EMPLOYEE BENEFITS SUMMARY

for

ROOKWOOD PROPERTIES
SINCE 1966

Prepared By:

Lang Financial Group, Inc.

Effective 05/01/2024

The benefit descriptions provided herein are intended to be brief outlines and should be used for guidance only. Complete provisions, descriptions, and exclusions of benefits are contained in the appropriate group contracts, plan booklets, and certificates of coverage. In the event of a discrepancy between the actual contracts and this document, the terms of the contracts will prevail. You may request to review contracts for each plan offered prior to enrollment. You will receive detailed certificates of coverage following your enrollment. Plan designs and employee contributions are subject to change.

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BENEFIT SUMMARY INTRODUCTION

To Our Valued Employees:

The following Employee Benefits Summary is prepared to acquaint you with the insurance coverages available to you and to help prepare you for enrollment into the programs. Being better informed will allow you to make better decisions regarding, and better use of, these valuable benefits.

It is with great care and attention that your benefits are selected and reviewed. It is our goal to provide you with the most competitive, comprehensive, and cost effective programs possible.

The benefit descriptions provided herein are intended to be brief outlines and should be used for guidance only. The entire provisions, descriptions, and exclusions of benefits are contained in the Master Group contract. In the event of a conflict between the Group Contract and this document, the terms of the Master Contract will prevail. You may request a summary plan description for each plan offered prior to enrollment or you will receive one shortly after your enrollment. Actual benefits, coverage levels, and premium contribution requirements are subject to change.

Thank you for taking the time to review the benefits available to you and for appreciating the value they deliver as an important piece of your employment with our company.

Sincerely,

Fred Kanter
Rookwood Properties

ROOKWOOD PROPERTIES

OVERVIEW OF ELIGIBILITY & BENEFITS

ELIGIBILITY

Employees:	Must work 30 or more hours per week
Spouse:	Legally married and domestic partners
Dependent Children:	Medical, Dental, Vision & Life - to age 26, terminating end of calendar month of attaining limiting age

SERVICE WAITING PERIOD AND WHEN BENEFITS BEGIN

Medical, Dental and Vision:	First of the month following date of hire
Life, Voluntary Life, Long Term Disability, & Short Term Disability:	Immediately following 90 days of employment

(Note: Employees must enroll for coverages within 30 days of becoming eligible to be assured of full benefits)

BENEFITS END

Medical, Dental & Vision:	Coverage terminates at the end of month following termination of eligibility/employment
Life, Voluntary Life, Long Term Disability, & Short Term Disability:	Coverage terminates end of last day worked

Continuation rights (i.e. State, COBRA, portability, conversion) may exist, typically within the first 30 days. Contact the insuring carrier for details and process.

BENEFITS AVAILABLE TO YOU

Life Insurance	The Hartford	Employer Paid
Short Term Disability Insurance	The Hartford	Employer Paid
Long Term Disability Insurance	The Hartford	Employer Paid
Medical Insurance	United Healthcare	Employee and Employer Paid
Dental Insurance	United Healthcare	Employee and Employer Paid
Voluntary Vision	United Healthcare	Employee Paid
Voluntary Life	The Hartford	Employee Paid

BENEFITS AVAILABLE TO YOUR DEPENDENTS

Medical Insurance	United Healthcare	Employee and Employer Paid
Dental Insurance	United Healthcare	Employee and Employer Paid
Voluntary Vision	United Healthcare	Employee Paid
Voluntary Life	The Hartford	Employee Paid

ROOKWOOD PROPERTIES

Contribution Schedule (05/01/2024)

EMPLOYEE CONTRIBUTION - PER BI-WEEKLY PAY BASIS (26 Pay Periods Per Year)

LIFE/AD&D INSURANCE - The Hartford	
Employee Life Insurance - $40,000	100% Employer Paid
VOLUNTARY LIFE/AD&D INSURANCE - The Hartford	
Employee, Spouse & Children Coverage	100% Employee Paid
SHORT TERM DISABILITY INSURANCE - The Hartford	
Employee Coverage	100% Employer Paid
LONG TERM DISABILITY INSURANCE - The Hartford	
Employee Coverage	100% Employer Paid

MEDICAL - UHC * Per Pay (26 Pays)	**Plan 1 – 3200/6400/100% (DJM6)**	**Plan 2 – 4000/8000 100% (CYPP)**	**Plan 3 - 3500/7000 80% (CYPT)**
Single	$81	$87	$80
Employee/Spouse	$187	$202	$186
Employee/Child(ren)	$142	$153	$141
Family Coverage	$267	$288	$264

If your spouse is eligible for his/her employer's coverage and you choose to enroll your spouse on Rookwood's medical plan, there will be an additional $50 charge per pay period as illustrated above.

DENTAL - UHC *	Per Pay (26) Contribution
Single	$5.10
Employee/Spouse	$16.43
Employee/Child(ren)	$16.43
Family	$19.75

VISION - UHC *	Per Pay (26) Contribution
Single	$2.78
Employee/Spouse	$5.27
Employee/Child(ren)	$6.18
Family	$8.70

Note:
The completion of enrollment forms are required if you are electing or waiving coverage.

You cannot be denied benefits eligibility if you enroll within 30 days of becoming eligible for coverage.

Failure to enroll "on a timely basis" (within 30 days of becoming eligible for coverage) will require waiting until an annual "open enrollment period". If you have experienced a life status change "qualifying event" (e.g. marriage, divorce, death of spouse, birth of a child, adoption, or loss of coverage) and enroll within 30 days of the event, you will be considered a timely enrollee.

* Employees may elect to contribute premium share with before-tax dollars as permitted under IRC Section 125.

PRE-TAX BENEFITS

Through Section 125 of the Internal Revenue Code (also referred to as “Cafeteria Plans”), certain benefits may be purchased by employees with before-tax dollars. This opportunity can be an advantage for employees by reducing the amount of taxes paid and increasing the amount of take-home pay.

You can take advantage of this pre-tax option by voluntarily reducing your gross pay by the exact dollar amount you would otherwise be paying for benefits through payroll deduction.

Here is an example of how the concept works. In this example, an employee must contribute toward the premium in order to participate in the employer’s group insurance plan.

(Note: The numbers used are for illustrative purposes only and are chosen for simplicity!)

ASSUMPTIONS:

Employee Gross Pay	$100
Required Premium Contribution	$20
Federal Tax	15.00%
State Tax	2.35%
Social Security Tax	7.65%

(Total of Federal, State, and Social Security Taxes = 25%)

ILLUSTRATION:

	Without Pre-Tax Benefit	With Pre-Tax Benefit*
Employee Gross Pay	$100	$100
Pre-Tax Premium Contribution	--	$20
Pay Subject to Taxes	$100	$80
Taxes (25% of above)	$25	$20
Net Pay	$75	$60
Payroll Deducted Premium	$20	--
Take-Home Pay	**$55**	**$60 ****

* Actual tax savings will be determined by an individual’s tax bracket and exemption election.

** Eligibility for additional savings is available for individuals employed in the State of Ohio. "City/Municipality" tax is saved for these employees (example: City of Cincinnati employees would save an additional 2.1% tax savings). States other than Ohio will have their own municipality tax rules apply.

NOTE: You cannot change or revoke your Pre-Tax Benefit election within a plan year unless there is significant change in your benefits coverage or in the cost of your insurance premium, or you have a change in family status in accordance with IRC Section 125 regulations.

Each year you will have the option to elect Pre-Tax Benefits.

As shown above, by reducing taxes, the Pre-Tax Benefit option increases the employee’s take-home pay. The employee makes the same premium contribution under either option but ends up with more money through the Pre-Tax Benefit.

TRIPLE CHOICE MEDICAL INSURANCE; EFFECTIVE 05/01/2024

Eligible employees are provided the choice to select between three (3) different plans of medical insurance:

United Healthcare		Plan 1 – 3200/6400/100% (DJM6)	Plan 2 – 4000/8000 100% (CYPP)	Plan 3 - 3500/7000 80% (CYPT)
Network		Choice Plus	Choice Plus	Choice Plus
Benefits Accumulate		Calendar Year	Calendar Year	Calendar Year
Health Savings Account (Employee Funded)		2024 Funding Limits: $4,150 Single; $8,300 All Other Age 55 or older additional $1,000	Not Permitted	Not Permitted
Deductible	Network	$3,200 Single; $6,400 Family Embedded	$4,000 Single; $8,000 Family Embedded	$3,500 Single; $7,000 Family Embedded
Preventive Services		Covered In Full	Covered In Full	Covered In Full
Coinsurance		100%	100%	80%
Out of Pocket		$5,000 Single; $10,000 Family	$4,000 Single; $8,000 Family	$7,150 Single; $14,300 Family
In/Out Patient Hosp.		100% after Deductible	100% after Deductible	80% after Deductible
Doctor Office (In Office/Telemedicine)		PCP: $25 after Deductible SCP: $50 after Deductible	PCP: $15 (under age 19 No Copay) SPC: Designated Network $50 SPC: Network $100	PCP: $15 (under age 19 No Copay) SPC: Designated Network $50 SPC: Network $100
Virtual Visits from a Designated Virtual Network Provider		No Copay	No Copay	No Copay
Urgent Care		$75 Copay after Deductible	$25 Copay	$25 Copay
Emergency Room		$250 Copay after Deductible	100% after Deductible	$300 Copay after Deductible then 80%
Prescription Drugs (Retail)		Deductible then $10/$40/$85/$250 (Mail Order 2.5x)	$10/$40/$85/$250 (Mail Order 2.5x)	$10/$40/$85/$250 (Mail Order 2.5x)
Bi-Weekly Deduction (26 Pays)		**Plan 1 – 3200/6400/100% (DJM6)**	**Plan 2 – 4000/8000 100% (CYPP)**	**Plan 3 - 3500/7000 80% (CYPT)**
Single		$81	$87	$80
Employee/Spouse		$187	$202	$186
Employee/Child(ren)		$142	$153	$141
Family Coverage		$267	$288	$264

If your spouse is eligible for his/her employer's coverage and you choose to enroll your spouse on Rookwood's medical plan there will be an additional $50 charge per pay period to the above amounts.

In making your selection, please review and weigh carefully the following summaries of benefits and network of participating providers. Compare the premium contributions required of each plan for the coverage category (i.e. Employee Only, Employee and Spouse, Employee and Child(ren), or Family) for which you will elect to be insured.

- The selection of the plan must be a common election shared by all covered family members
- The selection of the plan is an Annual Election which may be changed only at Open Enrollment.

Choice Plus plan details, all in one place.

Use this benefit summary to learn more about this plan's benefits, ways you can get help managing costs and how you may get more out of this health plan.

Check out what's included in the plan	Choice Plus
Network coverage only You can usually save money when you receive care for covered health care services from network providers.	☐
Network and out-of-network benefits You may receive care and services from network and out-of-network providers and facilities — but staying in the network can help lower your costs.	☑
Primary care physician (PCP) required With this plan, you need to select a PCP — the doctor who plays a key role in helping manage your care. Each enrolled person on your plan will need to choose a PCP.	☐
Referrals required You'll need referrals from your PCP before seeing a specialist or getting certain health care services.	☐
Preventive care covered at 100% There is no additional cost to you for seeing a network provider for preventive care.	☑
Pharmacy benefits With this plan, you have coverage that helps pay for prescription drugs and medications.	☑
Tier 1 providers Using Tier 1 providers may bring you the greatest value from your health care benefits. These PCPs and medical specialists meet national standard benchmarks for quality care and cost savings.	☑
Freestanding centers You may pay less when you use certain freestanding centers — health care facilities that do not bill for services as part of a hospital, such as MRI or surgery centers.	☐
Health savings account (HSA) With an HSA, you've got a personal bank account that lets you put money aside, tax-free. Use it to save and pay for qualified medical expenses.	☑

This Benefit Summary is to highlight your Benefits. Don't use this document to understand your exact coverage. If this Benefit Summary conflicts with the Certificate of Coverage (COC), Schedule of Benefits, Riders, and/or Amendments, those documents govern. Review your COC for an exact description of the services and supplies that are and are not covered, those which are excluded or limited, and other terms and conditions of coverage.

Here's a more in-depth look at how Choice Plus works.

Medical Benefits

	In Network	Out-of-Network
Annual Medical Deductible		
Individual	$3,200	$7,500
Family	$6,400	$15,000

All individual deductible amounts will count toward the family deductible, but an individual will not have to pay more than the individual deductible amount.

**After the Annual Medical Deductible has been met.*

You're responsible for paying 100% of your medical expenses until you reach your deductible. For certain covered services, you may be required to pay a fixed dollar amount - your copay.

Annual Out-of-Pocket Limit		
Individual	$5,000	$15,000
Family	$10,000	$30,000

All individual out-of-pocket maximum amounts will count toward the family out-of-pocket maximum, but an individual will not have to pay more than the individual out-of-pocket maximum amount.

Once you've met your deductible, you start sharing costs with your plan - coinsurance. You continue paying a portion of the expense until you reach your out-of-pocket limit. From there, your plan pays 100% of allowed amounts for the rest of the plan year.

The Federal individual Out-of-Pocket Limit applies to each individual regardless of whether the individual is enrolled in single coverage or family coverage.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Designated Network	Network	Out-of-Network
Preventive Care Services			
Preventive Care Services *Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a copay, co-insurance or deductible.* *Includes services such as Routine Wellness Checkups, Immunizations, Breast Pumps, Mammography and Colorectal Cancer Screenings.*		No copay	50%*
Office Services - Sickness & Injury			
Primary Care Physician *Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.* *Telehealth is covered at the same cost share as in the office.*		$25 copay*	50%*
Specialist *Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.* *Telehealth is covered at the same cost share as in the office.*		$50 copay*	50%*

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Designated Network	Network	Out-of-Network
Urgent Care Center Services		$75 copay*	50%*
Virtual Care Services		No copay	50%*
Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Visit Network Provider by contacting us at myuhc.com® or the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.			
Emergency Care			
Ambulance Services - Emergency Ambulance			
Air Ambulance		No copay*	No copay*
Ground Ambulance		No copay*	No copay*
Ambulance Services - Non-Emergency Ambulance[1]			
Air Ambulance		No copay*	No copay*
Ground Ambulance		No copay*	50%*
Dental Services - Accident Only		No copay*	No copay*
Emergency Health Care Services[1]		$250 copay*	$250 copay*
Inpatient Care			
Congenital Heart Disease (CHD) Surgeries[1]		No copay*	50%*
Habilitative Services - Inpatient[1]	The amount you pay is based on where the covered health care service is provided.		
Limit will be the same as, and combined with, those stated under Skilled Nursing Facility/Inpatient Rehabilitation Services.			
Hospital - Inpatient Stay[1]		No copay*	50%*
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services[1]		No copay*	50%*
Limited to 60 days per year.			
Outpatient Care			
Habilitative Services - Outpatient		$25 copay*	50%*
Limited to 20 visits of occupational therapy related to Autism Spectrum Disorder per year.			
Limited to 20 visits of physical therapy related to Autism Spectrum Disorder per year.			
Limited to 20 visits of speech therapy related to Autism Spectrum Disorder per year.			
Limited to 20 hours per week of clinical therapeutic intervention.			
Limits will be the same as, and combined with those stated under Rehabilitation Services - Outpatient Therapy and Manipulative Treatment.			

