Health & Welfare Benefits

April 1, 2026 - March 31, 2027

Full-Time

GOVERNMENT CONTRACT EMPLOYEES

onehealth

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Your Benefit Providers – Full Time

Benefit Type	Service Provider	Telephone	Email / Web
Medical / Rx	SECURUS BENEFITS	1-877-420-0785	portal.securusbenefits.com
Ancillary Benefits (Extra Cost Applies)			
Dental Life Insurance	BSI COMPANIES	1-888-298-6828	www.bsicompanies.com customerservice@bsicompanies.com
Vision	DavisVision™	1-800-836-2094	www.davisvision.com
Employee Assistance Program (EAP)	supportlinc	1-888-539-3327	www.supportlinc.com

Benefits Eligibility

Employees

Benefits for newly hired employees are effective on the first day of the month following 60 days of employment. Select a benefit plan as shown on the following pages.

Eligible Dependents (Extra Cost Applies)

You may enroll eligible dependents in the Medical, Dental & Vision benefits at an additional cost. Documentation will be required to verify your dependents' eligibility for coverage. Eligible dependents are defined below:

- **Spouse**, a person to whom you are legally married by ceremony.
- **Dependent children up to the age of 26**, regardless of marital status, student status, or financial dependency.

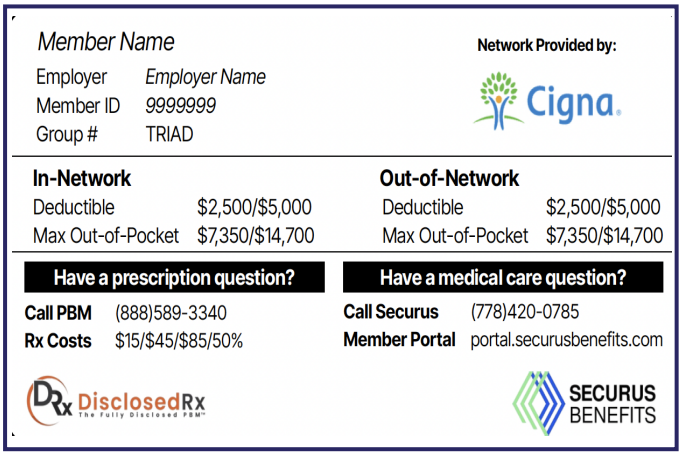
Dependent Verification

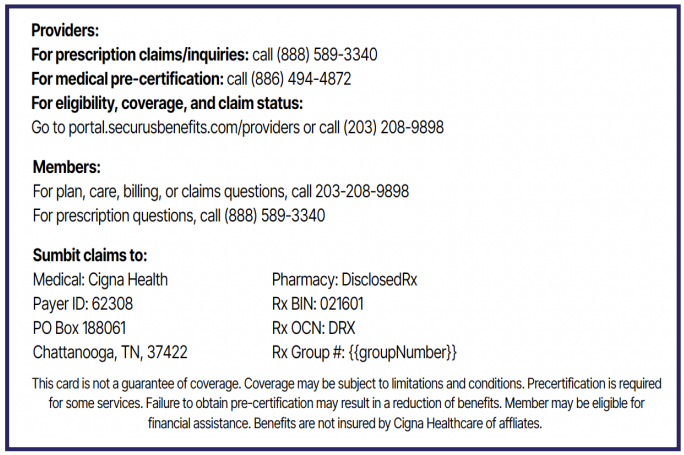
Please provide a copy of the following documents to the Benefits Department when enrolling your dependents so we can verify their eligibility for coverage.

- Spouse
  - – Marriage certificate.
- Dependent Child (for each child)
  - – Birth certificate with parents' name, custody decree, court papers for legal guardianship; adoption or adoption placement papers; qualified medical child support order.

Sample ID Cards

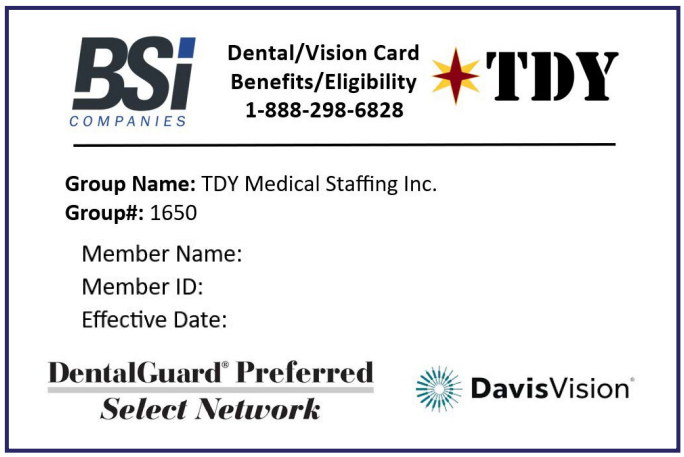
Medical / Rx





- Medical claims are processed by Securus

Dental + Vision (Extra Cost Applies)



- Dental claims are processed by BSI Companies
- Vision claims are processed by Davis Vision

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Your Personal ID Cards!

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Welcome to OneHealth

Thank you for allowing us to provide your medical benefits.

Cigna ChoiceFund PPO - your medical network

TRIAD - the name of your medical plan

Securus - Benefits Administrator that handles your claims, questions, etc.

Numbers to Reference:

- **Call Securus Concierge: 877-420-0785** for questions regarding your policy: claims, coverage, deductibles, etc.
- **Securus Member Portal:** portal.securusbenefits.com/signin
- **Call DisclosedRx: 888-589-3340** for question regarding prescriptions
- **Pharmacy Locator:** https://www.disclosedrx.com/pharmacy-locator
- **Call Evo Health : 1-855-636-3669** for questions regarding your Telehealth services
- **Use Cigna Provider Lookup** to search for a doctor:

