

2024 Benefit Enrollment Guide

WHAT'S INSIDE?

- ▶ How Your Benefits Work
- ▶ Your Insurance Plans
- ▶ Benefits Enrollment



INTRODUCTION



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Dear WoundCentrics Employees:

WoundCentrics takes great pride in its employees. These benefits make WoundCentrics a great place to work and are provided in order to let you know how much you are appreciated and respected.

We provide a benefit package that is appealing to our employees. Insurance coverage includes medical, dental, vision, life and disability. Benefits begin on the first day of the month following 60 days of employment in an eligible status.

This package provides a brief overview of your benefits. We encourage you to take the time to review and take advantage of the information presented in this guide to get the most value from your benefits program.

Sincerely,

Human Resources Department

Medicare Part D Notice (pages 26-27)

Employee Eligibility

Employees that are newly hired are eligible for benefits the 1st day of the month following 60 consecutive days of active employment in an eligible status.

Changing Coverage During the Year

You can change your coverage during the year only when you experience a qualified change in status, such as:

- Marriage, divorce, or legal separation
- Birth, adoption, or a child placed with you for adoption
- Start or stop of adoption proceedings
- Change in your child's dependent status
- Death of your spouse or child
- Change in your spouse's benefit or employment status

When a qualifying change occurs, you must notify your Human Resource Department and provide supporting documentation within 30 days of the event, and your benefit changes must be consistent with the event. If you do not do so within 30 days, you must wait until the next open enrollment to make benefit plan changes.

Paid Time Off (PTO)

Paid Time Off (PTO) is earned on the following schedule. PTO is accrued based on full-time pay periods worked, without regard for overtime hours worked.

Paid Time Off Schedule	
Years of Service	PTO Hours
0-1	128 PTO hours per year, earned at a rate of 0.0615 PTO hours per hour worked
1-3	168 PTO hours per year, earned at a rate of 0.0807 PTO hours per hour worked
4+	208 hours per year, earned at a rate of 0.0999 PTO hours per hour worked

Observed Holidays

- New Year's Day
- Labor Day
- Memorial Day
- Thanksgiving Day
- Independence Day
- Christmas Day



401(k) Eligibility

401(k) Enrollment and contribution available after 90 days of continuous employment with company match of 100% of the first 3% of employee salary contribution and 50% of the 4th and 5th % of employee salary contribution.

Medical Coverage (EBMS) - Imagine Health Locations

The medical plan allows you to use a national network of providers. You are not required to name a primary care physician and no referrals are needed to see a specialist. The plan allows you to seek care from a provider who is not in the network. To research In-Network providers within your area please visit <https://www.multiplan.com/webcenter/portal/ProviderSearch?SiteId=84484>.

Imagine Health Locations			
Medical Plans	Copay Plan	High Deductible Health Plan (HDHP)	
In-Network Benefits			
Office Visit Copay- Primary Care Physician	\$30	100% after Deductible	
Office Visit Copay- Specialist Care	\$60	100% after Deductible	
Office Visit Copay- Urgent Care	\$75	100% after Deductible	
Wellness Services	100%	100%	
Telemedicine Service Copay	\$0	\$0	
Coinsurance	80%	100%	
Employee Deductible	\$2,000	\$3,200	
Family Deductible	\$6,000	\$6,400	
Employee Out-of-Pocket	\$4,000	\$3,600	
Family Out-of-Pocket	\$8,000	\$7,200	
Inpatient Hospital Services	20% after Deductible	100% after Deductible	
Outpatient Surgery	20% after Deductible	100% after Deductible	
Emergency Room Copay (<i>Emergency Diagnosis</i>)	\$500	100% after Deductible	
Partners Direct Health / RBP Benefits			
Office Visit Copay			
Primary Care Physician	\$30 Copay	100% after Deductible	
Specialist Care	\$60 Copay	100% after Deductible	
Urgent Care	\$75 Copay	100% after Deductible	
Coinsurance	80%	100%	
Employee Deductible	\$2,000	\$3,200	
Family Deductible	\$6,000	\$6,400	
Employee Out-of-Pocket	\$4,500	\$4,000	
Family Out-of-Pocket	\$9,000	\$8,000	
Prescription Drugs			
RX Deductible	\$0		Shares Medical Deductible
Pharmacy Options (30 day supply)	Preferred	Non- Preferred	Preferred
Tier 1 - Generic Drugs	\$0	\$10	\$0 after Deductible
Tier 2 - Formulary Brand	\$40	\$50	\$40 after Deductible
Tier 3 - Non-Formulary Brand	\$70	\$80	\$70 after Deductible
Tier 4 - Specialty / Pharmacist Concierge Program	\$250	\$250	\$250 after Deductible
Maintenance Medication (90 Day Supply)			
Tiers 1/2/3	3x Retail Copay	3x Retail Copay	3x Retail Copay
Semi-Monthly Employee Contributions			
Employee	\$119.57		\$25.00
Employee + Spouse	\$382.52		\$160.37
Employee + Child(ren)	\$409.69		\$176.93
Family	\$672.64		\$337.29

 **Save money on covered prescriptions by using a Preferred Pharmacy!** Preferred Pharmacies are typically your private or family, locally owned pharmacy and grocery store chains. Non-Preferred Pharmacies are Target, CVS, Walgreen's, Walmart, Sam's Club and Rite-Aid. To download the Full Prescription Drug Formulary visit: <https://veracity.procarerx.com>.

Tier 4- Specialty Medications are managed through the Pharmacist Concierge Program and members that use this program are eligible to receive their medications at little to no cost. Please log onto veracity-rx.com initially and/or contact: 888-388-8228 for more information.

* Please Note: The information listed in the chart above is provided as a summary of the plan design options and cost for illustrative purposes. Additional details regarding plan specifics are provided in the official plan documents and are available in Human Resources Department.

Medical Coverage (EBMS) - All Other Locations/Partners Direct & RBP

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Introducing ELAP Services – Your Health Plan’s Partner for Fairness & Affordability

Overinflated hospital bills cause health plans to raise rates and members to pay more. ELAP eliminates this problem so that everyone pays only what's fair.

When life takes you here...

- Hospital
- Emergency Room
- Outpatient Surgery
- Doctor Visits

...ELAP eases the financial pain.

