Eagle KMC,LLC

BENEFITS BOOKLET

2022 Benefits Enrollment

BC/BS: Medical Plans / HRA

SecureCare: Dental, Vision,

Guardian: Life, Accident, CI

Transamerica, STD, Cancer

Legalshield : Commercial Drivers - CDLP, Legal and Identity Theft

Presented By,
Capitol Insurance Brokers, Inc

Enrollment Call Center - 833-781-7575
MONDAY - FRIDAY 9:00 A.M. - 5:00 P.M. PST

Enrollment Portal to Login:
www.eaglekmc.ease.com

CAPITOL INSURANCE
BROKERS INC. / BENEFIT CONSULTANTS
JEFFREY WM. GENNARO
PRESIDENT

The information in this Enrollment Guide is presented for illustrative purposes. The text contained in this Guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Guide and the actual plan documents the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your guide contact HR - Kirsten Despain at 520-574-4325

The information provided in this summary is for comparative purposes only. Actual claims paid are subject to the specific terms and conditions of each contract. This benefit summary does not constitute a contract.
The information in this booklet is proprietary. Please do not copy or distribute to others.

OPEN ENROLLMENT Call Center - 833-781-7575
Monday - Friday 9:00am to 5:00pm PST
Call to enroll by phone, or for assistance with your online enrollment.

MEDICAL BENEFITS

WHO IS ELIGIBLE?

Benefit eligible employees of Eagle KMC, LLC and Hawk KMC, LLC are eligible for the new fully insured medical plans effective January 1, 2022

HOW TO ENROLL/RE-ENROLL

Open Enrollment will begin when you receive your Login Email.
This is your opportunity to elect Medical, Dental, Vision, and, Worksite Benefits
Once you have made your pre-tax elections, you will not be able to change them until the 2023 open enrollment, unless you have a qualified life event change in status.

QUALIFIED CHANGES FOR 2022

Qualified changes in status include: marriage, divorce, legal separation, birth or adoption of a child, change in child's dependent status, death of spouse, child or other qualified dependent, or termination of adoption proceedings, or change in spouse's benefits or employment status.
When you decide to enroll in the plan with a life event change, you will be required to do so within 30 calendar days of the event.

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MEDICAL & PRESCRIPTION DRUG

BC/BS	Plan Option 1	Plan Option 2 with Eagle KMC HRA Plan after HRA Reimbursement	
Deductible	$6,000 Single $12,000 Family	$3,000 Single $6,000 Family	HRA reimburses 70% of last $3,000 of 6K Deductible. Max - $2,100 pcm / $4,200 Fam.
Coinsurance Max OOP- In Net	70 / 50 $ 6,750 Single $ 13,500 Family	70 / 50 $ 5,300 Single $10,600 Family	
Office Visit Copay	$25 PCP $75 Non- PCP $ 0 Telehealth	$25 PCP $75 Non- PCP $ 0 Telehealth	
Preventive Office Copay	Covered at 100%	Covered at 100%	
Emergency Room Urgent Care	$450 Copay then 30% coins after ded. $75 Copay	$450 copay then 30% coins after ded. $75 Copay	
Prescription Drug	$15/$55/$85/$150 SP $60/$110/$160/$210	$15/$55/$85/$150 SP $60/$110/$160/$210	

Please contact the CIB Team for additional information.

Coverage Level Weekly deductions	Plan 1	Plan 2 with Eagle KMC HRA Plan	
Single	$49.78	$58.95	
Single + Spouse	$177.44	$198.11	
Single + Child(ren)	$141.52	$158.96	
Family	$274.05	$311.66	

* Note: The plan illustrations above do not represent the complete Coverage and limitations, terms and conditions of the policy. Refer to the plandocument for a complete review

OPEN ENROLLMENT Call Center - 833-781-7575

Monday - Friday 9:00am to 5:00pm PST

Call to enroll by phone, or for assistance with your online enrollment.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit azblue.com/GroupPlanDoc2020N. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-877-475-8440 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: **$6,000**/individual or **$12,000**/family Out-of-network: **$12,000**/individual or **$24,000**/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. Unless a copay, fee, or other percent is shown, the coinsurance percent of the allowed amount that you pay for most services is 30% in-network and 50% out-of-network.
Are there services covered before you meet your deductible?	Yes. In-network primary care and specialist visits, certain in-network preventive services, in-network imaging services, prescription drugs, specialty drugs, emergency room care, in-network urgent care visits, in-network mental health visits, and hospice services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network: **$8,150**/individual or **$16,300**/family Out-of-network: **$16,300**/individual or **$32,600**/family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, out-of-network precertification charges, balance-bills, and costs for health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.

(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022)
(HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.azblue.com or call 1-877-475-8440 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

 All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/provider/day, deductible does not apply	50% coinsurance & balance bill	Specialist copay for most chiropractic services. Precertification may be required. $500 charge if no precertification for out-of-network services. No charge for medical telehealth consultations through BlueCare Anywhere℠.
	Specialist visit	$75 copay/provider/day, deductible does not apply		
	Preventive care/screening/ immunization	No charge		Preventive services not required to be covered by state or federal law are not covered. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.

* For more information about limitations and exceptions, see the plan or policy document at azblue.com/GroupPlanDoc2020N.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	Office visit copay (deductible does not apply) or 30% coinsurance.	50% coinsurance & balance bill	Cost share varies based on place of service and provider's network status and type. Precertification may be required. $500 charge if no precertification for out-of-network services.
	Imaging (CT/PET scans, MRIs)	$300 copay/procedure type/member/provider/day (deductible does not apply) for CT, MRI, MRA & PET scans		Cost share varies based on place of service and provider's network status and type. Precertification may be required. $500 charge if no precertification for out-of-network services.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.azblue.com	Level 1 (Generic drugs)	$15 copay/30 day supply, deductible does not apply	$15 copay/30 day supply & balance bill, deductible does not apply	Some drugs require precertification and won't be covered without it. 90-day supply costs 3 copays (retail pharmacy) and 2 copays (mail order). Mail order not covered out-of-network. If a generic drug is available, pay the generic cost share + the price difference between the allowed amount for the brand and generic drugs.
	Level 2 (Preferred brand drugs)	$55 copay/30 day supply, deductible does not apply	$55 copay/30 day supply & balance bill, deductible does not apply	
	Level 3 (Non-preferred brand drugs)	$85 copay/30 day supply, deductible does not apply	$85 copay/30 day supply & balance bill, deductible does not apply	
	Level 4	$150 copay/30 day supply, deductible does not apply	$150 copay/30 day supply & balance bill, deductible does not apply	
	Specialty drugs	Copays (deductible does not apply): Level A: $60 Level B: $110 Level C: $160 Level D: $210	Not covered	Specialty copay covers up to a 30-day supply. Some drugs require precertification and won't be covered without it.

