deals and pet care savings available only from Pet Benefit Solutions.

InspereX

InspereX is offering Wishbone Pet Insurance to employees.

Nobody wants to imagine their pet getting sick or injured - but when it comes to your pet's health, it's best to expect the unexpected.

Wishbone Pet Insurance is accepted at any vet in the U.S., including emergency hospitals. Our simple online claims process means you get your money back fast, whether it's for routine care or an accident.

Protecting your pet's health and your finances has never been easier!

AVAILABLE WISHBONE PLANS

Wishbone offers different plan options to fit your budget. Enroll in both for maximum coverage.

Accident & Illness Coverage

For the unexpected

- Up to 90% reimbursement
- $250 deductible
- $10,000 annual limit
- Includes 24/7 pet telehealth

Rates based on your pet's age, breed & zip code.

Wellness Coverage

For regular routine visits

ESSENTIAL PLAN	PREMIUM PLAN
Up to $300 in coverage	Up to $575 in coverage
$14/month	$25/month

Coverage is based on a schedule of benefits outlined during enrollment

Get a quote & enroll at **www.wishboneinsurance.com/insperex**

Wishbone Pet Insurance is a pet health insurance program offered by Pet Assure Corp., dba Pet Benefit Solutions, a licensed agency (NJ License Number 1677880). Insurance coverage is administered by Pet Benefit Solutions or Norse Specialty Insurance Company, Inc. and underwritten by Everspan Insurance Company, Providence Washington Insurance Company, Trisura Insurance Company, Clear Blue Insurance Company, or Clear Blue Specialty Insurance Company. Wishbone Wellness is not an insurance policy. Please visit https://www.wishboneinsurance.com/terms-and-conditions for more information.

wishbone

FREQUENTLY ASKED QUESTIONS

General

What is pet insurance?

Pet health insurance is an insurance policy that reimburses you for exam fees, diagnostics, and treatment related to eligible accidents and illnesses.

What is a wellness plan?

Wellness plans provide reimbursement based on a schedule of benefits for certain routine pet care services after paying in full at any vet practice. Wellness plans are not insurance.

My pet is already sick or injured. Can pet insurance help?

Pet insurance, as with all insurance, is for unexpected accidents and illnesses. Unfortunately, pet insurance does not cover pre-existing conditions. However, getting coverage for your pet will cover most future accidents and illnesses, should something happen.

Enrollment

How old does my pet need to be to receive coverage?

Enrollment is available for dogs older than eight weeks old or cats older than ten weeks old. Like children, young dogs and cats have the highest risk of accidents. And because their immune systems aren't mature, they're more susceptible to infectious diseases. Wishbone plans have no upper age limits, so senior dogs and cats get the same great coverage as kittens and puppies.

How do I enroll in Wishbone?

Visit **www.wishboneinsurance.com** to enroll.

Which plan should I enroll in?

Wishbone offers you the option to enroll in accident and illness coverage, wellness coverage, or both. Select the coverage that works best for your pet(s).

Accident and illness coverage helps with unexpected veterinary costs. Pet families who want to be prepared for large vet bills in the event of an accident or illness typically select this coverage. Pre-existing conditions are not covered in accident and illness plans.

Wishbone's wellness plans are designed to save you money on expected and preventative care for your pet. Pet families who want to be reimbursed for providing their pet with complete preventative care choose this coverage.

Can I use my own veterinarian?

Yes. When your pet is insured with Wishbone, you can use any veterinary clinic or hospital in the U.S., Canada, or any U.S. territory, like Puerto Rico. We want your pet to receive the best care possible, which is why we also cover visits to specialists and emergency after-hours clinics.

Coverage

Is my pet covered if we're traveling?

Yes, all Wishbone policies include coverage at licensed veterinarians when traveling in the U.S., Canada, or any U.S. territory, like Puerto Rico.

How long are my waiting periods?

A waiting period refers to the amount of time after you enroll before coverage begins.

Waiting periods may vary by type of coverage, payment method, enrollment date, and state insurance regulations. For specific information on your waiting periods, get a quote, give us a call at (800) 887-5708, or refer to your policy forms.

For all wellness plans, routine care coverage has no waiting periods and coverage begins the day following your effective date.

Do you use a benefit schedule?

Wishbone's accident and illness and accident only plans do not use a benefit schedule, which is a list that puts a limit on what each type of treatment can cost. Instead, Wishbone Pet Insurance reimburses you the amount after the reimbursement percentage and deductible are applied to your actual vet bill, up to your plan's maximum benefit. Add-on coverages may have separate limits. Reimbursements may vary by state. Review your policy form documents for more details.

Wishbone's wellness plans do use a benefit schedule for reimbursement. The reimbursement schedule is outlined during enrollment and in your member documentation.

Will Wishbone cover my pet's dental needs?

Good dental care is vitally important to the overall health of your pet. Wishbone's accident and illness and accident only plans cover extractions of broken teeth due to injury. For reimbursement on your pet's routine dental cleaning, you must enroll in a wellness plan that includes dental reimbursement.