- **Supporting claim limits:** ELAP helps your plan set fair limits on what it will pay for healthcare services to avoid wasteful spending.
- **Reviewing every hospital and facility bill:** ELAP examines every bill line-by-line to catch overcharging.
- **Resolving billing issues:** If your plan is overcharged, we will let you know that we're reducing payment. That's when we need you to look out for **balance billing**.

Know What You Owe

Make sure your EXPLANATION OF BENEFITS (EOB)...



From your health plan (not a bill)

Shows you what your plan covered and what you'll owe. If you owe money, you'll get a bill from the hospital/provider.

...Matches your BILL



From the hospital/facility

If this does not match your EOB, **simply contact ELAP**. They'll take care of it.

**Most of the time, you'll never have a reason to contact ELAP about a bill.
But if you do, the ELAP advocacy team is here to support you.**

ELAP Services – Your health plan’s affordability partner.

Telephone: 1-800-977-7381, 9 am - 7 pm ET | Fax: 1-888-560-2447 | balancebills@elapservices.com

Introducing EBMS Services – Your Health Plan’s Affordability Partner

EBMS’ Mobile App – miBenefits – is Here!

Need to check a claim or review benefits on the go? With the new miBenefits app, your benefit plan is one touch away. Now you can manage your benefits anywhere, anytime! EBMS’ miBenefits mobile app was designed for instant, complete, and secure access.

- Access digital ID cards for medical
- Receive real-time updates with push notifications
- Stay updated on claims, deductibles, out-of-pocket maximums, and more!
- Find a provider or pharmacy and search for benefit details

Questions? Contact us at 1-866-462-9054.



Frequently Asked Questions

What exactly does ELAP do? ELAP partners with your company to ensure hospital and facility payments do not exceed your health plan's limits and that they are for services rendered and nothing more. We do this by auditing all hospital and facility claims. ELAP Services will ensure the hospital makes a fair and reasonable profit on all services provided, but we greatly reduce excessive markups that are often seen on facility bills.

What types of medical bills does ELAP review? We review all medical bills with the exception of retail and mail order prescription drug claims. Your prescription drug claims are handled by ProCare Rx.

How do I know ELAP reviewed my claim? You will receive a notice from EBMS notifying you that ELAP has audited a claim for services rendered to you. The letter will list the date of service and facility. If you receive a bill for money outside of your member responsibility, this is called “balance billing” and you must submit the bill to ELAP.

What if the hospital or doctor denies care due to an outstanding billing issue? If the facility will not perform treatment without additional funds outside of your normal copay, then you should contact EBMS immediately and request to speak with a representative.

How does ELAP make my health plan better? Overinflated hospital bills cause health plans to raise rates and members to pay more. ELAP eliminates this problem so that everyone pays only what's fair and reasonable.

What should I do if a facility requests payment up front? The only out-of-pocket expense that you should pay to the facility in advance of or at the time of service is a copay (if applicable). You can contact your plan to confirm copay and/or deductible amounts. Since ELAP will often reduce the amount you owe after auditing a bill, you could overpay by paying up front and the facility will not reimburse you.

When do I have to contact ELAP? Sometimes a hospital or other facility does not accept the payment that we approve as fair and reasonable. In this case, they may bill you for the balance. This is called “balance billing” and when it happens, you need to contact us and send us your bill via fax, email or mail...

Email: balancebills@elapservices.com

FAX: 888.560.2447 ATTN Balance Bill Response Team

Mail: 1550 Liberty Ridge Drive, Suite 330 Wayne, PA 19087

What happens when I contact ELAP about balance billing?

You will receive assistance from a Member Services Advocate throughout the balance billing process. ELAP’s legal team will also go to work right away to handle the billing issue with healthcare facilities and collection agencies. It is **very important** that you send ELAP any bills or notices as you receive them.

**Questions about a medical bill?
Contact ELAP right away!**

Telephone: 1-800-977-7381, 9 am - 7 pm ET

Fax: 1-888-560-2447

balancebills@elapservices.com

Welcome to SwiftMD

SwiftMD is a telemedicine service that delivers quality health care directly to patients in need. SwiftMD Members enjoy access to high-quality, convenient medical care over the phone or videoconference, 24 hours a day, seven days a week — while saving you money.

Some of the Benefits of SwiftMD:

- 24/7 nationwide access to U.S. Board-Certified physicians
- Convenient consults from your home, office, or on the road, usually within 30 minutes
- Doctor makes diagnosis and recommends treatment, and sends prescriptions to your preferred local pharmacy
- Avoid unnecessary visits to the ER and Urgent Care, or long waits for appointments at your doctor's office
- No co-pays and no cost to you! WoundCentrics is paying for your membership!

Member Testimonials:

- "The doctor that I spoke with was kind and had an excellent bedside manner."
- "This service is amazing and convenient. I love it!"
- "Especially on the occasion you are unable to get in to see your primary physician, SwiftMD is a tremendous service. Prompt service and professional knowledgeable staff that let you know you are in good hands."

To Access your SwiftMD Account:

- When your Membership becomes active on January 1, 2024, simply call our Toll-Free Phone Number (1-833-794-3863) when seeking health advice. Your membership will be verified, and then your appointment will be scheduled! Receive a call back within 30 minutes of scheduling your appointment!

SwiftMD does not replace your PCP or specialists managing chronic and serious conditions. SwiftMD doctors do not prescribe controlled substances, psychiatric, and certain other medications. For more info review the Exclusionary Criteria at mySwiftMD.com. © SwiftMD. All Rights Reserved.



**Your SwiftMD
Program Start Date:**

January 1, 2024

Conditions We Treat

- Allergies and rashes
- Arthritis pain
- Back pain or injury
- Bone or joint pain, strain or injury
- Chickenpox
- Cold sores (fever blisters)
- Diarrhea
- Earache
- Eczema
- Conjunctivitis or pink eye
- Fever and flu
- Headache
- Impetigo
- Insect bites and stings
- Lice
- Lyme disease
- Nasal or respiratory congestion
- Prescriptions called in when appropriate
- Sinusitis
- Soft tissue and muscle injuries or pain
- Sore throat
- Stomach problems, nausea, vomiting, diarrhea
- Upper respiratory infections
- Upset stomach
- Urinary tract infections
- Vomiting
- Your individual medical concerns

Health Savings Account (Benefit Wallet)

If you elect the H.S.A. Plan, you are eligible to also establish and utilize the benefits of a Health Savings Account (HSA) which allows you to pay for qualified expenses with pre-tax dollars.

