



Employee Benefits Guide

2025 Plan Year

Integrated Design Solutions



Important Items to Remember

NEW HIRE WAITING PERIOD

New employees are eligible for company insurance benefits on the first of the month following date of hire.

TERMINATION OF BENEFITS

When your employment with the company is terminated, your benefits will be terminated at the end of the month following the termination date.

ELIGIBLE EMPLOYEES

To be eligible for company benefits, you must be a full time employee working an average of 30 hours per week throughout the year.

DEPENDENT CHILDREN

Children under the age of 26 are eligible to be covered under the benefits. When a dependent child turns 26 they will be removed from the dental plan at the end of the month that they turn 26 and medical and vision plan will terminate at the end of the year in which they turn 26.

OPEN ENROLLMENT

Employees can make changes to your plans (enroll in coverage, waive coverage, add/drop dependents, etc.) during this time period each year. Open enrollment typically occurs 45 days prior to IDS plan renewal. All changes made during this time period will take effect on the renewal date, Jan 1st.

MAKING PLAN CHANGES DURING THE YEAR

If you've had a qualifying life event (getting married, having a child, getting divorced, losing coverage, becoming eligible for Medicare, etc.) during the year, you're able to make coverage changes to your plan even though it's outside of the Open Enrollment window. Please turn in all paperwork within 30 days of your Qualifying Event. PLEASE NOTE: If adding a newborn baby to your plan, the baby's social security number will not be available right away. Please submit the paperwork without it, and provide it upon receipt.

COBRA

PLEASE NOTE: In the event your employment is terminated with the company, you will receive a letter in the mail giving you the opportunity to continue your Medical, Dental and Vision benefits for up to 18 months. This is called COBRA coverage. Your employer DOES NOT contribute to this coverage.

MINI COBRA

PLEASE NOTE: In the event your employment is terminated with the company, you will receive a packet in the mail giving you the opportunity to continue your Medical, Dental and Vision benefits for up to 12 months. This is called State Continuation, or Mini-COBRA. Your employer DOES NOT contribute to this coverage as they may when you are employed with them. You will be responsible for 102% of the actual cost of the insurance if you wish to continue with it.

STAY IN NETWORK

To obtain the best benefits, it's important to stay in the insurance carrier's network. Always check online or verify over the phone that a doctor or hospital is in network BEFORE your visit. Also, when having a procedure done in a hospital/facility, ask the hospital staff to make sure EVERY doctor/nurse/radiologist/anesthesiologist/etc. is in your network.

EXPLANATION OF BENEFITS

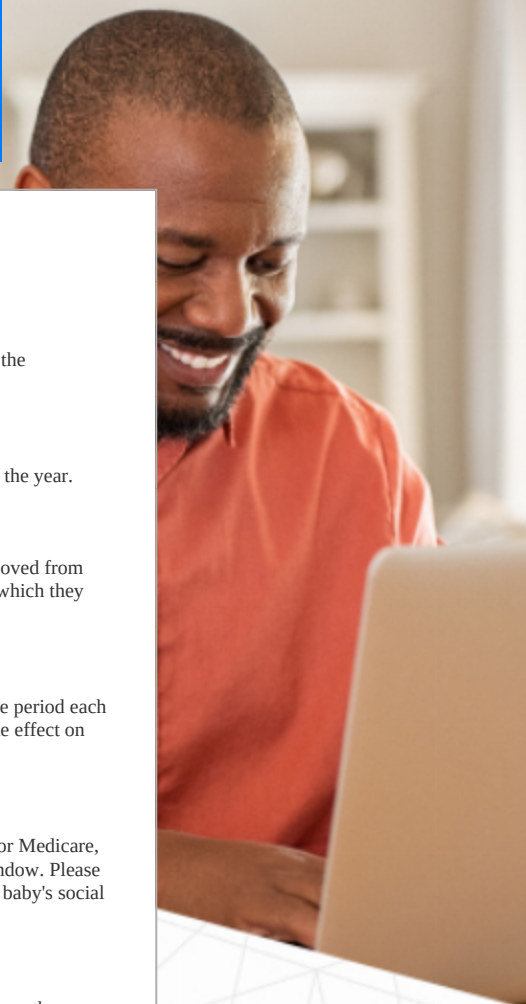
Commonly referred to as an "EOB". The EOB is a very useful document as it explains how the insurance carrier processed your claim. It shows the billed charges from the provider, the network discount applied, and what the resulting Negotiated Rate is. (Provider Charge - Network Discount = Negotiated Rate) It also shows whether the service was applied to your deductible or paid as a co-pay. It is not a bill, but merely an explanation of how the insurance carrier paid your claim.

NEED A NEW ID CARD OR ANOTHER ID CARD FOR A DEPENDENT?

You can register for the insurance carrier's website where you can print out temporary ID cards and order new cards, or you can contact insurance carrier from phone numbers listed on next page.

HAVE QUESTIONS ABOUT AN INSURANCE CLAIM?

PLEASE HAVE COPIES OF YOUR EXPLANATION OF BENEFITS ALONG WITH A COPY OF YOUR BILL(S) READY & CONTACT INSURANCE CARRIER.



Who to Contact if You Have Questions & Important Things to Know

Medical Plan Administrator- ASR Health Benefits

Address- P.O. Box 6392 Grand Rapids MI 49516-6392 Phone- (800) 968-2449 Business Hours: 8am - 4:30pm EST Websites: P.O. Providers- www.asrhealthbenefits.com, www.hap.org, www.aetna.com Claims- www.physicianscare.com

Prescriptions- Navitus

Phone- (866) 333-2757 Website: www.Navitus.com

Health Savings Account- HealthEquity

Member Service: 866-346-5800 available 24/7

Employer Services: 866.382.3510 M-F 7am-7pm cst employerservices@healthequity.com

Dental- Principal

Phone- (800) 247-4695 Website : www.principal.com

Life, AD&D, LTD, STD- UNUM

Phone- (877) 275-3539 Email- askunum@unum.com Website: www.unumprovident.com

Vision- NVA

Phone- (800) 672-7723 Website: www.e-nva.com

Waiving (Opting Out) of Coverage

You may opt out of coverage, however, you will be required to provide proof of health care coverage. If during the benefit year, you lose coverage involuntarily (e.g. your spouse loses a job, divorce, or you age out of your parent's plan), this is a Qualifying Life Event. See next section.

Qualifying Life Event

Types of qualifying life events that allow mid-year enrollment changes. (Not a complete list.) A change in marital status including marriage, divorce, legal separation, or annulment. A change in dependents, including a birth, death, adoption, and placement for adoption. A change in employment status of employee, spouse or dependents, including termination or commencement of employment. An employee's dependents satisfies or ceases to satisfy eligibility requirements for coverage due to attainment of age or change in student status. It is your responsibility to notify Human Resources within 30 days of the QLE.

Purchase Additional Vacation Option

Eligible IDS staff (all full-time regular employees and associates) have the opportunity to buy up to 40 hours of vacation time in 8 hour increments. This election has been incorporated into the Open Enrollment process through Employee Navigator. Time bought will be charged at the 2025 pay rate and withholding will begin with the first pay period of 2025 (January 10, 2025). This covers vacation taken between December 22, 2024 and December 20, 2025. This deduction would appear under the deductions section of your paystub with the code of VacW/H. Any unused vacation will be paid out on December 26, 2025.

Bi-Weekly Employee Contributions For Medical and Dental

Integrated Design Solutions offers an IRC (Internal Revenue Code) Section 125 Premium Conversion Plan. This allows your contributions toward medical and dental insurance to be made on pre-tax basis. Your taxable income is reduced by the amount of your contribution which reduces the income subject to federal and state income taxes as well as FICA taxes. The tax benefit amount that you receive will depend on your individual contribution and tax bracket. Medical Bi-Weekly Contribution: Single - \$62.12; Double - \$164.63; Family - \$223.64. There is an additional supplemental cost based on your annual salary which is 1% (hourly rate of \$28.21 to \$47.00) or 2% (Hourly rate of \$47.01 and higher). Bi-Weekly Calculation is hourly rate x 2080 hours = annual salary. Take annual salary and multiply by 1% or 2%, then divide by 26. Dental Bi-Weekly Contribution: Single - \$4.25; Double - \$7.00; Family - \$11.75. Vision Bi-Weekly Contribution: Single - \$0; Double - \$0; Family - \$0.

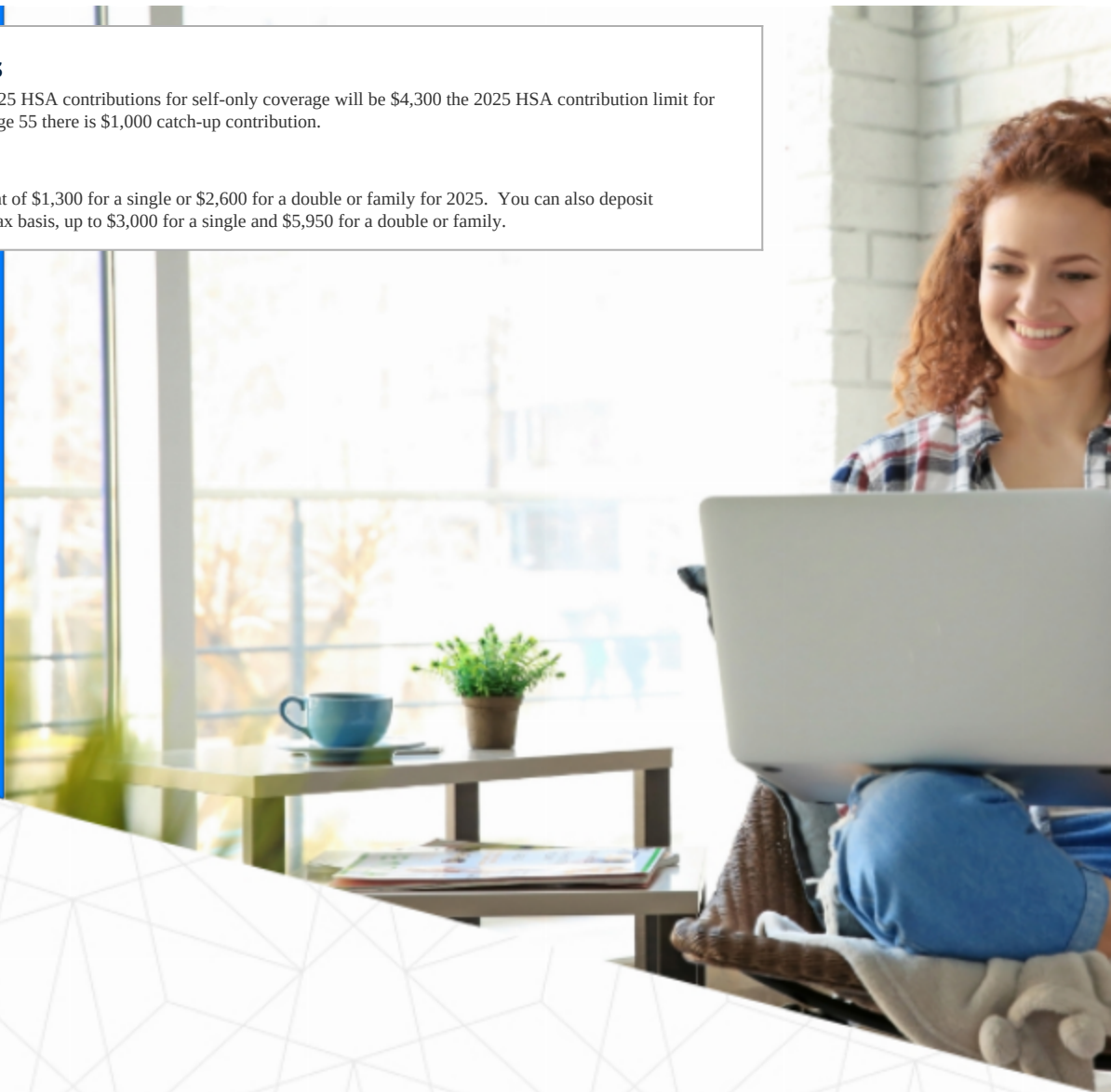


IRS Annual Maximums

The annual inflation-adjusted limit on 2025 HSA contributions for self-only coverage will be \$4,300 the 2025 HSA contribution limit for family coverage will be \$8,550. If over age 55 there is \$1,000 catch-up contribution.

IDS HSA Contribution

IDS will make a deposit into your account of \$1,300 for a single or \$2,600 for a double or family for 2025. You can also deposit additional funds to this account on a pretax basis, up to \$3,000 for a single and \$5,950 for a double or family.



Health Plan

ASR | Health Renewal

Plan Explanation

The plan is administered by ASR Administrators of Grand Rapids, Michigan. IDS' medical plan is a PPO HDHS Plan, which is a preferred provider organization (PPO) with a high deductible (HD) and health savings account (HSA). It was designed to provide employees with access to quality health care, comprehensive coverage, choice and the opportunity to save on taxes. The PPO portion of the plan is provided by Valenz Health. With a PPO plan, you have complete freedom to see any doctor of your choice. If you choose doctors and hospitals within the PPO network and have met your annual deductible, your out-of-pocket costs are covered. The pharmacy vendor is Navitus.