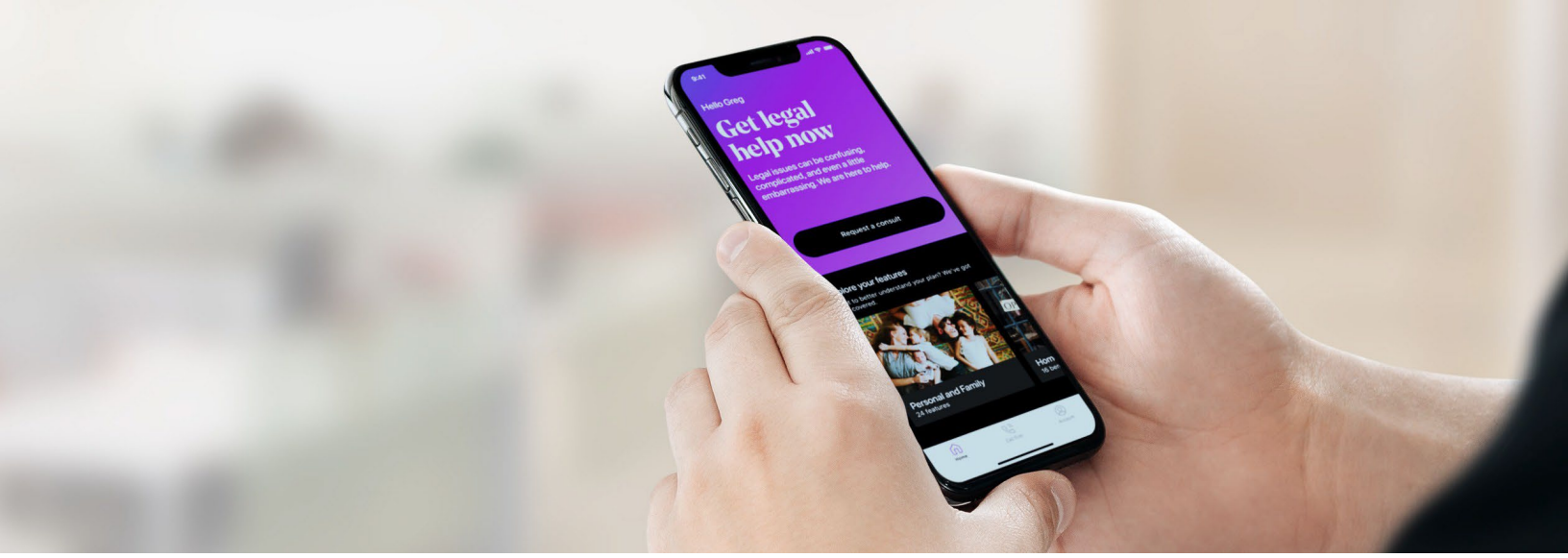
Claims

How do I file a claim?

The easiest and fastest way to file a claim is through your Wishbone member account. Once you log in, you can submit and view your claims online. Be sure to submit a completed claim form and supporting paid invoices within 180 days of the treatment date.

Wishbone Pet Insurance is a pet health insurance program offered by Pet Assure Corp., dba Pet Benefit Solutions, a licensed agency (NJ License Number 1677880). Insurance coverage is administered by Pet Benefit Solutions or Norse Specialty Insurance Company, Inc. and underwritten by Trisura Insurance Company, Clear Blue Insurance Company, or Clear Blue Specialty Insurance Company. Please visit https://www.wishboneinsurance.com/terms-and-conditions for more information.

Wishbone's wellness plans are not insurance and are administered by Pet Benefit Solutions.



LegalShield™

Legal Protection

LegalShield provides the legal protection you and your family need and deserve.

> "Great customer service. I'm very pleased with LegalShield. I recommend them to anyone and everyone any chance I get."
>
> **M.C. - LegalShield Member**

AFFORDABLE LEGAL PROTECTION

$11.87
SEMI MONTHLY

FOR MORE INFORMATION, VISIT

benefits.legalshield.com/insperex

Direct Access to a Dedicated Provider Law Firm
You will receive unlimited legal consultation and advice on personal legal matters. 100% of matters are covered in-network and your provider firm is even available for emergency situations.

Fast Response
An attorney will respond to your legal matter within four business hours or less.

Document Review And Preparation
An attorney can help you review and prepare common legal documents for Wills, Trusts, and more.

Court Representation
You will receive representation for legal matters such as traffic tickets and even house closings.

Letters And Phone Calls
Letters and phone calls can be made on your behalf to resolve legal matters such as warranty disputes or a dispute with a creditor.

Speeding Ticket Assistance
Your provider law firm will review your speeding ticket and even attend court on your behalf if required. You can easily upload your ticket using the LegalShield mobile app.

Mobile App
The LegalShield mobile app allows you to call your provider law firm directly and makes it easy to upload and prepare documents for fast legal review.

LegalShield provides access to legal services offered by a network of provider law firms to LegalShield members through membership-based participation. Neither LegalShield nor its officers, employees or sales associates directly or indirectly provide legal services, representation or advice. See a plan contract for specific state of residence for complete terms, coverage, amounts and conditions.

LegalShield provides coverage for common personal legal needs at every stage of life. The LegalShield plan provides coverage for:

FAMILY

- Bullying Protection
- Post-Nuptial/ Domestic Partnership Agreements
- Gender Identifier Change
- Elder Law Matters
- Civil and Social Discrimination
- Adoption
- Paternity
- Conservatorship
- Domestic Violence Protection
- Guardianship
- Name Change
- Juvenile Court Proceedings
- Immigration Assistance
- Administrative Hearing
- Incompetency Defense
- Juvenile Defense
- Prenuptial Agreements
- Reproductive Assistance

HOME

- Contractor Disputes
- Deeds
- Eviction and Tenant Issues
- Foreclosure
- Neighbor Disputes/ Easements
- Refinancing
- Purchase/Sale of House
- Real Estate Contracts/Financial Disputes
- Small Claims Assistance
- Zoning Applications
- Mortgages
- Boundary Title Disputes
- Home Equity Loans
- Property Tax Assessments

FINANCIAL

- Consumer Credit Services
- Affidavits
- Bankruptcy
- Consumer Protection
- Contracts/Financial Disputes
- Debt Collection
- IRS Audit Protection
- Rental Agreements
- Medicaid/Medicare Disputes
- Habeas Corpus
- Civil Litigation
- Identity Theft
- Promissory Notes
- Small Claims Assistance
- Personal Property Disputes
- Tax Audit Protection
- Veterans Benefit Disputes

ESTATE PLANNING

- Living Wills/Wills
- Probate
- Living Trusts/Trusts
- Power of Attorney
- Codicils
- Physician's Directive

AUTO

- Driver's License Restoration
- Motor Vehicle Property Damage
- Moving Traffic Violations/Traffic Tickets
- Property Damage Claims

GENERAL

- Office Consultation
- Telephone Advice
- Document Review
- Mobile App
- 24/7 Emergency Legal Access
- Demand Letters/ Phone Calls
- 25% Preferred Member Discount
- Legal Forms

MASA Medical Transport Solutions®

$14/MONTH

DID YOU KNOW?

25 MILLION PEOPLE are sent to the emergency room through ground or air ambulance every year*.

Insurance companies may not cover all air and ground ambulance expenses which can result in max in-network out-of-pocket costs of:**

$8,700 Individual
$17,400 Family

Ground ambulance out-of-network transportation costs may be even higher than in-network since the No Surprises Act does not apply to ground ambulance at this time.