The H.S.A. Plan is considered a High Deductible Health Plan (HDHP). A HDHP is intended to cover serious illness or injury after the deductible has been met. The HSA is owned by you and funded with pre-tax contributions. The HSA pays for out-of-pocket expenses incurred before the deductible is met. If you leave, you can take the funds remaining in your HSA with you. You MUST re-elect the funds that you're contributing to the Health Savings Account each year.

What is a High Deductible Health Plan (HDHP)?

A High Deductible Health Plan is an insurance plan that does not cover first dollar medical expenses (except for preventive care). It is a plan with a minimum annual deductible and a maximum out-of-pocket limit. These minimums and maximums are determined annually by the Internal Revenue Service (IRS) and are subject to change.

What is a Health Savings Account?

A Health Savings Account (HSA) is an account that can be funded with your tax-exempt dollars to help pay for eligible medical, prescription, dental, and vision expenses not covered by an insurance plan, including the deductible, coinsurance copays, and even in some cases, health insurance premiums.

Who is eligible for an HSA?

Anyone who is:

- Covered by a High Deductible Health Plan (HDHP)
- Not covered under another medical plan that is not a HDHP
- Not enrolled in Medicare benefits; or
- Not eligible to be claimed on another person's tax return

2024 HSA Contribution Limits	Contribution Limit	55+ Contribution
Single	\$4,150	\$1,000
Family	\$8,300	\$1,000

Key Benefits to an HSA

- Tax Savings:** Money taken out of your paycheck before taxes are calculated, thus reducing your reported taxable earnings.
- Portability:** The money in your account is yours to keep, so you can take it with you if you change employers, health plans, or retire.
- Savings:** Let the funds in your account grow tax-deferred. After age 65, you may make withdrawals from your HSA for any reason without penalty.
- Individual:** Your HSA is your individual account, setup in your name, with your listed beneficiary. It is completely your responsibility, very similar to a checking account. You are responsible for making sure funds are used for qualifying expenses and that your account is not funded beyond the annual maximum amount. You are also responsible for ensuring your demographic information, such as your address, is up to date on your account.
- Control:** You decide when to use your savings to pay for medical expenses.
- Dependents:** HSA funds can be used to pay health expenses for dependent children if they meet the definition of a dependent set by the IRS. A qualifying child(ren):
 - Has the same principal place of abode as the covered employee for more than one-half of the taxable year.
 - Has not provided more than one-half of his or her own support during the taxable year.
 - Is not yet 19 (or, if a student, not yet 26) at the end of the tax year or is permanently and totally disabled.

How to create a BenefitWallet account profile online

- Access the BenefitWallet member portal at www.mybenefitwallet.com.
- Click **First Time User** in the upper right-hand corner of the page.
- Enter the requested information to verify your account including your Social Security Number, date of birth, and ZIP code.
- If prompted, follow the steps to provide the last four digits of your BenefitWallet debit card, or request and enter a security code.
- Create your personal User ID and password.

Dental Coverage (Lincoln Financial)

The Base Plan (low option) provides benefits for both In and Out of Network providers. However, if you choose to see an out-of-network dentist, your out of pocket cost could be significantly higher. Services from non-participating dentist are subject to the same allowable charges as those from participating providers. Amounts in excess of these allowances will be the full responsibility of the insured. To locate a dentist in your area please visit LincolnFinancial.com/FindADentist.

Dental Summary of Benefits		
	BASE PLAN IN-NETWORK ONLY	BUY-UP PLAN I N/OUT OF NETWORK
Calendar Year Deductible (Individual/ Family)	\$50/\$150	\$50/\$150
Covered Services		
Preventive Care (<i>cleanings</i>)	100% Deductible Waived	100% Deductible Waived
Basic Care (<i>fillings</i>)	80% after Deductible	80% after Deductible
Major Care (<i>crowns, dentures</i>)	50% after Deductible	50% after Deductible
Orthodontia (<i>Adult & Child</i>)	50% after Deductible	50% after Deductible
Maximums		
Annual Maximum Benefit	\$1,500 per covered person	\$2,000 per covered person
Orthodontia Lifetime Benefit	\$1,000 per covered person	\$2,000 per covered person
Semi-Monthly Employee Contributions		
Employee	\$10.56	\$15.63
Employee + Spouse	\$21.10	\$31.24
Employee + Child(ren)	\$28.56	\$41.17
Family	\$43.25	\$62.68



Vision Coverage (Lincoln Financial)

Locate an in-network vision provider at www.lincolnfinancial.com or call 1-800-487-1485. If you use an out-of-network provider the benefits will be reduced and you will be required to submit a reimbursement to Lincoln Financial along with the receipt for your related expenses.

To locate a provider near you:

1. Visit lvc.lfg.com. On the right side of the page, use the Provider Quick Search.
2. In the Provider Quick Search box, enter a ZIP code or street address.
3. Click the Search button to display a list of providers close to you.



Blue View Vision Plan Summary of Benefits		
Benefit Features	IN-NETWORK	OUT OF NETWORK
Eye Exam	\$10 Copay	\$40 Allowance
Glasses		
Frames	\$130 allowance, 20% off remaining balance	\$45 Allowance
Lenses		
Single Vision	Paid in Full After Copay	\$40 Allowance
Bifocal	Paid in Full After Copay	\$60 Allowance
Trifocal	Paid in Full After Copay	\$80 Allowance
Contact Lenses (in lieu of Glasses)		
Exam and fitting	\$40 Allowance	NA
Elective	\$130 allowance	\$125 Allowance
Medically Necessary	100%	\$210 Allowance
Frequencies (months)		
Exams/Lens/Frame	12/12/24	12/12/24
Semi-Monthly Employee Contributions		
Employee		\$3.87
Employee + Spouse		\$7.33
Employee + Child(ren)		\$8.59
Family		\$12.09



Basic Life/AD&D (Lincoln Financial Group)

Your Basic Term Life and Accidental Death & Dismemberment coverage is through Lincoln Financial Group. All Active Full-Time Employees are eligible for the following benefits:

Basic Term Life and AD&D Summary of Benefits	
Life Benefit	\$15,000
AD&D Benefit	\$15,000
Accelerated Death Benefit	75% of Benefit Amount
Age Reduction Schedule	
65	Benefit reduces by 35%
70	Benefit reduces by 50%

Supplemental Term Life and AD&D (Lincoln Financial Group)

The death of a family member can mean not only dealing with the loss of a loved one, but the loss of financial security as well. With Lincoln Financial Group Term Life plan, an employee can achieve peace of mind by giving their family the financial security they can depend on. Supplemental AD&D is an additional death benefit that pays in the event a covered employee dies or is dismembered in a covered accident. AD&D benefit is a 24-hour coverage.

