Markovitz Enterprises, Inc & Badger Industries

2027 Employee Benefits Guide

An overview of the wide array of benefits provided by Markovitz Enterprises to help you enjoy increased well-being and financial security.



Prepared by Liberty Insurance Agency for Markovitz Enterprises, Inc

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Introduction

SELECT THE BEST BENEFITS FOR YOU AND YOUR FAMILY

Markovitz Enterprises & Superior Forge are please to provide a competitive benefits package to full-time eligible employees.

Open enrollment is a short period each year that allows you to make changes to your benefits. This guide outlines the benefits available so you can identify the best options for you and your family. Summaries of the benefits provided by the insurance carriers are included in your enrollment portal and should be reviewed for additional details regarding coverage

What's New ?

Effective January 1, 2027, we will be making the following changes

Medical: Remaining with Meritain utilizing the Aetna Network. lncreasing the deductibles bu $500 for all tiers

Additional Add-ons: Flexible Spending Account (FSA)

Who is Eligible?

If you are a full-time employee working 30 or more hours per week and have met your new hire waiting period, you are eligible to enroll in our benefit programs. Your spouse and dependent children are eligible for coverage as well (children up to age 26).

How to enroll:

We will be using Paycor for enrollment again this year, doing a semi-passive enrollment. When you login into your Paycor account you will make one of the following selections: (I do not want this benefit, Keep my Selection or View Plan Options). Please note, if you do not log into Paycor to complete, your current benefit coverages will automatically rollover for January 1, 2026,

When to enroll:

Open enrollment begins November 9, 2026 and runs through November 20, 2026. The benefits you choose during open enrollment will become effective January 1, 2027.

Choose Carefully:

Once you make your selections during open enrollment, you cannot make a change to your benefits until the next open enrollment period unless you experience a qualifying change in status. Qualifying events include things such as: marriage, divorce, birth of a child, etc. If you have a qualifying event and need to make changes to your coverage, please contact HR within 30 days of the event.

POS $1,500 80/60 (BASE PLAN)

Summary of Coverage

	In Network What you will pay	Out Of Network What you will pay
Deductible: Individual/Family	$1,500 / $3,000	$3,000 / $6,000
Coinsurance	20% after deductible	40% after deductible
Preventive Care	100% paid	40% after deductible
Primary Care Physician (PCP)	$10 copay	40% after deductible
Specialist	$40 copay	40% after deductible
Urgent Care	$30 copay	40% after deductible
Emergency Room	$125 copay	$125 copay
Labs, X-Rays, Advanced Imaging (MRI,PET,CAT)	20% after deductible	40% after deductible
Inpatient Hospital Services	20% after deductible	40% after deductible
Outpatient Surgery	20% after deductible	40% after deductible
Pharmacy Benefits		
Retail Prescription (31 day supply)	Generic - $20 / Brand - $40 / Non-Formulary - $65 / Specialty - $105	None
Mail Order Prescription (90 day supply)	Generic - $40 / Brand - $80 / Non-Formulary - $130	None
Out of Pocket Maximum	$8,550 / $17,100	$8,000 / $16,000

This booklet provides only a summary of your benefits. All services described within are subject to the definitions, limitations and exclusions set forth in each insurance carrier's or provider's contract.

POS $750 100/80 (HIGH PLAN)

Summary of Coverage

	In Network What you will pay	Out Of Network What you will pay
Deductible: Individual/Family	$750 / $1,500	$1500 / $3,000
Coinsurance	0% after deductible	20% after deductible
Preventive Care	100% paid	20% after deductible
Primary Care Physician (PCP)	$10 copay	20% after deductible
Specialist	$25 copay	20% after deductible
Urgent Care	$15 copay	20% after deductible
Emergency Room	$75 copay	$75 copay
Labs, X-Rays, Advanced Imaging (MRI,PET,CAT)	0% after deductible	20% after deductible
Inpatient Hospital Services	0% after deductible	20% after deductible
Outpatient Surgery	0% after deductible	20% after deductible
Pharmacy Benefits		
Retail Prescription (31 day supply)	Generic - $10 / Brand - $30 / Non-Formulary - $55 / Specialty - $95	None
Mail Order Prescription (90 day supply)	Generic - $20 / Brand - $60 / Non-Formulary - $110	None
Out of Pocket Maximum	$8,550 / $17,100	$4,000 / $8,000

This booklet provides only a summary of your benefits. All services described within are subject to the definitions, limitations and exclusions set forth in each insurance carrier's or provider's contract.



Find Care® Online Directory

Aetna Choice® Point of Service (POS) II

It's easy to find doctors and hospitals in your network

When you and your family need care, you can look for doctors and hospitals in the Aetna Choice POS II network. It's easy when you use the Find Care online directory from Aetna®. *With up-to-date listings, you can search for providers by name, specialty, gender, hospital affiliations and more.

Find Aetna providers online in just a few quick steps

You can use the directory anywhere you have internet access. Just:

1 Visit **https://www.aetna.com/dsepublic/#/mymeritain**.

2 Key in the ZIP code, city, county or state of the desired geographical area in the *Enter location here* field. Click *Search*.

3 Key in *Aetna Choice POS II (Open Access)* under *Select a Plan*. **Or** you can select *Aetna Choice POS II (Open Access)* from the list of plans. Click *Continue.*

4 There are two options available to search for providers. The guided flow search uses some of our most commonly searched terms and easily organizes them for our users to find. To use the guided search flow, choose and click on one of the categories under *Find what you need by category*. **Or see step five.**

5 Use the search box, which includes type-ahead suggestions and will present provider, facility, specialty and condition search options based on what is entered. These suggested options will present an exact match or relevant providers. *What do you want to search for near* (will display your chosen location).

6 Choose your provider from the list of providers displayed on the results screen. You can learn more about each by clicking on the provider's name.

7 Narrow your search results by using the *Filter & Sort* option. Choices include *Gender, Languages, Hospital Affiliations, Office Detail, Individual Practice Association Affiliations, Group Affiliations* and *Provider Type*.

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Why choose a primary care physician (PCP)?

Meritain Health® does not require you to choose a PCP, but we encourage you to choose one. Your PCP knows your health care needs, so they can help manage your health and coordinate your care. To find and choose a PCP, use the *Find Care* tool on your member website.

Find providers by phone

Need a provider when you're not near a computer? No problem. Simply call the Aetna Provider Line at **1.800.343.3140** from 8:00 AM–9:00 PM ET, Monday through Friday.



*Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company and its affiliates.

Providers are independent contractors and are not agents of Aetna or Meritain Health. Provider participation may change without notice. Neither Aetna nor Meritain Health provides care or guarantees access to health services. Information is believed to be accurate as of the production date; however, it is subject to change.

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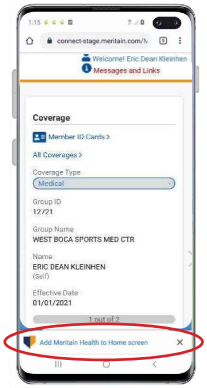


How to Access Your Mobile App

Android™ Phones

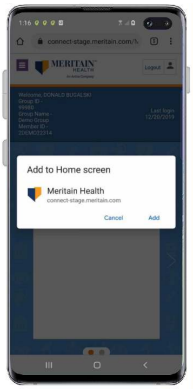
1

Once you log in to your member website through **www.meritain.com**, or **by scanning the QR code**, you'll be prompted with the pop-up message *Add Meritain Health® to Home Screen* at the bottom of the page. Click this message.



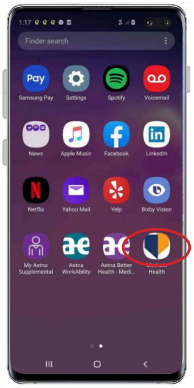
2

Then, click *Add* to add the app to your home screen.



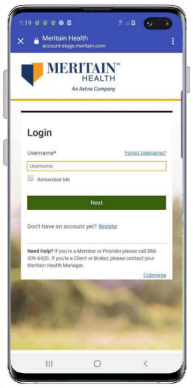
3

You should see the Meritain Health logo on your phone's home screen.



4

Now, simply launch the app from your home screen and log in.



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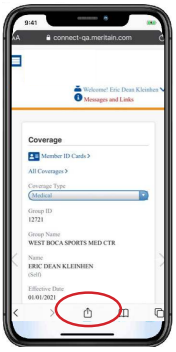


How to Access Your Mobile App

iPhone®

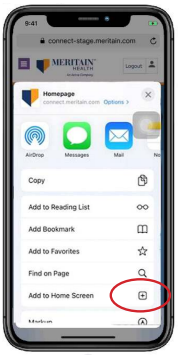
1

Once you log in to your member website through **www.meritain.com**, or **by scanning the QR code**, click the icon at the bottom of the page shown here.



2

Then, scroll through the menu options and select *Add to Home Screen*.



3

Click *Add* in the upper right-hand corner.



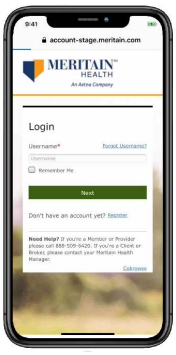
4

Your Meritain Health® app logo will then be installed and added to your home screen.



5

Now, you're all set to log in through the mobile app!



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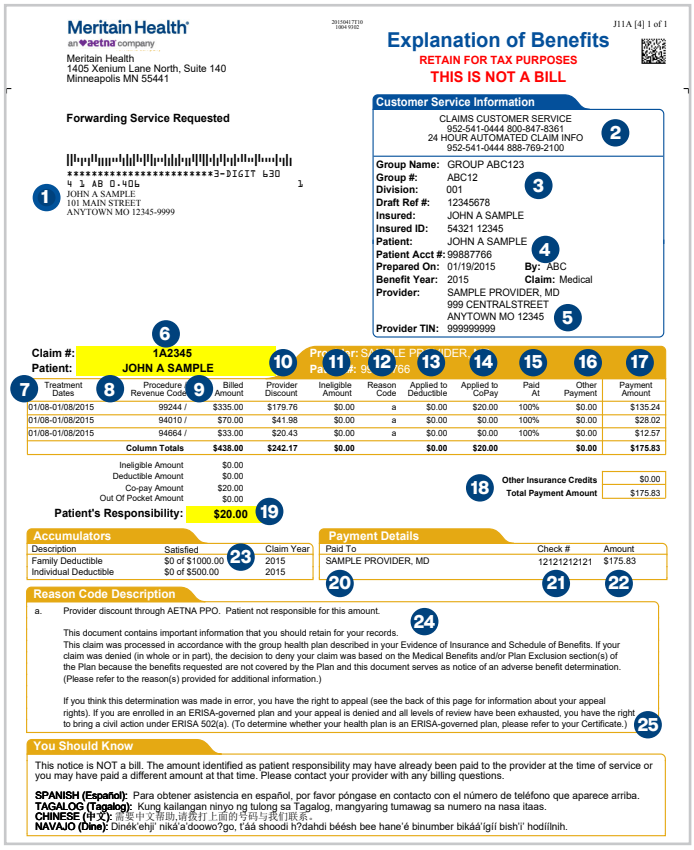
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Explanation of Benefits (EOB)

It's important for you to know how your benefits are paid. Your EOB is a helpful piece that can help you get started. The sample shown here provides an overview to reading and understanding your EOBs.

Sample EOB



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Meritain Health
1405 Xenium Lane North, Suite 140
Minneapolis MN 55441

Forwarding Service Requested

JOHN A SAMPLE
101 MAIN STREET
ANYTOWN MO 12345-9999

J11A [4] 1 of 1

Explanation of Benefits
RETAIN FOR TAX PURPOSES
THIS IS NOT A BILL

Customer Service Information
CLAIMS CUSTOMER SERVICE
952-541-0444 800-847-8361
24 HOUR AUTOMATED CLAIM INFO
952-541-0444 888-769-2100

Group Name: GROUP ABC123
Group #: ABC12
Division: 001
Draft Ref #: 12345678
Insured: JOHN A SAMPLE
Insured ID: 54321 12345
Patient: JOHN A SAMPLE
Patient Acct #: 99887766
Prepared On: 01/19/2015 By: ABC
Benefit Year: 2015 Claim: Medical
Provider: SAMPLE PROVIDER, MD
999 CENTRALSTREET
ANYTOWN MO 12345
Provider TIN: 999999999

Claim #: 1A2345
Patient: JOHN A SAMPLE

Treatment Dates	Procedure Revenue Code	Billed Amount	Provider Discount	Ineligible Amount	Reason Code	Applied to Deductible	Applied to CoPay	Paid At	Other Payment	Payment Amount
01/08-01/08/2015	99244 /	$335.00	$179.76	$0.00	a	$0.00	$20.00	100%	$0.00	$135.24
01/08-01/08/2015	94010 /	$70.00	$41.98	$0.00	a	$0.00	$0.00	100%	$0.00	$28.02
01/08-01/08/2015	94664 /	$33.00	$20.43	$0.00	a	$0.00	$0.00	100%	$0.00	$12.57
	Column Totals	$438.00	$242.17	$0.00		$0.00	$20.00		$0.00	$175.83

Ineligible Amount $0.00
Deductible Amount $0.00
Co-pay Amount $20.00
Out Of Pocket Amount $0.00
Patient's Responsibility: $20.00

Other Insurance Credits $0.00
Total Payment Amount $175.83

Accumulators

Description	Satisfied	Claim Year
Family Deductible	$0 of $1000.00	2015
Individual Deductible	$0 of $500.00	2015

Payment Details

Paid To	Check #	Amount
SAMPLE PROVIDER, MD	12121212121	$175.83

Reason Code Description

a. Provider discount through AETNA PPO. Patient not responsible for this amount.

This document contains important information that you should retain for your records.
This claim was processed in accordance with the group health plan described in your Evidence of Insurance and Schedule of Benefits. If your claim was denied (in whole or in part), the decision to deny your claim was based on the Medical Benefits and/or Plan Exclusion section(s) of the Plan because the benefits requested are not covered by the Plan and this document serves as notice of an adverse benefit determination. (Please refer to the reason(s) provided for additional information.)

If you think this determination was made in error, you have the right to appeal (see the back of this page for information about your appeal rights). If you are enrolled in an ERISA-governed plan and your appeal is denied and all levels of review have been exhausted, you have the right to bring a civil action under ERISA 502(a). (To determine whether your health plan is an ERISA-governed plan, please refer to your Certificate.)

You Should Know

This notice is NOT a bill. The amount identified as patient responsibility may have already been paid to the provider at the time of service or you may have paid a different amount at that time. Please contact your provider with any billing questions.

SPANISH (Español): Para obtener asistencia en español, por favor póngase en contacto con el número de teléfono que aparece arriba.
TAGALOG (Tagalog): Kung kailangan ninyo ng tulong sa Tagalog, mangyaring tumawag sa numero na nasa itaas.
CHINESE (中文): 需要中文帮助,请拨打上面的号码与我们联系。
NAVAJO (Dine): Dinék'ehjí níká a'doowo?go, t'áá shoodi h?dahdi béésh bee hane'é binumber bikáá'ígíí bish'i' hodíílnih.

Frequently asked questions

Q: Is this a bill?

A: No. Your EOB is simply an informational piece produced to help you better understand how your benefits have been applied.

Q: Do I owe money?

A: You can review section #19 of your EOB (Patient's Responsibility) carefully. This section will inform you if you are responsible for any amount.

Q: Will I receive a bill for payment?

A: If you owe money, you'll receive a bill directly from your provider's office. Just make your check payable to your provider.