EMERGENT PLUS MEMBERSHIP BENEFITS

A MASA MTS Membership provides the ultimate peace of mind at an affordable rate for emergency ground and air transportation assistance expenses within the continental United States, Alaska, Hawaii, and while traveling in Canada, regardless of whether the provider is in or out of your group healthcare benefits network. After the group health plan pays its portion, MASA works with providers to make certain our Members have no out-of-pocket expenses~ for emergency ambulance transportation assistance and other related services.

Emergency Air Ambulance Coverage[1]

MASA MTS covers out-of-pocket expenses~ associated with emergency air transportation to a medical facility for serious medical emergencies deemed medically necessary for you or your dependent family member.

Emergency Ground Ambulance Coverage[1]

MASA MTS covers out-of-pocket expenses~ associated with emergency ground transportation to a medical facility for serious medical emergencies deemed medically necessary for you or your dependent family member.

Hospital to Hospital Ambulance Coverage[1]

MASA MTS covers out-of-pocket expenses~ that you or a dependent family member may incur for hospital transfers, due to a serious emergency, to the nearest and most appropriate medical facility when the current medical facility cannot provide the required level of specialized care by air ambulance to include medically equipped helicopter or fixed-wing aircraft.

Repatriation to Hospital Near Home Coverage[1]

MASA MTS provides services and covers out-of-pocket expenses~ for the coordination of a Member's non-emergency transportation by a medically equipped, air or ground ambulance in the event of hospitalization more than one hundred (100) miles from the Member's home if the treating physician and MASA MTS' Medical Director says it's medically appropriate and possible to transfer the Member to a hospital nearer to home for continued care and recuperation.

MASA Medical Transport Solutions®

DID YOU KNOW?

2 MILLION PEOPLE

are sent to the emergency room through ground or air ambulance every year*.

Insurance companies may not cover all air and ground ambulance expenses which can result in in-network out-of-pocket costs.**

Ground ambulance out-of-network transportation costs may be even higher than in-network.

FLORIDA PLATINUM MEMBERSHIP BENEFITS

A MASA MTS Membership provides the ultimate peace of mind at an aff ordable rate for emergency ground and air transportation assistance expenses within the continental United States, Alaska, Hawaii, and while traveling in Canada, regardless of whether the provider is in or out of your group healthcare benefits network. After the group health plan pays its portion, MASA works with providers to make certain our Members have no out-of-pocket expenses~ for emergency ambulance transportation assistance and other related services.

Emergency Air Ambulance Coverage[3]

MASA MTS covers out-of-pocket expenses associated with emergency air transportation to a medical facility for serious medical emergencies deemed medically necessary for you or your dependent family member.

Emergency Ground Ambulance Coverage[3]

MASA MTS covers out-of-pocket expenses associated with emergency ground transportation to a medical facility for serious medical emergencies deemed medically necessary for you or your dependent family member.

Hospital to Hospital Ambulance Coverage[3]

MASA MTS covers out-of-pocket expenses that you or a dependent family member may incur for hospital transfers, due to a serious emergency, to the nearest and most appropriate medical facility when the current medical facility cannot provide the required level of specialized care by air ambulance to include medically equipped helicopter or fixed-wing aircraft.

Repatriation to Hospital Near Home Coverage[1]

MASA MTS provides services and covers out-of-pocket expenses for the coordination of a Member's non-emergency transportation by a medically equipped, air or ground ambulance in the event of hospitalization more than one hundred (100) miles from the Member's home if the treating physician and MASA MTS' Medical Director says it's medically appropriate and possible to transfer the Member to a hospital nearer to home for continued care and recuperation.

Patient Return Transportation Coverage[1]

MASA MTS provides services and covers the out-of-pocket expenses associated with coordinating a Member's transportation when hospitalized more than one hundred (100) miles from home, after discharge from the medical facility, by a regularly scheduled commercial airline to the commercial airport nearest the Member's home.

MASA Medical Transport Solutions®

PLATINUM SINGLE MEMBERSHIP BENEFITS

Companion Transportation Coverage[2]

MASA MTS provides services associated with the coordination of transportation for the Member's spouse, other family member, or companion to accompany the Member's emergency transport by a medically equipped, rotary (i.e., helicopter) or fixed-wing aircraft, giving due priority to the medical personnel and/or equipment and the welfare and safety of the patient.

Hospital Visitor Transportation Coverage[2]

MASA MTS provides services and covers air transportation expenses associated with coordinating a round-trip, regularly scheduled, commercial airfare for Member's spouse, other family Member or companion to join the Member in the event of in-patient hospitalization more than one hundred (100) statute miles from Member's home.

Minor Return Transportation Coverage[2]

MASA MTS provides services and covers out-of-pocket expenses associated with minor return transportation to a parent, legal guardian, or another person that can be responsible for the minor in the event that the minor is unattended as a result of Member's Emergency Air or Ground Ambulance, Hospital to Hospital Ambulance, Repatriation to Hospital Near Home, or Mortal Remains Transportation coverages. MASA MTS also provides for a qualified attendant to accompany the minor during travel when the minor's age and/or medical condition may require such care.

Vehicle & RV Return Coverage[2]

MASA MTS provides services and covers the out-of-pocket expenses associated with vehicle return transportation for one (1) a safe operational car, truck, van, motorcycle, travel trailer, or motor home to the Member's home. This service is available when a Member uses Emergency Air or Ground Ambulance, Hospital to Hospital Ambulance, Repatriation to Hospital Near Home, Patient Return Transportation or Mortal Remains Transportation Coverages. MASA MTS pays the cost of fuel, oil and driver.

Pet Return Transportation Coverage[2]

MASA MTS provides services and covers out-of-pocket expenses for the return transportation to a Member's home for up to two (2) pet(s) belonging to the Member that includes either a dog, cat or other small animal(s). This service is available when a Member uses Emergency Air or Ground Ambulance, Hospital to Hospital Ambulance, Repatriation to Hospital Near Home, Patient Return Transportation or Mortal Remains Transportation Coverages.

Organ Retrieval & Organ Recipient Transportation Coverage[4]

MASA MTS provides services and covers air transportation expenses associated with coordinating transportation for an organ when the Member requires an organ transplant. MASA MTS will also provide service and cover transportation costs of Member and Member's spouse, other family Member or a companion should the Member need to travel to the location where the procedure will occur. If medically necessary, the organ will be transported by a medically equipped fixed-wing aircraft; otherwise, the organ is delivered by a commercial airline to the suitable airport nearest the location of the operation.