Eligibility	All Active Full-Time Employees
Employee Life and AD&D	\$10,000 - \$500,000 in increments of \$10,000, not to exceed 5 times salary
Grandfathering	\$500,000 provided minimum participation requirement is met
Guarantee Issue Amount - Employee	\$200,000 (subject to eligibility rules and enrollment status guidelines)
Spouse Life & AD&D	\$5,000 - \$250,000 in increments of \$5,000, not to exceed 50% of the employee benefit amount
Guarantee Issue Amount - Spouse	\$30,000
Child Life and AD&D	Birth to 14 days: \$0 Age 15 days to 6 months: \$500 Age 6 months to 26 years (26 if full-time student): \$10,000
Age Reduction Schedule	Benefits reduce by 35% of the original amount at age 65; and further reduce by: 60% of the original amount at age 70; 75% of the original amount at age 75; and 90% of the original amount at age 80.

Supplemental Term Life and AD&D (Lincoln Financial Group)

Supplemental Term Life and AD&D Rates

Benefit Amount			
Age	Amount	Age	Amount
< 25	\$0.04	55 - 59	\$0.61
25 - 29	\$0.04	60 - 64	\$0.63
30 - 34	\$0.05	65 - 69	\$1.17
35 - 39	\$0.08	70 - 74	\$2.50
40 - 44	\$0.14	75 - 79	\$7.51
45 - 49	\$0.21	80 - 99	\$7.51
50 - 54	\$0.39		
Child Rate - 14 days to age 26 \$0.200 per \$1,000			



Voluntary Short Term Disability (Lincoln Financial Group)

Today, most Americans would not be able to make payments on their homes or keep their family financially stable without their current salary. STD reduces the burden during these unstable times. It is a convenient, economical way of securing an income while out of work from an unexpected injury or illness. Voluntary Group STD is a guaranteed issue coverage, which requires no health questionnaires to complete.

STD Summary of Benefits	
Benefit Amount	60% of weekly earnings
Maximum Weekly Benefit	\$1,000
Benefit Duration	24 weeks
Benefits Begin	15th day of injury 15th day of sickness
Pre-Existing Condition Limitation	3/6/12 months

Voluntary Long Term Disability (Lincoln Financial Group)

Long Term Disability, LTD, is offered through Lincoln Financial and provides you with a specific percentage of your pre-disability income on a monthly basis. This type of policy provides protection for a longer period of time, sometimes to age 65. LTD is often used in situations of a catastrophic disease or illness.

LTD Summary of Benefits	
Benefit Amount	60% of monthly earnings
Maximum Monthly Benefit	\$7,000
Benefit Duration	Later of Age 65 or SSNRA
Benefits Begin	180 days
Pre-Existing Condition Limitation	3/12 months

Long Term Disability Banded Rates			
Age	Rate	Age	Rate
0-29	\$0.403	50-54	\$3.175
30-34	\$0.693	55-59	\$4.051
35-39	\$1.156	60-64	\$3.394
40-44	\$1.764	65-69	\$2.664
45-49	\$2.457	70+	\$2.312

Critical Illness (Lincoln Financial Group)

Voluntary Group Critical Illness Insurance

Benefit Level Amounts	
Employee	\$10,000, \$20,000, \$30,000
Spouse & Child(ren)	\$5,000, \$7,500, \$10,000, \$15,000 not to exceed 50% of employee
Guaranteed Issue	
Employee	\$20,000
Spouse	\$10,000
Children	\$15,000
Pre-Existing Condition Limitation	3/6/12
Additional Features	Survivor Benefit, Work Incentive Benefit, Worksite Modification Benefit, FMLA Coverage Extension, Recurrent Disability

Age	Employee monthly per \$1,000	Spouse monthly per \$1,000
Under 24	\$0.343	\$0.343
25-29	\$0.343	\$0.343
30-34	\$0.548	\$0.548
35-39	\$0.548	\$0.548
40-44	\$1.025	\$1.025
45-49	\$1.025	\$1.025
50-54	\$1.972	\$1.972
55-59	\$1.972	\$1.972
60-64	\$3.559	\$3.559
65-69	\$3.559	\$3.559
70+	\$4.606	\$4.606
Child(ren) monthly rate per \$1,000 of coverage		\$0.450

Critical Illness Limitations and Exclusions

A pre-existing condition is any illness or injury for which You received medical treatment for, advice was rendered, prescribed or recommended within 12 months prior to the effective date of Your coverage. A pre-existing condition is not covered within the first 12 months of coverage.

Critical Illness benefits are not payable for a Covered Condition more than once per lifetime.

The Critical Illness benefit terminates once 300% of the Benefit Amount under the Certificate is paid.

No benefits are payable for a Covered Condition if it results from: (a) the misuse of alcohol or taking of drugs (other than under the direction of a Physician, who is neither You, a member of Your immediate family, or Your business associate); (b) Injury received during active participation in a riot, strike or civil commotion, or any act incidental thereto; or (c) Your or your dependents participation or attempt to participate in any illegal activity.

Benefits are subject to any Reduction of Benefits provision which may be included in the Certificate.

Covered Conditions must be separated by 180 days to be eligible for benefits.

You or your covered dependent must be registered by the United Network of Organ Sharing (UNOS) in order for a Major Organ Transplant, or kidney transplant necessitated by Kidney (Renal) Failure to be a Covered Condition.

If an Injury or illness causes more than one Covered Condition to occur, Critical Illness benefits are only payable under the greatest benefit level percentage and are payable once, up to 300% of the Benefit Amount under the Certificate.

Policy provisions may vary by state. Refer to a certificate or enrollment brochure for details about coverage features and limitations.

Accident (Lincoln Financial Group)

Voluntary Group Accident Insurance

Lincoln Financial Group's Accident insurance provides you with the extra money you need to help cover the increased expenses, medical or otherwise, you face when you suffer an injury due to an accident. The proceeds from your approved claim may be used however you wish.

