

**Louisiana**



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Systems**

**FPS**



**AUTO PARTS**

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LOGGING EQUIPMENT

# 2025-2026 Benefit Guide



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## Welcome Letter

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Dear Employees,

This “Employee Benefits Guidebook” is provided to you as a quick reference guide to address your benefits questions. The benefits offered to you through your employment with Louisiana Machinery Company are a valuable part of your compensation program. They can provide financial security and peace of mind to you and your dependents. We encourage you to share this guidebook with your family members and dependents to help you gain a better overall understanding of the benefits available to you.

Based on eligibility, you are only able to join or make changes to your benefit elections during either the annual Open Enrollment period or due to a qualifying life event, such as starting a new job, getting married, loss of other coverage, or for the birth/adoption of a child. In the case of a qualifying life event, you will have 30 days from the date of the event to join the plan, otherwise you may join the plan during the designated annual Open Enrollment period.

The Open Enrollment period generally occurs during the month of **July** with benefit elections becoming effective on **September 1**.

Please carefully review the information contained in this Guidebook. Should you have any questions or need further assistance please contact:

**Britt B. LeBlanc**  
Benefits Manager  
(985) 536-0470  
[britt.leblanc@louisianacat.com](mailto:britt.leblanc@louisianacat.com)



## Carrier Contacts

FUNCTION	CARRIER	Group #	PHONE	WEBSITE
Third Party Administrator (Medical)/ Precertification	United Medical Resources (UMR)	76-413049	(800) 826-9781	<a href="http://www.umar.com">www.umar.com</a>
Value-Based Payments Patient Advocacy	Healthscope Benefits	76-413049	(888) 713-8808	<a href="http://www.healthscopebenefits.com">www.healthscopebenefits.com</a>
Employee Assistance Program	Interface EAP	UN: LACAT PW: 970	(800) 324-4327	<a href="http://www.4eap.com">www.4eap.com</a>
Telemedicine	Medefy / MediOrbis		Connect through the Medefy mobile app or call (866) 633-4672	<a href="https://mediorbis.com">https://mediorbis.com</a>
Digital Medicine	Ochsner		(866) 273-0548	<a href="http://Connectedhealth.ochsner.org">Connectedhealth.ochsner.org</a>
Complex Care Provider	Accarent		(866) 771-0697	<a href="http://Accarenthealth.com">Accarenthealth.com</a>
Financial Relief	Samaritan Fund Program		(866) 764-9290	<a href="http://samaritanfundprogram.com">samaritanfundprogram.com</a>
Retail/Mail-Order Prescriptions	ServeYou Rx	VBP: 7604; EHDHP: 7603	(800) 759-3203	<a href="http://serve-you-rx.com/members/">serve-you-rx.com/members/</a>
\$0 Copay Mail-Order Rx	Global RxManage	20047775	(800) 883-8841	<a href="https://my.globalrxmanage.com/customers/louisiana-machinery-company/sign-up">https://my.globalrxmanage.com/customers/louisiana-machinery-company/sign-up</a>
Diabetes Care Plus Program	ServeYou Rx	VBP: 7604; EHDHP: 7603	(800) 759-3203	<a href="http://serve-you-rx.com/members/">serve-you-rx.com/members/</a>
HSA	UMB	UMB0010 ~ 0045003970014	(866) 520-4472	<a href="http://www.hsa.umb.com">www.hsa.umb.com</a>
Contributory Dental	Companion Life Dental	845-14-S3792	(877) 676-5789	<a href="https://companionlife.go2dental.com/member/dental_search/proxinp.cgi">https://companionlife.go2dental.com/member/dental_search/proxinp.cgi</a>
Voluntary Vision	Companion Life	845-14-S3792	(877) 676-5789	<a href="http://eyemed.com">eyemed.com</a>
Basic Life/AD&D, Voluntary Life, Short Term Disability, Long Term Disability	Companion Life	845-14-S3792	(877) 676-5789	<a href="http://MyOnlineBenefit.com">MyOnlineBenefit.com</a>
Legal Assistance	MetLaw	LA970-318	(800) 438-6388	<a href="http://Info.legalplans.com">Info.legalplans.com</a>
Identity Theft Protection	Aura Identity Guard	LAMACHINERYCO	(855) 443-7748	<a href="http://www.identityguard.com">www.identityguard.com</a>
Voluntary Critical Illness, Hospital Indemnity, Accident, Cancer, Permanent Life	APL	25992	800-256-8606	<a href="https://www.ampublic.com/">https://www.ampublic.com/</a>

# Benefits Basics Eligibility and How to Enroll

## Who is eligible?

If you are employed with Louisiana Machinery and are over the age of 18, you are eligible for company benefits if you are a regular full-time employee working at least 30 hours/week.

## You may enroll your:

- Spouse to whom you are legally married ONLY IF he/she does not have access to his/ her employer-sponsored coverage (medical only);
- Natural, step or legally adopted child(ren) up to the age of 26\*, who:
  - Do not need to be full-time students or an eligible dependent on your tax return;
  - Are not required to live with you;
  - May be married or unmarried

### *Please note:*

- \*Coverage terminates the last day of the month in which your child(ren) turns 26 years old.
- The spouse and/or child(ren) of your dependent child(ren) are not eligible for coverage.
- Disabled child(ren) age 26 or older, who are mentally impaired, physically handicapped or totally disabled. You must periodically provide medical documentation of such disability.

If you, as the employee elect to participate, your eligible family members may also be enrolled in the following coverages: Medical\*, Dental, Vision, HSA, Voluntary Life and Voluntary Worksite Products.

*Please note:* Your spouse is only eligible for coverage under LMC's Medical Plan IF he/she does not have access to his/ her employer-sponsored coverage (medical only).

## Types of Benefit Enrollments

Your benefits are in effect for one full Plan Year— September 1, 2025 through August 31, 2026. During this time, you cannot make changes to your benefit elections without a qualified status change (refer to the next page for details).

*Please Note:* Even if you do have a qualified status change during the year, you are never permitted to switch medical plan elections, (i.e. from VBP to HDHP or vice versa). There are three types of benefit enrollment:

- **Open Enrollment:** Occurs once a year and is your opportunity to change your benefit elections or add/change dependents. Coverage begins on September 1, 2025.
- **New Hire/Newly Eligible Enrollment:** For new employees, coverage begins on the 1st of the month coinciding with or following 30 days of hire. You have 30 days from your date of hire to elect your benefits. Coverage is effective retroactive to your eligibility date.
- **Qualified Status Change:** Other than during Open Enrollment or when you are newly hired (or newly benefits-eligible), you can only make changes to your benefits elections if you experience a qualified status change, as mandated by the IRS. Coverage begins on the date of the event. For example, newborn/ adoption coverage begins on the date of your child's birth/adoption. Refer to the next page for details.

# Benefits Basics Eligibility and How to Enroll

## Qualified Status Change

Based on IRS rules, you can only change certain benefits during the Plan Year with a qualified status change that is consistent with your plan change. For example, you can add your spouse to your plan when you get married.

If you experience a qualified status change, you may:

- Enroll for coverage (if you previously waived coverage);
- Add newly eligible dependents;
- Remove dependents who are no longer eligible; or
- Change your coverage level (for example, change “Employee Only” coverage to “Employee + Spouse”)

Qualified Status Changes Include:

- Work schedule change (for example, from full- time to part-time or vice versa);
- Birth, adoption, or placement for adoption
- Death
- Marriage or divorce;
- Change in employment status for you or your spouse;
- Change in dependents eligibility (for example, your child reaches age 26 or your spouse becomes eligible for Medicare or Medicaid); or
- Gain or loss of eligible dependents through custody, court order or guardianship.

Qualified Status Changes may be made by advising Human Resources of the event and providing any necessary documentation within 30 days of the event.

*Please Note:* If you do not notify Human Resources within 30 days of a qualifying event, you must wait until the next Open Enrollment period to add, drop, or change coverage.

## Termination

Coverage terminates the *last day of the month* in which the termination date occurs for Medical, Dental, and Vision, Basic Life, Voluntary Life, and Voluntary Worksite products. STD and LTD terminate the date of termination.



## Benefits Basics Eligibility and How to Enroll

Are you ready to enroll? The first step is to review your current benefits and what you anticipate for the coming year. Will you need to replace your glasses soon? Did you move recently or get married? Verify your personal information and contact details and make any necessary changes.

Once your information is up to date, it's time to make your benefit elections. The decisions you make during open enrollment can have a significant impact on your life and finances, so it is important to weigh your options carefully. See the next page for important changes and reminders about the coming benefit plan year.

### Existing Employees

Open enrollment begins on **Monday July 15, 2025** and runs through **Thursday July 31, 2025**. The benefits you choose during open enrollment will become effective on **September 1, 2025**. Remember, after your Open Enrollment you cannot make changes unless you experience a **Qualifying Event** (see 'How to Make Changes' on the previous page).

This year is an **Active** enrollment which means you must speak with a benefit counselor to enroll or waive coverage.

Fidelity Enrollment Services benefit counselors will be available to speak with employees one-on-one beginning July 21 through Thursday, July 31, 2025. This year, at select locations benefit counselors will be available onsite to assist in the enrollment process.

During these meetings, FES will :

- Review your benefits packages
- Answer questions and provide additional information
- Help you complete your enrollment in your elected benefits

You can schedule an appointment to speak with an FES representative in-person or by telephone using the QR code to the right or by calling (833) 737-1947 between Monday – Friday 8am - 5pm CDT during the open enrollment period.

### New Hires

If you are a new employee, you will have **30 days** from your first date of employment to elect your benefits. You can schedule a phone session using the QR code or calling (833) 737-1947 between Monday – Friday 8am - 5pm CDT. Coverage is effective the 1<sup>st</sup> of the month coinciding with or following 30 days after your date of hire. **Coverage is NOT automatic.**

### A Note about Rehires

If your employment with Louisiana Machinery ends due to termination of employment, leave of absence, or reduction of hours, and you are rehired as a full-time eligible employee within a 12 months from the date your termination, your coverage will be reinstated without being required to meet the 30-day eligibility period. Your coverage will be effective the 1<sup>st</sup> of the month, coinciding with or following your date of rehire.

If you do not qualify for eligibility under this Plan again (are not rehired or considered to be rehired for purposes of the Affordable Care Act) within 12 months from the date your coverage ended, and you did not perform any hours of service that were credited within the 12 month period, you will be treated as a new hire and will be required to meet all the requirements of a new Employee.

An Employee that is laid off and recalled within one year will be reinstated and will not be required to satisfy any Waiting Periods. If it is after the one-year period, the Employee will be treated as a new hire and will be required to meet all the requirements of a new hire.

# Benefits Basics Important Reminders

Changes and Additions Effective September 1, 2025	What's Staying the same?
<ul style="list-style-type: none"> <li>• <b>Medical Plan:</b> The VBP Plan has new Deductibles, MOOP, and Copays. Please see the Comparison table on page 13 for more details.</li> <li>• <b>Dental Plan:</b> New Dual Option! We now offer Base and Buy-up options for your Dental Coverage with annual maxes of \$1,000 (Base) or \$5,000 (Buy-up)!</li> <li>• <b>Vision:</b> New carrier! Companion Life will replace EyeMed as our Vision Carrier. While your group number and ID card will change, you will have access to the same network with the same plan design for the same rates.</li> <li>• The Voluntary Universal Life with <b>Transamerica</b> will be <b>discontinued</b>. You will have the option to port or withdrawal the cash value of your coverage.</li> </ul>	<ul style="list-style-type: none"> <li>• The HSA eligible embedded medical plan will remain with UMR</li> <li>• We will continue to offer the Value-Based Payments Medical Plan.</li> <li>• Companion Life will continue to offer Dental, Basic Life Insurance, Vol Life, STD and LTD</li> <li>• APL will once again be offering Hospital Indemnity, Accident, Critical Illness, Voluntary Life and Cancer plans.</li> </ul>

**Before you make your elections, remember some of your benefits are deducted from your pay on a pre-tax basis. This means you make your contributions before you pay federal or state taxes, as well as Social Security taxes. Lower taxes mean you keep more of what you earn.**

<p>Benefits that are deducted Pre-Tax:</p> <ol style="list-style-type: none"> <li>1. Medical</li> <li>2. Voluntary Dental</li> <li>3. Voluntary Vision</li> <li>4. HSA Contributions</li> <li>5. Voluntary 24-Hour Accident</li> <li>6. Voluntary Critical Illness</li> <li>7. Voluntary Hospital Indemnity</li> <li>8. Voluntary Cancer</li> </ol>	<p>Benefits that are deducted Post-Tax:</p> <ol style="list-style-type: none"> <li>1. Short Term Disability</li> <li>2. Long Term Disability</li> <li>3. Voluntary Life</li> <li>4. Voluntary Universal Life</li> <li>5. Identity Theft Protection</li> </ol>
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## Other Reminders:

Please refer to the Eligibility and Enrollment Section at the end of this Benefit Guide

1. Current contributions **WILL NOT** roll over. You **MUST** speak with an enroller **to enroll or waive your coverage** otherwise all coverages will terminate;
2. Only employees electing the EHSA Option are permitted to have an HSA;
3. Any covered non-essential health benefit drugs (non-EHB) will not count towards your OOP.
4. For Voluntary Life you may elect an additional \$10,000 of coverage for yourself, and \$5,000 for your spouse, up to the Guarantee Issue Amount during Open Enrollment, without completing Evidence of Insurability. The actively-at-work provision will apply.
5. For Voluntary Life/AD&D: Your employee election includes AD&D, however, spouses and children are not eligible for AD&D;
6. If you are a "late enrollee" (were previously offered coverage) and wish to enroll in the Voluntary Life or Disability, you will be required to complete medical questions (EOI).

## Benefits Basics Important Reminders

- **Review the coverage that Louisiana Machinery Company offers carefully before deciding about purchasing health insurance through a state marketplace.** You will hear about the availability of federal subsidies based on your income. Since your employer offers health insurance plans that meets certain minimum coverage standards and cost levels, you will not be eligible for a subsidy in the marketplace. Make sure you take the time to understand the health plan offered before declining coverage to purchase insurance through the marketplace. It is important to note that Louisiana Machinery subsidizes most of your group health coverage and allows you to pay for it on a pre-tax basis, which saves you money by lowering your taxable income. Coverage purchased through the marketplace, however, is not pre-tax. You can visit [healthcare.gov](https://www.healthcare.gov) to learn more about the marketplaces.
- **Tips to Save on Your Medical**
  - **Go Generic:** Generic drugs are the same as other medications, just without the brand name. The biggest difference is the price. Generics usually cost you 30% to 70% less than brand names.
  - **Review your Explanation of Benefits (EOB)** to make sure you are properly billed. Contact your doctor or other care provider if you suspect an incorrect charge.
  - **Ask for an Itemized Hospital Bill:** When visiting a hospital, always ask for an itemized hospital bill for each item of care. If you see a line item for “medical facility fee,” put in writing that you will not pay this fee. Under the Affordable Care Act, Section 2718(e), hospitals are required to disclose the medical facility fee price tag before the time of service. In addition, any hospital that charges a medical facility fee is in violation of the False Claims Act. Paying close attention to your itemized bill can save you money in the medical fees. For example, a follow up doctor visit is often paid at \$80, and a medical facility fee is often \$150, resulting in a total amount of \$230.
- **Emergency Room Visits:** Hospitals ERs are required to treat anyone who comes in the door but before they do, ERs will typically make you sign a contract, electronically, which patients will likely treat as though it were a “terms and conditions” document that doesn’t even have to be read...when in fact they are agreeing to be responsible for total charges. If you need to go to the ER, you can insist on seeing a printed copy of the consent and then write in their own language as follows: Superseding form consents, I consent to responsibility (including insurance) for up to 2 times Medicare following receipt of an itemized bill for appropriate treatment.
- **Double Insurance** is when you have two different health insurance plans. This may happen if you have coverage through your job and your Spouse’s plan. The benefits of double insurance is that you have two health plans that can help pay for care. The downside is that you have to pay two premiums, two deductibles, and deal with the potential confusion that comes with having two health plans.

When you have a primary and secondary health plan, the insurers use a framework to work together, so both health plans pay their fair share. Coordination of Benefits (COB) decides which plan pays first (primary plan) and which pays second (secondary plan.)

Here’s how COB works when there is a health insurance claim:

- 1.first goes to the primary plan. Insurer pays what it owes.
  - 2.there’s money still left on the bill, it then goes to the secondary insurer.
  - 3.that, if there’s still money left on the bill, the member gets a bill for the remaining balance.
- **Balance bills** primarily occur in two circumstances: 1) when an enrollee receives emergency care either at an out-of-network facility or from an out-of-network provider, or 2) when an enrollee receives elective nonemergency care at an in-network facility but is inadvertently treated by an out-of-network health care provider. Since the insurer does not have a contract with the out-of-network facility or provider, it may decide not to pay the entirety of the bill. In that case, the out-of-network facility or provider may then bill the enrollee for the balance of the bill. Recent legislation has addressed balance billing at the Federal level and 32 states have enacted laws to protect enrollees from balance billing at the state-level.

Starting in 2022, consumers won’t get balance bills when they seek emergency care, when they are transported by an air ambulance, or when they receive nonemergency care at an in-network hospital but are unknowingly treated by an out-of-network physician or laboratory. Payments are now negotiated by providers and health plans. Insurers and providers have 30 days to try to negotiate payment of out-of-network bills. If that fails, the claims go through an independent dispute resolution process with an arbitrator, who has the final say.



## Your personal guide to smart, cost-effective healthcare

Easy Access | Expert Guidance | Lower Costs

Care Guides ensure you get the most out of your healthcare benefits while saving time and money. Whether you're trying to understand your coverage, seeking care, or managing expenses, the Medefy App is your personal all-in-one solution.



### EXPERT BENEFITS NAVIGATION

- Clear, personalized insights into your health coverage.
- Find cost-efficient, top-tier specialists in your area
- Step-by-step guidance to better health decisions.



### DIRECT ACCESS TO GUIDES

- Chat with a Care Guide anytime—fast, free, and confidential.
- Understand your coverage with expert, personalized guidance.
- Resolve billing questions quickly and stress-free.



### SMART TOOLS FOR YOUR BENEFITS

- Your \$0 Rx Program through Rx Manage
- Instantly view and share your health insurance cards.
- Keep open enrollment materials at your fingertips.



Scan to download

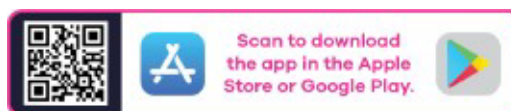


Download Medefy today and transform the way you manage your health!

## Benefits App and Telemedicine Medefy

Louisiana Machinery will continue to use Medefy to help you navigate your employee healthcare benefits and save money in the process. The Medefy app will help you find the best cost provider for the services that you need with around-the-clock access to Care Guides and availability to view your deductible/Out-of-Pocket accumulators.

<b>Your Benefits</b>	Direct access to all your digital insurance cards, benefit summaries, Employee Benefit Guide, direct contact with all carriers, provider search tools, compare prescription drug costs, estimate procedure costs, and chat with a Care Guide
<b>Telemedicine</b>	Connect to an on-call physician from our global provider network for time- sensitive medical needs. MediOrbis On-Demand Urgent Care connects top-tier physicians and patients within 10-minutes or less on average. With MediOrbis, patients can leverage 'new telemedicine' to access the care they need anytime, anywhere.