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Designated Network	Network	Out-of-Network
Home Health Care[1] *Limited to 60 visits per year.* *One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.*		No copay*	50%*
Lab, X-Ray and Diagnostic - Outpatient - Lab Testing[1] *Limited to 18 Definitive Drug Tests per year.* *Limited to 18 Presumptive Drug Tests per year.* *For Designated Network Benefits, laboratory services must be received from a Designated Diagnostic Provider. Network Benefits include laboratory services received from a Network provider that is not a Designated Diagnostic Provider.*	No copay*	50%*	50%*
Lab, X-Ray and Diagnostic - Outpatient - X-Ray and other Diagnostic Testing[1]		No copay*	50%*
Major Diagnostic and Imaging - Outpatient[1] *For Designated Network Benefits, services must be received from a Designated Diagnostic Provider. Network Benefits include services received from a Network provider that is not a Designated Diagnostic Provider.* *You may have to pay an extra copay, deductible or coinsurance for physician fees or pharmaceutical products.*	No copay*	You pay a $500 per occurrence deductible per service prior to and in addition to paying any Annual Deductible and any coinsurance amount. 50%*	You pay a $500 per occurrence deductible per service prior to and in addition to paying any Annual Deductible and any coinsurance amount. 50%*
Physician Fees for Surgical and Medical Services		No copay*	50%*
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment *Limited to 20 visits of cognitive rehabilitation therapy per year.* *Limited to 20 visits of manipulative treatments per year.* *Limited to 20 visits of occupational therapy per year.* *Limited to 20 visits of physical therapy per year.* *Limited to 20 visits of pulmonary rehabilitation therapy per year.* *Limited to 20 visits of speech therapy per year.* *Limited to 30 visits of post-cochlear implant aural therapy per year.* *Limited to 36 visits of cardiac rehabilitation therapy per year.*		$25 copay*	50%*
Scopic Procedures - Outpatient Diagnostic and Therapeutic *Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.*		No copay*	50%*
Surgery - Outpatient[1]		No copay*	50%*

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	What You Pay for Services		
	Designated Network	Network	Out-of-Network
Therapeutic Treatments - Outpatient[1] *Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.*		No copay*	50%*
Supplies and Services			
Diabetes Self-Management Items[1]	The amount you pay is based on where the covered health care service is provided under Durable Medical Equipment (DME), Orthotics and Supplies or in the Prescription Drug Benefits Section.		
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care[1]	The amount you pay is based on where the covered health care service is provided.		
Durable Medical Equipment (DME), Orthotics and Supplies[1] *Limited to a single purchase of a type of DME or orthotic every 3 years.* *Repair and/or replacement of DME or orthotics would apply to this limit in the same manner as a purchase. This limit does not apply to wound vacuums.*		No copay*	50%*
Enteral Nutrition		No copay*	50%*
Hearing Aids *Limited to $2,500 every year.* *Limited to a single purchase per hearing impaired ear every 3 years.* *Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.*		No copay*	50%*
Ostomy Supplies		No copay*	50%*
Pharmaceutical Products - Outpatient *This includes medications given at a doctor's office, or in a covered person's home.*		No copay*	50%*
Prosthetic Devices[1] *Limited to a single purchase of each type of prosthetic device every 3 years.* *Repair and/or replacement of a prosthetic device would apply to this limit in the same manner as a purchase.*		No copay*	50%*
Urinary Catheters		No copay*	50%*
Pregnancy			
Pregnancy - Maternity Services[1]	The amount you pay is based on where the covered health care service is provided except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.		
Mental Health Care & Substance Related and Addictive Disorder Services			
Inpatient[1]		No copay*	50%*
Outpatient		No copay*	50%*

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	Designated Network	Network	Out-of-Network
Partial Hospitalization[1]		No copay*	50%*
Other Services			
Cellular and Gene Therapy[1] *For Network Benefits, Cellular or Gene Therapy services must be received from a Designated Provider.*	The amount you pay is based on where the covered health care service is provided.		
Clinical Trials[1]	The amount you pay is based on where the covered health care service is provided.		
Fertility Preservation for Iatrogenic Infertility[1] *Limited to $20,000 per Covered Person per lifetime.* *Limited to $5,000 for Prescription Drug Products per Covered Person.* *Limited to 1 cycle of fertility preservation for Iatrogenic Infertility per lifetime.* *This Benefit limit will be the same as, and combined with, those stated under Preimplantation Genetic Testing (PGT) and Related Services.*		No copay*	50%*
Gender Dysphoria[1]	The amount you pay is based on where the covered health care service is provided or in the Prescription Drug Benefits Section.		
Hospice Care[1]		No copay*	50%*
Preimplantation Genetic Testing (PGT) and Related Services[1] *Benefit limits for related services will be the same as, and combined with, those stated under Fertility Preservation for Iatrogenic Infertility. This limit does not include Preimplantation Genetic Testing (PGT) for the specific genetic disorder. This limit includes Benefits for ovarian stimulation medications provided under the Outpatient Prescription Drug Rider.*		No copay*	50%*
Reconstructive Procedures[1]	The amount you pay is based on where the covered health care service is provided.		
Telehealth Services	The amount you pay is based on where the covered health care service is provided.		
Transplantation Services[1] *Network Benefits must be received from a Designated Provider.*	The amount you pay is based on where the covered health care service is provided.		

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

Pharmacy Benefits

Pharmacy Plan Details	
Pharmacy Network	National
Prescription Drug List	Essential
	In Network
Annual Pharmacy Deductible	
Individual	See the Annual Medical Deductible section
Family	See the Annual Medical Deductible section

Annual Deductible - Network and Out-of-Network

The Pharmacy Deductible is the amount you pay for pharmacy expenses per year before you begin to receive Pharmacy Benefits.

Prescription Drug Product Tier Level	Up to a 31-day supply		Up to a 90-day supply
	Retail and Specialty Pharmacy Network	**Out-of-Network Retail Pharmacy**	**In-Network Mail Order Pharmacy****
Tier 1 $	$10*	$10*	$25*
Tier 2 $$	$40*	$40*	$100*
Tier 3 $$$	$85*	$85*	$212.50*
Tier 4 $$$$	$250*	$250*	$625*

** Only certain Prescription Drug Products are available through mail order; please visit myuhc.com® or call Customer Care at the telephone number on the back of your ID card for more information. You will be charged a retail Copayment and/or Coinsurance for 31 days or 2 times for 60 days based on the number of days supply dispensed for any Prescription Order or Refills sent to the mail order pharmacy. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate, rather than a 30-day supply with three refills.

Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4.

If you are a member, you can find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging into your account on myuhc.com® or calling the Customer Care number on your ID card. If you are not a member, you can view prescription information at welcometouhc.com > Benefits > Pharmacy Benefits.

HEALTH SAVINGS ACCOUNTS

A Health Savings Account (HSA) is an account that you can put money into to save for future medical expenses. There are certain advantages to putting money into these accounts, including favorable tax treatment. HSAs were signed into law by President Bush on December 8, 2003.

Who Can Have an HSA

Any adult can contribute to an HSA if they:

- Have coverage under an HSA-qualified "high deductible health plan" (HDHP)
- Have no other first-dollar medical coverage (other types of insurance like specific injury insurance or accident, disability, dental care, vision care, or long-term care insurance are permitted).
- Are not enrolled in Medicare.
- Cannot be claimed as a dependent on someone else's tax return.

Contributions to your HSA can be made by you, your employer, or both. However, the total contributions are limited annually. If you make a contribution, you can deduct the contributions (even if you do not itemize deductions) when completing your federal income tax return. Contributions to the account must stop once you are enrolled in Medicare. However, you can keep the money in your account and use it pay for medical expenses tax-free.

High Deductible Health Plans (HDHPs)

You must have coverage under an HSA-qualified "high deductible health plan" (HDHP) to open and contribute to an HSA. Generally, this is health insurance that does not cover first dollar medical expenses.

Federal law requires that the health insurance deductible be at least:

$1,600 -- Self-only coverage (2024) $3,200 -- Family coverage (2024)

In addition, annual out-of-pocket expenses under the plan (including deductibles, co-pays, and co-insurance) cannot exceed:

$8,050 -- Self-only coverage (2024) $16,100 -- Family coverage (2024)

In general, the deductible must apply to all medical expenses (including prescriptions) covered by the plan. However, plans can pay for "preventive care" services on a first-dollar basis (with or without a co-pay). "Preventive care" can include routine pre-natal and well-child care, child and adult immunizations, annual physicals, mammograms, pap smears, etc.

Finding HDHP Coverage

Any company that sells health insurance coverage in your state may offer HDHP policies. Although Treasury cannot recommend any specific names of companies selling these policies, you should be able to find a qualified policy by contacting your current insurance company, an agent or broker licensed to sell health insurance in your state, or your state insurance department.

HSA Contributions

You can make a contribution to your HSA each year that you are eligible. **For 2024**, you can contribute up to **$4,150 if you have Self-only** coverage and **$8,300 if you have Family** coverage**.**

Catch-Up Contributions

Individuals **age 55 and older** can also make additional **"catch-up" contributions**. The maximum annual catch-up contribution is as follows: **$1,000**

Determining Your Contribution

Your eligibility to contribute to an HSA for each month is generally determined by the whether you have HDHP coverage on the first day of the month. Your maximum contribution for the year is the greater of: (1) *the full contribution*, or (2) *the pro rated amount*. The full contribution is the maximum annual contribution for the type of coverage you have on December 1. The pro rated amount is 1/12 of the maximum annual contribution for the type of HDHP coverage you have times the number of months you have that type of coverage. If your contribution is greater than the pro rated amount, and you fail to remain covered by an HDHP for the entire following year, the extra contribution above the pro rated amount is included in income and subject to an additional 20 percent tax.
(Contributions can be made as late as April 15 of the following year.)

Using Your HSA

You can use the money in the account to pay for any "qualified medical expense" permitted under federal tax law. This includes most medical care and services, and dental and vision care.

You can generally not use the money to pay for medical insurance premiums, except under specific circumstances, including:

- Any health plan coverage while receiving federal or state unemployment benefits.
- COBRA continuation coverage after leaving employment with a company that offers health insurance coverage.
- Qualified long-term care insurance.
- Medicare premiums and out-of-pocket expenses, including deductibles, co-pays, and coinsurance for:
  - → Part A (hospital and inpatient services)
  - → Part B (physician and outpatient services)
  - → Part C (Medicare HMO and PPO plans)
  - → Part D (prescription drugs)

You can use the money in the account to pay for medical expenses of yourself, your spouse, or your dependent children. You can pay for expenses of your spouse and dependent children even if they are not covered by your HDHP. Any amounts used for purposes other than to pay for "qualified medical expenses" are taxable as income and subject to an additional 20% tax penalty.

Examples of non-qualified expenses include:

- Medical expenses that are not considered "qualified medical expenses" under federal tax law (e.g., cosmetic surgery).
- Other types of health insurance unless specifically described above.
- Medicare supplements insurance premiums.
- Expenses that are not medical or health-related.

After you turn age 65, the 20% additional tax penalty no longer applies. If you become disabled and/or enroll in Medicare, the account can be used for other purposes without paying the additional 20% penalty.

Advantages of HSAs

Security: Your high deductible insurance and HSA protect you against high or unexpected medical bills.

Affordability: You should be able to lower your health insurance premiums by switching to health insurance coverage with a higher deductible.

Flexibility: You can use the funds in your account to pay for current medical expenses, including expenses that your insurance may not cover, or save the money in your account for future needs, such as-

- → Health insurance or medical expenses if unemployed
- → Medical expenses after retirement (before Medicare)
- → Out-of-pocket expenses when covered by Medicare
- → Long-term care expenses and insurance

Savings: You can save the money in your account for future medical expenses and grow your account through investment earnings.

Control: You make all the decisions about:

- → How much money to put into the account
- → Which company will hold the account
- → Which investments to make
- → Which medical expenses to pay from the account
- → Whether to invest any of the money in the account
- → Whether to save the account for future expenses or pay current medical expenses

Portability: Accounts are completely portable, meaning you can keep your HSA even if you:

- → Change jobs
- → Become unemployed
- → Change your marital status
- → Change your medical coverage
- → Move to another state

Ownership: Funds remain in the account from year to year, just like an IRA. There are no "use it or lose it" rules for HSAs.

Tax Savings: An HSA provides you triple tax savings -

(1) Tax deductions when you contribute to your account;
(2) Tax-free earnings through investment; and,
(3) Tax-free withdrawals for qualified medical expenses.

What Happens to My HSA When I Die?

If your spouse becomes the owner of the account, your spouse can use it as if it were their own HSA. If you are not married, the account will no longer be treated as an HSA upon your death. The account will pass to your beneficiary or become part of your estate (and be subject to any applicable taxes).

Opening Your Health Savings Account

Banks, credit unions, insurance companies and other financial institutions are permitted to be trustees or custodians of these accounts. Other financial institutions that handle IRAs or Archer MSAs are also automatically qualified to establish HSAs

Need More Information about HSAs?

Treasury's web site has additional information about Health Savings Accounts, including answers to frequently asked questions, related IRS forms and publications, technical guidance, and links to other helpful web sites. Treasury's HSA website can be found through www.treas.gov (search "Health Savings Accounts") or directly at the following address: www.treasury.gov/resource-center/faqs/taxes/pages/health-savings-accounts.aspx

Choice Plus plan details, all in one place.

Use this benefit summary to learn more about this plan's benefits, ways you can get help managing costs and how you may get more out of this health plan.

Check out what's included in the plan	Choice Plus
Network coverage only You can usually save money when you receive care for covered health care services from network providers.	☐
Network and out-of-network benefits You may receive care and services from network and out-of-network providers and facilities — but staying in the network can help lower your costs.	☑
Primary care physician (PCP) required With this plan, you need to select a PCP — the doctor who plays a key role in helping manage your care. Each enrolled person on your plan will need to choose a PCP.	☐
Referrals required You'll need referrals from your PCP before seeing a specialist or getting certain health care services.	☐
Preventive care covered at 100% There is no additional cost to you for seeing a network provider for preventive care.	☑
Pharmacy benefits With this plan, you have coverage that helps pay for prescription drugs and medications.	☑
Tier 1 providers Using Tier 1 providers may bring you the greatest value from your health care benefits. These PCPs and medical specialists meet national standard benchmarks for quality care and cost savings.	☑
Freestanding centers You may pay less when you use certain freestanding centers — health care facilities that do not bill for services as part of a hospital, such as MRI or surgery centers.	☐
Health savings account (HSA) With an HSA, you've got a personal bank account that lets you put money aside, tax-free. Use it to save and pay for qualified medical expenses.	☐

This Benefit Summary is to highlight your Benefits. Don't use this document to understand your exact coverage. If this Benefit Summary conflicts with the Certificate of Coverage (COC), Schedule of Benefits, Riders, and/or Amendments, those documents govern. Review your COC for an exact description of the services and supplies that are and are not covered, those which are excluded or limited, and other terms and conditions of coverage.

Here's a more in-depth look at how Choice Plus works.

Medical Benefits

	In Network	Out-of-Network
Annual Medical Deductible		
Individual	$4,000	$10,000
Family	$8,000	$20,000

All individual deductible amounts will count toward the family deductible, but an individual will not have to pay more than the individual deductible amount.