Voluntary Accident Insurance Summary	
Eligibility	All eligible, active full time employees
Coverage Type	24 Hour Coverage
Reduction Schedule	Benefits terminate at retirement or age 70, whichever occurs first
Ambulance / Air ambulance transportation within 90 days of the accident	\$225 / \$1,125
Initial care visit (Physician office or Urgent Care visit) within 60 days of the accident	\$75
Emergency care treatment within 72 hours of the accident	\$150
Major diagnostic exam (CT or CAT scans, MRI, PET scan, EEG, SPECT, joint imaging, DTI scan, and MRA scan) within 60 days of the accident	\$150
X-ray at initial or at any visit within 60 days of the accident	\$30

Accident Insurance Monthly Deductions

Employee	\$8.98
Employee + Spouse	\$14.99
Employee + Child	\$16.75
Family	\$22.61



Employee Assistance Program
800-423-2765

The resources you need to meet life's challenges



EmployeeConnectSM offers professional, confidential services to help you and your loved ones improve your quality of life.



In-person guidance

Some matters are best resolved by meeting with a professional in person. With *EmployeeConnectSM*, you and your family get:

- In-person help for short-term issues (up to five sessions with a counselor per person, per issue, per year)
- In-person consultations with network lawyers, including one free 30-minute in-person consultation per legal issue, and **25% off** subsequent meetings



Unlimited 24/7 assistance

You and your family can access the following services anytime – online, on the mobile app or with a toll-free call:

- Information and referrals on family matters, such as child and elder care, pet care, vacation planning, moving, car buying, college planning and more
- Legal information and referrals for family law, estate planning, consumer and civil law
- Financial guidance on household budgeting and short- and long-term planning



Online resources

EmployeeConnectSM offers a wide range of information and resources you can research and access on your own. Expert advice and support tools are just a click away when you visit GuidanceResources.com or download the GuidanceNowSM mobile app. You'll find:

- Articles and tutorials
- Videos
- Interactive tools, including financial calculators, budgeting worksheets and more

Please note this benefit is an employer paid benefit provided at no cost to you.

EmployeeConnectSM

EMPLOYEE ASSISTANCE PROGRAM SERVICES

Confidential help 24 hours a day, seven days a week for employees and their family members. Get help with:

- | | | |
|--------------|-------------|-----------------|
| ▪ Family | ▪ Emotional | ▪ Relationships |
| ▪ Parenting | ▪ Legal | ▪ Stress |
| ▪ Addictions | ▪ Financial | |

Insurance products issued by:
The Lincoln National Life Insurance Company
Lincoln Life & Annuity Company of New York
Lincoln Life Assurance Company of Boston

LTD-EAPEE-FLI001_Z01



Because life
doesn't always
go as planned.



No matter how well you plan, unexpected challenges will arise. When they do, help and support are nearby—thanks to *LifeKeys*® services from Lincoln Financial Group.

LifeKeys® services include:



Save money on shopping and entertainment

You have access to GuidanceResources® Online that includes 24/7 access to the Working Advantage discount network. You can save up to 60% on a variety of products and services, such as electronics, health and fitness, Broadway shows and much more. Also available in the GuidanceNow mobile app.



Help with important life matters

You'll find supportive tools and advice on a wide range of topics – including legal, financial, family and career on GuidanceResources® Online. It's one way to stay "in the know" on matters that impact your personal and professional life.



Protection against identity theft

Identity theft is widespread, and everyone is vulnerable. LifeKeys includes an online resource for the information you need to recognize and prevent identity theft – and restore your good name.



Online will preparation

Creating a will allows you to make vital decisions ahead of time – such as naming a guardian for your children or designating who will receive your property and assets after you pass away. Without a will, state officials will distribute your estate. EstateGuidance® offers you a quick and easy way to create and execute a will so you can rest easy knowing you've planned ahead for your family.



Guidance and support for your beneficiaries

LifeKeys' comprehensive program offers resources to help your loved ones address a range of common concerns. Services include grief counseling, advice on financial and legal matters and help coping with the occasional challenges of day-to-day life.

When you're enrolled in life or AD&D insurance, you have access to a wide range of services to help you and your loved ones through life's most important matters.

For your beneficiaries: help, guidance and support at a difficult time

The emotional impact of losing a loved one can be deep and long-lasting. All too often, financial or legal issues can add to the stress. *LifeKeys®* services can be a welcome resource for your beneficiaries.

These services are available for up to one year after a loss. Your beneficiaries will have access to six in-person sessions for grief counseling, legal, or financial information and unlimited phone counseling.

Grief counseling—advice, information and referrals on:

- Grief and loss
- Stress, anxiety and depression
- Memorial planning information
- Concerns about children and teens

Legal support—quick access to legal information on:

- Estate and probate law
- Real estate transactions
- Social Security survivor and child benefits
- Important documents your beneficiaries need

Financial services—online resources or advice from financial specialists on:

- Estate planning
- Budgeting
- Overcoming debt
- Bankruptcy
- Investments

Help with everyday life—comprehensive information on:

- Planning a memorial service
- Finding child care or elder care
- Financing your home
- Moving and relocation
- Making major purchases



It's easy to access *LifeKeys®* services. Just visit GuidanceResources.com, download the GuidanceNow mobile app, or call 1-855-891-3684. (First-time user: Enter Web ID LifeKeys)

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LincolnFinancial.com

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Affiliates are separately responsible for their own financial and contractual obligations.

LCN-2547049-051719
MAP 1/20 Z02
Order code: LFE-LKEYE-FLI001



Please note this benefit is an employer paid benefit provided at no cost to you.

LifeKeys® services are provided by ComPsych® Corporation, Chicago, IL. ComPsych® is not a Lincoln Financial Group® company. Coverage is subject to actual contract language. Each independent company is solely responsible for its own obligations. EstateGuidance® and GuidanceResources® Online are trademarks of ComPsych® Corporation.

Insurance products are issued by The Lincoln National Life Insurance Company, Fort Wayne, IN, Lincoln Life & Annuity Company of New York, Syracuse, NY, and Lincoln Life Assurance Company of Boston, Dover, NH. The Lincoln National Life Insurance Company does not solicit business in New York, nor is it licensed to do so. Product availability and/or features may vary by state. Limitations and exclusions apply.

