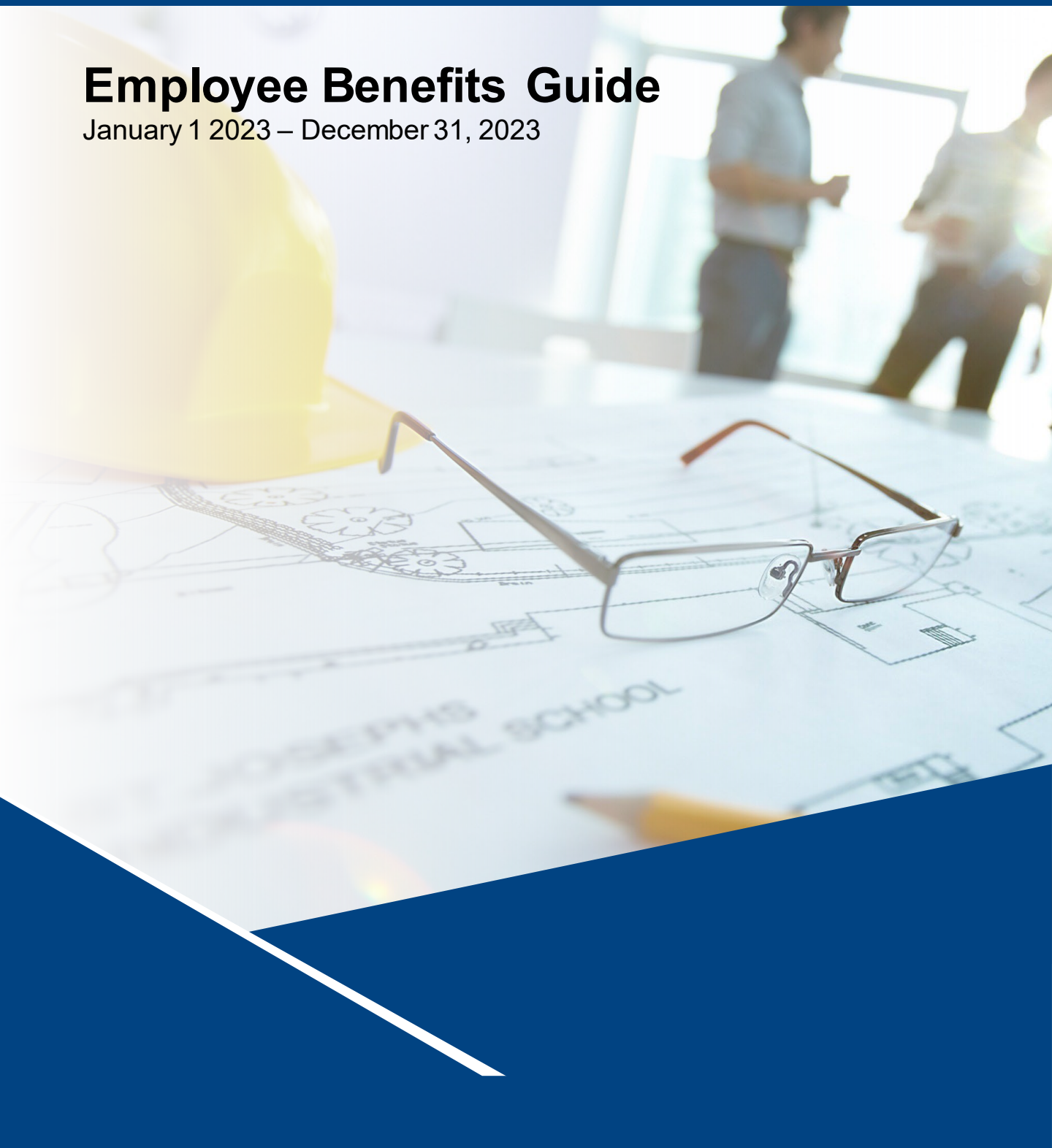


Employee Benefits Guide

January 1 2023 – December 31, 2023



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Welcome to Our Company! As an employee, enjoying your work and making valuable contributions to business are equally vital. The health, satisfaction and security of you and your family are important, not only to your well-being, but ultimately, in terms of achieving the goals of our organization. For the 2021 - 2022 plan year, Our Company, Inc. has worked hard to offer a competitive total rewards package that includes valuable and competitive benefits plans. These programs reflect our commitment to keeping our staff healthy and secure. We understand that your situation is unique, and we are offering an overall benefits package that can be shaped and molded by you to fit your needs. We hope this benefits booklet, along with our additional communication and decision-making tools, will help you make the best health care choices.