DEDUCTIBLE	IN-NETWORK	OUT-OF-NETWORK
Single	\$2,000	\$5,000
Double / Family	\$4,000	\$10,000
COINSURANCE		
Member %	0%	50%
OUT OF POCKET MAXIMUM		
Single	\$6,900	\$10,000
Double / Family	\$13,800	\$20,000
COMMONLY USED SERVICES		
Primary Care Physician Office Visit	No charge after Deductible	50% Coinsurance after Deductible
Specialist Office Visit	No charge after Deductible	50% Coinsurance after Deductible
Urgent Care	No charge after Deductible	50% Coinsurance after Deductible
Emergency Room	No charge after Deductible	No charge after in-network Deductible
PREVENTIVE CARE		
Preventive Services	No Charge	Not covered (except when required by law)
MAJOR MEDICAL EXPENSES		
Outpatient Surgery	No charge after Deductible	50% Coinsurance after Deductible
Inpatient Hospitalization / Surgery	No charge after Deductible	50% Coinsurance after Deductible
CT scan, PT scan, MRI	No charge after Deductible	50% Coinsurance after Deductible
Hospital Newborn Delivery	No charge after Deductible	50% Coinsurance after Deductible
PRESCRIPTION DRUG COVERAGE		
Generic (Tier 1)	25% of purchase price	50% of purchase price
Brand Name (Tier 2)	Lesser of 25% of purchase price or \$100	50% of purchase price
Non-Preferred (Tier 3)	Lesser of 25% of purchase price or \$150	50% of purchase price
Specialty (Tier 4)	25% of purchase price	N/A
Specialty (Tier 5)	25% of purchase price	N/A
Mail Order - 90 day Supply	Lesser of 25% of purchase price or \$200 for preferred brand name \$300 for non-preferred brand name	N/A
PLAN INFORMATION		
Plan Year	2025	
Deductible Period	1/1/2025 - 12/31/2025	
Network Type	HSA PPO	
Network Name	Physicians Care / Aetna	
Member Website	www.physicianscare.com	
Customer Service Phone Number	800-968-2449 is the number for ASR Health Benefits, this is who you should call with Medical Questions/ Concerns. When you call ID yourself as a participant under benefit plan group #895, ask to speak with a member of Claim Unit C. 866-333-2757 is the number for Navitus, this is who you should call when you have Prescription Questions/ Concerns.	

Disclaimer

Disclaimer: This is a partial listing of your covered benefits. For a complete accurate listing of covered benefits, limitations and exclusions, refer to your certificate of coverage.



Helping Members Identify an In-Network Provider

Looking for a local provider? Searching for a physician in a certain specialty? We're making it easier to find what you need, wherever you are. Just follow the simple steps below, depending on where you reside or where you travel.

Leading doctors and hospitals

The Physicians Care & HAP networks offer access to thousands of participating doctors in Michigan and northwest Ohio. Chances are very good your doctor is a participating provider.

Go with experience

As one of Michigan's largest and most experienced health plans, ASR/HAP offers you and your family a large network of doctors and hospitals. You also don't need referrals.

Out-of-State coverage

Outside of Michigan, you'll find a large network of doctors and hospitals across the country through our partnership with Aetna Signature Administrators® - one of the nation's largest health service networks.

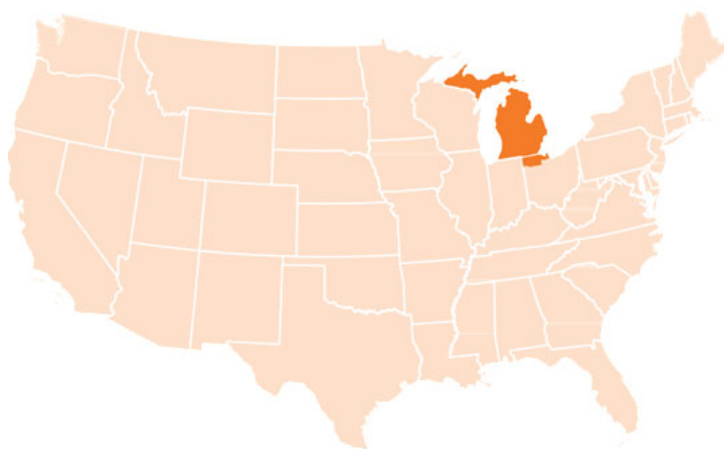
Aetna's network gives you access to more than 1.4 million providers, including over 6,100 hospitals and thousands of MinuteClinic® locations around the country.

Finding a doctor is easy

When seeking care in Michigan or northwest Ohio, visit asrhealthbenefits.com. Click on **Physicians Care & HAP Network**. If your provider in Michigan does not participate with Physicians Care & HAP, click on **Välenz Health**.

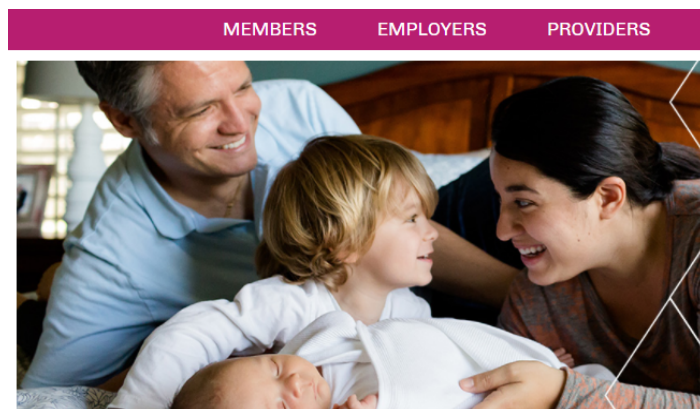
When seeking care outside of Michigan, visit asrhealthbenefits.com. Click on **Aetna National PPO Network**.

Have other questions? We're here to help. Call us at (800) 968-2449 or e-mail findprovider@asrhealthbenefits.com.



- Physicians Care & HAP Network
- Aetna National PPO network

* HAP PPO provider network includes these seven counties of northwest Ohio: Defiance, Fulton, Henry, Lucas, Ottawa, Williams, and Wood.



Search For Providers

Physicians Care & HAP Network



Aetna National PPO Network



Välenz Health



ASR Healthcare Choices

ASR makes it easy to find quality, affordable care. When you shop for healthcare, you have the power to decide what meets your needs, from the doctors you see to the costs for your services.

ESTIMATE COSTS

Get cost estimates for treatments and procedures like MRIs or flu shots

Estimate your costs

Type a medical service name to compare provider costs



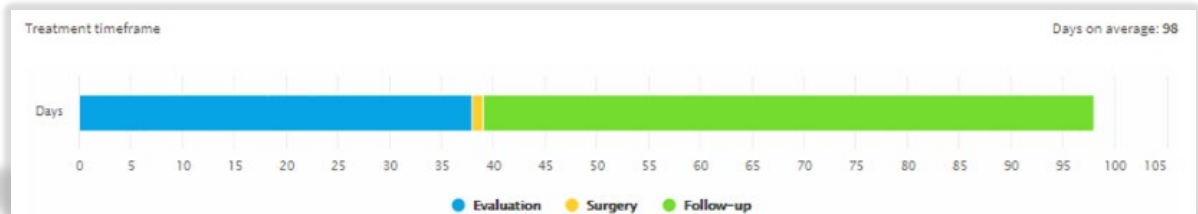
Shoulder Repair (Arthroscopic)

Shoulder Repair (Arthroscopic), Rotator Cuff

Shoulder Repair, Rotator Cuff

TREATMENT TIMELINES

Find treatment timelines for surgeries and long-term health problems



CONDITION INFORMATION

Learn about treatments and conditions and find doctors who offer them



Coronary Artery Disease (Atherosclerosis/Arteriosclerosis)

Coronary artery disease (CAD) is the most common type of heart disease. This disease causes narrowing or blockage of your coronary arteries, which supply oxygen-rich blood to your heart.



VISIT THE ASR MEMBER PORTAL TO START SAVING!

- Visit www.asrhealthbenefits.com or call (800) 968-2449 for assistance
- Get help activating your account
- Find the best priced, highest-quality healthcare
- Choose a doctor or specialist who meets your needs

Here's how to get started with ASR Healthcare Choices

Register at asrhealthbenefits.com.

Get access to your personalized account in a few simple steps.



Member Log-in

Username

Password

LOG-IN

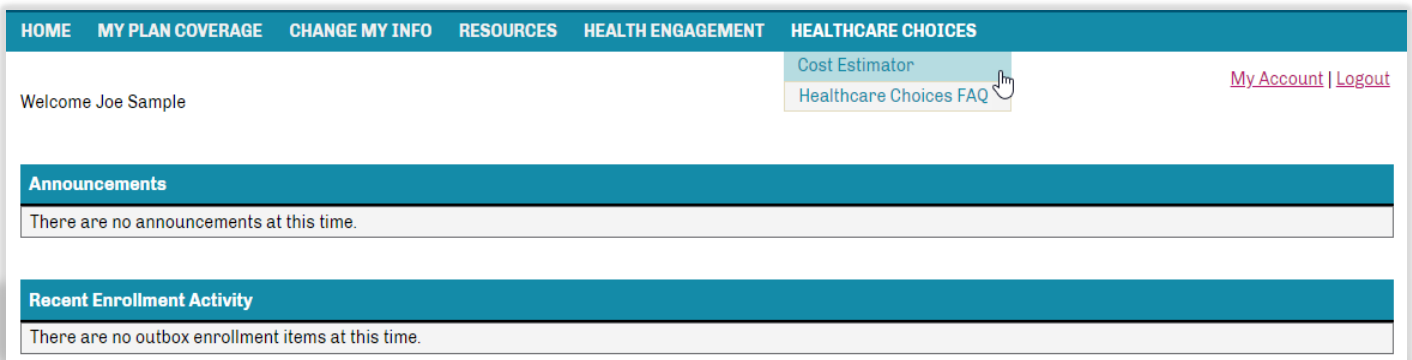
If you have forgotten your password click our [Password Reminder](#).

Need a Log-in?

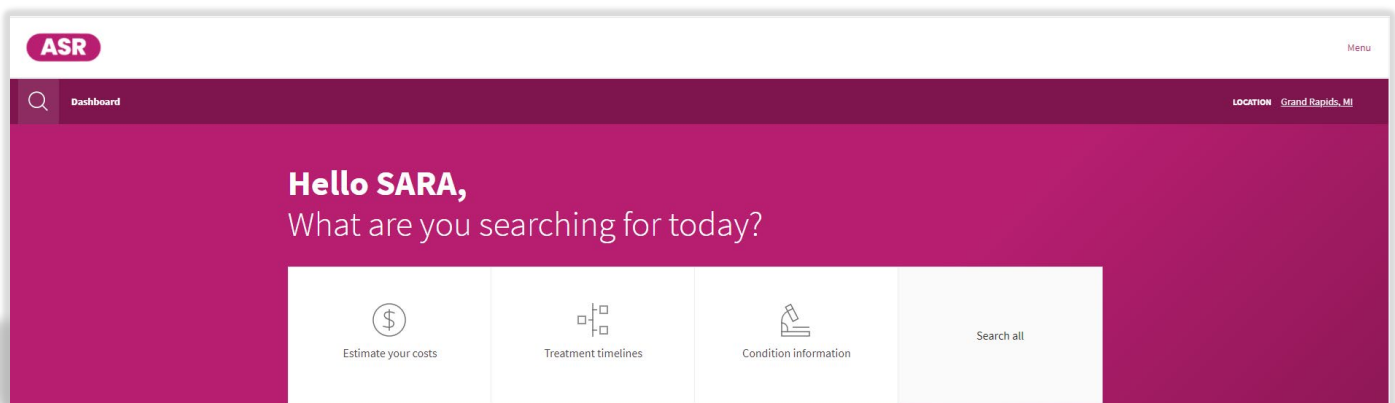
If you have not yet completed a log-in form, please take a moment to do so.

[SIGN UP FOR A LOG-IN](#)

Locate the **HEALTHCARE CHOICES** tab, and select **Cost Estimator** from the drop-down menu.



Begin estimating procedure costs, exploring treatment timelines, and more!