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How to read your EOB



1. Patient name and address
2. Customer service information
3. Employer/group identification
4. Patient identification
5. Provider identification: name, address and tax ID number
6. Claim number
7. Date(s) of service
8. Code or description for type of service provided
9. Total amount billed by provider
10. Network or negotiated discount, deducted from total charges
11. Amount not covered by the benefit plan
12. Explanation or detail of claim processing
13. Amount that falls under plan deductible, which is the patient's responsibility
14. Amount that falls under copay, which is the patient's responsibility
15. Percentage reimbursable (if any) after application of plan copays and deductibles
16. Amount paid (if any) by another benefit plan, which would be deducted from the plan's payment under the Coordination of Benefits provision
17. Amount paid to provider or covered individual
18. Total payment made
19. Amount patient is responsible for paying the provider; may include amounts already paid at the time of service
20. Recipient of payment
21. Check number
22. Total amount of check
23. Amount of deductible that has been satisfied for this plan year
24. Footnotes providing additional explanation (also may include other communication to the provider or the participant)
25. Appeal procedures

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MinuteClinic® Benefit

Give your employees more options with convenient and reliable high-quality care

MinuteClinic makes it easy for employees to get the care they need, when and where they need it. Now they can access eligible services, including MinuteClinic Virtual Care™ visits, at any in-network MinuteClinic location at no cost to them*. To find available locations, visit **https://www.cvs.com/minuteclinic/virtual-care**.

- MinuteClinic is a walk-in clinic located inside select CVS Pharmacy® and Target stores, and is the largest provider of retail health care in the United States—with over 900+ locations in 32 states and the District of Columbia.
- It's open every day, including evenings, for walk-in and scheduled appointments. MinuteClinic health care providers can diagnose and treat many common illnesses, injuries and conditions. They're also able to write prescriptions, when medically appropriate.
- MinuteClinic Virtual Care offers both general medical and mental well-being services by virtual visit seven days a week.
  Available in select states and mental well-being services through MinuteClinic are not a part of the MinuteClinic Benefit. See **cvs.com/minuteclinic** for mental health service eligible states.
- Mental health visits are not part of the no cost benefit. Employees will be required to pay out-of-pocket for in-person or virtual mental health services they receive.

For more information, contact your Meritain Health® representative.

Lower Costs

Improve Health

Boost Satisfaction

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*Visit **https://www.cvs.com/minuteclinic** for age and service restrictions. This is for informational purposes only. It is not medical advice and is not intended to be a substitute for proper medical care provided by a physician. Information is believed to be accurate as of the production date; however, it is subject to change. Eligible members enrolled in high-deductible plans must meet their deductible. However, such services would be subject to negotiated contract rates. Once the deductible has been met, members will be able to access MinuteClinic services at no cost-share. Members in Aetna Whole Health ACO, APCN Plus, HMO and indemnity plans may not be eligible for this benefit. Such members should refer to their benefit plan documents in order to determine coverage and applicable cost-share for walk-in clinic benefits and services, as applicable. Meritain Health, Aetna and MinuteClinic, LLC (which either operates or provides certain management support services to MinuteClinic-branded walk-in clinics) are within the CVS Health family. Meritain Health is not responsible or liable in any manner for services received at CVS MinuteClinic locations.

MERITAIN® HEALTH

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Case Management Services

Support when you need it most

When unexpected illness or injury occurs in your life, the last thing you want to think about is having to navigate your health benefits. That's why Meritain Health® offers case management, a no-cost and confidential program that helps you and your family through a difficult experience.

With case management, you'll speak to a dedicated case manager on a regular basis. Case managers are registered nurses and licensed social workers who assess your health and help you develop a suitable and affordable treatment plan. They also help you understand your condition and work with you, your providers and your loved ones to ensure you receive quality care. They may even find you savings or discounts through your benefits or certain physicians.

How to enroll

You, a family member or your provider can call to determine if case management services are right for you. We may also reach out to you if we think you would benefit, based on precertification required by your plan. Remember, case management is included in your health plan, so this service is at no cost to you.

If you fall ill or are injured, your main concern shouldn't be paperwork. Let a case manager help you and your family with your benefits and treatment so you can focus on getting better.

Case management provides you with:

- Personalized support for you and your family when serious injury or illness occurs.
- Help in understanding your health benefits, home care needs, treatment options and possible lifestyle changes.
- Communication facilitation between you and your doctor or hospital.
- Potential savings and discounts through your benefits.

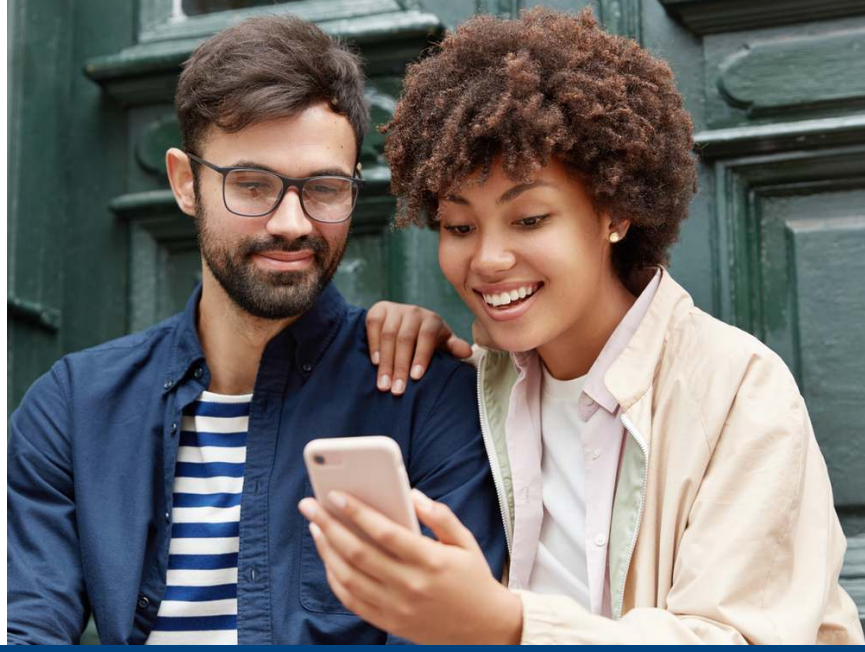
ADVOCATES FOR HEALTHIER LIVING

We are Meritain Health

As Advocates for Healthier Living, we provide easy-to-use health care benefits you can use to live well. We also take steps to help you save on the cost of your care. Contact us at the number on your ID card if you have any questions about your plan.

Teladoc® HEALTH

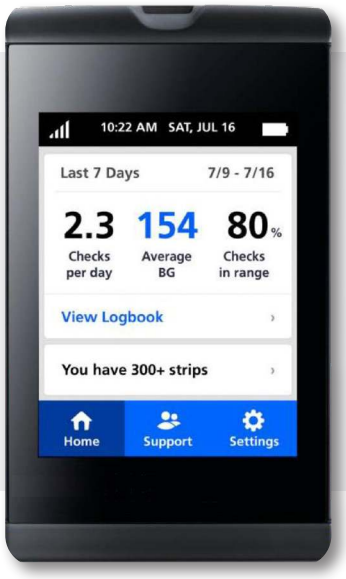
Diabetes Management by Teladoc Health®



Diabetes Management by Teladoc Health is a diabetes management program offering a personalized experience that helps you understand your blood sugar, develop healthy lifestyle habits and improve glycemic control. This program is available for you and your dependents with diabetes, at no additional cost!

With this program, you are supplied with:

- **A connected meter**. Your meter automatically uploads your blood glucose readings to your secure online account and provides real-time personalized tips.
- **Coaching support**. You are able to communicate with a coach anytime about diabetes questions concerning nutrition or lifestyle changes.
- **Unlimited strips at no cost to you.** When you are about to run out, we ship more supplies right to your door.



Benefits of Diabetes Management by Teladoc Health

Teladoc Health makes living with diabetes easier by offering:

- **Food and activity tracking**. This helps you recognize lifestyle habits.
- **24/7 remote monitoring**. This provides you with emergency outreach, if needed.
- **Optional family alerts**. This allows you to keep everyone in the loop.
- **Direct reporting**. You'll be able to send a health report directly from your meter.
- **Automatic uploads**. Your reporting will automatically be uploaded, eliminating the need for paper log books.

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Registering for Teladoc Health

You can use Teladoc Health anywhere you have internet access. To get started:

1. Visit **www.Teladoc.com** and click *Set Up Account*.
2. Enter your name, date of birth, ZIP code, email address, preferred language and gender and click *Continue*. The system will identify you based on this information. If you're unable to be identified, you'll be directed to Teladoc Health Customer Service.
3. On the next screen, enter the required information and click *Set up my account*. Your registration is now complete!

Complete your profile by clicking on *My Medical History*. You can enter your history right after registering or come back to finish it later.

If you have any questions, or run into any problems when setting up your account, call Teladoc Health at 1.800.TELADOC (1.800.835.2362).



This flyer is for information and is not meant as medical advice. Health benefits plans contain exclusions and limitations. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Information is believed to be accurate as of the production date; however, it is subject to change.

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Exclusive Employee Discounts

Your nationwide deals await

LifeMart® Employee Discount Program

Browse big savings on major brands for all your health and wellness needs. LifeMart is your employer's way of saying thanks for your hard work—and helping you keep more of your paycheck.

Access LifeMart anywhere, anytime, on any device. It's the fast and easy way to:

- Save money on all your health and wellness needs—from gyms, to diet plans, groceries and everything in between.
- Access offers personal wellness products and services—LifeMart also offers deals on everyday needs such as travel, tickets, car rentals, electronics and more.
- Get deals for the family—such as pet products, child care discounts, products for aging loved ones and more!
- Save time with instant, one-stop shopping—with no need to run out to the store or search the web.
- Discovering exclusive new deals on the brands you love—offers are updated regularly.

Getting Started with LifeMart

Accessing LifeMart is easy. Just complete the online registration by filling out your first name, last name, email address and a password. Once you're registered, you will be able to view and access discounts. Members also have the option to opt-in or out of of email notifications.

There are a few different ways to access LifeMart

1. Through your Meritain Health® member website. Click the *LifeMart* link under *Tools and Resources*, or click the *LifeMart* tile at the bottom of your homepage. From here, you'll be able to search for discounts directly within your member website.
2. Scan the QR below to be taken directly to LifeMart and start searching for discounts!

3. With the LifeMart mobile app you can access LifeMart discounts anywhere, anytime. Simply download the app and you can browse major savings on the go. It's available for download in the Google Play Store™ and iTunes Store®. **Please note:** you'll need to register online to access the LifeMart mobile app.

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Need Help?

You can reach out to the LifeMart help desk via email for assistance. Just click on the *Need Help* link in LifeMart! The Need Help feature also has commonly asked questions and answers to assist you. You can also use the direct customer support email **helpdesk@lifecare.com**.



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Wellness and Preventive Care

Take an easy step towards good health

Your number one way to help yourself and your family stay healthy is with preventive care. When combined with healthy eating and exercise, vaccines and early detection are your key to a long and healthy life. That's why your employer offers many preventive treatments at no cost to you when you visit a doctor in your network.

Wellness and preventive care

Your doctor may suggest:

- Screening tests, which may find health concerns before symptoms appear.
- Diagnostic tests, physicals and self-exams, which may find health issues early in their course.

Your doctor may use guidelines to recommend screenings. If you're considering getting a test, it's a good idea to speak with your doctor. Together, you can decide what is right for you.

Screenings for adults

Preventive screening	Group	Recommendation
Abdominal aortic aneurysm	Men, age 65-75	Once for men who have smoked tobacco.
Alcohol and tobacco use	Everyone	Annually
Anxiety	Everyone	Routinely—adults 18 years of age and older, including pregnant and postpartum women.
Blood pressure	Everyone	Annually
Breast cancer	Women, age 40 – 74	Mammogram every two years. Talk with your doctor to decide if you need them more often.[1]

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Screeening for adults

Preventive screening	Group	Recommendation
Cervical cancer	Women, beginning at age 21	Pap smear for women 21–65 years of age every three years. Women 30–65 years of age may have a Pap smear and human papillomavirus (HPV) testing every five years.[2]
Cholesterol	Everyone, beginning at age 35	Every five years.
Colorecterol cancer	Everyone, beginning at age 45	Every 10 years. Talk to your doctor.
Depression	Everyone	Annually
Hepatitis A & B	Everyone	Talk to your doctor.
Human papillomavirus (HPV)	Everyone	Talk to your doctor.
Diabetes	Everyone	Glucose test every three years. Talk to your doctor if you are at increased risk.
Lung cancer	Current or former smokers, age 55–80**	Annually
Osteoporosis	Women	For post-menopausal women; or under age 65 at increased risk for osteoporosis.
Prostate cancer	Men, age 55 – 69	Talk to your doctor.
Sexually transmitted diseases	Everyone	Annually
Tobacco use	Everyone, beginning at age 18	Annually
Tuberculosis infection	Everyone, beginning at age 18	Those with increased risk of latent tuberculosis infection
Unhealthy drug use	Everyone, beginning at age 18	Annually
Vision	Everyone	Annually
Weight	Everyone	Annually

*Plan features and availability may vary by location and group size. Not all health services are covered. See plan documentsfor a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features are subject to change.

** Smokers or former smokers with a 30 pack per year or more smoking history and, if a former smoker, has quit within the past 15 years.

[1]U.S. Preventive Services Task Force. Final recommendation statement. Breast cancer: screening. November 2018.

[2]U.S. Preventive Services Task Force. Final recommendation statement. Cervical cancer: screening. August 2018.

For more information about preventive care, you can visit the website for the United States Department of Health and Human Services at: http://healthfinder.gov/myhealthfinder.

You can also visit https://www.hrsa.gov/womens-guidelines and https://www.healthcare.gov/what-are-my-preventive-care-benefits

If you have questions, we can help. Simply call Meritain Health® Customer Service using the phone number on your member ID card.

172.12052024

Simple. Transparent. Versatile.
At Meritain Health®, we're creating unrivaled connections.

Follow us: @meritainhealth | Meritain Health

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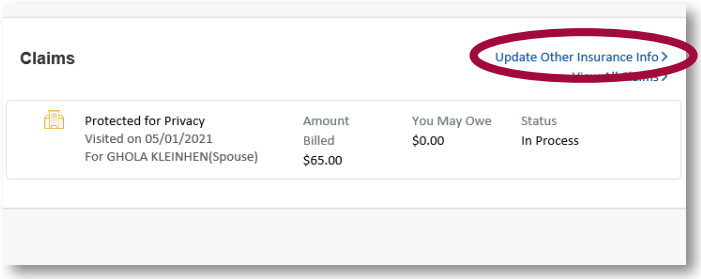
Accessing Other Insurance Coverage (OIC) Online

Your health care benefits plan includes a provision called Coordination of Benefits (COB). This means if one person is covered by two benefit plans, both plans share responsibility for covering that person's health care expenses. This helps prevent duplicate payments and helps hold down health care costs.

Examples of other coverage include: Medicare (due to age or disability), group coverage through a family member's employer, association coverage through a group you or a family member belongs to, student health coverage, or coverage mandated by a divorce decree.

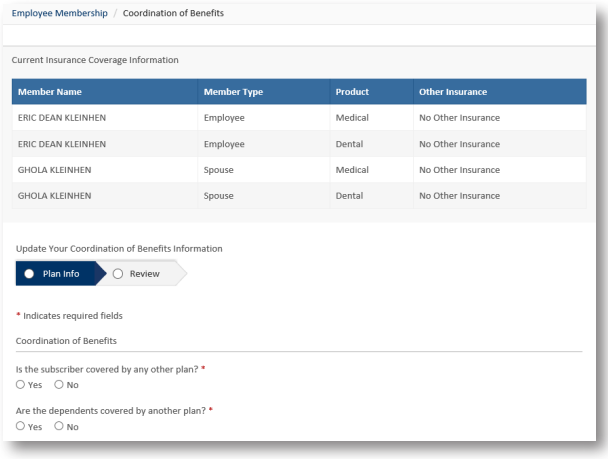
Meritain Health® may sometimes ask you to update this information so we can keep our records current.

