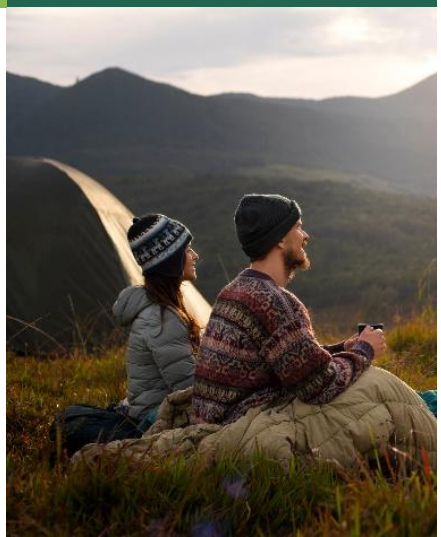


COMMUNITY CONNECTIONS

2026 BENEFIT GUIDE

January 1 – December 31, 2026

WELCOME

We are pleased to offer a comprehensive array of valuable benefits to protect your health, family and way of life. This guide answers some of the basic questions you may have about your benefits. Please read it carefully, along with any supplemental materials you receive.

Eligibility

You are eligible for benefits if you work 30 or more hours per week for medical and 38 hours or more for all other benefits. You may also enroll your eligible family members under certain plans you choose for yourself. Eligible family members include:

- Your legally married spouse
- Your domestic partner (DP) and/or their children, where applicable by state law
- Your biological children, stepchildren, adopted children or children for whom you have legal custody (age restrictions may apply). Disabled children age 26 or older who meet certain criteria may continue on your health coverage.

Coverage Begins

- **New Hires:** You must complete enrollment within 30 days of your date of hire. If you enroll on time, coverage is effective on the first of the month following 30 days. If you fail to enroll on time, you will NOT have benefits coverage (except for company-paid benefits) until you enroll during our next annual Open Enrollment period.
- **Open Enrollment:** Changes made during Open Enrollment are effective 01/01/2026.

Choose Carefully

Due to IRS regulations, you cannot change your elections until the next annual Open Enrollment period, unless you have a qualifying life event during the year. Following are examples of the most common qualifying life events:

- Marriage or divorce
- Birth or adoption of a child
- Child reaching the maximum age limit
- Death of a spouse, DP or child
- Lost coverage under your spouse's/DP's plan
- You gain access to state coverage under Medicaid or The Children's Health Insurance Program

Making Changes

To change your benefit elections, you must contact Human Resources within 30 days of the qualifying life event. Be prepared to show documentation of the event, such as a marriage license, birth certificate or a divorce decree. If changes are not submitted on time, you must wait until the next Open Enrollment period to change your elections.

ENROLLMENT

Please fill out your enrollment form and turn it into your benefits administrator.

Required Information—You will be required to enter a Social Security number (SSN) for all covered dependents when you enroll. The Affordable Care Act (ACA) requires the company to report this information to the IRS each year to show that you and your dependents have coverage. This information will be securely submitted to the IRS and will remain confidential.

Questions?

If you have questions about your benefits, please reach out to:

HR at HR@comconnections.org

Amber Hubbard at Amber.Hubbard@comconnections.org

Angela Nickich at angela.nickich@comconnections.org

Sheila McDonough at sheila.mcdonough@comconnections.org

TAKE A LOOK INSIDE

Health

- Medical Coverage
- Prescription Coverage
- Preventative Care
- Virtual Visits
- Dental Coverage
- Vision Coverage

Wealth

- Health Savings Account (HSA)
- Life & AD&D

Wellbeing

- Choose the Right Place to Go for Care
- Cancer Care
- Valenz health
- Maternity Management
- Employee Assistance Program
- Transcarent Surgery Benefit
- Prevention and Management

Perks

- Employee Discounts
- Medicare Guidance

Resources

- Find Aetna Provider
- Meritain Member Portal
- Meritain Mobile Web App
- Plan Contributions
- Important Contacts
- Benefit Terminology

BENEFIT ENROLLMENT

Enrollment Periods

Annual Open Enrollment

Each calendar year, Community Connections conducts an Open Enrollment. This is the time for you to re-evaluate your needs and elect benefit options for the new plan year.

New Hire and Newly Eligible Employee Enrollment

Newly hired or newly eligible employees must complete their online enrollment within 30 days of their date of hire or within 30 days of the date they become eligible.

Between Enrollment Periods

Generally, once you enroll, you cannot make changes to your enrollment selections until the next Open Enrollment period. You may make changes to your benefit elections outside of the annual Open Enrollment ONLY if you experience a Qualifying Life Event (QLE), as defined by the IRS. Benefit changes must also be consistent and made within 60 days of the QLE.

Qualifying life events (QLEs) that may allow you to make benefit changes:

Change in legal marital status

- Marriage
- Divorce, legal separation, annulment
- Death of your spouse

Change in your eligibility

- Taking or returning from a leave of absence
- Change in work schedule or status that causes a gain or loss of eligibility
- Change in family member's eligibility

Change in the number of eligible children

- Birth, adoption or death of a child
- Child gains or loses eligibility for coverage under the plan

They gain a benefit option or lose coverage

- New coverage choices made during their employer's annual enrollment
- You or your family member's COBRA coverage from another employer expires
- You or your family member becomes eligible for or loses Medicare or Medicaid
- You or your family member loses coverage under a government or educational institution's plan

Scan this code to watch a video about QLEs.

DOMESTIC PARTNER DISCLAIMER

Is My Domestic Partner Eligible?

Your domestic partner is eligible for coverage under the Company's plans if you meet one of these requirements:

- You have an active registered domestic partnership with a governmental body, or
- You both meet all of the following:
    - Are age 18 or older and legally competent
    - Have cohabitated for at least six months
    - Are not married to anyone else (even if legally separated)
    - Are not related by blood
    - Have financial interdependence, as demonstrated by joint ownership of real estate, bank accounts, mortgage, credit obligations, mutual beneficiary designations or powers of attorney

Dependent children of your domestic partner are also eligible for coverage if they are:

- Unmarried
- Primarily dependent on you or your partner for support
- Living with you (unless waived for student status)
- Meet age, student and incapacity requirements for the plan

Imputed Income and Tax Implications

If you add a family member to your coverage who is not considered a dependent under federal income tax law, your share of the cost of coverage must be paid on an after-tax basis. Your employer's share of the cost of benefits is also treated as taxable income, which is known as imputed income. The IRS considers health coverage for a domestic partner and/or their children a taxable benefit with imputed income that is subject to federal income tax and any other required payroll taxes.

Changes in Domestic Partnerships

When enrolling your domestic partner in coverage, you agree that you will notify the Company of any changes in your partnership status that would make your partner and/or their children ineligible for coverage. You must submit a Notice of Change in Domestic Partnership within 30 days of the change. Termination of coverage for domestic partners (and, in some cases, for children of domestic partners) is not a qualifying event for the purpose of continuing coverage under COBRA.