https://hcpdirectory.cigna.com/web/public/consumer/directory/search OneHealth

Benefit Plan Options

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Benefit Summary	1,000 Deductible	3,500 Deductible	5,000 Deductible	7,350 Deductible
Benefits	In-Network	In-Network	In-Network	In-Network
Deductible Individual / Family	$1,000 / $2000	$3,500 / $7,000	$5,000 / $10,000	$7,350 / $14,700
Coinsurance Plan Pays /Member Pays	80% / 20%	80% / 20%	80% / 20%	100%
Out-of-Pocket Maximum Individual / Family	$5,000 / $10,000	$7,350 / $14,700	$7,350 / $14,700	$7,350/$14,700
Routine Preventive Services (Non Diagnostic)	No Member Cost Sharing Deductible Waived	No Member Cost Sharing Deductible Waived	No Member Cost Sharing Deductible Waived	No Member Cost Sharing Deductible Waived
Lifetime Maximum	No Maximum	No Maximum	No Maximum	No Maximum
Co-Pay				
Primary Care Co-Pay	$20	$45	$45	$50
Specialist Co-Pay	$40	$90	$90	$100
Chiropractice Care Co-Pay Limited to 20 visits per benefit period	$20	$20	$20	$20
Urgent Care	$40	$90	$90	$100
Embedded No Cost Services				
Telemedicine	$0 Copay	$0 Copay	$0 Copay	$0 Copay
Virtual Primary Care	Included	Included	Included	Included
Advocacy Services	Included	Included	Included	Included
Facility & Professional Services (Patient Responsibility)				
Inpatient Hospital (patient responsibility)	20% after deductible	20% after deductible	20% after deductible	0% after deductible
Out Patient Services Surgical Services (Procedure & Anesthesia)	20% after deductible	20% after deductible	20% after deductible	0% after deductible
Emergency Room	20% after deductible	20% after deductible	20% after deductible	0% after deductible
Laboratory & Diagnostic Services (Patient Responsibility)				
Free Standing Lab & Diagnostic Services (Lab & x-ray)	No Charge	No Charge	No Charge	No Charge
Complex Diagnositc Services (CT, MRI, Ultra Sound, PET, Nuclear	20% after deductible	20% after deductible	20% after deductible	0% after deductible
Professional Fees	20% after deductible	20% after deductible	20% after deductible	0% after deductible
Prescription Drug Benefit				
Prescription Drug	In-Network	In-Network	In-Network	In-Network
Deductible	None	None	None	None
Speciality	Specialty See plan document for more information			
Retail (30 Day Supply)	$15/$45/$85	$15/$65/$100	$15/65/$100	$15/65/$100
Generic	Retail: $15 co-pay	Retail: $15 co-pay	Retail: $15 co-pay	Retail: $15 co-pay
Preferred Brand	Retail: $45 co-pay	Retail: $65 co-pay	Retail: $65 co-pay	Retail: $65 co-pay
Non-Preferred Brand	Retail: $85 co-pay	Retail: $100 co-pay	Retail: $100 co-pay	Retail: $100 co-pay
Mail Order (31-90 Day Supply)	$45/$90/$150	$45/$90/$150	$45/$90/$150	$45/$90/$150
Generic	Mail Order: $45 co-pay	Mail Order: $45 co-pay	Mail Order: $45 co-pay	Mail Order: $45 co-pay
Preferred Brand	Mail Order: $90 co-pay	Mail Order: $90 co-pay	Mail Order: $90 co-pay	Mail Order: $90 co-pay
Non-Preferred Brand	Mail Order: $150 co-pay	Mail Order: $150 co-pay	Mail Order: $150 co-pay	Mail Order: $150 co-pay
Non-Network Services (Patient Responsibility)				
Coinsurance Plan Pays/Member Pays	60% / 40%	60% / 40%	60% / 40%	50% / 50%
Deductible Individual/Family	$2,000 / $4,000	$7,000 / $14,000	$10,000 / $20,000	$14,700 / $29,400
Out of Pocket Maximum Individual/Family	$10,000 / $20,000	$14,700 / $29,400	$14,700 / $29,400	$16,000 / $32,000

- Always utilize services of in-network providers.
- Questions about coverage call 1-877-420-0785
- Ask your providers for an estimate
- Very important to understand what insurance will pay for or not pay for.

SECURUS BENEFITS

Monthly Pricing	Medical	Ancillary Benefits
	26 Pay Periods	26 Pay Periods
**PLAN $1,000	Employee Cost Per Check	Employee Cost Per Check
Employee Only	$161.08	$27.24
Employee/Spouse	$622.45	$55.74
Employee/Child(ren)	$530.17	$65.09
Family	$1,093.05	$101.76
**PLAN $3,500		
Employee Only	$74.30	$27.24
Employee/Spouse	$450.91	$55.74
Employee/Child(ren)	$375.59	$65.09
Family	$836.76	$101.76
**PLAN $5,000		
Employee Only	$49.07	$27.24
Employee/Spouse	$401.04	$55.74
Employee/Child(ren)	$330.65	$65.09
Family	$762.26	$101.76
PLAN $7,350	*Default Plan	
Employee Only	$0.00	$27.24
Employee/Spouse	$304.05	$55.74
Employee/Child(ren)	$243.24	$65.09
Family	$617.33	$101.76

The federal government provides a certain amount of funds to assist with paying for the medical benefits. The default plan (*$7,350 deductible) cost is $771.79 monthly. To obtain funds to pay this amount an employee must work 151.6 hours in two payroll cycles.

You may elect to purchase a **lower deductible plan but at an additional cost to you via payroll deduction on a per paycheck basis as shown above.

Frequently Asked Questions

- **How do I find a medical provider?**
  https://hcpdirectory.cigna.com/web/public/consumer/directory/search

- **When and how can I change my plan?**
  Plans and rates are good for one year from the initial offering date. Once launched, the Health Plan cannot cancel the coverage during the plan year. There will be an open enrollment period every 12 months from the plan start date.

- **Is Telehealth at no charge for any type of doctor?**
  Telehealth is no charge for your Primary Care Physician only. Telehealth calls for a Specialist are the Specialist Copay amount designated on your plan.

- **Are Lab and X-rays covered at 100% on our plans?**
  Yes when using the two noted companies. For Freestanding Labwork and X-rays utilize the service of Quest Laboratories and LabCorp.

- **Additional Services that are the same copay as your PCP:**
  PT/OT, Mental Health Services (outpatient, therapy), Speech Therapy, Chiropractic.

- **When and how do I get copies of my medical ID card?**
  You will receive a Welcome Letter within 7 days of the closing date of your enrollment period. The letter will include a link to the Portal where you can view or download and print a digital ID card. You will also receive a physical card by mail soon thereafter.

- **How do I follow up on a claim?**
  Members should call the number on their ID card to speak with a member advocate who can review their claim. If the member feels they need further assistance, they should then contact OneHealth customer service.

- **Do these plans cover international travel?**
  No. If someone seeks medical attention abroad this plan will not cover them. They should purchase travelers insurance for such instances.

Ancillary Benefits
Dental, Vision, Life + EAP

Benefits are provided as "package" and cannot be elected independently.

- Additional Cost Applies -

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Dental

Voluntary Option (Extra Cost Applies)

Pan-American Life's fully insured comprehensive dental plan provides members and their covered dependents with the Preventive Care, BasicCare, Major Care, and Orthodontia Services they need.