ASR Healthcare Choices

Rewardable Services

IMAGING SERVICES	REWARD
Bone and joint scan of whole body	\$50
Bone density study of spine or pelvis	\$50
Breast Tomosynthesis	\$50
Chest X-Ray	\$25
CT abdomen & pelvis w/o & w/ contrast	\$50
CT Angiography, Abdomen w/o & w/ contrast	\$50
CT Angiography, Head w/o & w/ contrast	\$50
CAT Scan, Lower Limb (without Contrast)	\$50
CT scan abdomen w/o & w/ contrast	\$50
CT scan chest w/o & w/ contrast	\$50
CAT Scan, Needle Imaging Guidance	\$50
CT scan head/brain w/o & w/ contrast	\$50
CT scan of lumbar lower spine w/o & w contrast	\$50
CT scan of mouth, jaw, and neck w/o contrast	\$50
CT Soft Tissue Neck w/ Dye	\$50
Doppler Echo for Carotid Artery Evaluation	\$50
Duplex Ultrasound Scan of Blood Flow, Complete & Limited, At	\$50
Echo Exam of Abdomen	\$50
Echocardiogram - Trans-thoracic with Doppler (Complete)	\$50
Echocardiogram - Trans-thoracic with Rest & Stress Test	\$50
Echocardiogram - Trans-thoracic with Rest & Stress Test (Co	\$50
Extremity Arterial Studies	\$50
Heart Muscle Image Spect Mult	\$50
Hepatobiliary Nuclear Medicine Imaging	\$50
Mammogram	\$50
MR Angiography Head w/o Dye	\$50
MRI Abdomen w/o & w/ contrast	\$50
MRI brain w/o & w/ contrast	\$50
MRI Breast	\$50
MRI lower limb with joint w/o & w/ contrast	\$50
MRI lower limb w/o & w/ contrast	\$50
MRI lumbar spine w/o & w/ contrast	\$50
MRI neck spine w/o & w/ contrast	\$50
MRI orbit/face/neck w/o & w/ contrast	\$50
MRI Pelvis w/o & w/ contrast	\$50
MRI spine w/o & w/ contrast	\$50
MRI Upper Limb Joint w/o & w/ contrast	\$50
MRI upper limb (other than joint) w/o contrast	\$50
Pet scan image from skull base to mid-thigh	\$50
Single Fetus Ultrasound After 14 Weeks	\$50
Single Fetus Ultrasound Before 14 Weeks	\$50
Single Fetus Ultrasound Detailed Fetal Exam	\$50
Transthoracic Echocardiogram for Congenital Heart Defects	\$50
Transvaginal Ultrasound (Obstetrical & Non-Obstetrical)	\$50
Ultrasound Exam Scrotum	\$50
Ultrasound of abdomen, breast(s) or pelvis	\$50
Ultrasound of Abdomen & Back (Retroperitoneal)	\$50
Ultrasound of head and neck (e.g. thyroid, parathyroid, paroti	\$50
Bone Age Studies	\$50
X-Ray Exam of Abdomen, Ankle, Finger(s), Foot, Hand, Hip, Kne	\$25
(3 views), Lower Spine, Neck Spine, Pelvis, Shoulder or Wrist	

INPATIENT SURGERIES	REWARD
Spinal fusion (lumbar)	\$100
Combined anterior/posterior spinal fusion	\$100
Coronary bypass with cardiac catheterization	\$100
Delivery (C-section or vaginal)	\$100
Hip or knee replacement	\$100
Hysterectomy	\$100
Major small & large bowel procedures	\$100
Removal of plaque build-up in the major neck (carotid) arterie	\$100
Removal of prostate gland and surrounding tissue	\$100
Revision of total hip or total knee replacement	\$100

OUTPATIENT SURGERIES	REWARD
ACL repair by arthroscopy	\$75
Appendix Removal (Laparoscopic)	\$75
Benign Breast Tumor Removal	\$75
Bladder repair for incontinence (sling)	\$75
Bladder Scope with stent or with Lithotripsy (Kidney Stone fragm	\$75
Breast biopsy percutaneous w/imaging or breast lumpectomy	\$75
Bronchoscopy	\$75
Bunionectomy	\$75
Carpal tunnel w/o or w/ Scope	\$75
Cataract removal	\$75
Cervical Biopsy w/ Scope	\$75
Colonoscopy with biopsy or removal of lesion(s)	\$75
Drainage of Bursa or Abscess	\$75
Dysrhythmia Focus Ablation	\$75
Esophagoscopy	\$75
Eyelid Revision	\$75
Fine Needle Aspiration for Biopsy w/Imaging	\$75
Hammertoe correction	\$75
Hysteroscopy with removal of lesion(s) or uterine lining (e.g. end	\$75
Kidney Stone Removal by Bladder Scope	\$75
Knee arthroscopy with cartilage repair	\$75
Laparoscopic removal of gallbladder, ovaries and/or fallopian tu	\$75
Left heart catheterization	\$75
Minor or Moderate Wound Repair	\$75
Mohs Surgery for Tumor Removal	\$75
Nasal/sinus - corrective surgery - septoplasty	\$75
Pre-malignant Skin Lesion Destruction	\$75
Reduction Mammoplasty	\$75
Repair Detached Retina	\$75
Repair Finger Tendon	\$75
Repair of blepharoptosis	\$75
Repair of umbilical or inguinal hernia (age 5+) or ventral hernia	\$75
Retinal Lesion Treatment - Photocoagulation	\$75
Screening colonoscopy	\$75
Shock wave treatment for kidney stones	\$75
Shoulder arthroscopy w/o & w rotator cuff repair	\$75
Sigmoidoscopy	\$75
Simple Biopsy of Uterus Lining	\$75
Skin Lesion Biopsy	\$75
Sleep Study with or without CPAP	\$75
Spinal fusion of neck - front	\$75
Spinal Injection for Pain Management	\$75
Steroid Injection into Tendon	\$75
Tonsillectomy and adenoidectomy	\$75
Total Hysterectomy (Laparoscopic)	\$75
Tympanostomy and myringotomy	\$75
Upper GI endoscopy w/o & w/ biopsy	\$75
Urethra and bladder scope	\$75
Uterine tissue sample (biopsy)	\$75
Varicose Vein Ablation or Treatment via Injection	\$75
Vasectomy	\$75

Health Savings Account

An HSA lets you save money for future healthcare costs while also saving on taxes. How? HSAs are the only benefit with a triple-tax advantage:¹ Tax-free contributions. Tax-free account growth. And tax-free spending on HSA-qualified expenses. It's your healthcare emergency safety net.

- ✓ No use-it-or-lose-it rule, HSAs rollover every year
- ✓ Available tax-free investing, just like a 401(k)²
- ✓ Requires an eligible high-deductible health plan (HDHP)



Don't tax your money. Max your money.

Get \$20 tax savings for every \$100 you contribute.³

HSA

Tax-free

No HSA

Taxed

2025 HSA Contribution Limits



\$4,300

Individual plan



\$8,550

Family plan

Members 55+ can contribute an extra \$1,000.

Spend tax-free.

There are thousands of HSA-qualified expenses. Here are just few:

- Medical
- Dental
- Vision
- Pharmacy
- Over-the-counter (OTC) medications
- Mental health services
- Lab fees



**See how much
you can save.**

HealthEquity.com/Learn/HSA

¹HSAs are never taxed at a federal income tax level when used appropriately for qualified medical expenses. Also, most states recognize HSA funds as tax-deductible with very few exceptions. Please consult a tax advisor regarding your state's specific rules. | ²Investments made available to HSA members are subject to risk, including the possible loss of the principal invested, and are not FDIC or NCUA insured, or guaranteed by HealthEquity, Inc. | ³Example for illustration only. Estimated savings are based on an assumed combined federal and state income tax bracket of 20%. Actual savings will depend on your taxable income and tax status. HealthEquity does not provide legal, tax or financial advice.



Your NVA Vision Benefit Summary

Schedule of Vision Benefits

Integrated Design Solutions
Group Number# 3222

How Your Vision Care Program Works

Benefit Frequency	Participating Provider	Non-Participating Provider
Examination Once Every Calendar Year	Covered 100% After \$10 copay	Reimbursed Amount Up to \$35
Lenses Once Every Calendar Year - Single Vision - Bifocal - Trifocal - Lenticular - Polycarbonates (under age 19)	Standard Glass or Plastic - Covered 100% After \$25 copay - Covered 100%	- Up to \$25 - Up to \$45 - Up to \$75 - Up to \$75 - Up to \$25 (SV) - Up to \$30 (Bi/Tri)
Frame Once Every Two Calendar Years	Retail Allowance Up to \$100 (20% discount off balance)*	Up to \$45
Contact Lenses Once Every Calendar Year	In lieu of Lenses	In lieu of Lenses
Elective Contact Lenses	Up to \$100 Retail (15% discount (Conventional) or 10% discount (Disposable) off balance)**	Up to \$75
Fit/Follow-Up***		
Standard Daily Wear	Covered 100% after \$20 copay	Up to \$20
Standard Extended Wear	Covered 100% after \$30 copay	Up to \$30
Specialty Wear	Covered 100% after \$50 copay	Up to \$50
Medically Necessary****	Covered 100%	Up to \$210

Eligible members and dependents are entitled to receive a vision examination and one (1) pair of lenses once every calendar year and a frame once every two calendar years or contact lenses and contact lens evaluation/fitting once every calendar year.

For your convenience, at the start of the program, you will receive two identification cards with participating providers in your zip code area listed on the back. At the time of your appointment, simply present your NVA identification card to the provider or indicate that your benefit is administered by NVA. The provider will contact NVA to verify eligibility. A vision claim form is not required at an NVA participating provider.

Be sure to inform the provider of your medical history and any prescription or over-the-counter (OTC) medications you may be taking.

To verify your benefit eligibility prior to calling or visiting your eye care professional, please visit our website at www.e-nva.com or download our mobile app by searching NVA Vision or contact NVA's Customer Service Department toll-free at 1.800.672.7723, TTY: 711 or NVA's Interactive Voice Response (IVR). Customer Service is available 24 hours a day, 7 days a week, 365 days a year. Any question any time.

If you are not a registered subscriber, you can still search our providers online by selecting the "Find a Provider" link on our home page. Enter group number 3222000001 or the group number on the identification card and enter in your search parameters. It's that easy!

*Does not apply to Wal-Mart / Sam's Club or

Lenscrafters locations or for certain proprietary brands.. ** Does not apply to Wal-Mart/Sam's Club, Lenscrafters, Contact Fill (NVA Mail Order) or certain locations at: Target, Sears, Pearle, & K-Mart and may be prohibited by some manufacturers.***Only covered if you choose Contact Lenses.

****Pre-approval from NVA required.

Fixed prices/courtesy discount do not apply at Walmart/Sam's Club and LensCrafters locations.

Lens options purchased from a participating NVA provider will be provided to the member at the amounts listed in the fixed option pricing list below:

\$75 Polarized \$30 Blended Bifocal (Segment) \$40 Blue Light Blocker (Standard) \$60 Blue Light Blocker (Premium) \$150 Blue Light Blocker (Ultra) \$12 Fashion Gradient \$20 Glass Photogrey (Single Vision) \$30 Glass Photogrey (Multi-Focal) \$55 High Index \$12 Ultraviolet Coating	\$25 Polycarbonate (Single Vision) 19 & over \$30 Polycarbonate (Multi-Focal) 19 & over \$10 Scratch-Resistant Coating (Standard) \$65 Transitions Single Vision (Standard) \$70 Transitions Multi-Focal (Standard) \$10 Solid Tint \$40 AR Coating – Tier 1 \$50 AR Coating – Tier 2 \$65 AR Coating – Tier 3 \$80 AR Coating – Tier 4	20% discount AR Coating – Tier 5 \$50 Progressive Tier -1 \$80 Progressive – Tier 2 \$100 Progressive – Tier 3 \$120 Progressive – Tier 4 \$140 Progressive – Tier 5 \$165 Progressive – Tier 6 \$190 Progressive – Tier 7 20% discount Progressive – Tier 8 \$39 Retinal Screening
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For lens options & services purchased from a participating NVA provider, NVA members will only pay the fixed maximum amount or the provider's Usual and Customary (U&C) charge less 20%, whichever is less. Options not listed will be priced by NVA providers at 20% off the Provider's Retail (U&C) price. Fixed prices are available in-network only. Discounts are not insured benefits. In certain states, members may be required to pay the full retail amount and not the negotiated discount amount at certain participating providers. Some optometrist affiliated with Optical Retail locations (i.e., LensCrafters, Walmart, Visionworks, etc.) are independent providers and may not participate in the NVA program.

Participating providers are not contractually obligated to offer sale prices in addition to outlined coverage. Regardless of medical or optical necessity, vision benefits are not available more frequently than specified in your policy.



Get a Better View

Plan Specific Details Online: The NVA website is easy to use and provides the most up to date information for program participants:
-Locate a nearby participating provider by name, zip code, or City/State, Verify eligibility for you or a dependent
-View benefit program and specific detail, Review claims, Print ID cards (when applicable), Nominate a non-participating provider to join the NVA network

Examinations: The comprehensive exam includes case history, examination for pathology or anomalies, visual acuity (clearness of vision), refraction, tonometry (glaucoma test) and dilation (if professionally indicated).

Lenses: NVA provides coverage in full for standard glass or plastic eyeglass lenses.

Frames: Select any frame from the participating provider's inventory. Any amount in excess of your plan allowance is the member's responsibility. Frame choices vary from office to office. (Visit NVA's website to view the Benefit maximizer Program)

Contact Lenses: The contact lens benefit includes all types of contact lenses such as hard, soft, gas permeable and disposable lenses. Medically necessary contact lenses includes fitting and follow up and may be covered with prior authorization when prescribed for: post cataract surgery, correction of extreme visual acuity problems that cannot be corrected to 20/70 with spectacle lenses, Anisometropia or Keratoconus.

Non-Participating Providers: You will be responsible for one hundred percent (100%) of the cost at the time of service at a non-participating provider. You can request a claim form from NVA via the website www.e-nva.com or you may submit receipts along with a letter containing the member's full name, patient's full name, address, ID# and sponsoring organization to NVA, P.O. Box 2187, Clifton, NJ 07015.

Laser Eye Surgery: NVA has chosen **The National LASIK Network** to serve their members. This network was developed by **LCA Vision** in 1999 and is one of the largest panels of LASIK surgeons in the U.S. Members are entitled to significant discounts and a free initial consultation with all in-network providers.

Hearing Discount: You will receive up to 60% savings at participating provider locations through NationsHearing®.

Discounts: In addition to your funded benefit you are eligible to access the **EyeEssential® Plan discount** (in Network Only) on additional purchases during the plan period. Please see table for more detail regarding NVA's discount plan:

*Discount is not applicable to mail order; however, you may get even better pricing on contact lenses through Contact Fill.