1 Select *Update Other Insurance Info*, located on the main homepage under the *Claims* section.



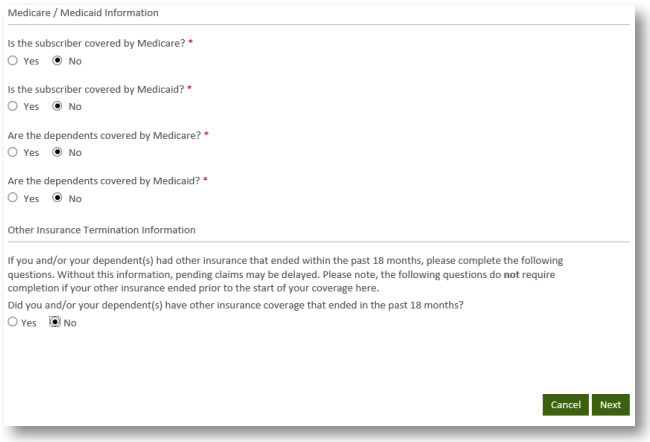
2 You'll be asked if you or any dependents have other coverage, other Medicare coverage and/or other Medicaid coverage. Simply answer *Yes* or *No* to report if you or anyone in your family has other health coverage.

3 If you answer *Yes*, you'll be asked for information about the other coverage like start date, carrier name, policy holder name, date of birth, etc. Just fill out the forms that open when you select *Yes*.

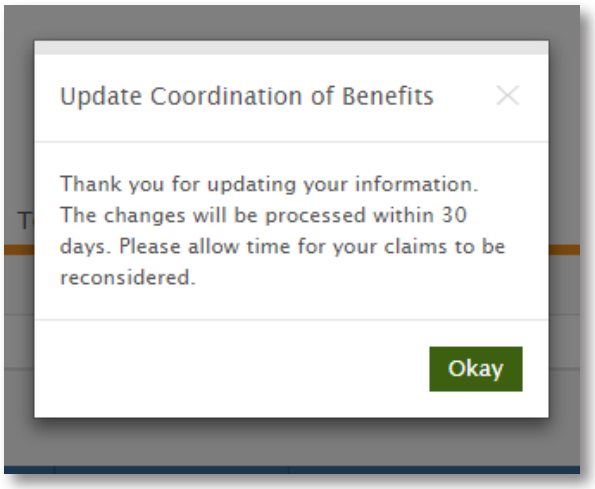


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4 After you complete the form, click *Next* to see a summary of the information.



5 If you agree with the summary, click *Submit* in the bottom right corner. If you need to make changes, click *Edit* at the top of the summary.



If you have any questions, you can call Customer Service at the number on the back of your ID card for assistance.

Please note: failure to update your COB will result in claims denial.

Other COB options are available

- You can *email* your COB form to:
  Forms.Direct@meritain.com
- Or you can mail it to:
  Meritain Health
  Eligibility Department
  P.O. Box 853921
  Richardson, TX 75085-3921
- Or fax to **716.541.6672**
  You should keep a copy of the fax confirmation record if you plan to call to confirm receipt.

Hello,

To help us properly handle future claims, please tell us about any <u>other</u> health care coverage you and/or your dependents may have. Examples include another group plan, an individual policy, COBRA, Medicare, state programs (such as Medicaid, CHIP, etc.), Social Security benefits due to a disability, or medical expenses covered by another person due to a court order/decree.

Please complete this form and submit it by:

- Mailing it to the address above;
- Faxing it to: **1.716.541.6672**; or,
- Taking a picture of it, and emailing it to: **forms.direct@meritain.com**.

OTHER INSURANCE COVERAGE		
Group Name	Employee Name	Employee date of birth
Group number *(if you already have an ID Card from Meritain Health)*	Member ID *(if you already have an ID Card from Meritain Health)*	
Do you and/or any of your dependents have any <u>other</u> health coverage? ❑ YES Please <u>complete the appropriate section(s) on the other side of this form</u> and return. ❑ NO Please return.		

IF THERE IS <u>OTHER</u> HEALTH CARE COVERAGE,
PLEASE COMPLETE THE APPROPRIATE SECTION(S) ON THE OTHER SIDE OF THIS FORM.

Failure to return this form may result in non-payment of claims.

For each type of <u>other</u> insurance coverage you and/or your dependents have, please complete the appropriate section.

For coverage through: **ANOTHER GROUP PLAN, AN INDIVIDUAL POLICY, COBRA OR STATE PROGRAM** *(ex: Medicaid)*		
What type of coverage is this? ❑ Medical ❑ Dental ❑ Vision		
Name of insurance company / program	Name of policy holder	
Birthdate of policy holder	Effective date of coverage	Termination date of coverage *(if applicable)*
Please list **<u>all</u>** family members covered by this plan, and their relation to the policy holder		

For coverage through: **ANOTHER GROUP PLAN, AN INDIVIDUAL POLICY, COBRA OR STATE PROGRAM** *(ex: Medicaid)*		
What type of coverage is this? ❑ Medical ❑ Dental ❑ Vision		
Name of insurance company / program	Name of policy holder	
Birthdate of policy holder	Effective date of coverage	Termination date of coverage *(if applicable)*
Please list **<u>all</u>** family members covered by this plan, and their relation to the policy holder		

For coverage through: **MEDICARE**		
Name of person covered by Medicare	Medicare ID number:	
Your retirement date *(if applicable)*	Your spouse's retirement date *(if applicable)*	
Part A effective date(s)	Part B effective date(s)	Part D effective date(s)
Reason for Medicare: ❑ Over age 65 ❑ Total disability ❑ End-stage renal disease *(provide dialysis date)* _____		

COURT ORDER OR DECREE	
Covered Individuals	Effective date
Name of person responsible for medical expenses	Address of person responsible for medical expenses
Please include a copy of the legal documentation showing responsibility for medical expenses.	

Health Plan Add Ons

- **Garner** - Garner helps members find the best providers that deliver the best outcome. Using Garner and the Aetna network will potentially eliminate your deductible. You can reach Garner at www.conceierge@getgarner.com or 1-866-761-9586

- **AllyHealth** - Ally Health is a comprehensive virtual medicine program that includes services for Virtual Urgent Care, Mental Health and EAP Services, all at you fingertips at a ZERO copay! You can reach AllyHealth at 1-877-283-3777.

- **FedLogic** - FedLogic is an organization that provides advocacy services with a team of experts dedicated to helping members find all the resources available and help you understand federal and state benefit options. You can reach FedLogic at 1-877-837-4196.

- **Regenexx** - Regenexx is an innovative treatment for orthopedic injuries that enhances your body's natural healing to treat damaged tendons, ligaments, muscle, bone and cartilage. You can reach Regenexx at 1-866-341-1166.

- **CancerCare** – CancerCare Program is a free, fully integrated cancer solution in your health plan that supports you from the first day of your diagnosis well into the stages of aftercare. CancerCare coordinates care and benefits for patients with new and existing cancers. You can reach CancerCare at 1-877-640-9610.

- **eHealth** – eHealth helps you decide if COBRA coverage is the best option for you if you leave Markovitz. They help make it easier for you to find affordable quality health coverage. You can go to www.ehealthinsurance.com/pareto or call at 1-844-744-0647.

- **Valenz Health formerly KISx Card** – The card is a bundled surgical and imaging cost containment solution. They handle over 430 elective surgeries, colonoscopies and all major imaging. The card focuses on “near-care” options for employees where they are seeing providers less than 60 miles from their home. This benefit is classified as an Out-of-Network benefit. The claims do not apply to In-Network benefits. You can reach Valenz Health at 1-877-438-5479

- **SmartConnect** - SmartConnect is a free service for you and your family members that are Medicare eligible. SmartConnect will help you compare the costs and benefits of your current Medical plan against Medicare plans to decide what is best option for you. You can reach SmartConnect at 1-855-810-8938.

Garner, your free healthcare benefit

garner™

What is Garner?

Garner is a free healthcare benefit offered by your employer.
It's free to use at no cost to you.

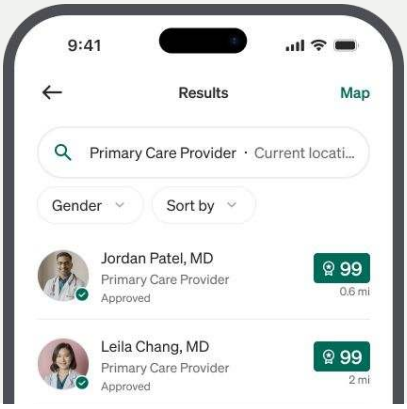
Garner helps you find the best doctors near you

Get money back on your medical bills **up to your benefit amount** for you and your family

Follow the steps below to get reimbursed.

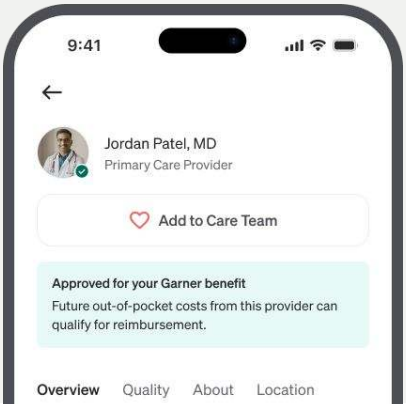
01

Search for top doctors in the Garner app



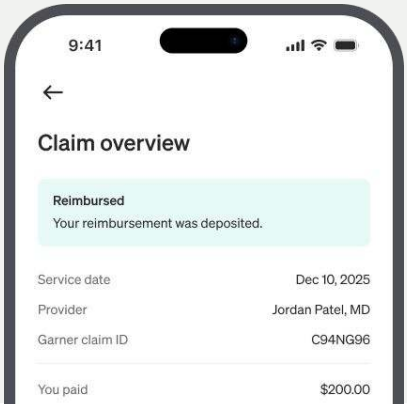
02

Add doctors to your Care Team before your visit



03

Get reimbursed for your out-of-pocket medical bills



Get reimbursed up to your benefit amount for you and your family.

Scan the QR code to create an account

garner.guide/create-my-account

Need our help?

You can contact our Concierge team via in-app chat or at concierge@getgarner.com after creating an account. Starting August 4, 2025, hours will extend to Mon–Fri, 8 a.m. –10 p.m. ET (previously 8 a.m.–8 p.m. ET).

Expert help when you need it. Garner's Concierge is here for you

garner™

As your first line of expert assistance, Garner's Concierge team is committed to answering your questions and helping you find the best care for you and your family. Whether you need help understanding your Garner benefit, finding Top Providers, or have questions about claims, our professionals are here to assist.

Hear what members are saying about the Garner Concierge:

"Everyone at Garner is very responsive and I've had all my questions answered promptly. Thank you."

"Concierge service is excellent. Quick, thorough responses to my claim submissions. Very professional!"

"I'm loving the Garner app. The concierge function is amazing — I love that I can get fast answers."

FAQs

Q: What if I do not understand how to use my Garner benefit?
A: The Concierge team is here to help you understand your benefit. They can explain the reimbursement process, help you search for providers, and answer any questions you have.

Q: Can the Garner Concierge help me find a new provider?
A: Yes! The Concierge can help you search for and add a Top Provider to your list of approved providers and your Care Team. Our Concierge staff will help you find the right specialist or PCP for your conditions and ensure providers can handle specific cases, have availability, and are in-network.

Q: What if I cannot find my Nurse Practitioner (NP) while searching for providers?
A: These providers are not listed in the app. Contact the Garner Concierge to confirm whether your Nurse Practitioner (NP) provider is approved for your Garner benefit. If they practice under a doctor who is a Top Provider, the Concierge can add your Nurse Practitioner (NP) provider to your list of Approved Providers and your Care Team.

Q: What do I do if I have a question about a claim?
A: To ask about your claim, contact the Concierge with the total claim amount, date of service, provider name, and procedure description. They will get back to you within one business day.

Q: How do I contact the Concierge?
A: You can message the Concierge through in-app chat, phone, or email at concierge@getgarner.com, Mon-Fri 8:00 a.m. to 10:00 p.m. ET.

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CFAQ-2-EN-062625

AllyHealth

Virtual Care. Anytime. Anywhere. Available Now!

With AllyHealth you have 24/7/365 access to virtual urgent care doctor appointments, access to mental health and wellbeing resources including short-term counseling, scheduled therapy, psychiatry visits, life coaching, practical daily support, and more. All available from home, office, or on the go, with no copays or consultation fees for you and your family. Plus, you'll have access to our Rx and medical bill savings programs - helping you save time, money, and frustration.



YOUR ALLYHEALTH
VIRTUAL CARE SERVICES INCLUDE

Virtual Urgent Care: $0 Copay — **877-283-3777 ext 1**
24/7/365 On-demand access to licensed physicians for common illnesses and medications when appropriate.
Details on page 2.

On-Demand and Short-Term Counseling: $0 Copay — **888-388-0397**
24/7/365 Access to counselors for in-the-moment mental health counseling, as well as access to scheduled short-term, solution-focused counseling. 100% Private and confidential, with free visits included in your plan!
Details on page 3.

Wellbeing and Practical Daily Support: $0 Copay — **888-388-0397**
Access to a concierge to help with everyday needs (ex: finding eldercare or childcare resources, planning a vacation, financial or legal guidance, and more).
Details on page 4.

Virtual Psychology: $0 Copay
Speak with a licensed psychologist for one-on-one talk therapy and psychology session(s) to address any general wellbeing or mental health needs.
Details on page 6.

Virtual Psychiatry: $0 Copay — **877-283-3777 ext 1**
Connect with a U.S. based, board-certified psychiatrist who can diagnose, treat and prescribe medications for a range of mental health needs, as necessary.
Details on page 7.

Savings Tools: FREE — **877-283-3777 ext 1**
Save big on your prescriptions and medical bills with our in-app healthcare savings tools.
Details on page 8.

Visit https://allyhealth.app/, scan QR to download the AllyHealth app, or call the phone numbers listed above.

SCAN HERE

THIS PLAN IS NOT INSURANCE and is not considered a Qualified Health Plan under the Patient Protection and Affordable Care Act. Copays and usage limitations may apply (review detail pages that follow for more information). If you have any questions about your plan, please contact your HR manager or AllyHealth customer support at support@allyhealth.net



AllyHealth

Virtual Urgent Care

Registration Steps Available on Page 1

Doctors can be hard to reach, illness can occur in the middle of the night, and sometimes you just have a question. In all of those circumstances – and many more – AllyHealth is a convenient and affordable solution.

HOW IT WORKS

Log into your account or call AllyHealth anytime, 24/7/365, to connect directly with a licensed physician by phone or video call within minutes at no cost to you and your family.

FEATURES INCLUDE

- ☑ No copays, deductibles, or per-call charges
- ☑ Prescriptions called into your local pharmacy
- ☑ Plan covers the entire family
- ☑ Fast and easy access, 24/7/365
- ☑ Avoid germ-filled waiting rooms
- ☑ Flexible and easy to use (available via web, mobile app, or simply by phone)

COMMON CONDITIONS WE TREAT

- Sore Throat
- Sinus Infection
- Cough
- Allergies
- Urinary Tract Infections
- Skin Rash/ Infections
- Fever/Headache
- Covid-19/Flu
- Rx Refill
- Pink Eye
- Constipation/ Diarrhea
- Stomach Pain
- Stress and Anxiety
- Ear Pain
- And More

WHEN TO USE ALLYHEALTH

- ☑ Instead of going to the ER or urgent care center for a non-emergency medical issue
- ☑ During or after normal business hours, nights, weekends, and even holidays
- ☑ If your primary care doctor or pediatrician is not available
- ☑ To request prescriptions or refills (when appropriate)
- ☑ If traveling and in need of medical care

*Average provider to patient call return time is under 17 minutes nationwide



AllyHealth

On-Demand and Short-Term Counseling

Registration Steps Available on Page 1

Improve your mental health and overall wellbeing by working with a counselor to address the issues that are making it difficult to manage at work or at home. You can turn to us for confidential support anytime, anywhere.