Required Documentation

Employees wishing to enroll a domestic partner for the first time will need to submit an Affidavit of Domestic Partnership to the Human Resources Department prior to completing their enrollment. Please contact HR at HR@comconnections.org for more information.

HEALTH

MEDICAL COVERAGE

PPO

The Preferred Provider Organization (PPO) plan, provided through Meritain, gives you the freedom to seek care from any provider of your choice. However, you will maximize your benefits and lower your out-of-pocket costs if you choose a provider who participates in the network.

A PPO plan relies on a network of health care clinics, hospitals and professionals who have agreed to provide their services at discounted rates. These preferred providers are considered "in-network." In general, you will pay less for in-network services than you would were you to seek care outside the network.

How You Pay for Services

- You pay a flat dollar amount–or copay–for covered health care treatments and services, such as doctor's office visits and prescription drugs.
- Once you satisfy your annual deductible, you will pay a percentage–or coinsurance–of the cost of the visit, and the plan will cover the rest.
- Once you hit your annual out-of-pocket maximum, the plan will cover 100% of the cost of covered services for the rest of the year.

To find an in-network provider, see page 32 in this benefit guide.

Scan this code to watch a video about comparing medical plan types.

MEDICAL COVERAGE

HDHP + HSA

The HDHP + HSA (High-Deductible Health Plan + Health Savings Account), provided through Meritain, is an insurance plan that typically offers lower premiums and higher deductibles. The highlight of this plan is that it allows you to open an HSA, which is a tax-advantaged personal savings account that lets you save pre-tax dollars to pay for any qualified health-related expenses (state taxation rules may apply). This includes most medical care and services, prescriptions, dental, vision and expenses related to meeting the plan's deductible. For a complete list of qualified health-related expenses, visit Publication 502.

For more information on the HSA, see page 17 in this benefit guide.

Individuals with HDHPs normally pay a lower amount each month but pay more on their yearly medical expenses before their insurance policy begins paying. You can visit any doctor, hospital or other health care provider you want, with greater cost savings in-network.

How You Pay for Services

- You pay the full cost of non-preventive health care services and prescription drugs until you meet the annual deductible. The deductible is waived for in-network routine preventive care services and medications on the preventive drug list.
- The HDHP includes coinsurance for prescription drugs only. You must meet the annual deductible before prescription coinsurance apply.
- Once you meet the annual deductible, you pay a percentage of your health care expenses (coinsurance), and the plan pays the rest.
- Once your deductible and coinsurance add up to the out-of-pocket maximum, this plan pays the full cost of all qualified health care services for the rest of the year.

MEDICAL COVERAGE

Following is a high-level overview of your medical plan options. For complete coverage details, please refer to the Summary Plan Description (SPD). **Note:** The deductibles and out-of-pocket maximums are per calendar year.

Key Benefits	PPO		HSA	
	In-Network	Out-of-Network[1]	In-Network	Out-of-Network[1]
Deductible (Individual/Family)	$500 / $1,000		$3,500 / $7,000	
Out-of-Pocket Max (Individual/Family)	$5,500 / $11,000		$3,500 / $7,000	
Office Visits (physician/specialist)	50%*		0%*	
Teladoc Virtual Visits	Covered In Full	Not Covered	0%*	Not Covered
Routine Preventive Care	Covered In Full		Covered In Full	
Diagnostics (lab/X-ray)	50%*		0%*	
Complex Imaging	50%*		0%*	
Chiropractic	50%*		0%*	
Ambulance	50%*		0%*	
Emergency Room	$350, then covered 100%		0%*	
Urgent Care Facility	50%*		0%*	
Inpatient Hospital Stay	50%*		0%*	
Outpatient Surgery	50%*		0%*	

Coinsurance percentages and copay amounts shown in the above chart represent what the member is responsible for paying.
*Benefits with an asterisk (*) require that the deductible be met before the Plan begins to pay.

1. If you use an out-of-network provider, you will be responsible for any charges above the maximum allowed amount.
2. The deductible is embedded. This means that once a family member meets their individual deductible, the plan will begin to pay coinsurance for that family member.
3. The out-of-pocket maximum is embedded. This means that, once an individual family member meets their out-of-pocket maximum, that individual's expenses are covered at 100%.

PREVENTIVE CARE

What is Preventive Care?

Regular preventive care can help you stay well, catch problems early on and may be potentially lifesaving. The ACA requires that certain preventive care services are provided for no cost, copayment or coinsurance. All medical plans cover preventive care services like screenings, immunizations and exams. When you visit in-network providers, you don't have to worry about any out-of-pocket costs for preventive care services. If you use an out-of-network provider, a deductible and out-of-network expenses may apply.

Preventive vs. Diagnostic Care

Preventive care is generally precautionary. For example, if your doctor recommends having a colonoscopy because of your age or family history, this would be considered preventive care. But if your doctor recommends a colonoscopy to investigate symptoms you're having, this would be considered diagnostic care, and your plan cost share will apply.

Scan this code to watch a video about preventive care.

VIRTUAL VISITS

Teladoc

Our telehealth program is a convenient and cost-effective way to get quick medical advice by phone, online or on your mobile device about many non-emergency conditions. It's just one more way our organization invests in you and your family.

Why Use Telehealth?

It's Affordable

A trip to the ER, urgent care center or doctor's office can easily set you back hundreds of dollars in out-of-pocket costs. A call to our telehealth program is covered in full regardless of your condition and is available for general medicine, dermatology, and behavioral health.

It's Convenient

Long wait times at the ER, urgent care center or doctor's office are an unfortunate reality for many. Whether you are at home or work or on the road, a medical professional is available 24/7/365 so you can get the care you need when and where it's convenient for you. Even better: There is no time limit to the consult, giving you plenty of time to ask questions and resolve your issue.

It's Easy to Use

A telehealth medical professional is never more than a phone call, click or tap away! Call Teledoc at 800-362-2667 or visit Teladoc.com.

Get Care in Minutes

It takes just a few minutes to set up your medical history online. Once you submit a request, it often takes less than 10 minutes for a doctor to call you back.

Common Reasons to Call

- Allergies
- Anxiety issues
- Back problems
- Bronchitis
- Cold and flu symptoms
- Ear infections
- Diarrhea or constipation
- Headaches and migraines
- Rash and skin problems
- Sore throat and stuffy nose
- Sprains and strains
- Urinary tract infections

Scan this code to watch a video about how telehealth works.

PRESCRIPTION COVERAGE

Retail Pharmacy

When you fill a prescription at a participating retail pharmacy, you may purchase up to a 30-day supply. At the participating pharmacy, you will need to present your ID card and an applicable payment. Most major pharmacies are in our plan's pharmacy network.