Your NVA EyeEssential® Plan Discount – In Network Only		
Service	Participating Provider	Lens Options
Eye Examination:	Member Cost: Retail Less \$10	\$12 Solid Tint/ Gradient Tint \$50 Standard Progressive Lenses \$75 Polarized Lenses \$65 Transitions Single Vision Standard \$70 Transitions Multi-Focal Standard \$15 Standard Scratch Coating \$12 UV Coating \$35 Polycarbonate \$45 Standard Anti-Reflective
Contact Lens Fitting:	Retail Less 10%	
Lenses:	Glass or Plastic	
Single Vision	\$35.00	
Bifocal	\$55.00	
Trifocal or Lenticular	\$70.00	
Frame:	Retail Less 35%	
Contact Lenses*:	Member Cost:	
Conventional	Retail Less 15%	
Disposable	Retail Less 10%	

Lens options purchased from a participating NVA provider will be provided to the member at the amounts listed in the fixed option price list above.

Options not listed will be priced by NVA providers at 20% off the Provider's Retail (U and C) price.

Wal-Mart / Sam's Club and Lenscrafters stores do not provide additional discounts.

Some optometrist affiliated with Optical Retail locations (i.e., LensCrafters, Walmart, Visionworks, etc.) are independent providers and may not participate in the NVA program.

At NVA, We Work Only for Our Clients.

Insurance coverage provided by National Guardian Life Insurance Company (NGLIC), 2E Gilman, Madison, WI 53703. Policy NVIGRP 5/07. NGLIC is not affiliated with the Guardian Life Insurance Company of America, a/k/a The Guardian or Guardian Life. A full description of your coverage, its limitations, exclusions and conditions is contained in the Insurance Policy issued to your Plan Sponsor at its place of business. That full description in the form of a Certificate of Coverage can be made available to you by requesting it from your Plan Sponsor.

Exclusions / Limitations: No payment is made for medical or surgical treatments / Rx drugs or OTC medications / non-prescription lenses / two pair of glasses in lieu of bifocals / subnormal visual aids / vision examination or materials required for employment / replacement of lost, stolen, broken or damaged lenses/ contact lenses or frames except at normal intervals when service would otherwise be available / services or materials provided by federal, state, local government or Worker's Compensation / examination, procedures training or materials not listed as a covered service / industrial safety lenses and safety frames with or without side shields / parts or repair of frame / sunglasses.

National Vision Administrators, L.L.C. • PO Box 2187 • Clifton, NJ 07015

Web: www.e-nva.com • Toll-Free: 1.800.672.7723

NVA® and EyeEssential® are registered marks of National Vision Administrators, L.L.C.

This document is intended as a program overview only and is not a certified document of the individual plan parameters.



Dental Plan

Principal | Dental Renewal

Plan Explanation

Comprehensive coverage is provided for eligible employees and their families which includes eligible dependent children up to the age of 26. Your HSA account can be used to cover co-pays. The plan has a maximum annual amount of coverage of \$1,000 per covered person. It also has an accumulation plan which may allow members to carry forward a portion of unused balance. A member must have submitted a claim during the year to qualify. If no claims were submitted, the entire balance is forfeited. If less than \$500 of benefits were used during the plan year, \$250 will be carried forward to the next plan year. The maximum balance that can be accumulated is \$1,000.

DEDUCTIBLE	IN-NETWORK	OUT-OF-NETWORK
Single	\$0	\$25
Double / Family	\$0	\$25
MAXIMUM THE CARRIER WILL PAY		
Annual Maximum	\$1,000	\$1,000
FREQUENCIES		
Cleaning	2x per Year	
Exam	2x per Year	
DENTAL COVERAGE		
Cleanings	100%	100%
Exams	100%	100%
X-Rays	100%	100%
Sealants	100%	100%
Fillings	100%	100%
Simple Extractions	100%	100%
Root Canal	60%	60%
Oral Surgery	60%	60%
Crowns	60%	60%
Dentures	60%	60%
Bridges	60%	60%
Orthodontia	50%	50%
Orthodontia Lifetime Deductible	\$0	
Orthodontia Lifetime Maximum	\$2,000	
OUT OF NETWORK EXPLANATION		
	Out of network dentists are NOT contracted with your dental insurance carrier. After you pay for the service based on your benefit plan, the insurance carrier will pay the out of network dentist the same rate they pay an in-network dentist. In most cases, the out of network dentist does not consider this as payment in full (like an in-network dentist would) and may "Balance bill" you. That is, they may ask you to pay the difference.	
PLAN INFORMATION		
Plan Year	2025	
Network Type	PPO HSA	
Network Name	Principal Plan Dental Network	
Member Website	https://www.principal.com	
Customer Service Phone Number	800-247-4695	

Disclaimer

Disclaimer: This is a partial listing of your covered benefits. For a complete accurate listing of covered benefits, limitations and exclusions, refer to your certificate of coverage.



Bi-Weekly Contributions for Medical and Dental

IDS offers an IRC (Internal Revenue Code) Section 125 Premium Conversion Plan. This allows your contributions toward medical and dental insurance to be made on a pre-tax basis. Your taxable income is reduced by the amount of your contribution which reduces income subject to Federal, State and FICA taxes. The tax benefit that you receive will depend on the contribution and tax bracket.

Plan	Single Bi- Weekly Deduction	Double Bi- Weekly Deduction	Family Bi- Weekly Deduction
Medical Base	\$62.12	\$164.63	\$223.64
Supplemental Medical Cost	There is an additional supplemental cost based on your annual salary which is 1% (Hourly rate of \$28.21 to \$47.00) or 2% (Hourly rate of \$47.01 and higher). Bi-Weekly Calculation is hourly rate x 2080 hours = annual salary and multiply by 1% or 2% then divide by 26.		
Dental	\$4.25	\$7.00	\$11.75

*These deductions will appear on your paystub as deductions. The code for Medical is ASR, the code for the Supplemental Medical is ASRSUP and the code for Dental is DEL.

Life Plan

UNUM | Life Coverage

Plan Explanation

IDS offers eligible employees Basic Life, Long Term Disability and Accidental Death and Disability (AD&D) coverage through UNUM Provident. Your basic life benefit is equal to the lesser of your base annual earnings (rounded to the next highest \$1,000) or \$50,000. AD&D benefits are also provided. If your death is determined to be an accident, the Accidental Death & Dismemberment (AD&D) portion of the policy will pay an additional benefit equal to the lesser of your base annual earnings (rounded to the next highest \$1,000) or \$50,000 to your beneficiary.

LIFE INSURANCE BENEFITS	
Life Insurance Coverage	1x annual salary, maximum benefit of \$50,000
Accidental Death & Dismemberment	1x annual salary, maximum benefit of \$50,000
Age Reduction Schedule	Life insurance is reduced by 65% after age 70, and reduced by 50% after age 75.
PLAN INFORMATION	
Plan Year	2025
Member Website	www.unumprovident.com or email: askunum@unum.com
Customer Service Phone Number	877-275-3539

Disclaimer

Disclaimer: This is a partial listing of your covered benefits. For a complete accurate listing of covered benefits, limitations and exclusions, refer to your certificate of coverage.

Voluntary Life

UNUM | Voluntary Life Coverage

Plan Explanation

You can elect to purchase Supplemental Life coverage in increments of \$10,000 up to the lesser of five times your base annual earnings or \$500,000. You may elect to purchase Supplemental Life coverage for your spouse in \$5,000 increments. The maximum benefit is the lesser of 100% of your (the employee's) Supplemental Life coverage or \$500,000. You may elect to purchase Supplemental Life coverage for your eligible dependent children aged 14 days to 19 years of age (or to age 26 if a full-time student) in \$2,000 increments. The premium amount provides life coverage for all of your eligible dependent children. In other words, your monthly rate is the same regardless of the number of eligible children that you have. The maximum amount of Life coverage on your dependent children is \$10,000.

LIFE INSURANCE BENEFITS

Employee Life Insurance Coverage	Amounts in \$10,000 benefit units as applied for by you, and approved by UNUM. Evidence for Insurability is required for an amount over \$50,000. Maximum Benefit is the lesser of 5 times your annual earnings, or \$500,000.
Spouse Life Insurance Coverage	Amounts in \$5,000 benefit units as applied for by you and approved by UNUM. Evidence for Insurability is required for an amount over \$25,000. Maximum Benefit is the lesser of 100% of your insurance, or \$500,000.
Child(ren) Life Insurance Coverage	Amounts in \$2,000 benefit units as applied for by you and approved by UNUM. Maximum Benefit for children: Birth to 6 months: \$1,000 6 months to age 19, or 26 if a full time student: The lesser of 100% of your insurance, or \$10,000
Age Reduction Schedule	Insurance amount reduces by 65% at age 70, and then by 50%
Guaranteed Insurability	You will be required to submit an Evidence of Insurability statement if: 1) in previous years you were eligible for Supplemental Life benefits but, have never elected to enroll OR 2) you are enrolled and chose to increase the amount of coverage such that the new supplemental life policy exceeds \$50,000.

PLAN INFORMATION

Plan Year	2025
Member Website	www.unumprovident.com or email askunum@unum.com
Customer Service Phone Number	877-275-3539

Disclaimer

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Short Term Disability

UNUM | Short Term Disability Coverage

Plan Explanation

Short term disability insurance is available to all eligible employees on an elective basis. This plan, through Unum Provident, is designed to provide a benefit to replace a portion of your lost income should you be unable to work due to a non-occupational illness or injury.

STD INSURANCE BENEFITS

Weekly Benefit	60% of weekly earnings up to \$750 per week. Up to 13 weeks.
When do benefits start? (Elimination period)	0 days due to an injury. 7 days due to sickness or illness.
How long do my benefits pay out?	13 weeks

PLAN INFORMATION

Plan Year	2025
Member Website	www.unumprovident.com or email askunum@unum.com
Customer Service Phone Number	877-275-3539

Disclaimer

Disclaimer: This is a partial listing of your covered benefits. For a complete accurate listing of covered benefits, limitations and exclusions, refer to your certificate of coverage.

Long Term Disability

UNUM | Long Term Disability Coverage

Plan Explanation

IDS offers Long Term Disability insurance which provides you with 60% of monthly (maximum \$6,000) income if you are totally disabled. Disability income benefits begin on the 91st day of disability and may be paid while you are disabled until you attain 65 years of age, or later, depending upon your age when the disability starts.

LTD INSURANCE BENEFITS	
Monthly Benefit	60% of monthly earnings with a maximum of \$10,000 per month for partners and \$6,000 per month for employees.
When do benefits start? (Elimination period)	90 days.
How long do my benefits pay out?	Age at Disability Maximum Period of Payment: Less than age 60 to age 65, but not less than 5 years Age 60, 60 months Age 61, 48 months Age 62, 42 months Age 63, 36 months Age 64, 30 months Age 65, 24 months Age 66, 21 months Age 67, 18 months Age 68, 15 months Age 69 and over, 12 months
Taxation of Benefit	Pre-tax means that you elect to pay taxes on the imputed value of the premium now, in the current tax year. This occurs through payroll. If you elect this option, your paystub will reflect the bi-weekly amount under earnings and deductions. Post-tax means that you are electing to pay taxes on any LTD benefits that you may receive as a result of an event occurring during the plan year resulting in LTD benefits. No taxes will be withheld if no LTD benefits are paid.
PLAN INFORMATION	
Plan Year	2025
Member Website	www.unumprovident.com or email, askunum@unum.com
Customer Service Phone Number	877-275-3539



Disclaimer

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Allstate BENEFITS

Protection for accidental
injuries on- and off-the-job,
24 hours a day

Accident Insurance

Today, active lifestyles in or out of the home may result in bumps, bruises and sometimes breaks. Getting the right treatment can be vital to recovery, but it can also be expensive. And if an accident keeps you away from work during recovery, the financial worries can grow quickly.

Most major medical insurance plans only pay a portion of the bills. Our coverage can help pick up where other insurance leaves off and provide cash to help cover the expenses.

With Accident insurance from Allstate Benefits, you can gain the advantage of financial support, thanks to the cash benefits paid directly to you. You also gain the financial empowerment to seek the treatment needed to be on the mend.

Here's How It Works

Our coverage pays you cash benefits that correspond with hospital and intensive care confinement. Your plan may also include coverage for a variety of occurrences, such as: dismemberment; dislocation or fracture; ambulance services; physical therapy and more. The cash benefits can be used to help pay for deductibles, treatment, rent and more.

Meeting Your Needs

- Guaranteed Issue, meaning no medical questions to answer
- Benefits are paid directly to you unless otherwise assigned
- Pays in addition to other insurance coverage
- Coverage also available for your dependents
- Premiums are affordable and can be conveniently payroll deducted
- Coverage may be continued; refer to your certificate for details

With Allstate Benefits, you can protect your finances against life's slips and falls.
Are you in Good Hands? You can be.

DID YOU KNOW ?

The number of injuries suffered
by workers in one year, both
on- and off-the-job, includes:¹

ON-THE-JOB (in millions)



Work
4.4

OFF-THE-JOB (in millions)



Home
9.2



Non-Auto
4.0



Auto
2.2

¹National Safety Council, Injury Facts®, 2017 Edition

Meet Daniel & Sandy

Daniel and Sandy are like most active couples; they enjoy the outdoors and a great adventure. They have seen their share of bumps, bruises and breaks. Sandy knows an accidental injury could happen to either of them. Most importantly, she worries about how they will pay for it.

Here is what weighs heavily on her mind:

- Major medical will only pay a portion of the expenses associated with injury treatments
- They have copays they are responsible for until they meet their deductible
- If they miss work because of an injury, they must cover the bills, rent/mortgage, groceries and their child's education
- If they need to seek treatment not available locally, they will have to pay for it



Daniel's story of injury and treatment turned into a happy ending, because he had supplemental Accident Insurance to help with expenses.