To help minimize out-of-pocket dental expenses members have access to the DentalGuard Preferred Select Network, one of the industry's largest dental preferred provider networks with dentists in over 120,000 locations across the country. Members are free to visit any dentist or specialist they wish. However, by visiting a dentist within the DentalGuard Preferred Select Network, members can save money. How?

- DentalGuard Preferred Select Network dentists are up to 35% less than what most dentists usually charge.
- By taking advantage of the lower fees offered by in-network providers, members can stretch their annual plan maximums further.

Outline of Dental Benefits

Dental Benefits	(per insured)
Coinsurance - Plan Pays	
Preventive - Type I	100%
Basic - TypeII	80%
Major - Type III	50%
Calendar Year Deductible	
Preventive - Type I	Waived
Basic - Type II & Major - Type III	$50
Calendar Year Maximum - (Types I-III)	$1,500
Waiting Period	
Preventive - Type I	None
Basic - Type II	None
Major - Type III	None

Orthodontia – Type IV (only for children if dependent coverage is elected.)	
Charges we cover (coinsurance)	50%
Lifetime Deductible	$50
Lifetime Maximum	$1,000
Waiting Period (Lifetime)	12 Months

Waiting period will not be waived for orthodontia.

BSi COMPANIES

Dental

Voluntary Option (Extra Cost Applies)

Preventive Care - Type I:

- Oral evaluations - 2 per calendar year.
- Prophylaxis (cleanings) - 2 per calendar year.
- Fluoride - 1 per calendar year. Dependents to age 14.
- Bitewing X-Rays - 1 series per calendar year.
- Space maintainers.

Basic Care - Type II:

- Sealants - 1 per tooth every 3 years. Dependents to age 14.
- Fillings - Amalgam, silicate, acrylic, synthetic porcelain and composite filling materials.
- Simple extractions.
- Denture repair or bridges - 1 per 2 years, limited to 20% replacement cost.
- X-Rays (diagnostic, full or panoramic) - 1 every 5 years.
- Re-cementing inlays, onlays, and crowns.
- General anesthesia and analgesic for oral surgery.
- Oral surgery - Removal of teeth. Extraction of tooth root. Alveolectomy, alveoplasty, and frenectomy. Excision oral tissue. Re-implantation or transplantation natural tooth. Excision tumor or cyst.
- Antibiotic injections administered by a dentist.
- Preauthorization required for all services over $300.

Major Care - Type III:

- Periodontics - Root scaling and planning, once per quadrant in any 24 month period.
- Endodontics - Root canal therapy.
- Dentures and bridge work - Initial placement only for natural tooth extracted while covered. Replacement after 10 years from placement if cannot be repaired. Realigning/Rebasing Dentures only once in any 2 year period.
- Inlays/Onlays/Crowns and other prosthetics - If unable to restore with filling materials. Replacement after 10 years of original placement. Will not apply if replacement is due to extraction of functioning natural teeth while covered.
- Missing tooth exclusion - Only replace teeth lost during time covered by our policy.
- Preauthorization required for all services over $300.

To locate a DentalGuard Preferred Select network dentist call 1-800-627-4200, or go to www.GuardianLife.com, and follow these steps:

1. Hover over My Account/Login, from the drop down, select “Find a Provider.”
2. Towards the middle of the page, Select the bullet point “If you have insurance outside Guardian that uses the DentalGuard Preferred Select network, search within that network.”
3. Enter your zip code, city or state to look up providers in your area.

BSI COMPANIES

Vision

Voluntary Option (Extra Cost Applies)

DavisVision™

Highlights

- Allowance on eyewear
- Covered-in-full routine exam
- $10 copay for standard lens options
- No in-network claim paperwork
- Free 1-year breakage warranty
- Fixed lens pricing
- Discounts on LASIK surgery included
- Hearing aid discounts

For more details about the plan, visit **davisvision.com/member** and enter your Client Code **[8999]** or call **1 (800) 836-2094** and enter your Client Code when prompted.

As a member, you have access to the Exclusive Collection of Frames. The Exclusive Collection is available at nearly 9,000 locations across the U.S.

Log in to browse frames, and find a Collection near you. The frame icon indicates that the provider carries the Collection.

Premier Vision Plan Overview

Benefits	In-Network
Eye Exams – every 12 months	**Covered-in-full**
Prescription Eyewear	
Frames – every 12 months	**$150 frame allowance + 20% off coverage[1]**
Exclusive Collections Frames (Fashion/Designer/Premier)	**Covered-in-full / Covered-in-full / Covered-in-full**
Lenses – every 12 months	**$10 copay for standard lenses**
Contacts[2] Evaluation and Fitting – every 12 months (in lieu of eyeglasses)	**$10 copay for conventional lens; Covered-in-full** **$10 copay for specialty lens; $60 allowance** **$150 materials allowance + 15% off overage[1]**
LASIK (refractive surgery)	**$200 one-time / lifetime allowance**

Davis Vision coverage is underwritten by HM Life Insurance Company, Pittsburgh, PA, under policy form series HMP902-VIS or similar, in all states except New York. In New York, coverage is underwritten by HM Life Insurance Company of New York, New York, NY, under policy form series HMP 902-VIS or similar. The coverage or service requested may not be available in all states and is subject to individual state approval.

1 Some limitations apply to additional discounts; discounts not applicable at all in-network providers.

2 Contact lens coverage varies by product selection. Visually Required contacts are covered in full with prior approval. Davis Vision has done its best to accurately reflect plan coverage herein. If differences exist between this document and the plan contract, the contract will prevail.

Vision

Voluntary Option (Extra Cost Applies)

DavisVision™

Lens Option	Copays for lens options and upgrades
Clear plastic single-vision, bifocal, trifocal or lenticular lenses (any RX)	$0
Oversized lenses	$0
Plastic lenses	$0
Polycarbonate lenses (children / adults)	$0 / $30
High index lenses	$55
Polarized lenses	$75
Progressive lenses (Standard / Premium / Ultra)	$50 / $90 / $140
Anti-reflective (AR) coating (Standard / Premium / Ultra)	$35 / $48 / $60
Ultraviolet coating	$12
Tinting of plastic lenses (Solid / Gradient)	$0
Plastic Photochromic Lenses (Transitions® Signature™)	$65
Scratch-resistant coating	$0
Scratch protection plan (Single vision / Multifocal)	$20 / $40

Out-of-network Benefits

You may receive services from an out-of-network provider, although you will receive the greatest value and maximize your benefit dollars if you select a provider who participates in the network.