Save Money on Medications

Ask for Generic Drugs

You can save money by asking for generic drugs. The FDA requires that generic drugs have the same high quality, strength, purity and stability as brand-name drugs. The next time you need a prescription, ask your doctor to prescribe a generic drug if it is available and appropriate.

Scan this code to watch a video about prescription drug coverage.

Use Mail Order

If you require regular medication for a long-term or chronic condition, such as arthritis or diabetes, you can save money by using your plan's mail-order service.

Setting Up Mail Order Online:

1. Register at Caremark.com/startnow and follow the instructions to request a new 90-day prescription.
2. Call the customer service number on the back of your ID card.

Key Benefits	PPO		HSA	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Retail Pharmacy				
Tier 1 – Generic	$15		0%*	
Tier 2 – Preferred	$45			
Tier 3 – Non-Preferred	$60			
Tier 4 - Specialty	30% coinsurance, max $300			
Mail Order Pharmacy				
Tier 1 – Generic	$45		0%*	
Tier 2 – Preferred	$135			
Tier 3 – Non-Preferred	$180			
Specialty Pharmacy Exclusive	Deductible and 30% Coinsurance; $300 max per 30-Day Supply. *Some drugs available through PrudentRx at no cost to you (see next page for details).			

PHARMACY PROGRAMS

Prior Authorization (PA)

A PA makes sure that you're getting the right medication for your condition. It may also help keep costs down, so you don't overpay.

When is a PA required?

It depends on your benefit plan. Here are common reasons a PA is needed:

- There may be a lower cost option that's just as effective.
- The medication potential for misuse or abuse.
- The medication is for certain conditions or diagnoses.

How does a PA get started?

You or your pharmacy can ask your doctor to start a PA. Then, your doctor sends us a PA by phone, fax or electronically. (We offer electronic PA submission that often provides a decision instantly.)

How does it work?

We gather additional information from your doctor that's required by your benefit plan. This information helps determine if the prescription is covered. We notify you and your doctor whether your PA is approved or denied as soon as possible – usually within a few days.

PrudentRx Copay Optimization Program

Prescriptions that are categorized as Specialty drugs are subject to a cost of 30% coinsurance, but with the PrudentRx Copay Optimization Program, members will receive their Specialty prescriptions at zero cost!

If you choose to not participate in the PrudentRx program, your regular cost share will apply.

If your Specialty tier prescription is not available through PrudentRx your regular cost share will apply.

How to receive Specialty Prescriptions at $0 cost

Eligible members will be automatically enrolled in the PrudentRx Copay Optimization Program. If PrudentRx requires additional information in order to secure your enrollment in this cost savings program, they will reach out to you directly to request additional information. If you have questions or would like to opt-out of this cost savings program, you can contact PrudentRx at 1-800-578-4403

DENTAL COVERAGE

Indemnity

Following is a high-level overview of your dental plan options. For complete coverage details, please refer to the Summary Plan Description (SPD). **Note:** The deductibles and annual benefit maximums are per calendar year.

Key Benefits	PPO	
	In-Network	Out-of-Network[1]
Deductible (Individual/Family)	$50 / $150	
Annual Benefit Maximum (per person)	$2,000	
Preventive Services	Covered In Full	
Basic Services	20%*	
Major Services	50%*	

DENTAL PLAN FACTS

- You may visit any dentist of your choice, but you'll receive the highest coverage when you visit in-network providers.
- If you visit an out-of-network provider, you will not benefit from discounted rates and will pay more for services.
- You may pay an annual deductible for select services.

Coinsurance percentages and copay amounts shown in the above chart represent what the member is responsible for paying.
*Benefits with an asterisk (*) require that the deductible be met before the Plan begins to pay.
1. If you use an out-of-network provider, you will be responsible for any charges above the maximum allowed amount.

VISION COVERAGE

Vision Plan

- Your eyesight is an integral part of your overall health and a key component of safety. This plan, provided through Meritain, gives you the freedom to seek care from the provider of your choice.
- Following is a high-level overview of your vision plan options. For complete coverage details, please refer to the Summary Plan Description (SPD).

Key Benefits	Vision Coverage
Maximum Benefit PCY	$500 Annual Maximum
Exam (1 PCY)	Covered In Full
Frames (1 PCY)	Subjected to the annual $500 Limit
Lenses (1 PCY)	
Contact Lenses (1 PCY) (In lieu of glasses)	

WEALTH

HEALTH SAVINGS ACCOUNT (HSA)

The HDHP + HSA Plan features an HSA provided through Avidia. The HSA lets you set aside pre-tax dollars to help offset your annual deductible and pay for qualified health care expenses.

How the HSA Works

- You contribute pre-tax dollars through automatic payroll deductions or make after-tax contributions that are deductible when you file your taxes.
- **Community Connections makes contributions your HSA Account to help it grow. See HR for more details.**
- You may change your contributions at any time throughout the year.
- You can withdraw HSA funds tax free to pay for current qualified health care expenses, or save them for the future, also tax free. Unused funds roll over from year to year and are yours to keep, even if you change medical plans or leave your employer.

Coverage Tier	2025	2026
Individual	$4,300	$4,400
Family	$8,550	$8,750
Catch-up Contributions	$1,000	$1,000

Scan this code to watch a video about HSA limits.

HEALTH SAVINGS ACCOUNT (HSA)

Key Features of the HSA

Triple-Tax Advantage

- You contribute funds pre-tax through convenient payroll deductions. This means the money comes out of your paycheck before income tax is calculated. So, you get to keep a bigger portion of your paycheck.
- HSA funds grow tax free, and unused funds roll over year to year. So, the more you save, the more your account will grow—just like a bank savings account.
- If you need to use your HSA funds, you can withdraw them tax free to pay for qualified health care expenses now and in the future—even in retirement.

Control

You own and control the money in your HSA. You decide how or whether you want to spend it. You can use it to pay for doctor's visits, prescriptions, braces, glasses—even laser vision correction surgery.

Investment Opportunities

Once you reach and maintain a minimum threshold, you can make investments to help your money grow tax free.

Savings Potential

Your HSA is like a "health care 401(k)." There is no "use it or lose it" rule. Your account grows over time as you continue to roll over unused dollars from year to year.

Portability

Your HSA is yours for life. The money is yours to spend or save, even if you change health plans,[1] retire or leave the organization.

Scan this code to watch a video about how an HSA works.

Preventive Medications List

If you are enrolled in an HSA-compatible medical plan, you may be able to access a range of preventive medications for a copay or coinsurance before meeting your deductible. These medications are contained in the HSA Preventive Drug List provided by your employer.