CHOOSE

Daniel and Sandy choose benefits to help protect their family if they suffer an accidental injury.



USE

Daniel was playing a pick-up game of basketball with his friends when he went up for a jump-shot and, on his way back down, twisted his foot and ruptured his Achilles tendon.

Here's Daniel's treatment path:

- Taken by ambulance to the emergency room
- Examined by a doctor and X-rays were taken
- Underwent surgery to reattach the tendon
- Visited by his doctor and released after a one-day stay in the hospital
- Had to immobilize his ankle for 6 weeks
- Seen by the doctor during a follow-up visit and sent to physical therapy to strengthen his leg and improve his mobility

Daniel would go online after each of his treatments to file claims. The cash benefits were direct deposited into his bank account.

Daniel is back playing basketball and enjoying life.



CLAIM

Daniel's Accident claim paid cash benefits for the following:

Ground Ambulance

Medicine

Emergency Room

X-rays

Initial Hospital Confinement

Daily Hospital Confinement

Accident Physician's Treatment

Tendon Surgery

General Anesthesia

Physical Therapy (3 days/week)

For a listing of benefits and benefit amounts, see your company's rate insert.

Using your cash benefits

Cash benefits provide you with options, because you decide how to use them.



Finances

Can help protect HSAs, savings, retirement plans and 401(k)s from being depleted.



Travel

Can help pay for expenses while receiving treatment in another city.



Home

Can help pay the mortgage, continue rental payments, or perform needed home repairs for after care.



Expenses

Can help pay your family's living expenses such as bills, electricity, and gas.



MyBenefits: 24/7 Access allstatebenefits.com/mybenefits

An easy-to-use website that offers 24/7 access to important information about your benefits. Plus, you can submit and check your claims (including claim history), request your cash benefit to be direct deposited, make changes to personal information, and more.

Dependent Eligibility

Coverage may include you, your spouse or domestic partner, and your children.

*Two treatments per covered person, per accident. **Up to three times per covered person, per accident. ¹Multiple dislocations, fractures, dismemberments or functional losses from the same accident are limited to the amount shown in the Benefit Amounts on rate insert. ²Two or more surgeries done at the same time are considered one operation. ³Paid for each day a room charge is incurred, up to 30 days for each covered person per continuous period of rehabilitation unit confinement, for a maximum of 60 days per calendar year. Not paid for days on which the Daily Hospital Confinement benefit is paid.

Benefits (subject to maximums as listed on the attached rate insert)

BASE POLICY BENEFITS

Initial Hospital Confinement

Daily Hospital Confinement - up to 365 days for any one accident

Intensive Care - up to 180 days for each period of continuous confinement

RIDER BENEFITS ADDED TO BASE POLICY

Accident Treatment & Urgent Care Rider

Benefits for: Ground Ambulance, Air Ambulance, Accident Physician's Treatment, X-ray, Urgent Care

Dislocation/Fracture Rider¹ - amount paid depends on type of dislocation or fracture. See Injury Benefit Schedule in rate insert

Emergency Room Services Rider - received as a result of injury

OPTIONAL/ADDITIONAL RIDER BENEFITS

Accidental Death, Dismemberment and Functional Loss Rider

Benefits for: Accidental Death, Common Carrier, Dismemberment¹, Functional Loss¹

Benefit Enhancement Rider

Accident Follow-Up Treatment - not payable for the same visit for which the Physical, Occupational or Speech Therapy benefit is paid*

Lacerations

Burns - treatment for one or more burns, other than sunburns

Skin Graft - for a burn for which a benefit is paid under the Burns benefit

Brain Injury Diagnosis - first diagnosis of concussion, cerebral laceration, cerebral contusion or intracranial hemorrhage. Must be diagnosed by CT Scan, MRI, EEG, PET scan or X-ray

Computed Tomography (CT) Scan and Magnetic Resonance Imaging (MRI) - treatments must be received within 30 days after the accident. Payable once per covered person, per accident, per calendar year

Paralysis - spinal cord injury resulting in complete/permanent loss of use of two or more limbs for 90 consecutive days

Coma with Respiratory Assistance - unconsciousness lasting 7 or more days; intubation required. Medically induced comas excluded

Open Abdominal or Thoracic Surgery - must be performed by a physician²

Tendon, Ligament, Rotator Cuff or Knee Cartilage Surgery - surgery for torn, ruptured, or severed tendon, ligament, rotator cuff or knee cartilage; pays the reduced amount shown for arthroscopic exploratory surgery²

Ruptured Disc Surgery - diagnosis and surgical repair to a ruptured disc of the spine by a physician²

Eye Surgery - surgery or removal of a foreign object by a physician

General Anesthesia - payable only if one of the rider Surgery benefits is paid

Blood and Plasma

Appliance - physician-prescribed wheelchair, crutches or walker to help with personal locomotion or mobility

Medical Supplies

Medicine

Prosthesis - physician-prescribed prosthetic arm, leg, hand, foot or eye lost as a result of an accident

Physical, Occupational or Speech Therapy - 1 treatment per day; maximum of 6 treatments per accident.

Includes chiropractic services. Not payable for same visit for which Accident Follow-Up Treatment benefit is paid

Rehabilitation Unit - must be hospital-confined due to an injury prior to being transferred to rehab³

Non-Local Transportation - obtaining treatment more than 50 miles from your home when not available locally. Ground or air ambulance is not covered**

Family Member Lodging - 1 adult family member to be with you while you are hospital confined. Not paid if family member lives within 50 miles of the hospital. Payable up to 30 days per accident

Post-Accident Transportation - three-day hospital stay more than 250 miles from your home, with a flight on a common carrier to return home. Payable only if the Daily Hospital Confinement benefit is paid

Broken Tooth - dental repair by crown, filling or extraction; only one of the three is covered per accident. Injury must be to natural teeth and cannot be due to biting or chewing

Residence/Vehicle Modification - permanent structural modification certified necessary by a physician, within 365 days after accident

Pain Management (Epidural Injection) - injection in the spine to manage pain due to an accidental injury

Miscellaneous Outpatient Surgery - physician-performed outpatient surgical procedure. Not paid if one of the following benefits is paid: Open Abdominal or Thoracic Surgery; Tendon, Ligament, Rotator Cuff or Knee Cartilage Surgery; Ruptured Disc Surgery; or Eye Surgery

Group Voluntary Accident (GVAP6)

24-Hour Accident Insurance from Allstate Benefits

BENEFIT AMOUNTS

Benefits are paid once per accident unless otherwise noted here or in the brochure

BASE POLICY BENEFIT		PLAN 1	PLAN 2
Initial Hospital Confinement (pays once/year)		\$1,500	\$2,000
Daily Hospital Confinement (pays daily)		\$300	\$400
Intensive Care (pays daily)		\$600	\$800
RIDER BENEFITS		PLAN 1	PLAN 2
Accident Treatment & Urgent Care Rider			
Ambulance	Ground	\$300	\$400
	Air	\$900	\$1,200
Accident Physician's Treatment		\$150	\$200
X-ray		\$300	\$400
Urgent Care		\$150	\$200
Dislocation/Fracture Rider ¹		\$6,000	\$8,000
Emergency Room Services Rider		\$300	\$400
Accidental Death ¹ , Dismemberment ¹ and Functional Loss ¹ Rider		\$60,000	\$100,000
Common Carrier (fare-paying passenger)		\$150,000	\$250,000
BENEFIT ENHANCEMENT RIDER		PLAN 1	PLAN 2
Accident Follow-Up Treatment (pays daily)		\$150	\$200
Lacerations		\$150	\$200
Burns	< 15% body surface	\$300	\$400
	15% or more	\$1,500	\$2,000
Skin Graft (% of Burns Benefit)		50%	50%
Brain Injury Diagnosis		\$900	\$1,200
Computed Tomography (CT) Scan and Magnetic Resonance Imaging (MRI) (pays once/year)		\$150	\$200
Paralysis (pays once)	Paraplegia	\$22,500	\$30,000
	Quadriplegia	\$45,000	\$60,000
Coma with Respiratory Assistance		\$30,000	\$40,000
Open Abdominal or Thoracic Surgery		\$3,000	\$4,000
Tendon, Ligament, Rotator Cuff or Knee Cartilage Surgery	Surgery	\$1,500	\$2,000
	Exploratory	\$450	\$600
Ruptured Spinal Disc Surgery		\$1,500	\$2,000
Eye Surgery		\$300	\$400
General Anesthesia		\$300	\$400
Blood and Plasma		\$900	\$1,200
Appliance		\$375.00	\$500.00
Medical Supplies		\$15.00	\$20.00
Medicine		\$15.00	\$20.00
Prosthesis	1 device	\$1,500	\$2,000
	2 or more devices	\$3,000	\$4,000
Physical, Occupational or Speech Therapy (pays daily)		\$90	\$120
Rehabilitation Unit (pays daily)		\$300	\$400
Non-Local Transportation		\$750	\$1,000
Family Member Lodging (pays daily)		\$300	\$400
Post-Accident Transportation (pays once/year)		\$600	\$800
Broken Tooth		\$300	\$400
Residence/Vehicle Modification		\$1,500	\$2,000
Pain Management (Epidural Injection)		\$150	\$200
Miscellaneous Outpatient Surgery		\$300	\$400

*Each benefit pays the amount shown. ¹Up to amount shown; see Injury Benefit Schedule on reverse. Multiple losses from same injury pay only up to amount shown above.

PLAN 1 PREMIUMS

MODE	EE	EE + SP	EE + CH	F
Weekly	\$4.16	\$7.19	\$9.02	\$11.37
Bi-Weekly	\$8.32	\$14.38	\$18.04	\$22.74
Semi-Monthly	\$9.01	\$15.58	\$19.53	\$24.63
Monthly	\$18.01	\$31.16	\$39.06	\$49.25

PLAN 2 PREMIUMS

MODE	EE	EE + SP	EE + CH	F
Weekly	\$5.74	\$9.93	\$12.40	\$15.50
Bi-Weekly	\$11.48	\$19.86	\$24.80	\$31.00
Semi-Monthly	\$12.43	\$21.50	\$26.86	\$33.57
Monthly	\$24.86	\$43.00	\$53.72	\$67.13

Issue ages: 18 and over if actively at work

EE=Employee; EE + SP = Employee + Spouse;

EE + CH = Employee + Child(ren); F = Family

Injury Benefit Schedule is on reverse

INJURY BENEFIT SCHEDULE

Benefit amounts for coverage and one occurrence are shown below.

COMPLETE DISLOCATION	PLAN 1	PLAN 2
Hip joint	\$6,000	\$8,000
Knee or ankle joint [^] , bone or bones of the foot [^]	\$2,400	\$3,200
Wrist joint	\$2,100	\$2,800
Elbow joint	\$1,800	\$2,400
Shoulder joint	\$1,200	\$1,600
Bone or bones of the hand [^] , collarbone	\$900	\$1,200
Two or more fingers or toes	\$420	\$560
One finger or toe	\$180	\$240
COMPLETE, SIMPLE OR CLOSED FRACTURE	PLAN 1	PLAN 2
Hip, thigh (femur), pelvis ⁺⁺	\$6,000	\$8,000
Skull ⁺⁺	\$5,700	\$7,600
Arm, between shoulder and elbow (shaft), shoulder blade (scapula), leg (tibia or fibula)	\$3,300	\$4,400
Ankle, knee cap (patella), forearm (radius or ulna), collarbone (clavicle)	\$2,400	\$3,200
Foot ⁺⁺ , hand or wrist ⁺⁺	\$2,100	\$2,800
Lower jaw ⁺⁺	\$1,200	\$1,600
Two or more ribs, fingers or toes, bones of face or nose	\$900	\$1,200
One rib, finger or toe, coccyx	\$420	\$560
LOSS	PLAN 1	PLAN 2
Life, hearing, speech, or both eyes, hands, arms, feet, or legs, or one hand or arm and one foot or leg	\$60,000	\$100,000
One eye, hand, arm, foot, or leg	\$30,000	\$50,000
One or more entire toes or fingers	\$6,000	\$10,000

[^]Knee joint (except patella). Bone or bones of the foot (except toes). Bone or bones of the hand (except fingers). ⁺⁺Pelvis (except coccyx). Skull (except bones of face or nose). Foot (except toes). Hand or wrist (except fingers). Lower jaw (except alveolar process).

FOR HOME OFFICE USE ONLY – GVAP6

Opt 1 - 3.0U Base; 3.0U D/F; 3.0U AUC; 3.0U ERS; 3.0U ADD; 3.0U BER; 24 Hour

Opt 2 - 4.0U Base; 4.0U D/F; 4.0U AUC; 4.0U ERS; 5.0U ADD; 4.0U BER; 24 Hour

ABQ V 5.03.2019 Rate Insert Creation Date: 7/18/2019



For use in enrollments situated in: MI. This rate insert is part of the approved brochure or form ABJ29986-6; it is not to be used on its own.

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CERTIFICATE SPECIFICATIONS

Conditions and Limits

When an injury results in a covered loss within 180 days, unless otherwise stated, from the date of an accident, and is diagnosed by a physician, Allstate Benefits will pay benefits as stated. Treatment must be received in the United States or its territories.

Eligibility

Your employer decides who is eligible for your group (such as length of service and hours worked each week).

Dependent Eligibility/Termination

Coverage may include you, your spouse or domestic partner, and your children. Coverage for children ends when the child reaches age 26, unless he or she continues to meet the requirements of an eligible dependent. Spouse coverage ends upon valid decree of divorce or your death. Domestic partner coverage ends upon termination of the domestic partnership or your death.