Out-of-network Reimbursement Schedule (up to)

Eye exam: $40	Trifocal Lenses: $80
Frame: $50	Lenticular Lenses: $100
Single-Vision Lenses: $40	Elective Contact Lenses: $105
Bifocal / Progressive Lenses: $60	Visually Required Contacts: $225

Questions or to locate a vision provider 1-800-836-2094 / davisvision.com/member

Additional Benefit

Voluntary Option (Extra Cost Applies)

Life Insurance	
TERM LIFE / AD&D	**$10,000 / $10,000**

- You may designate a new beneficiary at any time
- Life Insurance reduces from original benefit amount to 65% at age 65, to 40% at age 70, and to 25% at age 75.

Helpful Items to Consider:

- Always present your ID card to your providers.
- Visit in-network providers only for the best experience.
- Out of network are not covered.
- Your health insurance is your primary insurance. Medicare/Medicaid/Tricare is secondary.
- Always ask your service provider what your insurance will pay for or not pay for in advance.
- If you pay for something that does not seem correct – Ask questions or immediately call the number on your ID card.
- When in doubt call the number on your ID card.

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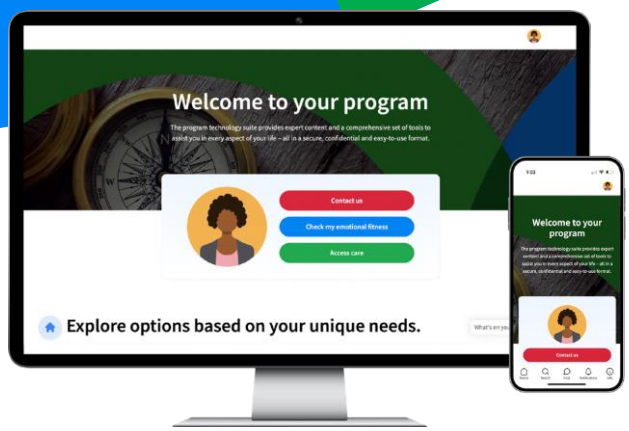
This communication highlights some of the benefit plans available. Your actual rights and benefits are governed by the official plan documents. If any discrepancy exists between this communication and the official plan documents, the official plan documents will always govern.

Emotional wellbeing and work-life balance resources to keep you at your best

SupportLinc offers expert guidance to help you and your family address and resolve everyday issues



In-the-moment support
Reach a licensed clinician by phone 24/7/365 when you call for assistance.

Short-term counseling
Access no-cost in-person or virtual (video) counseling sessions to resolve emotional concerns such as stress, anxiety, depression, burnout or substance use.

Work-life benefits
Receive expert consultations for financial and legal issues. Work-life specialists also provide convenience referrals for everyday needs such as child or elder care, pet care, home improvement or auto repair.

Confidentiality
Strict confidentiality standards ensure no one will know you have accessed the program without your written permission except as required by law.

Your web portal and mobile app
- Create a personal profile to quickly access support from a licensed clinician
- Complete the short Mental Health Navigator assessment and instantly receive personalized guidance to access care and support
- Receive recommendations and care options based on your unique needs
- Exchange text messages with a Coach
- Attend anonymous group support sessions on a variety of topics
- Strengthen your mental health and wellbeing at your own pace with self-guided digital therapy
- Discover flash courses, self-assessments, financial calculators, career resources, articles, tip sheets and videos

Explore Mindstream™
A fitness studio for your mind with live and on-demand sessions to help you strengthen your life skills and emotional health. Engage with sessions anytime and anywhere. Return daily to track progress and discover new releases.

supportlinc

Download the mobile app today!

888-539-3327

supportlinc.com
group code: **panamerican**

Summary of Benefits and Coverage

Plan $1,000

(What this Plan Covers & What You Pay For Covered Services)

TDY Medical Staffing, Inc.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit https://portal.securusbenefits.com or call +18774200785. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call +18774200785 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In Network: Individual: $1,000.00, Family: $2,000.00 Out of Network: Individual: $2,000.00, Family: $4,000.00	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Pharmacy: Generic drug (30 day supply), Generic drug (90 day supply), Preferred drug (30 day supply), Preferred drug (90 day supply), Specialty drug (30 day supply), Non-Preferred drug (30 day supply), Non-Preferred drug (90 day supply) In Network: Many services. See the grid below for details.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In Network: Individual: $5,000.00, Family: $10,000.00 Out of Network: Individual: $10,000.00, Family: $20,000.00	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, pre-certification penalties, balance-billed charges, & health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of pocket limit.
Will you pay less if you use a network provider?	You may pay less if you use a network provider.	
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	In Network: $20.00 Copay Out of Network: 40% Coinsurance after deductible	Some procedures may need pre-certification.
	Specialist visit	In Network: $40.00 Copay Out of Network: 40% Coinsurance after deductible	Some procedures may need pre-certification.
	Preventive care/screening/ immunization	In Network: No charge Out of Network: 40% Coinsurance after deductible	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	In Network: No charge after deductible Out of Network: 40% Coinsurance after deductible	Some procedures may need pre-certification.
	Imaging (CT/PET scans, MRIs)	In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible	Some procedures may need pre-certification.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available by calling +18885893340	Generic drugs	30 Day Supply: $15.00 Copay 90 Day Supply: $45.00 Copay	
	Preferred brand drugs	30 Day Supply: $45.00 Copay 90 Day Supply: $90.00 Copay	
	Non-preferred brand drugs	30 Day Supply: $85.00 Copay 90 Day Supply: $150.00 Copay	
	Specialty drugs	30 Day Supply: 50% Coinsurance 90 Day Supply: Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible	
	Physician/surgeon fees	In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible	Some procedures may need pre-certification.
If you need immediate medical attention	Emergency room care	In Network: 20% Coinsurance after deductible Out of Network: 20% Coinsurance after deductible	
	Emergency medical transportation	In Network: 20% Coinsurance after deductible Out of Network: 20% Coinsurance after deductible	Some procedures may need pre-certification.
	Urgent care	In Network: $40.00 Copay Out of Network: 40% Coinsurance after deductible	
If you have a hospital stay	Facility fee (e.g., hospital room)	In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible	Some procedures may need pre-certification.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
	Physician/surgeon fees	In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible	Some procedures may need pre-certification.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	In Network: $20.00 Copay Out of Network: 40% Coinsurance after deductible	
	Inpatient services	In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible	Some procedures may need pre-certification.
If you are pregnant	Office visits	In Network: $20.00 Copay Out of Network: 40% Coinsurance after deductible	
	Childbirth/delivery professional services	In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible	
	Childbirth/delivery facility services	In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible	Some procedures may need pre-certification.
If you need help recovering or have other special health needs	Home health care	In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible	60 visits per year. Some procedures may need pre-certification.
	Rehabilitation services	In Network: $20.00 Copay Out of Network: 40% Coinsurance after deductible	20 visits per year. Some procedures may need pre-certification.
	Habilitation services	In Network: $20.00 Copay Out of Network: 40% Coinsurance after deductible	20 visits per year. Some procedures may need pre-certification.
	Skilled nursing care	In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible	60 days per year.
	Durable medical equipment	In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible	Some procedures may need pre-certification.
	Hospice services	In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible	
If your child needs dental or eye care	Children's eye exam	$0	Limited to one exam every 24 months except if required more frequently under the Affordable Care Act
	Children's glasses	Not Covered	Glasses are not covered.
	Children's dental check-up	Not Covered	Dental services are not covered.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)
Specialty drug (90 day supply), Hearing Aids, Infertility, Experimental Therapies,