Qualified Health Care Expenses

- Qualified medical, dental and vision expenses not covered by the plans, as defined by the IRS in Publication 502 (https://www.irs.gov/forms-pubs/about-publication-502).
- COBRA premiums
- Qualified long-term care insurance and expenses
- Health insurance premiums when receiving unemployment compensation
- Medicare and retiree health insurance premiums (not Medicare Supplement premiums)

Important Notes

- You must meet certain eligibility requirements to have an HSA: You a) must be at least 18 years old, b) must be covered under a qualified HDHP, c) must not be enrolled in Medicare and d) cannot be claimed as a dependent on another person's tax return. For more information, please refer to IRS Publication 969 (https://www.irs.gov/forms-pubs/about-publication-969).
- Adult children must be claimed as dependents on your tax return for their medical expenses to qualify for payment or reimbursement from your HSA.

1. You must be enrolled in an IRS-qualified high-deductible health plan to contribute to an HSA.

LIFE INSURANCE

Life insurance, provided through UNUM, provides your named beneficiaries with a benefit following your death, while accidental death and dismemberment (AD&D) insurance provides a benefit to you following a covered accident that leads to dismemberment (such as the loss of a hand, foot or eye). Should your death occur due to a covered accident, both the life benefit and the AD&D benefit would be payable.

Basic Life and AD&D
(employer-paid)

Coverage Tier	Benefit Amount
Employee	$50,000

Supplemental Life and AD&D
(employee-paid)

If you determine you need more than the basic coverage, you may purchase additional insurance for yourself and your eligible family members.

CHOOSING A BENEFICIARY

You may choose anyone to be the beneficiary of your Life and AD&D policy in the event of your death or serious injury. Review your beneficiary designation periodically to ensure if reflects your current wishes. You may change your beneficiary anytime on the employee portal.

Scan this code to watch a video about how life insurance works.

Coverage Tier	Benefit Amount	Guaranteed Issue Amount
Employee	Range from $10,000 - $500,000 in $10,000 increments If you previously purchased coverage, you can increase it up to $100,000 with no medical underwriting.	$100,000
Spouse	Up to $500,000 in $5,000 increments If you previously purchased coverage, you can increase it up to $25,000 with no medical underwriting.	$25,000
Child(ren)	Up to $10,000 in $2,000 increments	$10,000

Note: During your initial eligibility period, you can secure coverage up to the Guaranteed Issue limits without the need for Evidence of Insurability (EOI, or information about your health). Please note that coverage amounts requiring EOI will only go into effect once the insurance carrier approves them.

Age Reduction: Coverage amounts for Life and AD&D Insurance for you and your dependents will reduce to 65% of the original amount when you reach age 70 and will reduce to 50% of the original amount when you reach age 75. Coverage may not be increased after a reduction.

WELLBEING

CHOOSE THE RIGHT PLACE TO GO FOR CARE

Knowing where to go for care can save your time, money, and sle. Our medical plan gives you a variety of care options for any medical issues you may face. Remember to save the Emergency Room for true emergencies.

PLEASE NOTE: The below information should be used for reference only. The is not a full or extensive list of treatment options or reasons to be seen at each care facility. If you have any questions on where to go for care, please consult your physician or medical care provider. In the event of a medical emergency, call 911.

Telehealth / Virtual Visit	Primary Care Provider (PCP)	Urgent Care Center	Emergency Room
Cost: $ | Time: 	Cost: $$ \| Time: 	Cost: $$$ | Time: 	Cost: $$$$ | Time: 
Benefit: • Lower cost • Speak to a doctor from anywhere • Reduced waiting room time	**Benefit:** • In-person examination • Reasonable price in-network • Familiarity with health history	**Benefit:** • Lower cost than an ER visit • Same-day visits are often available	**Benefit:** • Necessary for life-threatening conditions • Open 24/7, every single day of the year
Reasons to go: • Headaches • Fever & flu symptoms • Cough & sore throat • Skin irritations & rashes • Psychiatry services	**Reasons to go:** • Preventive care • Earaches & infections • Headaches • Skin irritations & rashes • Abdominal pain • Regular treatment for chronic conditions	**Reasons to go:** • Earaches & infections • Minor cuts, bumps, sprains, & burns • Allergic reactions • Animal bites • Mild asthma • Urinary tract infections • Back & join pain	**Reasons to go:** • Sudden numbness or weakness • Disorientation or difficulty speaking • Seizure or loss of consciousness • Severe cuts or burns • Overdoses • Uncontrolled bleeding • Coughing or vomiting blood • Heart attack or chest pain

CANCER CARE

The CancerCARE Program is a free, fully integrated cancer solution included 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 or existing cancers. Our expert medical team advocates for the best possible care in your community or at a leading national Centers of Excellence location.

Phone: 877.640.9610
Email: cancermanagement@cancercareprogram.cor
Website: Cancercareprogram.com

CancerCARE
Right Care. Right Place. Right Time.

DAY ONE HELP

- The day you receive a cancer diagnosis is overwhelming. Our CancerCARE professionals will answer questions about your diagnosis and help you evaluate your treatment options. They will also help maximize your health benefits and minimize your out-of-pocket expenses.
- *Register online or by phone promptly (within 72 hours) of diagnosis for the highest care impact.*

PERSONALIZED CARE

- Today's cancer treatments vary by cancer type, stage of spread, and the patient's genetic makeup. The most effective care occurs when it is genetically personalized for you. Genetic testing is often not a covered benefit; however, it is fully covered when used for treatment planning with CancerCARE's recommendation.

NATIONAL RESOURCES

- New treatments are developed and tested at leading cancer centers called Centers of Excellence. Treatment received from your local oncologist is often the best possible, but in some instances, we may suggest new treatments that are only offered at a Center of Excellence when those treatments could be more beneficial to you. Two examples would be Clinical Trials or proven new treatments that have not yet been written and given to community oncologists.

EXPERT MEDICAL TEAM

- During your Initial registration call, our highly trained Intake Coordinators will quickly gather your medical and health plan information. When a diagnosis permits, you will be assigned your own personal Oncology Nurse Expert who will answer any questions you have regarding your diagnosis as well as your care options. CancerCARE's entire team of Doctors, Nurses, and Medical Experts is dedicated to being with you throughout your treatment journey.

VALENZ® HEALTH

KISx Card: Surgery Simplified

Vālenz® Health offers KISx Card, the nation's largest surgical and imaging direct contracting solution. We deliver significant savings, while simplifying the complexity of healthcare - the way it should be.

Procedures:

- Ankle & Foot
- Arthroscopy
- ENT
- Elbow
- Gastroenterology
- General Surgery
- Hip
- Knee
- Shoulder
- Spine
- Urology
- Wrist & Hand
- And more!

How it works for Employees!

1. You have been diagnosed & need surgery or major imaging.
2. You call us at 877.438.5479
3. Your nurse will collect information about your procedure & locate a facility near you.
4. Your nurse will confirm procedure details with your facility & provider.
5. Upon the facility & provider validating the need for your procedure, your nurse will assist in scheduling your appointment.
6. You receive a voucher to present the day of your procedure. This replaces your insurance card.
7. You receive the procedure at $0 cost if you are enrolled on either POS Plan. If you are enrolled on the HSA plan, you must first meet your deductible due to IRS requirements prior to plan incentives.