**After the Annual Medical Deductible has been met.*

You're responsible for paying 100% of your medical expenses until you reach your deductible. For certain covered services, you may be required to pay a fixed dollar amount - your copay.

Annual Out-of-Pocket Limit		
Individual	$4,000	$20,000
Family	$8,000	$40,000

All individual out-of-pocket maximum amounts will count toward the family out-of-pocket maximum, but an individual will not have to pay more than the individual out-of-pocket maximum amount.

Once you've met your deductible, you start sharing costs with your plan - coinsurance. You continue paying a portion of the expense until you reach your out-of-pocket limit. From there, your plan pays 100% of allowed amounts for the rest of the plan year.

The Federal individual Out-of-Pocket Limit applies to each individual regardless of whether the individual is enrolled in single coverage or family coverage.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Designated Network	Network	Out-of-Network
Preventive Care Services			
Preventive Care Services		No copay	50%*
Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a copay, co-insurance or deductible.			
Includes services such as Routine Wellness Checkups, Immunizations, Breast Pumps, Mammography and Colorectal Cancer Screenings.			
Office Services - Sickness & Injury			
Primary Care Physician			
All other covered persons	$15 copay	$15 copay	50%*
Covered persons less than age 19	No copay	No copay	50%*
Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.			
Telehealth is covered at the same cost share as in the office.			

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Designated Network	Network	Out-of-Network
Specialist *Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.* *Telehealth is covered at the same cost share as in the office.*	$50 copay	$100 copay	50%*
Urgent Care Center Services		$25 copay	50%*
Virtual Care Services *Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Visit Network Provider by contacting us at myuhc.com® or the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.*		No copay	50%*
Emergency Care			
Ambulance Services - Emergency Ambulance			
Air Ambulance		No copay*	No copay*
Ground Ambulance		No copay*	No copay*
Ambulance Services - Non-Emergency Ambulance[1]			
Air Ambulance		No copay*	No copay*
Ground Ambulance		No copay*	50%*
Dental Services - Accident Only		No copay*	No copay*
Emergency Health Care Services[1]		No copay*	No copay*
Inpatient Care			
Congenital Heart Disease (CHD) Surgeries[1]		No copay*	50%*
Habilitative Services - Inpatient[1] *Limit will be the same as, and combined with, those stated under Skilled Nursing Facility/Inpatient Rehabilitation Services.*	The amount you pay is based on where the covered health care service is provided.		
Hospital - Inpatient Stay[1]		No copay*	50%*
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services[1] *Limited to 60 days per year.*		No copay*	50%*

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Designated Network	Network	Out-of-Network
Outpatient Care			
Habilitative Services - Outpatient *Limited to 20 visits of occupational therapy related to Autism Spectrum Disorder per year.* *Limited to 20 visits of physical therapy related to Autism Spectrum Disorder per year.* *Limited to 20 visits of speech therapy related to Autism Spectrum Disorder per year.* *Limited to 20 hours per week of clinical therapeutic intervention.* *Limits will be the same as, and combined with those stated under Rehabilitation Services - Outpatient Therapy and Manipulative Treatment.*		$15 copay	50%*
Home Health Care[1] *Limited to 60 visits per year.* *One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.*		No copay*	50%*
Lab, X-Ray and Diagnostic - Outpatient - Lab Testing[1] *Limited to 18 Definitive Drug Tests per year.* *Limited to 18 Presumptive Drug Tests per year.* *For Designated Network Benefits, laboratory services must be received from a Designated Diagnostic Provider. Network Benefits include laboratory services received from a Network provider that is not a Designated Diagnostic Provider.*	No copay*	50%*	50%*
Lab, X-Ray and Diagnostic - Outpatient - X-Ray and other Diagnostic Testing[1]		No copay*	50%*
Major Diagnostic and Imaging - Outpatient[1] *For Designated Network Benefits, services must be received from a Designated Diagnostic Provider. Network Benefits include services received from a Network provider that is not a Designated Diagnostic Provider.* *You may have to pay an extra copay, deductible or coinsurance for physician fees or pharmaceutical products.*	No copay*	You pay a $500 per occurrence deductible per service prior to and in addition to paying any Annual Deductible and any coinsurance amount. 50%*	You pay a $500 per occurrence deductible per service prior to and in addition to paying any Annual Deductible and any coinsurance amount. 50%*
Physician Fees for Surgical and Medical Services			
Primary care visits	No copay*	No copay*	50%*
Specialist care visits	No copay*	No copay*	50%*

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Designated Network	Network	Out-of-Network
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment *Limited to 20 visits of cognitive rehabilitation therapy per year.* *Limited to 20 visits of manipulative treatments per year.* *Limited to 20 visits of occupational therapy per year.* *Limited to 20 visits of physical therapy per year.* *Limited to 20 visits of pulmonary rehabilitation therapy per year.* *Limited to 20 visits of speech therapy per year.* *Limited to 30 visits of post-cochlear implant aural therapy per year.* *Limited to 36 visits of cardiac rehabilitation therapy per year.*		$15 copay	50%*
Scopic Procedures - Outpatient Diagnostic and Therapeutic *Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.*		No copay*	50%*
Surgery - Outpatient[1]		No copay*	50%*
Therapeutic Treatments - Outpatient[1] *Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.*		No copay*	50%*
Supplies and Services			
Diabetes Self-Management Items[1]	The amount you pay is based on where the covered health care service is provided under Durable Medical Equipment (DME), Orthotics and Supplies or in the Prescription Drug Benefits Section.		
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care[1]	The amount you pay is based on where the covered health care service is provided.		
Durable Medical Equipment (DME), Orthotics and Supplies[1] *Limited to a single purchase of a type of DME or orthotic every 3 years.* *Repair and/or replacement of DME or orthotics would apply to this limit in the same manner as a purchase. This limit does not apply to wound vacuums.*		No copay*	50%*
Enteral Nutrition		No copay*	50%*
Hearing Aids *Limited to $2,500 every year.* *Limited to a single purchase per hearing impaired ear every 3 years.* *Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.*		No copay*	50%*
Ostomy Supplies		No copay*	50%*

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	Designated Network	Network	Out-of-Network
Pharmaceutical Products - Outpatient *This includes medications given at a doctor's office, or in a covered person's home.*		No copay*	50%*
Prosthetic Devices[1] *Limited to a single purchase of each type of prosthetic device every 3 years.* *Repair and/or replacement of a prosthetic device would apply to this limit in the same manner as a purchase.*		No copay*	50%*
Urinary Catheters		No copay*	50%*
Pregnancy			
Pregnancy - Maternity Services[1]	The amount you pay is based on where the covered health care service is provided except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.		
Mental Health Care & Substance Related and Addictive Disorder Services			
Inpatient[1]		No copay*	50%*
Outpatient		$15 copay	50%*
Partial Hospitalization[1]		No copay*	50%*
Other Services			
Cellular and Gene Therapy[1] *For Network Benefits, Cellular or Gene Therapy services must be received from a Designated Provider.*	The amount you pay is based on where the covered health care service is provided.		
Clinical Trials[1]	The amount you pay is based on where the covered health care service is provided.		
Fertility Preservation for Iatrogenic Infertility[1] *Limited to $20,000 per Covered Person per lifetime.* *Limited to $5,000 for Prescription Drug Products per Covered Person.* *Limited to 1 cycle of fertility preservation for Iatrogenic Infertility per lifetime.* *This Benefit limit will be the same as, and combined with, those stated under Preimplantation Genetic Testing (PGT) and Related Services.*		No copay*	50%*
Gender Dysphoria[1]	The amount you pay is based on where the covered health care service is provided or in the Prescription Drug Benefits Section.		
Hospice Care[1]		No copay*	50%*

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	Designated Network	Network	Out-of-Network
Preimplantation Genetic Testing (PGT) and Related Services[1] *Benefit limits for related services will be the same as, and combined with, those stated under Fertility Preservation for Iatrogenic Infertility. This limit does not include Preimplantation Genetic Testing (PGT) for the specific genetic disorder. This limit includes Benefits for ovarian stimulation medications provided under the Outpatient Prescription Drug Rider.*		No copay*	50%*
Reconstructive Procedures[1]	The amount you pay is based on where the covered health care service is provided.		
Telehealth Services	The amount you pay is based on where the covered health care service is provided.		
Transplantation Services[1] *Network Benefits must be received from a Designated Provider.*	The amount you pay is based on where the covered health care service is provided.		

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

Pharmacy Benefits

Pharmacy Plan Details	
Pharmacy Network	National
Prescription Drug List	Essential

	In Network
Annual Pharmacy Deductible	
Individual	You do not have to pay a pharmacy deductible
Family	You do not have to pay a pharmacy deductible

Prescription Drug Product Tier Level	Up to a 31-day supply		Up to a 90-day supply
	Retail and Specialty Pharmacy Network	Out-of-Network Retail Pharmacy	In-Network Mail Order Pharmacy**
Tier 1 $	$10	$10	$25
Tier 2 $$	$40	$40	$100
Tier 3 $$$	$85	$85	$212.50
Tier 4 $$$$	$250	$250	$625

** Only certain Prescription Drug Products are available through mail order; please visit myuhc.com® or call Customer Care at the telephone number on the back of your ID card for more information. You will be charged a retail Copayment and/or Coinsurance for 31 days or 2 times for 60 days based on the number of days supply dispensed for any Prescription Order or Refills sent to the mail order pharmacy. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate, rather than a 30-day supply with three refills.

Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4.

If you are a member, you can find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging into your account on myuhc.com® or calling the Customer Care number on your ID card. If you are not a member, you can view prescription information at welcometouhc.com > Benefits > Pharmacy Benefits.

Choice Plus plan details, all in one place.

Use this benefit summary to learn more about this plan's benefits, ways you can get help managing costs and how you may get more out of this health plan.

Check out what's included in the plan	Choice Plus
Network coverage only You can usually save money when you receive care for covered health care services from network providers.	☐
Network and out-of-network benefits You may receive care and services from network and out-of-network providers and facilities — but staying in the network can help lower your costs.	☑
Primary care physician (PCP) required With this plan, you need to select a PCP — the doctor who plays a key role in helping manage your care. Each enrolled person on your plan will need to choose a PCP.	☐
Referrals required You'll need referrals from your PCP before seeing a specialist or getting certain health care services.	☐
Preventive care covered at 100% There is no additional cost to you for seeing a network provider for preventive care.	☑
Pharmacy benefits With this plan, you have coverage that helps pay for prescription drugs and medications.	☑
Tier 1 providers Using Tier 1 providers may bring you the greatest value from your health care benefits. These PCPs and medical specialists meet national standard benchmarks for quality care and cost savings.	☑
Freestanding centers You may pay less when you use certain freestanding centers — health care facilities that do not bill for services as part of a hospital, such as MRI or surgery centers.	☐
Health savings account (HSA) With an HSA, you've got a personal bank account that lets you put money aside, tax-free. Use it to save and pay for qualified medical expenses.	☐

This Benefit Summary is to highlight your Benefits. Don't use this document to understand your exact coverage. If this Benefit Summary conflicts with the Certificate of Coverage (COC), Schedule of Benefits, Riders, and/or Amendments, those documents govern. Review your COC for an exact description of the services and supplies that are and are not covered, those which are excluded or limited, and other terms and conditions of coverage.

Here's a more in-depth look at how Choice Plus works.

Medical Benefits

	In Network	Out-of-Network
Annual Medical Deductible		
Individual	$3,500	$7,500
Family	$7,000	$15,000

All individual deductible amounts will count toward the family deductible, but an individual will not have to pay more than the individual deductible amount.

**After the Annual Medical Deductible has been met.*

You're responsible for paying 100% of your medical expenses until you reach your deductible. For certain covered services, you may be required to pay a fixed dollar amount - your copay.

Annual Out-of-Pocket Limit		
Individual	$7,150	$15,000
Family	$14,300	$30,000

All individual out-of-pocket maximum amounts will count toward the family out-of-pocket maximum, but an individual will not have to pay more than the individual out-of-pocket maximum amount.

Once you've met your deductible, you start sharing costs with your plan - coinsurance. You continue paying a portion of the expense until you reach your out-of-pocket limit. From there, your plan pays 100% of allowed amounts for the rest of the plan year.

The Federal individual Out-of-Pocket Limit applies to each individual regardless of whether the individual is enrolled in single coverage or family coverage.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Designated Network	Network	Out-of-Network
Preventive Care Services			
Preventive Care Services		No copay	50%*
Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a copay, co-insurance or deductible.			
Includes services such as Routine Wellness Checkups, Immunizations, Breast Pumps, Mammography and Colorectal Cancer Screenings.			
Office Services - Sickness & Injury			
Primary Care Physician			
All other covered persons	$15 copay	$15 copay	50%*
Covered persons less than age 19	No copay	No copay	50%*
Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.			
Telehealth is covered at the same cost share as in the office.			

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Designated Network	Network	Out-of-Network
Specialist *Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.* *Telehealth is covered at the same cost share as in the office.*	$50 copay	$100 copay	50%*
Urgent Care Center Services		$25 copay	50%*
Virtual Care Services *Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Visit Network Provider by contacting us at myuhc.com® or the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.*		No copay	50%*
Emergency Care			
Ambulance Services - Emergency Ambulance			
Air Ambulance		20%*	20%*
Ground Ambulance		20%*	20%*
Ambulance Services - Non-Emergency Ambulance[1]			
Air Ambulance		20%*	20%*
Ground Ambulance		20%*	50%*
Dental Services - Accident Only		20%*	20%*
Emergency Health Care Services[1]		$300 copay then 20%*	$300 copay then 20%*
Inpatient Care			
Congenital Heart Disease (CHD) Surgeries[1]		20%*	50%*
Habilitative Services - Inpatient[1] *Limit will be the same as, and combined with, those stated under Skilled Nursing Facility/Inpatient Rehabilitation Services.*	The amount you pay is based on where the covered health care service is provided.		
Hospital - Inpatient Stay[1]		20%*	50%*
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services[1] *Limited to 60 days per year.*		20%*	50%*

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Designated Network	Network	Out-of-Network
Outpatient Care			
Habilitative Services - Outpatient *Limited to 20 visits of occupational therapy related to Autism Spectrum Disorder per year.* *Limited to 20 visits of physical therapy related to Autism Spectrum Disorder per year.* *Limited to 20 visits of speech therapy related to Autism Spectrum Disorder per year.* *Limited to 20 hours per week of clinical therapeutic intervention.* *Limits will be the same as, and combined with those stated under Rehabilitation Services - Outpatient Therapy and Manipulative Treatment.*		$15 copay	50%*
Home Health Care[1] *Limited to 60 visits per year.* *One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.*		20%*	50%*
Lab, X-Ray and Diagnostic - Outpatient - Lab Testing[1] *Limited to 18 Definitive Drug Tests per year.* *Limited to 18 Presumptive Drug Tests per year.* *For Designated Network Benefits, laboratory services must be received from a Designated Diagnostic Provider. Network Benefits include laboratory services received from a Network provider that is not a Designated Diagnostic Provider.*	20%*	50%*	50%*
Lab, X-Ray and Diagnostic - Outpatient - X-Ray and other Diagnostic Testing[1]		20%*	50%*
Major Diagnostic and Imaging - Outpatient[1] *For Designated Network Benefits, services must be received from a Designated Diagnostic Provider. Network Benefits include services received from a Network provider that is not a Designated Diagnostic Provider.* *You may have to pay an extra copay, deductible or coinsurance for physician fees or pharmaceutical products.*	20%*	You pay a $500 per occurrence deductible per service prior to and in addition to paying any Annual Deductible and any coinsurance amount. 50%*	You pay a $500 per occurrence deductible per service prior to and in addition to paying any Annual Deductible and any coinsurance amount. 50%*
Physician Fees for Surgical and Medical Services			
Primary care visits	20%*	20%*	50%*
Specialist care visits	20%*	20%*	50%*