For more information about limitations and exceptions, see the plan or policy document at https://portal.securusbenefits.com/signin

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)
Electroconvulsive Therapy, Abortion, Sterilization Reversal, Impotence, Massage, Reporting Codes, Biofeedback, Surrogacy, Gender Affirming Care, Obesity Treatment, Orthopedic Shoes (Except Diabetics)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)
Hospital Outpatient, Cardiac Rehabilitiation, Freestanding Laboratory, Injections, Chiropractic Services, Laboratory/Diagnostics, Private Duty Nursing, Radiation and Chemotherapy, Adult Eye Exam, Acupuncture

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Labor's Employee Benefits Security Administration at www.dol.gov/ebsa/healthreform or 1-866-444-EBSA. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the Department of Labor's Employee Benefits Security Administration at www.dol.gov/ebsa/healthreform or 1-866-444-EBSA.

Does this plan provide Minimum Essential Coverage? **Yes**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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

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

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of pre-natal care and a hospital delivery)

The plan's overall deductible
$1,000.00

Specialist copay	**$40**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700.00**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,000.00
Copayments	$80.00
Coinsurance	$2,340.00
What isn't covered	
Limits or exclusions	$0.00
The total Peg would pay is	**$3,420.00**

Managing Joe's Type 2 Diabetes

(A year of routine care of a well-controlled condition)

The plan's overall deductible
$1,000.00

Specialist copay	**$40**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs *(preferred brand)*
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600.00**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$1,000.00
Copayments	$65.00
Coinsurance	$920.00
What isn't covered	
Limits or exclusions	$0.00
The total Joe would pay is	**$1,985.00**

Mia's Simple Fracture

(Emergency room visit and follow up care)

The plan's overall deductible
$1,000.00

Specialist copay	**$40**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800.00**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,000.00
Copayments	$20.00
Coinsurance	$360.00
What isn't covered	
Limits or exclusions	$0.00
The total Mia would pay is	**$1,380.00**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Summary of Benefits and Coverage

Plan $3,500

(What this Plan Covers & What You Pay For Covered Services)

- Extra Cost Applies -

TDY Medical Staffing, Inc.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit https://portal.securusbenefits.com or call +18774200785. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call +18774200785 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In Network: Individual: $3,500.00, Family: $7,000.00 Out of Network: Individual: $7,000.00, Family: $14,000.00	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Pharmacy: Generic drug (30 day supply), Generic drug (90 day supply), Specialty drug (30 day supply), Non-Preferred drug (30 day supply), Non-Preferred drug (90 day supply), Preferred drug (30 day supply), Preferred drug (90 day supply) In Network: Many services. See the grid below for details.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In Network: Individual: $7,350.00, Family: $14,700.00 Out of Network: Individual: $14,700.00, Family: $29,400.00	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, pre-certification penalties, balance-billed charges, & health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of pocket limit.
Will you pay less if you use a network provider?	You may pay less if you use a network provider.	
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	In Network: $45.00 Copay Out of Network: 40% Coinsurance after deductible	Some procedures may need pre-certification.
	Specialist visit	In Network: $90.00 Copay Out of Network: 40% Coinsurance after deductible	Some procedures may need pre-certification.
	Preventive care/screening/ immunization	In Network: No charge Out of Network: 40% Coinsurance after deductible	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	In Network: No charge after deductible Out of Network: 40% Coinsurance after deductible	Some procedures may need pre-certification.
	Imaging (CT/PET scans, MRIs)	In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible	Some procedures may need pre-certification.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available by calling +18885893340	Generic drugs	30 Day Supply: $15.00 Copay 90 Day Supply: $45.00 Copay	
	Preferred brand drugs	30 Day Supply: $65.00 Copay 90 Day Supply: $90.00 Copay	
	Non-preferred brand drugs	30 Day Supply: $100.00 Copay 90 Day Supply: $150.00 Copay	
	Specialty drugs	30 Day Supply: 50% Coinsurance 90 Day Supply: Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible	
	Physician/surgeon fees	In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible	Some procedures may need pre-certification.
If you need immediate medical attention	Emergency room care	In Network: 20% Coinsurance after deductible Out of Network: 20% Coinsurance after deductible	
	Emergency medical transportation	In Network: 20% Coinsurance after deductible Out of Network: 20% Coinsurance after deductible	Some procedures may need pre-certification.
	Urgent care	In Network: $90.00 Copay Out of Network: 40% Coinsurance after deductible	
If you have a hospital stay	Facility fee (e.g., hospital room)	In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible	Some procedures may need pre-certification.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
	Physician/surgeon fees	In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible	Some procedures may need pre-certification.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	In Network: $45.00 Copay Out of Network: 40% Coinsurance after deductible	
	Inpatient services	In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible	Some procedures may need pre-certification.
If you are pregnant	Office visits	In Network: $45.00 Copay Out of Network: 40% Coinsurance after deductible	
	Childbirth/delivery professional services	In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible	
	Childbirth/delivery facility services	In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible	Some procedures may need pre-certification.
If you need help recovering or have other special health needs	Home health care	In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible	60 visits per year. Some procedures may need pre-certification.
	Rehabilitation services	In Network: $45.00 Copay Out of Network: 40% Coinsurance after deductible	20 visits per year. Except cardiac rehabilitation, which has a 36 visit/year limit. Some procedures may need pre-certification.
	Habilitation services	In Network: $45.00 Copay Out of Network: 40% Coinsurance after deductible	20 visits per year. Some procedures may need pre-certification.
	Skilled nursing care	In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible	60 days per year.
	Durable medical equipment	In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible	Some procedures may need pre-certification.
	Hospice services	In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible	
If your child needs dental or eye care	Children's eye exam	$0	Limited to one exam every 24 months except if required more frequently under the Affordable Care Act
	Children's glasses	Not Covered	Glasses are not covered.
	Children's dental check-up	Not Covered	Dental services are not covered.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)
Specialty drug (90 day supply), Hearing Aids, Infertility, Experimental Therapies, Electroconvulsive Therapy, Abortion, Sterilization Reversal, Impotence, Massage, Reporting Codes, Biofeedback, Surrogacy, Gender Affirming Care, Obesity Treatment, Orthopedic Shoes (Except Diabetics)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)
Hospital Outpatient, Freestanding Laboratory, Private Duty Nursing, Injections, Adult Eye Exam, Chiropractic Services, Laboratory/Diagnostics, Radiation and Chemotherapy, Acupuncture

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Labor's Employee Benefits Security Administration at www.dol.gov/ebsa/healthreform or 1-866-444-EBSA. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the Department of Labor's Employee Benefits Security Administration at www.dol.gov/ebsa/healthreform or 1-866-444-EBSA.