MATERNITY MANAGEMENT

ProgynyHealth Maternity & NICU Care

From admission to the NICU through first birthday, and beyond, ProgenyHealth's focus is on infant health outcomes and the wellbeing of families and caregivers by affirming standardization of care, following best practices and engaging in peer-to-peer conversations with providers..

By the Numbers

- 125+ NICU-centric clinical team
- 70K+ NICU cases to date
- 90% member satisfaction
- 1400+ hospitals served throughout the U.S.
- 55%+ reduction in hospital readmission rates
- 10-15% reduction in NICU spend

Progeny HEALTH®

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Life is full of challenges and sometimes balancing them all can be difficult. We are proud to provide a confidential program dedicated to supporting the emotional health and well-being of our employees and their families. The Employee Assistance Program (EAP) is provided at NO COST to you through UNUM.

The EAP can help with the following issues, among many others:

- Mental health
- Relationships
- Substance use
- Child and eldercare
- Grief and loss
- Legal or financial issues

EAP Benefits

- Assistance for you and your household members
- Up to 3 in-person or virtual sessions with a counselor per event, per year, per individual
- Unlimited toll-free phone access and online resources

QUESTIONS?

To learn more, visit www.unum.com/lifebalance.

For questions, contact UNUM at 800-854-1446

Scan this code to watch a video about how an EAP works.

TRANSCARENT SURGERY BENEFIT

- Eliminate your out-of-pocket costs by utilizing Transcarent to travel to a Center of Excellence for the following surgeries and procedures:
- Cardiac procedures
- Spine surgeries
- Vascular surgeries
- Specific cancer treatments (only surgical tumor removal)
- Orthopedic surgeries
- Other planned surgeries

Transcarent gives you access to:

- Centers of Excellence for major planned surgeries and procedures.
- Coverage for travel costs for you and a companion.
- Provisions to eliminate your out-of-pocket costs.
- A dedicated Care Coordinator.
- Taxable Recovery Benefit Included: $1,500

Simply call Transcarent at (800) 680-1366 to speak with a Care Coordinator or visit Transcarent online at transcarent.com.

PREVENTION AND MANAGEMENT

Hinge Health

Keep muscle and joint pain at bay! Thanks to Hinge Health, you don't have to turn to expensive surgical or medication options to ease your muscle and joint pain. Hinge Health's digital exercise therapy is an easy, effective and customized solution that will get you back on your feet.

When you sign up for the therapy program, you'll get:

- A personalized therapy program with unlimited exercises and stretches developed for you by physical therapists.
- Your own care team, which includes a qualified health coach and physical therapist you can turn to for questions and help setting goals. Get in touch with them via text, email, phone or video chat.

Best of all, Hinge Health is completely free to you. To learn more or join, visit https://www.hingehealth.com/for-individuals/

PERKS

EMPLOYEE DISCOUNTS

BenefitHub

Provide by HUB International, BenefitHub is an exclusive employee discount program that can help you save big on thousands of items daily such as travel, apparel, tickets, auto, electronics, insurance, education, restaurants and so much more!

To get started:

- Go to mypathperks.benefithub.com
- Enter Code **K7WEWL**
- Click on "Any Offer"
- Complete the Sign-Up Form

Questions? Call 813.675.2210

LifeMart Member Discount Program

LifeMart offers exclusive savings on major purchases and everyday essentials from brands you know and love, all in one convenient location. With discounts on travel, entertainment, child & senior care, wellness, home & auto, and so much more - LifeMart is the way to save.

- **Saving with LifeMart is easy:**
- Search for discounts by category
- Select an offer to review the details
- Simply follow the redemption instructions to access discounts

Plus, you can access LifeMart discounts anywhere, anytime, with the LifeMart mobile app*. Simply download the app and you can browse major savings on the go. Available for download in the Google Play Store and iTunes Store.

**Pre-registration is required.*

- Access via your Aetna Member Portal at www.aetna.com
- Click on the Health & Wellness Tab > Health & Wellness Discounts > Click on any of the Health & Wellness tiles to access the LifeMart Discount Website

MEDICARE GUIDANCE

HUB Medicare Advocacy

The HUB Senior and Individual Team Medicare advocacy service is available at no cost to you and your family members who are approaching Medicare eligibility and/or who are already Medicare eligible. HUB can:

- Answer basic questions about Medicare coverage and enrollment
- Provide guidance on how to avoid late enrollment penalties and coverage gap pitfalls, including COBRA
- Compare current coverage to Medicare and explain the differences between the two
- Provide retiree benefits counseling
- Help individuals shopping for Medicare Supplement Plans, Advantage Plans and Part D

For more information or to get started, call 833-482-7471 or email Senior.IFP@hubinternational.com.

RESOURCES

FIND AN AETNA PROVIDER

Find an Aetna Provider

1. Find providers by phone: 800.343.3140, OR
2. From the **Aetna.com** home page, or select "Find a Doctor"
    1. Under "Don't have a member account?". Select "Plan from an employer"
    2. Enter location under "Continue as Guest"
    3. Select a plan to search the network in top right corner, this can be found on your ID card as well.
        - **Medical:** Aetna Choice PPO

    There are two ways to search:

    1. You can enter your providers name or specialty in the search bar.
    2. You can also browse by category.

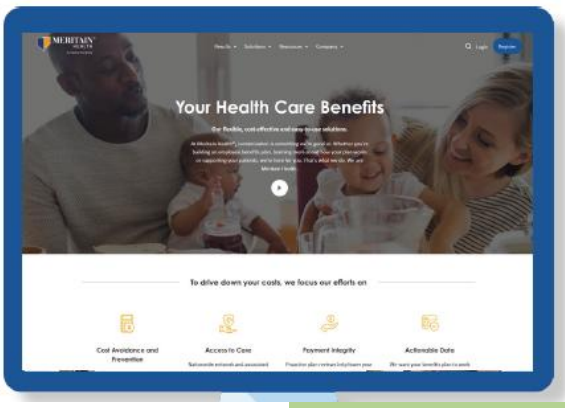
    When you get your results, you can use the tool bar to narrow your search. Filter by specialty, area of expertise, gender, and spoken languages.

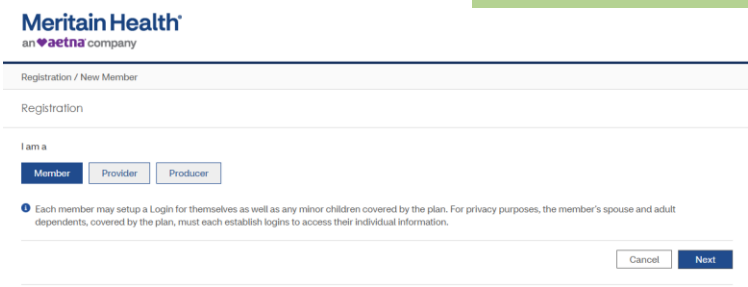
Scan this code to watch a video about choosing a provider.