When Coverage Ends

Coverage under the policy and riders ends on the earliest of: the date the policy or certificate is canceled; the last day of the period for which you made any required contributions; the last day you are in active employment, except as provided under the Temporary Layoff, Leave of Absence, or Family and Medical Leave of Absence provision; the date you are no longer in an eligible class; the date your class is no longer eligible; or discovery of fraud or material misrepresentation when filing a claim.

Continuing Your Coverage

You may be eligible to continue coverage when coverage under the policy ends. Refer to your Certificate of Insurance for details.

EXCLUSIONS AND LIMITATIONS

Exclusions and Limitations for Policy and the following riders: Accident Treatment and Urgent Care Rider; Dislocation/Fracture Rider; Emergency Room Services Rider; Accidental Death, Dismemberment and Functional Loss Rider; and Benefit Enhancement Rider

Benefits are not paid for: injury incurred before the effective date; act of war or participation in a riot, insurrection or rebellion; suicide or attempt at suicide; intentionally self-inflicted injury or action; any bacterial infection (except pyogenic infections from an accidental cut or wound); participation in aeronautics unless a fare-paying passenger on a licensed common-carrier aircraft; engaging in an illegal occupation or committing or attempting an assault or felony; driving in any race or speed test or testing any vehicle on any racetrack or speedway; injury while under the influence of alcohol (as defined by the laws of the state of Michigan), narcotics, or any other controlled substance or drug, unless taken as prescribed by a physician; serving as an active member of the Military, Naval, or Air Forces of any country or combination of countries.

This brochure is for use in enrollments situated in MI, and is incomplete without the accompanying rate insert. This material is valid as long as information remains current, but in no event later than July 24, 2022.

Group Accident benefits are provided under policy form GVAP6, or state variations thereof. Accident Rider benefits are provided under the following rider forms, or state variations thereof: Accident Treatment and Urgent Care Rider GP6AUC; Accidental Death, Dismemberment and Functional Loss Rider GP6ADD; Benefit Enhancement Rider GP6BE; Dislocation/Fracture Rider GP6DF; and Emergency Room Services Rider GP6ERS.

The coverage provided is limited benefit supplemental accident insurance. The policy is not a Medicare Supplement Policy. If eligible for Medicare, review Medicare Supplement Buyer's Guide available from Allstate Benefits.

This is a brief overview of the benefits available under the group policy underwritten by American Heritage Life Insurance Company (Home Office, Jacksonville, FL). Details of the coverage, including exclusions and other limitations are included in the certificates issued. For additional information, you may contact your Allstate Benefits Representative.

The coverage does not constitute comprehensive health insurance coverage (often referred to as "major medical coverage") and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.



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Allstate
BENEFITS

Protection when faced with
a critical illness diagnosis
and you need treatment

Critical Illness Insurance

No one is ever really prepared for a life-altering critical illness diagnosis. The whirlwind of appointments, tests, treatments and medications can add to your stress levels.

The treatment to recovery is vital, but it can also be expensive. Your medical coverage may only cover some of the costs associated with treatment. You're still responsible for deductibles and coinsurance. If treatment keeps you out of work, the financial worries can grow quickly and stress levels may rise.

Critical Illness coverage helps provide financial support if you are diagnosed with a covered critical illness. With the expense of treatment often high, seeking the treatment you need could seem like a financial burden. When a diagnosis occurs, you need to be focused on getting better and taking control of your health, not stressing over financial worries.

Here's How It Works

You choose benefits to protect yourself and any family members if diagnosed with a critical illness. Then, if diagnosed with a covered critical illness, you will receive a cash benefit based on the percentage payable for the condition.

Meeting Your Needs

- Guaranteed Issue, meaning no medical questions to answer at initial enrollment
- Coverage available for individual and child(ren) or family
- Covered dependents receive 50% of your Basic-Benefit Amount
- Benefits paid regardless of any other medical or disability plan coverage
- Premiums are affordable and conveniently payroll deducted
- Coverage may be continued; refer to your certificate for details
- 100% of your Basic-Benefit Amount is paid for Advanced Alzheimer's Disease and Advanced Parkinson's Disease

With Allstate Benefits, you can make treatment decisions without putting your finances at risk. **Are you in Good Hands? You can be.**

DID YOU KNOW ?



Every **40** seconds,
an American will suffer
a heart attack¹



Every **40** seconds,
someone in the U.S.
has a stroke²

¹https://www.cdc.gov/heartdisease/heart_attack.htm

²<https://www.cdc.gov/stroke/facts.htm>

Meet Ashley

Ashley is like any single parent who has been diagnosed with a critical illness. She's worried about her future, her children and how they will cope with her treatments. Most importantly, she worries about how she will pay for it all.

Here is what weighs heavily on her mind:

- Major medical only pays a portion of the expenses associated with my treatment
- I have copays I am responsible for until I meet my deductible
- If I am not working due to my treatments, I must cover my bills, rent/mortgage, groceries and my children's education
- If the right treatment is not available locally, I will have to travel to get the treatment I need



Ashley's story of diagnosis and treatment turned into a happy ending, because she had supplemental Critical Illness Insurance to help with expenses.



CHOOSE

Ashley chooses Critical Illness benefits and rider benefits to help protect her and her children, if they are diagnosed with a critical illness.



USE

During Ashley's annual wellness exam, her doctor noticed an irregular heartbeat. She underwent an electrocardiogram (EKG) test and stress test, which confirmed she had a blockage in one of her coronary arteries.

Here's Ashley's treatment path:

- Ashley has her annual wellness exam
- Her doctor notices an abnormality in her heartbeat; tests are performed and she is diagnosed with coronary artery disease
- After visits with doctors, surgeons and an anesthesiologist, Ashley undergoes surgery
- Surgery is performed to remove the blockage with a bypass graft. She is visited by her doctor during a 4-day hospital stay and released
- Ashley followed her doctor required treatment during a 2-month recovery period, and had regular doctor office visits

Ashley is doing well and is on the road to recovery.



CLAIM

Ashley's Critical Illness claim paid her cash benefits for the following:

Coronary Artery Bypass Surgery

The cash benefits were direct deposited into her bank account.

For a listing of benefits and benefit amounts, see your company's rate insert.

Using your cash benefits

Cash benefits provide you with options, because you decide how to use them.



Finances

Can help protect HSAs, savings, retirement plans and 401(k)s from being depleted.



Travel

Can help pay for expenses while receiving treatment in another city.



Home

Can help pay the mortgage, continue rental payments, or perform needed home repairs for after care.



Expenses

Can help pay your family's living expenses such as bills, electricity, and gas.



MyBenefits: 24/7 Access allstatebenefits.com/mybenefits

An easy-to-use website that offers 24/7 access to important information about your benefits. Plus, you can submit and check your claims (including claim history), request your cash benefit to be direct deposited, make changes to personal information, and more.

Specified Chronic Illness Rider -

Adrenal Hypofunction (Addison's Disease); Lou Gehrig's Disease (ALS); Arthritis; Huntington's Chorea; Multiple Sclerosis; Muscular Dystrophy; Osteomyelitis; Osteoporosis.

Benefits (subject to maximums as listed on the attached rate insert)

Benefit paid upon diagnosis of one of the following conditions

INITIAL CRITICAL ILLNESS BENEFITS*

Heart Attack - the death of a portion of the heart muscle due to inadequate blood supply. Established (old) myocardial infarction and cardiac arrest are not covered

Stroke - the death of a portion of the brain producing neurological sequelae including infarction of brain tissue, hemorrhage and embolization from an extra-cranial source. Transient ischemic attacks (TIAs), head injury, chronic cerebrovascular insufficiency and reversible ischemic neurological deficits are not covered

End Stage Renal Failure - irreversible failure of both kidneys, resulting in peritoneal dialysis or hemodialysis. Renal failure caused by traumatic events, including surgical trauma, are not covered

Major Organ Transplant - pays either Candidate Benefit if placed on National Transplant List, or Surgery Benefit for transplant of heart, lungs, liver, pancreas or kidneys. Lungs and kidneys are each considered one major organ, regardless of whether one or both lungs or kidneys are transplanted. Surgery Benefit not paid if Candidate Benefit paid; also not paid for mechanical or non-human organs

Coronary Artery Bypass Surgery - to correct narrowing or blockage of one or more coronary arteries with bypass graft. Abdominal aortic bypass, balloon angioplasty, laser embolectomy, atherectomy, stent placement and non-surgical procedures are not covered

Waiver of Premium (employee only) - premiums waived if disabled for 90 consecutive days due to a critical illness or specified disease

CANCER CRITICAL ILLNESS BENEFITS*

Carcinoma In Situ - non-invasive cancer, including early prostate cancer (stages A, I, II) and melanoma that has not invaded the dermis. Other skin malignancies, pre-malignant lesions (such as intraepithelial neoplasia), benign tumors and polyps are not covered

Invasive Cancer - malignant tumor with uncontrolled growth, including Leukemia and Lymphoma. Carcinoma in situ, non-invasive or metastasized skin cancer and early prostate cancer are not covered

REOCCURRENCE OF CRITICAL ILLNESS BENEFITS*

Initial Critical Illness - second diagnosis more than 12 months after the first date of diagnosis for which an Initial Critical Illness benefit was paid

Cancer Critical Illness - second diagnosis more than 12 months after the last date treatment was received for which a Cancer Critical Illness benefit was paid

RIDER BENEFITS

Skin Cancer Rider - includes diagnosis of basal cell carcinoma and squamous cell carcinoma. Must not have been paid within 365 days. Malignant melanoma and pre-cancerous conditions such as leukoplakia; actinic keratosis; carcinoma; hyperplasia; polycythemia; non-malignant melanoma; moles; and similar diseases or lesions are not covered

Cardiopulmonary Enhancement Rider - once per illness per covered person

Sudden Cardiac Arrest - payable if it is the primary diagnosis. Myocardial infarction (heart attack) is not covered

Pulmonary Embolism

Pulmonary Fibrosis

Second Evaluation, Transportation and Lodging Rider -

Second Evaluation - must be obtained prior to surgery or treatment and by a physician other than your current physician. One second evaluation per surgery or treatment

Non-Local Transportation - traveling to receive outpatient treatment for a covered critical illness more than 75 miles from home

Outpatient Lodging - while receiving outpatient treatment for a covered critical illness more than 75 miles from home

Family Member Lodging and Transportation - for one adult family member to accompany and care for an incapacitated covered person during non-local hospital stays (more than 75 miles from family member's home) for specialized treatment. Transportation benefit not paid if Non-Local Transportation benefit paid

Specified Chronic Illness Rider* - must be certified by a physician as having one of the chronic illnesses listed to the left. Must be unable to perform at least two daily activities¹ for at least 90 days

Supplemental Critical Illness Rider*-

Advanced Alzheimer's Disease - must exhibit impaired memory and judgment and be certified unable to perform at least two daily activities¹ without adult assistance

Advanced Parkinson's Disease - must exhibit two or more of the following: muscle rigidity, tremor, or bradykinesia (slowness in physical and mental responses); and be certified unable to perform at least two daily activities¹ without adult assistance

Benign Brain Tumor - a non-malignant tumor limited to brain, meninges, cranial nerves or pituitary gland. Tumors of the skull, pituitary adenomas less than 10mm, and germinomas are not covered

Coma - unconscious and not responsive to external stimulation or responsive to internal needs. Medically-induced coma, coma resulting from alcohol or drug use, and diagnosis of brain death are not covered

Complete Loss of Hearing - permanent loss of hearing in both ears

Complete Loss of Sight - permanent loss of vision in both eyes

Complete Loss of Speech - permanent loss of speech or verbal communication

Paralysis - permanent loss of muscle function in two or more limbs, due to disease or injury. Does not include loss of muscle function limited to fingers or toes

*Benefits paid once per covered person. When all benefits have been used, the coverage terminates. ¹Daily activities include: bathing, dressing, toileting, bladder and bowel continence, transferring and eating.

Critical Illness Insurance (GVCIP4)

from Allstate Benefits

BENEFIT AMOUNTS

Percentages below are based on the Basic Benefit Amount chosen by your employer.

†Covered dependents receive 50% of your benefit amount.

INITIAL CRITICAL ILLNESS BENEFITS [†]	PLAN 1
Heart Attack (100%)	\$15,000
Stroke (100%)	\$15,000
End Stage Renal Failure (100%)	\$15,000
Major Organ Transplant (100%)	\$15,000
Coronary Artery Bypass Surgery (25%)	\$3,750
Waiver of Premium (employee only)	Yes
CANCER CRITICAL ILLNESS BENEFITS [†]	PLAN 1
Invasive Cancer (100%)	\$15,000
Carcinoma in Situ (25%)	\$3,750
REOCCURRENCE OF CRITICAL ILLNESS BENEFITS [†]	PLAN 1
Initial Critical Illness (same amount as Initial Critical Illness Benefit)	Yes
Cancer Critical Illness (same amount as Cancer Critical Illness Benefit)	Yes
RIDER BENEFITS	PLAN 1
Skin Cancer Rider	\$250
Cardiopulmonary Enhancement Rider [†]	
Sudden Cardiac Arrest (25%)	\$3,750
Pulmonary Embolism (25%)	\$3,750
Pulmonary Fibrosis (25%)	\$3,750
Second Evaluation, Transportation and Lodging Rider	
Second Evaluation	\$1,000
Non-Local Transportation ¹ Air Fare	\$500 or
(per trip or mile ³) Personal Vehicle	\$0.50/mile
Outpatient Lodging ² (daily)	\$100
Family Member Lodging ² (daily)	\$100
and Transportation ¹ (per trip or mile ³) Air Fare	\$500 or
Personal Vehicle	\$0.50/mile
Specified Chronic Illness Rider [†] (50%)	\$7,500
Supplemental Critical Illness Rider [†]	
Advanced Alzheimer's Disease (100%)	\$15,000
Advanced Parkinson's Disease (100%)	\$15,000
Benign Brain Tumor (100%)	\$15,000
Coma (100%)	\$15,000
Complete Loss of Hearing (100%)	\$15,000
Complete Loss of Sight (100%)	\$15,000
Complete Loss of Speech (100%)	\$15,000
Paralysis (100%)	\$15,000

¹Limit of \$5,000 in a calendar year. ²Limit of \$1,000 in a calendar year. ³Maximum of 1,000 miles.