This benefits booklet is a summary description of Our Company, Inc. benefit plans. If there is a discrepancy between these summaries and the written legal plan documents, the plan documents shall prevail. This booklet and plan summaries do not constitute a contract of employment. This brochure provides a summary of your benefit options and is designed to help you make choices and enroll for coverage. If you would like more information about any of the benefits described here, please contact the Human Resources Department.

UPDATE ON HEALTH CARE REFORM



Effective January 1, 2019 the Tax Cuts and Jobs Act (TJCA) repealed the individual mandate to maintain health insurance or be responsible for a "shared responsibility payment". However, beginning in 2020, California implemented a new state individual mandate, thus establishing a law for individuals to have health insurance or else risk a penalty.

We hope to keep offering these benefits as a valuable part of your total compensation in the future in addition to offering coverage that satisfies all the health reform requirements both state and federally.

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

MEDICAL INSURANCE

Kaiser Permanent | HMO Medical Plan

With the Kaiser Permanente Health Maintenance Organization (HMO) plan, services must be obtained at a Kaiser Permanente facility, except in the case of an emergency. Kaiser Permanente integrates all elements of healthcare such as physicians, medical centers, pharmacy, and administration in one convenient facility. In addition, Kaiser Permanente offers online tools so you can email your doctor's office, make appointments, refill prescriptions, and more.

Finding a Kaiser HMO Medical Provider

Go to www.kp.org or call (800)464-4000

You must access care through a Kaiser facility unless it is a medical emergency.

Blue Shield of California | HMO Medical Plan

With the Blue Shield Health Maintenance Organization (HMO) plan, you must choose a primary care physician (PCP) or medical group within the **TRIO HMO network**. All of your care must be directed through your PCP or medical group. Any specialty care you need will be coordinated through your PCP and will generally require a referral or a authorization. You will receive benefits only if you use the doctors, clinics and hospitals that belong to the medical group in which you are enrolled, except in the case of an emergency.

Finding a Blue Shield Trio HMO Medical Provider

go to www.blueshieldca.com and click "find a provider" or call (800) 393-6130 to find a provider near you.

HMO = Select a plan: 2021 Small Business (including Covered California).

Sub Plan: select the name of the plan you are enrolling with; Platinum Trio HMO 0/20, Gold Trio HMO 500/35, Gold Trio HMO 1500/35, Silver Trio HMO 2350/65

Plan Differences	Kaiser HMO	Blue Shield HMO
Cost Sharing	Copay, deductible, coinsurance	Copay, deductible, coinsurance
Network Size	Kaiser providers, hospital and pharmacies only	Trio ACO
In-Network Benefits	YES	YES
Non-Networks	Not Covered	Not covered
Access to Providers - Primary Care Physician - Referral for Specialist	Managed by your Primary Care Physician Required / Within Kaiser	Managed by your Primary Care Physician Required Required

Summary of Benefits and Coverage (SBC)

Health insurance issuers and group health plans are required to provide you with an easy-to-understand summary about your health plan's benefits and coverage, referred to as a Summary of Benefits and Coverage (SBC). This guide is designed to help you understand the medical plan options offered to you by Our Company, Inc. Please refer to the SBC and the carrier contract provided by Kaiser Permanente and Blue Shield for additional plan details.

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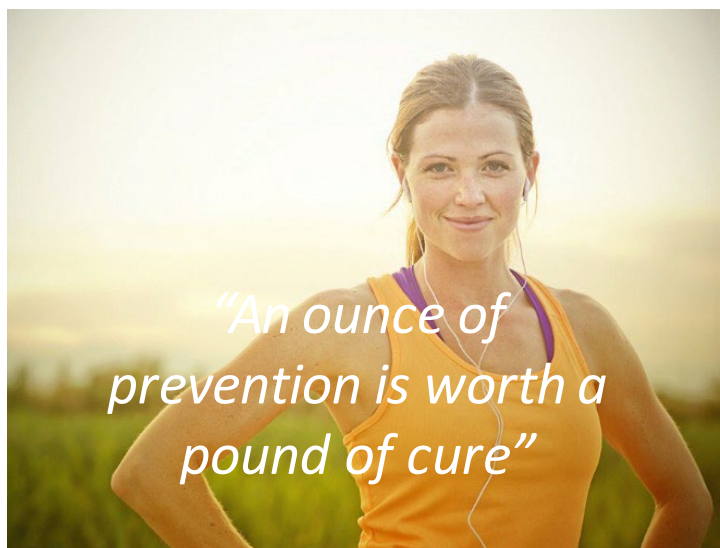
MEDICAL INSURANCE