Mortal Remains Transportation Coverage[1]

MASA MTS covers the air transportation expense for a Member's mortal remains in the event of their death when it occurs more than one hundred (100) statute miles from home. Remains are transported by a regularly scheduled commercial airline to the commercial airport nearest a Member's home.

$24.17/MONTH SINGLE

$32.50/MONTH FAMILY

The information provided in this product information sheet is for informational purposes only. The benefits listed, and the descriptions thereof do not represent the full terms and conditions applicable for usage and may only be offered in some memberships. Premiums and benefits vary depending on the benefits selected. For a complete list of benefits, premiums, and full terms, conditions, and restrictions, please refer to the applicable member services agreement for your territory. MASA MTS products and services are not available in AK, NY, WA, ND, and NJ. **For FL residents, MASA MTS provides insurance coverage whereby Medical Air Services Association of Florida, Inc. is a prepaid limited health service organization licensed under Chapter 636, Florida Statutes, license number: 65-0265219 and is doing business as MASA MTS with its principal place of business at 1250 S. Pine Island Road, Suite 500, Plantation, FL 33324.** MASA MTS utilizes third-party transportation service providers for all transportation services. MASA Global, MASA MTS and MASA TRS are registered service marks of MASA Holdings, Inc., a Delaware corporation. Void where prohibited by law.

~If a member has a high deductible health plan that is compatible with a health savings account, benefits will become available under the MASA membership for expenses incurred for medical care (as defined under Internal Revenue Code ("IRC") section 213 (d)) once a member satisfies the applicable statutory minimum deductible under IRC section 223(c) for high-deductible health plan coverage that is compatible with a health savings account.

COVERAGE TERRITORIES:

1. Worldwide Coverage - Repatriation to Hospital Near Home Coverage, Patient Return Transportation Coverage, and Mortal Remains Transportation Coverage benefits shall extend Worldwide. Worldwide Coverage shall automatically extend to the United States, Canada, Mexico, the Caribbean (excluding Cuba), the Bahamas and Bermuda (collectively, "Basic Coverage Area") (excluding countries referenced on the Office of Foreign Assets Control ("OFAC") countries, and Antarctica), and extend elsewhere contingent upon ten (10) day prior notice of such travel. Notice may be provided by (i) certified mail, return receipt requested, to the MASA Corporate office; (ii) electronic mail, including delivery confirmation; or (iii) facsimile, including confirmation of delivery, and MASA's written acknowledgment of such notice. Notice must include a travel itinerary of travel destinations and dates. Unless otherwise authorized by MASA MTS in writing, Worldwide coverage shall apply up to ninety (90) days per trip.

2. Basic Coverage Area – Companion Transportation Coverage, Hospital Visitor Transportation Coverage, Minor Return Transportation Coverage, Vehicle & RV Return Coverage, and Pet Return Transportation Coverage benefits shall extend to the United States, Canada, Mexico, the Caribbean (excluding Cuba), the Bahamas and Bermuda. Vehicle & RV Return Coverage shall be limited to only rental vehicles in Hawaii, the Caribbean (excluding Cuba), the Bahamas and Bermuda.

3. United States and Canada Only – Emergency Air Ambulance Coverage, Emergency Ground Ambulance Coverage, and Hospital to Hospital Ambulance Coverage benefits shall only be provided in the United States and Canada.

4. United States Only – Organ Retrieval & Organ Recipient Transportation benefits shall only be provided in the United States.

SOURCES:
**ACEP NOW 2014*
*** Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2022 and Pharmacy Benefit Manager Standards. May 5, 2021.*

MASA Medical Transport Solutions®

1250 S. Pine Island Rd., Suite 500,
Plantation, FL 33324

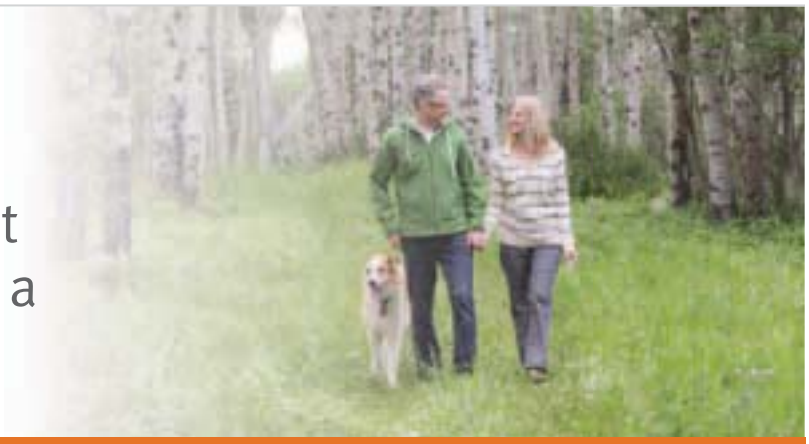
800-643-9023 I www.masamts.com

MASAPLTS_FLR_FL_SINnFAM_103122

Basic Enhanced Employee Assistance Program

Mutual of Omaha

Life's not always easy. Sometimes a personal or professional issue can get in the way of maintaining a healthy, productive life.



Your Employee Assistance Program (EAP) can be the answer for you and your family.

Mutual of Omaha's EAP assists employees and their eligible dependents with personal or job-related concerns, including:

- Emotional well-being
- Family and relationships
- Legal and financial matters
- Healthy lifestyles
- Work and life transitions

EAP BENEFITS

- Unlimited telephone access to EAP professionals 24 hours a day, seven days a week
- Telephone assistance and referral
- Service for employees and eligible dependents
- Robust network of licensed mental health professionals
- Three face-to-face sessions* with a counselor (per household per calendar year)

  *Face-to-face visits can also be used toward legal consultations

  *California Residents: Knox-Keene Statute limits no more than three face-to-face sessions per six-month period per person.
- Legal assistance and financial services
  - *Online will preparation*
  - *Legal library & online forms*
  - *Telephonic financial consultation*
- Resources for:
  - *Financial tools & resources*
  - *Substance abuse and other addictions*
  - *Dependent and elder care assistance & referral services*
- Access to a library of educational articles, handouts and resources via *mutualofomaha.com/eap*

WHAT TO EXPECT

You can trust your EAP professional to assess your needs and handle your concerns in a confidential, respectful manner. Our goal is to collaborate with you and find solutions that are responsive to your needs.