Does this plan provide Minimum Essential Coverage? **Yes**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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

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

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of pre-natal care and a hospital delivery)

The plan's overall deductible
$3,500.00

Specialist copay	**$90**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700.00**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$3,500.00
Copayments	$180.00
Coinsurance	$1,840.00
What isn't covered	
Limits or exclusions	$0.00
The total Peg would pay is	**$5,520.00**

Managing Joe's Type 2 Diabetes

(A year of routine care of a well-controlled condition)

The plan's overall deductible
$3,500.00

Specialist copay	**$90**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs *(preferred brand)*
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600.00**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$3,500.00
Copayments	$110.00
Coinsurance	$420.00
What isn't covered	
Limits or exclusions	$0.00
The total Joe would pay is	**$4,030.00**

Mia's Simple Fracture

(Emergency room visit and follow up care)

The plan's overall deductible
$3,500.00

Specialist copay	**$90**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800.00**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,800.00
Copayments	$45.00
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$0.00
The total Mia would pay is	**$2,845.00**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Summary of Benefits and Coverage

Plan $5,000

(What this Plan Covers & What You Pay For Covered Services)

- Extra Cost Applies -

TDY Medical Staffing, Inc.

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Important Questions	Answers	Why This Matters:
What is the overall deductible?	In Network: Individual: $5,000.00, Family: $10,000.00 Out of Network: Individual: $10,000.00, Family: $20,000.00	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Pharmacy: Generic drug (30 day supply), Non-Preferred drug (90 day supply), Generic drug (90 day supply), Specialty drug (30 day supply), Non-Preferred drug (30 day supply), Preferred drug (30 day supply), Preferred drug (90 day supply) In Network: Many services. See the grid below for details.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In Network: Individual: $7,350.00, Family: $14,700.00 Out of Network: Individual: $14,700.00, Family: $29,400.00	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, pre-certification penalties, balance-billed charges, & health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of pocket limit.
Will you pay less if you use a network provider?	You may pay less if you use a network provider.	
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	In Network: $45.00 Copay Out of Network: 40% Coinsurance after deductible	Some procedures may need pre-certification.
	Specialist visit	In Network: $90.00 Copay Out of Network: 40% Coinsurance after deductible	Some procedures may need pre-certification.
	Preventive care/screening/ immunization	In Network: No charge Out of Network: 40% Coinsurance after deductible	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	In Network: No charge after deductible Out of Network: 40% Coinsurance after deductible	Some procedures may need pre-certification.
	Imaging (CT/PET scans, MRIs)	In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible	Some procedures may need pre-certification.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available by calling +18885893340	Generic drugs	30 Day Supply: $15.00 Copay 90 Day Supply: $45.00 Copay	
	Preferred brand drugs	30 Day Supply: $65.00 Copay 90 Day Supply: $90.00 Copay	
	Non-preferred brand drugs	30 Day Supply: $100.00 Copay 90 Day Supply: $150.00 Copay	
	Specialty drugs	30 Day Supply: 50% Coinsurance 90 Day Supply: Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible	
	Physician/surgeon fees	In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible	Some procedures may need pre-certification.
If you need immediate medical attention	Emergency room care	In Network: 20% Coinsurance after deductible Out of Network: 20% Coinsurance after deductible	
	Emergency medical transportation	In Network: 20% Coinsurance after deductible Out of Network: 20% Coinsurance after deductible	Some procedures may need pre-certification.
	Urgent care	In Network: $90.00 Copay Out of Network: 40% Coinsurance after deductible	
If you have a hospital stay	Facility fee (e.g., hospital room)	In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible	Some procedures may need pre-certification.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
	Physician/surgeon fees	In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible	Some procedures may need pre-certification.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	In Network: $45.00 Copay Out of Network: 40% Coinsurance after deductible	
	Inpatient services	In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible	Some procedures may need pre-certification.
If you are pregnant	Office visits	In Network: $45.00 Copay Out of Network: 40% Coinsurance after deductible	
	Childbirth/delivery professional services	In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible	
	Childbirth/delivery facility services	In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible	Some procedures may need pre-certification.
If you need help recovering or have other special health needs	Home health care	In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible	60 visits per year. Some procedures may need pre-certification.
	Rehabilitation services	In Network: $45.00 Copay Out of Network: 40% Coinsurance after deductible	20 visits per year. Some procedures may need pre-certification.
	Habilitation services	In Network: $45.00 Copay Out of Network: 40% Coinsurance after deductible	20 visits per year. Some procedures may need pre-certification.
	Skilled nursing care	In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible	60 days per year.
	Durable medical equipment	In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible	Some procedures may need pre-certification.
	Hospice services	In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible	
If your child needs dental or eye care	Children's eye exam	$0	Limited to one exam every 24 months except if required more frequently under the Affordable Care Act
	Children's glasses	Not Covered	Glasses are not covered.
	Children's dental check-up	Not Covered	Dental services are not covered.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)
Specialty drug (90 day supply), Hearing Aids, Infertility, Experimental Therapies,

For more information about limitations and exceptions, see the plan or policy document at https://portal.securusbenefits.com/signin

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)
Electroconvulsive Therapy, Abortion, Sterilization Reversal, Impotence, Massage, Reporting Codes, Biofeedback, Surrogacy, Gender Affirming Care, Obesity Treatment, Orthopedic Shoes (Except Diabetics)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)
Injections, Freestanding Laboratory, Hospital Outpatient, Adult Eye Exam, Cardiac Rehabilitiation, Chiropractic Services, Laboratory/Diagnostics, Radiation and Chemotherapy, Private Duty Nursing, Acupuncture

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Labor's Employee Benefits Security Administration at www.dol.gov/ebsa/healthreform or 1-866-444-EBSA. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the Department of Labor's Employee Benefits Security Administration at www.dol.gov/ebsa/healthreform or 1-866-444-EBSA.