**FACT:** 70% of doctor's visits are for informational purposes only or are for matters that could easily be handled over the phone or via video.

**FACT:** 66% of all emergency room visits are for non-emergencies.

**FACT:** 36 million Americans have been treated through telemedicine tele-consultations.

**SCENARIO:** Jane Doe wakes up in the middle of the night to find that her young daughter has a fever. Jane is concerned and wants to consult with a physician.

Her options?

- 1. Visit Urgent Care or Emergency Room** – Both Urgent Care (if she can find one open late) and the ER will be expensive options since any costs incurred will go towards the deductible first. If the deductible has already been met, she will still need to pay her portion (coinsurance) of the costs.
- 2. Wait until morning and schedule a doctor's appointment** – Even if she feels the matter can wait the several days that it will take her to get an appointment with her physician, she will still need to meet her deductible and pay her coinsurance portion before the visit will be covered.
- 3. Use MediOrbis through the Medefy app or call (866) 633-4672** – Jane can consult a qualified physician, receive a diagnosis, and even have a prescription instantly dispatched to the nearest pharmacy...all without leaving her home or paying any additional costs.

## Benefits App and Telemedicine Medefy

### Get Care Now, Not Later

Feeling sick? Skip the waiting room and get care fast. Medefy Care Guides can connect you with in-network virtual providers- so you can see a doctor from the comfort of home through the Medefy app.

- 24/7 Availability: Get connected to care any time- no hold times.
- Quality Doctors: Talk with licensed, board-certified physicians across the country.
- Complete Care: Receive treatment plans, medical reports, and aftercare instructions
- Seamless Follow-Up: Medefy Care Guides help with next steps and anything in between.

## VIRTUAL CARE ON YOUR SCHEDULE



**Medefy**

2s ago

Care Guides can connect you with top physicians now. Try virtual care today!



Download the  
Medefy App Here



# Medical Plan Comparison

## Important Plan Parameters

- Deductibles, Out-of-Pocket Maximums, and Annual Limits are on a Plan Year basis, (i.e. September 1 through August 31). NOT Calendar Year
- Out-of-Pocket Maximums include deductible and coinsurance.
- Pre-existing condition limitations not applicable.
- Dependent children covered to age 26, regardless of full-time student/marital status or access to other group coverage.

	Option 1	Option 2	
<b>Plan Design</b>	<b>Value-Based Payment Plan</b>	<b>Embedded High-Deductible Health Plan</b>	
<b>Administrator</b>	<b>HealthScope Benefits</b>	<b>UMR</b>	
<b>Network</b>	<b>Open Access</b>	<b>United Healthcare (UHC) Choice Plus</b>	
<b>Plan Provision</b>	Value-Based Payments (VBP)	In-Network	Out-of-Network
<b>Lifetime/ Plan Year Max</b>	Unlimited - Includes Prescription Drugs, Mental & Nervous/ Substance Abuse Benefits		
<b>Individual Deductible</b>	\$2,000	\$4,000	\$6,000
<b>Family Deductible</b>	\$4,000	\$8,000	\$12,000
<b>Individual Out-of-Pocket Maximum</b>	\$6,250	\$4,000	\$10,000
<b>Family Out-of-Pocket Maximum</b>	\$12,500	\$8,000	\$20,000
<b>Coinsurance</b>	80%	100%	80%
<b>Primary Care Physician / Specialist Visit</b>	\$25 Copay / \$50 Copay	100% after Deductible	80% after Deductible
<b>PPACA Preventative Care</b>	100%	100%	80% after Deductible
<b>Inpatient Hospital</b>	80% after Deductible	100% after Deductible	80% after Deductible
<b>Emergency Room</b>	\$500 Copay	100% after Deductible	
<b>Urgent Care</b>	\$25		
<b>Prescription Drugs</b>	<b>ServeYou Rx, Global RxManage for all medical options.</b>		
<b>Tier 1</b>	\$15 Copay	100% after Deductible	80% after Deductible
<b>Tier 2</b>	\$35 Copay	100% after Deductible	80% after Deductible
<b>Tier 3</b>	\$60 Copay	100% after Deductible	80% after Deductible
<b>Mail Order</b>	3x copayment amount	100% after Deductible	80% after Deductible

## Medical Plan Preventative Care

**Patient Protection and Affordable Care Act (PPACA)** implemented a provision to offer certain health preventive services from network providers at no out-of-pocket cost to you or your family.

*All Preventive Care Services are subject to age limits and limits per year. See Plan Document for details.*

- Routine Adult Physical Exam/Immunizations
- Routine Well Child Exams/Immunizations
- Routine Gynecological Care Exams
- Routine Mammograms
- Routine Digital Rectal Exams/ Prostate-Specific Antigen Test
- Colorectal Cancer Screening

**Please Note:** You may need to pay all or part of the costs when services are completed to diagnose, monitor or treat illness, pregnancy or injury, rather than prevent an illness, pregnancy or injury.

### **Adult Preventive Care:**

- Colorectal cancer screening for adults at 50-75
- Diabetes screening for adults 40-70 at higher risk
- Lung cancer screenings for adults at all specified ages who smoke or have quit within the past 15 years
- Tuberculosis screening for latent infection for adults at higher risk
- Abdominal aortic aneurysm one time screening for men of specified ages who have ever smoked
- Low to moderate dose statin use for adults 40-75 at higher risk
- Vitamin D supplementation to prevent falls in community dwelling for adults age 65 and older
- Over the counter and prescription smoking cessation medications for members 18 years and older

### **Medications and Supplements (covered with a doctor's prescription):**

- Aspirin
- Colonoscopy preparation
- Smoking Cessation
- Statin
- Vitamin D
- Fluoride chemoprevention—supplements starting at age 6 months for children without fluoride in their water sources
- Gonorrhea preventive medicine for the eyes of all newborns
- Iron supplements for children ages 6-12 months at risk for anemia
- Children's immunizations such as Chickenpox, Rotavirus, tetanus, Tdap, meningococcal, pneumococcal, Hepatitis A, Hepatitis B, inactivated poliovirus, etc.

### **Women Preventive Services (includes pregnant women):**

- Genetic counseling for women who have tested positive for BRCA
- Breast cancer chemoprevention
- Domestic and interpersonal violence—screenings & referral for intervention services
- HIV screenings for pregnant women
- Preeclampsia screening for all pregnant women
- Breast cancer mammography screenings every 1-2 years for women age 40 or over
- Bacteriuria—urinary tract or other infection screenings for pregnant women
- HPV-DNA test—high risk testing every 3 years for women with normal cytology results who are age 30 or older
- Prenatal vitamins/folic acid for women who are, may become pregnant, or are capable of pregnancy
- Osteoporosis (bone density) screening for women age 65 and over and women at higher risk
- Gestational diabetes screenings for women after 24 weeks of gestation
- Hepatitis B screening for younger women and other women at higher risk
- Cervical cancer screening for women at specified ages and intervals

## Medical Plan Contributions

Contributions are tiered by your use of tobacco. You are required to complete the Tobacco questions when enrolling in medical coverage and your use determines your rates. This is because of the impact smoking and other tobacco products have on your health.

**REMEMBER:** Your Medical, Dental, and Vision contributions are deducted from your paycheck on a **pre-tax** basis, which means that your taxable pay is lower - and so is the amount you pay for Social Security, Medicare, federal and state income taxes. Employees can choose to have the full amount of HSA contributions deducted pre-tax from the 1st paycheck, or to have pre-tax deductions spread over 26 pay periods. You may also elect not to fund your HSA contributions pre-tax and file these contributions on your tax returns. If you chose to add additional funds throughout the year, these will be added post-tax.

Coverage Level	Employee Contributions Non-Tobacco Monthly / Semi-Monthly- Pre-Tax		Employee Contributions Tobacco Monthly / Semi-Monthly- Pre-Tax	
	Value-Based Payment Plan	Embedded HDHP	Value-Based Payment Plan	Embedded HDHP
Employee Only	\$45.00 / \$22.50	\$54.00 / \$27.00	\$70.00 / \$35.00	\$83.00 / \$41.50
Employee + Spouse	\$212.00 / \$106.00	\$274.00 / \$137.00	\$281.00 / \$140.50	\$381.00 / \$190.50
Employee + Child(ren)	\$178.00 / \$89.00	\$227.00 / \$113.50	\$245.00 / \$122.50	\$300.00 / \$150.00
Employee + Family	\$323.00 / \$161.50	\$397.00 / \$198.50	\$443.00 / \$221.50	\$530.00 / \$265.00



Interested in quitting? Call 1-800-QUIT-NOW or enroll at [quitnow.net/louisiana](https://quitnow.net/louisiana) for support.

At [quitwithusla.org](https://quitwithusla.org), you can find information and support about how to best plan and prepare to quit and access to free counseling, virtual coaching, and access to Nicotine Replacement Therapy like patches or gum. They also provide details about further support options such as apps, in-person counseling, and possible prescription solutions. Quit with Us LA also offers tips on maintaining your new habits.

Remember! Most people who quit using tobacco have to make multiple attempts and each try helps you stop using tobacco!

### PREPARE

Resources to help you prepare to quit

### ACT

Support to start your quit journey

### MAINTAIN

Information and guidance to stay quit

# Value-Based Payment Plan HealthScope Benefits

## How the Value-Based Payments Plan Works

Louisiana Machinery has joined with HealthScope Benefits (HSB), a UMR affiliate, to bring you a Value-Based Payment (VBP) plan.

Value-Based Payments Plans work just like a Classic PPO plan in some regards. As a member, you will still only be responsible for copays at primary care physician (\$25) and specialist offices (\$50). However, but VBP Plans do not have a traditional network of facilities like a Classic PPO. Instead, VBP plan uses Medicare plus a percentage and cost information to determine a fair and reasonable price for your medical services. They are open access, and you may choose any hospital to receive care.

However, your costs will be lower if you follow HealthScope Benefits' recommendations. Not all facilities charge the same amount for their services. Before you receive treatment at a hospital, please use the HST Connect mobile app or call HealthScope's Patient Advocacy Center (PAC) to verify that the facility has contracted prices for its services. HealthScope must first verify that the facility you plan to receive treatment is charging a reasonable price above Medicare referenced price.


It is imperative that employees contact HealthScope to verify that their facility is charging a reasonable price for services. If you do not verify your facility with HealthScope, you may be subject to prices over 500% of Medicare price, depending on the facility.

Since Louisiana Machinery's Plan is self-insured, any claim incurred on covered participants is technically paid by Louisiana Machinery, it benefits both Louisiana Machinery and the employees to be educated in how VBP works. This, in turn, will better control claim costs so that Louisiana Machinery can continue to sustain a comprehensive and competitive healthcare plan for employees.

**Contact PAC via:**  
Phone: (888) 837-2237  
Fax: (949) 891-0420  
Email: pac@hstechnology.com  
Monday - Friday 7:00AM-5:00PM PST  
HSTConnect (mobile app)

### Mobile app features:

- Find hospitals and other healthcare services, either In-Network or with high acceptance rates
- Compare quality ratings and pricing for specific procedures
- View deductibles, copays and other plan information
- Direct dial healthcare providers and get driving directions
- Prescription pricing estimates
- Look up information about procedures
- Communicate and receive notifications from HST's Patient Advocacy Center and submit balance bills directly through the app
- Access to HST's Provider Acceptance Rates help minimize the risk of balance billing.



Scan here to download, or find it in the App Store for iOS or Android



# Value-Based Payment Plan HealthSCOPE Benefits

**Louisiana CAT**  
 Issuer (80840) 911-40026-00  
 Member ID: 27261055  
 Member: ARICA SAMPLE 00 MED  
 Dependent(s): ADAM SAMPLE 01 MED  
 Office Visit: \$25 / Specialist \$50  
 Printed: 08/26/2025

Louisiana Machinery  
**PHCS**  
 for Value-Driven Health Plans  
 Group Number: 76415034  
**SERVE YOU**  
 RxBIN: 610548  
 RxPCN: SERVU  
 RxGrp: 7604

Providers are reimbursed pursuant to the terms of the Plan Document up to the Reasonable and Allowable Amount (subject to reference pricing). Physician (and ancillary if applicable) services may be subject to a PPO Network. The Plan will only consider an Assignment of Benefits (AOB) valid under the condition that the Provider accepts the payment received from the Plan as consideration in full for the services, supplies, and/or treatment rendered, less any required deductible/copay/coinsurance.

Self-funded plan administered by HealthSCOPE Benefits

Medical Deductible: \$2,000/\$4,000  
 OOPM: \$6,250/\$12,500\*  
 \*includes pharmacy

PRECERTIFICATION is required for inpatient admissions, and other specific outpatient services. Please call MedWatch at 800-432-8421 for a complete service list and to pre-certify. Failure to pre-certify may result in a reduction of benefits.

Assignment of Benefits (AOB) is a waiver of the Provider's right to balance bill the patient. Depositing checks received from the Plan represents accord and satisfaction and will take precedence over any previous terms. Please see the Plan Document or contact HealthSCOPE Benefits at 844-800-0921.

For Members: [www.healthscopebenefits.com](http://www.healthscopebenefits.com) 844-800-0920  
 To find a provider go to [www.hstconnect.com](http://www.hstconnect.com) or call 844-800-0920

For Providers: [www.healthscopebenefits.com](http://www.healthscopebenefits.com) 844-800-0921

Claims: EDI # 40026, HealthSCOPE Benefits, PO Box 30962, Salt Lake City, UT 84130-0962

Pharmacists & Members: 800-759-3203 [www.serve-you-rx.com](http://www.serve-you-rx.com)

Remember to bring the following to your first appointment with a new doctor:  
**Medical Records & Insurance Card · Medications · Special Needs**

ServeYou Rx Numbers:  
 VBP Plan: 7604  
 EHDHP: 7603

The number assigned specifically to you to track all of your benefits and claims information.

A list of the family members who are covered under your plan.

The number assigned to identify your group health plan.

Information about your prescription drug plan. Pharmacists use this to process your claims.

Self-funded plan administered by HealthSCOPE Benefits

## More on the back

Look for important contact information, including the customer service phone number to call for answers to claims or benefit questions. You can also go to [healthscopebenefits.com](http://healthscopebenefits.com) to check your benefits, claims status, accumulators and eligibility.

Call this number only when you need medical services and your plan requires prior authorization for those services.

Call this number when you have questions about pharmacy benefits.

Visit this website to find a provider in the physician network.

This card must be presented each time services are required.

Call HealthSCOPE CARE at 866-454-4502 for plan required prior authorization. FAILURE TO CALL FOR PRIOR AUTHORIZATION MAY REDUCE BENEFITS.

For Members: [www.HealthSCOPEBenefits.com](http://www.HealthSCOPEBenefits.com) 844-600-0920

For Providers: [www.HealthSCOPEBenefits.com](http://www.HealthSCOPEBenefits.com) 844-600-0921

Claims: EDI # 40026, HealthSCOPE Benefits, PO Box 30962, Salt Lake City, UT 84130-0962  
 For Facility and Out-of-network Professional Claims:  
<https://planlimits.com/group-name>

Pharmacists & Members: 800-XXX-XXXX

# Value-Based Payment Plan HealthScope Benefits

**Example:** You need an elective procedure performed in the hospital. Medicare would pay \$10,000 for that particular procedure (and the hospital accepts the Medicare allowable charge). However, the hospital/facility will charge you a mark-up price of \$50,000, or 500% of the Medicare allowable charge. Using the Medicare guide as a reference, our Plan may offer to pay \$15,000 or 150% of Medicare, thus reducing the price of the procedure significantly (and lowering your costs accordingly).

## Frequently Asked Questions

### What is Value-Based Payments (VBP)?

Value-Based Payments is a transparent way to determine how hospitals will be paid for medical services. It works by reimbursing hospitals based on a reference price: Medicare (plus a percent). Because it is fully transparent and based on cost, the result is a price that is fair to both you and the provider. VBP provides open access to facilities with no network restrictions.

### Does VBP apply to all procedures?

VBP only applies to procedures rendered at hospitals, surgery centers, outpatient Facilities and dialysis centers. Physicians and other non-hospital providers are covered under your (PPO) network.

### Will my provider accept VBP?

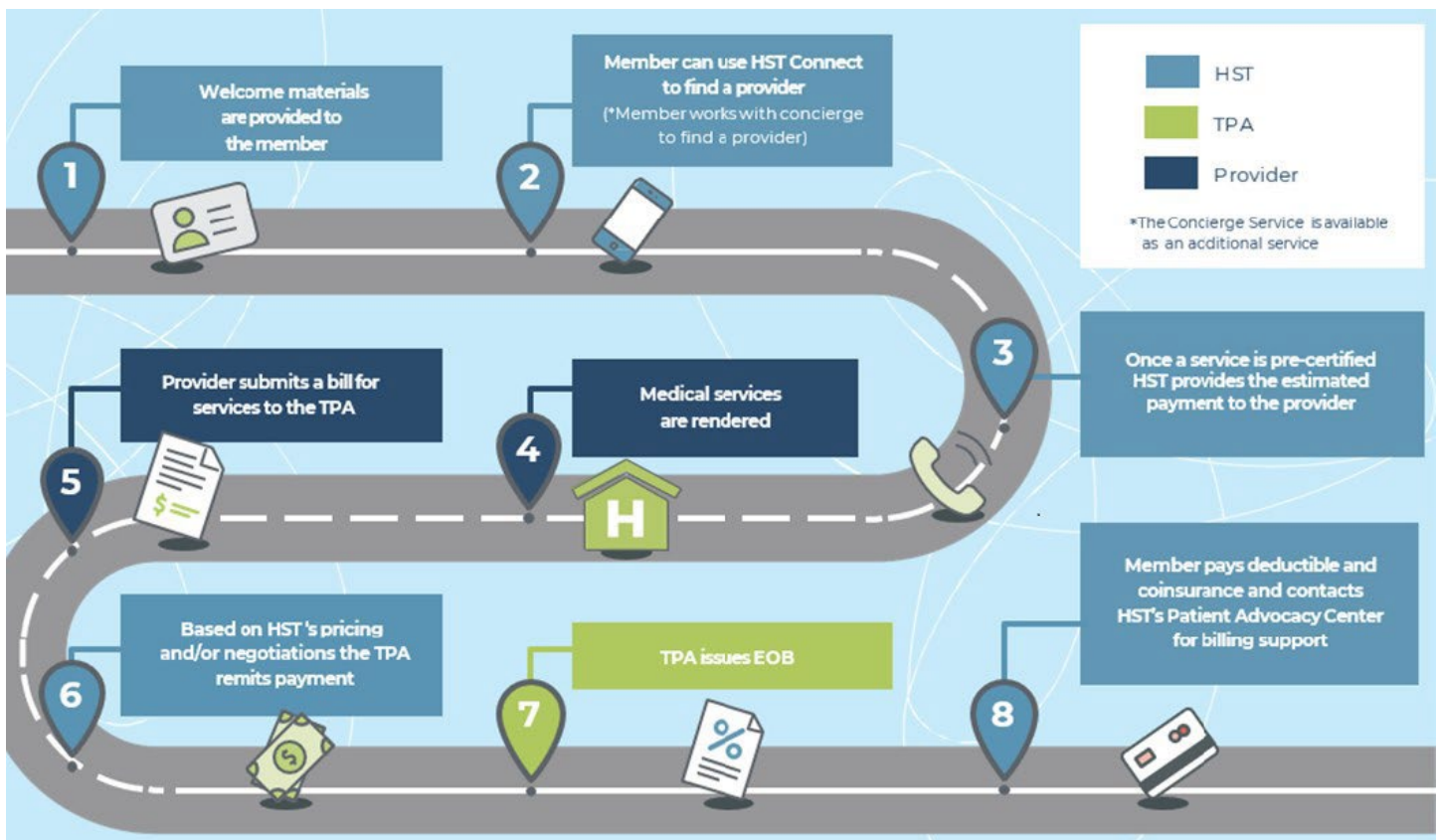
Providers are required to adhere to your benefit plan. If a hospital has questions, they will confirm your coverage by calling the telephone number on your identification card.