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	What You Pay for Services		
	Designated Network	Network	Out-of-Network
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment *Limited to 20 visits of cognitive rehabilitation therapy per year.* *Limited to 20 visits of manipulative treatments per year.* *Limited to 20 visits of occupational therapy per year.* *Limited to 20 visits of physical therapy per year.* *Limited to 20 visits of pulmonary rehabilitation therapy per year.* *Limited to 20 visits of speech therapy per year.* *Limited to 30 visits of post-cochlear implant aural therapy per year.* *Limited to 36 visits of cardiac rehabilitation therapy per year.*		$15 copay	50%*
Scopic Procedures - Outpatient Diagnostic and Therapeutic *Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.*		20%*	50%*
Surgery - Outpatient[1]		20%*	50%*
Therapeutic Treatments - Outpatient[1] *Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.*		20%*	50%*
Supplies and Services			
Diabetes Self-Management Items[1]	The amount you pay is based on where the covered health care service is provided under Durable Medical Equipment (DME), Orthotics and Supplies or in the Prescription Drug Benefits Section.		
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care[1]	The amount you pay is based on where the covered health care service is provided.		
Durable Medical Equipment (DME), Orthotics and Supplies[1] *Limited to a single purchase of a type of DME or orthotic every 3 years.* *Repair and/or replacement of DME or orthotics would apply to this limit in the same manner as a purchase. This limit does not apply to wound vacuums.*		20%*	50%*
Enteral Nutrition		20%*	50%*
Hearing Aids *Limited to $2,500 every year.* *Limited to a single purchase per hearing impaired ear every 3 years.* *Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.*		20%*	50%*
Ostomy Supplies		20%*	50%*

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Designated Network	Network	Out-of-Network
Pharmaceutical Products - Outpatient *This includes medications given at a doctor's office, or in a covered person's home.*		20%*	50%*
Prosthetic Devices[1] *Limited to a single purchase of each type of prosthetic device every 3 years.* *Repair and/or replacement of a prosthetic device would apply to this limit in the same manner as a purchase.*		20%*	50%*
Urinary Catheters		20%*	50%*
Pregnancy			
Pregnancy - Maternity Services[1]	The amount you pay is based on where the covered health care service is provided except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.		
Mental Health Care & Substance Related and Addictive Disorder Services			
Inpatient[1]		20%*	50%*
Outpatient		$15 copay	50%*
Partial Hospitalization[1]		20%*	50%*
Other Services			
Cellular and Gene Therapy[1] *For Network Benefits, Cellular or Gene Therapy services must be received from a Designated Provider.*	The amount you pay is based on where the covered health care service is provided.		
Clinical Trials[1]	The amount you pay is based on where the covered health care service is provided.		
Fertility Preservation for Iatrogenic Infertility[1] *Limited to $20,000 per Covered Person per lifetime.* *Limited to $5,000 for Prescription Drug Products per Covered Person.* *Limited to 1 cycle of fertility preservation for Iatrogenic Infertility per lifetime.* *This Benefit limit will be the same as, and combined with, those stated under Preimplantation Genetic Testing (PGT) and Related Services.*		20%*	50%*
Gender Dysphoria[1]	The amount you pay is based on where the covered health care service is provided or in the Prescription Drug Benefits Section.		
Hospice Care[1]		20%*	50%*

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Designated Network	Network	Out-of-Network
Preimplantation Genetic Testing (PGT) and Related Services[1] *Benefit limits for related services will be the same as, and combined with, those stated under Fertility Preservation for Iatrogenic Infertility. This limit does not include Preimplantation Genetic Testing (PGT) for the specific genetic disorder. This limit includes Benefits for ovarian stimulation medications provided under the Outpatient Prescription Drug Rider.*		20%*	50%*
Reconstructive Procedures[1]	The amount you pay is based on where the covered health care service is provided.		
Telehealth Services	The amount you pay is based on where the covered health care service is provided.		
Transplantation Services[1] *Network Benefits must be received from a Designated Provider.*	The amount you pay is based on where the covered health care service is provided.		

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

Pharmacy Benefits

Pharmacy Plan Details	
Pharmacy Network	National
Prescription Drug List	Essential

	In Network
Annual Pharmacy Deductible	
Individual	You do not have to pay a pharmacy deductible
Family	You do not have to pay a pharmacy deductible

Prescription Drug Product Tier Level	Up to a 31-day supply		Up to a 90-day supply
	Retail and Specialty Pharmacy Network	Out-of-Network Retail Pharmacy	In-Network Mail Order Pharmacy**
Tier 1 $	$10	$10	$25
Tier 2 $$	$40	$40	$100
Tier 3 $$$	$85	$85	$212.50
Tier 4 $$$$	$250	$250	$625

** Only certain Prescription Drug Products are available through mail order; please visit myuhc.com® or call Customer Care at the telephone number on the back of your ID card for more information. You will be charged a retail Copayment and/or Coinsurance for 31 days or 2 times for 60 days based on the number of days supply dispensed for any Prescription Order or Refills sent to the mail order pharmacy. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate, rather than a 30-day supply with three refills.

Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4.

If you are a member, you can find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging into your account on myuhc.com® or calling the Customer Care number on your ID card. If you are not a member, you can view prescription information at welcometouhc.com > Benefits > Pharmacy Benefits.

Another way to access care for $0*

For non-emergent care, same-day care.

Your employees and their covered family members of all ages can connect with a licensed care provider through 24/7 Virtual Visits. Care is available around the clock, every day and medications, if needed may be prescribed.**

Start here		
24/7 Virtual Visits	**Urgent Care**	**Emergency Room**
$0*	Average cost:[1] $190	Average cost:[1] $1,700

Additional access

Your employees can connect to a doctor by video or phone*** through **myuhc.com®** or the UnitedHealthcare® app

24/7 Virtual Visits providers can diagnose and treat common conditions, such as:

- Flu
- Fever
- Migraines
- Sinus infections
- Pink Eye
- Headaches
- Sore throat
- Bronchitis
- Allergies

*The Designated Virtual Visit Provider's reduced rate for a 24/7 Virtual Visit is subject to change.
**Certain prescriptions may not be available, and other restrictions may apply.
***Data rates may apply.

continued

United Healthcare

Access to care for common medical conditions

24/7 Virtual Visit experience

Meet Tessa, a working mom with young children.*

- Tessa is getting ready for work when she notices her son has a rash
- She schedules a 24/7 Virtual Visit through myuhc.com and sees a virtual provider within 15 minutes
- The provider diagnoses her son with contact dermatitis and sends a prescription to a local pharmacy
- Tessa picks up the prescription on her way to daycare and then heads to work

To learn more, click here or scan the QR code for access to a video to learn more about our virtual care offerings.

Contact your broker or a UnitedHealthcare representative for more information

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*This is a fictitious person and scenario to help illustrate how the experience may work. Licensed stock photo used.

[1] Average allowed amounts charged by UnitedHealthcare Network Providers and not tied to a specific condition or treatment. Actual payments may vary depending upon benefit coverage. The information and estimates provided are for general information and illustrative purpose only. 24/7 Virtual Visits are not included with UnitedHealthcare's Preventive Plan.

Not all medical conditions can be treated through virtual care. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician contact is needed. Benefits do not include email, or fax and standard telephone calls, or for services that occur within medical facilities (CMS defined originating facilities).

The UnitedHealthcare® app is available for download for iPhone® or Android®. iPhone is a registered trademark of Apple, Inc. Android is a registered trademark of Google LLC.

24/7 Virtual Visits is a service available with a Designated Virtual Network Provider via video, or audio-only where permitted under state law. Unless otherwise required, benefits are available only when services are delivered through a Designated Virtual Network Provider. 24/7 Virtual Visits are not intended to address emergency or life-threatening medical conditions and should not be used in those circumstances. Services may not be available at all times, or in all locations, or for all members. Check your benefit plan to determine if these services are available.

Administrative services provided by United HealthCare Services, Inc. or their affiliates. Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. 23-2352409

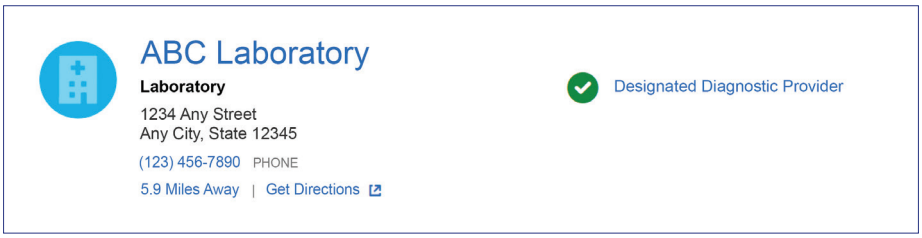
Say hello to the Designated Diagnostic Provider benefit

Designated Diagnostic Providers (DDP) are laboratory and imaging service providers that meet certain quality and efficiency requirements. With your DDP benefit, you'll have the highest level of coverage—and likely save money—when you use a DDP for outpatient lab and imaging services. If you don't use a DDP, your services may receive a lower level of coverage and you may be responsible for a higher out-of-pocket cost.

Just look for the green check mark

To find a lower-cost DDP near you, go to **myuhc.com® > Find Care & Costs > Medical Directory > Places**.

Choose whether you'd like lab or imaging services and then look for the green check ✓ to confirm DDP status.



DDP outpatient lab and imaging services

Using a DDP may help you save money on many services, including:

Lab services

- Blood draws
- Blood glucose tests
- Metabolic tests/panels
- Rapid strep tests

Imaging services

- CT and PET scans
- MRI/MRAs
- Nuclear medicine scans

Get started

Find DDPs at **myuhc.com** or on the UnitedHealthcare® app

United Healthcare

Healthier habits, healthier lifestyle

Take small steps for lasting change with Real Appeal®, an online weight management support program.

Get healthier, at no additional cost to you

Real Appeal on Rally Coach™ is a proven weight management program designed to help you get healthier and stay healthier. It's available to you and eligible family members at no additional cost as part of your benefits.

Take small steps toward healthier habits

Set achievable nutrition, exercise and weight management goals that keep you motivated to create lasting change. Track your progress from your daily dashboard, too.

Support and community along the way

Feel supported with personalized messages, online group sessions led by coaches and a caring community of members.

Get a Success Kit delivered right to your door.

Make the most of tools and resources like weight and food scales, a portion plate and more. Your Success Kit is delivered after you attend your first live group session.

Join today at enroll.realappeal.com or scan this code

United Healthcare | Real Appeal®

Real Appeal is a voluntary weight loss program that is offered to eligible members at no additional cost as part of their benefit plan. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical and/or nutritional advice. Participants should consult an appropriate health care professional to determine what may be right for them. Results, if any, may vary. Any items/tools that are provided may be taxable and participants should consult an appropriate tax professional to determine any tax obligations they may have from receiving items/tools under the program.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates.

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Get in on UHC Rewards

Good news—your health plan comes with a way to earn up to $1,000. UnitedHealthcare Rewards is included in your health plan at no additional cost.

There's so much good to get

With UHC Rewards, a variety of actions—including things you may already be doing, like tracking your steps or sleep—lead to rewards. The activities you go for are up to you, and the same goes for ways to spend your earnings.

Here are just a few of the ways you can earn:

Connect a tracker	**$65**
Take a health survey	**$25**
Get an annual checkup	**$50**
Get a biometric screening	**$75**

Visit UHC Rewards for the full list of rewardable activities that are available to you—and look for new ways of earning rewards to be added throughout the year.

Earn up to

$1,000

continued

United Healthcare

There are 2 ways to get started

On the UnitedHealthcare® app

- Scan this code to download the app
- Sign in or register
- Select **UHC Rewards**
- Activate UHC Rewards and start earning
- Though not required, connect a tracker and get access to even more reward activities

On myuhc.com®

- Sign in or register
- Select **UHC Rewards**
- Activate UHC Rewards
- Choose reward activities that inspire you—and start earning

Your health

Get in on an experience that's designed to help inspire healthier habits

Your goals

Personalize how you earn by choosing the activities that are right for you

Your rewards

Earn up to $1,000 for completing rewardable activities

Questions?

Call customer service at **1-866-230-2505**

United Healthcare

UnitedHealthcare®

FlexAppeal Enhanced dental plan

Consumer MaxMultiplier National Options PPO 30 Network/covered dental services

X8576 /UCR90

	NON-ORTHODONTICS		ORTHODONTICS	
	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK
Individual Annual Deductible	$50	$50	$0	$0
Family Annual Deductible	$150	$150	$0	$0
Annual Maximum Benefit* *(The total benefit payable by the plan will not exceed the highest listed maximum amount for either Network or Non-Network services.)*	$1500 per person per Calendar Year	$1500 per person per Calendar Year	$1000 per person per Lifetime	$1000 per person per Lifetime
Annual Deductible Applies to Preventive and Diagnostic Services	No			
Annual Deductible Applies to Orthodontic Services	No			
Waiting Period	No waiting period			
Orthodontic Eligibility Requirement	Child Only Up to Age 19			

COVERED SERVICES**	NETWORK PLAN PAYS***	NON-NETWORK PLAN PAYS****	BENEFIT GUIDELINES
PREVENTIVE & DIAGNOSTIC SERVICES			
Periodic Oral Evaluation	100%	100%	Limited to 2 times per consecutive 12 months.
Radiographs - Bitewing	100%	100%	Bitewing: Limited to 1 series of films per calendar year. Complete/Panorex: Limited to 1 time per consecutive 36 months.
Radiographs - Intraoral/Extraoral	100%	100%	Limited to 2 films per calendar year.
Lab and Other Diagnostic Tests	100%	100%	
Dental Prophylaxis (Cleanings)	100%	100%	Benefit is not to exceed in combination with periodontal maintenance 4 per consecutive 12 months.
Fluoride Treatments	100%	100%	Limited to covered persons under the age of 16 years and limited to 2 times per consecutive 12 months.
Sealants	100%	100%	Limited to covered persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.
Space Maintainers	100%	100%	For covered persons under the age of 16 years, limit 1 per consecutive 60 months.
BASIC DENTAL SERVICES			
Restorations; Amalgam or Composite (Anterior & Posterior)	80%	80%	Multiple restorations on one surface will be treated as a single filling.
General Services - Emergency Treatment	80%	80%	Covered as a separate benefit only if no other service was done during the visit other than X-rays.
General Services - Occlusal Guards	80%	80%	Limited to 1 guard every consecutive 36 months.
General Services - Anesthesia	80%	80%	When clinically necessary.
Simple Extractions	80%	80%	Limited to 1 time per tooth per lifetime.
Oral Surgery - Brush Biopsy	80%	80%	
Oral Surgery - Surgical Extractions	80%	80%	
Oral Surgery - Partial/Bony	80%	80%	
Oral Surgery - Other	80%	80%	
Endodontics - Pulpotomy	80%	80%	Root Canal Therapy: Limited to 1 time per tooth per lifetime.
Endodontics - Other	80%	80%	
Periodontal Maintenance	80%	80%	Benefit is not to exceed in combination with dental prophylaxis 4 per consecutive 12 months.
Periodontics - Non Surgical	80%	80%	Scaling and Root Planing: Limited to 1 time per quadrant per consecutive 24 months.
Periodontics - Surgical	80%	80%	Limited to 1 quadrant or site per consecutive 36 months per surgical area.
Periodontics - Osseous Surgery	80%	80%	Limited to 1 quadrant or site per consecutive 36 months per surgical area.
MAJOR DENTAL SERVICES			
Inlays/Onlays/Crowns**	50%	50%	Limited to 1 time per tooth per consecutive 60 months.
Dentures and other Removable Prosthetics	50%	50%	Full Denture/Partial Denture: Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.
Fixed Partial Dentures (Bridges)**	50%	50%	Limited to 1 time per tooth per consecutive 60 months.
Implant Services	50%	50%	Limited to 1 time per tooth per consecutive 60 months.
ORTHODONTIC SERVICES			
Diagnose or correct misalignment of the teeth or bite	50%	50%	

* This plan includes a maximum benefit award program. Some of the unused portion of your annual maximum benefit may be available in future benefit periods.