FEATURES INCLUDE

- ☑ 24/7 in-the-moment support and immediate single-session therapy available any time by phone or video call from licensed mental health counselors
- ☑ Scheduled short-term, structured counseling sessions available by phone, video call, or in-person
- ☑ In-app messaging with a mental health coach available
- ☑ Mindfulness coaching to help you reduce stress, emphasize the present, and establish greater mind-body balance
- ☑ Computerized cognitive behavioral therapy for those who prefer to work at their own pace
- ☑ 100% confidential
- ☑ Available to you and your family members
- ☑ Access from the privacy of your home or office when and where you need it

WHEN TO USE

- For help working through life's everyday stressors and issues
- To take a solution-focused approach with one or more specific issues for short-term or in-the-moment help
- When you want to work on improving yourself and feeling better
- If you have questions about how we can help, just call and we can assist

HOW IT WORKS

1. Call or Log On To Your Account
Call, download the app or log into the member portal.

2. Select Wellbeing Support
Click the "Wellbeing Support" tile in your account and click "Get Help Now" or simply ask for this service if you call in by phone.

3. Connect with a Mental Health Coach or Counselor
Select your preferred method of support and connect with a coach or counselor. You can connect by phone, video call, in-app message, or in person.

COMMON ISSUES WE SUPPORT

- Addiction
- Alcoholism
- Anxiety
- Bereavement
- Bullying/ Harassment/ Discrimination
- Career/ Job-related Stress
- Depression
- Domestic Violence
- Eating Disorders
- Family Problems
- Gambling
- Grief & Loss Assistance
- Parenting issues
- Postpartum Depression
- Relationship & Marriage Issues
- Separation
- Stress
- Substance Abuse
- Trauma & PTSD
- Work or Coworker Issues
- And More



AllyHealth

Wellbeing and Practical Daily Support

Registration Steps Available on Page 1

To help you make time for what matters most, you and your family have access to life coaches, as well as experts on child and elder care topics and skilled researchers to provide support for any work, personal, or everyday matter that's important to you and your family. We'll discuss your concerns, provide information on options, and then conduct research to find local resources to help you implement your action plan. What's more, our team is available 24/7 by phone or on-app to provide you and your family with real-time support.

FEATURES INCLUDE

- ☑ 24/7 access by phone or through our app
- ☑ Custom research matching local resources and providers to your specific needs
- ☑ Support for you, as well as those in your family and/or household
- ☑ Follow-up to be sure that the assistance met your complete satisfaction

SUPPORT IS AVAILABLE FOR

- **Dependent Care:** Child care and parenting; adult care and aging; and care for individuals with special needs or disability.
- **Daily Living Information Services:** A variety of day-to-day information support services for concerns, such as home maintenance, travel, housing, or relocation.
- **Legal Support:** Consumer rights, matrimonial law, traffic issues, civil litigation, tenancy, wills, and probate.
- **Financial Support:** Credit and debt, budgeting, taxation, benefits, mortgages, and insurance.
- **Elder Care:** Home care agencies, assisted living facilities, skilled nursing facilities, geriatric care management, financial assistance, and community resources.
- **Life Coaching:** Establish a vision, set goals and create an action plan; then engage in up to five follow-up meetings to help recalibrate, refresh, and progress with your goals; progress towards any goal - career, parenting, relationship, time management, etc.

HOW IT WORKS

1. Call or Log On To Your Account
Call, download the app or log into the member portal.

2. Select Practical Daily Support
Click the "Practical Daily Support" tile in your account and click "Get Help Now" or simply ask for this service if you call in by phone.

3. Connect with an Expert
You will be connected with one of our experts who will take detailed notes and assist you with your issues.

WHEN TO USE

- When you are feeling the stress of taking care of a loved one and need support
- When you need advice for legal or financial questions or issues
- To help plan for many of life's regular daily struggles
- To work on yourself with the help of a life coach
- If you have questions about how we can help, just call and we can assist



AllyHealth

Virtual Psychology

Registration Steps Available on Page 1

Speak with a licensed psychologist for one-on-one talk therapy and psychology session(s) to address any general wellbeing or mental health needs.

FEATURES INCLUDE

- ☑ Schedule an appointment by phone or online, from the comfort of home
- ☑ New patient appointments scheduled within 3 days or less, on average
- ☑ No-cost sessions included, and no claims to your health plan*
- ☑ 100% confidential
- ☑ Family coverage means the whole family can benefit from these services

WHEN TO USE

Our goal is to provide you with convenient, affordable mental health support, when and where you need it most.

- If you have a mental health question and you just need professional guidance
- When you need someone to assist or talk through everyday concerns such as stress, relationship difficulties or any mental health issues
- For talk therapy to work through life's tough moments and issues
- When you need help dealing with stress, anxiety, life changing events and much more

SIMPLE AS 1, 2, 3, 4

1. Log In To Account
Download the AllyHealth app, or visit the member portal to schedule a consultation with a psychologist within 3 business days on average for new patients.

2. Request a Consultation
Request a consultation with a psychologist, update electronic health records, and complete an intake questionnaire.

3. Connect with a Psychologist
Connect with a psychologist for an appointment to discuss any issues that you may want or need to address.

4. Schedule Follow-Up Sessions
Schedule follow-up sessions as-needed, as determined between you and your care provider.

COMMON ISSUES WE SUPPORT

- Anxiety
- Depression
- Stress Management
- Grief & Loss
- Trauma & PTSD
- Panic Disorders
- Addiction & Substance Abuse
- Men's Issues
- Women's Issues
- Relationship Issues
- Parenting Issues
- Life Changes
- And More!

AllyHealth plans typically include up to ten (10) $0 copay mental health sessions (psychiatry and psychology combined) per family per year, but plan designs may vary. If you have questions about your plan, please contact your HR manager or AllyHealth support at support@allyhealth.net.



AllyHealth

Virtual Psychiatry

Registration Steps Available on Page 1

Connect with a U.S. based, board-certified psychiatrist who can diagnose, treat and prescribe medications for a range of mental health needs, as necessary.

FEATURES INCLUDE

- ☑ Schedule an appointment by phone or online, from the comfort of home
- ☑ New patient appointments are scheduled within 3 days or less, on average
- ☑ No-cost visits included, and no claims to the health plan*
- ☑ Manage mental health medications and issues with ongoing, continued sessions with the same provider
- ☑ 100% confidential
- ☑ Family coverage means the whole family can benefit from these services

WHEN TO USE

Our goal is to provide you with convenient, affordable mental health support, when and where you need it most.

- If you've tried talk therapy or other resources and feel like you may need more support
- When you or your care team believe you may benefit from a prescription to help with your mental health or wellbeing
- When you need help dealing with depression, stress, anxiety, panic disorders, and much more

SIMPLE AS 1, 2, 3, 4

1. Log In To Account
Download the AllyHealth app, or visit the member portal to schedule a consultation with a psychiatrist within 3 business days on average for new patients.

2. Request a Consultation
Request a consultation with a psychiatrist, update electronic health records, and complete an intake questionnaire.

3. Connect with a Psychiatrist
Connect with a psychiatrist for an appointment to assess symptoms, evaluate medical and family history, and help determine a course of action moving forward.

4. Prescription Will Be Sent
Prescription will be sent electronically to your local pharmacy if appropriate, at provider's discretion.

COMMON CONDITIONS WE TREAT

- Anxiety
- Depression
- Bipolar Disorders
- Stress Management
- Grief & Loss
- LGBTQ Support
- Trauma & PTSD
- Panic Disorders
- Addiction & Substance Abuse
- Men's Issues
- Women's Issues
- Postpartum Depression
- Relationship Issues
- Parenting Issues
- Life Changes
- And More

*AllyHealth plans typically include up to ten (10) $0 copay mental health sessions (psychiatry and psychology combined) per family per year, but plan designs may vary. If you have questions about your plan, please contact your HR manager or AllyHealth support at support@allyhealth.net.



AllyHealth

Savings and Transparency Tools

Registration Steps Available on Page 1

Tired of paying full price for prescriptions and out-of-pocket medical bills? Through the AllyHealth app, you have access to two incredible tools focused on saving you money.

FREE RX DISCOUNT PROGRAM

- ☑ 10-85% prescription discounts versus cash price on most short-term and acute care medications
- ☑ Online drug price lookup tool helps you find the price of prescriptions at participating locations by zip code
- ☑ Over 65,000 participating pharmacy locations, including independent, national and regional chain pharmacies nationwide
- ☑ No cost, membership, or personal information is required

MEDICAL BILL SAVER

- ☑ Save 20-50% on most out-of-network bills of $500 or more
- ☑ No up-front fee - Save or the service is free and only pay fee if your negotiation is successful (success fee is equal to 35% of the negotiated discount)
- ☑ Gain control over your medical spending without feeling the need to become a health care expert
- ☑ Reduce your medical bills regardless of your insurance status or procedure
- ☑ Track your annual savings

HOW TO USE RX DISCOUNT PROGRAM

1. In the AllyHealth app, click the "Prescription Savings" tile.
2. Search our network of pharmacies for your prescription.
3. Select the best price and the most convenient location for you.
4. Present the savings information to your pharmacist to save!

HOW TO USE MEDICAL BILL SAVER

1. In the AllyHealth app, click the "Medical Bill Review" tile.
2. If this is your first time using the service, then click the "Get Started" button and then follow the instructions to get started and submit your bill for review. Make sure to use the code "ALY100" to get access to your benefits.
3. If you've used the service before, click the "Access Portal" button any time to visit the online portal to see the status of your negotiation or to submit additional bills.
4. We will alert you when the process is complete. If your negotiation is successful, then you will pay the discounted amount, plus the success fee.

WHAT IS REGENEXX?

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

THE REGENEXX DIFFERENCE

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



CONDITIONS TREATED

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

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

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

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

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

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

LEARN MORE

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

To register for one of our weekly webinars, visit **regenexxbenefits.com/webinar?mailer**.

FEDlogic

BADGER

EMPLOYEE ACCESS CODE: badg25

Federal & State Benefit Navigation

A team of experts, ready to help.

FEDlogic is an advocacy service provided by your employer that gives you access to a team of experts who can assist you in understanding federal and state benefit options. FEDlogic's experts have worked for the Social Security Administration and have spent years mastering these policies from the inside out. Without education and advocacy, many individuals don't take advantage of all the benefits available to them. FEDlogic's experts can provide you with peace of mind, ensuring that you identify and maximize all of your benefits. FEDlogic does not sell, endorse, or promote any products or services. FEDlogic is a team of unbiased advocates with decades of experience, here to help!

Medicare	*Retirement*	*Disability*
Healthcare.gov	*SSI*	*Medicaid*
Critical Illness	*Dialysis*	*ALS*
Survivor's Benefits	*Veteran's Benefits*	*Tribal Benefits*
COBRA	*Premature Baby*	*Catastrophic Claims*

Reasons to call *an expert*

- *You're approaching or have reached age 65 and want help navigating Medicare*
- *You're 62+ and want to maximize your retirement benefits or plan for the future*
- *You or a family member have been diagnosed with a critical illness or disability*
- *You have a child born prematurely and is in the NICU*
- *You have lost a spouse and need help navigating survivor's benefits*
- *You are unable to work or have lost affordable health coverage*

How it works

1. **Make a phone consultation appointment**
   Call us at 877-837-4196 or scan the QR code to schedule a phone consultation with one of our experts. Be sure to make the appointment at a time when family members are available to listen and ask questions as well. Calls typically last an hour and are unlimited, confidential, and free.

2. **Tell us your story, ask questions, and learn**
   You don't have to wade through tons of complex and confusing information to figure out what applies to you. We take the time to listen to your story and understand your needs, concerns, and goals. Then, we empower you with the unbiased information you need to maximize your benefits and make the best decision for your situation.

3. **Enroll in your benefits**
   Once you feel confident you have all the information you need to make the best decision for you and your family, we'll walk you through the application and approval process.

4. **Have Peace of Mind**
   Without education and advocacy, many people don't tap into all the Social Security and Medicare benefits they've paid into during a lifetime of employment. You'll have the peace of mind knowing that you're getting all the benefits you deserve.
   So, sit back, relax and celebrate!

It's all about *you.*

Our experts are here to help your family navigate federal and state benefits. Our services are provided for you and your family by your employer and are always 100% free, confidential, and unlimited. FEDlogic will never promote, endorse, or sell any type of product or insurance.

877-837-4196

FEDLOGICGROUP.COM

SERVICES@FEDLOGICGROUP.COM

CancerCARE
Medical Excellence Program by INTERLINK





What is CancerCARE?

CancerCARE is a cutting edge program designed to optimize the treatment of your cancer and increase the likelihood of your speedy recovery. It is a free benefit provided by your health plan sponsor to help maximize your treatment and well-being.

How do I benefit from the CancerCARE program?

- 1 in 2 men and 1 in 3 women will be diagnosed with cancer in their lifetime
- Cancer care is costly. CancerCARE specialists can help maximize your benefit coverage and lower out-of-pocket expenses.
- Approximately 20% of cancer diagnoses are incomplete or incorrect. CancerCARE's Pathology/DiagnosticCOE network will affirm select diagnoses for correct treatment planning from the beginning.
- Receive access to clinical trials at leading centers, often providing more effective treatment and better outcomes
- When applicable, you will be encouraged to obtain care at INTERLINK's CancerCOE Network (Centers of Excellence). The CancerCOE Network is comprised of the nation's leading centers for cancer treatment.

What does the program offer?

- Increased benefit coverage for evidenced-based cancer treatment
- Coordination and navigation of your cancer care, including access to skilled oncology experts to help you through your cancer treatment decisions
- Guidance on cancer treatment plans based off of the most current evidence-based treatment protocols developed by an alliance of world renowned cancer specialists
- Opportunity to obtain care in your community or at a national center
- Physician access to evidence based drug and biologic dosing that helps protect from under or over treatment of cancer
- INTERLINK's CancerCOE Network; a network of the nations leading cancer centers

How do I use this program?

- When you or a covered family member is diagnosed with cancer, benefits are increased if you call and register with the CancerCARE Triage Center at: **1-877-640-9610**

What happens when I call?