Understanding the full value of covered benefits allows you to take responsibility for maintaining good health and incorporating healthy habits into your lifestyle. Some examples include getting regular physical examinations, mammograms and immunizations. Through the plans offered by Our Company, Inc., all covered individuals and family members are **eligible to receive routine wellness services like these, at no cost; all copays, coinsurance, and deductibles are waived.**

WHICH PREVENTIVE CARE SERVICES ARE COVERED?

The US Preventive Services Task Force maintains a regular list of recommended services that all Affordable Care Act (i.e. Health Care Reform) compliant insurance plans should cover at 100% for in-network providers. Although there are many more, below is a list of common services that are included in the plans offered this year:

- › Routine Physical Exam
- › Well Baby and Child Care
- › Well Woman Visits
- › Immunizations
- › Routine Bone Density Test
- › Routine Breast Exam
- › Routine Gynecological Exam
- › Screening for Gestational Diabetes
- › Obesity Screening and Counseling
- › Routine Digital Rectal Exam
- › Routine Colonoscopy
- › Routine Colorectal Cancer Screening
- › Routine Prostate Test
- › Routine Lab Procedures
- › Routine Mammograms
- › Routine Pap Smear
- › Smoking Cessation
- › Health Education/Counseling Services
- › Health Counseling for STDs and HIV
- › Testing for HPV and HIV
- › Screening and Counseling for Domestic Violence



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MEDICAL INSURANCE



Plan Features	Platinum 90 HMO 0/10 ALT	Platinum 90 HMO 0/20	Gold 80 HMO 250/35
	Kaiser Only	Kaiser Only	Kaiser Only
Metall ic Level	PLATINUM	PLATINUM	GOLD
Calendar Year Deductibles (Individual/Family)	\$0 / \$0	\$0 / \$0	\$250 / \$500
Co-Insurance (Plan Pays)	90% v alue	90% v alue	80% v alue
Prev entive Care	Cov ered in full	Cov ered in full	Cov ered in full deductible waived
Primary Care Visit	\$10 Copay per visit	\$20 Copay per visit	\$35 Copay per visit deductible waived
Specialist Visit	\$20 Copay per visit	\$30 Copay per visit	\$55 Copay per visit deductible waived
Diagnostic Lab (Most laboratory tests)	\$20 Copay per visit	\$20 Copay per visit	\$35 Copay per visit deductible waived
Diagnostic X-ray (Most X-rays and diagnostic testing)	\$40 Copay per visit	\$30 Copay per visit	\$55 Copay per visit deductible waived
Complex Imaging (Most MRI/CT/PET scans)	\$150 Copay per visit	\$100 Copay per visit	\$250 Copay per visit deductible waived
Outpatient Surgery	\$300 Copay per visit	\$125 Copay per visit	\$335 Copay per visit (after deductible)
Inpatient Hospitalization	\$500 Copay per admission	\$250 Copay per day up to five days per admission	\$600 Copay per day up to five days per admission (after deductible)
Emergency Room	\$200 Copay per visit	\$150 Copay per visit	\$250 Copay per visit (after deductible)
Urgent Care	\$10 Copay per visit	\$20 Copay per visit	\$35 Copay per visit deductible waived
Prescription Drugs/ RX			
- Deductible	\$0 -No Rx deductible	\$0 -No Rx deductible	\$0 -No Rx deductible
- Generic	\$5 Copay	\$5 Copay	\$15 Copay
- Brand Name	\$15 Copay	\$20 Copay	\$40 Copay
- Speciality Drugs	10% up to \$250 maximum	10% up to \$250 maximum	20% up to \$250 maximum
Pediatric Dental & Vision for members age 0-18 only	Children's Dental DHMO - see handout	Children's Dental DHMO - see handout	Children's Dental DHMO - see handout
Calendar Year Out-of-Pocket Max (Individual/Family)	\$3,000 / \$6,000	\$4,500 / \$9,000	\$7,800 / \$15,600

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CONTRIBUTIONS - PER PAY (52 WEEKLY) - HMO MEDICAL

Your company pays 50% toward the health plan you choose. All dependents must enroll on the same plan as the employee.