MERITAIN MEMBER PORTAL

Create a Meritain Member Account

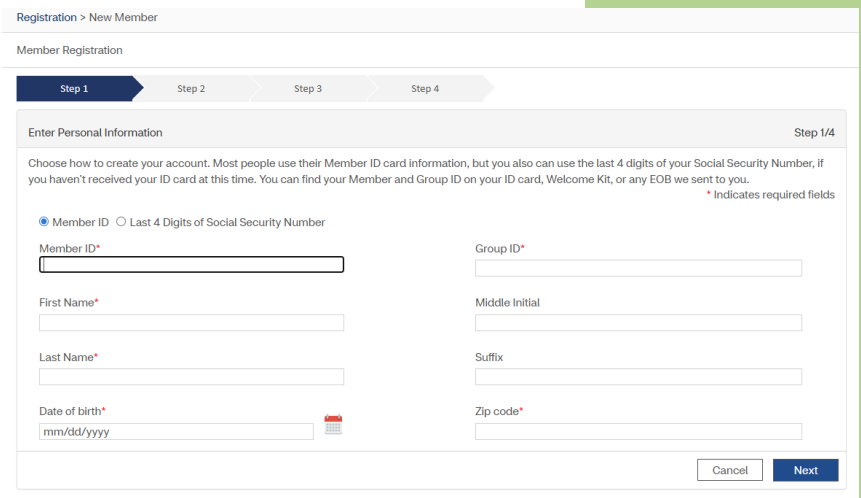
1. Go to Meritain.com and select "Login" or "Register"
2. Select "I am a Member", click "Next"
3. Complete the 4-step registration process to access:
    - Printing forms
    - Estimating Costs
    - Viewing EOBs and pending claims
    - Finding in-network providers
    - Accessing your benefit summary
    - Print ID cards





What You'll Find:

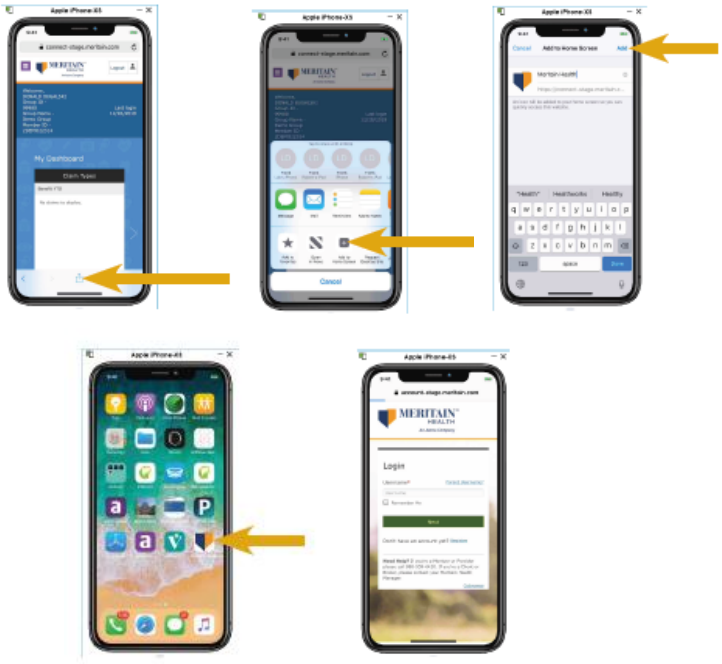
- **Digital ID Card:** You can also download a copy of your digital ID card. Simply click on the *Member ID Card* icon in the coverage box—you will be able to easily access a copy of your ID card!
- **Healthcare Plan Overview:** You can view deductibles and out-of-pocket maximums on the main page when you log in to your member account.
- **Claims Information:** Just click *Claims* to view your claim information. The *Apply* button lets you view all claims. Claims with statuses of *In Process, Processed* or *Awaiting Review* will be displayed. You can view and print the Explanation of Benefits (EOBs) by clicking for the claim details under the claim number.
- **Teladoc®**



MERITAIN MOBILE WEB APP

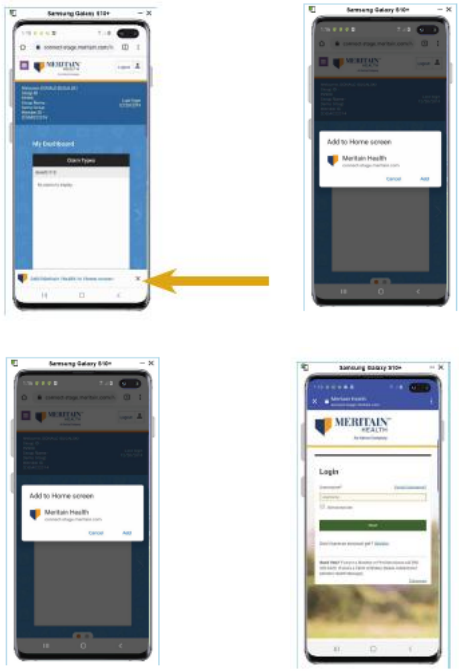
iPhone

1. Once you log in to your member portal through **www.meritain.com**, click the icon at the bottom of the page. (see arrow).
2. Then, scroll through the menu options and select *Add to Home Screen*.
3. Click *Add* in the upper righthand corner.
4. Your Meritain Health® app logo will then be installed and added to your home screen.
5. Then, you'll be able to log in through the app instead of going though the web page.



Android

1. Once you log in to your member portal through **www.meritain.com**, 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, you can click *Add* to add the logo to the home page or *Cancel* to opt-out.
3. Your Meritain Health app logo will then be installed and added to your home screen.
4. Then, launch the app from your home screen and log in.



PLAN CONTRIBUTIONS

Your contributions toward the cost of benefits are automatically deducted from your paycheck. The amount will depend on the plan you select and if you choose to cover eligible family members. See your HR Team for current medical, dental, & vision costs.

Opt Out Incentive

Employees who have other coverage available to them and waive our benefit plan, are eligible for a $325/ month incentive.

See Amber for more details.

PLAN CONTRIBUTIONS

Your contributions toward the cost of benefits are automatically deducted from your paycheck. The amount will depend on the plan you select and if you choose to cover eligible family members.