Your EAP benefits are provided through your employer. There is ***no cost*** to you for utilizing EAP services. If additional services are needed, your EAP will help locate appropriate resources in your area.

Don't delay if you need help. Visit *mutualofomaha.com/eap* or call 800-316-2796 for confidential consultation and resource services.

Benefits that work™

Insurance products and services are offered by Mutual of Omaha Insurance Company or one of its affiliates. Home office: 3300 Mutual of Omaha Plaza, Omaha, NE 68175. Mutual of Omaha Insurance Company is licensed nationwide. United of Omaha Life Insurance Company is licensed nationwide, except in New York. Companion Life Insurance Company, Hauppauge, NY 11788-2937, is licensed in New York. Each underwriting company is solely responsible for its own contractual and financial obligations. Some exclusions or limitations may apply.

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Worldwide Travel Assistance

TRAVEL ASSISTANCE TRAVELS WITH YOU

Mutual of Omaha

Experiencing an emergency while traveling can be especially difficult. Knowing who to call for medical problems, currency exchange issues or lost luggage is critical. Take comfort in knowing that Travel Assistance* travels with you worldwide, offering access to a network of professionals who can help you with local medical referrals or provide other emergency assistance services in foreign locations.

ENJOY YOUR TRIP – WE'LL BE THERE IF YOU NEED US

Travel Assistance can help you avoid unexpected bumps in the road anywhere in the world. For you, your spouse and dependent children on any single trip, up to 120 days in length, more than 100 miles from home.

PRE-TRIP ASSISTANCE**

Minimize travel hassles by calling us pre-departure for:

- Information regarding passport, visa or other required documentation for foreign travel
- Travel, health advisories and inoculation requirements for foreign countries
- Domestic and international weather forecasts
- Daily foreign currency exchange rates
- Consulate and embassy locations

IMMEDIATE ATTENTION FOR EMERGENCIES WHILE TRAVELING

While traveling more than 100 miles from home you may access Travel Assistance services 24/7 by calling the toll-free number for immediate help from a travel assistance professional.

EMERGENCY TRAVEL SUPPORT SERVICES

- Telephonic translation and interpreter services – 24/7 access to telephone translation services
- Locating legal services – referrals for local attorney or consular offices and help maintain business and family communications until legal counsel is retained (includes coordination of financial assistance for bonds/bail)
- Baggage – assistance with lost, stolen or delayed baggage while traveling on a common carrier
- Emergency payment and cash – assistance with advance of funds for medical expenses or other travel emergencies by coordinating with your credit card company, bank, employer, or other sources of credit; includes arrangements for emergency cash from a friend, family member, business or credit card
- Emergency messages – assistance with recording and retrieving messages between you, your family and/or business associates at any time
- Document replacement – coordination of credit card, airline ticket or other documentation replacement
- Vehicle return – if evacuation or repatriation is necessary, return your unattended vehicle to the car rental company

*Brought to you by Mutual of Omaha. Services provided by AXA Assistance USA (AXA)
**Available at any time, not subject to 100-mile travel radius
MUGC9734

WORLDWIDE TRAVEL ASSISTANCE

Services available for business and personal travel.

For inquiries within the U.S. call toll free: **1-800-856-9947**

Outside the U.S. call collect: **(312) 935-3658**

WORLDWIDE TRAVEL ASSISTANCE

Services available for business and personal travel.

For inquiries within the U.S. call toll free: **1-800-856-9947**

Outside the U.S. call collect: **(312) 935-3658**

MEDICAL ASSISTANCE

- Locating medical providers and referrals
- Communication on your medical status with family, physicians, employer, travel company and consulate
- Emergency evacuation if adequate medical facilities are not available, including payment of covered expenses
- Transportation home for further treatment – in the event of death, assist in the return of mortal remains
- Transportation arrangements for the visit of a family member or friend if your hospitalization is more than seven calendar days
- Return home for dependent children if your hospitalization is more than seven calendar days
- Assistance with lodging arrangements if convalescence is needed prior to, or after, medical treatment
- Coordination with your health insurance carrier during a medical emergency
- Assistance obtaining prescription drugs or other necessary personal medical items

IDENTITY THEFT

Your Travel Assistance benefit automatically includes Identity Theft Assistance, coordinated at no additional cost. Whether at home or traveling, this benefit provides education, prevention and recovery information to help you protect your identity.

EDUCATION AND PREVENTION

- Comprehensive ID theft assistance guide
- Tips to defend against ID theft

RECOVERY INFORMATION

- Information regarding the steps to recover from credit card and check fraud
- Guidelines if your Social Security number is compromised
- Instructions for lost or stolen passport
- Contact list for financial institutions, credit bureaus and check companies

ASSISTANCE

If you need help with an ID theft issue, case managers are available 24 hours a day, seven days a week and can be reached by calling the same toll-free number used to contact AXA: 800-856-9947.

TRAVEL ASSISTANCE PLAN LIMITATIONS

AXA will not pay emergency evacuation, medically necessary repatriation, repatriation of remains or other expenses incurred while traveling within 100 miles of participant's place of residence, or for any one of the following reasons:

- A single trip lasts more than 120 days in length
- Traveling against the advice of a physician
- Traveling for medical treatment
- Pregnancy and childbirth (exception: complications of pregnancy)

Expenses for emergency evacuation, medically necessary repatriation, repatriation of remains, return of dependent children, family or friend transportation arrangement and vehicle return are limited to $200,000 per person per event.

All additional costs would be the responsibility of the member. This includes medical costs which are the responsibility of the person receiving medical services. Services must be authorized and arranged by AXA Assistance USA, Inc. designated personnel to be eligible for this program. No reimbursement claims for out-of-pocket expenses will be accepted.

Travel assistance services are independently offered and administered by AXA Assistance USA, Inc. (AXA). Insurance benefits provided as part of Travel Assistance underwritten by a third party. AXA is not affiliated in any way with Mutual of Omaha Companies. There may be times when circumstances beyond AXA Assistance USA's control hinder its endeavors to provide services. AXA Assistance USA will make all reasonable efforts to help you resolve the emergency situation.