### How does it work with my doctors?

VBP only affects care at hospitals. Physicians, specialists, and other non-hospital providers are covered under your PPO network and are unchanged. Your PPO plan gives you access to a wide network of physicians, and you will pay the lowest rates when you use In-Network physicians. You are covered when you go Out-of- Network, although your costs may be higher.

### How do I know how much I will be charged for my procedure?

By utilizing HSTConnect (our mobile app) you can view your estimated costs up front. As usual, you will be responsible for your copay, deductible, and coinsurance up to the annual out-of-pocket maximum.



## Value-Based Payment Plan HealthScope Benefits

HealthScope Benefits educates and negotiates with health care providers before your procedure is performed. This is paramount in eliminating the potential for a balance bill. However, if a provider does bill you, HealthScope will work on your behalf to get the bill resolved. By choosing wisely, you can keep your costs as low as possible.

### HealthScope Services Include:

- Patient Support
- Pre-Service Negotiations
- Scheduling of Services
- Manage Certifications & Referrals
- Confirmation of Pricing
- Assistance with Balance Billing

By Louisiana Machinery participating in Value-Based Payments (VBP) for hospital or facility charges, it allows you to have a transparent method of determining how much you will pay for hospital/facility services. It works by reimbursing hospitals based on a reference price: Medicare plus a percentage.

Louisiana Machinery's VBP Plan continues to cover eligible charges related to inpatient/outpatient hospital, ambulatory/surgical facilities, emergency room, skilled nursing, home health care, physician visits, X-ray/Laboratory facilities and prescription drug charges.

Situations may occur when the Plan will recommend alternate facilities...this sometimes happens if the hospital and the plan cannot agree on a price. When possible, you should choose one of the recommended facilities since your costs will be lower.

### Have Billing Issues?

As with any plan, you may occasionally receive a hospital bill above and beyond what was agreed on your statement (this is known as "balance billing"). If a balance bill occurs, DO NOT PAY IT. Contact HealthScope immediately and a patient advocate will work directly with the hospital on your behalf. Call HealthScope toll free at (888) 713-8808.

**I have paid my required copay, deductible, or out-of-pocket maximum reflected on my EOB; however, I have still received a bill from the provider of service.**

This is referred to as balance billing. Balance billing is when a health care provider accepts the allowed amount from an insurance plan and then bills the patient for the difference between the charge and the allowed amount. HealthScope Benefits has you covered in case you receive a balance bill.

### What should I do if I receive a balance bill from a provider of care?

If a provider bills you for an amount above the patient responsibility identified on your Explanation of Benefits (EOB), don't pay the bill! Contact HealthScope Benefits as soon as you get your first balance bill at the number on your ID card. You can follow the phone prompts to be connected to the appropriate team to handle your balance billing situations. Customer Care will need a copy of the balance bill so have your statement ready.

A Patient Advocacy Center (PAC) Advocate will take over your case and deal directly with the hospital on your behalf. The provider may be directed to provider portal for virtual negotiation. If necessary, they will send you an authorization form which allows HealthScope to engage with the provider.

## Embedded High-Deductible Health Plan UMR

LA Machinery is pleased to continue to offer a traditional HSA-qualified, Embedded High-Deductible Health Plan (EHDHP) administered by UMR that meets the health care needs of you and your covered dependents. Through it, you have access to United Healthcare's United Choice Plus network of providers.

- Comprehensive medical and prescription drug coverage with a combined Medical/ Pharmacy Out-of-Pocket maximum that limits your financial exposure
- Has a higher deductible and Out-of-Pocket maximum than the VBP Option but allows for enrollment in an HSA.
  - You can contribute to an HSA pre-tax.
  - While the money is limited to eligible healthcare spending, the money can be used for family members not enrolled in the LMC EHDHP plan and saved from year to year
  - Louisiana Machinery contributes a matching amount of up to \$62.50 per month.

Please note:

- **Network:** United Healthcare (UHC) Choice Plus
- **Pharmacy Benefit Manager:** ServeYou Rx, RxManage for all medical options
- In-Network, Out-of-Network Deductibles, and Out-of-Pocket Maximums are separate and do not cross apply.
  - As a reminder, Deductibles, Out-of-Pocket Maximums, and Annual Limits are on a Plan Year basis, (i.e. September 1 through August 31). NOT Calendar Year.
- Embedded HDHP Deductible: If you enroll in employee and dependent coverage, you will have an embedded family deductible.
  - The 1<sup>st</sup> \$4,000 in eligible claims made by one member will be applied to the \$8,000 family deductible.
  - The 2<sup>nd</sup> \$4,000 can be satisfied by the other covered individuals in any combination. The individual total deductible is \$4,000.
- Pre-existing condition limitations not applicable
- Dependent children covered to age 26, regardless of full-time student/marital status or access to other group coverage.
- Emergency Room charges covered at In-Network level for emergency purposes only. Out-of-Network charges subject to a percentage of Medicare Allowable.
- PPACA Preventive care services covered in full (In-Network only) All Out-of-Network charges subject to Reasonable & Customary
- For non-preventive services and prescriptions, you must first satisfy your deductible before the plan pays its share of covered expenses
- The "Plan Year Maximums" with regards to visits are the total for In-Network and Out-of-Network expenses. For example, if a maximum of 30 visits is listed twice under a service, the Plan Year maximum is 30 visits total, which may be split between In-Network and Out-of-Network providers

## Embedded High-Deductible Health Plan UMR

If you are not making any changes to your medical plan this Open Enrollment, you will NOT be receiving new medical ID cards for the 2025-2026 Plan Year. If you are a new employee or have chosen to make changes to your medical coverage and have not yet received your ID card for the EHDHP options by September 1, 2025, please provide the following information to your doctor or pharmacy:

LOUISIANA MACHINERY

**UMR** A UnitedHealthcare Company

**Issuer (80840) 911-39026-02**

**Member ID: 29439207**      **Group Number: 76-413049**

**Member:**  
CARLY SAMPLE 00 MED

**Dependents:**  
SPOUSE SAMPLE 01 MED

SERVE YOU

Rx BIN: 610548  
Rx PCN: SERVU  
Rx GRP: 7603

**UnitedHealthcare**  
Choice Plus Network

Self-funded plan administered by UMR

EHDHP  
0730

Printed: 08-03-2022

This card must be presented each time services are requested.

Medical: In Net	Out of Net
Ded: \$4,000/\$8,000*	\$6,000/\$12,000
OOPM: \$4,000/\$8,000*	\$10,000/\$20,000

\*Includes pharmacy

Call UMR CARE at 866-494-4502 for plan required prior authorization.  
FAILURE TO CALL FOR PRIOR AUTHORIZATION MAY REDUCE BENEFITS.

**For Members:**      [www.umar.com](http://www.umar.com)      800-826-9781

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**For Providers:**      [www.umar.com](http://www.umar.com)      877-233-1800

Claims: EDI # 39026, UMR, PO Box 30541, Salt Lake City, UT 84130-0541

First Health  
(800) 780-6465  
First Health is a UnitedHealthcare company.

**Pharmacists & Members:** 800-759-3203      [www.serve-you-rx.com](http://www.serve-you-rx.com)

Remember to bring the following to your first appointment with a new doctor:

**Medical Records & Insurance Card · Medications · Special Needs**

ServeYou Rx Numbers:

VBP Plan: 7604

EHDHP: 7603

### How to Confirm a Provider is in Network with United Healthcare's Choice Plus PPO Network

1. Go to [www.UMR.com](http://www.UMR.com).
2. Click "Find a Provider"
3. Click on "Medical"
4. Scroll down to "U" and click on "United Healthcare Choice Plus"
5. You will be redirected to show the results

This will lead you to the United Healthcare Web site, where you can choose to search by physician, hospital, or other facilities. Or you can call UMR customer service at (800) 826-9781.

**PLEASE CONTACT UMR WITH ANY ELIGIBILITY OR BENEFITS QUESTIONS**



# Health Savings Account (HSA) UMB

When you enroll in Louisiana Machinery's High-Deductible Health Plan, you have the option to open a Health Savings Account (HSA). HSA funds can be used to pay for eligible medical, dental and vision expenses for you and your eligible dependents, including deductibles, coinsurance, prescriptions, acupuncture and more, tax-free, now and in the future. Family members do not need to be covered under your plan in order to use the HSA funds.

## HOW IT WORKS

With the HSA, you are in charge. You decide:

- How much you'll contribute;
- When to pay for eligible expenses with HSA funds directly (*you can also reimburse yourself from the account*);
- How and if you want to invest your HSA funds (*a balance of at least \$2,000 is required to invest*); and
- Whether to save HSA funds for future expenses or retirement.

The HSA offers significant tax savings: Contributions are exempt from federal income tax (state tax treatment varies), payments/ withdrawals for eligible expenses are tax-free and earned interest is not taxed. Your HSA funds belong to you even if you change jobs or retire and unused funds roll over from year to year.

## IRS REGULATIONS

- Must be enrolled in an IRS-qualified High-Deductible Health Plan
- You cannot be covered by any other medical plan, entitled to Medicare benefits or be eligible to be claimed as a dependent on another person's tax return
- See Publication 502 at [www.irs.gov](http://www.irs.gov) for eligible expenses
- For proof of expense eligibility, save receipts

### **Please Note:**

- HSA Contribution Limits are Calendar Year, NOT Plan Year (IRS Guidelines).
- If you are "enrolled" in Medicare, you are able to enroll in the EHDHP, however, you are NOT eligible to contribute to the HSA.

## CONTRIBUTIONS

To contribute to your HSA, you can:

- Elect an annual contribution that will be divided into equal amounts and withdrawn, before taxes, from your paycheck all year; and/or
- Make a deposit of your own using post-tax funds at any time during the year (and claim a tax credit)

*You are not required to contribute to your HSA.*

### **ANNUAL IRS CONTRIBUTION LIMITS**

The IRS limits the total amount that can be contributed to your HSA from all sources.

#### **For 2025, IRS contribution limits are:**

- Employee Only Coverage: \$4,300
- Family Coverage: \$8,550
- Age 55+ catch up contributions are \$1,000

#### **For 2026, IRS contribution limits are:**

- Employee Only Coverage: \$4,400
- Family Coverage: \$8,750
- Age 55+ catch up contributions are \$1,000

***If you are enrolled in the EHDHP Option 2, Louisiana Machinery will match dollar for dollar up to \$62.50 per month into your HSA account.***



## Health Savings Account (HSA) UMB

**QUESTION:** Do I need to designate a beneficiary for my HSA account?

**ANSWER:** You are **not required** to name a beneficiary; however, you should name a beneficiary for your HSA, just as you would for your company retirement plan. After your death, any funds remaining in your HSA are payable to the beneficiary you named on the account. If one is not designated it will be transferred to the spouse. For someone other than a spouse, the tax benefits of account ownership do not transfer.

### ***Naming Your Spouse***

If you name a spouse as your HSA beneficiary, at your death the HSA will become your spouse's own HSA. They can maintain the HSA in their own name and can continue to access the funds. Distributions for qualified medical expenses will be income tax free. The spouse does not need to have HSA-eligible health insurance to continue to hold the HSA. However, if they do and they are eligible, they may make contributions to the HSA.

### ***Naming Your Children***

You may also name children or other non-spouses a beneficiary. However, the account value of the HSA account becomes taxable to the non-spouse beneficiary in the year of the account holder's death. That means the entire account will be taxable in one year.

The amount taxable to the beneficiary is reduced by any qualified medical expenses for the deceased HSA owner that are paid by the beneficiary within one year after the date of death.

### ***Naming Your Estate***

It is also possible to name an estate as an HSA beneficiary. There is a special rule that applies if the beneficiary of an HSA is the estate. If the estate is the beneficiary, then the total distribution is included on the deceased HSA owner's final tax return.



# Health Savings Account (HSA) UMB

		Spouse 1				
		No Coverage	Self-Only Non-HDHP	Self-Only HDHP	Family Non-HDHP	Family HDHP
Spouse 2	No Coverage	Neither person is eligible to contribute to an HSA.	Neither person is eligible to contribute to an HSA.	Spouse 1 is eligible and may contribute up to \$4,150, but Spouse 2 is not eligible to contribute to an HSA.	Neither person is eligible to contribute to an HSA.	Spouse 1 is eligible and may contribute up to \$8,300 but Spouse 2 is not eligible to contribute to an HSA unless he/she is covered under Spouse 1's HDHP. In this case the maximum combined contribution of \$8,300 must be divided between them based on agreement.
	Self-Only Non-HDHP	Neither person is eligible to contribute to an HSA.	Neither person is eligible to contribute to an HSA.	Spouse 1 is eligible and may contribute up to \$4,150, but Spouse 2 is not eligible to contribute to an HSA.	Neither person is eligible to contribute to an HSA.	Spouse 1 is eligible and may contribute up to \$8,300, but Spouse 2 is not eligible to contribute to an HSA.
	Self-Only HDHP	Spouse 2 is eligible and may contribute up to \$4,150, but Spouse 1 is not eligible to contribute to an HSA.	Spouse 2 is eligible and may contribute up to \$4,150, but Spouse 1 is not eligible to contribute to an HSA.	Both people are eligible to have their own HSA and the maximum that can be contributed to each HSA is \$4,150.	Neither is eligible to contribute unless Spouse 2 is not covered under Spouse 1's non-HDHP plan. In that case Spouse 2 may contribute up to \$4,150 to an HSA.	Both people are eligible and treated as if they have family coverage. Their maximum combined contribution of \$8,300 must be divided between them based on agreement.
	Family Non-HDHP	Neither person is eligible to contribute to an HSA.	Neither person is eligible to contribute to an HSA.	Neither is eligible to contribute unless Spouse 1 is not covered under Spouse 2's non-HDHP plan. In that case Spouse 1 may contribute up to \$4,150 to an HSA.	Neither person is eligible to contribute to an HSA.	Spouse 1 is only eligible to contribute up to \$8,300 if he/she is not covered under Spouse 2's non-HDHP plan. Spouse 2 is not eligible to contribute to an HSA.
	Family HDHP	Spouse 2 is eligible and may contribute up to \$8,300, but Spouse 1 is not eligible to contribute to an HSA unless he/she is covered under Spouse 2's HDHP. In this case the maximum combined contribution of \$8,300 must be divided between them based on agreement.	Spouse 2 is eligible and may contribute up to \$8,300, but Spouse 1 is not eligible to contribute to an HSA.	Both people are eligible and treated as if they have family coverage. The maximum combined contribution of \$8,300 must be divided between them based on agreement.	Spouse 2 is only eligible to contribute up to \$8,300 if he/she is not covered under Spouse 1's non-HDHP plan. Spouse 1 is not eligible to contribute to an HSA.	Both people are eligible and treated as if they have family coverage. The maximum combined contribution of \$8,300 must be divided between them based on agreement.

# Chronic Illness Management Ochsner Digital Health


What if you could get the one-on-one, personalized care you need to manage your high blood pressure or Type 2 diabetes without having to make multiple trips to the doctor? Today, thanks to your specialized care team and easy-to-use Bluetooth technology, it's possible!

Ochsner Digital Medicine helps patients manage their chronic conditions from home while staying connected to a dedicated care team. Using advanced analytics, our care team is able to create a personalized plan for you. Our convenient programs are designed to help you take control of your health. Whatever your goals, we'll help you reach them – one small, manageable step at a time.

## Member Enrollment Is Seamless

Dedicated **Digital Medicine** support is available to guide members through the process step-by-step.






**Enroll today.**  
Visit [ochsner.org/join-LouisianaCat](https://ochsner.org/join-LouisianaCat)  
or call Digital Medicine Concierge Kayla at **888-675-0045**.

NO COST  
TO YOU!

### Benefits of Ochsner Digital Medicine

-  Know you're on a medication you'll actually want to take because it makes YOU feel better.
-  Receive personalized care using your smartphone from a team that specializes in high blood pressure and Type 2 diabetes.
-  Learn how to adopt healthier habits that fit your busy lifestyle.

#### How do I sign up?

Visit [ochsner.org/join-LouisianaCat](https://ochsner.org/join-LouisianaCat) or call Digital Medicine Concierge Kayla at **888-675-0045**.

#### How do the programs work?

- Take readings from home with a digital blood pressure cuff or glucometer that connects to your smartphone.
- Get treatment from a licensed clinician who monitors your readings and adjusts medications as needed.
- Create healthy habits with advice and support from your health coach.

#### What does the program cost?

The high blood pressure and Type 2 diabetes programs are covered by the Louisiana Cat insurance at **no cost to you**.

#### Who is eligible to participate?

- Your company's health plan members age 18+ with a smartphone (Android or iOS).
- Existing diagnosis of high blood pressure and/or Type 2 diabetes.<sup>1</sup>



## Healthcare Centers of Excellence Program Summary

### QUALITY HEALTHCARE

You and your dependents now have access to Accarent's Centers of Excellence network of highly-rated medical providers specializing in complex care.

### MEDICAL CASE MANAGEMENT

Accarent will support your care journey with concierge services and nurse case management when navigating a difficult diagnosis or medical procedure.

### Cancer Diagnosis Confirmation and Recommended Treatment Plan:



The Cancer Diagnosis Confirmation and Recommended Treatment Plan program is designed to confirm a cancer diagnosis and provide a recommended treatment plan for adult and pediatric patients with a preliminary cancer diagnosis. The patient collaborates with a multi-disciplinary team to address their unique oncologic needs and provide a custom treatment plan to take home to their local oncologist or remain with Accarent's center of excellence for treatment.

### Organ and Bone Marrow Transplant Management



Accarent's certified nurse case managers and concierges make up the Accarent Care Team—which has over 20 years of experience in assisting transplant patients in navigating a complex process. To help the patient during this difficult time in their life, Accarent's Nurse Case Managers answer any questions, coordinate care with providers, facilitate medical records transfer, and assist with lodging and transportation.

## LOUISIANA CAT MEMBER BENEFITS



**PEDIATRIC & ADULT SPECIALIZED CARE**



**NO OUT-OF-POCKET COST**



**NURSE CASE MANAGEMENT**



**TRAVEL AND LODGING ASSISTANCE AVAILABLE**

### CONTACT ACCARENT FOR ASSISTANCE



[casemanagement@accarenthealth.com](mailto:casemanagement@accarenthealth.com)



[www.accarenthealth.com](http://www.accarenthealth.com)



**1-866-771-0697**

866-474-5842

[regenxxbenefits.com/louisianacat](http://regenxxbenefits.com/louisianacat)



## WHAT IS REGENEXX?

Regenexx is an innovative treatment for orthopedic injuries that enhances your body's natural healing processes. To treat damaged tendons, ligaments, muscle, bone, and cartilage, our physicians draw your blood platelets and bone marrow aspirate and process them in our advanced orthobiologics laboratories. We then inject them precisely at the site of your injury using image guidance. Regenexx procedures provide a lower-risk, lower-cost, minimally invasive alternative for up to 70 percent of elective orthopedic surgeries.