Members Age	Platinum 90 HMO 0/10 + Alt		Platinum 90 HMO 0/20		Gold 80 HMO 250/35	
	Employee Only	Dependents	Employee Only	Dependents	Employee Only	Dependents
0-14	\$49.41	\$72.49	\$48.15	\$71.23	\$41.39	\$64.46
15	\$55.57	\$78.64	\$54.20	\$77.28	\$46.83	\$69.91
16	\$57.92	\$81.00	\$56.51	\$79.59	\$48.91	\$71.99
17	\$60.27	\$83.35	\$58.82	\$81.90	\$50.99	\$74.07
18	\$62.81	\$85.89	\$61.31	\$84.39	\$53.23	\$76.31
19	\$62.12	\$85.19	\$60.57	\$83.65	\$52.25	\$75.32
20	\$64.74	\$87.82	\$63.15	\$86.23	\$54.57	\$77.64
21	\$67.46	\$90.54	\$65.82	\$88.89	\$56.97	\$80.04
22	\$67.46	\$90.54	\$65.82	\$88.89	\$56.97	\$80.04
23	\$67.46	\$90.54	\$65.82	\$88.89	\$56.97	\$80.04
24	\$67.46	\$90.54	\$65.82	\$88.89	\$56.97	\$80.04
25	\$67.82	\$90.90	\$66.17	\$89.25	\$57.29	\$80.37
26	\$69.63	\$92.71	\$67.95	\$91.03	\$58.89	\$81.97
27	\$71.80	\$94.88	\$70.08	\$93.16	\$60.81	\$83.89
28	\$75.33	\$98.41	\$73.55	\$96.63	\$63.93	\$87.01
29	\$78.23	\$101.31	\$76.40	\$99.47	\$66.49	\$89.57
30	\$79.68	\$102.76	\$77.82	\$100.89	\$67.77	\$90.85
31	\$81.85	\$104.93	\$79.95	\$103.03	\$69.70	\$92.77
32	\$84.03	\$107.10	\$82.08	\$105.16	\$71.62	\$94.69
33	\$85.38	\$108.46	\$83.42	\$106.50	\$72.82	\$95.89
34	\$86.83	\$109.91	\$84.84	\$107.92	\$74.10	\$97.17
35	\$87.56	\$110.64	\$85.55	\$108.63	\$74.74	\$97.82
36	\$88.28	\$111.36	\$86.26	\$109.34	\$75.38	\$98.46
37	\$89.01	\$112.08	\$86.97	\$110.05	\$76.02	\$99.10
38	\$89.73	\$112.81	\$87.69	\$110.76	\$76.66	\$99.74
39	\$91.18	\$114.26	\$89.11	\$112.18	\$77.94	\$101.02
40	\$92.63	\$115.71	\$90.53	\$113.61	\$79.22	\$102.30
41	\$94.80	\$117.88	\$92.66	\$115.74	\$81.14	\$104.22
42	\$96.88	\$119.96	\$94.71	\$117.78	\$82.98	\$106.06
43	\$99.78	\$122.86	\$97.55	\$120.63	\$85.54	\$108.62
44	\$103.40	\$126.48	\$101.11	\$124.18	\$88.75	\$111.82
45	\$107.66	\$130.73	\$105.29	\$128.36	\$92.51	\$115.59
46	\$112.73	\$135.80	\$110.26	\$133.34	\$96.99	\$120.07
47	\$118.43	\$141.51	\$115.86	\$138.94	\$102.03	\$125.11
48	\$124.95	\$148.02	\$122.26	\$145.34	\$107.80	\$130.87
49	\$131.38	\$154.45	\$128.58	\$151.65	\$113.48	\$136.56
50	\$138.62	\$161.70	\$135.69	\$158.76	\$119.88	\$142.96
51	\$145.77	\$168.85	\$142.71	\$165.79	\$126.21	\$149.28
52	\$153.65	\$176.73	\$150.44	\$173.52	\$133.17	\$156.25
53	\$161.61	\$184.69	\$158.27	\$181.34	\$140.22	\$163.29
54	\$170.22	\$193.29	\$166.71	\$189.79	\$147.82	\$170.90
55	\$178.82	\$201.90	\$175.16	\$198.23	\$155.43	\$178.50
56	\$188.14	\$211.22	\$184.31	\$207.39	\$163.67	\$186.75
57	\$197.56	\$220.64	\$193.56	\$216.63	\$171.99	\$195.07
58	\$207.61	\$230.68	\$203.42	\$226.50	\$180.88	\$203.96
59	\$212.59	\$235.66	\$208.31	\$231.39	\$185.28	\$208.36
60	\$222.64	\$245.71	\$218.28	\$241.26	\$194.17	\$217.24
61	\$231.33	\$254.40	\$226.71	\$249.79	\$201.85	\$224.93
62	\$237.03	\$260.11	\$232.32	\$255.39	\$206.89	\$229.97
63	\$244.18	\$267.26	\$239.34	\$262.41	\$213.22	\$236.29
64+	\$248.53	\$271.61	\$243.61	\$266.68	\$217.06	\$240.13