Does this plan provide Minimum Essential Coverage? **Yes**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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

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

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of pre-natal care and a hospital delivery)

The plan's overall deductible
$5,000.00

Specialist copay	**$90**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700.00**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$5,000.00
Copayments	$180.00
Coinsurance	$1,540.00
What isn't covered	
Limits or exclusions	$0.00
The total Peg would pay is	**$6,720.00**

Managing Joe's Type 2 Diabetes

(A year of routine care of a well-controlled condition)

The plan's overall deductible
$5,000.00

Specialist copay	**$90**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs *(preferred brand)*
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600.00**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$5,000.00
Copayments	$110.00
Coinsurance	$120.00
What isn't covered	
Limits or exclusions	$0.00
The total Joe would pay is	**$5,230.00**

Mia's Simple Fracture

(Emergency room visit and follow up care)

The plan's overall deductible
$5,000.00

Specialist copay	**$90**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800.00**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,800.00
Copayments	$45.00
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$0.00
The total Mia would pay is	**$2,845.00**

The plan would be responsible for the other costs of these EXAMPLE covered services.

"Default Plan"

Summary of Benefits and Coverage

Plan $7,350

(What this Plan Covers & What You Pay For Covered Services)

TDY Medical Staffing, Inc.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit https://portal.yuzu.health or call +18774200785. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call +18774200785 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In Network: Individual: $7,350.00, Family: $14,700.00 Out of Network: Individual: $14,700.00, Family: $29,400.00	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Pharmacy: Generic drug (30 day supply), Generic drug (90 day supply), Specialty drug (30 day supply), Preferred drug (30 day supply), Preferred drug (90 day supply), Non-Preferred drug (30 day supply), Non-Preferred drug (90 day supply) In Network: Many services. See the grid below for details.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In Network: Individual: $7,350.00, Family: $14,700.00 Out of Network: Individual: $14,700.00, Family: $29,400.00	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, pre-certification penalties, balance-billed charges, & health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of pocket limit.
Will you pay less if you use a network provider?	You may pay less if you use a network provider.	
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	In Network: $50.00 Copay Out of Network: 50% Coinsurance after deductible	Some procedures may need pre-certification.
	Specialist visit	In Network: $100.00 Copay Out of Network: 50% Coinsurance after deductible	Some procedures may need pre-certification.
	Preventive care/screening/ immunization	In Network: No charge Out of Network: 50% Coinsurance after deductible	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	In Network: No charge after deductible Out of Network: 50% Coinsurance after deductible	Some procedures may need pre-certification.
	Imaging (CT/PET scans, MRIs)	In Network: No charge after deductible Out of Network: 50% Coinsurance after deductible	Some procedures may need pre-certification.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available by calling +18885893340	Generic drugs	30 Day Supply: $15.00 Copay 90 Day Supply: $45.00 Copay	
	Preferred brand drugs	30 Day Supply: $65.00 Copay 90 Day Supply: $90.00 Copay	
	Non-preferred brand drugs	30 Day Supply: $100.00 Copay 90 Day Supply: $150.00 Copay	
	Specialty drugs	30 Day Supply: 50% Coinsurance 90 Day Supply: Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	In Network: No charge after deductible Out of Network: 50% Coinsurance after deductible	
	Physician/surgeon fees	In Network: No charge after deductible Out of Network: 50% Coinsurance after deductible	Some procedures may need pre-certification.
If you need immediate medical attention	Emergency room care	In Network: No charge after deductible Out of Network: No charge after deductible	
	Emergency medical transportation	In Network: No charge after deductible Out of Network: No charge after deductible	Some procedures may need pre-certification.
	Urgent care	In Network: $100.00 Copay Out of Network: 50% Coinsurance after deductible	
If you have a hospital stay	Facility fee (e.g., hospital room)	In Network: No charge after deductible Out of Network: 50% Coinsurance after deductible	Some procedures may need pre-certification.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
	Physician/surgeon fees	In Network: No charge after deductible Out of Network: 50% Coinsurance after deductible	Some procedures may need pre-certification.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	In Network: $50.00 Copay Out of Network: 50% Coinsurance after deductible	
	Inpatient services	In Network: No charge after deductible Out of Network: 50% Coinsurance after deductible	Some procedures may need pre-certification.
If you are pregnant	Office visits	In Network: $50.00 Copay Out of Network: 50% Coinsurance after deductible	
	Childbirth/delivery professional services	In Network: No charge after deductible Out of Network: 50% Coinsurance after deductible	
	Childbirth/delivery facility services	In Network: No charge after deductible Out of Network: 50% Coinsurance after deductible	Some procedures may need pre-certification.
If you need help recovering or have other special health needs	Home health care	In Network: No charge after deductible Out of Network: 50% Coinsurance after deductible	60 visits per year. Some procedures may need pre-certification.
	Rehabilitation services	In Network: $50.00 Copay Out of Network: 50% Coinsurance after deductible	20 visits per year. Some procedures may need pre-certification.
	Habilitation services	In Network: $50.00 Copay Out of Network: 50% Coinsurance after deductible	20 visits per year. Some procedures may need pre-certification.
	Skilled nursing care	In Network: No charge after deductible Out of Network: 50% Coinsurance after deductible	60 days per year.
	Durable medical equipment	In Network: No charge after deductible Out of Network: 50% Coinsurance after deductible	Some procedures may need pre-certification.
	Hospice services	In Network: No charge after deductible Out of Network: 50% Coinsurance after deductible	
If your child needs dental or eye care	Children's eye exam	$0	Limited to one exam every 24 months except if required more frequently under the Affordable Care Act
	Children's glasses	Not Covered	Glasses are not covered.
	Children's dental check-up	Not Covered	Dental services are not covered.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)
Specialty drug (90 day supply), Hearing Aids, Infertility, Nutritional Supplements and

For more information about limitations and exceptions, see the plan or policy document at https://portal.yuzu.health/signin

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)
Vitamins, Experimental Therapies, Electroconvulsive Therapy, Abortion, Sterilization Reversal, Impotence, Massage, Reporting Codes, Biofeedback, Surrogacy, Gender Affirming Care, Obesity Treatment, Orthopedic Shoes (Except Diabetics)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)
Hospital Outpatient, Injections, Chiropractic Services, Private Duty Nursing, Radiation and Chemotherapy, Adult Eye Exam, Freestanding Laboratory, Acupuncture, Cardiac Rehabilitiation, Laboratory/Diagnostics

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Labor's Employee Benefits Security Administration at www.dol.gov/ebsa/healthreform or 1-866-444-EBSA. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the Department of Labor's Employee Benefits Security Administration at www.dol.gov/ebsa/healthreform or 1-866-444-EBSA.