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TravelConnect® services

Make travel less stressful.

We're here to assist you with:

- Emergency pet boarding and/or return
- Return of traveling companion
- ID recovery assistance
- Vehicle return
- Emergency travel arrangements
- Lost or stolen travel documents
- Language translation services
- Medical and dental referrals
- Corrective lens and medical device replacement
- Medication and vaccine delivery
- Evacuation coordination for an emergency security or political event, or natural disaster*
- Destination information

Detach and keep this card with you at all times.



TravelConnect®

Global Assistance Program

Provided by On Call International

Medical, Security, & Travel Assistance Services for Participants Traveling 100+ Miles from Home

Visit <https://mysearchlightportal.com> and enter Group ID #: LFGTravel123 for access to Plan Documents, International Calling Instructions, and Destination Information.



Caring support and assistance when you travel.

TravelConnect is a comprehensive program that can bring help, comfort, and reassurance if you face a medical emergency while traveling 100 or more miles from home. Whether traveling for business or leisure, if you are enrolled in life and/or AD&D insurance, you and your loved ones can count on *TravelConnect* for responsive and caring support — 24 hours a day, 7 days a week.

You can count on *TravelConnect* services to:

Coordinate and provide transportation from an initial medical facility that cannot adequately treat the patient due to their condition.

Coordinate travel and airfare for your dependent children.* This includes the services, transportation expenses and accommodations of a qualified escort.

TravelConnect will also coordinate and pay for a safe evacuation due to natural disaster, or when a political or security threat occurs.

Medical care, and travel services recovery. Assistant services include, but are not limited to:

- Medical record requests
- Intermediary services
- Recovering lost or stolen documents or luggage
- Medical and dental referrals
- Language translation
- Corrective lenses and medical device replacement
- Arrangements for a deceased traveler



For a complete list of *TravelConnect* services, go to mysearchlightportal.com and enter your group ID: LFGTravel123.

Please note this benefit is an employer paid benefit provided at no cost to you.

Insurance products issued by:
The Lincoln National Life Insurance Company
Lincoln Life Assurance Company of Boston

LFE-TRAV-FLI001_Z08

401(k) Retirement Program (Equitable)

401(k) Participant Website Guide

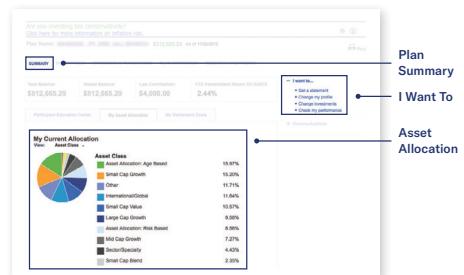
How to get there

- Participant website: <https://mrppar.equitable.com>
- Enter your **user ID** and **password**. If this is the first time to the new site, you can click on Set Up Your Account to establish credentials to access the site.

If you have any questions, please call a Retirement Plan Account Manager at 1-800-526-2701.

Summary

Easily access your overall and vested account balance, your last contribution and YTD personalized investment performance, as well as a graphic breakdown of your account balance by asset class, investment option and contribution type. You can also get quick access to other site features through the **I Want To** options on the right.



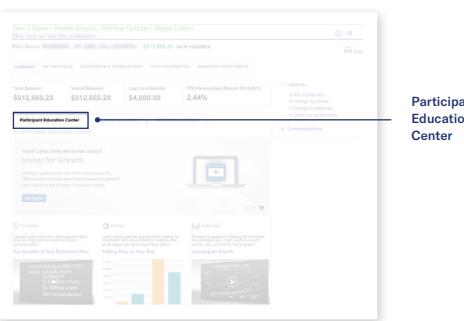
My Profile

You can view and update your address, and other personal and beneficiary information. You can also elect to go paperless for statements on the Communications tab.



Participant Education Center

The Participant Education Center provides information that can assist you with planning, saving and investing for retirement. Through the center, you will have access to articles, videos, calculators and interactive tools designed to educate you on topics that are important for retirement planning.

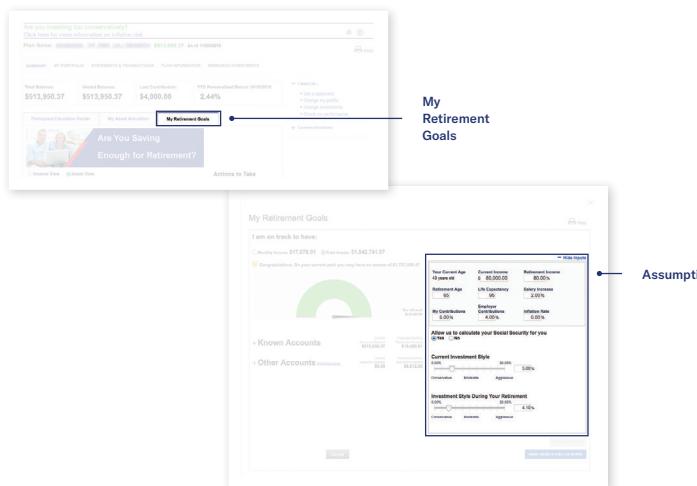


My Retirement Goals

My Retirement Goals provides you a way to help track your progress in meeting your retirement goals.

You enter some goals, assumptions on investment performance and information on other retirement accounts and Social Security, and then every time you visit the site, you will be presented with a gauge that shows where you are on meeting your goals either on annual income or overall asset basis.

You can always go in and modify these goals and any underlying assumptions at any time and recalculate.

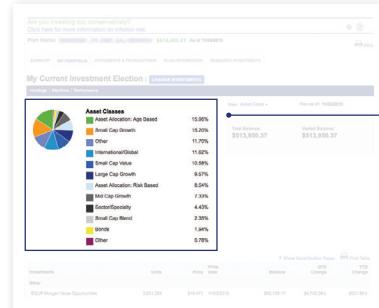


401(k) Retirement Program (Equitable)

401(k) Participant Website Guide

My Portfolio

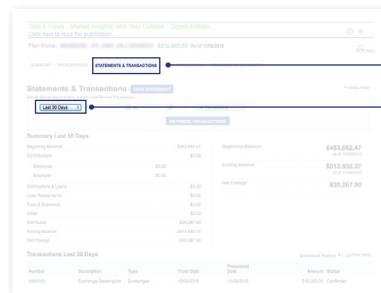
Get a detailed breakdown of your account by investment, asset class or contribution type. You will also be able to view your allocations for future contributions and personalized performance information.