This booklet provides only a summary of your benefits. All benefits described within are subject to the definitions, limitations, and conditions set forth in each insurance contract or program contract.

VISION INSURANCE

The vision plan provides professional vision care and high quality lenses and frames through a broad network of optical specialists. You will receive richer benefits if you utilize a network provider. If you utilize a non-network provider, you will be responsible to pay all charges at the time of your appointment and will be required to file an itemized claim with Humana.

Plan Features	PPO Vision Plan 130
IN NETWORK (EYEMED VISION)	
Vision Exam	\$10 Copay
Lenses	
Single	\$15 Copay
Bifocal	\$15 Copay
Trifocal	\$15 Copay
Progressive	\$15 Copay
Frames	\$130 Allowance (20% off balance over \$130)
Elective Contact Lenses (in lieu of frames, lenses; applies to materials only)	\$130 allowance (15% off balance over \$130)
Medically Necessary Contact Lenses	Covered in full
Frequency (Months)	
Exam	Every 12 Months
Lenses	Every 12 Months
Frames	Every 24 Months
Contacts	Every 12 Months
OUT OF NETWORK	
Vision Exam	Up to \$30 Benefit
Lenses	
Single	Up to \$25 Benefit
Bifocal	Up to \$40 Benefit
Trifocal	Up to \$60 Benefit
Progressive	Up to \$40 Benefit
Frames	Up to \$65 Benefit
Elective Contact Lenses	Up to \$104 Benefit
Medically Necessary Contact Lenses	Up to \$200 Benefit
Frequency	Same as IN NETWORK

Finding a Vision Provider

Go to www.humana.com or call (800)233-4013 to find a provider near you.

- Click on “find a doctor” and then search vision providers. You will select “through my employer” and then the Humana Vision Network.



Note: The *Humana EyeMed Vision* vision network includes 50,000 access points nation wide. There are private practice eye-care providers, as well as retail providers. Please note, benefits may vary at affiliate locations.

CONTRIBUTIONS - PER PAY (52 WEEKLY) - DENTAL/VISION

Humana Dental

	LS0200 Plan Summary	Voluntary Dental PPO09
Employee	\$4.12	\$9.71
Employee + Spouse	\$9.39	\$22.07
Employee + Child(ren)	\$7.91	\$18.66
Employee + Family	\$13.35	\$31.40

Humana Vision

	PPO Vision 130
Employee	\$1.95
Employee + Spouse	\$3.89
Employee + Child(ren)	\$3.70
Employee + Family	\$5.81

Worksheet to tally Medical/Dental/Vision Contributions

NOTE: Add dependent medical premiums for each member enrolling, up to 3 children under age 21. Adult dependents do not have a limit.

Add medical costs
by
member's age

Employee	
Spouse	
Child 1 (under 21)	
Child 2 (under 21)	
Child 3 (under 21)	
Child 1 (over 21)	
Child 2 (over 21)	
Child 3 (over 21)	
Total Per Paycheck	