### THE REGENEXX DIFFERENCE

Regenexx is a nonsurgical outpatient procedure performed either in a single day or in a series of three treatments over two weeks. Most patients are encouraged to return to activity within a week of their procedure. Patients with health factors such as heart issues or risk of stroke can find a safer alternative to surgery with Regenexx.

### YOUR REGENEXX BENEFIT

**Regenexx** is covered as an in-network benefit within the Louisiana Machinery Company health plans.

Within the group, members can select from either a PPO plan or a High Deductible health plan. In-network benefits for specialist services within your plan and in-network co-pay, deductible, and out-of-pocket maximums apply for all Regenexx services.

**Non-Regenexx** services may fall under a different benefit level, and may or may not be treated as in-network.

### CONDITIONS TREATED

#### Ankle/Foot

- Achilles tendinopathy
- Arthritis
- Bunions
- Instability
- Ligament sprain or tear
- Plantar fasciitis

#### Hand/Wrist/Elbow

- Arthritis
- Carpal tunnel
- CMC joint arthritis (thumb)
- Tennis elbow
- Trigger finger
- Ulnar nerve entrapment

#### Hip

- Arthritis
- Bursitis Labral/labrum tear
- Joint-replacement alternative
- Osteonecrosis
- Tendinopathy

#### Knee

- Arthritis
- Joint-replacement alternative
- Meniscus tear
- Sprain or tear of ACL/PCL
- Sprain or tear of the MCL/LCL
- Tendinopathy

#### Shoulder

- Arthritis
- Joint-replacement alternative
- Labral tear
- Rotator cuff tear
- Rotator cuff tendinosis

#### Spine

- Back or neck nerve pain
- Bulging, collapsed, or herniated disc
- Ruptured or torn disc
- Degenerative disc disease
- Disc extrusion
- Disc protrusion

### LEARN MORE

To find out more about your Regenexx benefit and whether Regenexx is an option for you, contact our education center.

To register for one of our weekly webinars, visit [regenxxbenefits.com/webinar?mailer](http://regenxxbenefits.com/webinar?mailer).  
Call us today at 866-474-5842 or visit [regenxxbenefits.com/louisianacat](http://regenxxbenefits.com/louisianacat) to learn more.



## Giving the Peace of Mind to Heal

The Samaritan Fund Program sources funds from Samaritan Sponsors to pay for all medical expenses for individuals with serious medical conditions with high-cost treatments.



"You are our guardian angel.... We are now not on edge, not stressed. Now we can focus on medical care and actually enjoy time with our daughter instead of stressing about the financial piece..."

**Thank you, Thank you, Thank you"**

**- PARTICIPANT**



**SCAN TO APPLY**



866-764-9290 | [samaritanfundprogram.com](http://samaritanfundprogram.com)  
[service@samaritanfundprogram.com](mailto:service@samaritanfundprogram.com)

## HOW IT WORKS



If you have a serious medical condition with high cost treatment, electronically submit a confidential Medical Insurance Release form.



A Samaritan Fund Program Representative reaches out to explain the program, answer questions, and gather your information.



If approved a personalized Samaritan Fund Program offer is issued.



If you wish to accept you will sign and submit your offer letter.



Your account is set up and we issue your debit card for medical expenses.



Enjoy the Peace of Mind to Heal and submit your feedback on your Samaritan Fund Program experience.



**Prescription Drug benefits are handled differently between the two medical plans:**

- **Value-Based Payments:** Expenses count toward your Out-of-Pocket maximum but not your deductible. *Be sure to review the \$0 Copay Traditional PPO ACA Preventive Drug List associated with this Plan.*
- **Embedded High-Deductible Health Plan:** You pay the full cost for prescriptions until you reach your medical plan deductible. Expenses count toward your medical plan deductible and Out-of-Pocket

<p>Refer to your <b>SERVEYOU Rx MEMBER PORTAL</b> at <a href="http://serve-you-rx.com">serve-you-rx.com</a> to make the most of your prescription benefit. Click on 'Members' then 'Serve You Rx Members' for helpful tools including Member Forms, Preferred Drug Lists, Exclusions, pricing tools, and drug information such as side effects, missed dosage instructions, etc.</p> <p>ServeYou Rx offers a Free Meter Program for diabetes care. If you would like a new free OneTouch meter, call the OneTouch Service Center at (866) 355-9962, order code: 594PRX100.</p>	<p>Serve You Rx is your prescription drug vendor. You can contact Serve You Rx at</p> <p><b>(800) 759-3203</b> or</p> <p><b><a href="http://serve-you-rx.com/members/">serve-you-rx.com/members/</a></b></p>
<p><b>Why are certain medications chosen for Prior Authorization Review?</b></p> <ul style="list-style-type: none"> <li>• May have high potential for serious side effects or adverse interaction with other drugs</li> <li>• May have the potential to be frequently used incorrectly</li> <li>• May have better alternatives</li> <li>• May have high potential for abuse</li> <li>• Should be used only for very specific conditions</li> </ul>	<p><b>Emphasis on Generics</b></p> <p>Prescriptions are filled with a generic medication whenever possible, unless otherwise indicated by your physician ("Dispense as Written"). These are generally available at the lowest out-of-pocket cost, are just as effective as brand name drugs and meet FDA standards.</p> <p>If you or your doctor choose a brand name medication when a generic is available, you are responsible for the brand copay PLUS the difference in cost between the brand name and generic drug.</p> <p>For certain medications, you must try a generic drug or receive prior approval for coverage of a non-preferred brand drug. If you do not, coverage will be denied, and you will pay the full cost of the brand drug.</p>



## Diabetes Care Plus<sup>SM</sup> Program

Our Diabetes Care Plus program helps participants manage their blood sugar levels and other related health problems.

**This program offers:**



### MORE AFFORDABLE MEDICATION

- Copay Assistance: Serve You Rx will help enroll you in manufacturer assistance programs for select diabetes medications.\*
- Select medications and testing supplies to treat diabetes, high cholesterol, and high blood pressure are available at a reduced copay, which can be \$0 in some instances.



### FREE METER PROGRAM

Serve You Rx offers preferred coverage for ContourNext blood glucose test strips and meters. You will need a new meter if you switch to ContourNext test strips.

Serve You Rx's Free Meter Program allows you to get a blood glucose meter at no charge. For information on the free meter, contact Ascensia Diabetes Care, makers of the ContourNext brand, at 1-800-401-8440. Mention ID code CTR-OPX.



### HOME DELIVERY

Experience the convenience of home delivery for select medications at affordable prices. Easily refill orders online, by phone, or via mail, with pharmacist consultation available 24/7.



### ADHERENCE MONITORING

Serve You Rx will provide refill reminders for select diabetes, high cholesterol, high blood pressure, and antidepressant medications. Adherence is vital to help avoid unpleasant side effects, active symptoms from your condition, or your medication not working as it should.



### UTILIZATION MANAGEMENT

Some diabetes medications may be subject to clinical programs such as prior authorization, step therapy, or quantity limits. These programs ensure that your prescription is medically necessary and reduces costs by encouraging the use of generics and preferred brands.

Your diabetes medication(s) and blood glucose test strips must be obtained via Amazon Pharmacy.

\*The copay assistance provided by the drug manufacturer is thought of as a secondary benefit. Therefore, the amount of funding provided by the drug manufacturer will not count toward your annual deductible or out-of-pocket maximum. Drug manufacturer copay assistance programs may have monthly and/or annual limits on the financial assistance they provide, and the drug manufacturer may change or discontinue these copay assistance programs at any time without notice. Copay assistance programs are not available to patients seeking prescription reimbursement under any federal, state, or government-funded insurance programs (for example, Medicare, Medicaid, TRICARE).

**Call us at 800-759-3203 to get your medications transferred to Amazon Pharmacy.**

# Prescription Drugs ServeYou Rx

## How the Specialty Drug Access Program Works



If you are taking a specialty medication, a member of the ServeYou Rx patient access support team will contact you to describe the Specialty Drug Access Program and answer your questions about the program



ServeYou Rx's patient access support team will work with you to complete the financial assistance application(s). Be prepared to provide information from your most recent tax return, W2 form, or pay stub.



ServeYou Rx works directly with your prescriber to complete the doctor or prescriber section of the paperwork



ServeYou Rx works directly with the assistance program to confirm program participation, if qualified, and schedule delivery of the medication to your preferred location.



**What if I don't qualify?** If you do not qualify for a drug manufacturer or patient assistance program, a member of the ServeYou Rx patient access support team will contact you to discuss other options for access to your specialty drug treatment.

Questions about the ServeYou Rx Specialty Drug Access Program? Call **800-759-3203, press option 2**. To view the ServeYou Rx Specialty Drug List, visit [serveyourx.com](http://serveyourx.com).



# Prescription Drugs Alternative Sources

Louisiana Machinery offers you several ways to save you money on your prescription drugs. Take advantage of the programs below:

**ServeYou Rx** manages Louisiana Machinery’s overall prescription drug program. **Contact Customer Service at (800) 759-3203** for any general questions regarding the pharmacy program, prior authorization, the Specialty Assistance, or Patient Assistance Program.

**Global RxManage** offers international sourcing of certain Brand-Name medications that could save you significant cost. **Contact Customer Service (800) 883-8841** to see which Brand-Name medications qualify or a list medication on the Formulary.

## International Brand-Name Drugs: Global RxManage

RxManage is a program, where you have access to several high-cost medications at \$0 copay. This program allows you to order from a formulary of 250 brand medications from pharmacies in New Zealand, Australia, Canada, and England. The medication will be exactly the same as what you currently take; to be on the formulary, a medication must be available from the same manufacturer internationally as the U.S. brand, or from the international license holder.

### How to Place an Order on the Global RxManage:

- You can place your first order online at <https://my.globalrxmanage.com/customers/louisiana-machinery-company/sign-up>, or by phone at **(800) 883-8841**.
- Once established, your online account is available 24 hours a day, 7 days a week. Login to your computer or mobile device using your Account ID and password at <https://my.globalrxmanage.com/customers/login>
- It will take 10-15 working days for you to receive the medication after it has shipped. Please make sure you have a 30 day supply on hand before placing your first order for each medication.

### IF YOU HAVE QUESTIONS:

Call RxManage call center that is open 9 am to 9 pm (EST) Monday through Friday and 9 am to 4 pm (EST) Saturday and Sunday to answer questions and take your orders. You can also email Rx Manage at [inquiries@rxmanage.com](mailto:inquiries@rxmanage.com)

**ATTENTION!**  
**LOUISIANA CAT EMPLOYEES**

**\$0 CO-PAY\***

**available for over 250 Brand Medications**

90 90 day supply | Order by phone 1-800-883-8841 | Order online (Mobile friendly) | Email us at [inquiries@rxmanage.com](mailto:inquiries@rxmanage.com)

**RxManage** \*when ordered with RxManage (International Pharmacy Program)  
[rxmanage.com](http://rxmanage.com)



## International Pharmacy Program

The International Program allows you to order from a formulary of over 250 medications. Have a 30-day supply of each medication before placing your first order. Receive your order 10-15 working days after the order has shipped.


### About RxManage


RxManage removes the borders and barriers to medications. We source from dispensing pharmacies in New Zealand, Australia, United Kingdom, and Canada.

Using the QR code below, you can easily order brand-name medications. They will be delivered to your home and dispensed safely and accurately by our international network of doctors and pharmacists in Tier 1 countries. We also offer automatic refills, so you'll never run out.

**90** 90-day supply

 **Email us at**  
inquiries@rxmanage.com

 **Order online**  
Use QR code

 **Order by phone**  
1-800-883-8841

### Ordering is easy!

Submit your order using the QR code below or via our call center.

The RxManage call center is open 9am - 9pm Monday to Friday (EST) and 9am - 4pm Saturday and Sunday to answer simple questions or take your orders.



Scan this QR code for a  
**NEW ACCOUNT ACTIVATION**

# Employee Assistance Program (EAP) Interface EAP

Employees and their families often face challenging daily demands, including issues at work, with family, finances and more, which is why your company provides an Employee Assistance Program (EAP), at no cost to you. These services that are available to you and your dependents, provide confidential support, resources, and information to get through life's challenges.

## Confidential Counseling

Your Employee Assistance Program (EAP) is a confidential assistance program to help address the personal issues you and your dependents are facing. This service is staffed by experienced clinicians who are available by phone 24 hours a day, seven days a week. A consultant is available to listen to your concerns and refer you to a local provider for **8 in-person counseling or e-counseling sessions per diagnosis** for a variety of personal concerns, including:

- Depression;
- Stress and anxiety;
- Marital and family conflicts;
- Mental Wellness
- Alcohol and drug abuse;
- Job pressure;
- Elder Care; and
- Grief and loss.

Sessions are provided per problem, per family, per provider, per plan year. If longer-term care is needed, Interface will assist with access to community referrals.

## Legal Resources

When legal issues arise, attorneys are available to provide confidential support with practical, understandable information and assistance. If you require representation, you can also be referred to a qualified attorney in your area for up to three 30-minute consultation, with a 25% discount for ongoing services covering many legal issues including:

- Divorce and family law;
- Bankruptcy;
- Debt obligations;
- Criminal actions;
- Landlord and tenant issues;
- Civil lawsuits;
- Real estate transactions; and
- Contracts.

## Financial Tools

Financial issues can arise at any time, from dealing with debt to saving for college. Our financial professionals are here to discuss your concerns and provide you with the tools and information you need to address your finances, including:

- Saving for college;
- Tax questions;
- Getting out of debt;
- Estate planning;
- Retirement planning; and
- Access to a Licensed Financial Planner.

You have access to three 30-minute consultations per family, per plan year with a financial advisor telephonically.

## Online Work/Life Resources

Access to unlimited self-help tools on work/life resources. Resources are available to all employees and family members. Work/Life resources includes resources for: childcare, elder care, school/college resources, adoption assistance, pet care services and access to additional educational materials and calculators.

## Online Wellness Resources

Access to weekly wellness lessons on a variety of topics such as stress less, healthy weight, women's health, back pain management, eating healthy and men's health. Also available, quarterly wellness webinars on topics such as: The importance of sleep, Workplace workouts, Eating healthy on the go, Stress management.

## Private and Confidential Referrals

It is difficult to know where to turn when personal problems arise. The EAP offers support for you and your family. Call to access any of the professional services offered by your Employee Assistance Program.

### Call or Email

(800) 324-4327  
[info@ieap.com](mailto:info@ieap.com)

### Visit

Visit [www.4eap.com](http://www.4eap.com)  
 Username: LACAT  
 Password: 970



## Contributory Dental Plan Companion Life- New DUAL OPTION!

The Louisiana Machinery Employee Voluntary Dental Plan provides you and your family with coverage for preventive dental care and both major and minor dental procedures to improve overall oral health. New this year, we are offering a **dual option with an annual max of \$1,000 (Base) or \$5,000 (Buy-up)**. The Buy-up plan also includes Orthodontia coverage, allowing you to tailor your plan selections to your and your family's needs.

Summary	Dental Base		Dental Buy-up	
	In-Network	Out-of-Network	In-Network	Out-of-Network*
Annual Deductible (Individual/Family)	\$50 / \$150		\$50 / \$150	
Annual Benefit Maximum per Member (Excluding orthodontia, <b>diagnostic and preventive care</b> )	<b>\$1,000 per person per year</b>		<b>\$5,000 per person per year</b>	
Diagnostic & Preventive Care (Oral exams, X-rays, Cleanings (3 times per benefit year), Fluoride Treatments, Sealants, Space Maintainers, Palliative Treatment)	100% Deductible Waived		100% Deductible Waived	
Basic Restorative Care (Endodontics, Periodontics, Fillings, Simple and Surgical Extractions, Anesthesia, Other Oral Surgery)	80% after Deductible	Services covered at the 90 <sup>th</sup> percentile of UCR.	80% after Deductible	Services covered at the 90 <sup>th</sup> percentile of UCR.
Major Restorative Care (Denture Relines and Rebases/Adjustments, Re-pairs to Dentures, Crowns, and Bridges, Crowns (Post and Core), Onlays (Post and Core), Complete and Partial Dentures, Fixed Bridge Work, Implants, Perio Trays)	50% after Deductible		50% after Deductible	
Lifetime Orthodontia Maximum	Not Applicable		\$1,000 per person	
Orthodontia (For children up to age 19)	Not Applicable		50%	

To locate a provider, go to [https://companionlife.go2dental.com/member/dental\\_search/proxinp.cgi](https://companionlife.go2dental.com/member/dental_search/proxinp.cgi) to search for a dentist by address, zip, name or specialty.

Coverage Level	Base Plan		Buy-up Plan	
	Monthly Rates	Semi-Monthly Rates	Monthly Rates	Semi-Monthly Rates
Employee Only	\$12.48	\$6.24	\$22.05	\$11.03
Employee + Spouse	\$24.58	\$12.29	\$43.14	\$21.57
Employee + Child(ren)	\$31.74	\$15.87	\$52.88	\$26.44
Employee + Family	\$43.83	\$21.92	\$76.56	\$38.28

**NOTE:** Please refer to your Companion Life Dental Certificate of Coverage for details. If this summary conflicts in any way with your Companion Life Dental Certificate of Coverage, the Certificate of Coverage shall prevail.

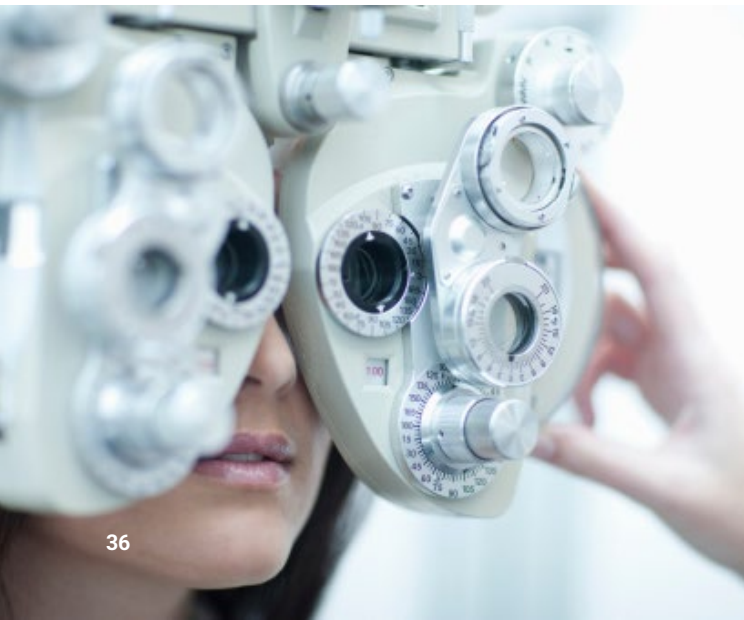
## Voluntary Vision Companion Life

The Louisiana Machinery Employee Vision Plan provides you and your family with coverage for eye exams, lenses and frames. This coverage is offered to you on a voluntary basis. This year, we are changing to Companion Life as our vision carrier but staying with the EyeMed Vision Network!