Carry this card with you when you travel

Brought to you by Mutual of Omaha.
Services provided by AXA Assistance USA

Carry this card with you when you travel

Brought to you by Mutual of Omaha.
Services provided by AXA Assistance USA

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Mutual Solutions

Will Preparation Services

Services provided by Epoq, Inc.

Create your will at
www.willprepservices.com
and use the code MUTUALWILLS
to register

Creating a will is an important investment in your future. It specifies how you want your possessions to be distributed after you die.

Whether you're single, married, have children or are a grandparent, your will should be tailored for your life situation.

That's why it's good you have access to FREE online will preparation services provided by Epoq, Inc. (Epoq).

Easy, Free and Secure

Epoq offers a secure account space that allows you to prepare wills and other legal documents. Create a will that's tailored to your unique needs from the comforts of your own home.

Epoq provides the following FREE documents:

- Last Will and Testament
- Power of Attorney
- Healthcare Directive
- Living Trust

Here's how it works:

- Log on to www.willprepservices.com and use the code MUTUALWILLS to register
- Answer the simple questions and watch the customization of your document happen in real time
- Download, print and share any document instantly
- Don't forget to update your documents with any major life changes, including marriage, divorce, and birth of a child
- Make the document legally binding — Check with your state for requirements

Mutual of Omaha

Underwritten by
United of Omaha Life Insurance Company
A Mutual of Omaha Company

Will and other document preparation services are independently offered by Epoq, Inc. (Epoq) and are subject to its terms of service and privacy policy. Epoq is an online service that provides certain legal forms and legal information. Epoq is not a law firm and is not a substitute for an attorney's advice. United of Omaha Life Insurance Company and Companion Life Insurance Company (United and Companion) and Epoq are independent, unaffiliated companies. Although United and Companion make Epoq's services available to group life insurance customers, the use of Epoq's services is entirely voluntary. United and Companion do not provide, are not responsible for, do not assume any liability for and do not guarantee the accuracy, adequacy or results of any service, advice or documents provided by Epoq. United and Companion also are not responsible and do not assume liability for any disclosure of personal data or information by Epoq. These services are only available to group life insurance customers of United and Companion.

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InspereX

CONTACTS & **MORE**

Carrier Contact Information

Refer to this list when you need to contact one of your benefits vendors.
For general information, contact Human Resources.

Medical

Cigna (Group # 614348)
Member Services Number: 1-866-494-2111
Web Address: www.MyCigna.com
Network: Open Access Plus

Health Savings Account

HealthEquity
Member Services Number: 1-866-346-5800
Web Address: www.healthequity.com

Flexible Spending Account

Chard Snyder
Member Services Number: 1-866-346-5800
Web Address: www.healthequity.com

Critical Illness/Hospital Indemnity/Accidental Injury

Cigna (Group # 614348)
Member Services Number: 1-866-494-2111
Web Address: www.MyCigna.com

Dental

Principal Financial Group (Group #1117502)
Member Services Number: 1-888-986-3343
Web Address: www.Principal.com

Vision

EyeMed Vision Care (Group # 9800947)
Member Services Number: 1-866-939-3633
Web Address: www.EyeMed.com

Life / AD&D

Mutual of Omaha
Member Services Number: 1-800-769-7159
Web Address: www.mutualofomaha.com

Disability

Mutual of Omaha
Member Services Number: 1-800-769-7159
Web Address: www.mutualofomaha.com

Telemedicine

SAM by UCM Digital Health
Phone: 1-844-484-7362
Web Address: www.sambyucm.com

Employee Assistance Program

Mutual of Omaha
Phone: 1-800-316-2796
Web Address: www.mutualofomaha.com/eap

Identity Theft Protection (ZeroFox)

IDX (ZeroFox)
Phone: 1-800-939-4170
Web Address: www.idx.us

Total Pet Plan

Pet Benefit Solutions
Phone: 1-800-891-2565
Web Address: www.petbenefits.com

Legal Shield

Legal Shield
Phone: 1-866-470-1694
Web Address: www.legalshield.com

Medical Transport Solutions

MASA
Phone: 1-877-503-0585
Web Address: www.masamts.com

Annual Notices

KENTUCKY – Medicaid
Website: http://chfs.ky.gov/dms/default.htm
Phone: 1-800-635-2570

LOUISIANA – Medicaid
Website: http://www.lahipp.dhh.louisiana.gov
Phone: 1-888-695-2447

MAINE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-977-6740
TTY 1-800-977-6741

MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/MassHealth
Phone: 1-800-462-1120

MINNESOTA – Medicaid
Website:http://www.dhs.state.mn.us/
Click on Health Care, then Medical Assistance
Phone: 1-800-657-3629

MISSOURI – Medicaid
Website:
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml
Phone: 1-800-694-3084

NEBRASKA – Medicaid
Website: www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633

NEVADA – Medicaid
Website: http://dwss.nv.gov/
Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website:http://www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 603-271-5218

NEW JERSEY – Medicaid and CHIP
MedicaidWebsite:http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
MedicaidPhone: 1-609-631-2392
CHIPWebsite: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website: http://www.nyhealth.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: http://www.ncdhhs.gov/dma
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-800-755-2604

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website: http://www.oregonhealthykids.gov
http://www.hijossaludablesoregon.gov
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website: http://www.dpw.state.pa.us/hipp
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid
Website: www.ohhs.ri.gov
Phone: 401-462-5300

SOUTH CAROLINA – Medicaid
Website: http://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: https://www.gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Website:http://health.utah.gov/upp
Phone: 1-866-435-7414

VERMONT–Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

Annual Notices

Your HIPAA Rights

Health Insurance Portability and Accountability Act (HIPAA)

Title II of the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations at 45 CFR Parts 160 through 164 (HIPAA) contain provisions governing the use and disclosure of Protected Health Information (PHI) by group health plans, and provide privacy rights to participants in those plans. These rules are called the HIPAA Privacy Rules.

You will receive a "Notice of Privacy Practices" from the Administrator(s) and/or Insurer(s) that contains information about how your individually identifiable health information is protected under the HIPAA Privacy Rules and who you should contact with questions or concerns.