- You will speak with an intake specialist who will collect your demographic information and provide information about the program
- If you have questions or concerns, you will have access to a skilled oncology nurse
- You will be given information on how to ensure you receive the most appropriate treatment for your diagnosis based on most current evidence
- You will be provided educational materials and directed to online resources
- You will have access to the CancerCARE program throughout your entire cancer treatment for questions or concerns as long as eligible

ParetoHealth

Employee Benefits



eHealth: Your guide to finding COBRA-alternative health insurance coverage

CUSTOM HEALTH INSURANCE EXCHANGE

Find your solution:

eHealth®

Visit our custom Health Insurance Exchange:

https://www.ehealthinsurance.com/pareto

shop

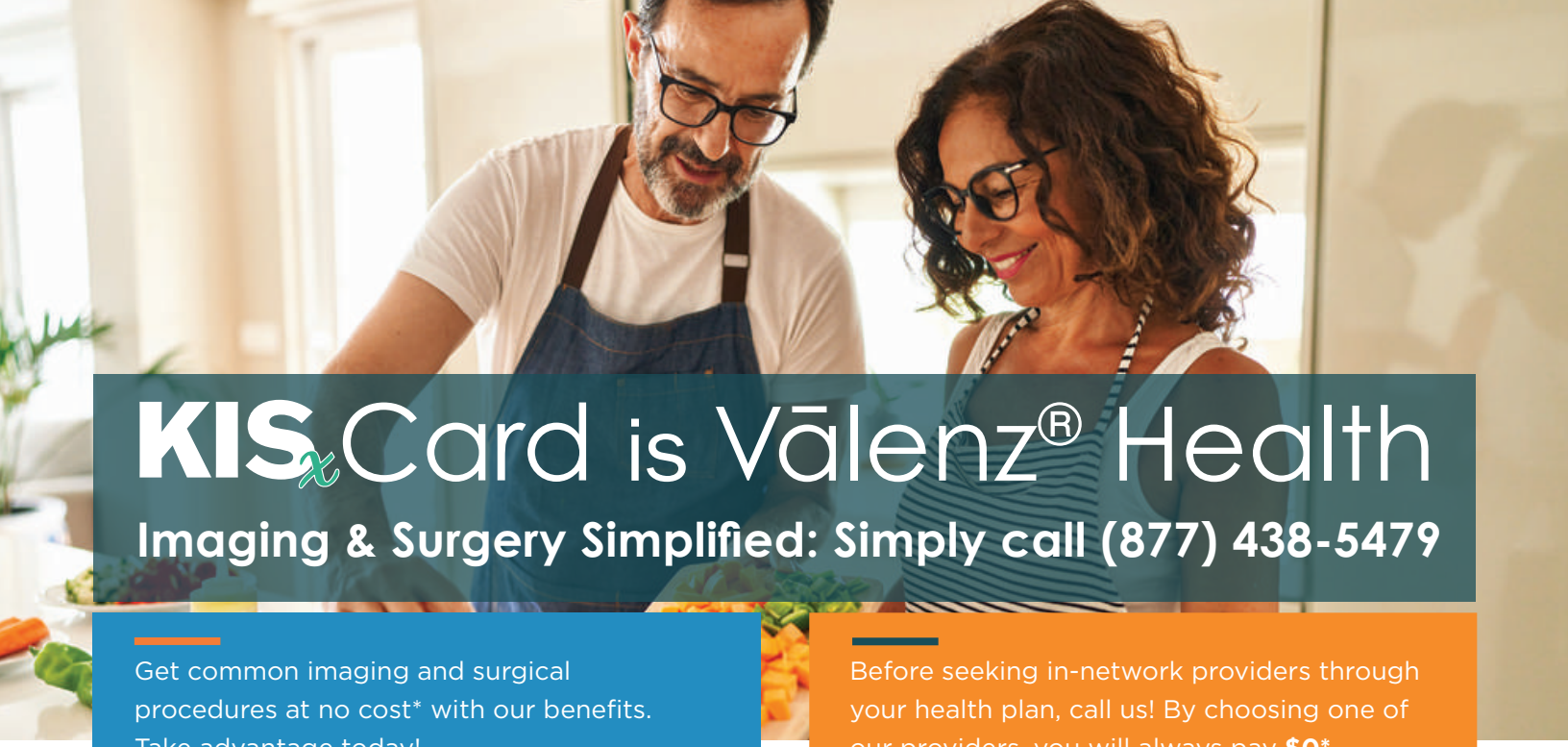
compare

enroll

eHealth Insurance makes it easier to find affordable, quality health insurance coverage-often at a lower cost than what you pay for COBRA coverage. Search their online Health Insurance Exchange to explore your options today!

To begin shopping, visit **https://www.ehealthinsurance.com/pareto**. From there, you can compare plans and enroll in whatever plan best meets your needs. Need assistance? No problem. eHealth's experienced agents are ready to help! Use the online chat or give us a call at 844-744-0647





KISx Card is Vālenz® Health

Imaging & Surgery Simplified: Simply call (877) 438-5479

Get common imaging and surgical procedures at no cost* with our benefits. Take advantage today!

Before seeking in-network providers through your health plan, call us! By choosing one of our providers, you will always pay **$0***.

Common Procedures:

- Ankle & Foot
- Arthroscopy
- Colonoscopy
- ENT
- Elbow
- Gastroenterology
- General Surgery
- Hernia Repair
- Hip
- Imaging
- Knee
- Shoulder
- Spine
- Urology
- Wrist & Hand
- And More



*HSA Plans require first dollar coverage from patient before procedure up to IRS Minimum, before program incentives are received.

SmartConnect
POWERED BY SMARTMATCH

ParetoHealth

Give us a call at:
(855) 248-1648

MEDICARE WHILE WORKING: *WHAT YOU NEED TO KNOW*

Many individuals work past age 65, and understanding how Medicare compares to employer-sponsored health insurance can be complex. You may wonder if you need to enroll in Medicare if you have job-based coverage or if Medicare is more cost-effective.

Through individualized guidance, our agents will help you navigate:

- Medicare Basics
- Health Savings Accounts (HSAs) and Medicare
- Medicare Enrollment Timing and Avoiding Penalties
- Secondary Medicare Coverage Options

HOW DOES IT WORK?

First, your SmartConnect agent will get to know you and your specific healthcare needs

Then, they will compare your current coverage to a variety of Medicare plans in your area

Finally, if you find a plan you like, they can help you enroll right away

SCAN ME

(855) 248-1648

smartconnectplan.com/schedule

Getting Started with SmithRx: What to Expect

As you get prepared to use your SmithRx benefits, here's what to you need to know:

Show Your New ID Card at the Pharmacy: You will receive a new pharmacy benefits ID card in the mail. Once your plan is active, present this card to your pharmacy on your first visit to make sure you're charged correctly for your prescriptions.

Medication or Plan Changes: If any changes are required for your current prescriptions to maintain coverage, you will receive a letter in the mail detailing the update and next steps.

Seamless Access: SmithRx partners with over 56,000 retail pharmacies nationwide—including CVS, Walgreens, Walmart and Costco, plus regional chains and local pharmacies. This broad network means you can likely keep using your preferred retail pharmacy.

SmithRx Member Portal and Mobile App

Easily access your pharmacy benefits anytime, anywhere with the SmithRx Member Portal and Mobile app.

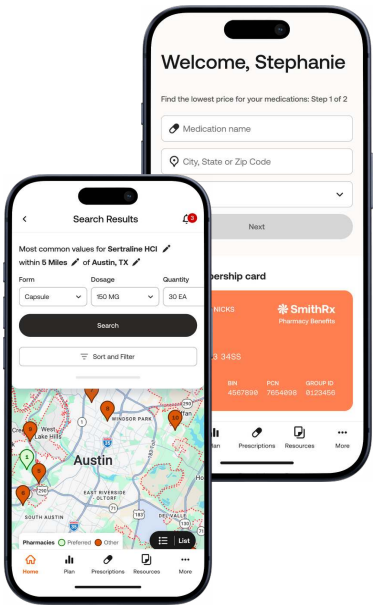
Key Features:

Digital ID Card: Access a digital copy of your SmithRx Member ID Card whenever you need it.

Prior Authorization Tracking: Monitor the status of prior authorization requests in real-time.

Coverage Details: View your plan information, prescription history, and track spending against your out-of-pocket maximum and deductible.

Find My Meds: Enter your prescription details to find the lowest-cost pharmacy and low-cost alternative medications (if available).



Getting Started

To create your account, visit **member.mysmithrx.com** (or scan the QR code). Alternatively, download the **SmithRx Mobile app** from the Apple App Store or Google Play.

At the login screen, enter your email address and select **"Create your account."** Follow the instructions to complete your registration.

SmithRx Drug Pathways

Connecting Members with the lowest-cost medication options

We work behind the scenes to find prescriptions that may be eligible for savings through **SmithRx Drug Pathways**. Each Pathway is designed to connect eligible members to the lowest-cost option for their medications.

How We Connect You With Savings

If you have a prescription eligible for savings, a Connect Team **Patient Advocate** will reach out to you via phone, text, email and a notification in your Member Portal. They will explain your savings options and guide you every step of the way.

How Pathways Can Work

Below are some examples of how SmithRx Drug Pathways can translate to real savings*.

Penny Cillin refills the generic version of her high-cost Multiple Sclerosis medication through Cost Plus Drugs. **Her copay is reduced to $0 per fill.**

Phil Script pays a standard copay for his medication at a retail pharmacy. After enrolling in the Access Pathway, he can choose a reduced copay at the same pharmacy, or switch to Costco Mail Order Pharmacy for a **$0 copay** per fill.

*The *savings available are based on your plan design.*

Mail Order & Specialty Pharmacy Partners

Because SmithRx does not own any pharmacies, our only priority is finding you the absolute lowest price. To ensure you maximize your savings, you may be directed to fill certain prescriptions through a specific partner to unlock the lowest-cost.

Mail Order Pharmacy Partners

Costco Mail Order Pharmacy	Amazon Pharmacy	Cost Plus Drugs Pharmacy
Get Started: rx.costco.com	Get Started: amazon.com/smithrx	Get Started: Costplusdrugs.com
Support: (800) 607-6861	Support: Online Chat	Support: (833) 926-3384

Specialty Pharmacy Partners

Costco Specialty Pharmacy

To enroll, call: (855) 213-0070

Senderra Specialty Pharmacy:

To enroll, call: (888) 777-5547

SmithRx Member Support

Member Support Team

The SmithRx Member Support team is dedicated to ensuring you understand your plan and can access your medications with ease.

If you ever experience trouble picking up your medication at the pharmacy, call Member Services **while you are there.** Many issues can be resolved in real-time so you can walk away with your medication.

SMITHRX MEMBER SUPPORT

Chat
On our website or in the member portal

Email
help@smithrx.com

Phone
(844)454-5201

Live Support Hours: Monday through Friday, 8 am - 9 pm ET and Saturdays 9 am - 7 pm ET.

Connect Team

The Patient Advocates on the Connect Team are dedicated to helping members unlock the prescription savings available through Drug Pathways.

SMITHRX CONNECT TEAM SUPPORT

Email
connect@smithrx.com

Phone
(844) 385-7612

Live Support Hours: Monday through Friday, 8 am - 8 pm ET and Saturdays 10 am - 3 pm ET.

Frequently Asked Questions

What is a formulary?

A formulary is a list of brand-name and generic medications that are covered by your benefit plan. Formularies vary by plan. SmithRx regularly reviews this list based on clinical guidelines, safety, effectiveness, and cost. Being on the formulary doesn't guarantee coverage, and the list may change over time.

How do I know if my medication is covered?

You can access a list of covered drugs (ie: the formulary) through the SmithRx Member Portal or Mobile App.

- **Formulary Look-up Tool:** Search your medication to verify coverage requirements, find low-cost alternatives or view copay tiers.
- **Find My Meds:** Enter your prescription details to find the lowest-cost pharmacy for your medication and estimated out-of-pocket cost, based on your plan.

Please note that your plan benefits may also have coverage restrictions that may not be represented on the drug formulary.

What if my medication is not in the formulary?

The formulary lists medications in many therapeutic areas. If your medication is not covered, there may be a lower cost alternative available. If you have explored all other alternatives, your doctor may be able to seek an exception based on medical necessity. Please contact SmithRx Member Support to assist with finding alternatives if your medication is not listed in the formulary.

My medication needs prior authorization. What does this mean?

A prior authorization (PA) is a review your plan requires for certain medications. If a PA is required, your doctor will submit the request to SmithRx—no action is usually required from you.

How long does a PA approval take?

On average, non-urgent requests are processed within 5 days, but may take up to 15 days. Urgent requests are processed under 3 business days, but can take as little as 24 hours

How will I know if my PA request was approved or denied?

- **Status Updates:** You can view the status of your prior authorization requests in the SmithRx Member Portal or Mobile App. Be sure to update your SmithRx account profile

with your preferred notification preferences (email or text). You will be notified of updates based on your contact information.

- **Final Decision:** You will receive a letter in the mail with the decision (approved or denied). You will also receive an email or text notification, based on the contact information and preferences we have on file.

National Chain Pharmacy Listing

Below is a list of national pharmacy chains that participate in the SmithRx pharmacy network. Many additional independent pharmacies across the United States also participate in our network.There are 75,000+ pharmacies in our network.

This list is subject to change. To determine if a pharmacy is currently in our network, please call SmithRx at (844) 454-5201.

Albertsons
Bartell Drugs
Bashas' United Drug
Baylor Scott and White Pharmacy
Bi-Mart Pharmacy
Brookshire Pharmacy
City Market
Costco Pharmacy
Cub Pharmacy
CVS Pharmacy
Dierberg Pharmacy
Dillon Pharmacy
Duane Reade
Fairview Pharmacy
Food City Pharmacy
Food Lion Pharmacy
Fred Meyer Pharmacy
Fred's Pharmacy
Fry's Food and Drug
Giant Eagle Pharmacy
Giant Pharmacy
Hannaford Food and Drug
Harps Pharmacy
Harveys Supermarket
H-E-B Grocery
Henry Ford Medical Center Pharmacy
Homeland Pharmacy
Hy-Vee
Ingles Markets Pharmacy
King Soopers Pharmacy
Kinney Drugs
Knight Drugs
Kroger Pharmacy
Maxor Pharmacy
Medicap Pharmacy
Medicine Shoppe Pharmacy
Navarro Discount Pharmacy
Pick N Save Pharmacy
Pillpack
Publix Super Market
Quality Food Center
Ralphs Pharmacy
Recept Pharmacy
Rite Aid Pharmacy
Safeway Pharmacy
Save Mart
Sav-Mor
Schnuck Market
Shoprite Pharmacy
Smith's Pharmacy
Stop & Shop Pharmacy
Target
Thrifty Drug Store
Tom Thumb Pharmacy
U Save It
Vons Pharmacy
Walgreens
Walmart
Wegman Food Market
Winn Dixie

SmithRx Connect

Connecting you to the lowest cost prescription solutions

SmithRx can help lower your drug costs

Did you know your local retail pharmacy may not always be the lowest cost option?
SmithRx Connect can help you navigate alternative sources and supports you throughout the process. We'll do the work so you can stay healthy and happy.



Patient Assistance Programs

Many high cost specialty medications can be accessed through Patient Assistance Programs. SmithRx will help you navigate through the process while you reduce out of pocket costs on the medications that work for you.

CoPay Coupon Maximization

Did you know it's possible to leverage additional savings on traditional branded medications? If Patient Assistance is not available, our team will work with preferred pharmacy partners to capture coupon savings through our Copay Max program.

International Sourcing

Our contracted network of international pharmacies helps members obtain medications at a lower cost. The international network dispenses select medications from first-tier countries to ensure product purity and safety. If you are using a medication that qualifies, our team can work with you on the potential to source your medication internationally.

We are here to help

The SmithRx Member Support Team is dedicated to connecting you with the tools and resources needed to lower your out of pocket costs for medications. We can answer your questions and support you throughout the process. Our goal is to simplify your pharmacy benefits and connect your savings on your prescriptions.

SmithRx Connect - Access Plus
Patient Assistance Program

Here is a list of frequently asked questions members have regarding SmithRx's Access Plus program. If you still have questions after reviewing this document or would like to speak to someone regarding your individual situation, please reach out to SmithRx by calling 1-844-385-7612 or emailing connect@smithrx.com.

What is Access Plus and how was it designed?

Many high-cost specialty medications can be accessed through advocacy foundations and grant programs when a medication is not covered under the pharmacy benefit. SmithRx assists in navigating the patient assistance landscape to obtain medication coverage. Our dedicated member support specialists will assist you in navigating and applying to these different programs.

What are the benefits of the program?

If you qualify for Access Plus programs, you will be able to receive your medication at no cost to you or your employer.

How will I know that my medication is a part of the Access Plus program?

If you are taking medications that qualify for the Access Plus program you will receive communication from our support specialists via phone or email. It is important that you engage with them and provide them the information they request.

Is there any way to "opt out" of the program?

No. It is considered part of the plan benefit design and thus subject to program requirements for continued coverage under the plan.

Do I still need to go through the program if I already pay $0 for my medication?

Yes. Many members currently utilize copay coupon cards that help bring down their out-of-pocket costs, but the employer still pays the remainder of the cost. If you meet the qualifications of the Access Plus programs, you can receive your medication at no cost to you or your employer

What steps do I need to take if my medication qualifies for Access Plus?