Voluntary Life and AD&D – Monthly Premium

Monthly Life Cost		
Coverage	**Employee Per $10,000**	**Spouse Per $5,000**
15-24	$0.500	$0.250
25-29	$0.700	$0.350
30-34	$0.900	$0.450
35-39	$1.500	$0.750
40-44	$2.100	$1.050
45-49	$3.400	$1.700
50-54	$4.900	$2.250
55-59	$6.700	$3.350
60-64	$8.300	$4.150
65-69	$12.700	$6.350
70 & over	$20.600	$10.300

Monthly Life Cost for Dependent Child Coverage	
Coverage Amount	Rate
Per $2,000	$0.500

**Due to rounding, your actual payroll deduction amount may vary slightly.*

Monthly AD&D Cost		
	Coverage Amount	Rate
Employee	Per $10,000	$0.300
Spouse	Per $5,000	$0.150
Child	Per $2,000	$0.060

How to Calculate Premiums

1. Choose the amount of employee coverage that you want to buy.
2. Look up the premium costs for your age group for the coverage amount you are selecting on the chart above.
3. Choose the amount of coverage you want to buy for your spouse. Again, find the premium costs on the chart above.
   Note: Premiums are based on your age, not your spouse's.
4. Choose the amount of coverage you want to buy for your dependent children. The premium costs for each coverage option are shown above.

IMPORTANT CONTACTS

Benefit	Carrier	Group Number	Phone Number	Website / Email
Medical	Meritain	TBD	888.324.5789	www.meritain.com
Dental	Meritain	TBD	888.324.5789	www.meritain.com
Vision	Meritain	TBD	888.324.5789	www.meritain.com
COBRA	Meritain	TBD	888.324.5789	www.meritain.com
Life and AD&D / Vol. Life and AD&D	UNUM	702522	866.679.3054	www.unum.com
Employee Assistance Program (EAP)	UNUM	N/A	800.854.1446	www.unum.com/lifebalance
Health Savings Account (HSA)	Avidia	N/A	866.387.1978	www.avidiabank.com
Benefits Administrator	HR	N/A	N/A	HR@comconnections.org
Benefits Administrator	Amber Hubbard	N/A	N/A	Amber.Hubbard@comconnections.org
Benefits Administrator	Angela Nickich	N/A	N/A	angela.nickich@comconnections.org
Benefits Administrator	Sheila McDonough	N/A	N/A	sheila.mcdonough@comconnections.org

ANNUAL NOTICES & BENEFIT SUMMARIES

See your Human Resources department or Employee Navigator for annual notices and benefit summaries.

This communication highlights some of your benefit plans. Your actual rights and benefits are governed by the official plan documents. If any discrepancy exists between this communication and the official plan documents, the plan documents will prevail. We reserve the right to change any benefit plan without notice. Benefits are not a guarantee of employment.

HUB

BENEFIT TERMINOLOGY

Diagnostic test

Medical tests designed to establish the presence (or absence) of disease as a basis for treatment decisions in symptomatic or screen positive individuals. Note that diagnostic tests are different than screening tests. Screenings are primarily designed to detect early disease or risk factors for disease in apparently healthy individuals.

Durable medical equipment (DME)

Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include oxygen equipment, wheelchairs or crutches.

Eligible expense

Amount on which payment is based for covered medical services. This may be called "allowed amount maximum," "payment allowance" or "negotiated rate." If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. See balance billing.

Emergency Room

You should visit an emergency room if you are experiencing any life-threatening condition, such as chest pain, shortness of breath, serious bodily injury, severe abdominal pain or loss of consciousness.

Embedded deductible

Once a person covered under a family plan reaches the individual embedded deductible, all covered expenses for that individual will be paid at the coinsurance amount even when the family deductible may not have been satisfied. For example, PPO Option I features an in-network family deductible of $1,000. If one member of the family satisfies the individual $500 deductible, the medical carrier will pay 50% of the remaining in-network expenses. Once another person or a combination of persons meet the remaining $500, the embedded family deductible is considered satisfied.

Embedded out-of-pocket maximum

Once a person covered under a family plan reaches the individual embedded out-of-pocket maximum, all covered expenses for that individual will be paid at 100% even when the family out-of-pocket maximum may not have been satisfied. For example, PPO Option I features a family out-of-pocket maximum of $11,000. If one member of the family satisfies the individual out-of-pocket maximum of $5,500, the medical carrier will pay 100% of remaining in-network expenses for that individual. Once another person or a combination of persons meet the remaining portion, the embedded family out-of-pocket maximum is considered satisfied.

Employee contribution

The amount an employee contributes through payroll deductions for their medical and other insurance and savings program benefits.

Excluded services

Medical services that your medical plan doesn't pay for or cover.

Explanation of benefits

Every time you use your health insurance, your health plan sends you a record called an "explanation of benefits" (EOB) or "member health statement" that explains how much you may owe. The EOB also shows the total cost of care, how much your plan paid, and the amount an in-network doctor or other health care professional is allowed to charge a plan member (called the "allowed amount"). An EOB is generated for every single health claim, including prescriptions. It is not a bill, but rather a tool members can use to make sure they're not paying more than their insurer expects them to for services rendered.

Generic drugs

Medications that are comparable to brand-name drugs in dosage form, strength, quality, performance characteristics and intended use, per the FDA. Generic drugs are almost always priced more attractively than their brand-name counterparts.

BENEFIT TERMINOLOGY

Health care FSA

Funded through pre-tax payroll deductions, a health care flexible spending account (FSA) is a cost-savings tool that allows you to pay for qualified health care-related expenses with pre-tax dollars.

High-Deductible health plan (HDHP)

A HDHP is a type of health insurance plan that typically offer lower premiums in exchange for higher deductibles. The deductible, which is the amount you must pay out of pocket for covered medical expenses before your insurance begins to pay, is higher for HDHPs compared to traditional PPO plans. These plans allow individuals to pay a lower monthly premium and instead cover more of their medical expenses through out-of-pocket deductibles.

Health savings account (HSA)

An employer- and employee-funded savings plan that reimburses you for qualified out-of-pocket medical expenses. Funded through pre-tax payroll deductions by the employer and employee, HSAs are only available to people enrolled in a qualified high-deductible health plan. Unspent balances aren't forfeited; they roll over and accumulate over time.

In-network coinsurance

The percentage you pay of the allowed amount for covered medical services to providers who contract with your health insurance carrier. In-network coinsurance costs you less than out-of-network coinsurance payments.

In-network provider

The facilities, providers and suppliers our health insurance carrier contracted with to provide medical services. Your out-of-pocket expenses will be lower, and you will not be responsible for filing claims if you visit a participating in-network provider.

Mail order Rx

The Company's medical carrier offers this method of delivery for prescription drug orders to assist in delivering drugs more conveniently and at a lower cost. Through mail order, members can obtain a 90-day supply at one time versus a 30-day supply at a traditional pharmacy. Most suitable for maintenance medications or any drug taken daily, such as contraceptives or blood pressure medications, your copay is cheaper through mail order.

Medically necessary

Medical services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms, and that meet accepted standards of medicine.