Does this plan provide Minimum Essential Coverage? **Yes**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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

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

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of pre-natal care and a hospital delivery)

The plan's overall deductible
$7,350.00

Specialist copay	**$100**
Hospital (facility) copay	**$0**
Other copay	**$0**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700.00**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$7,350.00
Copayments	$0.00
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$0.00
The total Peg would pay is	**$7,350.00**

Managing Joe's Type 2 Diabetes

(A year of routine care of a well-controlled condition)

The plan's overall deductible
$7,350.00

Specialist copay	**$100**
Hospital (facility) copay	**$0**
Other copay	**$0**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs *(preferred brand)*
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600.00**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$5,600.00
Copayments	$115.00
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$0.00
The total Joe would pay is	**$5,715.00**

Mia's Simple Fracture

(Emergency room visit and follow up care)

The plan's overall deductible
$7,350.00

Specialist copay	**$100**
Hospital (facility) copay	**$0**
Other copay	**$0**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800.00**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,800.00
Copayments	$50.00
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$0.00
The total Mia would pay is	**$2,850.00**

The plan would be responsible for the other costs of these EXAMPLE covered services.

MEDICAL EXCLUSIONS

Some health care services are not covered by the Plan. In addition to the General Exclusions set forth in the General Limitations and Exclusions section above, these include, but are not limited to, any charge for care, supplies, or services, which are:

Alternative Medicine. For holistic or homeopathic treatment, naturopathic services, and thermography, including drugs, unless the TPA grants an exception.

Biofeedback. For biofeedback, which is considered by the plan to be Investigational.

Education or Training Program. Performed by a Physician or other Provider enrolled in an education or training program when such services are related to the education or training program, except as specifically provided herein.

Gender-Affirming Operation. Related to a gender-affirming operation.

Hair Pieces. For wigs, artificial hair pieces, human or artificial hair transplants, or any Drug, prescription or otherwise, used to eliminate baldness except for hair loss resulting from chemotherapy.

Impregnation and Infertility Treatment. Following charges related to impregnation and infertility Treatment: artificial insemination, fertility Drugs, G.I.F.T. (Gamete Intrafallopian Transfer), impotency Drugs such as Viagra, surrogate mother (unless the surrogate is a Participant, in which case the Preventive Care and/or Pregnancy expenses will be covered in accordance with the Plan provisions), donor eggs, collection or purchase of donor semen (sperm) or oocytes (eggs), and freezing of sperm, oocytes, or embryos, or any type of artificial impregnation procedure, whether or not such procedure is successful.

Obesity. Charges for bariatric surgery, including but not limited to, gastric bypass, gastric sleeves, stapling and intestinal bypass, and lap band surgery, including reversals, related to both obesity and Class III obesity (if BMI is equal to or greater than 40.0 kg/m²). For non-Class III obesity, related to care and treatment of obesity, weight loss or dietary control. This Exclusion does not apply to obesity screening and counseling that are covered under the Preventive Care benefit.

Oral Surgery. For oral surgery or dental treatment, except as specifically provided in the Plan.

Routine Patient Costs for Participation in an Approved Clinical Trial. For costs for participation in an Approved Clinical Trial. The following items are excluded from approved clinical trial coverage under this Plan:

1. The cost of an Investigational new drug or device that is not approved for any indication by the U.S. Food and Drug Administration, including a drug or device that is the subject of the Approved Clinical Trial.
2. The cost of a service that is not a health care service, regardless of whether the service is required in connection with participation in an Approved Clinical Trial.
3. The cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular Diagnosis.
4. A cost associated with managing an Approved Clinical Trial.
5. The cost of a health care service that is specifically excluded by the Plan.

6. Services that are part of the subject matter of the Approved Clinical Trial and that are customarily paid for by the research institution conducting the Approved Clinical Trial.

If one or more participating Providers do participate in the Approved Clinical Trial, the qualified plan Participant must participate in the Approved Clinical Trial through a participating, Network Provider, if the Provider will accept the Participant into the trial.

The Plan does not cover routine patient care services that are provided outside of this Plan's health care Provider Network unless Non-Network benefits are otherwise provided under this Plan.

Sexual Dysfunction. For any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.

Sterilization Reversal. For sterilization procedure reversal.

Tobacco Smoking Cessation. For nicotine withdrawal programs, facilities, Drugs or supplies, except as specified under Preventive Care.

Vision Care. Expenses for the following:

1. For eye refractions, eyeglasses, contact lenses, or the vision examination for prescribing or fitting eyeglasses or contact lenses (except for aphakic patients, and soft lenses or sclera shells intended for use in the treatment of Illness or Injury).
2. For radial keratotomy or other plastic surgeries on the cornea in lieu of eyeglasses.
3. Vision therapy (orthoptics) and supplies.
4. Orthokeratology lenses for reshaping the cornea of the eye to improve vision.

**** CONTINUATION COVERAGE RIGHTS UNDER COBRA ****

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: BSi Companies, 304 Ridgeland Dr, Greenville, SC 29601.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. A copy of the Social Security Administration determination notice must be provided within 60 days of the date of the determination and prior to the end of the 18th month on continuation coverage and send to: BSi Companies, 304 Ridgeland Dr, Greenville, SC 29601.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both) where the dependent(s) automatically lose coverage; gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/agencies/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Plan Administrator: BSi Companies - 304 Ridgeland Dr, Greenville, SC 29601

Insurance plan contacts vary with the plan over time and as the company implements new plans. For current Plan Representative, please call the insurance company directly.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2026. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana Medicaid Customer Service Line: 1-888-342-6207 Louisiana Medicaid email: healthy@la.gov Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp LaHIPP phone: 1-877-697-6703 LaHIPP email: La.HIPP@la.gov LaHIPP fax: 1-888-716-9787 LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2026, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 3/31/2026)

SPECIAL ENROLLMENT NOTICE

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

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

To request special enrollment or obtain more information, contact BSI Companies at **1-888-298-6828.**

NEWBORNS' ACT DISCLOSURE

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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

WHCRA ENROLLMENT NOTICE

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 the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore deductibles and coinsurance may apply. If you would like more information on WHCRA benefits, call your plan administrator at **1-888-298-6828.**

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

This group health plan complies with the privacy requirement for Protected Health Information (PHI) under HIPAA. A copy of the Notice of Privacy Practices is available from the insurance carriers for dental and vision insurance. A copy of the Notice of Privacy Practices for medical and prescription drugs is available from Human Resources.