* For more information about limitations and exceptions, see the plan or policy document at azblue.com/GroupPlanDoc2020N.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance & balance bill	Additional $1,000 access fee for all bariatric surgeries. Precertification may be required. $500 charge if no precertification for out-of-network services.
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	$450 copay/facility/day, deductible does not apply		If admitted to hospital, copay is waived and you pay inpatient deductible for facility and ancillary services. In the event the provider's billed charges exceed the allowed amount, balance billing will apply.
	Emergency medical transportation	30% coinsurance		None.
	Urgent care	$75 copay/provider/day, deductible does not apply	50% coinsurance & balance bill	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance & balance bill	Additional $1,000 access fee for all bariatric surgeries. Precertification may be required. $500 charge if no precertification for out-of-network services.
	Physician/surgeon fees			
	Long-term acute care (LTAC)	30% coinsurance days 1-100 and 50% coinsurance days 101-365	50% coinsurance & balance bill	Precertification may be required. $500 charge if no precertification for out-of-network services. Limit of 365 total LTAC days per member.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Copay applies to office, home, walk-in clinic visits (deductible does not apply). Amount varies based on PCP/Specialist. 30% coinsurance applies to all other locations.	50% coinsurance & balance bill	Cost-share varies based on place of service and provider's network status and type. $20 copay for counseling telehealth consultation and $45 copay for psychiatric telehealth consultations through BlueCare Anywhere℠.
	Inpatient services	30% coinsurance	50% coinsurance & balance bill	Precertification may be required. $500 charge if no precertification for out-of-network services.

* For more information about limitations and exceptions, see the plan or policy document at azblue.com/GroupPlanDoc2020N.

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you are pregnant	Office Visits	Office visit copay (deductible does not apply) or 30% coinsurance	50% coinsurance & balance bill	Only one copay is collected for services included in delivering physician's global charge. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing does not apply for in-network preventive services.
	Childbirth/delivery professional services	30% coinsurance		
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	Home health care/Home infusion therapy	30% coinsurance	50% coinsurance & balance bill	Limited to 6 hours of care per member per day. Precertification may be required. $500 charge if no precertification for out-of-network services.
	Rehabilitation services • EAR = Extended Active Rehabilitation Facility • PT/ST/OT = Physical Therapy, Occupational Therapy, Speech Therapy	30% coinsurance except 50% coinsurance for: ▪ days 61-120 of EAR ▪ days 91-180 of SNF	50% coinsurance and balance bill for: ▪ days 61-120 of EAR ▪ days 91-180 of SNF	Limit of 120 days/calendar year for Extended Active Rehabilitation Facility (EAR) and 180 days/calendar year for Skilled Nursing Facility (SNF). $500 charge if no precertification for out-of-network services. *Limited coverage available for habilitation services to treat autism spectrum disorder for groups of 51 or more eligible employees.
	Habilitation services	Not covered*	Not covered*	
	Skilled nursing care	30% coinsurance	50% coinsurance & balance bill	
	Durable medical equipment	Office visit copay (deductible does not apply) or 30% coinsurance	50% coinsurance & balance bill	Cost share varies based on place of service and provider's network status and type. Precertification may be required. $500 charge if no precertification for out-of-network services.
	Hospice services	No charge	No charge except balance bill	Deductible and coinsurance waived. Precertification may be required. $500 charge if no precertification for out-of-network services.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Excluded
	Children's glasses	Not covered	Not covered	Excluded
	Children's dental check-up	Not covered	Not covered	Excluded

* For more information about limitations and exceptions, see the plan or policy document at azblue.com/GroupPlanDoc2020N.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture • Care that is not medically necessary • Cosmetic surgery, cosmetic services & supplies • Custodial care • Dental care except as stated in plan • DME rental/repair charges that exceed DME purchase price • Experimental and investigational treatments except as stated in plan • Eyewear except as stated in plan • Flat feet treatment and services • Genetic and chromosomal testing, except as stated in plan	• Habilitation services, except certain autism services • Hearing aids • Home health care and infusion therapy exceeding 6 hours of care per member per day • Homeopathic services • Infertility medication and treatment • Inpatient EAR treatment exceeding 120 days per calendar year and inpatient SNF treatment exceeding 180 days per calendar year • Long-term care, except long-term acute care up to a 365 days benefit plan maximum • Massage therapy other than allowed under medical coverage guidelines	• Naturopathic services • Out-of-network Mail Order, out-of-network Specialty, and out-of-network 90 day supplies of drugs • Private-duty nursing • Respite care, except as stated in plan • Routine foot care • Routine vision exams • Sexual dysfunction treatment and services • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery	• Chiropractic care	• Non-emergency care when travelling outside the U.S.

* For more information about limitations and exceptions, see the plan or policy document at azblue.com/GroupPlanDoc2020N.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- For group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental group health plans, contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact the Arizona Department of Insurance (602-364-2499, or 1-800-325-2548 in Arizona but outside the Phoenix area) regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- For group health coverage subject to ERISA, contact Blue Cross Blue Shield of Arizona at 1-877-475-8440. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. If your coverage is insured, you may also contact the Arizona Department of Insurance at 602-364-2499, or 1-800-325-2548 in Arizona but outside the Phoenix area.
- For non-federal governmental group health plans and church plans that are group health plans, contact Blue Cross Blue Shield of Arizona at 1-877-475-8440. If your coverage is insured, you may also contact the Arizona Department of Insurance at 602-364-2499, or 1-800-325-2548 in Arizona but outside the Phoenix area.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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

* For more information about limitations and exceptions, see the plan or policy document at azblue.com/GroupPlanDoc2020N.

Multi-language Interpreter Services

Spanish: Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Blue Cross Blue Shield of Arizona, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 602-864-4884.

Navajo: Díí kwe'é atah nílínigíí Blue Cross Blue Shield of Arizona haada yit'éego bína'ídílkidgo éí doodago Háída bíjá anilyeedígíí t'áadoo le'é yína'ídílkidgo beehaz'áanii hóló díí t'áá hazaadk'ehjí háká a'doowołgo bee haz'ą doo bąąh ílínígóó. Ata' halne'ígíí kojį' bich'į' hodíilnih 877-475-4799.

Chinese: 如果您，或是您正在協助的對象，有關於插入項目的名稱 Blue Cross Blue Shield of Arizona 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 在此插入數字 877-475-4799。

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Blue Cross Blue Shield of Arizona quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 877-475-4799.

Arabic:
إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Blue Cross Blue Shield of Arizona، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة .للتحدث مع مترجم اتصل ب 877-475-4799.

Tagalog: Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Blue Cross Blue Shield of Arizona, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 877-475-4799.

Korean: 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Blue Cross Blue Shield of Arizona 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 877-475-4799 로 전화하십시오.

French: Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Blue Cross Blue Shield of Arizona, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 877-475-4799.

German: Falls Sie oder jemand, dem Sie helfen, Fragen zum Blue Cross Blue Shield of Arizona haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 877-475-4799 an.