(Plan allows member to receive either contacts and frame, or frame and lens services. Contacts are only in lieu of spectacle lenses.)

Summary	In-Network	Out-of-Network
Annual Exam (Once per Plan Year)	\$10 Copay	Covered up to \$40
Plastic Lenses (Once per Plan Year)		
•Single Vision, Bifocal, Trifocal, Lenticular	\$10 Copay	Up to \$30, Up to \$50, Up to \$70, Up to \$70
•Standard Progressive	\$65 Copay	Up to \$50
•Premium Progressive, Tier 1-4	\$95-\$185 Copay	Up to \$50
<b>LENS OPTIONS</b>		
•Anti Reflective Coating - Standard	\$45 Copay	Up to \$23
•Anti Reflective Coating - Premium Tier 1-3	\$57 - \$85 Copay	Up to \$23
•Photochromic - Non-Glass	\$75	Not Covered
•Polycarbonate - Standard	\$40	Not Covered
•Polycarbonate - Standard < 19 years of age	\$0 Copay	Up to \$20
•Scratch Coating - Standard Plastic	\$0 Copay	Up to \$8
•Tint - Solid and Gradient	\$15	Not Covered
•UV Treatment	\$15	Not Covered
•All Other Lens Options	20% off retail price	Not covered
Frames (Every 24 months)	\$0 copay; 20% off balance over \$130 allowance	Up to \$91
Contact Lenses* (Every 12 months)		
•Conventional	\$0 copay; 15% off balance over \$130 allowance	Up to \$91
•Disposable	\$0 Copay; 100% of balance over \$130 Allowance	Up to \$91
•Medically Necessary	\$0 Copay; paid-in-fill	Up to \$300
•Standard Fit and Follow-up**	Up to \$40; contact lens fit and two follow-up visits	Not Covered
•Premium Fit and Follow-up**	10% off retail price	Not Covered

\*\* Contact lenses fit and two follow-up visits are available once a comprehensive eye exam has been completed.



To Find a Provider, visit [eyemed.com](http://eyemed.com), select "Find an Eye Doctor" then select the Insight Network, and enter your zip code. Remember to provide your Companion member ID# or social security number, name, and date of birth when you make an appointment.

Coverage Level	Monthly Rates	Semi-Monthly Rates
Employee Only	\$6.68	\$3.34
Employee + Spouse	\$11.99	\$6.00
Employee + Child(ren)	\$12.67	\$6.34
Employee + Family	\$20.01	\$10.00

**NOTE:** Please refer to your Companion Life Dental Certificate of Coverage for details. If this summary conflicts in any way with your Companion Life Dental Certificate of Coverage, the Certificate of Coverage shall prevail.

## Basic Life and AD&D Insurance Companion Life

The Louisiana Machinery Basic Life/AD&D plan is a 100% employer-paid benefit that provides your family with financial protection in the event of your death or the death of a covered dependent (**as long as you are enrolled in medical**).

The Accidental Death & Dismemberment (AD&D) plan protects you and your family in the event of your death or injury due to a covered accident in addition to the benefit provided by your Life coverage.

**Be sure to designate your beneficiaries during enrollment.**

Plan Provision	Coverage / Description
<b>Benefit Amount</b>	\$50,000
<b>Accidental Death Benefit</b>	\$50,000
<b>Accidental Dismemberment Benefit</b>	Percent of benefit based on dismemberment
<b>Age Reduction</b>	Reduces 33% at age 65 Reduces 45% of the original amount at age 70 Benefits terminate at retirement
<b>Waiver of Premium</b>	To age 60 (12-month waiting period) Terminates at age 65 if disabled before age 60
<b>Accelerated Life Benefit</b>	Included
<b>Actively at Work Provision</b>	You must be actively at work on your effective date of coverage in order for your policy to be in force
<b>NOTE:</b> Please refer to the Companion Life Certificate of Coverage for details. If this summary of benefits conflicts in any way with The Hartford Certificate of Coverage, the Certificate of Coverage shall prevail.	



## Voluntary Life and AD&D Insurance Companion Life

The Louisiana Machinery Voluntary Term Life plan allows employees to elect additional life and dependent life coverage to supplement the Basic Life policy. This coverage is entirely optional and is paid for by the employee. Spouse and dependent child coverage is only available if the employee is insured for Voluntary coverage.

### Employee Summary of Benefits

Plan Provision	Coverage/Description
<b>Benefit Amount*</b>	7x annual salary in \$5,000 increments to a maximum of \$500,000
<b>Minimum Benefit Amount</b>	\$10,000
<b>Age Reduction</b>	Reduces to 67% of the original amount at age 65 Reduces to 45% of the original amount at age 70
<b>Guarantee Issue</b>	\$225,000
<b>Waiver of Premium</b>	To age 65 (6 month waiting period) if disabled prior to age 60
<b>Accelerated Death Benefit</b>	Included
<b>Portability</b>	Included
<b>Actively at Work Provision</b>	Included

**\*Employee elections include AD&D of same Benefit Amount. Spouses and Children are not eligible for AD&D.**

### Spouse Summary of Benefits

Plan Provision	Coverage/Description
<b>Benefit Amount</b>	In \$5,000 increments up to \$250,000, not to exceed 50% of employee's voluntary life benefit amount.
<b>Minimum Benefit Amount</b>	\$5,000
<b>Age Reduction</b>	Reduces to 67% of the original amount at spouse age 65 Reduces to 45% of the original amount at spouse age 70
<b>Guarantee Issue</b>	\$50,000

### Child(ren)\* Summary of Benefits

Plan Provision	Coverage/Description
<b>Benefit amount (live birth to 26 years)**</b>	\$10,000
<b>Guarantee Issue</b>	\$10,000

\*Your cost per paycheck does not vary by your child(ren)'s age or by the number of children covered

\*\*You may enroll your eligible child(ren) up to age 26 (if they are not in the military);

### Evidence of Insurability

When enrolling for Voluntary Life Insurance, Evidence of Insurability (EOI) is required when you:

- Elect above the Guaranteed Issue amount: more than \$225,000 in employee coverage or more than \$50,000 in spouse coverage;
- Do not enroll when first eligible, regardless of Benefit Amount
- Increase your current coverage amount by more than \$10,000 (employee) or \$5,000 (spouse);

**Employees that are already enrolled in the Voluntary Life program, may elect an additional \$10,000 of voluntary coverage and spouses an additional \$5,000 up to the Guarantee Issue (GI) during Open Enrollment without Evidence of Insurability (EOI).**

# Voluntary Life and AD&D Insurance Companion Life

## Age-Banded Employee Monthly Contributions (Post-Tax Payroll Deductions)

Age Category	Monthly Rate/ \$1,000 of Coverage	Coverage Amount and Monthly Premium (12 pay periods. Divide by 2 for Semi-Monthly Deductions)								
		\$10,000	\$25,000	\$50,000	\$75,000	\$100,000	\$125,000	\$150,000	\$175,000	\$200,000
15-34	\$.13	\$1.30	\$3.25	\$6.50	\$9.75	\$13.00	\$16.25	\$19.50	\$22.75	\$26.00
35-39	\$.15	\$1.50	\$3.75	\$7.50	\$11.25	\$15.00	\$18.75	\$22.50	\$26.25	\$30.00
40-44	\$0.19	\$1.90	\$4.75	\$9.50	\$14.25	\$19.00	\$23.75	\$28.50	\$33.25	\$38.00
45-49	\$0.26	\$2.60	\$6.50	\$13.00	\$19.50	\$26.00	\$32.50	\$39.00	\$45.50	\$52.00
50-54	\$0.38	\$3.80	\$9.50	\$19.00	\$28.50	\$38.00	\$47.50	\$57.00	\$66.50	\$76.00
55-59	\$0.61	\$6.10	\$15.25	\$30.50	\$45.75	\$61.00	\$76.25	\$91.50	\$106.75	\$122.00
60-64	\$0.72	\$7.20	\$18.00	\$36.00	\$54.00	\$72.00	\$90.00	\$108.00	\$126.00	\$144.00
65-69	\$1.19	\$11.90	\$29.75	\$59.50	\$89.25	\$119.00	\$148.75	\$178.50	\$208.25	\$238.00
70-74	\$1.90	\$19.00	\$47.50	\$95.00	\$142.50	\$190.00	\$237.50	\$285.00	\$332.50	\$380.00
75 +	\$2.50	\$25.00	\$62.50	\$125.00	\$187.50	\$250.00	\$312.50	\$375.00	\$437.50	\$500.00

Spouse Monthly contributions (regardless of age): \$0.14 per \$1,000 of coverage

Child Monthly contributions (regardless of number of children): \$1.10 per \$10,000 of coverage



## Disability Income Benefits Companion Life

LA Machinery's Short Term Disability plan provides a weekly benefit for expenses incurred if you cannot work several weeks due to an illness or injury. Your doctor must certify that you are unable to return to work on a full-time or partial basis. STD Benefits Include: Maternity Benefits, Continuation of Coverage Under FMLA, and Partial Disability Benefits.

Short-Term Disability	
Plan Provision	Coverage / Description
<b>Weekly Benefit</b>	60% of weekly earnings
<b>Maximum Weekly Benefit</b>	\$1,500
<b>Maximum Benefit Duration*</b>	Salaried Employees: 26 weeks Hourly Employees: 25 weeks
<b>Elimination Period (Accident and Sickness)</b>	Salaried Employees: Benefits begin on 8th day Hourly Employees: Benefits begin on 15th day
<b>Pre-existing Condition Limitation</b>	None for initial enrollees
<b>Partial Disability</b>	Included

\*Benefit Duration is until the earliest of resolution of your disability, you reach a total duration of 25 or 26 weeks; or in the event of your death

Disabilities caused by an occupational injury or illness are not covered.

**NOTE:** Please refer to the Companion Life Certificate of Coverage for details. If this summary of benefits conflicts in any way with The Hartford Certificate of Coverage, the Certificate of Coverage shall prevail.

LA Machinery's Long Term Disability plan provides a monthly benefit in the event that you become disabled and are unable to work. Long Term Disability provides replacement income to give you financial security.

Long-Term Disability	
Plan Provision	Coverage / Description
<b>Monthly Benefit</b>	Salaried Employees: 60% of Monthly Earnings Hourly Employees: 50% of Monthly Earnings
<b>Maximum Monthly Benefit*</b>	Salaried Employees: \$15,000 Hourly Employees: \$8,000
<b>Minimum Monthly Benefit</b>	\$100
<b>Elimination Period</b>	180 days
<b>Pre-existing Condition Limitation</b>	<i>3/3/12 If you were treated or diagnosed for a medical condition 3 months prior to your coverage or hire date, you will be eligible for LTD benefits after 3 months free of treatment period followed by a 12-month waiting period</i>
<b>Social Security Integration</b>	Primary and Family
<b>Own Occupation</b>	2 Years
<b>Maximum Duration of Benefits</b>	Social Security Normal Retirement Age (SSNRA)
<b>Mental &amp; Nervous/Substance Abuse</b>	2 Years (24 Months Per Occurrence)
<b>Partial Disability</b>	Included

\*If you qualify for disability benefits from any other sources, your LTD benefit will be reduced so as not to exceed your elected coverage amount. Other sources of LTD benefits may include: Disability benefits from Social Security, State-compulsory benefit act or law, Retirement plan, and Worker's Compensation

**NOTE:** Please refer to the Companion Life Certificate of Coverage for details. If this summary of benefits conflicts in any way with The Hartford Certificate of Coverage, the Certificate of Coverage shall prevail.

# Disability Income Benefits Companion Life

## Disability Income Benefits with Louisiana Machinery are Contributory!

This means that like your Medical coverage, LMC covers some of your premiums and you cover the rest if you wish to enroll in coverage. LMC covers **60%** of the cost.


**To elect coverage, you MUST enroll in both short- and long-term disability. In other words, you cannot elect long term disability without also electing short term disability, and vice versa.**


Employee Contributions			
Short-Term Disability		Long-Term Disability	
\$0.106 per \$10 of covered benefit		\$0.176 per \$100 covered payroll	
To calculate your monthly cost:	Example	To calculate your monthly costs:	Example
1. Take your annual earnings and divide by 52 to get your weekly earnings. (if this amount is greater than \$1,500/week, use \$1,500).	$\$78,900/12 = \$1,517.31$ ; choose \$1,400	1. Indicate your monthly earnings. If your monthly earnings are greater than \$8,000 (Hourly) or \$15,000 (Salary), indicate \$8,000 or \$10,000 respectively.	$\$78,900/12 = \$6,575.00$
2. Multiply the result of Step 2 by 0.60.	$\$1,400 * 0.60 = \$840$	2. Multiply the result by 0. the monthly rate of \$0.176.	$\$6,575.00 * \$0.176 = \$1,157.20$
3. Divide the result of Step 3 by 10.	$\$840/10 = \$84$	3. Divide the result of Step 2 by 100 to obtain your <b>monthly</b> cost.	$\$1,157.20 / \$100 = \$11.57$
4. Multiply the result of Step 4 by \$0.106. This amount is your <b>monthly</b> cost. If you are paid semi-monthly, divide by 2 for your per paycheck deductions.	$\$84 * \$0.106 = \$8.90$	If you are paid semi-monthly, divide by 2 for your per paycheck deductions.	





# Voluntary Identity Theft Protection Aura Identity Guard


 Industry-leading alert speeds<sup>1</sup>


 Personalized threat alerts


 Cyberbullying alerts and social media monitoring

 Safe browsing tools

 Secure VPN connection

 Helps stop unauthorized data use

 Removes personal data

 Reduces spam + robocalls

Louisiana Machinery's IdentityTheft Protection plan includes comprehensive identity monitoring, fraud remediation and restoration, and identity theft reimbursement. This benefit is 100% voluntary and paid for by you. It is also portable should you leave LMC.

Visit [IdentityGuard.com](https://IdentityGuard.com) or call (855) 443-7748 for more details

### Coverage includes:

- Financial Fraud Protection
- Identity Theft Protection including \$5m ID Theft Insurance
- White Glove Fraud Resolution Service
- VPN and Online Privacy
- Digital Vault
- Family Safety (Family Plans only)
- monitoring and alerts;
- 24/7 Privacy Advocate support, and more

### Pricing:

- \$11.95/month for Individual coverage
- \$20.95/month for Family coverage



**NOTE:** Please refer to the Aura Identity Guard Certificate of Coverage for details. If this summary of benefits conflicts in any way with the Aura Identity Guard Certificate of Coverage, the Certificate of Coverage shall prevail.



## Voluntary Legal Assistance MetLaw

Louisiana Machinery is continuing to provide you with a voluntary plan that offers convenient access to legal services you may not be able to afford on your own. This plan provides access to legal representation for you and your family at only \$21.00 a month. The Nationwide network includes over 15,000 attorneys.

To access legal advisors call (800) 821-6400 or visit the website [info.legalplans.com](http://info.legalplans.com) with the password LEGAL.

Coverage	Benefit
<b>Consumer Protection</b>	Small Claims Assistance, Personal Property Protection
<b>Debt Matters</b>	Debt Collection Defense, Identity Theft Defense, Personal Bankruptcy or Wage Earner Plan, Tax Audits
<b>Defense of Civil Lawsuit</b>	Administrative Hearing Representation, Civil Litigation Defense, Incompetency Defense
<b>Document Preparation</b>	Affidavits, Deeds, Demand Letters, Mortgages, Promissory Notes, Document Review, Elder Law Matters
<b>Family Law</b>	Name Change, Prenuptial Agreement, Protection from Domestic Violence, Adoption and Legitimization (Contested and Uncontested), Guardianship or Conservatorship (Contested or Uncontested)
<b>Immigration</b>	Immigration Assistance
<b>Personal Injury</b>	Personal Injury (25% Network Maximum)
<b>Real Estate Matters</b>	Zoning Applications, Boundary or Title Disputes (Primary Residence), <u>Primary Residence – Tenant Only:</u> (1) Eviction and Tenant Problems, (2) Security Deposit Assistance, <u>Primary, Secondary or Vacation Homes:</u> (1) Home Equity Loans, (2) Property Tax Assessment, (3) Refinancing of Home, (4) Sale or Purchase of Home
<b>Traffic and Criminal Matters</b>	Juvenile Court Defense, Traffic Ticket Defense (No DUI), Restoration of Driving Privileges
<b>Wills and Estate Planning</b>	Trusts, Living Wills, Powers of Attorney, Probate (10% Network Discount), Wills and Codicils, Dependent Definition

To continue coverage, terminated and retired employees must apply for portable enrollment within 30 days of their last day of employment by calling **(800) GET-MET8**. Portable enrollment remains in effect for a 30-month period and is non-renewable. Enrollment is prepaid and the cost is equal to the enforce group rate x30.

## Additional Voluntary Plans American Public Life (APL)

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### APL

An array of Voluntary Worksite coverages are available through American Public Life (APL). These voluntary benefits can help fill in any gaps in your coverage and provide additional financial security for you and your dependents. You can customize your APL benefit package by choosing the plans that best fit your individual needs. APL benefits of various types are available for purchase, some on an after-tax basis.

Available voluntary benefits offered include:

- Accident Insurance
- Critical Illness
- Cancer
- Hospital Indemnity
- Portable Term Life

For more details and rates, please see the brochures attached to this guide.

*Please Note: Louisiana Machinery Company, LLC is not endorsing the policy, contributing towards premium payments, or receiving any form of payment for allowing APL to offer this policy. All questions regarding these benefits should be directed to the APL.*



# Additional Voluntary Plans American Public Life (APL)



## Group Accident Insurance



Accident Insurance can provide protection to help with the high cost of a covered accidental injury. From a simple physician's office visit, to x-rays, ambulance transportation or an intensive care admission due to an accidental injury – unexpected expenses can add up.