** Your dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exist, your plan bases reimbursement on the least costly treatment alternative. If you and your dentist have agreed on a treatment which is more costly than the treatment on which the plan benefit is based, you will be responsible for the difference between the fee for service rendered and the fee covered by the plan. In addition, a pre-treatment estimate is recommended for any service estimated to cost over $500; please consult your dentist.

*** The network percentage of benefits is based on the discounted fee negotiated with the provider.

**** The non-network percentage of benefits is based on the schedule of usual and customary fees in the geographic area in which the expenses are incurred.

In accordance with the Illinois state requirement, a partner in a Civil Union is included in the definition of Dependent. For a complete description of Dependent Coverage, please refer to your Certificate of Coverage.

UnitedHealthcare/dental exclusions and limitations

Dental Services described in this section are covered when such services are:

A. Necessary;
B. Provided by or under the direction of a Dentist or other appropriate provider as specifically described;
C. The least costly, clinically accepted treatment; and
D. Not excluded as described in the Section entitled, General Exclusions.

GENERAL LIMITATIONS

1. **PERIODIC ORAL EVALUATION** Limited to 2 times per consecutive 12 months.
2. **COMPLETE SERIES OR PANOREX RADIOGRAPHS** Limited to 1 time per consecutive 36 months.
3. **BITEWING RADIOGRAPHS** Limited to 1 series of films per calendar year.
4. **EXTRAORAL RADIOGRAPHS** Limited to 2 films per calendar year.
5. **DENTAL PROPHYLAXIS** Is Covered in combination with periodontal maintenance but not on the same date of service, benefit is not to exceed in combination with periodontal maintenance 4 per consecutive 12 months.
6. **FLUORIDE TREATMENTS** Limited to covered persons under the age of 16 years, and limited to 2 times per consecutive 12 months.
7. **SPACE MAINTAINERS** Limited to covered persons under the age of 16 years, limited to 1 per consecutive 60 months. Benefit includes all adjustments within 6 months of installation.
8. **SEALANTS** Limited to covered persons under the age of 16 years, and once per first or second permanent molar every consecutive 36 months.
9. **RESTORATIONS (Amalgam or Composite)** Multiple restorations on one surface will be treated as a single filling.
10. **PIN RETENTION** Limited to 2 pins per tooth; not covered in addition to cast restoration.
11. **INLAYS AND ONLAYS** Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.
12. **CROWNS** Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.
13. **POST AND CORES** Covered only for teeth that have had root canal therapy.
14. **SEDATIVE FILLINGS** Covered as a separate benefit only if no other service, other than x-rays and exam, were performed on the same tooth during the visit.
15. **SCALING AND ROOT PLANING** Limited to 1 time per quadrant per consecutive 24 months.
16. **ROOT CANAL THERAPY** Limited to 1 time per tooth per lifetime.
17. **PERIODONTAL MAINTENANCE** Is covered in combination with dental prophylaxis but not on the same date of service, benefit is not to exceed in combination with dental prophylaxis 4 per consecutive 12 months.
18. **FULL DENTURES** Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.
19. **PARTIAL DENTURES** Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.
20. **RELINING AND REBASING DENTURES** Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.
21. **REPAIRS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES** Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.
22. **PALLIATIVE TREATMENT** Covered as a separate benefit only if no other service, other than the exam and radiographs, were performed on the same tooth during the visit.
23. **OCCLUSAL GUARDS** Limited to 1 guard every consecutive 36 months and only covered if prescribed to control habitual grinding.
24. **FULL MOUTH DEBRIDEMENT** Limited to 1 time every consecutive 36 months.
25. **GENERAL ANESTHESIA** Covered only when clinically necessary.
26. **OSSEOUS GRAFTS** Limited to 1 per quadrant or site per consecutive 36 months.
27. **PERIODONTAL SURGERY** Hard tissue and soft tissue periodontal surgery are limited to 1 quadrant or site per consecutive 36 months per surgical area.
28. **REPLACEMENT OF COMPLETE DENTURES, FIXED OR REMOVABLE PARTIAL DENTURES, CROWNS, INLAYS OR ONLAYS AND IMPLANTS, IMPLANT CROWNS, IMPLANT PROTHESIS** Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.

GENERAL EXCLUSIONS

1. Dental Services that are not Necessary.
2. Hospitalization or other facility charges.
3. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
4. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.
5. Any Dental Procedure not directly associated with dental disease.
6. Any Dental Procedure not performed in a dental setting.
7. Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition wi not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
8. Any implant procedures performed which are not listed as Covered implant procedures in the Schedule of Covered Dental Services.
9. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
10. Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
11. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
12. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
13. Replacement of complete dentures, fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
14. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.
15. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
16. Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled under the Policy.
17. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
18. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis o this nature.
19. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).

GENERAL EXCLUSIONS

20. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
21. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
22. Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.
23. Dental Services otherwise Covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Services for dental conditions arising prior to th date individual Coverage under the Policy terminates.
24. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
25. Orthodontic service Coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, or a surgical procedure to correct a malocclusion, replacement of retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan.
26. Foreign Services are not Covered unless required as an Emergency.
27. Dental Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
28. Any Dental Services or Procedures not listed in the Schedule of Covered Dental Services.

Get rewarded for taking care of your smile

Our Consumer MaxMultiplier® program rewards you for keeping up with your dental care by adding dollars to next year's annual maximum. It's included as part of your dental plan.

How the program works

Earn award dollars for visiting your dentist at least once a year.[1]

Your award dollars will help to pay for claims that go beyond your annual maximum.

Unused award dollars can roll over each year.

Earn up to

$500

to add to your 1500 annual maximum

Award dollars can add up

Here's an example of the award dollars you could earn if you visit your dentist at least once this year:

This year's annual maximum is	If your total claims are less than	You'll earn a reward of
$1500	$750	$400

Plus, if you have a Dental PPO plan and all claims are with network dentists, you'll earn an extra $100. Your award dollars will be added to next year's annual maximum to pay for qualifying claims. To view your annual maximum balance, log in to **myuhc.com®**.

continued

United Healthcare

Program rules

1. $1,500 is the most award dollars that can be rolled over to the annual maximum. The total annual maximum cannot go above $3,000.
2. If your plan has different annual network and out-of-network maximums, the award dollars will be based on the annual out-of-network maximum. Award dollars are added to your annual maximum the following year.
3. Award dollars can be used for claims filed up to 180 days after your benefit period ends.
4. Award dollars can be used for both network and out-of-network claims.
5. Award dollars do not apply to orthodontic services.
6. If you sign up for a UnitedHealthcare Dental PPO or Dental In-Network Only (INO) plan in the last 3 months of a benefit period, you will have to wait until the end of the first full month of the next benefit period to participate in this program.
7. If you end your coverage, but sign up again within 6 months with the same employer, you can keep your award balance as long as your employer still offers a dental plan with Consumer MaxMultiplier. If 6 months or more pass, you will lose the award balance.
8. If your employer decides to change your dental plan, your award balance will move with you as long as the new plan includes Consumer MaxMultiplier.

Questions? Call the member phone number on your digital ID card

United Healthcare

[1] You will not actually earn cash that you can access or withdraw. UnitedHealthcare adds the award dollars to your annual maximum for the following year and applies them to qualifying claims.

The company does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities.

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter.

ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 (Chinese)，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

Vision Benefit Summary
Powered by UnitedHealthcare Vision Network
Customer Service and Provider Locator: (800) 638-3120
myuhcvision.com

Plan SH107

UnitedHealthcare Vision has been trusted for more than 50 years to deliver affordable, innovative vision care solutions to the nation's leading employers through experienced, customer-focused people and the nation's most accessible, diversified vision care network.

	Exam with Materials
Benefit Frequency	
Comprehensive Exam(s)	Once every 12 months
Comprehensive Exam(s) for persons with diabetes	Twice every 12 months
Eyeglass Lenses	Once every 12 months
Frames	Once every 24 months
Contact Lenses instead of Eyeglasses	Once every 12 months
In-Network Services	
Copays	
Exam(s)	$ 10.00
Eyeglasses (lenses and frame)	$ 25.00
Contact lenses instead of Eyeglasses	$ 25.00
Retinal Screening for persons with diabetes	$ 0.00
Frame Benefit - for frames that exceed the allowance, an additional 30% discount may be applied to the overage[1]	
Private Practice Provider	$ 150.00 retail frame allowance
Retail Chain Provider	$ 150.00 retail frame allowance
Lens Options - this list highlights the discounted cost on our most popular lens options. Exact pricing may vary; confirm cost with your provider prior to purchase.	
Standard Scratch Coating	$0
Scratch Warranty	$10
Tint	$14
UV Coating	$16
Photochromic	$67
Anti-Reflective Tier I	$30
Anti-Reflective Tier II	$50
Anti-Reflective Tier III	$75
Anti-Reflective Tier IV	$95
Roll and Polish Edges	$13
Progressive Tier I	$55
Progressive Tier II	$100
Progressive Tier III	$150
Progressive Tier IV	$200
Progressive Tier V	$250
High Index (<1.66)	$53
High Index (1.66-1.73)	$63
Polycarbonate for Adults	$33
Polycarbonate for Dependent Children	$0
Contact Lens Benefit[2]	
Elective contact lenses Allowance is applied toward the purchase of contact lenses. Contact lens copay is waived.	$150.00
Elective contact lens fitting and evaluation Allowance is applied toward the contact lens fitting/evaluation fees.	$40.00
Necessary contact lenses[3]	Covered in full after copay (if applicable).

UnitedHealthcare®

Children's and Maternity Eye Care Benefit

Members age 0-12 and members pregnant or breastfeeding are eligible for a 2nd exam 60 days after the initial exam. Members age 0-12 and members pregnant or breastfeeding are also eligible for a replacement frame and lenses if they have a prescription change of 0.5 diopter or more. The 2nd exam and replacement benefits are the same as the initial exam, frame and lens benefits.

Out-of-Network Reimbursements (Copays do not apply)	
Exam(s)	Up To $40.00
Frames	Up To $45.00
Single Vision Lenses	Up To $40.00
Lined Bifocal and Progressive Lenses	Up To $60.00
Lined Trifocal Lenses	Up To $80.00
Lenticular Lenses	Up To $80.00
Elective Contacts instead of Eyeglasses[2]	Up To $125.00
Contact Lens Fitting and Evaluation	Up To $0.00
Necessary Contacts instead of Eyeglasses[3]	Up To $210.00

Discounts

Laser vision
UnitedHealthcare has partnered with QualSight LASIK, the largest LASIK manager in the United States, to provide our members with access to discounted laser vision correction services. Member savings represent up to 35% off the national average price of Traditional LASIK. Contracted prices start at $945 per eye for Traditional LASIK and $1,395 per eye for Custom LASIK. Discounts are also provided on newer technologies such as Custom Bladeless (all laser) LASIK. For more information, visit myuhcvision.com.

Additional Material
At a participating in-network provider you will receive up to a 20% discount on an additional pair of eyeglasses or contact lenses. This program is available after your vision benefits have been exhausted. Please note that this discount shall not be considered insurance, and that UnitedHealthcare shall neither pay nor reimburse the provider or member for any funds owed or spent. Additional materials do not have to be purchased at the time of initial material purchase.

Contact Lens
Order extra contact lenses at uhccontacts.com for 10% off.

Hearing Aids
As a UnitedHealthcare Vision plan member, you can save on custom-programmed hearing aids when you buy them from UnitedHealthcare Hearing. To find out more go to UHCHearing.com. When placing your order use promo code MYVISION to get the special price discount.

Blue Light Eyesafe
UnitedHealthcare Vision has collaborated with Eyesafe® to provide members with a 20% discount off the retail price on blue-light screen filters for their devices. Members can receive the discount by visiting myuhcvision.com and clicking on the Eyesafe link.

[1]30% discount available at most participating in-network provider locations. May exclude certain frame manufacturers. Please verify discounts with your provider.
[2]Contact lenses are instead of eyeglass lenses and/or eyeglass frames.
[3]Necessary contact lenses are determined at the provider's discretion for certain conditions. If your provider considers your contacts necessary, you should ask your provider to contact UnitedHealthcare Vision confirming the reimbursement that UnitedHealthcare will make before you purchase such contacts.

Important to Remember:

In-Network

- Always identify yourself as a UnitedHealthcare Vision member when making your appointment. This will assist the provider in obtaining your benefit information.
- Patient lens options are subject to change.

Choice and Access of Vision Care Providers

UnitedHealthcare offers its vision program through a national network including both private practice and retail chain providers. To access the Provider Locator service or for a printed directory, visit our website myuhcvision.com or call (800) 638-3120, 24 hours a day, seven days a week. You may also view your benefits, search for a provider or print an ID card online at myuhcvision.com.
In-Network Provider - Copays and non-covered patient options are paid to provider by program participant at the time of service.
Out-of-Network Provider - Participant pays all billed charges to the provider, and UnitedHealthcare reimburses the participant for services rendered up to the maximum allowance. Copays do not apply to out-of-network benefits. Receipts for payments should be submitted within 90 days after the date of service to the following address: UnitedHealthcare Vision, Attn. Claims Department, P.O. Box 30978, Salt Lake City, UT 84130. If it was not reasonably possible to give written proof in the time required, the Company will not reduce or deny the claim for this reason. However, proof must be filed as soon as reasonably possible, but no later than 1 year after the date of service unless the Covered Person was legally incapacitated.

Customer Service is available toll-free at (800) 638-3120 from 8:00 a.m. to 11:00 p.m. Eastern Time Monday through Friday, and 9:00 a.m. to 6:30 p.m. Eastern Time on Saturday.

READ YOUR PLAN CAREFULLY - THIS BENEFIT SUMMARY PROVIDES A VERY BRIEF DESCRIPTION OF THE IMPORTANT FEATURES OF YOUR PLAN. THIS IS NOT THE INSURANCE CONTRACT. YOUR FULL RIGHTS AND BENEFITS ARE EXPRESSED IN THE ACTUAL PLAN DOCUMENTS THAT ARE AVAILABLE TO YOU UPON YOUR REQUEST TO US.