Member health statement

Every time you use your health insurance, your health plan sends you a record called a "member health statement" or an "explanation of benefits" (EOB) that explains how much you may owe. The member health statement also shows the total cost of care, how much your plan paid and the amount an in-network doctor or other health care professional is allowed to charge a plan member (called the "allowed amount").

Negotiated rate

Amount on which payment is based for covered medical services. This may be called "allowed amount maximum," "payment allowance" or "eligible expense." If an out-of-network provider charges more than the allowed amount, you may have to pay the difference.

Network

The facilities, providers and suppliers a health insurance carrier contracted with to provide medical services at a pre-negotiated discount. Your out-of-pocket expenses will be lower, and you will not be responsible for filing claims if you visit a participating in-network provider.

BENEFIT TERMINOLOGY

Non-preferred brand-name drugs

Generally, these are higher-cost medications that have recently come on the market. In most cases, an alternative preferred medication is available, be it a preferred brand-name drug or a generic.

Non-preferred provider

A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider.

Open Enrollment

A period during which a health insurance company is required to accept applicants without regard to health history.

Out-of-network coinsurance

The percentage you pay of the allowed amount for covered medical services to providers who do not contract with your health insurance carrier. Out-of-network coinsurance costs you more than in-network coinsurance. An out-of-network provider can balance bill you for charges over the allowed amount.

Out-of-network provider

A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see an out-of-network provider.

Out-of-pocket maximum

The most you pay during a policy period (a calendar year) before your plan begins to pay 100% of the allowed amount. This limit does not include your premium or balance-billed charges.

Over-the-counter drug

A drug that you can buy without a prescription from a drugstore or most general or grocery stores. For example, Benadryl, Tylenol, and Ibuprofen are sold over-the-counter. The opposite of a prescription drug.

Payment allowance

Amount on which payment is based for covered medical services. This may be called "allowed amount maximum," "negotiated rate" or "eligible expense." If an out-of-network provider charges more than the allowed amount, you may have to pay the difference.

Preauthorization

A medically necessary determination by a health insurance carrier for a medical service, treatment plan, prescription drug, medical or prosthetic device or certain types of durable medical equipment. Sometimes called preauthorization, prior authorization or prior approval, many plans require preauthorization for certain services before you can receive them, except in cases of emergency. Preauthorization isn't a promise your medical plan will cover the cost.

Preferred/brand-name drug

These are medications for which generic equivalents are not available. They have been on the market for some time and are widely accepted. They cost more than generic drugs, but less than non-preferred brand-name drugs.

Preferred provider

A provider who a contract with your health insurer or plan to provide services to you at a pre-negotiated discount.

Prescription drugs

Medications you can only obtain with a prescription from your doctor. Prescriptions must be taken to a pharmacy (or sent to a mail-order facility) where a licensed pharmacist will fill it for you. For example, Lipitor, Vicodin and Albuterol can only be obtained with a prescription. The opposite of an over-the-counter drug.

BENEFIT TERMINOLOGY

Prescription drug coverage

Coverage that helps pay for prescription drugs and medications covered under a health insurance carrier's formulary. A formulary is the list of FDA-approved drugs covered under a medical plan. Each drug is classified into a tier and each tier determines the copayment you will pay for the drug. These tiers typically, but not always, are: Generic (Tier 1), Preferred Brand (Tier 2), Non-Preferred Brand (Tier 3), and Specialty.

Your cost will depend on the level of drug specified by your doctor. A generic drug is a medication whose active ingredients, safety, dosage, quality and strength are identical to that of its brand-name counterpart. Preferred brand-name drugs generally do not have a generic equivalent, while those listed as non-preferred brand-name drugs generally do have a generic or preferred brand-name equivalent.

Your copay for preferred brand-name drugs is less than the copay for non-preferred brand-name drugs because you don't have the generic option available to you.

Premium (Insurance)

The fees paid to an insurance carrier to provide coverage. These fees are usually shared between you and the Company, though there are insurance benefits the Company pays for entirely, while there are others that you pay for yourself.

Premium (Medical)

The amount that is paid for your medical coverage. You and the Company share this cost, which is paid monthly to the insurance carrier.

Pre-tax deduction

Payments deducted from your gross pay before Medicare, federal, and state taxes are calculated, thus reducing your taxable wages and tax liability.

Prior approval/authorization

A medically necessary determination by a health insurance carrier for a medical service, treatment plan, prescription drug, medical or prosthetic device or certain types of durable medical equipment. Sometimes called preauthorization, prior authorization or precertification, many plans require preauthorization for certain services before you can receive them, except in cases of emergency. Preauthorization isn't a promise your medical plan will cover the cost.

Post-tax deduction

Payments deducted from your net pay after Medicare, federal and state taxes are calculated, thereby having no impact on your taxable wages and tax liability.

Preventive care

Medical treatments performed with the intention of preventing a health issue. For example, vaccinations and age-appropriate screenings are almost always considered to be preventive.

Primary care physician (PCP)

A physician who directly provides or coordinates a wide range of medical services for a patient. Primary care physicians include medical doctors, doctors of osteopathic medicine, internists, family practitioners, general practitioners, OB/GYNs and pediatricians. The opposite of a specialist.

Provider

A physician, health care professional or health care facility, certified or accredited as required by state law.

Qualifying life event (QLE)

QLEs are major events in an enrollee's life that allow them to make specific changes to their insurance policy outside of an annual Open Enrollment period. This usually includes the birth or adoption of a child, marriage, divorce, death of a spouse or change in the spouse's employment or insurance status. These changes must typically be made within 31 days of the QLE.

BENEFIT TERMINOLOGY

Special enrollment period

Special enrollment periods allow you to make changes to your insurance plan or sign up for a new policy outside of Open Enrollment. They're almost always triggered by QLEs.

Specialist

A physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat for certain types of symptoms and conditions. The opposite of a primary care physician. For example, a dermatologist is considered a specialist.

Specialty drugs

Prescription medications that require special handling, administration or monitoring. These drugs are used to treat complex, chronic conditions, such as multiple sclerosis, rheumatoid arthritis, hepatitis C and hemophilia.

Telehealth

Telehealth is the use of telecommunication technologies through which you and your personal physician, who is treating you and knows your health history, can talk live over the phone or video chat, by appointment, during regular office hours. Services such as medication management, regular visits and online counseling are particularly well suited to Telehealth, since consistent and regular visits with your physician typically improve outcomes.

Telemedicine

Telemedicine is the use of telecommunication technologies where you and an on-call physician can talk live (24/7/365) over the phone or video chat. Services that are particularly well-suited to telemedicine include the discussion of symptoms, receiving a diagnosis, learning your treatment options and minor health issues such as pink eye or sore throat. Prescription can also be facilitated through telemedicine. Please note that each time you reach out for telemedicine services, you might speak with a different physician.

Urgent care

An illness or injury serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Wellness

Wellness refers to a healthy state of being.

Scan this code to watch a video about benefit terms.