Account by Investment

Statements & Transactions

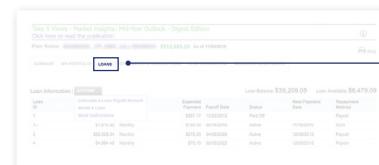
View statements for the past year and get an account at a glance for the last 30 days, 90 days or any custom period of your choosing. You will also get a list of all transactions during the period selected and the ability to click and get all the details on those transactions. You can also download transaction history for a specified period to an Excel file.



Statements & Transactions
Customizable Period

Loans

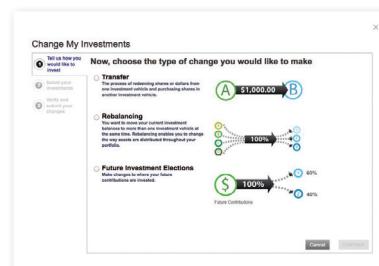
If your plan has loans available as an option, there will be a Loans tab with details on any outstanding loans, including the option to model loans, and calculate and pay off loans via ACH. If applicable, you can also change banking instructions on any loan you are paying through automatic bank account deductions.



Loans

Change My Investments

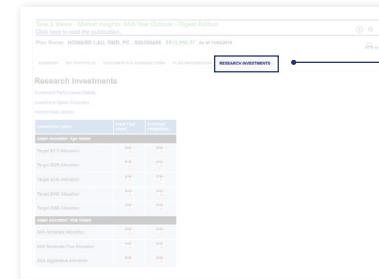
Easy step-by-step guide to completing transfers between investment options, rebalancing your portfolio and updating your investment allocation for future contributions.



Change My Investments

Research Investments

Get information on each of the investment options available in your retirement account, including fund fact sheets, summary prospectuses, fees and performance information.



Research Investments



Employee Benefit Assistants You Can Count On

Marsh McLennan Agency provides you and your family members a complimentary member claims service to help with claims, billing, missing ID cards and more!

Give Member Claims Advocate a call if:

-  You received a provider bill or EOB but do not feel the claim was processed correctly.
-  You are at the doctor or pharmacy and having trouble with your coverage.
-  You need to confirm if a provider is In-Network.
-  You are missing your ID card.

You can reach the Member Claims Advocate team by phone or email.

Monday through Friday, 8:15 AM EST – 5:15 PM EST
Email: mmajslbenefitclaims@MarshMMA.com
Toll Free: (800) 226-4518



MarshMcLennan
Agency

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid

Website: <http://myalhipp.com/>
Phone: 1-855-692-5447

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program
Website: <http://myakhipp.com/>
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: <https://health.alaska.gov/dpa/Pages/default.aspx>

ARKANSAS – Medicaid

Website: <http://myarhipp.com/>
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid

Health Insurance Premium Payment (HIPP) Program
<http://dhcs.ca.gov/hipp>
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website: <https://www.healthfirstcolorado.com/>
Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711
CHP+: <https://hcpf.colorado.gov/child-health-plan-plus>
CHP+ Customer Service: 1-800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI): <https://www.mycohibi.com/> HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

Website: <https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/>
hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid

GA HIPP Website: <https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp>
Phone: 678-564-1162, Press 1
GA CHIPRA Website: <https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra>
Phone: 678-564-1162, Press 2

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64
Website: <http://www.in.gov/fssa/hip/>
Phone: 1-877-438-4479
All other Medicaid
Website: <https://www.in.gov/medicaid/>
Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website:
<https://dhs.iowa.gov/ime/members>
Medicaid Phone: 1-800-338-8366
Hawki Website:
<http://dhs.iowa.gov/Hawki>
Hawki Phone: 1-800-257-8563
HIPP Website: <https://dhs.iowa.gov/ime/members/medicaid-a-to-z/ipp>
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: <https://www.kancare.ks.gov/>
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)
Website: <https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx>
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: <https://kidshealth.ky.gov/Pages/index.aspx>
Phone: 1-877-524-4718
Kentucky Medicaid Website: <https://chfs.ky.gov/agencies/dms>

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or
1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
<https://www.maine.gov/dhhs/ofi/applications-forms>
Phone: 1-800-977-6740
TTY: Maine relay 711

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

MASSACHUSETTS – Medicaid and CHIP

Website: <https://www.mass.gov/masshealth/pa>
 Phone: 1-800-862-4840
 TTY: 711
 Email: masspremystery@accenture.com

MINNESOTA – Medicaid

Website: <https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp>
 Phone: 1-800-657-3739

MISSOURI – Medicaid

Website: <http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>
 Phone: 573-751-2005

MONTANA – Medicaid

Website: <http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>
 Phone: 1-800-694-3084
 Email: HHSHIPPPProgram@mt.gov

NEBRASKA – Medicaid

Website: <http://www.ACCESSNebraska.ne.gov>
 Phone: 1-855-632-7633
 Lincoln: 402-473-7000
 Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: <http://dhcfp.nv.gov>
 Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: <https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program>
 Phone: 603-271-5218
 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218

NEW JERSEY – Medicaid and CHIP

Medicaid Website: <http://www.state.nj.us/humanservices/dmabs/clients/medicaid/>
 Medicaid Phone: 609-631-2392
 CHIP Website: <http://www.njfamilycare.org/index.html>
 CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/
 Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: <https://medicaid.ncdhhs.gov/>
 Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: <https://www.hhs.nd.gov/healthcare>
 Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: <http://www.insureoklahoma.org>
 Phone: 1-888-365-3742

OREGON – Medicaid

Website: <http://healthcare.oregon.gov/Pages/index.aspx>
 Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid

Website: <https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx>
 Phone: 1-800-692-7462
 CHIP Website: <https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx>
 CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP

Website: <http://www.eohhs.ri.gov/>
 Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid

Website: <https://www.scdhhs.gov>
 Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid

Website: <http://dss.sd.gov>
 Phone: 1-888-828-0059

TEXAS – Medicaid

Website: <https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program>
 Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Medicaid Website: <https://medicaid.utah.gov/>
 CHIP Website: <http://health.utah.gov/chip>
 Phone: 1-877-543-7669

VERMONT – Medicaid

Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access
 Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Website: <https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select>
<https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs>
 Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid

Website: <https://www.hca.wa.gov>
 Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid

Website: <https://dhhr.wv.gov/bms/>
<http://mywvhipp.com/>
 Medicaid Phone: 304-558-1700
 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP

Website: <https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm>
 Phone: 1-800-362-3002

WYOMING – Medicaid

Website: <https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/>
 Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor Employee Benefits

Security Administration

www.dol.gov/agencies/ebsa
 1-866-444-EBSA (3272)

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

www.cms.hhs.gov
 1-877-267-2323, Menu Option 4, Ext. 61565

Important Healthcare Reform Notices

Privacy Rights under HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandates that your private health information is protected and confidential. This Plan, the Plan Administrator and the Plan Sponsor will not disclose information that is protected by HIPAA, as required by law. To obtain a copy of your HIPAA Privacy Rights, contact your Human Resources Department.