UnitedHealthcare vision coverage provided by or through UnitedHealthcare Insurance Company, located in Hartford, Connecticut, UnitedHealthcare Insurance Company of New York, located in Islandia, New York, or its affiliates. Administrative services provided by Spectera, Inc., United HealthCare Services, Inc. or their affiliates. Plans sold in Texas use policy form number VPOL.06.TX, VPOL.13.TX or VPOL.18.TX and associated COC form number VCOC.INT.06.TX, VCOC.CER.13.TX or VCOC.18.TX. Plans sold in Virginia use policy form number VPOL.06.VA, VPOL.13.VA or VPOL.18.VA and associated COC form number VCOC.INT.06.VA, VCOC.CER.13.VA or VCOC.18.VA. If you opt to receive vision care services or vision care materials that are not covered benefits under this plan, a participating vision care provider may charge you their normal fee for such services or materials. Prior to providing you with vision care services or vision care materials that are not covered benefits, the vision care provider will provide you with an estimated cost for each service or material upon your request. This cost may be higher than if you had received only covered vision services and you may incur additional out-of-pocket expenses. Eyewear materials may be ordered through our national lab network.

UnitedHealthcare®

With our large vision network, there's always a provider in sight

Finding a trustworthy provider who meets your lifestyle, eye care and eyewear needs is easier with UnitedHealthcare.

With UnitedHealthcare Vision Network, you can take advantage of personalized care at a local doctor or convenient evening and weekend hours at your favorite well-known retail chain or specialty online retailers.

Well-known practices and brands in our large national network include:

- 1-800 Contacts—including ExpressExam*
- Allegany Optical
- America's Best
- Bard Optical
- befitting.com
- Berkeley Eye Center
- Clarkson Eyecare
- Cohen's Fashion Optical
- Costco Optical
- Dr. Tavel Family Eye Care
- Eye Doctor's Optical Outlets
- Eyeglass World
- EyeMart Express
- For Eyes
- General Vision Services
- GlassesUSA.com
- Henry Ford OptimEyes
- JCPenney Optical
- LensCrafters—including lenscrafters.com
- Meijer Optical
- Midwest Vision Centers
- My Eye Lab
- MyEyeDr.
- National Vision
- Nationwide Vision
- Pearle Vision
- Rosin Eyecare
- Rx Optical
- Sam's Club
- SEE Inc.
- Shawnee Optical
- Shopko
- Stanton Optical
- Sterling Optical
- SVS Vision

Making it easier for you to find a provider

To find the provider who best meets your needs, sign in to **myuhcvision.com** or call **1-800-638-3120**.

Some providers or locations may not participate in your plan.

*For virtual prescription renewal only. ExpressExam may not be available for all vision plans and is not in all states.

continued

United Healthcare

Well-known practices and brands in our large national network include:

- Target Optical—including targetoptical.com
- Texas State Optical
- Today's Vision
- Total Vision
- Vision Source
- Visionworks
- Vista Optical
- Walmart
- Warby Parker—including warbyparker.com
- Wisconsin Vision

See more ways to save

Keep out-of-pocket costs low by visiting **uhccontacts.com** or **uhcglasses.com** where you'll have a variety of brands and frame choices at your fingertips.

Call
1-800-638-3120

Visit
myuhcvision.com

United Healthcare

The examples provided are for general knowledge purposes only and should not be interpreted as a preference or recommendation of any particular provider, brand, or company. We encourage members to choose providers based on their individual needs and preferences.

The company does not discriminate on the basis of race, color, national origin, sex, age or disability in health programs and activities.

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter.

To ask for help, please call 1-800-638-3120, TTY 711, Monday through Friday, 7 a.m. to 10 p.m. CST.

ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-800-638-3120, TTY 711.

請注意：如果您說中文 (Chinese), 我們免費為您提供語言協助服務。請致電：1-800-638-3120, TTY 711。

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ADDITIONAL SERVICES

ROOKWOOD PROPERTIES, INC.

If you are enrolled in insurance coverage with The Hartford, you may also be eligible to receive additional services. These services help with challenges that come before and after a claim. Be sure to read the information provided below; The Hartford wants to be there when you need us.

SERVICES AVAILABLE

COVERAGE ENROLLED IN	ADDITIONAL SERVICES AVAILABLE
Short Term Disability	Ability Assist Counseling Services Health Champion
Long Term Disability	Ability Assist Counseling Services Health Champion Travel Assistance and ID Theft Protection Services
Life	Ability Assist Counseling Services Health Champion Beneficiary Assist Counseling Services EstateGuidance Will Services Funeral Concierge Services Travel Assistance and ID Theft Protection Services

ASKED & ANSWERED

WHAT IS ABILITY ASSIST COUNSELING SERVICES?

Ability Assist®[1] Counseling Services provides access to Master's degree clinicians for 24/7 assistance if you're enrolled in our short term or long term disability plan. This includes 3 face-to-face visits per occurrence per year for emotional concerns and unlimited phone consultations for financial, legal, and work-life concerns.

For more information on Ability Assist® Counseling Services:
Call 1-800-964-3577
Visit www.guidanceresources.com
Company name: **Abili** Company ID: **HLF902**

WHAT IS BENEFICIARY ASSIST COUNSELING SERVICES?

Beneficiary Assist®[2] Counseling Services offers compassionate expertise to help you, your beneficiaries (those you name in your policy) and immediate family members cope with emotional, financial and legal issues that arise after a loss. Includes unlimited phone contact with professionals, as well as five face-to-face sessions* available for up to one year.

For more information on Beneficiary Assist® Counseling Services, call 1-800-411-7239.

*California residents are limited to three prepaid behavioral health counseling sessions in any six-month period. Except for acute emergencies and other special circumstances, additional sessions for California employees are available on a fee-for-service basis.

WHAT IS ESTATEGUIDANCE WILL SERVICES?

EstateGuidance®[3] Will Services helps you protect your family's future by creating a customized and legally binding online will. Online support is also available from licensed attorneys, if needed.

For more information on EstateGuidance® Will Services:
www.estateguidance.com Use Code: **WILLHLF**

WHAT IS FUNERAL CONCIERGE SERVICES?

Funeral Concierge Services[4] provides a suite of online tools to guide you through key decisions before a loss, including help comparing funeral-related costs. After a loss, this service includes family advocacy and professional negotiation of funeral prices with local providers—often resulting in significant financial savings. In addition, Express Pay is a service that delivers proceeds in as little as 48 hours, allowing beneficiaries to use proceeds immediately for funeral expenses.

For more information on Funeral Concierge Services:
Call 1-866-854-5429 or visit www.everestfuneral.com/hartford Use Code: **HFEVLC**

WHAT IS HEALTHCHAMPION?

HealthChampion[SM5] offers unlimited access to benefit specialists and nurses for administrative and clinical support to address medical care and insurance claims concerns if you're enrolled in our short term or long term disability plan. Service includes: claims and billing support, explanation of benefits, cost estimates and fee negotiation, information related to conditions and available treatments, and support to help prepare for medical visits.

For more information on HealthChampion[SM] Services
Call 1-800-964-3577
Visit www.guidanceresources.com
Company name: **Abili** Company ID: **HLF902**

WHAT IS TRAVEL ASSISTANCE AND IDENTITY THEFT SUPPORT SERVICES?

Travel Assistance[6] is available when traveling more than 100 miles from home and for 90 days or less. Services include but are not limited to:

- Medical assistance, including worldwide medical referrals, medical monitoring, prescription transfer, replacement of medical devices and corrective lenses.
- Emergency transports, medical repatriations and evacuations and repatriations of mortal remains.
- Pre-trip information, lost luggage/document assistance and legal referrals.

Identity Theft Support Services[6] provide 24/7/365 assistance including education on how to prevent theft and guidance on what to do if a theft occurs. Caseworkers help review credit information, and if a theft has occurred, will notify major credit bureaus, assist with completing an identity theft affidavit, help with replacing credit/debit cards and more.

For more information on Travel Assistance or Identity Theft Support Services:

- Call from U.S. and Canada: 800-243-6108 (toll-free)
- Call from Outside U.S.: 202-828-5885
- Or email: assist@imglobal.com

In the event of a life-threatening travel emergency, call local emergency authorities first for immediate assistance before contacting our Travel Assistance partner.

[1]AbilityAssist® services are offered through The Hartford by ComPsych®. ComPsych is not affiliated with The Hartford and is not a provider of insurance services. The Hartford is not responsible and assumes no liability for the goods and services provided by ComPsych and reserves the right to discontinue any of these services at any time. Services may not be available in all states. Visit https://www.thehartford.com/employee-benefits/value-added-services for more information.
[2]BeneficiaryAssist® services are offered through The Hartford by ComPsych®. ComPsych is not affiliated with The Hartford and is not a provider of insurance services. The Hartford is not responsible and assumes no liability for the goods and services provided by ComPsych and reserves the right to discontinue any of these services at any time. Services may not be available in all states. Visit https://www.thehartford.com/employee-benefits/value-added-services for more information.
[3]Estate Guidance® services are provided through The Hartford by ComPsych®. A simple will does not cover printing or certain other features. These features are available at an additional cost to you. ComPsych is not affiliated with The Hartford and is not a provider of insurance services. The Hartford is not responsible and assumes no liability for the goods and services provided by ComPsych and reserves the right to discontinue any of these services at any time. Estate Guidance is a registered trademark of ComPsych. Services may not be available in all states. Visit https://www.thehartford.com/employee-benefits/value-added-services for more information.
[4]Funeral Concierge services is offered through Everest Funeral Package, LLC (Everest). Everest and the Everest logo are service marks of Everest Funeral Package, LLC. Everest is not affiliated with The Hartford and is not a provider of insurance services. Everest and its affiliates have no affiliation with Everest ReGroup, Ltd., Everest Reinsurance Company or any of their affiliates. The Hartford is not responsible and assumes no liability for the services provided by Everest Funeral Package, LLC as described in these materials and reserves the right to discontinue any of these services at any time. Services may not be available in all states. Visit https://www.thehartford.com/employee-benefits/value-added-services for more information.
[5]HealthChampion[sm] services are provided through The Hartford by ComPsych®. ComPsych is not affiliated with The Hartford and is not a provider of insurance services. The Hartford doesn't provide basic hospital, basic medical, or major medical insurance. HealthChampion specialists are only available during business hours. Inquiries outside of this timeframe can either request a call-back the next day or schedule an appointment. The Hartford is not responsible and assumes no liability for the goods and services provided by ComPsych and reserves the right to discontinue any of these services at any time. Health Champion is a service mark of ComPsych. Services may not be available in all states.
Visit https://www.thehartford.com/employee-benefits/value-added-services for more information.
[6]Travel Assistance and Identity Theft Support services are offered through a vendor which is not affiliated with The Hartford. These services are not insurance. The Hartford is not responsible and assumes no liability for the goods and services described in these materials and reserves the right to discontinue any of these services at any time. Services may not be available in all states.
Visit https://www.thehartford.com/employee-benefits/value-added-services for more information.

The Buck's Got Your Back ®

5962a NS 05/21

GROUP SHORT-TERM DISABILITY INSURANCE BENEFIT HIGHLIGHTS

THE HARTFORD

Just over 1 in 4 of today's 20 year-olds will become disabled before they retire (age 67).[1]

ROOKWOOD PROPERTIES, INC.

A disability can happen to anyone. A back injury, pregnancy, or serious illness can lead to months without a regular paycheck. If you're unable to work for a short period of time due to a non-work-related condition, illness or injury, short-term disability insurance offers financial protection by paying you a portion of your earnings.

To learn more about Short-Term Disability insurance, visit **thehartford.com/employee-benefits/employees**

COVERAGE INFORMATION

BENEFIT PERCENTAGE	MAXIMUM	MINIMUM	SICKNESS BENEFIT STARTS	INJURY BENEFIT STARTS	BENEFIT DURATION
70%	$150	$15	On the 15th day sick	On the 15th day injured	11 weeks

PREMIUMS

Your employer pays 100% of the premium for your coverage.[2]

ASKED & ANSWERED

WHO IS ELIGIBLE?

You are eligible if you are an active full-time employee who works at least 30 hours per week on a regularly scheduled basis. Excluding management employees.

AM I GUARANTEED COVERAGE?

This insurance is guaranteed issue coverage - it is available without having to provide information about your health.

WHEN CAN I ENROLL?

Your employer will automatically enroll you for this coverage.

WHEN DOES THIS INSURANCE BEGIN?

This insurance will become effective on the date you become eligible. You must be actively at work with your employer on the day your coverage takes effect.

WHEN DOES THIS INSURANCE END?

This insurance will end when you no longer satisfy the applicable eligibility conditions, premium is unpaid, you leave your employer, or the coverage is no longer offered.

WHAT DOES IT MEAN TO BE DISABLED?

Disability is defined in The Hartford's certificate with your employer.

Due to accidental bodily injury, sickness, mental illness, substance abuse or pregnancy you are unable to perform the essential duties of your occupation, and as a result, you are earning 20% or less of your pre-disability weekly earnings or you are able to perform some, but not all, of the essential duties of your occupation and as a result, you are earning more than 20% but less than 80% of your pre-disability weekly earnings.

Pre-disability earnings are defined in your policy.

[1]U.S. Social Security Administration Fact Sheet. Web. 14 October 2020 https://www.ssa.gov/news/press/factsheets/basicfact-alt.pdf
[2]Rates and/or benefits may be changed on class basis.

The Buck's Got Your Back ®

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ROOKWOOD PROPERTIES, INC. NCSTD BHS_PUBLICATION DATE: 3/21/2023 00152424

GROUP LONG-TERM DISABILITY INSURANCE BENEFIT HIGHLIGHTS

More than 1 in 4 adults in the U.S. has some type of disability.[1]

ROOKWOOD PROPERTIES, INC.

A disability can happen to anyone. Long-term disability insurance helps protect your paycheck if you're unable to work for a long period of time after a serious condition, injury or sickness.

To learn more about Long-Term Disability insurance, visit **thehartford.com/employee-benefits/employees**

COVERAGE INFORMATION

BENEFIT PERCENTAGE (PERCENT OF YOUR EARNINGS)	MAXIMUM	MINIMUM (BASED ON MONTHLY INCOME LOSS BEFORE THE DEDUCTION OF OTHER INCOME BENEFITS)	BENEFIT STARTS (ELIMINATION PERIOD)	BENEFIT DURATION
60%	$6,000	$50	After 90 days disabled	Disabled before: Age 63 Benefit duration: As long as you are disabled Benefit duration maximum: The greater of your Social Security Normal Retirement Age or 4 years

PREMIUMS

Your employer pays 100% of the premium for your coverage.[2]

ASKED & ANSWERED

WHO IS ELIGIBLE?

You are eligible if you are an active full-time employee who works at least 30 hours per week on a regularly scheduled basis. Excluding management employees.

AM I GUARANTEED COVERAGE?

This insurance is guaranteed issue coverage – it is available without having to provide information about your health.

This coverage is subject to a pre-existing condition exclusion. Please refer to the Limitations & Exclusions sheet provided with this benefit highlights sheet for more information on limitations and exclusions, such as pre-existing conditions.