Russian: Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Blue Cross Blue Shield of Arizona, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 877-475-4799.

Japanese: ご本人様、またはお客様の身の回りの方でも、Blue Cross Blue Shield of Arizona についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、877-475-4799 までお電話ください。

Farsi:
اگر شما، یا کسی که شما به او کمک میکنید ، سوال در مورد Blue Cross Blue Shield of Arizona ، داشته باشید حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید .877-475-4799 تماس حاصل نمایید.

Assyrian:
[illegible] ،Blue Cross Blue Shield of Arizona [illegible] 877-475-4799.

Serbo-Croatian: Ukoliko Vi ili neko kome Vi pomažete ima pitanje o Blue Cross Blue Shield of Arizona, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, nazovite 877-475-4799.

Thai: หากคุณ หรือคนที่คุณกาลังช่วยเหลือมีค่าถามเกี่ยวกับ Blue Cross Blue Shield of Arizona คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่าม โทร 877-475-4799

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

About These Coverage Examples

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

Peg is Having a Baby

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

The plan's overall deductible	**$6,000**
Specialist copayment	**$75**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

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

Total Example Cost $12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$6,000
Copayments	$430
Coinsurance	$1,080
What isn't covered	
Limits or exclusions	$50
The total Peg would pay is	**$7,560**

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$6,000**
Specialist copayment	**$75**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

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

Total Example Cost $5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$50
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,070**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	**$6,000**
Specialist copayment	**$75**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

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

Total Example Cost $2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,940
Copayments	$510
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,450**

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

Blue Cross Blue Shield of Arizona (BCBSAZ) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. BCBSAZ provides appropriate free aids and services, such as qualified interpreters and written information in other formats, to enable people with disabilities to communicate effectively with us. BCBSAZ also provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, call 602-864-4884 for Spanish and 1-877-475-4799 for all other languages and other aids and services.

Eagle KMC HRA Plan

Section 105 – Health Reimbursement Arrangement (HRA) Plan Highlight Your employer has established a Section 105, Health Reimbursement Arrangement (HRA) Plan. This Summary Plan description describes the benefits, terms and conditions of the Plan as it applies to eligible employees on or after the plan year dates.

PLAN BENEFITS (Benefit(s) allowed per covered member (PCM) for reimbursement under the Plan)

	EMPLOYEE (Member) PAYS	HRA REIMBURSES
DEDUCTIBLE REIMBURSEMENT	The first $6,000.00 of Employee DEDUCTIBLE expenses. (2X Family)	**Buy-Up Plan** - Once the member has met his/her DEDUCTIBLE responsibility, he/she will receive reimbursement for 70% of the last $3,000.00 of incurred **IN-NETWORK** DEDUCTIBLE expenses. The maximum CALENDAR YEAR reimbursement is $2,100.00 pcm and $4,200 with Dependent (s)
REIMBURSEMENT INFORMATION	T ◆ The eligible HRA OUT-OF-POCKET expenses include only IN-NETWORK Deductibles ◆ Copays and Out of network expenses are excluded from reimbursement ◆ RX copays are excluded from reimbursement ◆ **COMBINED ANNUAL MAXIMUM -** **B**uy up Plan = $2,100 pcm with a max of $4,200 w Dep (s).	

REIMBURSEMENT PROCESS

Once, you (an eligible member) have reimbursable expenses; please submit your Explanation of Benefits, or EOB, (provided by the insurance company – A sample EOB is included for your reference) or proof of the expense, plus a Reimbursement Request to:

MAILING ADDRESS FOR Administrator	CLAIM CONTACT RE: REIMBURSEMENTS	ONLINE REIMBURSEMENTS
Davis Flex Spending Solutions, Inc. P.O.Box 20211 Boulder, CO 80308	(866) 607-9750 Ext 801	dfss.summitfor.me

PLAN DEFINITION AND FUNDING

This is a Section 105 Accident and Health Plan, as classified by the Internal Revenue Code. This benefit plan is classified as a welfare plan by the Department of Labor. The Employer funds this Plan.

PLAN ADMINISTRATOR/EMPLOYER	ADMINISTRATION AGENT
Eagle KMC, LLC 850 W Silverlake Rd Tucson, Arizona 85713 Tel. 520-574-4325	Davis Flex Spending Solutions, Inc. P.O.Box 20211 Boulder, CO 80308 (866) 607-9750 Ext 801

TAX ID NUMBER	ERISA NUMBER
On file at the Employer's office	510
PLAN YEAR DATES	
The 2022 Plan Year will begin 01/01/2022 and ends 12/31/2022. The HRA Plan Year will auto renew thereafter, unless otherwise notified.	
CLAIM RUN OUT DATES	
The member has until 3/30/2023 to turn in a claim after the 2022 Calendar Year has ended.Terminated employees who have not chosen to extend their HRA benefit through COBRA, have from the end of the month that they are terminated, plus 90 days to submit claims for reimbursement.	

ELIGIBILITY REQUIREMENTS Eligibility requirements include participation in the group medical plan.

EMPLOYEE TERMINATION

You will automatically cease to be a participant on the earliest of the following dates:

1. Your death;
2. The date the Plan terminates;
3. The your employment with the employer is terminated for whatever reason;
4. The date the sponsor determines you made fraudulent or improper use of a plan, certificate or identification.

CONTINUATION OF COVERAGE, COBRA (applicable to employers with 20 or more employees)

Continuation Coverage means your right, or your spouse and dependents' right to continue to be covered under this Medical Expense Reimbursement Plan if participation by you (including your spouse and dependents) otherwise would end due to the occurrence of a "Qualifying Event." Duration of coverage will depend upon the qualified event, and will be either 18, 29 or 36 months. Qualifying Event is:

1. Termination of your employment (other than for gross misconduct), or reduction of your work hours below eligibility requirements;
2. Your death;
3. Your divorce or legal separation from your spouse;
4. Your becoming eligible to receive Medicare benefits;
5. Your dependent ceases to be a dependent.

It will be your obligation to inform the Plan Administrator of the occurrence of any Qualifying Event within 60 days of the occurrence, other than a change in your employment status. The Plan Administrator, in turn, has a legal obligation to furnish you, or your spouse, as the case may be, with separate, written options to continue the coverage provided through this Plan at stated premium costs for the remainder of the Plan Year. The notification you will receive will explain other terms and conditions of the continued coverage.

PLAN TERMINATION

The Plan or any portion of the Plan can be amended or terminated, in whole or in part at any time, by your employer in the same manner as the plan was adopted. Consent of any Participant, employee or any other person referenced in the Plan is not required to terminate the Plan.

CLAIM APPEALS

If you believe you are entitled to a benefit under the Plan that is different from the amount that has been paid, you may file an appeal with the Plan Sponsor. Such an appeal must be made in writing and must contain the following information: the reason for the appeal; the facts supporting the appeal; the amount claimed; and the name and address of the person filing the appeal. The Plan Sponsor will generally make a decision within 90 days after receipt of the appeal. If an appeal is denied, the claimant may seek to review the Plan Sponsor's decision. The request must be submitted in writing within 60 days of the date of denial. Unless special circumstances arise, a written decision will be given to the claimant within 60 days of the review request.