The HIPAA Privacy Rules apply to group health plans. These plans are commonly referred to as "HIPAA Plans" and are administered to comply with the applicable provisions of HIPAA. PHI is individually identifiable information created or received by HIPAA Plans that relates to an individual's physical or mental health or condition, the provision of health care to an individual, or payment for the provision of health care to an individual. Typically, the information identifies the individual, the diagnosis, and the treatment or supplies used in the course of treatment. It includes information held or transmitted in any form or media, whether electronic, paper or oral. When PHI is in electronic form it is called "ePHI."

The HIPAA Plans may disclose PHI to the Plan Sponsor only as permitted under the terms of the Plan, or as otherwise required or permitted by HIPAA. The Plan Sponsor agrees to use and disclose PHI only as permitted or required by the HIPAA Privacy Rules and the terms of the Plan.

The HIPAA Plans (or an Insurer with respect to the HIPAA Plans) may disclose enrollment and disenrollment information to the Plan Sponsor. Also, the HIPAA Plans (or an Insurer with respect to the HIPAA Plans) may disclose Summary Health Information to the Plan Sponsor if the Plan Sponsor requests the information for the purposes of (1) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (2) modifying, amending or terminating the Plan. "Summary Health Information" means information that summarizes the claims history, claims expenses or types of claims experienced by individuals covered under the HIPAA Plans and has almost all individually identifying information removed. The HIPAA Plans may also disclose PHI to the Plan Sponsor pursuant to a signed authorization that meets the requirements of the HIPAA Privacy Rules. Other than these disclosures, the Plan Sponsor will not create or receive PHI from the HIPAA Plans.

Your COBRA Continuation Coverage Rights

Continuing Health Care Coverage through COBRA

This section provides an overview of COBRA continuation coverage. The coverage described may change as permitted or required by applicable law. When you first enroll in coverage, you will receive from the Plan Administrator/COBRA Administrator your initial COBRA notice. This notice and subsequent notices you receive will contain current requirements applicable for you to continue coverage.

The length of COBRA continuation coverage (COBRA coverage) depends on the reason that coverage ends, called the "qualifying event." These events and the applicable COBRA continuation period are described below.

If you and/or your eligible dependent(s) choose COBRA coverage, the Employer is required to offer the same medical and prescription drug coverage that is offered to similarly situated employees. Proof of insurability is not required to elect COBRA coverage. In other words, you and your covered dependents may continue the same healthcare coverage you had under the Plan before the COBRA qualifying event.

If you have a new child during the COBRA continuation period by birth, adoption, or placement for adoption, your new child is considered a qualified beneficiary. Your new child is entitled to receive coverage upon his or her date of birth, adoption, or placement for adoption, provided you enroll the child within 30 days of the child's birth/adoption/placement for adoption. If you do not enroll the child under your coverage within 30 days, you will have to wait until the next open enrollment period to enroll your child.

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You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

For more information about the Marketplace, visit www.HealthCare.gov.

COBRA Qualifying Events and Length of Coverage

Each person enrolled in benefits will have the right to elect to continue healthcare benefits upon the occurrence of a qualifying event that would otherwise result in such person losing healthcare benefits. Qualifying events and the length of COBRA continuation are as follows:

18-MonthContinuation

Healthcare coverage for you and your eligible dependent(s) may continue for 18 months after the date of the qualifying event if your:

- employment ends for any reason other than gross misconduct; or
- hours of employment are reduced.

If you or your eligible dependent is disabled at the time your employment ends or your hours are reduced, the disabled person may receive an extra 11 months of COBRA coverage in addition to the 18-month continuation period (for a total of 29 months of coverage from the date of the qualifying event). If the individual entitled to the disability extension has non-disabled family members who have COBRA coverage due to the same qualifying event, those non-disabled family members will also be entitled to the 11-month extension, including any child born or placed for adoption within the first 60 days of COBRA coverage.

The 11-month extension is available to any COBRA participant who meets all of the following requirements:

- he or she becomes disabled before or within the first 60 days of the initial 18-month coverage period (including a child born or placed for adoption with you); and
- he or she notifies the Plan Administrator (or its designated COBRA Administrator) within 60 days of the date on the Social Security Administration determination letter, and provides a copy of the disability determination; and
- he or she notifies the Plan Administrator (or its designated COBRA Administrator) before the initial 18-month COBRA coverage period ends.

You must also notify the Plan Administrator (or its designated COBRA Administrator) within 30 days of the date Social Security Administration determines that you or your dependent is no longer disabled.

36-MonthContinuation

Coverage for your eligible dependent(s) may continue for up to 36 months if coverage is lost due to your:

- death;
- divorce or legal separation;
- eligibility for Medicare coverage; or
- dependent child's loss of eligible dependent status under this Plan

Note: If any of these events (other than Medicare entitlement) occur while your dependents are covered under COBRA (because of an 18-month or 18-month plus 11 month extension qualifying event), coverage for the second qualifying event may continue for up to a total of 36 months from the date of the first COBRA qualifying event. In no case, however, will COBRA coverage be continued for more than 36 months in total.

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If you become eligible for Medicare before a reduction in hours or your employment terminates, coverage for your dependents may be continued for up to 18 months from the date of your reduction in hours or termination of employment, or for up to 36 months from the date you became covered by Medicare, whichever is longer.

COBRA Notifications

If you or your covered dependents lose coverage under the Plan because your employment status changes, you become entitled to Medicare, or you die, the Plan Administrator (or its designated COBRA administrator) will automatically provide you or your dependents with information about COBRA continuation coverage, including what actions you must take by specific deadlines.

If your covered dependent loses coverage as a result of your divorce, legal separation, or a dependent child's loss of eligibility under the Plan, you or your dependent must notify the Employer within 60 days of the qualifying event. The Plan Administrator (or its designated COBRA administrator) will automatically send you or your dependent, as applicable, COBRA enrollment information. If you or your dependent fails to provide notification of the event within 60 days, you or your dependent forfeits all continuation of coverage rights under COBRA. To continue COBRA coverage, you and/or your eligible dependents must elect and pay the required cost for COBRA coverage by completing and returning your COBRA enrollment form.

NOTE: If you have a new child during the COBRA continuation period by birth, adoption or placement for adoption, your new child is entitled to the status of a qualified beneficiary. As such, your new child is entitled to receive coverage upon his or her date of birth, date of adoption or date placement for adoption is made and you become legally obligated to provide support for the child, provided you enroll the child within thirty (30) days of the child's birth/adoption/placement.