Women's Health and Cancer Rights Act

Under the Women's Health and Cancer Rights Act of 1998, a plan participant or beneficiary who elects breast reconstruction in connection with a covered mastectomy is also entitled to the following benefits: All states of reconstruction of the breast on which the mastectomy was performed; Surgery and reconstruction of the other breast to produce a symmetrical appearance; and, Prostheses and treatment of physical complications of the mastectomy, including lymphedemas. Health plans must provide coverage of mastectomy-related benefits in a manner determined in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services are subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan.

Newborns' and Mothers' Health Protection Act

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

Summary of Benefits (SBC) and Coverage & Uniform Glossary

As required by the Patient Protection and Affordable Care Act (Healthcare Reform), the Summary of Benefits and Coverage (SBC) for the medical plan(s) offered and the Uniform Glossary are available from Human Resources.



Summary Plan Description (SPD) Notice

As required under the Employee Retirement Income Security Act (ERISA), all employees and their covered dependents must be given access to a copy of the Summary Plan Description (SPD) for the associate welfare benefit plans.

The SPD outlines the eligibility, schedule of benefits, and covered/excluded items of the benefit plans offered by your employer.

Employees and/or their covered dependents can obtain a copy of an SPD from Human Resources.

Medicare Part D Notice: Prescription Drug Coverage and Medicare

This notice has information about your current prescription drug coverage with WoundCentrics and 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 get help to make decisions about your prescription drug coverage is at the end of this notice.

Please note: If you are not Medicare eligible, and none of your covered family members are Medicare eligible, no action is required on your part.

There are two important things you need 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.

- WoundCentrics has determined that the prescription drug coverage offered by The WoundCentrics medical plan 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 through December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What happens to your current coverage if you decide to join a Medicare Drug Plan? If you decide to join a Medicare drug plan, your current WoundCentrics medical coverage will not be affected. Participants may keep this coverage if they elect Part D and this plan will coordinate with Part D coverage. If you decide to join a Medicare drug plan and drop your current WoundCentrics medical plan coverage, be aware that you and your dependents will be able to get this coverage back.

Medicare Part D Notice: Prescription Drug Coverage and Medicare

When will you pay a higher premium (penalty) to join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with WoundCentrics medical plan and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this notice or your current Prescription Drug

Coverage: Contact the Human Resources Department at 806-712-1096 x 4928. NOTE: You may receive this notice at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage changes. You also may request a copy.

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.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov.
- 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 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

General Notice of COBRA Continuation Coverage Rights

Introduction

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

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

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

What is COBRA Continuation Coverage?

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

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

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

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

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

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

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

When is COBRA Coverage Available?

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 30 days after the qualifying event occurs.

General Notice of COBRA Continuation Coverage Rights

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

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

Disability extension of 18-month period of continuation coverage

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

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

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under

the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, 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.

If you have questions

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

Plan Contact Information

COBRA Administrator

EBMS

Phone: 406-869-5555



New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Shellie Torres at 806-712-1096 ext. 4928.

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

¹ An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

EXCHANGE NOTICE

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name Wound Centrics	4. Employer Identification Number (EIN) 46-1600830	
5. Employer address 5224 75th St. Suite D.	6. Employer phone number 806-712-1096	
7. City Lubbock	8. State TX	9. ZIP code 79424
10. Who can we contact about employee health coverage at this job? Shellie Torres		
11. Phone number (if different from above) 806-712-1096 ext. 4928	12. Email address shellie.torres@woundcentrics.com	

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

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

- Some employees. Eligible employees are:

Full Time Employees working an average of 30 hours per week

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

Spouse and Dependent Children up to age 26

- We do not offer coverage.

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

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

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



Carrier Contact Information

Medical (EBMS)

Customer Service: 888-326-7144
Website: <https://mibenefits.ebms.com>
Provider Website: <https://www.multiplan.com/webcenter/portal/ProviderSearch?SiteId=84484>

Dental (Lincoln Financial)

Customer Service: 800-423-2765

Vision (Lincoln Financial)

Customer Service: 800-440-8453

Life and Disability (Lincoln Financial)

Customer Service: 800-487-1485

Employee Assistance Program (Lincoln Financial)

Customer Service: 800-423-2765

ELAP Member Services

Phone: 800-977-7381
Hours: 9am-7pm EST
Fax: 888-560-2447
Email: balancebills@elapservices.com
Mail: ELAP Services
1550 Liberty Ridge
Suite 330
Wayne, PA 19087

HR Department

Shellie Torres
Phone: 806-712-1096 ext. 4928
shellie.torres@woundcentrics.com
Christina Barragan
Phone: 806-712-1096 ext 4929
christina.barragan@woundcentrics.com

Marsh McLennan Agency

Ellen Flynn
Phone: 706-596-4654
Ellen.Flynn@MarshMMA.com
Sara Franks
Phone: 706-645-8221
Sara.Franks@marshmma.com

Please note that this guide is a general summary of your benefits. For specific details, you may refer to each carrier's summary plan description. Every effort has been made to ensure that this booklet accurately represents the benefits. However, if there are any discrepancies between the terms in this booklet and the terms in the plan document, the plan document will prevail.

NOTES



WoundCentrics
INTEGRATED SOLUTIONS
FOR ADVANCED WOUND CARE

**National
Storage
Solutions**



PHYSICIANS
UNITY

*This communication represents a brief summary of the various benefits available to you and is provided as a reference only. The actual carrier policies determine coverage and contain exclusions, limitations, full coverage terms, conditions and requirements. Any notices included in this document do not replace other potential employer requirements for communication.