ERISA RIGHTS

As a participant in the welfare benefit plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to examine, without charge, at the Plan Administrator's office and at other specified locations, all Plan Documents including insurance contracts, and to obtain copies of all Plan Documents and other Plan information upon written request to the Plan Administrator. The Administrator in turn may apply a reasonable charge for copies. You are also entitled to receive a summary of the Plan's financial report, if applicable. Finally, the Plan Administrator is required by law to furnish each participant with a copy of the summary annual report, with certain expectations. You are entitled to continue health care coverage under the Plan for yourself, spouse or dependents if there is a loss of health insurance coverage as a result of a qualifying event.

ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your plan - called fiduciaries of the plan - have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or from exercising your rights under ERISA. If your claim for a welfare benefit is denied or ignored in whole or in part, you have a right to know why this was done, and must receive a written explanation of the reason for denial. You have the right to have the Plan Administrator review and reconsider your claim.

Under ERISA, you can take steps to enforce the above rights. For instance, if you require materials from the Plan and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If your claim for benefits is denied or ignored, in whole or in part, you may file suit in state or federal court. If it should happen that the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for assuming your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in state or federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay the costs and fees. If you have any questions about your Plan, you should contact the Plan Sponsor. If you have questions about this statement or about your rights under ERISA, you may also obtain certain publications with your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administrator, or by contacting the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor (listed in your telephone directory), or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administrator, U.S. Department of Labor, 200 Constitution Avenue NW., Washington, DC 20210.

Eagle KMC, LLC
The Eagle KMC HRA Plan

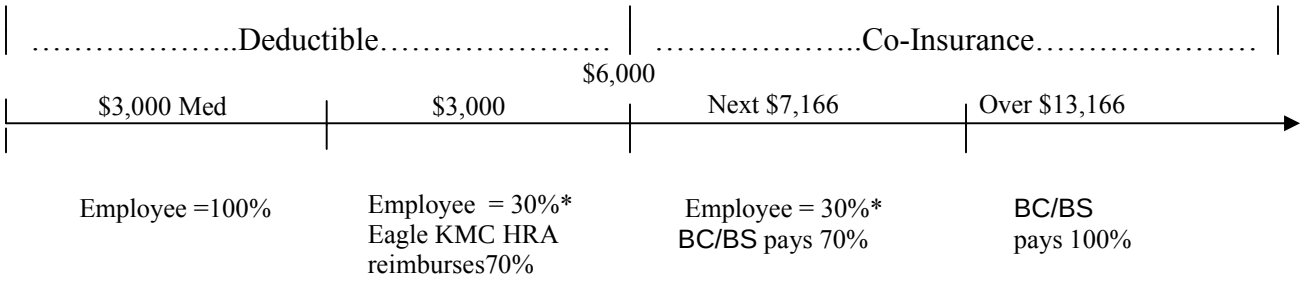
In-Network Deductible - 3K PLAN

- Employee pays the first $3,000 of the IN-Network deductible per covered member up to $6,000 CY Max.
- The employee is responsible for the next $3,000 per covered member. The Eagle KMC HRA will reimburse the employee 70% of this $3,000 of deductible to a maximum of $2,100 pcm up to $4,200 maximum.
- To put this another way, for the first $6,000 deductible the employee is responsible for $3,900 per covered member up to $7,800 maximum after receiving the HRA reimbursement.

The Total Deductible Annual Maximum reimbursement for a Covered member is $2,100

The Total Deductible Annual Maximum reimbursement for a Covered member and dependents is $4,200.

BC/BS Preferred - $6,000 Ded –70/50 Coins PPO PlanHRA
Illustration: 70% of last $3,000 of In-Net. Deductible



Employee Pays up to after reimbursement:								
$3,000	+	$900	+	$2,150	+	0	=	$6,050 **
Eagle KMC HRA reimburses up to:								
$ 0	+	$2,100	+	0	+	0	=	$2,100 **
				Out of Pocket Maximum				$8,150

* Net Employee cost after Eagle KMC HRA Reimbursement.

**Illustration is based on HRA reimbursement of 70% of remaining Deductible after the first $3,000.

(Since Copays also count against the OOP Maximum they can change the illustrated numbers shown above.)

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, [insert contact information]. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.[insert].com or call 1-800-[insert] to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	You pay the first: **$3000.00** Single You pay the first: **$3000.00** first person, $**3000** for remaining family members	See the chart starting on page 2 for your costs for services this plan covers. If you participate in your employer's HRA, the HRA will pay for or reimburse you for certain, qualified medical expenses for amounts under the deductible, up to the balance available in your HRA.
Are there services covered before you meet your deductible?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	This plan has no out-of-pocket limit.	There is no limit on how much you could pay during a coverage period for your share of the cost of covered services, except as shown in the health plan which is described in a separate SBC
What is not included in the out-of-pocket limit?	Not Applicable	Not applicable because there's no **out-of-pocket** limit on your expenses under this HRA plan, but see the health plan SBC for an **out-of-pocket** limit under that plan.
Will you pay less if you use a network provider?	Yes. Only in-network providers are covered.	This plan treats **providers** the same in determining payment for the services, however the amount paid by this plan will depend on amount you owe under the health plan. This amount may vary depending on whether you use a **network provider**.
Do you need a referral to see a specialist?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

Questions: Call **1-303-444-7478** or log on to view your account at **www.myflexonline.com.**
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-800-444-3272.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$3000 Employee Only Coverage Deductible + 30% of Remaining Health Plan Deductible (max $3900) $3000 First Family Member +30% of Remaining Health Plan Deductible, $3000 Remaining Family Members + 30% of Remaining Health Plan (max $7800)	N/A Out of Network Expenses Are Not Covered Prescription drug expenses subject to deductible are not reimbursable under the HRA.	Coverage is limited to individual's HRA account balance.
	Specialist visit			
	Preventive care/screening/ immunization			
If you have a test	Diagnostic test (x-ray, blood work)			
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.[insert].com	Generic drugs			
	Preferred brand drugs			
	Non-preferred brand drugs			
	Specialty drugs			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)			
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care			
	Emergency medical transportation			
	Urgent care			
If you have a hospital stay	Facility fee (e.g., hospital room)			
	Physician/surgeon fees			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$3000 Employee Only Coverage Deductible + 30% of Remaining Health Plan Deductible (max $3900) $3000 First Family Member +30% of Remaining Health Plan Deductible, $3000 Remaining Family Members + 30% of Remaining Health Plan (max $7800)	N/A Out of Network Expenses Are Not Covered	
	Inpatient services			
If you are pregnant	Office visits			
	Childbirth/delivery professional services			
	Childbirth/delivery facility services			Coverage is limited to individual's HRA account balance.
If you need help recovering or have other special health needs	Home health care			
	Rehabilitation services			
	Habilitation services			
	Skilled nursing care			
	Durable medical equipment			
	Hospice services			
If your child needs dental or eye care	Children's eye exam			
	Children's glasses			
	Children's dental check-up			

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Amounts in excess of HRA account balance.
- Expenses not subject to deductible.
- Rx deductible expenses

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Out of network expenses
-
-

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: [insert State, HHS, DOL, and/or other applicable agency contact information]. Other coverage options may be available to you too, including buying

individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: [insert applicable contact information from instructions].