WHEN CAN I ENROLL?

Your employer will automatically enroll you for this coverage.

WHEN DOES THIS INSURANCE BEGIN?

This insurance will become effective on the date you become eligible. You must be actively at work with your employer on the day your coverage takes effect.

WHEN DOES THIS INSURANCE END?

This insurance will end when you no longer satisfy the applicable eligibility conditions, premium is unpaid, you leave your employer, or the coverage is no longer offered.

WHAT DOES IT MEAN TO BE DISABLED?

Disability is defined in The Hartford's certificate with your employer. Typically, disability means that you cannot perform one or more of the essential duties of your occupation due to injury, sickness, pregnancy or other medical condition covered by the insurance, and as a result, your current monthly earnings are less than 80% of your pre-disability earnings. Once you have been disabled for 3 years following the elimination period, you must be prevented from performing one or more of the essential duties of any occupation and as a result, your current monthly earnings are less than or equal to 60% of your pre-disability earnings.

Pre-disability earnings are defined in your policy.

WILL MY BENEFIT BE TAXED?

The cost of your core coverage is not included in your gross income on IRS Form W-2, unless you elect otherwise prior to the beginning of a new plan year. This means your benefit will be taxed.

BASIC and SUPPLEMENTAL GROUP TERM LIFE and ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE BENEFIT HIGHLIGHTS

THE HARTFORD

More than half of Americans (53%) expressed a heightened need for life insurance because of COVID-19.[1]

ROOKWOOD PROPERTIES, INC.

The group term Life and Accidental Death and Dismemberment (AD&D) insurance available through your employer gives extra protection that you and your family may need. Life and AD&D insurance offers financial protection by providing you coverage in case of an untimely death or an accident that destroys your income-earning ability. Life benefits are disbursed to your beneficiaries in a lump sum in the event of your death.

To learn more about Life and AD&D insurance, visit **thehartford.com/employee-benefits/employees**

COVERAGE INFORMATION

APPLICANT	BASIC COVERAGE	SUPPLEMENTAL COVERAGE
Employee	Benefit[2]: $40,000 AD&D: Included	Benefit[3]: Increments of $10,000 Maximum: the lesser of 5x earnings or $300,000 AD&D: Included
Spouse	Not Included	Benefit[3]: Increments of $5,000 Maximum: the lesser of 50% of your supplemental coverage or $150,000 AD&D: Included
Child(ren)	Not Included	Benefit: $10,000 AD&D: Included

AD&D BENEFITS – PERCENT OF COVERAGE AMOUNT PER ACCIDENT

Covered accidents or death can occur up to 365 days after the accident. The total benefit for all losses due to the same accident will not exceed 100% of your coverage amount.

LOSS FROM ACCIDENT	BASIC COVERAGE	SUPPLEMENTAL COVERAGE
Life	100%	100%
Both Hands or Both Feet or Sight of Both Eyes	100%	100%
One Hand and One Foot	100%	100%
Speech and Hearing in Both Ears	100%	100%
Either Hand or Foot and Sight of One Eye	100%	100%
Movement of Both Upper and Lower Limbs (Quadriplegia)	100%	100%
Movement of Both Lower Limbs (Paraplegia)	75%	75%
Movement of Three Limbs (Triplegia)	75%	75%
Movement of the Upper and Lower Limbs of One Side of the Body (Hemiplegia)	50%	50%
Either Hand or Foot	50%	50%
Sight of One Eye	50%	50%
Speech or Hearing in Both Ears	50%	50%
Movement of One Limb (Uniplegia)	25%	25%

[2]Your basic benefit will be reduced by 35% at age 65, 60% at age 70 and 75% at age 75. Reductions will be applied to the original amount.

[3]Your supplemental benefit will be reduced by 35% at age 65, 60% at age 70, 75% at age 75 and 100% at age 80. Reductions will be applied to the original amount.

Thumb and Index Finger of Either Hand	25%	25%

PREMIUMS

Your employer pays 100% of the premium for your (employee) basic coverage. Your contribution for voluntary coverage is shown on the Premium Worksheet. [4]

ASKED & ANSWERED

WHO IS ELIGIBLE?

You are eligible if you are an active full-time employee who works at least 30 hours per week on a regularly scheduled basis. Excluding management employees.
Your spouse and child(ren) are also eligible for coverage. Any child(ren) must be under age 26.

CAN I INSURE MY DOMESTIC OR CIVIL UNION PARTNER?

Yes. Any reference to “spouse” in this document includes your domestic partner, civil union partner or equivalent, as recognized and allowed by applicable law.

AM I GUARANTEED COVERAGE?

Basic insurance is guaranteed issue coverage – it is available without having to provide information about your health.

If you are newly eligible and elect an amount that exceeds the guaranteed issue amount of $100,000, you will need to provide evidence of insurability that is satisfactory to The Hartford before the excess can become effective.

If you are currently participating in this coverage you may increase your current coverage by $20,000, not to exceed $100,000, without providing evidence of insurability. If you were previously eligible and are electing coverage for the first time, you may elect coverage in the amount of $20,000. Additional coverage amounts will require evidence of insurability that is satisfactory to The Hartford before the excess can become effective.

For your spouse coverage, if you are newly eligible and elect an amount that exceeds the guaranteed issue amount of $30,000, your spouse will need to provide evidence of insurability that is satisfactory to The Hartford before the excess can become effective.

If your spouse is currently participating in this coverage you may increase your spouse's current coverage by $10,000, not to exceed $30,000, without your spouse providing evidence of insurability. If you were previously eligible and are electing spouse coverage for the first time, you may elect coverage in the amount of $10,000. Additional coverage amounts will require your spouse to provide evidence of insurability that is satisfactory to The Hartford before the excess can become effective.

Supplemental insurance is guaranteed issue coverage – it is available without having to provide information about your child(ren)’s health.

AD&D is available without having to provide information about your or your family’s health.

HOW DO I PAY FOR THIS INSURANCE?

Premiums will be automatically paid through payroll deduction, as authorized by you during the enrollment process. This ensures you don’t have to worry about writing a check or missing a payment.

WHEN CAN I ENROLL?

Your employer will automatically enroll you for basic coverage. If you have not already done so, you must designate a beneficiary.

You may enroll in supplemental coverage during any scheduled enrollment period, within 31 days of the date you have a change in family status, or within 31 days of the completion of any eligibility waiting period established by your employer.

WHEN DOES THIS INSURANCE BEGIN?

Basic insurance will become effective for you on the date you become eligible.

Subject to any eligibility waiting period established by your employer, supplemental insurance will become effective in accordance with the terms of the certificate (usually the first day of the month following the date you elect coverage).

You must be actively at work with your employer on the day your coverage takes effect. Your spouse and child(ren) must be performing normal activities and not be confined (at home or in a hospital/care facility).

WHEN DOES THIS INSURANCE END?

This insurance will end when you (or your dependent(s)) no longer satisfy the applicable eligibility conditions, premium is unpaid, or the coverage is no longer offered.

CAN I KEEP THIS INSURANCE IF I LEAVE MY EMPLOYER OR AM NO LONGER A MEMBER OF THIS GROUP?

Yes, you can take this life coverage with you. Coverage may be continued for you and your dependent(s) under a group portability certificate or an individual conversion life certificate. Your spouse may also continue insurance in certain circumstances. The specific terms and qualifying events for conversion and portability are described in the certificate. Conversion and portability are not available for AD&D coverage.

LIMITATIONS & EXCLUSIONS

THE HARTFORD

This insurance coverage includes certain limitations and exclusions. The certificate details all provisions, limitations, and exclusions for this insurance coverage. A copy of the certificate can be obtained from your employer.

GROUP LIFE INSURANCE

GENERAL LIMITATIONS AND EXCLUSIONS

- Your basic benefit will be reduced by 35% at age 65, 60% at age 70 and 75% at age 75. Reductions will be applied to the original amount.
- Your supplemental benefit will be reduced by 35% at age 65, 60% at age 70, 75% at age 75 and 100% at age 80. Reductions will be applied to the original amount.
- A supplemental or voluntary life benefit will not be paid if death occurs by suicide within two years (or as allowed by state law) of purchasing this coverage.
- You and your dependent(s) must be citizens or legal residents of the United States, its territories and protectorates.

DEPENDENT LIMITATIONS AND EXCLUSIONS

- Coverage may only be elected for dependents when you elect and are approved for coverage for yourself.
- Coverage may not be elected for a dependent who has employee coverage under this certificate.
- Coverage may not be elected for a dependent who is in active full-time military service.
- Child(ren) may only be covered as a dependent of one employee.
- Infants may receive a reduced benefit prior to the age of six months.

5962a NS 05/21 Life Form Series includes GBD-1000, GBD-1100, or state equivalent.

GROUP ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

GENERAL LIMITATIONS AND EXCLUSIONS

- Your basic benefit will be reduced by 35% at age 65, 60% at age 70 and 75% at age 75. Reductions will be applied to the original amount.
- Your supplemental benefit will be reduced by 35% at age 65, 60% at age 70, 75% at age 75 and 100% at age 80. Reductions will be applied to the original amount.
- This insurance does not cover losses caused by:
    - Sickness; disease; or any treatment for either
    - Any infection, except certain ones caused by an accidental cut or wound
    - Intentionally self-inflicted injury, suicide or suicide attempt
    - War or act of war, whether declared or not
    - Injury sustained while in the armed forces of any country or international authority
    - Taking prescription or illegal drugs unless prescribed by or administered by a licensed physician
    - Injury sustained while committing or attempting to commit a felony
    - Injury sustained while driving while intoxicated
- You and your dependent(s) must be citizens or legal residents of the United States, its territories and protectorates.

DEPENDENT LIMITATIONS AND EXCLUSIONS

- Coverage may only be elected for dependents when you elect and are approved for coverage for yourself.
- Coverage may not be elected for a dependent who has employee coverage under this certificate.
- Child(ren) may only be covered as a dependent of one employee.

DEFINITIONS

- Loss means, with regard to hands and feet, actual severance through or above wrist or ankle joints; with regard to sight, speech or hearing, entire and irrecoverable loss thereof; with regard to thumb and index finger, actual severance through or above the metacarpophalangeal joints; with regard to movement, complete and irreversible paralysis of such limbs.
- Injury means bodily injury resulting directly from an accident, independent of all other causes, which occurs while you or your dependent(s) have coverage.

5962c NS 05/21 Accident Form Series includes GBD-1000, GBD-1300, or state equivalent.

GROUP SHORT TERM DISABILITY INSURANCE

LIMITATIONS AND EXCLUSIONS

GENERAL EXCLUSIONS

- You must be under the regular care of a physician to receive benefits.
- You cannot receive disability insurance benefit payments for disabilities that are caused or contributed to by:
    - War or act of war (declared or not)
    - The commission of, or attempt to commit a felony
    - An intentionally self-inflicted injury
    - Your being engaged in an illegal occupation
    - Sickness or injury for which workers' compensation benefits are paid, or may be paid, if duly claimed
    - Sickness or injury sustained as a result of doing any work for pay or profit for another employer, including self-employment
    - You have already satisfied the pre-existing condition requirement of your previous insurer

OFFSETS

- Your benefit payments will be reduced by other income you receive or are eligible to receive due to your disability, such as:
    - Social Security disability insurance (please see next section for exceptions)
    - Other employer-based insurance coverage you may have
    - Unemployment benefits
    - Settlements or judgments for income loss
    - Retirement benefits that your employer fully or partially pays for (such as a pension plan)
- Your benefit payments will not be reduced by certain kinds of other income, such as:
    - Retirement benefits if you were already receiving them before you became disabled
    - Retirement benefits that are funded by your after-tax contributions your personal savings, investments, IRAs or Keoghs profit-sharing
    - Most personal disability policies
    - Social Security cost-of-living increases

This example is for purposes of illustrating the effect of the benefit reductions and is not intended to reflect the situation of a particular claimant under the Policy:

Insured's weekly [Pre-Disability Earnings/Basic weekly Pay] $1,000
Short term disability benefits percentage x 60%
Unreduced maximum benefit $600
Less Social Security disability benefit per week - $300
Less state disability income benefit per week - $100
Total amount of short term disability benefit per week $200

THIS POLICY PROVIDES LIMITED BENEFITS.
This limited benefit plan (1) does not constitute major medical coverage, and (2) does not satisfy the individual mandate of the Affordable Care Act (ACA) because the coverage does not meet the requirements of minimum essential coverage.
In New York: This Disability policy provides disability income insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State Department of Financial Services.
5962e NS 05/21 Disability Form Series includes GBD-1000, GBD-1200, or state equivalent.

GROUP LONG TERM DISABILITY INSURANCE

LIMITATIONS AND EXCLUSIONS

GENERAL EXCLUSIONS

- You must be under the regular care of a physician to receive benefits.
- You cannot receive disability insurance benefit payments for disabilities that are caused or contributed to by:
    - War or act of war (declared or not)
    - The commission of, or attempt to commit a felony
    - An intentionally self-inflicted injury
    - Your being engaged in an illegal occupation

PRE-EXISTING CONDITIONS

- Your insurance excludes the benefits you can receive for pre-existing conditions. In general, if you were diagnosed or received care for a condition before the effective date of your certificate, you will be covered for a disability due to that condition only if:
    - You have not received treatment for your condition for 6 months before the effective date of your insurance, or
    - You have been insured under this coverage for 24 months prior to your disability commencing, so you can receive benefits even if you're receiving treatment, or
    - You have already satisfied the pre-existing condition requirement of your previous insurer

LIMITATIONS

- **Mental Illness and Substance Abuse Limitation.** If you are disabled because of Mental Illness or because of alcoholism or the use of narcotics, sedatives, stimulants, hallucinogens or other similar substance, benefits will be payable for a maximum of 24 months in your lifetime, unless at the end of that 24 months, you are confined to a hospital or other place licensed to provide medical care for your disability.

OFFSETS

- Your benefit payments will be reduced by other income you receive or are eligible to receive due to your disability, such as:
    - Social Security disability insurance (please see next section for exceptions)
    - Workers' compensation
    - Other employer-based insurance coverage you may have
    - Unemployment benefits
    - Settlements or judgments for income loss
    - Retirement benefits that your employer fully or partially pays for (such as a pension plan)
- Your benefit payments will not be reduced by certain kinds of other income, such as:
    - Retirement benefits if you were already receiving them before you became disabled
    - Retirement benefits that are funded by your after-tax contributions your personal savings, investments, IRAs or Keoghs profit-sharing
    - Most personal disability policies
    - Social Security cost-of-living increases

This example is for purposes of illustrating the effect of the benefit reductions and is not intended to reflect the situation of a particular claimant under the Policy:

Insured's monthly [Pre-Disability Earnings/Basic Monthly Pay] $3,000
Long term disability benefits percentage x 60%
Unreduced maximum benefit $1,800
Less Social Security disability benefit per month - $900
Less state disability income benefit per month - $300
Total amount of long term disability benefit per month $600

THIS POLICY PROVIDES LIMITED BENEFITS.
This limited benefit plan (1) does not constitute major medical coverage, and (2) does not satisfy the individual mandate of the Affordable Care Act (ACA) because the coverage does not meet the requirements of minimum essential coverage.
In New York: This Disability policy provides disability income insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State Department of Financial Services.
5962d NS 05/21 Disability Form Series includes GBD-1000, GBD-1200, or state equivalent.