ISSUE AGE PREMIUMS

PLAN 1	AGE	EE/EE+CH EE+SP/F	Uni-Tobacco
WEEKLY	18-29	\$1.44	\$2.19
	30-39	\$3.21	\$4.90
	40-49	\$6.69	\$10.21
	50-59	\$12.02	\$18.33
	60-64	\$16.54	\$25.19
	65+	\$26.41	\$40.12

PLAN 1	AGE	EE/EE+CH EE+SP/F	Uni-Tobacco
BI-WEEKLY	18-29	\$2.88	\$4.38
	30-39	\$6.42	\$9.80
	40-49	\$13.38	\$20.42
	50-59	\$24.04	\$36.66
	60-64	\$33.08	\$50.38
	65+	\$52.82	\$80.24

PLAN 1	AGE	EE/EE+CH EE+SP/F	Uni-Tobacco
SEMI-MONTHLY	18-29	\$3.11	\$4.74
	30-39	\$6.96	\$10.61
	40-49	\$14.49	\$22.11
	50-59	\$26.03	\$39.71
	60-64	\$35.82	\$54.58
	65+	\$57.21	\$86.92

PLAN 1	AGE	EE/EE+CH EE+SP/F	Uni-Tobacco
MONTHLY	18-29	\$6.22	\$9.48
	30-39	\$13.91	\$21.22
	40-49	\$28.97	\$44.22
	50-59	\$52.06	\$79.42
	60-64	\$71.64	\$109.16
	65+	\$114.42	\$173.83

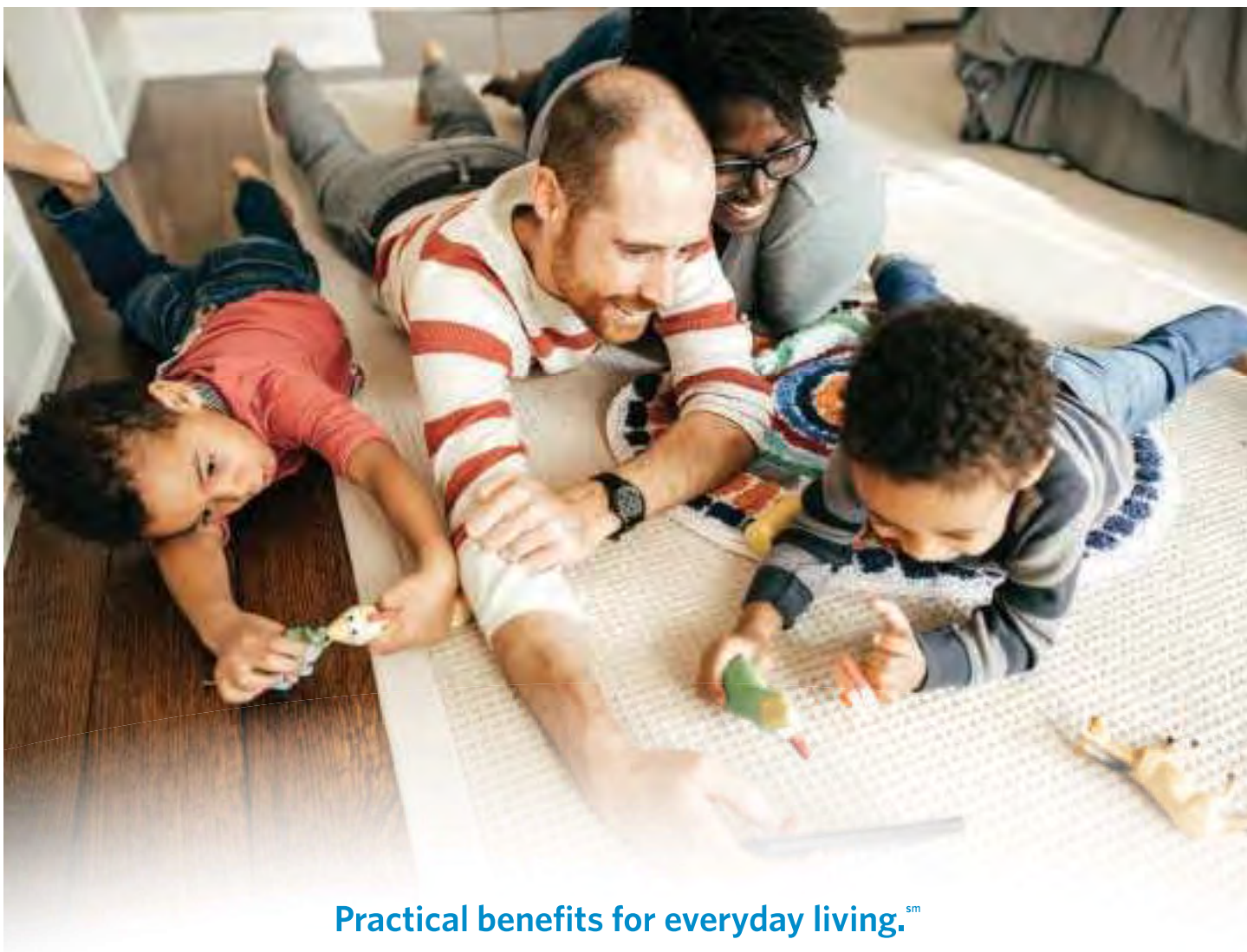
EE + CH = Employee + Child(ren); and F = Family



For use in enrollments situated in: MI. This rate insert is part of the approved brochure, form and ABJ30303-1; it is not to be used on its own.

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GVCIP4-Insert-46991-No Pre-Ex



Practical benefits for everyday living.sm

When you choose Allstate Benefits, you receive more than just coverage that helps you protect your finances when faced with life's uncertainties; you also get the support of the Good Hands® promise.

We've been insuring and protecting families for over 50 years with the name that America knows and trusts. Our affordable and valuable coverage options help empower hard-working individuals and their families to make the best decisions for their care and finances.

After you've elected coverage, register with our website, MyBenefits, for anytime access to your coverage and benefit information. Plus, MyBenefits allows you to file fast and easy claims that we'll deposit right into your bank account (direct deposit authorization required).

Allstate Benefits. We can help give you and your family financial peace of mind. Are you in good hands?®

CERTIFICATE SPECIFICATIONS

Eligibility

Your employer decides who is eligible for your group (such as length of service and hours worked each week). Issue ages are 18 and over.

Dependent Eligibility/Termination

Family members eligible for coverage are your spouse or domestic partner and children. Coverage for children ends when the child reaches age 26, unless he or she continues to meet the requirements of an eligible dependent. Spouse coverage ends upon valid decree of divorce or your death. Domestic partner coverage ends when the domestic partnership ends or your death.

When Coverage Ends

Coverage under the policy ends on the earliest of: the date the certificate is canceled; the date the policy is canceled; you stop paying your premium; the last day of active employment; you or your class are no longer eligible; a false claim is filed; or when all benefits have been paid under the policy and riders, if applicable.

Continuing Your Coverage

You may be eligible to continue coverage when coverage under the policy ends. Refer to your Certificate of Insurance for details.

BENEFIT CONDITIONS

Conditions and Limits

A diagnosis occurring before your coverage begins is not payable; however, a diagnosis of any covered critical illness or specified disease after your effective date will be payable. Benefits are subject to all limitations and exclusions. All critical illnesses must meet the definitions and dates of diagnoses stated in the policy and be diagnosed by a physician while coverage is in effect. The date of diagnosis for each illness must be separated by 30 days.

If the first diagnosis of cancer occurs before the effective date of coverage, benefits are paid for a subsequent diagnosis of cancer after the effective date, subject to the terms and conditions in the certificate.

Exclusions

Benefits are not paid for: intentionally self-inflicted injury or action; the covered person's commission or attempt to commit a felony or the covered person's being engaged in an illegal activity (as defined by the laws of the state of Michigan); suicide while sane, or self-destruction while insane, or any attempt at either; criminal activity, including the illegal use or abuse of alcohol or any substance, which rises to the level of a misdemeanor or felony.



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allstatebenefits.com

This brochure is for use in enrollments situated in MI and is incomplete without the accompanying rate insert.

This material is valid as long as information remains current, but in no event later than July 29, 2022.

Group Critical Illness benefits are provided under policy form GVCIP4, or state variations thereof. Critical Illness Rider benefits are provided under the following rider forms, or state variations thereof: Skin Cancer Rider GCIP4SCR; Cardiopulmonary Enhancement Rider GCIP4CER; Second Evaluation, Transportation and Lodging Rider GCIP4SER; Specified Chronic Illness Rider GCIP4SC1R; and Supplemental Critical Illness Rider GCIP4SR2.

The coverage provided is limited benefit supplemental critical illness insurance. The policy is not a Medicare Supplement Policy. If eligible for Medicare, review Medicare Supplement Buyer's Guide available from Allstate Benefits.

This is a brief overview of the benefits available under the group policy underwritten by American Heritage Life Insurance Company (Home Office, Jacksonville, FL). Details of the coverage, including exclusions and other limitations are included in the certificates issued. For additional information, you may contact your Allstate Benefits Representative.

The coverage does not constitute comprehensive health insurance coverage (often referred to as "major medical coverage") and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.

AllstateSM Identity Protection Select



Strong protection
for your employees'
identity and finances



Identity theft impacts
10 million¹
consumers a year

When fraud occurs, unraveling it
can be overwhelming and costly.
In 2020 alone, identity theft victims
experienced nearly

\$13.3 billion¹
in total fraud losses.

Introducing...

Allstate Identity Protection *Select*, a new product that provides comprehensive financial and identity monitoring to help employees protect themselves against the impact of identity theft. **Allstate Identity Protection Select** is available to employers who offer it with at least one Allstate Benefits Voluntary Benefit product. And as part of this special offer, employees gain access to exclusive pricing for Allstate Identity Protection *Select*.

Protecting your employees also protects your business

Identity theft affects employees and employers

- 85% of identity theft victims feel worried, angry and frustrated²
- Distraction and stress increase the potential for absenteeism, threatening overall productivity²
- With 73% of passwords duplicated, often across work and personal accounts, stolen employee PII could be used to access an employer's sensitive client or customer information³

More **SECURE** Employees = More **SECURE** Employers

Sources - ¹Javelin Strategy & Research, "2021 Identity Fraud Study: Shifting Angles," March 2021. ²The Identity Theft Resource Center, "Identity Theft: The Aftermath Report," 2019. ³Microsoft, "One simple action you can take to prevent 99.9 percent of attacks on your accounts," August 2019

We make it simple



Enrollment integration

Sign up for all products in one simple process



Consolidating billing

Allstate Benefits products and Allstate Identity Protection **Select** all on one bill



Seamless customer care

Just one support number for employers to call for help with all products

Allstate Identity Protection Select provides everything employees need to gain more peace of mind:



Detect

View and manage alerts in real time to help identify threats



Resolve

Identity Specialists are on call 24/7 to help members recover from identity theft – even if the fraud occurred before members were a customer



Reimburse

If identity theft occurs, we'll cover out-of-pocket expenses, lost wages, legal fees and stolen funds

Allstate Identity Protection Select



Individual Premiums

Monthly	\$5.95
Semi-Monthly	\$2.98
Bi-Weekly	\$2.75
Weekly	\$1.37



Family Premiums

Monthly	\$11.95
Semi-Monthly	\$5.98
Bi-Weekly	\$5.52
Weekly	\$2.76

9thly, 10thly, Quarterly, Semi-Annual and Annual rates are also available

With Allstate Identity Protection **Select**, members are able to¹

- Check their identity health score
- Get comprehensive identity and financial monitoring
- View and manage alerts in real time
- Receive high-risk financial transaction alerts
- Depend on in-house customer care specialists 24/7
- Rely on \$1 million identity theft expense coverage**
- Protect themselves and their family (everyone that's "under the member's roof and wallet")***
- And much more!

Protect your employees and their families

Families are more likely to experience identity theft than individuals. And when they do experience fraud, it takes families two times longer to resolve. Plus, the costs families incur as a result of fraud are three times higher.⁴ Our Family Plan provides coverage for kids and teens of all ages, so employees can help protect their future and give them a safe head start. If they are dependent on your employee financially or live under their roof, they're covered.^{***}

Contact your Allstate Benefits representative today to learn more about **Allstate Identity Protection Select**.

Good hands working together can do great things.SM

Sources - ⁴Javelin Strategy & Research, "Identity Fraud and Families — Impacts of a Digitally Connected Life," 2020.