Does this plan provide Minimum Essential Coverage? [N/A]
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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

Language Access Services:

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

About these Coverage Examples:

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

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$3000
Specialist *[cost sharing]*	$N/A
Hospital (facility) *[cost sharing]*	30%
Other *[cost sharing]*	30%

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

Total Example Cost	**$**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3000.00*
Copayments	100%
Coinsurance	30%
What isn't covered	
Limits or exclusions	$*
The total Peg would pay is	**$***

***$3000, plus coinsurance and amount in excess of individual's account balance.**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$3000
Specialist *[cost sharing]*	$N/A
Hospital (facility) *[cost sharing]*	30%
Other *[cost sharing]*	30%

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

Total Example Cost	**$**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3000
Copayments	100%
Coinsurance	30%
What isn't covered	
Limits or exclusions	$*
The total Joe would pay is	**$***

***$3000, plus coinsurance and amount in excess of individual's account balance.**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$3000
Specialist *[cost sharing]*	$N/A
Hospital (facility) *[cost sharing]*	30%
Other *[cost sharing]*	30%

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

Total Example Cost	**$**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$3000
Copayments	100%
Coinsurance	30%
What isn't covered	
Limits or exclusions	$*
The total Mia would pay is	**$***

***$3000, plus coinsurance and amount in excess of individual's account balance.**

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

SECURECARE DENTAL
GROUP INSURANCE

EAGLE KMC LLC
Dental Benefits Summary

Group ID: 10006564
Effective: 01/01/2022

EMPLOYEE **PLAN OPTIONS** (Employee may select one of the two plans)	**THE COPAY PLAN**		**THE PPO MAC PLAN**	
	Network	Non-Network [2]	Network	Non-Network [2]
Office Visit Copay	None		None	
Type I: Diagnostic and Preventive [1] Type II: Basic [1] Type III: Major [1]	See Schedule AZ500	See Schedule AZ500	100% 80% 50%	80% 60% 40%
Endodontic & Periodontic Services [1]	See Schedule AZ500		Type II: Basic	
Deductible	None		$50 per person; $150 per family; Calendar year (Type II, & III Services)	
Calendar Year Maximum	None		$ 1,500 per person	
Type I Waiting Period [4]	None	None	None	None
Type II Waiting Period [4]	None	None	None	None
Type III Waiting Period [4]	None	12 months	None	None
Discount Orthodontic Fee Program [3]	Included	Not Included	Included	Not Included
Insured Orthodontic Coverage	None		50%, up to $750/12 months; $1,500 lifetime	
Insured Orthodontic Waiting Period	None		12 Months	
Weekly Premium Rates — Employee	$ 3.62		$ 7.00	
Employee + Spouse	$ 6.92		$ 13.30	
Employee + Child(ren)	$ 8.01		$ 19.21	
Employee + Family	$ 10.38		$ 24.88	
Plan Code	A5C1		2MCG	

[1] SUMMARY OF COVERED SERVICES (The Certificate of Coverage will include a complete list of Covered Services)

Type I: **Diagnostic & Preventive**	Oral Examinations (2 per calendar year) * Routine Cleanings (2 per calendar year) * Topical fluoride up to age 16 (1 per calendar year) * Diagnostic x-rays, full or panoramic (1 in any 3-year period) * Bitewing x-rays (2 per calendar year) * Emergency palliative treatment to relieve pain * Space maintainers (for premature loss of primary tooth).
Type II: **Basic**	Fillings using amalgam, silicate, acrylic, synthetic porcelain and composite filling materials * Simple extractions * Antibiotic injections administered by Dentist * Oral Surgery, including customary postoperative treatment. * Endodontics - root canal therapy, pulpotomy * Periodontics - treatment of gum disease.
Type III: **Major**	Restorative - inlays, onlays, crowns (5-year waiting period for replacement) * Prosthodontics - full or partial dentures or bridges (5-year waiting period for replacement) * Endodontics - root canal therapy, pulpotomy * Periodontics - treatment of gum disease.

NOTES: Pre Treatment Review recommended for services or supplies over $300. **ELIGIBILITY:** Full-time Employees working at least 30 hours per week, and their dependents. See page 2 for details.

2-For PPO MAC plans, non-network benefits are paid on a Maximum Allowable Charge (MAC) basis. For PPO, Indemnity & SecureFlex UCR plans, non-network benefits are paid on a Usual, Customary, and Reasonable (UCR) basis. The employee is responsible for non-network balance billing that may result.

4-Replacement Benefits: Time periods satisfied under the employer's prior qualifying group dental plan (without coverage gap) will reduce Type I, II, III Waiting Periods.

Insured benefits under the SecureCare Dental Insurance Plan are provided under the Master Policy. This brochure is a summary of the SecureCare Dental benefits. It is not a contract and not part of the policy, but simply an outline of benefits provided under the Master Group Policy. For complete details consult the Certificate of Coverage.

SecureCare Dental Plan Information

Eligibility for Enrollment

You may enroll yourself for coverage if you (1) are an active employee; (2) meet your employer's eligibility criteria (e.g., number of work hours, job classification); and (3) have completed any applicable waiting period for coverage.

An employee may also enroll (1) his/her lawful spouse; (2) his/her child (natural, legally-adopted, step, or foster) who is under age 26. (3) his/her grandchild who is under age 19, and whom the employee can claim as an exemption on his/her federal income tax return; and (4) his/her handicapped child or grandchild older than the maximum age limit, who receives at least 50% support and care from the employee.

Effective Date of Coverage

Your coverage will begin on the first day of the month following your completed enrollment, provided (1) you are Actively At Work on such date; and (2) your first premium has been paid by you, or on your behalf. (Actively At Work means you are performing all customary job duties of your occupation, at your usual place of employment [or would be able to do so if it is a regular paid vacation day, or a regular non-working day, provided you are at work on the last preceding regular work day].)

If you enroll for dependent coverage, such coverage will begin the same day your coverage begins. If you enroll for dependent coverage at a later date, coverage on such eligible dependent(s) will begin on the first day of the month following completed enrollment, and payment of premium. If a dependent is Disabled (hospital confined; or unable to perform the regular and customary activities of a person in good health, and of the same age) on the date their coverage is to begin, coverage on that dependent will be delayed until the first of the month coincident with, or next following, the date Disability no longer exists.