1. You will be contacted by our support specialist to begin the enrollment process.
2. You will need to electronically sign an authorization form that allows our specialist to act on your behalf for the sole purpose of applying for these grant programs.
3. Some applications may require additional documentation (i.e., tax return, medical expense summary). You will be asked to submit this documentation to us via secure encrypted email.
4. Some applications may require us to work with your doctor. If that is the case, we may ask you to contact your doctor to request that they submit the required forms.
5. It's important that you work with us throughout this process to ensure timely approval of your application and prevent any delays in your medical treatment.

If approved, how much will I need to pay for my medications?

If approved, the medication will be shipped to you free of charge.

What if my application is denied?

If denied but your medication is covered on the formulary,you can continue to get your medication through the pharmacy benefit as usual. Please contact the SmithRxmember support team at (844) 385-7612 for further information.

Dental Insurance

Sun Life

COMMONLY COVERED

- Exams and cleanings
- X-rays
- Fillings
- Tooth extractions
- Child braces

PROTECTS YOUR SMILE.
You can feel more confident with dental insurance that encourages routine cleanings and checkups. Dental insurance helps protect your teeth for a lifetime.

PREVENTS OTHER HEALTH ISSUES.
Just annual preventive care alone can help prevent other health issues such as heart disease and diabetes. Many plans cover preventive services at or near 100% to make it easy for you to use your dental benefits.

LOWERS OUT-OF-POCKET EXPENSES.
Seeing an in-network dentist can reduce your fees approximately 30% from their standard fees. Add the benefits of your coinsurance to that and things are looking good for your wallet.

DENTAL FAST FACTS

Treating the inflammation from periodontal disease can help manage other health problems such as heart disease and diabetes.[1]

50% of adults over the age of 30 are suffering from periodontal disease.[2]

MARKOVITZ ENTERPRISES, INC.

All Eligible Employees

POLICY # 953178

Sun Life Assurance Company of Canada

2733471 DEN10 CL1 09/30/2025 16:26:36

Good news! *Your plan covers routine services like cleanings and exams at* ***100%.***

CALENDAR YEAR MAXIMUM	IN-NETWORK	OUT-OF-NETWORK
Type I, II, III (Preventive, Basic and Major Services)	$2,000 per person (includes Preventive Rewards)	$2,000 per person (includes Preventive Rewards)
Type IV Ortho Service	$1,000 lifetime per child	$1,000 lifetime per child

CALENDAR YEAR DEDUCTIBLE

PROCEDURE	IN-NETWORK	OUT-OF-NETWORK
Type I Preventive Services	N/A	N/A
Type II, III (Basic and Major Services)	$50 individual/$150 family	$50 individual/$150 family
Type IV Ortho Services	N/A	N/A

THE PLAN PAYS THE FOLLOWING PERCENTAGE FOR PROCEDURES

PROCEDURE	IN-NETWORK	OUT-OF-NETWORK
Type I Preventive Services	100%	100%
Type II Basic Services	80%	80%
Type III Major Services	50%	50%
Type IV Ortho Services	50%	50%

SERVICES

Type I Preventive Dental Services, including:

- Oral evaluations – 1 in any 6 month period
- Routine dental cleanings – 1 in any 6 month period (frequency combined with periodontal maintenance)
- Fluoride treatment – 1 in any 6 month period. *Only for children under age 19*
- Sealants – no more than 1 per tooth in any 36 month period, only for permanent molar teeth. Only for children under age 14
- Bitewing x-rays – 1 in any 12 month period
- Intraoral complete series x-rays – 1 in any 60 month period
- Minor gum disease (non-surgical periodontics)
- Scaling and root planing – 1 in any 24 month period per area
- Periodontal maintenance – 1 time in 3 consecutive months, frequency combined with routine dental cleanings and limited to 4 in any 12 consecutive months
- Genetic test for susceptibility to oral diseases

Type II Basic Dental Services, including:

- New fillings
- Space maintainers – *only for children under age 19*
- Simple extractions, incision and drainage
- Surgical extractions of erupted teeth, impacted teeth, or exposed root
- Biopsy (including brush biopsy)
- Endodontics (includes root canal therapy) – 1 per tooth in any 24 month period
- General anesthesia/IV sedation – medically required
- Localized delivery of antimicrobial agents
- Major gum disease (surgical periodontics)

Type III Major Dental Services, including:

- Dentures and bridges – subject to 5 year replacement limit
- Stainless steel crowns– *only for children under age 19*
- Inlay, onlay, and crown restorations – 1 per tooth in any 5 year period

Type IV Ortho Services, including:

- Orthodontic treatment is limited to your dependent children

Waiting Periods

For a complete description of services and waiting periods, please review your certificate of insurance. If you were covered under your employer's prior plan the wait will be waived for any type of service covered under the prior plan and this plan.

- No waiting period for preventive, basic, or major services
- No waiting period for orthodontic services

Frequently asked questions

How does a PPO work?
PPO stands for Participating Provider Organization. With a dental PPO plan, dental providers agree to participate in a dental network by offering discounted fees on most dental procedures. When you visit a provider in the network, you could see lower out-of-pocket costs because providers in the network agree to these pre-negotiated discounted fees on eligible claims.

How do I find a dentist?
Simply visit www.sunlife.com/findadentist. Follow the prompts to find a dentist in your area who participates in the PPO network. You do not need to select a dentist in advance. The PPO network for your plan is the Sun Life Dental Network® with 130,000+ unique dentists[3].

Do I have to choose a dentist in the PPO network?
No. You can visit any licensed dentist for services. However, you could see lower out-of-pockets costs when you visit a dentist in the network.

Are my dependents eligible for coverage?
Yes. Your plan offers coverage for your spouse[4] and dependent children. An eligible child is defined as a child to age 26.[5]

What if I have already started dental work, like a root canal or braces, that requires several visits?
Your coverage with us may handle these procedures differently than your prior plan. To ensure a smooth transition for work in progress, call our dental claims experts before your next visit at 800-442-7742.

Do I have to file the claim?
Many dentists will file claims for you. If a dentist will not file your claim, simply ask your dentist to complete a standard American Dental Association (ADA) claim form and mail it to:

Sun Life
PO Box 311
Milwaukee, WI 53201-0311

How can I get more information about my coverage or find my dental ID card?
After the effective date of your coverage, you can view benefit information online at your convenience through your Sun Life account. To create an account go to www.sunlife.com/account and register. You can also access this information from our mobile app, which is available for Apple and Android devices. Or you can call Sun Life's Dental Customer Service at 800-442-7742. You can also call any time, day or night, to access our automated system and get answers to common questions when it's convenient for you.

What value added benefits does my plan include?
Your plan includes our Lifetime of Smiles® program, with benefits many people prefer, such as up to four periodontal cleanings in a year[6,7] and brush biopsies for the early detection of oral cancer.

Your plan also includes Preventive Rewards so you can get up to $1500 added to your annual maximum for the next year. The amount added is based on your paid claims for preventive services during the prior year.

CONSIDER A PRE-DETERMINATION OF BENEFITS

They allow us to review your provider's treatment plan to let you know before treatment is started how much of the work should be covered by the plan, and how much you may need to cover. We recommend them for any dental treatment expected to exceed $500.

1. American Academy of Periodontology https://www.perio.org/consumer/gum-disease-and-other-diseases (accessed 07/21).
2. American Academy of Periodontology https://www.perio.org/newsroom/periodontal-disease-fact-sheet (accessed 07/21).
3. Zelis Network Analytics data as of January 2022 and based on unique dentist count. Sun Life's dental networks include its affiliate, Dental Health Alliance, L.L.C.® (DHA), and dentists under access arrangements with other dental networks. Nationwide counts are state level totals.
4. If permitted by the Employer's employee benefit plan and not prohibited by state law, the term "spouse" in this benefit includes any individual who is either recognized as a spouse, a registered domestic partner, or a partner in a civil union, or otherwise accorded the same rights as a spouse.
5. Please see your employer for more specific information.
6. Classification of services varies by plan design.
7. Total number of combined prophylaxis cleaning and periodontal maintenance procedures cannot exceed 4 in a 12 month period.

Read the *Important information* section for more details including limitations and exclusions

Benefit adjustments

Benefits will be coordinated with any other dental coverage. Under the Alternative Treatment provision, benefits will be payable for the most economical services or supplies meeting broadly accepted standards of dental care.

Late entrant

If you or a dependent apply for dental insurance more than 31 days after you become eligible, you or your dependent are a late entrant. The benefits for the first 12 months for late entrants will be limited as follows:

TIME INSURED CONTINUOUSLY UNDER THE POLICY	BENEFITS PROVIDED FOR ONLY THESE SERVICES
Less than 12 months	Preventive and Basic Services
At least 12 months	Preventive, Basic, Major and Ortho Services

We will not pay for treatments subject to the late entrant limitation, and started or completed during the late entrant limitation period.

To become insured, you must meet the eligibility requirements set forth by your employer. Your coverage effective date will be determined by the Policy and may be delayed if you are not actively at work on the date your coverage would otherwise go into effect. Similarly, dependent coverage, if offered, may be delayed if your dependents are in the hospital (except for newborns) on the date coverage would otherwise become effective. Refer to your Certificate for details.

Limitations and exclusions

Exclusions and limitations may vary by state law and regulations. This list may not be comprehensive. Please see your Certificate or ask your benefits administrator for details.

Dental

We will not pay a benefit for any Dental procedure, which is not listed as a covered dental expense. Any dental service incurred prior to the Effective date or after the termination date is not covered, unless specifically listed in the certificate. A member must be a covered dental member under the Plan to receive dental benefits. The Plan has frequency limitations on certain preventive and diagnostic services, restorations (fillings), periodontal services, endodontic services, and replacement of dentures, bridges and crowns. All services must be necessary and provided according to acceptable dental treatment standards. Treatment performed outside the United States is not covered, except for emergency dental treatment, subject to a maximum benefit.

This Overview is preliminary to the issuance of the Policy. Refer to your Certificate for details. Receipt of this Overview does not constitute approval of coverage under the Policy. In the event of a discrepancy between this Overview, the Certificate and the Policy, the terms of the Policy will govern. Product offerings may not be available in all states and may vary depending on state laws and regulations.

This plan does not provide coverage for pediatric oral health services that satisfies the requirements for "minimum essential coverage" as defined by The Patient Protection and Affordable Care Act (PPACA).

Sun Life companies include Sun Life and Health Insurance Company (U.S.) and Sun Life Assurance Company of Canada (collectively, "Sun Life").

Group insurance policies are underwritten by Sun Life Assurance Company of Canada (Wellesley Hills, MA) in all states, except New York, under Policy Form Series 15-GP-01 and 16-DEN-C-01.

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GVBH-EE-8384 SLPC 29579

Sun Life®

Why create a Sun Life account?

Below are the different ways you can use your Sun Life account.



1. **It's the easiest way to submit your claim!**
2. **Upload claim documents** directly to your account—making it the fastest way to get your information to us.
3. **View your claim status, payment information,** and other important information about your claim in one spot.
4. **Report your return to work date** as well as time if you need to take an intermittent leave.
5. **Apply for Evidence of Insurability.** Our site leads you step by step through the process.
6. **Access Employee Assistance Program (EAP)** resources, **benefits information** and more.
7. **It's mobile friendly,** so you can do everything right from your smartphone or tablet!

Have Dental with us?

You can find your most recent dental visit history, view and print your personalized dental ID card, and search for an in-network dental provider.

Register for an account today at www.sunlife.com/createaccount

For more information or to register by phone, call 800-247-6875, Monday through Friday from 8 a.m. to 8 p.m. ET.

Group insurance policies are underwritten by Sun Life Assurance Company of Canada (Wellesley Hills, MA) in all states, except New York. In New York, group insurance policies are underwritten by Sun Life and Health Insurance Company (U.S.) (Lansing, MI).

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WFL-10712-i (11/23)

Tips for using your dental plan

Your dentist office will want to know that you are a Sun Life plan member at your next visit. Simply share a copy of your new dental ID card with them. You can access a copy of your dental ID card through your Sun Life account. Quick references to register and access your account are included on this page. Please note that printed dental ID cards are not provided and/or mailed to your home.

Check out our short video for step-by-step instructions on downloading your dental ID card at sunlife.com/dentalIDCard.

Online services

Your mobile-responsive Sun Life account gives you access to everything you need to know about your dental plan, including your dental ID card, benefit schedule and more. To complete your registration, you will need your social security number or member ID, and date of birth. Register today at sunlife.com/account.

Sun Life Dental (U.S.) mobile app

Our mobile app lets you access benefit information, including your dental ID card and find a dentist, on the go! Available for iOS and Android devices, find the app at sunlife.com/mobileapps.

24/7 virtual dental visits

Sun Life PPO dental members[1] have access to dental visits through teledentistry.com/sunlife.[2]

Find a dentist

If your plan leverages one of our networks, you can easily search for a dentist online. Your network is listed on the back of your dental ID card. To find a participating dentist, visit sunlife.com/findadentist.

Is your dentist not in our network? Nominate your dentist at sunlife.com/findadentist!

Dental Health Center

Get the most from your dental plan by visiting our Dental Health Center. Learn more about dental treatments, average costs, and you can even pose questions through ask-a-dentist. Take control of your dental health at sunlife.com/dentalhealthcenter.



We look forward to providing you and your family with dental benefits and great service!

1. Teledentistry.com services are only available to members covered under dental PPO plans issued or administered by Sun Life Assurance Company of Canada or, in New York, dental PPO plans issued or administered by Sun Life and Health Insurance Company (U.S.) who have access to the Sun Life Dental Network, Sun Life Focus Dental Network, Assurant Dental Network or Assurant Focus Dental Network. Members covered under a prepaid or indemnity plan are not eligible for services through Teledentistry.com. 2. Only available where permitted by applicable law. Teledentistry services may not be available in all states. A TeleDentistry.com consultation may count as a problem-focused exam (D0140) under your dental plan. Plans contain limitations and exclusions. Coverage for exams may be subject to frequency limitations. Please review your applicable coverage.

This dental plan does not provide coverage for pediatric oral health services that satisfies the requirements for "minimum essential coverage" as defined by the Patient Protection and Affordable Care Act. ("PPACA").

Group insurance policies are underwritten by Sun Life Assurance Company of Canada (SLOC) (Wellesley Hills, MA) in all states, except New York. Prepaid dental products are provided and administered by SLOC, and are provided by prepaid dental companies, affiliated with SLOC, in certain states except New York. Prepaid dental companies are Denticare of Alabama, Inc., United Dental Care of Arizona, Inc., UDC Dental California, Inc., United Dental Care of Colorado, Inc., Union Security DentalCare of Georgia, Inc., United Dental Care of Missouri, Inc., Union Security DentalCare of New Jersey, Inc., United Dental Care of New Mexico, Inc., UDC Ohio, Inc., United Dental Care of Texas, Inc., and United Dental Care of Utah, Inc. In New York, insurance products and prepaid dental products are underwritten or provided and administered by Sun Life and Health Insurance Company (U.S.) (SLHIC) (Lansing, MI).