The Buck's Got Your Back ®

Premium Worksheet

Rates and/or benefits can change. Rates are based on the employee's age and increase as you enter each new age category.

SUPPLEMENTAL TERM LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE

Bi-weekly Premium Amount (Cost per Pay Period – 26/Year)

Benefit	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
$10,000	$0.42	$0.42	$0.42	$0.55	$0.78	$1.11	$2.12	$3.23	$3.78	$6.55	$15.54	$59.63
$20,000	$0.83	$0.83	$0.83	$1.11	$1.57	$2.22	$4.25	$6.46	$7.57	$13.11	$31.08	$119.26
$30,000	$1.25	$1.25	$1.25	$1.66	$2.35	$3.32	$6.37	$9.69	$11.35	$19.66	$46.62	$178.89
$40,000	$1.66	$1.66	$1.66	$2.22	$3.14	$4.43	$8.49	$12.92	$15.14	$26.22	$62.16	$238.52
$50,000	$2.08	$2.08	$2.08	$2.77	$3.92	$5.54	$10.62	$16.15	$18.92	$32.77	$77.70	$298.15
$60,000	$2.49	$2.49	$2.49	$3.32	$4.71	$6.65	$12.74	$19.38	$22.71	$39.32	$93.24	$357.78
$70,000	$2.91	$2.91	$2.91	$3.88	$5.49	$7.75	$14.86	$22.62	$26.49	$45.88	$108.78	$417.42
$80,000	$3.32	$3.32	$3.32	$4.43	$6.28	$8.86	$16.98	$25.85	$30.28	$52.43	$124.32	$477.05
$90,000	$3.74	$3.74	$3.74	$4.98	$7.06	$9.97	$19.11	$29.08	$34.06	$58.98	$139.86	$536.68
$100,000	$4.15	$4.15	$4.15	$5.54	$7.85	$11.08	$21.23	$32.31	$37.85	$65.54	$155.40	$596.31
$110,000	$4.57	$4.57	$4.57	$6.09	$8.63	$12.18	$23.35	$35.54	$41.63	$72.09	$170.94	$655.94
$120,000	$4.98	$4.98	$4.98	$6.65	$9.42	$13.29	$25.48	$38.77	$45.42	$78.65	$186.48	$715.57
$130,000	$5.40	$5.40	$5.40	$7.20	$10.20	$14.40	$27.60	$42.00	$49.20	$85.20	$202.02	$775.20
$140,000	$5.82	$5.82	$5.82	$7.75	$10.98	$15.51	$29.72	$45.23	$52.98	$91.75	$217.56	$834.83
$150,000	$6.23	$6.23	$6.23	$8.31	$11.77	$16.62	$31.85	$48.46	$56.77	$98.31	$233.10	$894.46
$160,000	$6.65	$6.65	$6.65	$8.86	$12.55	$17.72	$33.97	$51.69	$60.55	$104.86	$248.64	$954.09
$170,000	$7.06	$7.06	$7.06	$9.42	$13.34	$18.83	$36.09	$54.92	$64.34	$111.42	$264.18	$1,013.72
$180,000	$7.48	$7.48	$7.48	$9.97	$14.12	$19.94	$38.22	$58.15	$68.12	$117.97	$279.72	$1,073.35
$190,000	$7.89	$7.89	$7.89	$10.52	$14.91	$21.05	$40.34	$61.38	$71.91	$124.52	$295.26	$1,132.98
$200,000	$8.31	$8.31	$8.31	$11.08	$15.69	$22.15	$42.46	$64.62	$75.69	$131.08	$310.80	$1,192.62
$210,000	$8.72	$8.72	$8.72	$11.63	$16.48	$23.26	$44.58	$67.85	$79.48	$137.63	$326.34	$1,252.25
$220,000	$9.14	$9.14	$9.14	$12.18	$17.26	$24.37	$46.71	$71.08	$83.26	$144.18	$341.88	$1,311.88
$230,000	$9.55	$9.55	$9.55	$12.74	$18.05	$25.48	$48.83	$74.31	$87.05	$150.74	$357.42	$1,371.51
$240,000	$9.97	$9.97	$9.97	$13.29	$18.83	$26.58	$50.95	$77.54	$90.83	$157.29	$372.96	$1,431.14
$250,000	$10.38	$10.38	$10.38	$13.85	$19.62	$27.69	$53.08	$80.77	$94.62	$163.85	$388.50	$1,490.77
$260,000	$10.80	$10.80	$10.80	$14.40	$20.40	$28.80	$55.20	$84.00	$98.40	$170.40	$404.04	$1,550.40
$270,000	$11.22	$11.22	$11.22	$14.95	$21.18	$29.91	$57.32	$87.23	$102.18	$176.95	$419.58	$1,610.03
$280,000	$11.63	$11.63	$11.63	$15.51	$21.97	$31.02	$59.45	$90.46	$105.97	$183.51	$435.12	$1,669.66
$290,000	$12.05	$12.05	$12.05	$16.06	$22.75	$32.12	$61.57	$93.69	$109.75	$190.06	$450.66	$1,729.29
$300,000	$12.46	$12.46	$12.46	$16.62	$23.54	$33.23	$63.69	$96.92	$113.54	$196.62	$466.20	$1,788.92

SPOUSE/PARTNER SUPPLEMENTAL TERM LIFE LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE

Bi-weekly Premium Amount (Cost per Pay Period – 26/Year)

Age	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
$5,000	$0.21	$0.21	$0.21	$0.28	$0.39	$0.55	$1.06	$1.62	$1.89	$3.28	$7.77	$29.82
$10,000	$0.42	$0.42	$0.42	$0.55	$0.78	$1.11	$2.12	$3.23	$3.78	$6.55	$15.54	$59.63
$15,000	$0.62	$0.62	$0.62	$0.83	$1.18	$1.66	$3.18	$4.85	$5.68	$9.83	$23.31	$89.45
$20,000	$0.83	$0.83	$0.83	$1.11	$1.57	$2.22	$4.25	$6.46	$7.57	$13.11	$31.08	$119.26
$25,000	$1.04	$1.04	$1.04	$1.38	$1.96	$2.77	$5.31	$8.08	$9.46	$16.38	$38.85	$149.08
$30,000	$1.25	$1.25	$1.25	$1.66	$2.35	$3.32	$6.37	$9.69	$11.35	$19.66	$46.62	$178.89
$35,000	$1.45	$1.45	$1.45	$1.94	$2.75	$3.88	$7.43	$11.31	$13.25	$22.94	$54.39	$208.71
$40,000	$1.66	$1.66	$1.66	$2.22	$3.14	$4.43	$8.49	$12.92	$15.14	$26.22	$62.16	$238.52

CREATION DATE: 6/24/2021
ROOKWOOD PROPERTIES INC/894503/00125562

$45,000	$1.87	$1.87	$1.87	$2.49	$3.53	$4.98	$9.55	$14.54	$17.03	$29.49	$69.93	$268.34
$50,000	$2.08	$2.08	$2.08	$2.77	$3.92	$5.54	$10.62	$16.15	$18.92	$32.77	$77.70	$298.15
$55,000	$2.28	$2.28	$2.28	$3.05	$4.32	$6.09	$11.68	$17.77	$20.82	$36.05	$85.47	$327.97
$60,000	$2.49	$2.49	$2.49	$3.32	$4.71	$6.65	$12.74	$19.38	$22.71	$39.32	$93.24	$357.78
$65,000	$2.70	$2.70	$2.70	$3.60	$5.10	$7.20	$13.80	$21.00	$24.60	$42.60	$101.01	$387.60
$70,000	$2.91	$2.91	$2.91	$3.88	$5.49	$7.75	$14.86	$22.62	$26.49	$45.88	$108.78	$417.42
$75,000	$3.12	$3.12	$3.12	$4.15	$5.88	$8.31	$15.92	$24.23	$28.38	$49.15	$116.55	$447.23
$80,000	$3.32	$3.32	$3.32	$4.43	$6.28	$8.86	$16.98	$25.85	$30.28	$52.43	$124.32	$477.05
$85,000	$3.53	$3.53	$3.53	$4.71	$6.67	$9.42	$18.05	$27.46	$32.17	$55.71	$132.09	$506.86
$90,000	$3.74	$3.74	$3.74	$4.98	$7.06	$9.97	$19.11	$29.08	$34.06	$58.98	$139.86	$536.68
$95,000	$3.95	$3.95	$3.95	$5.26	$7.45	$10.52	$20.17	$30.69	$35.95	$62.26	$147.63	$566.49
$100,000	$4.15	$4.15	$4.15	$5.54	$7.85	$11.08	$21.23	$32.31	$37.85	$65.54	$155.40	$596.31
$105,000	$4.36	$4.36	$4.36	$5.82	$8.24	$11.63	$22.29	$33.92	$39.74	$68.82	$163.17	$626.12
$110,000	$4.57	$4.57	$4.57	$6.09	$8.63	$12.18	$23.35	$35.54	$41.63	$72.09	$170.94	$655.94
$115,000	$4.78	$4.78	$4.78	$6.37	$9.02	$12.74	$24.42	$37.15	$43.52	$75.37	$178.71	$685.75
$120,000	$4.98	$4.98	$4.98	$6.65	$9.42	$13.29	$25.48	$38.77	$45.42	$78.65	$186.48	$715.57
$125,000	$5.19	$5.19	$5.19	$6.92	$9.81	$13.85	$26.54	$40.38	$47.31	$81.92	$194.25	$745.38
$130,000	$5.40	$5.40	$5.40	$7.20	$10.20	$14.40	$27.60	$42.00	$49.20	$85.20	$202.02	$775.20
$135,000	$5.61	$5.61	$5.61	$7.48	$10.59	$14.95	$28.66	$43.62	$51.09	$88.48	$209.79	$805.02
$140,000	$5.82	$5.82	$5.82	$7.75	$10.98	$15.51	$29.72	$45.23	$52.98	$91.75	$217.56	$834.83
$145,000	$6.02	$6.02	$6.02	$8.03	$11.38	$16.06	$30.78	$46.85	$54.88	$95.03	$225.33	$864.65
$150,000	$6.23	$6.23	$6.23	$8.31	$11.77	$16.62	$31.85	$48.46	$56.77	$98.31	$233.10	$894.46

CHILD(REN) SUPPLEMENTAL TERM LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE

Bi-weekly Premium Amount (Cost per Pay Period – 26/Year)

Benefit Amount	Cost For All Children
$10,000	$0.92

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The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing companies Hartford Life Insurance Company and Hartford Life and Accident Insurance Company. Home Office is Hartford, CT.

This document explains the general purpose of the insurance described, but in no way changes or affects the policy as actually issued. In the event of a discrepancy between this document and the policy, the terms of the policy apply. **Benefits are subject to state availability. Policy terms and conditions vary by state.** Complete details are in the Certificate of Insurance issued to each insured individual and the Master Policy as issued to the policyholder.

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, 2024. 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	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp 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	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
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: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	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. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	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.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx 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	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
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**

EMPLOYEE RIGHTS UNDER THE FAMILY AND MEDICAL LEAVE ACT

The United States Department of Labor Wage and Hour Division

Leave Entitlements

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

Benefits & Protections

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

Eligibility Requirements

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

Requesting Leave

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

Employer Responsibilities

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

Enforcement

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:

1-866-4-USWAGE

(1-866-487-9243) TTY: 1-877-889-5627

www.dol.gov/whd

U.S. Department of Labor | Wage and Hour Division

Newborns' and Mothers' Health Protection Act Notice

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).

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1,2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

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[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact
Lynn Johnson 513-469-5988
_____.

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name	4. Employer Identification Number (EIN)
Rookwood Properties	31-0724388
5. Employer address	**6. Employer phone number**
8160 Corporate Park Drive, Suite 220	513-469-5988

7. City	8. State	9. ZIP code
Cincinnati	Ohio	45242

10. Who can we contact about employee health coverage at this job?	
Lynn Johnson	
11. Phone number (if different from above)	12. Email address ljohnson@rookwoodproperties.com

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

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☒ Some employees. Eligible employees are:

    Employees that work 30 hours or more per week on average.

- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are:

    Legally married spouse or domestic partners; children to the age of 26 (Specific State rules may apply.

  - ☐ We do not offer coverage.

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

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

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

Need Assistance? Carrier Websites and Customer Service Numbers

If you need personal assistance with benefits, contact your Human Resources department:

Lynn Johnson
Phone: 513-469-5988
ljohnson@rookwoodproperties.com

ROOKWOOD PROPERTIES SINCE 1966

Group Medical, Dental, and Vision Benefits www.myuhc.com (Medical and Dental) www.myuhcvision.com (Vision) Phone: 800.357.0978 (Medical) Phone: 877-816-3597 (Dental) Phone: 800.638-3120 (Vision)	UnitedHealthcare®
Health Savings Account Phone: 833.299.0168	PAYCHEX®
Employer Paid Life, Voluntary Life, Short Term Disability and Long Term Disability www.thehartford.com Phone: 800.549.6514 (Disability) Phone: 888.563.1124 (Life)	The Hartford
Employee Assistance Program (EAP) Phone: 800.964.3577 www.guidanceresources.com Company Name: Abili Company ID: HLF902	ComPsych® GuidanceResources® Worldwide
Travel Assist and Identity Theft Support Phone: 800.243.6108 (Call from US and Canada) Phone: 202.828.5885 (Call from outside US) Email: assist@imglobal.com Group #: 894503 Group Name: Rookwood Properties	IMG®

Heather Shapiro
513.699.2992 Direct Phone
hshapiro@langgroup.com

Steve McAbee
513.699.2966 Direct Phone
smcabee@langgroup.com

Lang Financial Group, Inc.

ACKNOWLEDGMENT

By signing below, I acknowledge the following:

The Summary of Benefits provided is intended to be a guide to coverage and plan provisions only and is subject to change.

Full description of benefits, provisions, limitations, and exclusions may be found in appropriate group contracts, plan booklets, and certificates of coverage.

When provided to me, it is my responsibility to review the above mentioned documents for complete details of benefits programs.

I understand that obtaining benefits coverage involves meeting eligibility requirements and enrolling for elected coverages.

The enrollment process may include:

* completion of enrollment forms
* submission of a certificate of prior creditable coverage (medical insurance)
* submission of a health statement for underwriting approval (life and disability insurance)

Failure to enroll “on a timely basis” (within 30 days of becoming eligible for coverage) may result in:

* the requirement of the submission of a health statement for underwriting approval (life and disability insurance)
* the requirement of waiting until an “open enrollment period”
* the postponement of benefits
* the denial of coverage

Certain coverages may impose pre-existing condition limitations on benefits.

Coverage voluntarily declined will require the completion of a “Waiver of Coverage” form.

Taking advantage of “Pre-tax Benefits” requires the completion of a separate enrollment form.

A “Change in Status” form must be completed and signed if a life status change “qualifying event” (e.g. marriage, divorce, death of spouse, birth of a child, adoption, or loss of coverage) results in enrollment into previously waived benefits coverage or for changes in pre-tax elections outside of plan anniversary dates.

For more information and to answer any questions I may have, I will consult my employer.

I hereby acknowledge that I have read and understand the above statements.

Print Name	***Witness***
Signature	Date