End of Coverage

Your coverage will end on the earliest of (1) the date the policy ends; (2) the date you enter the Armed Forces of any country; (3) the end of the month during which you cease eligibility; or (4) the end of the last period for which premium payment has been made by you or on your behalf. Coverage on your dependents will end on the earliest of (1) the date your coverage ends; (2) the date your dependent no longer meets eligibility requirements; (3) the date your dependent enters the Armed Forces of any country; or (4) the end of the last period for which premium payment has been for dependent coverage.

Expenses Not Covered

No benefits are payable for, and any applicable Deductible amount may not be reduced by, any of the following:

- any service or supply (a) not listed as a Covered Service within the Schedule of Benefits, (b) payable under any medical expense plan, or (c) rendered by someone who is related to the covered person by blood, marriage, or adoption; or is normally a member of the covered person's household;
- any procedure (a) begun, but not completed; (b) begun before insurance begins; or (c) begun after insurance ends;
- any prosthetic appliance (a) for which the impression (for new or modified device) was made before insurance begins; (b) installed before insurance begins; or (c) finally installed or delivered more than 30 days after insurance ends;
- any treatment which is elective, or primarily cosmetic in nature, and/or not recognized as a generally accepted dental practice by the American Dental Association, as well as any replacement of prior cosmetic restorations;
- any procedure that (a) is determined to be not Medically Necessary, (b) does not offer a favorable prognosis, (c) does not have uniform professional endorsement, or (d) is experimental in nature;
- the correction of congenital malformations, including anodontia and cleft palate;
- the replacement of lost, discarded, or stolen appliances; or any duplicate device or appliance;
- cast restorations, inlays, onlays, and crowns for teeth that are not broken down by extensive decay or accidental injury, or for teeth that can be restored by other means (such as an amalgam or composite filling);
- restoration of third molars, except fillings;
- crowns, inlays and onlays used to restore teeth with micro fractures or fracture lines, undermined cusps, or existing large restorations without overt pathology;
- replacement of (a) bridges, (b) full or partial dentures, (c) crowns, inlays or onlays, or (d) occlusal guards (night guards, except for bruxism); unless such item is more than five years old and cannot be made serviceable;
- appliances, services, or procedures relating to: (a) the change or maintenance of vertical dimension; (b) correction of attrition, abrasion, erosion, or abfraction; (c) biteregistration; (d) bite analysis; or (e) splints, other than provisional splints;
- Procedures related to implants (other than what is listed as covered in COVERED DENTAL SERVICES, CLASS/TYPE III Major Services, item 11.), and any complications as of the result of implants; removal of implants; precision or semi-precision attachments; denture duplication; overdentures and surgery; or other customized services or attachments
- services provided for any type of (a) temporomandibular joint (TMJ) dysfunction; (b) muscular or skeletal deficiencies involving TMJ or related structures; or (c) myofascial pain;
- orthognathic surgery;
- orthodontic treatment, unless stated otherwise;
- treatment of malignancies;
- general anesthesia and intravenous sedation (regardless of the age of the patient), except in conjunction with covered oral surgery procedures;
- hospital services, or services of anesthetists or anesthesiologists;
- prescribed drugs;
- any instruction for diet, plaque control, or oral hygiene;
- dental disease, defect, or injury caused by a declared or undeclared war, or any act of war;
- charges for failure to keep a scheduled visit, or for the completion of any claim forms;
- expenses compensable under Workers' Compensation or Employers' Liability Laws or by any coverage provided or required by law (including, but not limited to, group, group-type and individual automobile "No Fault" coverage);
- expenses provided, or paid for, by any governmental program or law, except as to charges which the person is legally required to pay;
- services for which there would be no charge in the absence of insurance, or for any service or treatment provided without charge;
- Interpretation of a diagnostic image by a practitioner not associated with the capture.

Coordination of Benefits

Other coverage you have may affect benefits payable under the policy, to ensure that the total benefits from all plans will not exceed 100% of eligible expenses.

Administered by:
Southwest Preferred Dental Organization

Underwritten by:
American National Life Insurance Company of Texas
Galveston, TX

SECURECARE
GROUP INSURANCE
Dental ▪ Vision

Group: EAGLE KMC, LLC

Effective Date: January 1, 2022

Group ID: #1000-6564

Premier Vision Plan

Healthy eyes and clear vision are an important part of your overall health and quality of life. Your vision plan helps you care for your eyes while saving you money by offering:

Paid-in-full eye examinations, eyeglasses and contacts!

Frame Collection: Your plan includes a selection of designer, name brand frames that are completely covered in full./1

One-year eyeglass breakage warranty included on plan eyewear at no additional cost!

How to locate a Network Provider...

Just visit us at www.securecarevision.com and click "Look for a Vision Provider" to locate a provider near you including:

Visionworks

Weekly Premium	Premier Plan
Employee	$ 1.53
Employee plus Spouse	$ 2.80
Employee plus Children	$ 2.60
Employee plus Family	$ 4.00
Vision Plan Code	**V103**

Contact your Human Resources department today to enroll.

For more information about the plan, visit us at www.securecarevision.com or call:
1 (888) 429-0914.

Insured and Underwritten by:
American National Life Insurance Company of Texas
Galveston, Texas

SC-Vis-P-0814-SB.24012.0814

IN-NETWORK BENEFITS	
Eye Examination	Every 12 months, **Covered in full** after $10 copayment
Eyeglasses	
Spectacle Lenses	Every 12 months, **Covered in full** For standard single-vision, lined bifocal, or trifocal lenses after $10 copayment
Frames	Every 24 months, **Covered in full** Any Fashion, Designer or Premier frame from Davis Vision's Collection/1 (value up to $225). **OR** $150 retail allowance toward any frame from provider, plus 20% off balance/2
Contact Lenses	
Contact Lens Evaluation, Fitting & Follow Up Care	Every 12 months,Collection Contacts: **Covered in full** after $10 copay, **OR** Non Collection Contacts: Standard Contacts: **Covered in full** after $10 copay Specialty Contacts/3: $60 allowance with 15% off balance/2 after $10 copay
Contact Lenses (in lieu of eyeglasses)	Every 12 months, **Covered in full** Any contact lenses from Davis Vision's Contact Lens Collection/1 **OR** $150 retail allowance toward provider supplied contact lenses, plus 15% off balance/2

ADDITIONAL DISCOUNTED LENS OPTIONS & COATINGS		
MOST POPULAR OPTIONS Savings based on in-network usage and average retail values.	Without SecureCare	With SecureCare
Scratch-Resistant Coating	$ 40	$ 0
Polycarbonate Lenses	$ 64	$ 0/4
Standard Anti-Reflective (AR) Coating	$ 62	$ 35
Standard Progressives (no-line bifocal)	$ 154	$ 0
Plastic Photosensitive (Transitions®/5)	$ 123	$ 65