Plan Provision	Coverage/Description
Type of Coverage	24-Hour Coverage
Spouse or Partner Coverage	Spouse or Partner benefit amounts are 100% of the insured's benefit amount, unless otherwise stated.
Dependent Child(ren) Coverage	Dependent child(ren) benefit amounts are 100% of the insured's benefit amount, unless otherwise stated.
Continuation Coverage Based on defined qualifying events defined in your certificate	Coverage will be continued for 12 months following the date the insured ceased active employment.
Portability Coverage	Included, age 79 or younger
Post-Accident Time Frame Requirement Unless otherwise defined, confinement, stay, treatment, therapy, diagnosis, surgery, paralysis, dismemberment, death or prescription of covered items must occur within the defined number of days after a covered accident or for inpatient rehabilitation, if applicable to the plan, within the defined number of days after the date of discharge from the hospital.	90 day(s)
<b>Hospital Benefits</b>	
Hospital Admission (Pays only once per day, even if the confinement or observation long stay is the result of more than one injury.)	\$2,000/1 day(s)
Hospital Confinement Pays once per stay	\$350/365 day(s)
ICU Admission (Pays only once per day, even if the confinement is the result of more than one injury.)	\$2,000/1 day(s)
ICU Confinement Pays once per day	\$700/30 day(s)
<b>Severe Burn Benefits</b>	
2nd degree & 3rd degree Burns Pays once per covered accident based on degree and size of burn	\$200 to \$10,000
Skin Graft1	50% of severe burn benefit amount
<b>Lodging and Travel Benefits</b>	
Non-Local Transportation	\$375/up to 3 round trip(s)
Family Lodging	\$150/30 night(s)
<b>Ambulance Benefits</b>	
Air Ambulance	\$600/3 day(s)
Ground or Water Ambulance	\$200/3 day(s)

## Additional Voluntary Plans American Public Life (APL)

### Group Accident Insurance

Plan Provision	Coverage/Description
<b>Emergency Dental &amp; Vision Treatment Benefits</b>	
Emergency dental extraction of a broken sound, natural tooth	\$200
Emergency repair of a broken sound, natural tooth with a crown	\$150
Eye surgery or removal of a foreign object	\$150
<b>Appliance and Prosthesis Benefits</b>	
Wheelchair, motorized scooter, walker, walking boot, any other medical device used for mobility, including a brace, cane and crutches - based on type of appliance	\$200/1 day(s)
Prosthesis (Pays once per covered accident, per plan year based on number of devices)	\$750 to \$1,500
<b>Other Benefits</b>	
Blood/Plasma/Platelets	\$450/1 day(s)
<b>Accident Screening Benefit</b>	
Accident Screening <sup>1</sup>	\$50/1 per covered person, up to 4 per family. Additional screening tests included
<b>Initial Treatment Benefits</b>	
Emergency Room Treatment Pays once per day	\$300/3 day(s)
Urgent Care Treatment Pays once per day	\$150/2 day(s)
Physician's Office Treatment Pays once per day	\$100/3 day(s)
Telemedicine Pays once per day	\$25/5 day(s)
<b>Diagnostic Benefits</b>	
X-ray	\$200/5 day(s)
Major Diagnostic Exam	\$75/1 day(s)
<b>Therapy Benefits</b>	
Inpatient Rehabilitation	\$200/30 day(s)
Physical Therapy	\$50/10 day(s)
Extended Treatment	\$50/5 day(s) Benefits includes Chiropractic Therapy, Acupuncture Therapy
<b>Coma and Paralysis Benefits</b>	
Coma (Must continue for at least 7 day(s) before a benefit is payable. Pays once per covered accident.)	\$15,000
Paralysis (Must continue for at least 90 day(s) before a benefit is payable)	Quadriplegia - \$22,500 Paraplegia - \$11,250

## Additional Voluntary Plans American Public Life (APL)

### Group Accident Insurance

Plan Provision	Coverage/Description
<b>Accidental Death Benefits</b>	
Insured - \$25,000	Insured - \$25,000 Spouse or Partner - \$15,000 Dependent Child(ren) - \$5,000
Common Carrier Accidental Death	Insured - \$100,000 Spouse or Partner - \$50,000 Dependent Child(ren) - \$20,000
Accidental Death Seatbelt	Insured - \$5,000 Spouse or Partner - \$2,500 Dependent Child(ren) - \$1,250
<b>Dismemberment Benefits</b>	
Dismemberment - Single, Double, Finger/Toe	\$2,000 to \$20,000
<b>Dislocation Benefits</b>	
Dislocation (open reduction) - based on joint involved	\$375 to \$5,000
Dislocation (closed reduction) percentage <sup>1</sup>	50% of open reduction benefit amount
Partial dislocation percentage <sup>1</sup>	25% of open reduction benefit amount
<b>Fracture Benefits</b>	
Fracture (open reduction) - based on bone involved	\$375 to \$5,000
Fracture (closed reduction) percentage <sup>1</sup>	50% of open reduction benefit amount
Chip fracture percentage <sup>1</sup>	25% of open reduction benefit amount
<b>Laceration Benefits</b>	
Based on length of laceration	\$75 to \$100/3 day(s)
<b>Inpatient Surgery Benefits</b>	
Pays once per covered accident based on type of surgery	\$1,500
<b>Outpatient Surgery Benefits</b>	
Tendon/ligament/rotator cuff/torn knee cartilage - based on type of surgery	\$750 to \$1,000/1 day(s)
<b>Brain Injury Benefits</b>	
Concussion	\$450/1 day(s)

Coverage Level	Monthly Rates	Semi-Monthly Rates
Employee Only	\$12.82	\$6.41
Employee + Spouse	\$19.95	\$9.97
Employee + Child(ren)	\$26.21	\$13.10
Employee + Family	\$36.00	\$18.00

## Additional Voluntary Plans American Public Life (APL)



### Group Critical Illness Insurance



Critical Illness insurance from APL can help you prepare for the financial impact you may face after a heart attack, stroke, invasive cancer or other covered critical illnesses.

Plan Provision	Coverage/Description		
	Plan 1 Insured Benefit Amount <sup>2</sup>	Plan 2 Insured Benefit Amount <sup>2</sup>	Plan 3 Insured Benefit Amount <sup>2</sup>
<b>Critical Illness Covered Conditions</b>			
<b>Nicotine Class</b>	Non-Nicotine/Nicotine rates apply to all family members if any family member applying for coverage uses Nicotine products		
<b>Spouse Coverage</b>	Available		
<b>Dependent Child(ren) Coverage</b>	Available		
<b>Pre-Existing Condition</b>	Waived		
<b>Pre-Existing Condition Limitation</b>	Not applicable		
<b>Benefit Waiting Period</b>	30 days		
<b>Tier 1 Cancer<sup>3</sup></b>			
Invasive Cancer	\$10,000.00	\$20,000.00	\$30,000.00
Non-Invasive Cancer	\$2,500.00	\$5,000.00	\$7,500.00
Benign Brain Tumor	\$10,000.00	\$20,000.00	\$30,000.00
Skin Cancer	\$250.00	\$250.00	\$250.00
<b>Tier 1 Vascular<sup>3</sup></b>			
Heart Attack	\$10,000.00	\$20,000.00	\$30,000.00
Coronary Artery Disease (Bypass Surgery)	\$2,500.00	\$5,000.00	\$7,500.00
Stroke	\$10,000.00	\$20,000.00	\$30,000.00
<b>Tier 1 Other<sup>3</sup></b>			
Bone Marrow Transplant	\$10,000.00	\$20,000.00	\$30,000.00
Major Organ Failure	\$10,000.00	\$20,000.00	\$30,000.00
End Stage Renal Failure	\$10,000.00	\$20,000.00	\$30,000.00
<b>Tier 2 Vascular<sup>3</sup></b>			
Sudden Cardiac Arrest	\$2,500.00	\$5,000.00	\$7,500.00
<b>Tier 2 Other<sup>3</sup></b>			
Acute Respiratory Distress Syndrome (ARDS)	\$2,500.00	\$5,000.00	\$7,500.00
Addison's Disease	\$2,500.00	\$5,000.00	\$7,500.00
Advanced Alzheimer's Disease	\$10,000.00	\$20,000.00	\$30,000.00
Advanced Parkinson's Disease	\$10,000.00	\$20,000.00	\$30,000.00

## Additional Voluntary Plans American Public Life (APL)

Plan Provision		Coverage/Description		
Critical Illness Covered Conditions	Plan 1 Insured Benefit Amount <sup>2</sup>	Plan 2 Insured Benefit Amount <sup>2</sup>	Plan 3 Insured Benefit Amount <sup>2</sup>	
Tier 2 Other <sup>3</sup>				
Amyotrophic Lateral Sclerosis (ALS)	\$2,500.00	\$5,000.00	\$7,500.00	
Coma	\$10,000.00	\$20,000.00	\$30,000.00	
Complete Loss of Sight	\$10,000.00	\$20,000.00	\$30,000.00	
Complete Loss of Speech	\$10,000.00	\$20,000.00	\$30,000.00	
Complete Loss of Hearing	\$10,000.00	\$20,000.00	\$30,000.00	
Diphtheria	\$2,500.00	\$5,000.00	\$7,500.00	
Encephalitis	\$2,500.00	\$5,000.00	\$7,500.00	
Huntington's Disease	\$2,500.00	\$5,000.00	\$7,500.00	
Legionnaire's Disease	\$2,500.00	\$5,000.00	\$7,500.00	
Lyme Disease	\$2,500.00	\$5,000.00	\$7,500.00	
Malaria	\$2,500.00	\$5,000.00	\$7,500.00	
Meningitis	\$2,500.00	\$5,000.00	\$7,500.00	
Multiple Sclerosis (MS)	\$2,500.00	\$5,000.00	\$7,500.00	
Myasthenia Gravis	\$2,500.00	\$5,000.00	\$7,500.00	
Necrotizing Fasciitis	\$2,500.00	\$5,000.00	\$7,500.00	
Occupational Hepatitis	\$2,500.00	\$5,000.00	\$7,500.00	
Occupational HIV	\$2,500.00	\$5,000.00	\$7,500.00	
Osteomyelitis	\$2,500.00	\$5,000.00	\$7,500.00	
Permanent Paralysis	\$10,000.00	\$20,000.00	\$30,000.00	
Poliomyelitis	\$2,500.00	\$5,000.00	\$7,500.00	
Pulmonary Embolism	\$2,500.00	\$5,000.00	\$7,500.00	
Pulmonary Fibrosis	\$2,500.00	\$5,000.00	\$7,500.00	
Rabies	\$2,500.00	\$5,000.00	\$7,500.00	
Rocky Mountain Spotted Fever	\$2,500.00	\$5,000.00	\$7,500.00	
Ruptured Aneurysm	\$2,500.00	\$5,000.00	\$7,500.00	
Severe Arthritis	\$2,500.00	\$5,000.00	\$7,500.00	
Severe Mental Illness	\$2,500.00	\$5,000.00	\$7,500.00	
Severe Osteoporosis	\$2,500.00	\$5,000.00	\$7,500.00	
Sickle Cell Anemia	\$2,500.00	\$5,000.00	\$7,500.00	
Systemic Lupus	\$2,500.00	\$5,000.00	\$7,500.00	
Systemic Sclerosis (Scleroderma)	\$2,500.00	\$5,000.00	\$7,500.00	

## Additional Voluntary Plans American Public Life (APL)

Plan Provision	Coverage/Description		
Tetanus	\$2,500.00	\$5,000.00	\$7,500.00
Tuberculosis	\$2,500.00	\$5,000.00	\$7,500.00
Type I Diabetes	\$2,500.00	\$5,000.00	\$7,500.00
<b>Childhood Conditions<sup>3</sup></b>			
Cerebral Palsy	\$2,500.00	\$5,000.00	\$7,500.00
Cleft Lip and/or Cleft Palate	\$2,500.00	\$5,000.00	\$7,500.00
Cystic Fibrosis	\$2,500.00	\$5,000.00	\$7,500.00
Down Syndrome	\$2,500.00	\$5,000.00	\$7,500.00
Muscular Dystrophy	\$2,500.00	\$5,000.00	\$7,500.00
Spina Bifida	\$2,500.00	\$5,000.00	\$7,500.00
Tay-Sachs Disease	\$2,500.00	\$5,000.00	\$7,500.00
<b>Additional Occurrence</b>	Included		
<b>Recurrence Benefit</b>	Included, 100%		
<b>Recurrence Separation Period</b>	12 months		
<b>Wellness Benefits<sup>8</sup></b>	Maximum of 1 per covered person, up to 4 per family		
<b>Health Screening</b>	\$50, payable for a wellness test; or routine physical exam; or any additional generally medically accepted screening test used to evaluate risk or promote prevention of a covered condition.		
<b>Mammography</b>	\$50, payable once every 2 Years	\$50, payable once every 2 Years	\$50, payable once every 2 Years
<b>Continuation Coverage</b>	Included	Included	Included
<b>Portability Coverage</b>	Included, age 79 or younger	Included, age 79 or younger	Included, age 79 or younger

## Additional Voluntary Plans American Public Life (APL)

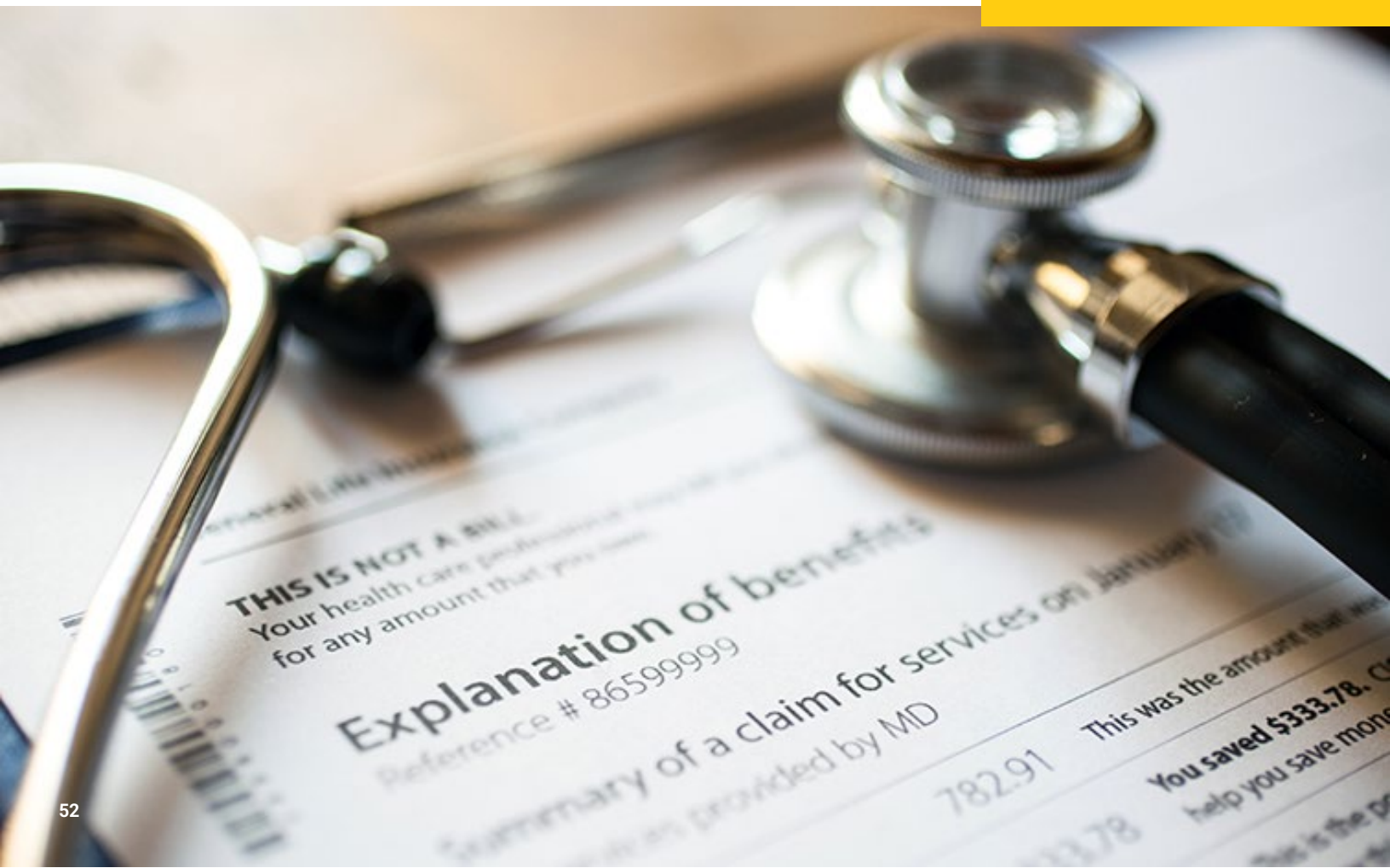
Non-Nicotine Plan 1 Monthly Age Based Premium**			Nicotine Plan 1 Monthly Age Based Premium**		
Age	Employee	Employee + Spouse	Age	Employee	Employee + Spouse
18-29	\$4.25	\$7.07	18-29	\$5.16	\$8.45
30-39	\$8.63	\$13.78	30-39	\$11.66	\$18.38
40-49	\$16.77	\$26.22	40-49	\$25.09	\$38.70
50-59	\$28.95	\$44.77	50-59	\$44.38	\$67.86
60-69	\$38.44	\$59.24	60-69	\$59.41	\$90.70
70-79	\$58.00	\$88.08	70-79	\$163.38	\$255.23
Non-Nicotine Plan 1 Semi-Monthly Age Based Premium**			Nicotine Plan 1 Semi-Monthly Age Based Premium**		
Age	Employee	Employee + Spouse	Age	Employee	Employee + Spouse
18-29	\$2.12	\$3.53	18-29	\$2.58	\$4.22
30-39	\$4.31	\$6.89	30-39	\$5.83	\$9.19
40-49	\$8.38	\$13.11	40-49	\$12.54	\$19.35
50-59	\$14.47	\$22.38	50-59	\$22.19	\$33.93
60-69	\$19.22	\$29.62	60-69	\$29.70	\$45.35
70-79	\$29.00	\$44.04	70-79	\$81.69	\$127.61
Non-Nicotine Plan 2 Monthly Age Based Premium**			Nicotine Plan 2 Monthly Age Based Premium**		
Age	Employee	Employee + Spouse	Age	Employee	Employee + Spouse
18-29	\$7.11	\$11.40	18-29	\$12.09	\$14.17
30-39	\$15.60	\$24.23	30-39	\$21.76	\$33.46
40-49	\$31.51	\$48.32	40-49	\$48.15	\$73.28
50-59	\$55.34	\$84.33	50-59	\$84.06	\$130.48
60-69	\$73.23	\$112.37	60-69	\$115.83	\$175.29
70-79	\$114.95	\$174.06	70-79	\$323.81	\$504.35
Non-Nicotine Plan 2 Semi-Monthly Age Based Premium**			Nicotine Plan 2 Semi-Monthly Age Based Premium**		
Age	Employee	Employee + Spouse	Age	Employee	Employee + Spouse
18-29	\$3.55	\$5.70	18-29	\$6.04	\$7.08
30-39	\$7.80	\$12.11	30-39	\$10.88	\$16.73
40-49	\$15.75	\$24.16	40-49	\$24.07	\$36.64
50-59	\$27.67	\$42.16	50-59	\$42.03	\$65.24
60-69	\$36.61	\$56.18	60-69	\$57.91	\$87.64
70-79	\$57.47	\$87.03	70-79	\$161.90	\$252.17

## Additional Voluntary Plans American Public Life (APL)

Non-Nicotine Plan 3 Monthly Age Based Premium**			Nicotine Plan 3 Monthly Age Based Premium**		
Age	Employee	Employee + Spouse	Age	Employee	Employee + Spouse
18-29	\$8.15	\$14.95	18-29	\$9.49	\$17.16
30-39	\$17.21	\$28.60	30-39	\$23.97	\$39.22
40-49	\$39.87	\$63.01	40-49	\$66.65	\$104.70
50-59	\$81.51	\$127.23	50-59	\$154.18	\$239.38
60-69	\$159.51	\$246.35	60-69	\$320.50	\$494.39
70-79	\$172.44	\$260.68	70-79	\$485.77	\$755.36

Non-Nicotine Plan 3 Semi-Monthly Age Based Premium**			Nicotine Plan 3 Semi-Monthly Age Based Premium**		
Age	Employee	Employee + Spouse	Age	Employee	Employee + Spouse
18-29	\$4.07	\$7.47	18-29	\$4.74	\$8.58
30-39	\$8.60	\$14.30	30-39	\$11.98	\$19.61
40-49	\$19.93	\$31.50	40-49	\$33.32	\$52.35
50-59	\$40.75	\$63.61	50-59	\$77.09	\$119.69
60-69	\$79.75	\$123.17	60-69	\$160.25	\$247.19
70-79	\$86.22	\$130.34	70-79	\$242.88	\$377.68



## Additional Voluntary Plans American Public Life (APL)



### Group Cancer Insurance



If you or a family member are diagnosed with cancer, APL's Cancer Insurance may help cover the costs associated with the detection and treatment of cancer and help you be more financially prepared.