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GDFL-6866-NP-m (04/24)

Markovitz Enterprises

Insight network

SUMMARY OF BENEFITS

VISION CARE SERVICES	IN-NETWORK MEMBER COST AT PLUS PROVIDERS	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
EXAM SERVICES			
Exam	*$0 copay*	*$10 copay*	*Up to $40*
Retinal imaging	*Up to $39*	*Up to $39*	*Not covered*
CONTACTS LENS FIT AND FOLLOW-UP			
Fit and Follow-up - Standard	*Up to $40;*	*Up to $40;*	*Not covered*
Fit and Follow-up - Premium	*10% off retail price*	*10% off retail price*	*Not covered*
FRAME			
Frame	*$0 copay; 20% off balance over $200 allowance*	*$0 copay; 20% off balance over $150 allowance*	*Up to $105*
STANDARD PLASTIC LENSES			
Single Vision	*$25 copay*	*$25 copay*	*Up to $30*
Bifocal	*$25 copay*	*$25 copay*	*Up to $50*
Trifocal/Lenticular	*$25 copay*	*$25 copay*	*Up to $70*
Progressive - Standard	*$80 copay*	*$80 copay*	*Up to $50*
Progressive - Premium Tier 1 - 4	*$110 - 200 copay*	*$110 - 200 copay*	*Up to $50*
LENS OPTIONS			
Anti Reflective Coating - Standard	*$45 copay*	*$45 copay*	*Up to $5*
Anti Reflective Coating - Premium Tier 1 - 2	*$57 - 68*	*$57 - 68*	*Up to $5*
Anti Reflective Coating - Premium Tier 3	*$85 copay*	*$85 copay*	*Up to $5*
Photochromic - Non-Glass	*$75*	*$75*	*Not covered*
Polycarbonate - Standard	*$40*	*$40*	*Not covered*
Scratch Coating/Tint/UV Treatment	*$15*	*$15*	*Not covered*
All Other Lens Options	*20% off retail price*	*20% off retail price*	*Not covered*
CONTACT LENSES			
Contacts - Conventional	*$0 copay; 15% off balance over $200 allowance*	*$0 copay; 15% off balance over $150 allowance*	*Up to $150*
Contacts - Disposable	*$0 copay; 100% of balance over $200 allowance*	*$0 copay; 100% of balance over $150 allowance*	*Up to $150*
Contacts - Medically Necessary	*$0 copay; paid-in-full*	*$0 copay; paid-in-full*	*Up to $300*
ADDITIONAL GLASSES ALLOWANCE			
Glasses Allowance	*40% off retail*; 100% of balance over $100*	*40% off retail*; 100% of balance over $50*	*Up to $40*
OTHER			
Hearing Care from Amplifon Network	*Discounts on hearing aids; call 1.877.203.0675*	*Discounts on hearing aids; call 1.877.203.0675*	*Not covered*
Lasik or PRK from U.S. Laser Network	*15% off retail or 5% off promo price; call 1.800.988.4221*	*15% off retail or 5% off promo price; call 1.800.988.4221*	*Not covered*

FREQUENCY	ALLOWED FREQUENCY – ADULTS	ALLOWED FREQUENCY – KIDS
Exam	*once every calendar year*	*once every calendar year*
Frame	*once every calendar year*	*once every calendar year*
Lens	*once every calendar year*	*once every calendar year*
Contact Lens	*once every calendar year*	*once every calendar year*
Additional Glasses Allowance	*once every calendar year*	*once every calendar year*

Plan allows member to receive frame and lens services or contacts.

**Complete pair (frame & lens with or without lens options) purchase required to receive 40% discount. 20% discount applied if complete pair not purchased.*
Log into eyemed.com/member to see all plans included with your benefits. EyeMed reserves the right to make changes to the products available on each tier. All providers are not required to carry all brands on all tiers. For current listing of brands by tier, call 866-939-3633. No benefits will be paid for services or materials connected with or charges arising from: medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures; Refraction, when not provided as part of a Comprehensive Eye Examination; services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; any Vision Examination or any corrective Vision Materials required by a Policyholder as a condition of employment; safety eyewear; solutions, cleaning products or frame cases; non-prescription sunglasses plano (non-prescription)lenses; plano (non-prescription) contact lenses; two pair of glasses in lieu of bifocals; electronic vision devices; services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; or lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available. Fees charged by a Provider for services other than a covered benefit and any local, state or Federal taxes must be paid in full by the Insured Person to the Provider. Such fees, taxes or materials are not covered under the PolicySome provisions, benefits, exclusions or limitations listed herein may vary by state.Plan discounts cannot be combined with any other discounts or promotional offers. In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see online provider locator to determine which participating providers have agreed to the discounted rate. Underwritten by Fidelity Security Life Insurance Company® of Kansas City, Missouri, except in New York. Fidelity Security Life Policy number VC-146, form number M-9184. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer.

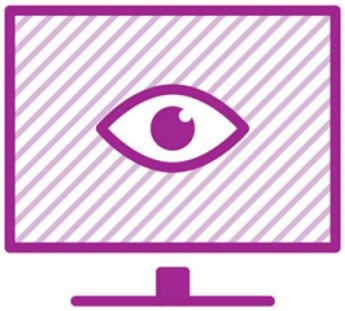
Savings plus convenience plus choice

PLUS Providers add another layer of coverage

Staying in-network helps you save money on eye exams, frames and lenses. Visiting a PLUS Provider is designed to help you save even more. And since PLUS Providers are already in our network, the additional perks are built right into your vision benefits.

No promo codes, no coupons, no paperwork. The same vision benefits, plus a little more savings.





The choice is yours

Find plenty of in-network eye doctors – including PLUS Providers – on our Provider Locator. Just look for the PLUS.

Need extra assistance? Contact us at 1.866.939.3633 or visit eyemed.com.

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION TARGET OPTICAL



Flores

HEALTH CARE

FLEXIBLE SPENDING ACCOUNT

THE HEALTH CARE FLEXIBLE SPENDING ACCOUNT (FSA) CAN REIMBURSE YOU FOR ELIGIBLE EXPENSES YOU OR YOUR ELIGIBLE DEPENDENTS INCUR THAT ARE NOT PAID BY YOUR EXISTING HEALTH CARE PLAN.

YOUR STEPS TO SAVINGS!

1 **REALIZE THE TAX SAVINGS**

You can set aside pre-tax money into an account to be reimbursed for eligible medical expenses. Savings will depend on your tax bracket. For example, if you are taxed at 25% and you enroll for $3,300 you would save $825 in taxes.

2 **ESTIMATE YOUR EXPENSES**

Plan for your upcoming expenses and include your spouse and dependents, if eligible. A brief list of expenses can be found to the right. A comprehensive list of allowable expenses and an expense worksheet can be found at www.flores247.com.

3 **ENROLL AND MANAGE YOUR ACCOUNT**

Contact your Human Resources Department to find out how to enroll for this benefit. Flores will send a custom Participant ID number via mail or email to help you manage your account. Contact information can be found on the back of this flyer.

ELIGIBLE EXPENSES

- Medical co-payments, co-insurance and deductibles
- Routine wellness visits
- Prescription expenses
- Vision expenses (including eye exams, eyeglasses and contact lenses)
- LASIK surgery
- Dental expenses (excluding cosmetic procedures)
- Orthodontia payments
- Hearing expenses
- Over-the-counter Medications
- Menstrual Care Items

HEALTH CARE FSA FAQs

FREQUENTLY ASKED QUESTIONS

HOW CAN I SUBMIT A CLAIM? Claims may be uploaded to your account on our participant Flores247 Web Portal, www.flores247.com, or using our Flores Mobile app. You may also submit your request for reimbursement via fax or mail, if you prefer. Please note that all claims must be received by the filing deadline for the applicable plan year in which your expenses were incurred.

WHAT MUST BE INCLUDED ON RECEIPTS? All receipts for reimbursement must include the following information: Date of service, Description of Service, Out-of-Pocket Cost, Provider Name, and Patient Name.

WILL I HAVE A DEBIT CARD? Possibly. If your plan offers the debit card, you can use your Flores Benefits Card at the point of purchase. Remember to keep all of your receipts in case they are requested for review.

DO I NEED TO RE-ENROLL IN THE HEALTH CARE FSA EACH YEAR? Yes, you must re-enroll with each new plan year. Elections do not rollover from year to year.

WHEN WILL I HAVE ACCESS TO THE FUNDS IN MY HEALTH CARE FSA? After your first Health Care FSA contribution to the plan, you will have access to the total amount you have elected for the plan year, regardless of the current balance in your flexible spending account.

CAN I SUBMIT MY SPOUSE'S / DEPENDENT'S MEDICAL EXPENSES TO MY HEALTH CARE FSA? Regardless of who is covered on your medical insurance, the Health Care FSA may reimburse expenses for your spouse or any qualifying tax or adult dependent.

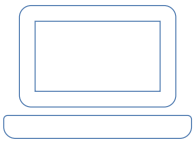
HOW WILL REIMBURSEMENTS BE ISSUED? Reimbursements will be mailed as a check to your home address. If you would like to have your reimbursement issued as a direct deposit, you may add your direct deposit information on the participant website (www.flores247.com) or submit a completed Direct Deposit Information Form. If your plan offers the debit card, you may use this card at the point of purchase to access your FSA dollars.

CAN I CHANGE MY ELECTION DURING THE PLAN YEAR? You may only change your annual election during the plan year if you experience a qualifying status change event. You must notify your employer within 30 days of any status change event in order to change your election. See the Allowable Status Changes Guide on our website (www.flores247.com) for further information.

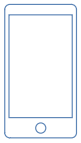
WHAT HAPPENS TO MY HEALTH CARE FSA IF I TERMINATE FROM THE COMPANY? Any expenses submitted for reimbursement must be incurred prior to your termination date or the benefit end date specified by your company. Claims must be submitted prior to the claims filing deadline for the plan year during which you terminated. In certain situations you may be eligible to continue your participation in the Health Care FSA through the election of COBRA. Please contact your Human Resource Department for further information.

WILL UNUSED FUNDS ROLLOVER TO THE NEXT YEAR? Possibly. If your employer has adopted the FSA carryover, any unused balance up to $660 that remains in your account as of the last day of the plan year will roll into the new plan year for you to be able to use towards eligible expenses you incur during the new plan year.

HOW DO I OBTAIN MY ACCOUNT DETAILS?



WEBSITE
Visit www.flores247.com and log in using Participant ID or User Name and password



MOBILE APP
Download our mobile app from your app store



PID & PASSWORD
ASSISTANCE
Dial 800.840.7684

HOW DO I SUBMIT DOCUMENTS TO FLORES?

ONLINE
Visit www.flores247.com and upload documents securely

MOBILE
Download Flores Mobile app Available for Apple or Android devices

MAIL
Flores & Associates, LLC
PO Box 31397
Charlotte, NC 28231

FAX
800.726.9982 or 704.335.0818

Revised 10/24

CUSTOMER SERVICE 1.800.532.3327

The content of this handout has been prepared by Flores & Associates, LLC for informational purposes only and does not constitute legal or tax advice. This information is an interpretation of selected portions of the Internal Revenue Code (IRC) as of 12/1/2018 and is subject to continual revisions.



DEPENDENT CARE

FLEXIBLE SPENDING ACCOUNT

THE DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA) CAN REIMBURSE YOU FOR DAY CARE EXPENSES PROVIDED FOR YOUR DEPENDENTS SO THAT YOU (AND YOUR SPOUSE, IF YOU ARE MARRIED) CAN WORK. CARE MUST BE FOR A DEPENDENT CHILD UNDER AGE 13 OR A DEPENDENT OF ANY AGE THAT LIVES IN YOUR HOUSEHOLD THAT IS INCAPABLE OF SELF-CARE.

YOUR STEPS TO SAVINGS!

1 **REALIZE THE TAX SAVINGS**

You can set aside pre-tax money into an account to be reimbursed for eligible dependent childcare expenses. Savings will depend on your tax bracket. For example, if you are taxed at 25% and you enroll for $5,000 you would save $1,250 in taxes.

2 **ESTIMATE YOUR EXPENSES**

Plan for your upcoming expenses. A brief list of expenses can be found to the right. A comprehensive list of allowable expenses and an expense worksheet can be found at www.flores247.com.

3 **ENROLL AND MANAGE YOUR ACCOUNT**

Contact your Human Resource Department to find out how to enroll for this benefit. Flores will mail a custom Participant ID number to your home address to help you manage your account. Contact information can be found on the back of this flyer.

ELIGIBLE EXPENSES

- Preschools
- Before and after school care
- Day camps

INELIGIBLE EXPENSES

- Overnight camps
- Tuition / kindergarten & educational expenses
- Regular fees not applied to care of child

DEPENDENT CARE FAQs

FREQUENTLY ASKED QUESTIONS

HOW CAN I SUBMIT A CLAIM?

Claims may be uploaded to your account on our participant website, www.flores247.com, or using our Flores Mobile app. You may also submit your request for reimbursement via fax or mail, if you prefer. Please note that all claims must be received by the filing deadline for the applicable plan year in which your expenses were incurred.

HOW WILL REIMBURSEMENTS BE ISSUED?

Reimbursements will be mailed as a check to your home address. If you would like to have your reimbursement issued as a direct deposit, you may add your direct deposit information on the participant website (www.flores247.com) or submit a completed Direct Deposit Information Form.

WILL I HAVE A DEBIT CARD?

No, there is no debit card associated with the Dependent Care FSA. To obtain reimbursement, you will file a claim at www.flores247.com. Enroll in our e-Status alerts at www.flores247.com to receive claim and reimbursement confirmations via email or text.

DO I NEED TO RE-ENROLL IN THE DEPENDENT CARE FSA?

Yes, you must re-enroll with each new plan year. Elections do not rollover from year to year.

WHAT EXPENSES ARE ELIGIBLE TO BE REIMBURSED FROM THE DEPENDENT CARE FSA?

Your Dependent Care FSA can reimburse you for day care expenses provided for your dependent that allow you (and your spouse, if applicable) to work. Care must be for a dependent child under the age of 13, or a dependent of any age that lives in your household and is incapable of self-care. See the Allowable Dependent Care Expenses Guide on our website (www.flores247.com) for further information.

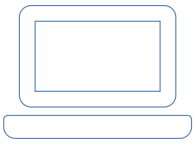
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You may only change your annual election during the plan year if you have a qualifying status change event. You must notify your employer within 30 days of any status change event in order to change your election. See the Allowable Status Changes Guide on our website (www.flores247.com) for further information.

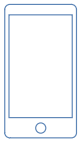
WHAT HAPPENS TO MY DEPENDENT CARE FSA IF I TERMINATE FROM THE COMPANY?

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MAIL
Flores & Associates, LLC
PO Box 31397
Charlotte, NC 28231

FAX
704.335.0818 or 800.726.9982

Revised 10/23

CUSTOMER SERVICE 1.800.532.3327

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Group Life Insurance

Summary of Coverage

Markovitz pays 100% of the cost for the Life insurance coverage. The Life benefit amount is based on class. The AD&D benefit matches the Life benefit amount. The age reduction benefit is reduced to 65% at age 65 and to 50% at age 70.

Life insurance isn't a fun thing to think about, but, if you have people who depend on you for financial support, then Life insurance is really about protecting them in case something happens to you. Your designated beneficiary would collect a financial benefit upon your death.

Group Life insurance coverage is an employer sponsored safety net incase the worst happens with no out-of-pocket costs to you.

This booklet provides only a summary of your benefits. All services described within are subject to the definitions, limitations and exclusions set forth in each insurance carrier's or provider's contract.



Disability Insurance Short-term

Summary of Coverage

Markovitz is paying 100% of the cost for Short-term disability. Please see your HR department to find out what your Short-term Disability benefit is.

Disability insurance is coverage that provides you with income protection should you be unable to work due to an injury or illness. With disability coverage, you are compensated for a portion of your lost income.

Short-term disability (STD) coverage begins within so many days of the event causing your disability. The coverage allows you to continue to receive pay at a fixed weekly amount or a set percentage of your income.

This booklet provides only a summary of your benefits. All services described within are subject to the defini ons, limita ons and exclusions set forth in each insurance carrier's or provider's contract.

Accident Insurance

You can purchase this coverage for you and your family. Child coverage is available to age 26.

HELPS YOUR FINANCES AFTER A MISHAP.
When you, your spouse or child has a covered accident, like a fall from a bicycle that requires medical attention, you can receive cash benefits to help cover the unexpected costs.

HELPS COVER RELATED EXPENSES.
While health plans may cover direct costs associated with an accident, you can use accident benefits to help cover related expenses like lost income, child care, deductibles and co-pays.