Lower costs and more benefits! *See the savings!*

Service	Without SecureCare	With SecureCare
Eye Examination	$ 100	$ 10
Lenses		
Bifocals	$ 80	$ 10
Scratch-Resistant Coating	$ 40	$ 0
Transitions®/5	$ 123	$ 65
Frame	$ 150	$ 0
Total	$ 493	$ 85

Savings up to:
$408

1/ The Davis Vision Collection is available at most participating independent provider locations. Collection is subject to change. Davis Vision is the national eyecare network used by SecureCare Vision.
2/ Additional discounts not applicable at Walmart, Sam's Club or Costco locations.
3/ Including, but not limited to toric, multifocal and gas permeable contact lenses.
4/ For dependent children, monocular patients and patients with prescriptions of 6.00 diopters or greater.
5/ Transitions® is a registered trademark of Transitions Optical Inc.
6/Routine eye examinations do not include professional services for contact lens evaluations. Any applicable fees above the evaluation and fitting allowance are the responsibility of the member.
SecureCare Vision has made every effort to correctly summarize your vision plan features. In the event of a conflict between this information and your organization's contract with SecureCare Vision, the terms of the contract or insurance policy will prevail. 5/25/14

SECURECARE VISION PLANS OFFER

Value for our Members

A comprehensive benefit ensuring low out-of-pocket cost to members and their families. Our goal is 100% member satisfaction.

Convenient Network Locations

A national network of credentialed preferred providers throughout the 50 states.

Freedom of Choice

Access to care through either our network of independent, private practice doctors (optometrists and ophthalmologists) or select retail partners.

Value-Added Features:

- Replacement contacts through LENS123® mail-order contact lens replacement service, saving both time and money.
- Laser Vision Correction discounts of up to 25% off the provider's Usual & Customary fees, or 5% off advertised specials, whichever is lower.

Contact SecureCare Vision

For more details about the plan visit us at: www.securecarevision.com or call:

1 (888) 429-0914.

ADDITIONAL OPTIONS	WITHOUT SecureCare	WITH SecureCare
FRAMES		
Fashion Frame (from Davis Vision Collection)	$ 125	$ 0
Designer Frame (from Davis Vision Collection)	$ 175	$ 0
Premier Frame (from Davis Vision Collection)	$ 225	$ 0
LENSES		
All Ranges of Prescriptions and Sizes	**$ 90**	**$ 0**
Plastic Lenses	**$ 33**	**$ 0**
Oversized Lenses	**$ 20**	**$ 0**
Tinting of Plastic Lenses	**$ 20**	**$ 0**
Scratch-Resistant Coating	**$ 40**	**$ 0**
Polycarbonate Lenses	$ 64	$ 0[1/]
Ultraviolet Coating	$ 28	$ 0
Standard Anti-Reflective (AR) Coating	$ 62	$ 35
Premium AR Coating	$ 80	$ 48
Ultra AR Coating	$ 113	$ 60
Standard Progressive Addition Lenses	$ 154	$ 0
Premium Progressives (Varilux® [2/], etc.)	$ 248	$ 40
Ultra Progressives (Varilux® [2/], etc.)	$ 430	$ 90
High-Index Lenses	$ 120	$ 55
Polarized Lenses	$ 103	$ 75
Plastic Photosensitive Lenses	$ 123	$ 65
Scratch Protection Plan (Single vision | Multifocal lenses)		$ 20 | $ 40

[1/] Polycarbonate lenses are covered in full for dependent children, monocular patients and patients with prescriptions 6.00 diopters or greater.

[2/] Varilux® is a registered trademark of Societe Essilor International

Out-of-Network Benefits

You may receive services from an out-of-network provider, although you will receive the greatest value and maximize your benefit dollars if you select a provider who participates in the network. If you choose an out-of-network provider, you must pay the provider directly for all charges and then submit a claim for reimbursement to:

Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110

Out-of-network Reimbursement Schedule
Eye Examination up to $40 | Frame up to $50 Spectacle Lenses (per pair) up to: Single Vision $40, Bifocal $60, Trifocal $80, Lenticular $100 Elective Contacts up to $105, Medically Necessary Contacts up to $225

Insured and Underwritten by:
American National Life Insurance Company of Texas
Galveston, Texas

DAVIS VISION
EYECARE REFRAMED℠

Guardian / Transamerica
VOLUNTARY BENEFITS

Accident

24-Hour coverage protects you on and off-the-job for any accidents you seek medical treatment for. Plans pays you a scheduled amount for an Emergency Room visit, Doctor Visit or Urgent Care visit and procedures done to treat you for a covered accident. Helps to pay for deductible and coinsurance out-of-pocket expenses. (See your benefit summary for specific details). Should you ever leave your employment, you may take this plan with you, usually at the same rates.

Disability Insurance

Paycheck Insurance– Starts paying you a paycheck once your physician declares you disabled from a sickness, injury or maternity leave. There is a choice of either a 7 day elimination period or 14 day elimination period. The elimination period is the period of time you must be disabled before benefits are paid out. As long as you are considered disabled by your physician you may receive benefits for up to 3 months. Should you ever leave your employment, you may take this plan with you, usually at the same rates. (See your benefit summary for specific details).

Critical Illness

Coverage for Heart-Stroke-Cancer and Other Critical Illnesses that pay you a lump-sum benefit when you are diagnosed with a Heart-Attack, Stroke, Internal Cancer and other illnesses. Dependent children are automatically covered at 50% of your benefit amount. Should you ever leave your employment, you may take this plan with you, usually at the same rates. (Please see your benefit summary for specific details).

Voluntary Life Insurance

Additional Life Insurance helps protect you and your family in the event of your death and helps to pay for funeral expenses, mortgages, final expenses, college funds and allows your family time to make decisions about their future. Family coverage is available for your dependent spouse and children.

Lock in your coverage: New Eligible Employees that enroll in at least $10,000 of coverage may increase your coverage up to guaranteed issue amount at a future enrollment without answering medical questions. **If you previously purchased coverage**, you can increase it up to the guaranteed issue amount ($100,000) to meet your growing needs – with no health questions or exams!"

Should you ever leave your employment, you may take this plan with you, usually at the same rates. (Please see your benefit summary for specific details).

Legal Shield

Unexpected legal questions arise every day, and with LegalShield on your side, you'll have access to a quality law firm for covered personal situations, even 24/7 for emergency situations, no matter how traumatic or how trivial they may seem. Because our dedicated law firms are prepaid, their sole focus is to serve you, rather than bill you.

Annual Open Enrollment
December 1st - 15th

New Hire Enrollments
Close 15 days prior to your coverage effective date

www.eaglekmc.ease.com

2022 EMPLOYEE MODEL NOTICES

IMPORTANT INFORMATION

Employee & Eligible Beneficiaries,

As an employee and participant in our employee benefit programs, you and your beneficiaries may have various rights and privileges related to these programs. Laws governing health care require us to provide you with these notifications. Listed below are important notices to retain for your records. In the past, many of these notices were sent individually and are now grouped together to more clearly communicate your rights, and to simplify distribution. If you have any questions please contact your Group Administrator.