Plan Provision	Coverage/Description	
	Plan 1 Insured Benefit	Plan 2 Insured Benefit
Spouse Coverage	Available	Available
Dependent Child(ren) Coverage	Available	Available
Pre-Existing Condition Period/Pre-Existing Condition Exclusion Period	12 months/12 months	12 months/12 months
Cancer Treatment Benefit	Level 2	Level 2
Radiation Therapy, Chemotherapy, Immunotherapy Maximum per 12-month period	\$10,000.00	\$10,000.00
Hormone Therapy Maximum of 12 treatments per calendar year	\$50 per treatment	\$50 per treatment
Experimental Treatment	paid in same manner and under the same maximums as any other benefit	paid in same manner and under the same maximums as any other benefit
Cancer Screening Benefit Rider	Level 1	Level 4
Diagnostic Testing 1 test per calendar year	\$50 per test	\$100 per test
Follow-Up Diagnostic Testing 1 test per calendar year	\$100 per test	\$100 per test
Medical Imaging	\$500 per test; 1 test(s) per calendar year	\$500 per test; 2 test(s) per calendar year
Surgical Benefit Rider	Level 2	Level 2
Surgical Operation	\$30 unit dollar amount; Max \$3,000 per operation	\$30 unit dollar amount; Max \$3,000 per operation
Anesthesia	25% of amount paid for covered surgery	25% of amount paid for covered surgery
Bone Marrow Transplant Maximum per lifetime	\$6,000.00	\$6,000.00
Stem Cell Transplant Maximum per lifetime	\$600.00	\$600.00
Prosthesis, Surgical implantation, Non-surgical (not hair piece) 1 device per site, per lifetime	\$1,000 per device \$100 per device	\$1,000 per device \$100 per device

## Additional Voluntary Plans American Public Life (APL)

Plan Provision	Coverage/Description	
	Plan 1 Insured Benefit	Plan 2 Insured Benefit
Patient Care Benefit Rider	Level 1	Level 3
Hospital Confinement	Insured or Spouse: \$100 per day of hospital confinement, days 1-30; \$100 per day of hospital confinement, days 31+ Eligible Dependent Child(ren): \$200 per day of hospital confinement, days 1-30; \$200 per day of hospital confinement, days 31+	Insured or Spouse: \$200 per day of hospital confinement, days 1-30; \$400 per day of hospital confinement, days 31+ Eligible Dependent Child(ren): \$400 per day of hospital confinement, days 1-30; \$800 per day of hospital confinement, days 31+
Outpatient Facility	\$200 per day surgery is performed	\$400 per day surgery is performed
Attending Physician	\$30 per day of hospital confinement	\$40 per day of hospital confinement
Dread Disease	\$100 per day of hospital confinement, days 1-30; \$100 per day of hospital confinement, days 31+	\$200 per day of hospital confinement, days 1-30; \$400 per day of hospital confinement, days 31+
Extended Care Facility	\$100 per day	\$200 per day
Donor	\$100 per day	\$200 per day
Home Health Care	\$100 per day	\$200 per day
Hospice Care	\$100 per day; maximum of 365 days per lifetime	\$200 per day; maximum of 365 days per lifetime
US Government, Charity Hospital or HMO	\$100 per day of hospital confinement, days 1-30; \$100 per day of hospital confinement, days 31+	\$200 per day of hospital confinement, days 1-30; \$400 per day of hospital confinement, days 31+
Miscellaneous Benefit Rider	Level 1	Level 2
Cancer Treatment Center Evaluation or Consultation - 1 per lifetime	Not included	\$750.00
Evaluation or Consultation Travel and Lodging - 1 per lifetime	Not included	\$350.00
Second / Third Surgical Opinion Per diagnosis of cancer	\$300 / \$300	\$300 / \$300
Drugs and Medicine	\$150 per inpatient confinement;	\$50 per outpatient prescription, maximum \$150 per month
Hair Piece (Wig) - 1 per lifetime	\$150.00	\$150.00
Transportation and Lodging Transportation - maximum 12 trips per calendar year for all modes of transportation combined Lodging - up to a maximum of 100 days per calendar year	actual coach fare or \$0.40 per mile for travel by bus, plane or train; \$0.40 per mile for travel by car; \$50 per day for lodging	actual coach fare or \$0.75 per mile for travel by bus, plane or train; \$0.75 per mile for travel by car; \$100 per day for lodging
Family Member Transportation and Lodging Transportation - maximum 12 trips per calendar year for all modes of transportation combined Lodging - up to a maximum of 100 days per calendar year	actual coach fare or \$0.40 per mile for travel by bus, plane or train; \$0.40 per mile for travel by car; \$50 per day for lodging	actual coach fare or \$0.75 per mile for travel by bus, plane or train; \$0.75 per mile for travel by car; \$100 per day for lodging

## Additional Voluntary Plans American Public Life (APL)

Plan Provision	Coverage/Description	
	Plan 1 Insured Benefit	Plan 2 Insured Benefit
Blood, Plasma and Platelets	\$300 per day	\$300 per day
Ambulance Maximum of 2 trips per hospital confinement for all modes of transportation combined	Ground: \$200 per trip Air: \$2,000 per trip	Ground: \$200 per trip Air: \$2,000 per trip
Inpatient Special Nursing Services	\$150 per day of hospital confinement	\$150 per day of hospital confinement
Outpatient Special Nursing Services	\$150 per day	\$150 per day
Medical Equipment Maximum of 1 benefit per calendar year	Not included	\$150.00
Physical, Occupational, Speech, Audio Therapy and Psychotherapy	\$25 per visit; maximum of \$1,000 per calendar year	\$25 per visit; maximum of \$1,000 per calendar year
Waiver of Premium	Included	Included
Internal Cancer First Occurrence Benefit Rider	Not included	Level 1
Lump Sum Benefit Maximum 1 per lifetime	Not included	Insured or Spouse: \$2,500 Eligible Dependent Child(ren): \$3,750
Increase in Coverage	Only available at annual renewal. Must be approved by APL and premium rates will be based upon the insured's attained age. Subject to the Time Limit on Certain Defenses and Pre-Existing Condition provisions, as defined in the policy.	
Portability Amendment Rider	Included	
Continuity of Coverage Amendment Rider (Takeover)	Included, credit given for time served under prior coverage for: Pre-Existing Condition Limitation Eligibility Requirements	

Coverage Level Age 18+	Plan 1		Plan 2	
	Monthly Rates	Semi-Monthly Rates	Monthly Rates	Semi-Monthly Rates
Employee Only	\$14.00	\$7.00	\$22.30	\$11.15
Employee + Spouse	\$24.50	\$12.25	\$38.90	\$19.45
Employee + Child(ren)	\$16.60	\$8.30	\$26.30	\$13.15
Employee + Family	\$27.00	\$13.50	\$42.90	\$21.45



### MedChoice Group Hospital Indemnity Insurance



Hospital indemnity insurance may help cover the costs of an unexpected illness or serious accident that results in a hospital stay, outpatient surgery or treatment in a doctor's office. Focus on recovery, not your finances, with a hospital indemnity plan from APL.

Summary of Benefits	
HSA Compatible	No
Spouse Coverage	Available
Dependent Child(ren) Coverage	Available
Pregnancy Coverage/Waiting Period	Included/ 10 Months
Hospital Admission Benefit	\$1,000 per day; max of 1 day(s)
Hospital Confinement Benefit	\$150 per day; max of 10 day(s)
Intensive Care Unit Admission Benefit	\$1,000 per day; max of 1 day(s)
Intensive Care Unit	Benefit \$300 per day; max of 10 day(s)
Rehabilitation Benefit	\$25 per day; max of 5 day(s)
Additional Rider(s)	
Portability Option Rider	Included

Coverage Level	Monthly Rates	Semi-Monthly Rates
Employee Only	\$13.00	\$6.50
Employee + Spouse	\$38.09	\$19.04
Employee + Child(ren)	\$15.34	\$7.67
Employee + Family	\$43.03	\$21.51

# Additional Voluntary Plans American Public Life (APL)



## Portable Term Life Insurance



Will your loved ones be afforded the same lifestyle and opportunities after you're gone? Whether you've never had life insurance or simply want more coverage, you can help protect your family's future with APL's Portable Term Life Insurance.

### Key feature

- Portable coverage goes with you, through the end of the term, if you change jobs or retire
- You choose the period of time ("term") that best suits your current stage of life
- Insure your family with options for your spouse and child(ren) (employee coverage required)
- No health questions or exams at initial enrollment\*

### Family Coverage

#### Spouse Life Benefit

- Term (period of time) is the same length as yours

#### Child Life Benefit

- Children ages 14 days to 26 years old
- One rate insures all eligible children in your household

Plan Provision	Coverage/Description	
	Plan 1	Plan 2
Certificate Term	20 Years	30 Years
Benefit Amounts All face amounts may not be available for all ages.	Employee: \$10,000 to \$150,000 in \$1,000 increments Spouse: \$10,000 to \$100,000 in \$1,000 increments Child(ren): \$50,000	Employee: \$10,000 to \$150,000 in \$1,000 increments Spouse: \$10,000 to \$100,000 in \$1,000 increments Child(ren): \$50,000
Insured Guarantee Issue	\$150,000.00	\$150,000.00
Spouse Guarantee Issue	100% of Insured Amount to a maximum of \$100,000	100% of Insured Amount to a maximum of \$100,000
Child(ren) Guarantee Issue	\$50,000.00	\$50,000.00
Accidental Death Benefit Rider	Included	Included
Certificate Portability	Included	Included

## Additional Voluntary Plans American Public Life (APL)

Eligible dependent(s) means your lawful spouse or any other person lawfully defined as the spouse; and/or your child (natural, step, adopted or placed for adoption, and any other child lawfully defined as a child) who is at least 14 days old and under 26 years of age. Lawfully means as defined under the civil union, domestic partnership, marriage or other family or domestic relations laws, including case law, of the state where the policy is delivered or issued for delivery. You must be actively at work on the effective date or coverage will be deferred until you return to work. Dependent coverage will not become effective while the dependent is confined at home under a physician's care, receiving or applying to receive disability benefits from any source, or hospitalized.

### Limitations

If a covered person commits suicide, while sane or insane, within two years from the covered person's certificate effective date, APL will not pay the benefit proceeds. Instead, APL's liability will be limited to a return to the beneficiary of all premiums paid by you and a return to the policyholder of all premiums paid by the policyholder, less any indebtedness.

### Accidental Death Benefit Rider

If applicable to the plan, death must result from and occur within 180 days of a qualifying accidental bodily injury as defined in the rider. No benefits will be payable under this rider if the covered person's death results from, or is contributed to, whether directly or indirectly from war or any act caused by war while the covered person is in military service (the term "war" includes declared or undeclared war or any conflict between the armed forces of any country or countries); intentionally self-inflicted bodily injury, suicide or attempted suicide, whether sane or insane; participating in a riot, insurrection or terrorist activity; voluntarily taking any drug (unless administered by a physician and taken according to the physician's instructions or an over the counter drug taken in accordance with instructions); poison, gas or fumes, unless a direct result of an occupational accident; committing or attempting to commit an illegal act, which would constitute a felony; or air travel, except while riding as a fare-paying passenger on a regularly scheduled commercial airline, or as a passenger for transportation only and not as a pilot or crew member.

### Termination of Insurance

Insurance coverage under this certificate, including any attached riders, will end on the earliest of these dates: the date the grace period ends if the premium remains unpaid; the date the term period expires, as shown on the certificate schedule of insurance; the date you convert coverage to an individual plan; the date in which you request to terminate the coverage for an eligible dependent; the date the covered person no longer qualifies as an insured or eligible dependent; the date the policy terminates if portability coverage has not been elected or the date of the covered person's death. APL may terminate the coverage of any person who submits a fraudulent claim.

### Continuation of Coverage

Coverage under the certificate will continue for all covered persons under the certificate if the insured is totally disabled on the date coverage ends if the insured notifies APL of their total disability on the date coverage ends, the insured provides acceptable documentation of their total disability, and the policyholder continues to pay the due premium. The benefits continued will be the same as those that were in force under the certificate on the day before total disability. Continuation of coverage will end on the earliest of six months, the duration of the insured's total disability or the date the insured elects portability or conversion.

### Portability

If your coverage terminates for reasons other than non-payment of premium, you may be eligible to port coverage. The requirements for election of portability, election of dependent portability and termination of portability are defined in your certificate. If you are not eligible for portability coverage, then you may be eligible to convert to an individual policy.

### Conversion

If your coverage ended for any reason other than non-payment of premium, you may be eligible to convert coverage during one of the conversion periods. The conversion periods, requirements for election of conversion and election of dependent conversion are defined in the your certificate.

## Additional Voluntary Plans American Public Life (APL)

Issue Age	APL 20 Year Premium Per \$1000		APL 30 Year Premium Per \$1000	
	Monthly Rates	Annual Rates	Monthly Rates	Annual Rates
17	\$0.31	\$3.66	\$0.35	\$4.19
18	\$0.31	\$3.66	\$0.35	\$4.19
19	\$0.31	\$3.66	\$0.35	\$4.19
20	\$0.31	\$3.66	\$0.35	\$4.19
21	\$0.31	\$3.66	\$0.35	\$4.19
22	\$0.31	\$3.66	\$0.35	\$4.19
23	\$0.31	\$3.66	\$0.35	\$4.19
24	\$0.31	\$3.66	\$0.35	\$4.19
25	\$0.31	\$3.66	\$0.35	\$4.19
26	\$0.31	\$3.66	\$0.35	\$4.19
27	\$0.31	\$3.66	\$0.35	\$4.19
28	\$0.31	\$3.66	\$0.35	\$4.19
29	\$0.31	\$3.66	\$0.35	\$4.19
30	\$0.31	\$3.66	\$0.35	\$4.19
31	\$0.31	\$3.66	\$0.35	\$4.19
32	\$0.31	\$3.66	\$0.35	\$4.19
33	\$0.31	\$3.66	\$0.35	\$4.19
34	\$0.31	\$3.66	\$0.36	\$4.32
35	\$0.31	\$3.66	\$0.38	\$4.58
36	\$0.31	\$3.66	\$0.40	\$4.84
37	\$0.32	\$3.79	\$0.44	\$5.23
38	\$0.34	\$4.05	\$0.46	\$5.49
39	\$0.36	\$4.32	\$0.49	\$5.89
40	\$0.38	\$4.58	\$0.53	\$6.41
41	\$0.41	\$4.97	\$0.57	\$6.80
42	\$0.45	\$5.36	\$0.62	\$7.46
43	\$0.48	\$5.76	\$0.68	\$8.11
44	\$0.52	\$6.28	\$0.74	\$8.89
45	\$0.58	\$6.93	\$0.81	\$9.68
46	\$0.62	\$7.46	\$0.86	\$10.33
47	\$0.66	\$7.98	\$0.94	\$11.25
48	\$0.72	\$8.63	\$1.02	\$12.30
49	\$0.77	\$9.29	\$1.11	\$13.34
50	\$0.84	\$10.07	\$1.20	\$14.39
51	\$0.89	\$10.73	\$1.29	\$15.43
52	\$0.96	\$11.51	\$1.38	\$16.61
53	\$1.04	\$12.43	\$1.49	\$17.92
54	\$1.11	\$13.34	\$1.61	\$19.36
55	\$1.20	\$14.39	\$1.73	\$20.80
56	\$1.30	\$15.57	\$1.89	\$22.63
57	\$1.41	\$16.87	\$2.05	\$24.59
58	\$1.53	\$18.31	\$2.22	\$26.68
59	\$1.67	\$20.01	\$2.42	\$29.04
60	\$1.82	\$21.84	\$2.63	\$31.52
61	\$2.01	\$24.07	\$0.00	\$0.00
62	\$2.20	\$26.42		
63	\$2.43	\$29.17		
64	\$2.68	\$32.18		
65	\$2.96	\$35.58		
66	\$3.25	\$38.98		
67	\$3.56	\$42.77		
68	\$3.89	\$46.70		
69	\$4.27	\$51.27		
70	\$4.69	\$56.24		

Rates:

- Uni-Nicotine
- No Policy Fee
- Face Amounts: \$10,000 - \$150,00

# Important Notices

## Annual Compliance Notices

[COBRA Rights General Notice](#)

[Genetic Information Nondiscrimination Act \(GINA\) of 2008](#)

[HIPAA Special Enrollment Rights](#)

[Medicare Part D Notice of Creditable Coverage](#)

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[Newborns and Mothers Health Protection Act](#)

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[Wellness Program \(Health Contingent\)](#)

[Wellness Program \(ADA Wellness Program\)](#)

[Women's Health and Cancer Rights Act \(WHCRA\)](#)

## COBRA RIGHTS

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Company plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

**You may have other options available to you when you lose group health coverage.** For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs.

Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

### What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the plan is lost because of the qualifying event. Under the plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Employees and their qualified dependents are responsible for notifying the Company of any change in address or status (e.g., divorce, insurance eligibility, child becoming ineligible due to age, etc.) within 30 days of the event.

If applicable, your participation in the Health Care Flexible Spending Account (FSA) can also continue on an after-tax basis through the remainder of the plan year in which you qualify for COBRA. The opportunity to elect the same coverage that you had at the time the qualifying event occurred extends to all qualified beneficiaries. If you make contributions to the Health Care FSA for the year in which your qualifying event occurs, you may continue to make these contributions on an after-tax basis. This way, you can be reimbursed for certain medical expenses you incur after your qualifying event, but before the end of the plan year.

You may be offered to continue your coverage under the Health Care FSA if you have not overspent your account. The determination of whether your account for a plan year is overspent or underspent as of the date of the qualifying event depends on three variables: (1) the elected annual limit for the qualified beneficiary for the plan year; (2) the total reimbursable

## Important Notices

claims submitted to the Cafeteria Plan for that plan year before the date of the qualifying event; and (3) the maximum amount that the Cafeteria Plan is permitted to require to be paid for COBRA coverage for the remainder of the plan year. The elected annual limit less the claims submitted is referred to as the “remaining annual limit.” If the remaining annual limit is less than the maximum COBRA premium that can be charged for the rest of the year, then the account is overspent. You may not re-enroll in the Health Care FSA during any annual enrollment for any plan year that follows your qualifying event.

Supporting documentation like a divorce decree, death certificate or proof of other insurance may be required as proof of a qualifying event. This general notice does not fully describe COBRA or the plan. More complete information is available from the Plan Administrator and in the summary plan document.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

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

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

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

### **When is COBRA Coverage Available?**

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of

hours of employment, death of the employee, or the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), the employee must notify the Plan Administrator of the qualifying event.

### **How is COBRA Coverage Provided?**

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

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee’s hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee’s hours of employment, COBRA continuation coverage generally lasts for

## Important Notices

only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

### **Disability extension of 18-month period of continuation coverage.**

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

Documentation from the Social Security administration certifying a disability will be required.