^{*}Certain features require additional activation. ^{**}Identity theft insurance covering expense and stolen funds reimbursement is underwritten by American Bankers Insurance Company of Florida, an Assurant company. The description herein is a summary and intended for informational purposes only and does not include all terms, conditions and exclusions of the policies described. Please refer to the actual policies for terms, conditions, and exclusions of coverage. Coverage may not be available in all jurisdictions. Product may be updated or modified prior to availability. ^{***}For family plans only.

Allstate Identity Protection is offered and serviced by InfoArmor, Inc., a subsidiary of The Allstate Corporation. Allstate Identity Protection offers its products and services subject to its own terms, limitations and exclusions. Allstate Benefits makes no representations or warranties regarding the Allstate Identity Protection Select program, and is not responsible



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www.allstate.com or allstatebenefits.com

IMPORTANT DISCLOSURES

NOTE TO ALL EMPLOYEES

Certain Federal Regulations require employers to provide disclosures of these regulations to all employees. The remainder of this document provides you with the required disclosures related to our employee benefits plan. If you have any questions or need further assistance please contact your Plan Administrator as follows:

Integrated Design Solutions

Nicole Kolhagen – Human Resources Manager

Address: 1441 West Long Lake Rd. Suite 200, Troy, MI 48098

Phone: 248-823-2100

NOTICE REGARDING SPECIAL ENROLLMENT RIGHTS

If you do not timely or properly complete the enrollment process, you and your Eligible Dependents generally will not be covered under the applicable Plan for the remainder of the Plan Year, except as described below. Also, if you fail to specifically enroll your Eligible Dependents on the enrollment form, your Eligible Dependents will not be covered under the applicable Plan for the remainder of the Plan Year, except as otherwise provided below.

(a.) If you decline enrollment for yourself or your dependents because you or your dependent had other health insurance or group health plan coverage, either through COBRA or otherwise, you may enroll yourself and Eligible Dependents in the Health Program within 30 days of the loss of that coverage. For this purpose, “loss of coverage” will occur if the other group health plan coverage terminates as a result of: (i) termination of employer contributions for the other coverage; (ii) exhaustion of the maximum COBRA period; (iii) legal separation or divorce; (iv) death; (v) termination of employment; (vi) reduction in hours of employment; or (vii) failure to elect COBRA coverage.

However, a loss of coverage will not be deemed to occur if the other coverage terminates due to a failure to pay premiums or termination for cause. At the time you enroll in the Employer’s Plan, you must provide a written statement from the administrator of the other health plan that you no longer have that coverage.

(b.) You are eligible to enroll yourself and your Eligible Dependent in the Health Program within 30 days of the date you acquire a new Eligible Dependent through marriage, birth, adoption or placement for adoption. Your enrollment will become effective on the date of marriage, birth, adoption or placement for adoption. (Note pre-tax payments may not be made for retroactive coverage due to marriage.)

(c.) You are eligible to enroll yourself and your Eligible Dependent in the Plan within 60 days after either:

(1.) You or your Eligible Dependent’s Medicaid coverage under title XIX of the Social Security Act or CHIP coverage through a State child health plan under title XXI of the Social Security Act is terminated as a result of loss of eligibility for such coverage; or

(2.) You or your Eligible Dependent is determined to be eligible for employment assistance under Medicaid or CHIP to help pay for coverage under the Plan.

NOTICE REGARDING WOMEN’S HEALTH AND CANCER RIGHTS ACT

(JANET'S LAW)

On October 21, 1998, Congress passed a Federal Law known as the Women's Health and Cancer Rights Act. The law includes important new protections for breast cancer patients who elect breast reconstruction in connection with a mastectomy. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and patient, for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymph edemas

These benefits will be provided subject to the same deductible and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, please call your plan administrator.

NEWBORNS AND MOTHERS NOTICE

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

NOTICE REGARDING MICHELLE'S LAW

On Thursday, October 9, 2008, President Bush signed into law H.R. 2851, known as Michelle's Law. This law requires employer health plans to continue coverage for employees' dependent children who are college students and need a medically necessary leave of absence. This law applies to both fully insured and self-insured medical plans.

The dependent child's change in college enrollment must meet the following requirements:

The dependent is suffering from a serious illness or injury. The leave is medically necessary.

The dependent loses student status for purposes of coverage under the terms of the plan or coverage. Coverage for the dependent child must remain in force until the earlier of:

- One year after the medically necessary leave of absence began.
- The date the coverage would otherwise terminate under the terms of the plan.

A written certification by the treating physician is required. The certification must state that the dependent child is suffering from a serious illness or injury and that the leave is medically necessary. Provisions under this law became effective for plan years beginning on or after October 9, 2009.

This booklet is intended for illustration and informational purposes only. The plan documents, insurance certificates and policies will serve as the governing documents to determine plan eligibility, benefits and payments. In the case of conflict between the information in this booklet and the official plan documents, the plan documents will always govern

NOTICE REGARDING PATIENT PROTECTION RIGHTS

Integrated Design Solutions group health plan allows members to designate a Primary Care Provider. The following paragraphs outline certain protections under the Patient Protection and Affordable Care Act (Affordable Care Act) and only apply when the Plan requires or allows the designation of a Primary Care Provider.

You will have the right to designate any primary care provider who participates in the Plan's network and who is available to accept you and/or your Eligible Dependents. For children, you may designate a pediatrician as the primary care provider. You also do not need prior authorization from the Plan or from any other person (including your primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Plan's network. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan or procedures for making referrals or notifying primary care provider or Plan of treatment decisions.

If you do not make a provider designation, the Plan may make one for you. For information on how to select or change a primary care provider, and for a list of the participating primary care providers, pediatricians, or obstetrics or gynecology health care professionals, please contact the insurer.

HIPAA PRIVACY

The Plan complies with the privacy requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These requirements are described in a Notice of Privacy Practices that was previously given to you. A copy of this notice is available upon request.

MEDICARE NOTICE

You must notify Integrated Design Solutions when you or your dependents become Medicare eligible. Integrated Design Solutions is required to contact the insurer to inform them of your Medicare status. Federal law determines whether Medicare or the group health plan is the primary payer. You must also notify Medicare directly that you have group health insurance coverage. Privacy laws prohibit Medicare from discussing coverage with anyone other than the Medicare beneficiary or their legal guardian. The toll-free number to Medicare Coordination of Benefits is 1-800-999-1118.

If you have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices in your prescription drug plan. Please see the complete Medicare Part D Coverage Notice below.

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MEDICARE PART D COVERAGE NOTICE – IMPORTANT INFORMATION ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please note that the following notice only applies to individuals who are eligible for Medicare.

Medicare eligible individuals may include employees, spouses or dependent children who are Medicare eligible for one of the following reasons.

- Due to the attainment of age 65
- Due to certain disabilities as determined by the Social Security Administration
- Due to end-stage renal disease (ESRD)

If you are covered by Medicare, please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Integrated Design Solutions and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

Integrated Design Solutions has determined that the prescription drug coverage offered by your company plan, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. If your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 through December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?

If you decide to join a Medicare drug plan, your current coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drugs. The prescription drug coverage is part of the Group Health Plan and cannot be separated from the medical coverage. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits. You have the option to waive the coverage provided under the Group Health Plan due to your eligibility for Medicare. If you decide to waive coverage under the Group Health Plan due to your Medicare eligibility, you will be entitled to re-enroll in the plan during the next open enrollment period.

WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

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

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE

Contact your HR Representative. You will receive this notice each year and again, if this coverage through your company changes. You also may request a copy of this notice at any time.

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FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE

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

Visit www.medicare.gov

Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help.

Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information, visit U.S. Social Security Administration’s at www.socialsecurity.gov or call 1-800-772-1213 (TTY 1-800-325-0778).

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

Integrated Design Solutions

Nicole Kolhagen – Human Resources Manager

Address: 1441 West Long Lake Rd. Suite 200, Troy, MI 48098

Phone: 248-823-2100

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

There is an additional way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

Each year, the open enrollment period for health insurance coverage through the Marketplace runs from Nov. 1 through Dec. 15 of the previous year. After Dec. 15, you can get coverage through the Marketplace only if you qualify for a special enrollment period or are applying for Medicaid or the Children’s Health Insurance Program (CHIP).

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CAN I SAVE MONEY ON MY HEALTH INSURANCE PREMIUMS IN THE MARKETPLACE?

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

DOES EMPLOYER HEALTH COVERAGE AFFECT ELIGIBILITY FOR PREMIUM SAVINGS THROUGH THE MARKETPLACE?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards.

If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.83 percent of your household income for 2021 (9.61 percent for 2022), or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

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

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

HOW CAN I GET MORE INFORMATION?

For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources.

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

THE GENETIC INFORMATION NONDISCRIMINATION ACT (GINA)

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits discrimination in group health plan coverage based on genetic information.

Builds on HIPAA's protections. GINA expands the genetic information protections included in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Before the Affordable Care Act, HIPAA prevented a plan or issuer from imposing a preexisting condition exclusion based solely on genetic information. Under the Affordable Care Act, plans are prohibited from excluding coverage or benefits due to any preexisting condition. HIPAA continues to prohibit discrimination in eligibility, benefits, or premiums based on a health factor (including genetic information).

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Additional underwriting protections. GINA provides that group health plans cannot adjust premiums or contribution amounts for a plan, or a group of similarly situated individuals under the plan, based on genetic information of one or more individuals in the group. (However, premiums may be increased for the group based upon the manifestation of a disease or disorder of an individual enrolled in the plan.)

Prohibits requiring genetic testing. GINA generally prohibits plans and issuers from requesting or requiring an individual to undergo a genetic test. However, a health care professional providing health care services to an individual is permitted to request a genetic test. A plan or issuer may request the results of a genetic test to determine payment of a claim for benefits, but only the minimum amount of information necessary in order to determine payment. There is also a research exception that permits a plan or issuer under certain conditions to request (but not require) that a participant or beneficiary undergo a genetic test.

Restricts collection of genetic information. GINA prohibits plans from collecting genetic information (including family medical history) from an individual prior to or in connection with enrollment in the plan, or at any time for underwriting purposes. Thus, under GINA, plans and issuers are generally prohibited from offering rewards in return for the provision of genetic information, including family medical history information collected as part of a Health Risk Assessment (HRA).

GINA includes an exception for incidental collection of genetic information, provided the information is not used for underwriting purposes. However, the GINA regulations make clear that the incidental collection exception is not available if it is reasonable for the plan or issuer to anticipate that health information will be received in response to a collection, unless the collection explicitly states that genetic information should not be provided.

Other protections. GINA also contains individual insurance market provisions, administered by the Department of Health and Human Services' Centers for Medicare & Medicaid Services, privacy and confidentiality provisions, administered by the Department of Health and Human Services' Office for Civil Rights, and employment-related provisions, administered by the Equal Employment Opportunity Commission (EEOC).

For more information, see the **Frequently Asked Questions Regarding the Genetic Information Nondiscrimination Act** on the EBSA Website.

NO SURPRISES ACT

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is “balance billing” (sometimes called “surprise billing”)?

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

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

“Surprise billing” is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

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YOU ARE PROTECTED FROM BALANCE BILLING FOR:

Emergency services

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

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

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

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

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

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

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

If you believe you've been wrongly billed, you may contact Michigan Department of Insurance and Financial Services PO Box 30220 Lansing, MI 48909. Call toll free Monday – Friday 8:00 am – 5:00 pm (800) 999-6442.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP,

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you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2018. Contact your State for more information:

ALABAMA – MEDICAID Website: http://myalhipp.com/ Phone: 1-855-692-5447	FLORIDA – MEDICAID Website: http://flmedicaidtprecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – MEDICAID The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	GEORGIA – MEDICAID Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – MEDICAID Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	INDIANA – MEDICAID Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – HEALTH FIRST COLORADO (COLORADO'S MEDICAID PROGRAM) & CHILD HEALTH PLAN PLUS (CHP+) Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	IOWA – MEDICAID Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562

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KANSAS – MEDICAID	NEW HAMPSHIRE – MEDICAID
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/ombp/nhcpp/ Phone: 603-271-5218
KENTUCKY – MEDICAID	NEW JERSEY – MEDICAID AND CHIP
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – MEDICAID	NEW YORK – MEDICAID
Website: http://dhh.louisiana.gov/index.cfm/subhome/ n/331	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – MEDICAID	NORTH CAROLINA – MEDICAID
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – MEDICAID AND CHIP	NORTH DAKOTA – MEDICAID
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – MEDICAID	OKLAHOMA – MEDICAID AND CHIP
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – MEDICAID	OREGON – MEDICAID
Website: https://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – MEDICAID	PENNSYLVANIA – MEDICAID
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/Healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – MEDICAID	RHODE ISLAND – MEDICAID
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEVADA – MEDICAID	SOUTH CAROLINA – MEDICAID
Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - MEDICAID	WASHINGTON – MEDICAID
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473

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TEXAS – MEDICAID Website: http://gethipptexas.com/ Phone: 1-800-440-0493	WEST VIRGINIA – MEDICAID Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – MEDICAID AND CHIP Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	WISCONSIN – MEDICAID AND CHIP Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
VERMONT– MEDICAID Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	WYOMING – MEDICAID Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – MEDICAID AND CHIP Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since January 31, 2018, or for more information on special enrollment rights, contact either:

U.S. DEPARTMENT OF LABOR SECURITY ADMINISTRATION www.cms.hhs.gov 1-866-444-EBSA (3272)	U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES www.cms.hhs.gov 1-877-267-2323, Menu Option 4, Ext. 61565
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PAPERWORK REDUCTION ACT STATEMENT

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

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

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