NOTIFICATIONS

HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that we notify you about two very important provisions in the plan. The first is your right to enroll in the plan under its "special enrollment provision" 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 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. However, you must 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. However, you must 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.

Second, is the existence of any preexisting condition exclusion rules in the plan that may temporarily exclude coverage for certain preexisting conditions that you or a member of your family may have. For plan year starting in 2013, a preexisting condition exclusion cannot be longer than 12 months from your enrollment date (18 months for a late enrollee). A pre-existing condition exclusion that is applied to you must be reduced by the prior creditable coverage you have that was not interrupted by a significant break in coverage. You may show creditable coverage through a certificate of creditable coverage given to you by your prior plan or insurer (including an HMO) or by other proof. Refer to your plan document for additional details. Preexisting condition limitations or exclusions will no longer be applicable upon plan renewal in 2014 and for plan years starting in 2014 and beyond. Last, a HIPAA certificate of creditable coverage notice is generally given by the provider when there is a loss of coverage, this notice should be retained for your records as proof of creditable coverage. All questions about preexisting condition exclusion, special enrollment rights and creditable coverage should be directed to your health plan provider or plan administrator listed above. As of the first day of the 2014 plan year, the plan does not impose limitations on coverage for pre-existing conditions.

HIPAA Notice of Privacy Practices

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.

As Required by Law. 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, right 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.

CHIP NOTICE - 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 are 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 will not 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 any of the state's list here, contact your state Medicaid or CHIP office to find out if premium assistance is available. If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. **ALABAMA** – Medicaid Website: http://www.medicaid.alabama.gov Phone: 1-855-692-5447, **ALASKA** – Medicaid Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529, **ARIZONA** – CHIP Website: http://www.azahcccs.gov/applicants Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437, **COLORADO** – Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943, **FLORIDA** – Medicaid Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268, **GEORGIA** – Medicaid Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150, **IDAHO** – Medicaid Website: http://healthandwelfare.idaho.gov/Medical/Medicaid/PremiumAssistance/tabid/1510/Default.aspx Medicaid Phone: 1-800-926-2588, **INDIANA** – Medicaid Website: http://www.in.gov/fssa Phone: 1-800-889-9949, **IOWA** – Medicaid Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562, **KANSAS** – Medicaid Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884, **KENTUCKY** – Medicaid Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570, **LOUISIANA** – Medicaid Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447, **MAINE** – Medicaid Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741, **MASSACHUSETTS** – Medicaid and CHIP Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120, **MINNESOTA** – Medicaid Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629, **MISSOURI** – Medicaid Website:

http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005, **MONTANA** – Medicaid Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084, **NEBRASKA** – Medicaid Website: www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633, **NEVADA** – Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900, **NEW HAMPSHIRE** – Medicaid Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218, **NEW JERSEY** – Medicaid and CHIP Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710, **NEW YORK** – Medicaid Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831, **NORTH CAROLINA** – Medicaid Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100, **NORTH DAKOTA** – Medicaid Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604, **OKLAHOMA** – Medicaid and CHIP Website: http://www.insureoklahoma.org Phone: 1-888-365-3742, **OREGON** – Medicaid Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075, **PENNSYLVANIA** – Medicaid Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462, **RHODE ISLAND** – Medicaid Website: www.ohhs.ri.gov Phone: 401-462-5300, **SOUTH CAROLINA** – Medicaid Website: http://www.scdhhs.gov Phone: 1-888-549-0820, **SOUTH DAKOTA** – Medicaid Website: http://dss.sd.gov Phone: 1-888-828-0059, **TEXAS** – Medicaid Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493, **UTAH** – Medicaid and CHIP Website: http://health.utah.gov/upp Phone: 1-866-435-7414, **VERMONT**– Medicaid Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427, **VIRGINIA** – Medicaid and CHIP Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282, **WASHINGTON** – Medicaid Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473, **WEST VIRGINIA** – Medicaid Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability, **WISCONSIN** – Medicaid Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002, **WYOMING** Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531. The list of States offering a premium assistance program is current as of July 31, 2014. States offering CHIP assistance may change without notice.

For more information on special enrollment rights, or to verify if any other State now offers premium assistance, contact either: U.S. Department of Labor Employee Benefit Security Administration www.dol.gov/ebsa 1-866-444-EBSA (3272), U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services www.cms.hhs.gov 1-877-267-2323, Menu Option 4, Ext. 61565

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office 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.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not 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, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3272).

WHCRA

The Women's Health and Cancer Rights Act (WHCRA) of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). Call your health insurance issuer for more information.

This notice informs you of the Federal regulation that requires all health plans that cover mastectomies to also cover reconstruction of the removed breast. If you have had or are going to have a mastectomy, you may be entitled to certain benefits. 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 lymphedemas.

NMHPA

Newborns' and Mothers' Health Protection Act 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 http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/nmhpa_factsheet.html.

USERRA

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; then 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.

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 **1-866-4-USA-DOL** or visit its **website at http://www.dol.gov/vets**. An interactive online USERRA Advisor can be viewed at **http://www.dol.gov/elaws/userra.htm**. 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.

GINA

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.

MHPA/MHPAEA

Mental Health Parity and Addiction Equity Act (MHPA/MHPAEA) require that group health plans not unfairly restrict treatment with regards to benefits/services applicable to mental health or substance use disorders. Additional information and details can be found by visiting the Department of Labor's Mental Health Parity webpage locate at http://www.dol.gov/ebsa/newsroom/fsmhpaea.html.

FMLA

Family Medical Leave Act (FMLA) entitles eligible employees of covered employers to take unpaid, job-protected leave for specific family and medical reasons if the employee has been with the company for one year, has worked at least 1250 hours during the prior 12 months and works in an area where there are at least 50 employees within 75 miles. Public agencies as well as public and private secondary schools are covered employers without regard to the number of employees employed. For additional details, visit the Department of Labor FMLA page. Notify the organization when you have a qualifying leave such as birth or adoption of a child, a serious health condition, to care for a spouse, child or parent with a serious medical condition or for reservist or National Guard provisions related to you or an immediate family member leaving for military duty or being injured in active duty.

COBRA NOTICE

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 Flexible Spending Account 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 Flexible Spending Account 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 Flexible Spending Account 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 (e.g., $2,550 of coverage); (2) the total reimbursable 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 Flexible Spending Account during any annual enrollment for any Plan Year that follows your qualifying event.

Supporting documentation like a divorce decree, death certificate, 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's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's 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 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.

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 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.

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.

MEDICARE PART D NOTICE

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

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. We have determined the prescription drug coverage 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 Individuals. Visit 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 cancelation 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 person listed in this notifications report. 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.

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 800-MEDICARE (800-633-4227). TTY users should call (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 (800) 772-1213 (TTY 1-800-325-0778).

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).