Cost of COBRA Coverage

You or your eligible dependent pay the full cost for healthcare coverage under COBRA, plus any required administrative fee up to two percent, or up to 102 percent of the full premium cost, except in the case of an 11-month disability extension where you may be required to pay up to 150 percent of the full premium cost for coverage.

COBRA Continuation Coverage Payments

Each qualified beneficiary may make an independent COBRA coverage election. You elect coverage by completing and returning your COBRA enrollment form as instructed in your enrollment materials within 60 days of the date you receive information about your COBRA rights or, if later, the date of your qualifying event.

The first COBRA premium payment is due no later than 45 days from the date COBRA coverage is elected. Although COBRA coverage is retroactive to the date of the initial qualifying event, no benefits will be paid until the full premium payment is received. Each month's premium is due prior to the first day of the month of coverage. You or your dependent is responsible for making timely payments.

If you or your dependent fails to make the first payment within 45 days of the COBRA election, or subsequent payments within 30 days of the due date (the grace period), COBRA coverage will be canceled permanently, retroactive to the last date for which premiums were paid. COBRA coverage cannot be reinstated once it is terminated.

COBRA premium payments that are returned by the bank for insufficient funds will result in termination of your COBRA coverage if a replacement payment in the form of a cashier's check, certified check, or money order is not made within the grace period.

COBRA premium payments must be mailed to the address indicated on your premium notice. Even if you do not receive your premium notice, it is your responsibility to contact the COBRA administrator. Your COBRA coverage will end if payment is not made by the due date on your notice. It is your responsibility to ensure that your current address is on file.

You may be eligible for state or local assistance to pay the COBRA premium. For more information, contact your local Medicaid office or the office of your state insurance commissioner.

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How Benefit Extensions Impact COBRA

If you have a qualifying event that could cause you to lose your coverage, the length of any benefit extension period is generally considered part of your COBRA continuation coverage period and runs concurrently with your COBRA coverage.

If you take a leave under the Family and Medical Leave Act (FMLA), COBRA begins;

- at the end of the leave if you do not return after the leave; or
- on the date of termination if you decide to terminate your employment during the leave.

When COBRA Coverage Ends

COBRA coverage for a covered individual will end when any of the following occur:

- The premium for COBRA coverage is not paid on a timely basis (monthly payments must be postmarked within the 30-day grace period, your initial payment must be postmarked within 45 days of your initial election).
- The maximum period of COBRA coverage, as it applies to the qualifying event, expires.
- The individual becomes covered under any other group medical plan.
- The individual becomes entitled to Medicare.
- The Employer terminates its group health plan coverage for all employees.
- Social Security determines that an individual is no longer disabled during the 11-month extension period.

Women's Health & Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- 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;
- Prostheses;and,
- Treatment of physical complications of themastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance or copays applicable to other medical and surgical benefits provided under this Plan. Therefore, the deductibles and coinsurance shown in the medical section of this guide apply.

If you would like more information on WHCRA benefits, call your Plan Administrator.

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

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

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums. If you or your dependents are not eligible for Medicaid, CHIP, or a state premium assistance program you may be able to buy individual insurance coverage through a Health Insurance Marketplace (such as Covered California). 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 in Appendix D, you can 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, you can contact your state Medicaid or CHIP office using the information contained in Appendix D, or call **1-877-543-7669** or go to **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the state if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. 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, 2014. You should contact your State for further information on eligibility –

ALABAMA – Medicaid
Website: http://www.medicaid.alabama.gov
Phone: 1-855-692-5447

ALASKA – Medicaid
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/
Phone(Outside of Anchorage): 1-888-318-8890
Phone(Anchorage):907-269-6529

ARIZONA – CHIP
Website: http://www.azahcccs.gov/applicants
Phone(Outside Maricopa Cty): 1-877-764-5437
Phone(Maricopa Cty): 602-417-5437

COLORADO – Medicaid
Medicaid Website: http://www.colorado.gov/
Medicaid Phone (In state): 1-800-866-3513
Medicaid Phone (Out of state): 1-800-221-3943

FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website: http://dch.georgia.gov/
Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)
Phone: 1-800-869-1150

IDAHO – Medicaid
www.healthandwelfare.idaho.gov/Medical/Medicaid/PremiumAssistance/tabid/1510/Default.aspx
Phone: 1-800-926-2588

INDIANA – Medicaid
Website: http://www.in.gov/fssa
Phone: 1-800-889-9949

IOWA – Medicaid
Website: www.dhs.state.ia.us/hipp/
Phone: 1-888-346-9562

KANSAS – Medicaid
Website:http://www.kdheks.gov/hcf/
Phone: 1-800-792-4884

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VIRGINIA – Medicaid and CHIP
Medicaid & CHIP Website:
http://www.coverva.org/programs_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid
Website:
www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid
Website: www.dhhr.wv.gov/bms/
Phone: 1-877-598-5820, HMS Third Party Liability

WISCONSIN – Medicaid
Website: www.badgercareplus.org/pubs/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: health.wyo.gov/healthcarefin/equalitycare
Phone: 307-777-7531

To see if any more states have added a premium assistance program since July 31, 2014, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/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

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Important Notice about your 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 InspereX Holdings, LLC and its subsidiary companies and your option 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 three 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. InspereX Holdings, LLC has determined that the prescription drug coverage offered by the Cigna OAP, Cigna HDHP1 and Cigna HDHP 2 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 15th to December 7th. 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 decide to join a Medicare drug plan, your current InspereX Holdings, LLC coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current InspereX Holdings, LLC coverage, be aware that you and your dependents may 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 InspereX Holdings, LLC 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 person listed below for further information 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 InspereX Holdings, LLC changes. You also may request a copy of this notice at any time.

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You can 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.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. Visit www.socialsecurity.gov or call 1 800 772 1213 (TTY 1 800 325 0778)

About This Summary

This summary describes the benefits available to you as a benefit eligible employee of InspereX. This guide is meant as a summary and does not contain all the details of each plan or policy, notably limitations and exclusions. If there is ever a question about one of these plans or policies, or if there is a conflict between information in this summary and the official plan or policy documents, the formal wordings in those documents will govern. These benefits may be changed at any time and do not represent a contractual obligation on the part of InspereX.