PAYS CASH BENEFITS DIRECTLY TO YOU.
Accident Insurance can be used however you want, and it pays in addition to any other coverage you may already have. Benefits are payable directly to you. And get this – there are no health questions or pre-existing conditions limitations.

What's more, all family members on your plan are eligible for a wellness-screening benefit, also paid directly to you once each year per covered person.

ACCIDENT FAST FACTS

Falls
are the leading cause of injuries treated in emergency rooms every year, for people of all ages.[1]

This coverage pays benefits whether your covered accident happens at work, at home, or away (also known as 24-hour coverage).

What's covered

Once your coverage goes into effect, you can file a claim for covered accidents that occur after your insurance plan's effective date. Unless otherwise specified, benefits are payable only once for each covered accident, as applicable. The full list of benefits is listed here.

DISLOCATIONS	OPEN (SURGERY)	CLOSED (NO SURGERY)
Hip	$4,000	$2,000
Knee, ankle, or bones of the foot	$2,000	$1,000
Elbow, wrist or Lower jaw	$800	$400
Shoulder	$1,000	$500
Collarbone or bones of the hand	$1,600	$800
Finger(s) or toe(s)	$200	$100
FRACTURES	**OPEN (SURGERY)**	**CLOSED (NO SURGERY)**
Hip or thigh	$4,000	$2,000
Skull-depressed	$6,000	$3,000
Skull-simple	$3,000	$1,500
Vertebral processes, Bones of the face, Nose, Lower jaw, Collarbone, Shoulder, Forearm, Hand, Wrist, Foot, Ankle, Kneecap, Elbow or Heel	$700	$350
Leg	$2,000	$1,000
Vertebrae, Sternum or Pelvis	$1,600	$800
Upper jaw or upper arm	$800	$400
Rib, Finger, Toe or Coccyx	$400	$200
Multiple ribs	$1,000	$500
ADDITIONAL INJURIES		
Eye injury - surgical repair		$125
Eye injury - object remove		$125
Gunshot wound		$250
Paralysis—paraplegia		$12,500
Paralysis—quadriplegia		$25,000
Coma		$5,000
Concussion		$50
BURNS	**2ND DEGREE**	**3RD DEGREE**
20-40 square centimeters	$200	$500
41-65 square centimeters	$400	$1,000
66-160 square centimeters	$600	$3,000
161-225 square centimeters	$800	$7,000
More than 225 square centimeters	$1,000	$10,000
Skin graft	50% of the applicable Burn Benefit	
LACERATIONS		
No sutures and treated by doctor		$20
Single laceration under 5 cm with sutures		$35
5-15 cm with sutures (total of all lacerations)		$125
Greater than 15 cm with sutures (total of all lacerations)		$250

MEDICAL SERVICES	
Diagnostic Exam - Arteriogram, Angiogram, CT, CAT, EKG, EEG, or MRI (1 time per benefit year)	$100
Diagnostic Exam - X-ray (1 time per covered accident)	$50
Accident Emergency Treatment, non-emergency room (once per covered accident)	$100
Physician's Follow-up Treatment office visit (per visit, up to 6 times per covered accident)	$50
Physical Therapy (per visit up to 10 visits per covered accident)	$50
Medical Devices	$400
Epidural Pain Management (up to 2 times per covered accident)	$100
Prescription drug	$35
Prosthesis (one)	$250
Prosthesis (two)	$500
Blood, Plasma, or Platelet Transfusion	$100
HOSPITAL	
Hospital Admission (once per benefit year)	$750
Hospital Confinement (per day up to 365 days per covered accident)	$250
Intensive Care Unit Admission (once per Benefit Year; payable instead of Hospital Admission benefit if Confined immediately to ICU)	$2,500
Intensive Care Unit Confinement (per day up to 14 days, payable in addition to any Hospital Confinement benefit)	$300
Ambulance (Ground)	$300
Ambulance (Air)	$1,000
Emergency Room Admission	$150
Family Lodging (per day up to 30 days per benefit year)	$50
Transportation (100 or more miles up to 3 times per covered accident)	$250
Rehabilitation Unit (per day up to 30 days per covered accident)	$50
SURGERY	
Miscellaneous Surgery requiring general anesthesia (not covered by any other benefit)	$300
Open Surgery	$1,250
Exploratory Surgery or Debridement	$250
Tendon/Ligament/Rotator Cuff Tear	$500
Torn Knee Cartilage	$500
Ruptured/Herniated Disc	$500
EMERGENCY DENTAL	
Emergency Dental extraction	$30
Emergency Dental crown	$100
WELLNESS	
Wellness Screening Benefit (once per benefit year)	$50

LIFE AND DISMEMBERMENT LOSSES*	
Accidental Death	$25,000
Accidental Death Common Carrier (pays an additional benefit if accidental death occurs while traveling as a fare-paying passenger on a public conveyance)	$100,000
Catastrophic Loss: Both arms or both hands, both legs or both feet, one hand and one foot or one arm and one leg, or irrecoverable loss of sight of both eyes	$15,000
Loss of one hand, foot, leg, or arm	$7,500
Loss of sight of one eye or loss of one eye	$7,500
Two or more fingers or toes	$2,000
One finger or one toe	$1,000
Loss of hearing of one ear or loss of one ear	$2,500

*Benefits displayed for life and dismemberment are for the employee only. Spouse benefits are 100% of the employee benefit amount for death and 100% of the employee benefit amount for dismemberment. Dependent children benefits are 50% of the employee benefit amount for death and 50% of the employee benefit amount for dismemberment.

Frequently asked questions

How do I file an accident claim?

If you have an accident after the effective date of coverage, you can file a claim with us by downloading forms from our website. We'll ask that you and your doctor provide information about the accident and the treatment provided.

What happens once my claim is approved?

The benefit amount you receive will depend on your injury and/or the treatment provided. Remember, benefits are payable only once for each covered accident, unless noted otherwise in the benefit schedule.

Is there a time period that I need to follow?

Injuries and other related benefits due to a covered accident must be diagnosed or treated within a defined period of time from the date of your accident. This could be as few as three days for certain benefits. Please refer to your Certificate for details.

How do I get the Wellness Screening Benefit?

You may be paid the benefit when you or a covered family member submit proof of a covered screening each year, like specific blood tests and cancer screenings, cardiac stress tests, immunizations, school sports exams and more (may vary by state). Our wellness screening benefit claim form can also be downloaded from our website.

Can I take my insurance with me if I leave my employer?

Depending upon state variations and your employer's plan, you may have an option to continue group coverage when your employment terminates. Your employer can advise you about your options.

Is my benefit taxable?

If you or your employer pay for all or part of the cost of coverage on a pre-tax basis, some or all of your benefit amount will be tax reported on a Form 1099 as taxable income. Please reach out to a tax advisor or your employer if you have any questions.

Accident insurance is a limited benefit policy. The Certificate has exclusions that may affect any benefits payable. Benefits payable are subject to all terms and conditions of your Certificate.

1. "Health, United States, 2016," US Department of Health and Human Services, Table 75.

Read the *Important information* section for more details including limitations and exclusions.

Critical Illness Insurance

HELPS PROTECT YOUR FINANCES FROM AN ILLNESS.
When you, your spouse or child is diagnosed with a covered condition, you can receive a cash benefit to help pay unexpected costs not covered by your health plan.

HELPS COVER RELATED EXPENSES.
While health plans may cover direct costs associated with a critical illness, you can use your benefit to help with related expenses like lost income, child care, travel to and from treatment, deductibles and co-pays.

PAYS A CASH BENEFIT DIRECTLY TO YOU.
Critical Illness insurance can be used however you want, and it pays in addition to any other coverage you may already have.
What's more, all family members on your plan are eligible for a wellness-screening benefit, also paid directly to you once each year per covered person.

With Critical Illness Insurance, you also get access to health care support services. You can talk with medical and claims experts about your medical coverage, benefits, diagnosis and treatment options.

BENEFITS [You can purchase this coverage at a group rate.]	
For you	You can choose between **$10,000** and **$30,000** of coverage, in increments of $10,000. No medical questions asked.
For your spouse	If you elect coverage for yourself, you can choose between **$10,000** and **$30,000** of coverage, in increments of $10,000. No medical questions asked. Not to exceed 100% of your coverage amount.
For your child(ren)	If you elect coverage for yourself, you can choose between **$5,000** and **$20,000** of coverage, in increments of $5,000. No medical questions asked. Not to exceed 100% of your coverage amount. An eligible child is defined as your child from birth to age 26.

What's covered

Once your coverage goes into effect, you can file a claim for covered conditions diagnosed after your insurance plan's effective date. Below is the full list of conditions.

COVERED CONDITIONS – *The plan pays 100% of the benefit amount unless stated otherwise.*		
Core Conditions	Heart Attack[R] End-Stage Kidney Disease[R] Occupational HIV/Hepatitis B, C, or D Major Organ Failure[R]	Stroke[R] Coronary Artery Bypass Graft[R] (Pays 25%) Angioplasty[R] (Pays 5%)
Cancer Conditions	Invasive Cancer[R] Noninvasive Cancer[R] (Pays 25%) Skin Cancer[R] (Pays 5%)	
Other Conditions	Complete Blindness Complete Loss of Hearing Loss of Speech Benign Brain Tumor Coma	Severe Burns Advanced ALS/Lou Gehrig's Disease Advanced Parkinson's Disease (Pays 25%) Advanced Alzheimer's Disease (Pays 25%) Paralysis
Wellness Screening Benefit	Payable to any covered person on your plan one time each year, once you provide proof of an eligible health screening.	Employee $50 Spouse $50 Child $50

[R] = *Recurrence Benefit available*

When would I need the Recurrence Benefit?

Sometimes people are diagnosed with the same condition twice. If this happens to you, and 12 consecutive months have passed between the first and second diagnoses, we'll pay you an additional benefit (the amount of which is noted in your Certificate). Only the conditions marked (R) in the table above are eligible for the Recurrence Benefit. Once a Recurrence Benefit has been paid, no additional benefit will be paid for that critical illness.

Frequently asked questions

Do I need to answer any health questions to enroll?

If you contribute to the cost of your insurance, you may need to complete health questions if you don't elect coverage when it's first available to you and you want to elect at a later date, or if you want to increase coverage. To answer health questions, please fill out our Evidence of Insurability application. Health questions must be approved by Sun Life before coverage takes effect. Please see your Certificate for details.

What if I have a pre-existing condition?

If you are diagnosed with a covered critical illness within 12 months of your insurance taking effect or 12 months following any increase in your amount of insurance, we will not pay any benefit for any pre-existing condition. A pre-existing condition includes anything you have sought treatment for in the 3 months prior to your insurance becoming effective. Treatment can include consultation, advice, care, services or a prescription for drugs or medicine.

How do I file a critical illness claim?

If you have a diagnosis after the effective date of coverage, you can file a claim with us by downloading forms from our website. We'll ask that you and your doctor provide information about your medical condition.

How do I get the Wellness Screening Benefit?

You may be paid the benefit when you or a covered family member submit proof of a covered screening each year, like specific blood tests, cancer screenings, cardiac stress tests, immunizations, school sports exams and more (may vary by state). The claim form can also be downloaded from our website.

Can I receive benefits for more than one critical illness?

Yes. In order to receive benefits for more than one critical illness, there must be at least 6 consecutive months between each diagnosis date. You can only claim benefits once for each covered condition unless a recurrence benefit is payable.

How is my benefit taxed?

If you or your employer pay for all or part of the cost of coverage on a pre-tax basis, some or all of your benefit amount will be tax reported on a Form 1099 as taxable income. Please reach out to a tax advisor or your employer if you have any questions.

Can I take my insurance with me if I leave my employer?

Depending upon state variations and your employer's plan, you may have an option to continue coverage when your employment terminates. Your employer can advise you about your options.

CRITICAL ILLNESS FAST FACT

*Most heart attack victims are middle-aged or older; the risk of a heart attack climbs for men after age 45 and for women after age 55.***

**"What Are Your Odds of a Heart Attack?" health.com, June 2018.

Critical Illness insurance is a limited benefit policy. The certificate has exclusions, limitations and benefit waiting periods for certain conditions that may affect any benefits payable. Benefits payable are subject to all terms and conditions of the certificate.

Read the *Important information* section for more details including limitations and exclusions.

Hospital Indemnity Insurance

HELPS PROTECT YOUR FINANCES.
When you, your spouse or child are facing a hospital stay, you can receive a benefit to help pay unexpected expenses not covered by your plan.

HELPS COVER RELATED EXPENSES.
While health plans may cover direct costs associated with an illness or injury, you can use your hospital indemnity benefits to help cover related expenses like lost income, child care, deductibles and copays.

PAYS CASH BENEFITS DIRECTLY TO YOU.
Hospital Indemnity insurance payments can be used however you want, and it pays in addition to any other coverage you may already have. Benefits are payable directly to you.

You can purchase this coverage for you and your family. Child coverage is available to age 26.

BENEFITS	
Benefits are payable for hospital stays due to:	• Sickness • Accidents* • Routine pregnancy • Complications of pregnancy • Newborn complications • Mental and nervous disorders • Substance abuse
Additional reasons to sign up:	• No medical questions to answer - guaranteed issue coverage • Benefits add up - many of your benefits can all be payable on the same day

*Confinements due to an accident must be within 365 days of the accident.

What's covered

This plan provides benefits due to hospital stays for covered accidents or sickness. Once your Hospital Indemnity coverage goes into effect, you can file a claim for covered hospital stays occurring after your plan's effective date.

The benefits shown in the schedule are payable for each person covered by the plan unless otherwise stated.

BENEFIT SCHEDULE

FIRST DAY BENEFITS Payable per benefit year	**CHOICE 1**
First day hospital confinement – This benefit pays the first day you stay in a regular hospital bed.	$1,500 per day 1 day
CONFINEMENT BENEFITS Payable per benefit year	**CHOICE 1**
Hospital confinement – This benefit pays for a hospital stay in a standard room. Payable with: • *First day hospital confinement benefit*	$200 per day Up to 30 days
Intensive Care Unit (ICU) confinement – This benefit pays for a hospital ICU stay. Payable with: • *First day hospital confinement benefit* • *Hospital confinement benefit*	$200 per day Up to 10 days
ADDITIONAL AND ENHANCED BENEFITS Payable per benefit year	**CHOICE 1**
Wellness screening benefit – This benefit pays for a covered wellness test or exam even without a hospital stay.	$50 per day 1 day per insured per benefit year

Frequently asked questions

What benefits will I receive for my newborn child?
If your newborn has to stay in the Neonatal Intensive Care unit (NICU), benefits are payable. Hospital stays for routine newborn care are not covered.

How do I file a Hospital Indemnity claim?
If you are confined to the hospital after the effective date of coverage, you can file a claim with us by downloading forms from our website. You will need to provide information about your hospital stay.

Do I need to file my claim within a certain timeframe?
You should file your claim within 30 days of a covered confinement or as soon as reasonably possible.

How do I get the Wellness Screening Benefit?
You can receive payment if you or a family member have a covered screening test or exam. This benefit is payable each year for specific blood tests, cancer screenings, cardiac stress tests, immunizations, school sports exams and more (may vary by state). The claim form can be downloaded from our website.

Is my benefit taxable?
If you or your employer pay for all or part of the cost of coverage on a pre-tax basis, some or all of your benefit amount will be tax reported on a Form 1099 as taxable income. Please reach out to a tax advisor or your employer if you have any questions.

Can I take my insurance with me if I leave my employer?
Depending upon state variations and your employer's plan, you may have an option to continue coverage when your employment terminates. Your employer can advise you about your option.

Please read the *Important information* section of this document.

Markovitz Enterprises

2027 Employee Benefits Guide

Prepared by Liberty Insurance Agency for Markovitz Enterprises