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

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

### **Are there other coverage options besides COBRA Continuation Coverage?**

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

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

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

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

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

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

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

### **If you have questions**

Questions concerning your plan or your COBRA continuation coverage rights should be addressed to the Plan Administrator indicated above or in the summary plan description. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security

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Administration (EBSA) in your area or visit [www.dol.gov/ebsa](http://www.dol.gov/ebsa). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov)

### Keep your plan informed of address changes

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

### THE GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 ("GINA")

GINA protects employees against discrimination based on their genetic information. Unless otherwise permitted, your employer may not request or require any genetic information from you or your family members. The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to any requests for medical information, if applicable. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

### HIPAA SPECIAL ENROLLMENT RIGHTS

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that we notify you about important provisions in the plan. You have the right to enroll in the plan under its "special enrollment provision" provided that you meet participation requirements, including: if you marry, acquire a new dependent, or if you decline coverage under the plan for an eligible dependent while other coverage is in effect and later the dependent loses that other coverage for certain qualifying reasons. Special enrollment must take place within 30 days of the qualifying event.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage) provided that you meet participation requirements. You must request enrollment, however, within 30 days or any longer period that applies under the plan, after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days or any longer period that applies under the plan, after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact the Plan Administrator mentioned above.

If you have declined enrollment for yourself or your dependents (including your spouse) while coverage under Medicaid or a state Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and your dependents in this program if you or your dependents lose eligibility for that other coverage. You must, however, request enrollment within 60 days after you or your dependents' Medicaid or CHIP coverage ends. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or a CHIP program with respect to coverage under this plan, you may be able to enroll yourself and your dependents (including your spouse) in this plan. You must, however, request enrollment within 60 days after you or your dependents become eligible for the premium assistance. To request special enrollment or obtain more information, contact the Plan Administrator indicated in this notice.

### MEDICARE PART D NOTICE (NOTICE OF CREDITABLE COVERAGE)

#### About Your Prescription Drug Coverage and Medicare

This notice has information about your current prescription drug coverage and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can

## Important Notices

get help to make decisions about your prescription drug coverage is at the end of this notice.

Two important things to know about your current coverage and Medicare's prescription drug coverage:

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

### **When Can You Join A Medicare Drug Plan?**

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. Plan participants are eligible if they are within three months of turning age 65, are already 65 years old or if they are disabled. However, if you lose your current creditable prescription drug coverage through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

### **What Happens to your Current Coverage if You Decide to Join a Medicare Drug Plan?**

If you decide to join a Medicare drug plan, your current coverage will not be affected, and benefits will be coordinated with Medicare. Refer to your plan documents provided upon eligibility and open enrollment or contact your provider or the Plan Administrator for an explanation and/or copy of the prescription drug coverage plan provisions/options under the plan available to Medicare-eligible individuals when you become eligible for Medicare Part D.

Visit [www.cms.hhs.gov/CreditableCoverage](http://www.cms.hhs.gov/CreditableCoverage) which outlines the prescription drug plan provisions/options Medicare-eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and current coverage is dropped, be aware you and your dependents will not be able to get this coverage back. Refer to plan documents or contact your provider or the Plan Administrator before making any decisions.

*Note: In general, different guidelines exist for retirees regarding cancellation of coverage and the ability to get that coverage back. Retirees who terminate or lose coverage will not be able to get back on the plan unless specific contract language or other agreement exists. Contact the Plan Administrator for details.*

### **When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?**

You should also know if you drop or lose your current coverage and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For more information about this notice or your current prescription drug coverage, *contact the Plan Administrator for details.* You will get this notice each year. You will also get it before the next Medicare part D drug plan enrollment period and if this coverage changes. You also may request a copy of this notice at any time.

### **For more information about your options under Medicare prescription drug coverage**

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

## Important Notices

### For more information about Medicare prescription drug coverage:

Visit [www.Medicare.gov](http://www.Medicare.gov) or call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help. Call 800-MEDICARE (800-633-4227) (TTY: 877-486-2048). If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available.

For information about this extra help, visit Social Security on the web at [www.socialsecurity.gov](http://www.socialsecurity.gov) or call 800-772-1213 (TTY: 800-325-0778).

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

### MENTAL HEALTH PARITY

The Mental Health Parity and Addiction Equity Act (MHPA/ MHPAEA) of 2008 requires that group health plans must not unfairly restrict treatment with respect to coverage and cost sharing requirements for mental health or substance use disorders relative to the coverage and cost sharing requirements offered under the plan’s medical and surgical benefits. Additional information and details can be found by visiting the Department of Labor’s Mental Health Parity website: [www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity](http://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity)

### NEWBORNS’ AND MOTHERS’ HEALTH PROTECTION ACT

The Newborns’ and Mothers’ Health Protection Act (NMHPA) requires that group health plans and health insurance issuers who offer childbirth coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.

However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Refer to your plan document for specific information about childbirth coverage or contact your Plan Administrator.

For additional information about NMHPA provisions and how self-funded non-Federal governmental plans may opt-out of the NMHPA requirements, visit [www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/nmhp\\_a\\_factsheet.html](http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/nmhp_a_factsheet.html).

### PAPERWORK REDUCTION ACT STATEMENT

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

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20220 or email [ebsa.opr@dol.gov](mailto:ebsa.opr@dol.gov) and reference the OMB Control Number 1210-0137.

### 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

## Important Notices

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](http://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](http://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](http://www.askebsa.dol.gov) or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility –

<b>ALABAMA – Medicaid</b>	<b>ALASKA – Medicaid</b>
Website: <a href="http://myalhipp.com/">http://myalhipp.com/</a> Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: <a href="http://myakhipp.com/">http://myakhipp.com/</a> Phone: 1-866-251-4861 Email: <a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a> Medicaid Eligibility: <a href="https://health.alaska.gov/dpa/Pages/default.aspx">https://health.alaska.gov/dpa/Pages/default.aspx</a>
<b>ARKANSAS – Medicaid</b>	<b>CALIFORNIA – Medicaid</b>
Website: <a href="http://myarhipp.com/">http://myarhipp.com/</a> Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: <a href="http://dhcs.ca.gov/hipp">http://dhcs.ca.gov/hipp</a> Phone: 916-445-8322 Fax: 916-440-5676 Email: <a href="mailto:hipp@dhcs.ca.gov">hipp@dhcs.ca.gov</a>
<b>COLORADO – Health First Colorado (Colorado's Medicaid Program) &amp; Child Health Plan Plus (CHP+)</b>	<b>FLORIDA – Medicaid</b>
Health First Colorado Website: <a href="https://www.healthfirstcolorado.com/">https://www.healthfirstcolorado.com/</a> Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: <a href="https://hcpf.colorado.gov/child-health-plan-plus">https://hcpf.colorado.gov/child-health-plan-plus</a> CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): <a href="https://www.mycohibi.com/">https://www.mycohibi.com/</a> HIBI Customer Service: 1-855-692-6442	Website: <a href="https://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html">https://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html</a> Phone: 1-877-357-3268
<b>GEORGIA – Medicaid</b>	<b>INDIANA – Medicaid</b>
GA HIPP Website: <a href="https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp">https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp</a> Phone: 678-564-1162, Press 1 GA CHIPRA Website: <a href="https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra">https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra</a> Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: <a href="https://www.in.gov/medicaid/">https://www.in.gov/medicaid/</a> <a href="http://www.in.gov/fssa/dfr/">http://www.in.gov/fssa/dfr/</a> Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584

## Important Notices

<p><b>IOWA – Medicaid and CHIP (Hawki)</b></p> <p>Medicaid Website:  <a href="http://iowa.gov/health-human-services">Iowa Medicaid   Health &amp; Human Services</a>            Medicaid Phone: 1-800-338-8366            Hawki Website:  <a href="http://iowa.gov/healthy-well-kids">Hawki - Healthy and Well Kids in Iowa   Health &amp; Human Services</a>            Hawki Phone: 1-800-257-8563            HIPP Website: <a href="http://iowa.gov/health-insurance-premium-payment">Health Insurance Premium Payment (HIPP)   Health &amp; Human Services (iowa.gov)</a>            HIPP Phone: 1-888-346-9562</p>	<p><b>KANSAS – Medicaid</b></p> <p>Website: <a href="https://www.kancare.ks.gov/">https://www.kancare.ks.gov/</a>            Phone: 1-800-792-4884            HIPP Phone: 1-800-967-4660</p>
<p><b>KENTUCKY – Medicaid</b></p> <p>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:  <a href="https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx">https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx</a>            Phone: 1-855-459-6328            Email: <a href="mailto:KIHIPPPROGRAM@ky.gov">KIHIPPPROGRAM@ky.gov</a>            KCHIP Website: <a href="https://kynect.ky.gov">https://kynect.ky.gov</a>            Phone: 1-877-524-4718            Kentucky Medicaid Website: <a href="https://chfs.ky.gov/agencies/dms">https://chfs.ky.gov/agencies/dms</a></p>	<p><b>LOUISIANA – Medicaid</b></p> <p>Website: <a href="http://www.medicicaid.la.gov">www.medicicaid.la.gov</a> or <a href="http://www.ldh.la.gov/lahipp">www.ldh.la.gov/lahipp</a>            Phone: 1-888-342-6207 (Medicaid hotline) or            1-855-618-5488 (LaHIPP)</p>
<p><b>MAINE – Medicaid</b></p> <p>Enrollment Website:  <a href="https://www.mymaineconnection.gov/benefits/s/?language=en_US">https://www.mymaineconnection.gov/benefits/s/?language=en_US</a>            Phone: 1-800-442-6003            TTY: Maine relay 711            Private Health Insurance Premium Webpage:  <a href="https://www.maine.gov/dhhs/ofl/applications-forms">https://www.maine.gov/dhhs/ofl/applications-forms</a>            Phone: 1-800-977-6740            TTY: Maine relay 711</p>	<p><b>MASSACHUSETTS – Medicaid and CHIP</b></p> <p>Website: <a href="https://www.mass.gov/masshealth/pa">https://www.mass.gov/masshealth/pa</a>            Phone: 1-800-862-4840            TTY: 711            Email: <a href="mailto:masspremassistance@accenture.com">masspremassistance@accenture.com</a></p>
<p><b>MINNESOTA – Medicaid</b></p> <p>Website:  <a href="https://mn.gov/dhs/health-care-coverage/">https://mn.gov/dhs/health-care-coverage/</a>            Phone: 1-800-657-3672</p>	<p><b>MISSOURI – Medicaid</b></p> <p>Website: <a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a>            Phone: 573-751-2005</p>
<p><b>MONTANA – Medicaid</b></p> <p>Website: <a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP">http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP</a>            Phone: 1-800-694-3084            Email: <a href="mailto:HSHIPPPProgram@mt.gov">HSHIPPPProgram@mt.gov</a></p>	<p><b>NEBRASKA – Medicaid</b></p> <p>Website: <a href="http://www.ACCESSNebraska.ne.gov">http://www.ACCESSNebraska.ne.gov</a>            Phone: 1-855-632-7633            Lincoln: 402-473-7000            Omaha: 402-595-1178</p>
<p><b>NEVADA – Medicaid</b></p> <p>Medicaid Website: <a href="http://dhcfp.nv.gov">http://dhcfp.nv.gov</a>            Medicaid Phone: 1-800-992-0900</p>	<p><b>NEW HAMPSHIRE – Medicaid</b></p> <p>Website: <a href="https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program">https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program</a>            Phone: 603-271-5218            Toll free number for the HIPP program: 1-800-852-3345, ext. 15218            Email: <a href="mailto:DHHS.ThirdPartyLiabi@dhhs.nh.gov">DHHS.ThirdPartyLiabi@dhhs.nh.gov</a></p>
<p><b>NEW JERSEY – Medicaid and CHIP</b></p> <p>Medicaid Website:  <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a>            Phone: 1-800-356-1561            CHIP Premium Assistance Phone: 609-631-2392            CHIP Website: <a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a>            CHIP Phone: 1-800-701-0710 (TTY: 711)</p>	<p><b>NEW YORK – Medicaid</b></p> <p>Website: <a href="https://www.health.ny.gov/health_care/medicaid/">https://www.health.ny.gov/health_care/medicaid/</a>            Phone: 1-800-541-2831</p>
<p><b>NORTH CAROLINA – Medicaid</b></p> <p>Website: <a href="https://medicaid.ncdhhs.gov/">https://medicaid.ncdhhs.gov/</a>            Phone: 919-855-4100</p>	<p><b>NORTH DAKOTA – Medicaid</b></p> <p>Website: <a href="https://www.hhs.nd.gov/healthcare">https://www.hhs.nd.gov/healthcare</a>            Phone: 1-844-854-4825</p>
<p><b>OKLAHOMA – Medicaid and CHIP</b></p> <p>Website: <a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a>            Phone: 1-888-365-3742</p>	<p><b>OREGON – Medicaid and CHIP</b></p> <p>Website: <a href="http://healthcare.oregon.gov/Pages/index.aspx">http://healthcare.oregon.gov/Pages/index.aspx</a>            Phone: 1-800-699-9075</p>

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<p><b>PENNSYLVANIA – Medicaid and CHIP</b></p> <p>Website: <a href="https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html">https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html</a>            Phone: 1-800-692-7462            CHIP Website: <a href="http://www.pa.gov/childrens-health-insurance-program">Children's Health Insurance Program (CHIP) (pa.gov)</a>            CHIP Phone: 1-800-986-KIDS (5437)</p>	<p><b>RHODE ISLAND – Medicaid and CHIP</b></p> <p>Website: <a href="http://www.eohhs.ri.gov/">http://www.eohhs.ri.gov/</a>            Phone: 1-855-697-4347, or            401-462-0311 (Direct Rlte Share Line)</p>
<p><b>SOUTH CAROLINA – Medicaid</b></p> <p>Website: <a href="https://www.scdhhs.gov">https://www.scdhhs.gov</a>            Phone: 1-888-549-0820</p>	<p><b>SOUTH DAKOTA - Medicaid</b></p> <p>Website: <a href="http://dss.sd.gov">http://dss.sd.gov</a>            Phone: 1-888-828-0059</p>
<p><b>TEXAS – Medicaid</b></p> <p>Website: <a href="http://www.healthandhuman-services.gov/health-insurance-premium-payment-hipp-program-texas">Health Insurance Premium Payment (HIPP) Program   Texas Health and Human Services</a>            Phone: 1-800-440-0493</p>	<p><b>UTAH – Medicaid and CHIP</b></p> <p>Utah's Premium Partnership for Health Insurance (UPP) Website: <a href="https://medicaid.utah.gov/upp/">https://medicaid.utah.gov/upp/</a>            Email: <a href="mailto:upp@utah.gov">upp@utah.gov</a>            Phone: 1-888-222-2542            Adult Expansion Website: <a href="https://medicaid.utah.gov/expansion/">https://medicaid.utah.gov/expansion/</a>            Utah Medicaid Buyout Program Website: <a href="https://medicaid.utah.gov/buyout-program/">https://medicaid.utah.gov/buyout-program/</a>            CHIP Website: <a href="https://chip.utah.gov/">https://chip.utah.gov/</a></p>
<p><b>VERMONT– Medicaid</b></p> <p>Website: <a href="http://www.vermont.gov/health-insurance-premium-payment-hipp-program">Health Insurance Premium Payment (HIPP) Program   Department of Vermont Health Access</a>            Phone: 1-800-250-8427</p>	<p><b>VIRGINIA – Medicaid and CHIP</b></p> <p>Website: <a href="https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select">https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select</a>  <a href="https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs">https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs</a>            Medicaid/CHIP Phone: 1-800-432-5924</p>
<p><b>WASHINGTON – Medicaid</b></p> <p>Website: <a href="https://www.hca.wa.gov/">https://www.hca.wa.gov/</a>            Phone: 1-800-562-3022</p>	<p><b>WEST VIRGINIA – Medicaid and CHIP</b></p> <p>Website: <a href="https://dhhr.wv.gov/bms/">https://dhhr.wv.gov/bms/</a>  <a href="http://mywvhipp.com/">http://mywvhipp.com/</a>            Medicaid Phone: 304-558-1700            CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)</p>
<p><b>WISCONSIN – Medicaid and CHIP</b></p> <p>Website: <a href="https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm">https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm</a>            Phone: 1-800-362-3002</p>	<p><b>WYOMING – Medicaid</b></p> <p>Website: <a href="https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/">https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/</a>            Phone: 1-800-251-1269</p>

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

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

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

### PREVENTIVE CARE

Health plans will provide in-network, first-dollar coverage, without cost-sharing, for preventative services and immunizations as determined under health care reform regulations. These include, but are not limited to, cancer screenings, well-baby visits and influenza vaccines. For a complete list of covered services, visit: [www.HealthCare.gov/coverage/preventive-care-benefits](http://www.HealthCare.gov/coverage/preventive-care-benefits)

### PRIVACY PRACTICES NOTICE REMINDER

The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) requires that we maintain the privacy of protected health information, give notice of our legal duties and privacy practices regarding health information about you and follow the terms of our notice currently in effect.

You may request a copy of the current Privacy Practices from the Plan Administrator explaining how medical information about you may be used and disclosed, and how you can get access to this information.

## Important Notices

We will disclose Health Information when required to do so by international, federal, state or local law.

You have the right to inspect and copy to an electronic copy of electronic medical records, right to get notice of a breach, right to amend, right to an accounting of disclosures, right to request restrictions, right to request confidential communications, right to a paper copy of this notice and the right to file a complaint if you believe your privacy rights have been violated.

### SUMMARY OF BENEFITS AND COVERAGE (SBCs)

You may request a paper copy of the SBCs (free of charge), from your employer. Your employer is required to make SBCs available that summarize important information about health benefit plan options in a standard format, to help you compare across plans and make an informed choice. The health benefits available to you provide important protection for you and your family and choosing a health benefit option is an important decision.

### SURPRISE MEDICAL BILLS NOTICE

#### YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

#### What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

#### You are protected from balance billing for:

##### **Emergency services**

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

##### **Certain services at an in-network hospital or ambulatory surgical center**

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

## Important Notices

You're **never** required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

### **When balance billing isn't allowed, you also have the following protections:**

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact HHS, in coordination with the Department of the Treasury, Department of Labor and the Office of Personnel Management at 1-800-985-3059.

Visit <https://www.cms.gov/nosurprises/consumers> for more information about your rights under federal law.

### **USERRA NOTICE**

The Uniformed Services Employment and Reemployment Rights Act (USERRA) protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

#### **Reemployment Rights**

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- You ensure that your employer receives advance written or verbal notice of your service;
- You have five years or less of cumulative service in the uniformed services while with that particular employer;
- You return to work or apply for reemployment in a timely manner after conclusion of service; and
- You have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

#### **Right to Be Free From Discrimination and Retaliation**

If you are a past or present member of the uniformed service, have applied for membership in the uniformed service or are obligated to serve in the uniformed service, an employer may not deny you initial employment, reemployment, retention in employment, promotion or any benefit of employment because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

#### **Health Insurance Protection**

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

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

## Important Notices

### Enforcement

The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations. For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 866-4-USA-DOL or visit [www.dol.gov/vets](http://www.dol.gov/vets). An interactive online USERRA Advisor can be viewed at <https://webapps.dol.gov/elaws/vets/userra/>.

If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation. You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the Internet at this address: [www.dol.gov/vets/programs/userra/poster.htm](http://www.dol.gov/vets/programs/userra/poster.htm).

### WOMEN'S HEALTH AND CANCER RIGHTS ACT

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

a manner determined in consultation with the attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your Plan Administrator at the number above.

**Louisiana**



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