UPPER RIVER SERVICES

BENEFITS OVERVIEW

PLAN YEAR: 2025-2026

40 State St
St. Paul, MN 55107

651-292-9293

ursi.net

CONTACTS

At Upper River Services, we are committed to a comprehensive employee benefit program that helps our employees stay healthy, feel secure, and maintain a work/life balance. Please refer to this list when you need to contact one of our benefit partners. For general information contact your Plan Administrator, Bridget Carbary.

MEMBER SERVICE CONTACT INFORMATION

	MEDICAL: **HealthPartners**	952-883-5000	healthpartners.com	8170 33rd Ave S Bloomington, MN 55425
	HEALTH SAVINGS ACCOUNT (HSA): **Associated Bank**	800-270-7719	associatedbank.com	433 Main Street Green Bay, WI 54301
	VOLUNTARY DENTAL: **HealthPartners**	952-883-5000	healthpartners.com	8170 33rd Ave S Bloomington, MN 55425
	VOLUNTARY VISION: **Lincoln Financial**	800-440-8453	lvc.lfg.com	8801 Indian Hills Drive Omaha, NE 68114
	LIFE AND DISABILITY: **Lincoln Financial**	800-423-2765	lfg.com	8801 Indian Hills Drive Omaha, NE 68114
	PLAN ADMINISTRATOR: **Bridget Carbary**	651-292-9293	bridget@ursi.net	40 State St St. Paul, MN 55107

2025 Group Insurance Rates for Upper River Services

IMPORTANT: If your spouse is eligible for company-provided medical coverage at their company (other than self-employment) and you elect to cover your spouse on the Upper River Services Health Plan then you will be charged $150.00 each month in addition to the below listed monthly premium rates for your elected benefit coverage

26 Week

Employee share of premium (Deduction) - 26 week

HDHP Plan - Medical	Weekly	Monthly	Annually
Family	$ 221.54	$ 960.00	$ 5,760.00
EE + Spouse	$ 207.69	$ 900.00	$ 5,400.00
EE + Child(ren)	$ 147.69	$ 640.00	$ 3,840.00
Single	$ 73.85	$ 320.00	$ 1,920.00

Dental	Weekly	Monthly	Annually
Family	$ 59.44	$ 257.58	$ 1,545.48
EE+1	$ 39.63	$ 171.72	$ 1,030.32
Single	$ 19.81	$ 85.86	$ 515.16

Vision	Weekly	Monthly	Annually
Family	$ 7.90	$ 34.24	$ 205.44
EE + Spouse	$ 4.79	$ 20.76	$ 124.56
EE + Child(ren)	$ 5.61	$ 24.32	$ 145.92
Single	$ 2.52	$ 10.92	$ 65.52

52 Week

Employee share of premium (Deduction) - 52 week

HDHP Plan - Medical	Weekly	Monthly	Annually
Family	$ 110.77	$ 480.00	$ 5,760.00
EE + Spouse	$ 103.85	$ 450.00	$ 5,400.00
EE + Child(ren)	$ 73.85	$ 320.00	$ 3,840.00
Single	$ 36.92	$ 160.00	$ 1,920.00

Dental	Weekly	Monthly	Annually
Family	$ 29.72	$ 128.79	$ 1,545.48
EE+1	$ 19.81	$ 85.86	$ 1,030.32
Single	$ 9.91	$ 42.93	$ 515.16

Vision	Weekly	Monthly	Annually
Family	$ 3.95	$ 17.12	$ 205.44
EE + Spouse	$ 2.40	$ 10.38	$ 124.56
EE + Child(ren)	$ 2.81	$ 12.16	$ 145.92
Single	$ 1.26	$ 5.46	$ 65.52

MEDICAL

Who is eligible and when:

Active full-time employees working 30 or more hours per week are eligible for medical on the first of the month following 60 days of employment.

If you are an active employee and elect medical coverage for yourself, you may also cover your eligible dependents. Eligible dependents include your spouse and dependent children under the age of 26.

Plan Information:

Carrier: **HealthPartners**

Group Number: 60170

Plan Year: April 1, 2025 through March 31, 2026

Deductible Year: Calendar (January – December)

Plan Network: Current provider listings are available at healthpartners.com

Plan Options	High Deductible Health Plan (HDHP) $4,000-100% HSA Plus Plan TieredChoice Network	
	Individual	**Family**
Deductible	$4,000 **$3,300 Select Tier**	$8,000 **$6,600 Select Tier**
Preventive Care Visit healthcare.gov for a list of covered screenings	No charge	
Coinsurance	0% after deductible	
Out of Pocket Maximum	$4,000	$8,000
Office Visit	0% after deductible	
Prescription Drug Coverage	**Preventive Drugs: $0, deductible does not apply** Formulary: 0% after deductible Non-Formulary: not covered	

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-883-2177 or visit us at www.healthpartners.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-883-2177 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Level 1 (Select Tier): $3,300 Individual, $6,600 Family Level 2 (Standard Tier): $4,000 Individual, $8,000 Family Out-of-network: $13,000 Individual, $26,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Coinsurance marked with * under What You Will Pay and benefits with no charge are not subject to deductible	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Level 1 (Select Tier): $3,300 Individual, $6,600 Family Level 2 (Standard Tier): $4,000 Individual, $8,000 Family Out-of-network medical/pharmacy: $20,000 Individual, $40,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges (unless balanced billing is prohibited), and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.healthpartners.com/TieredChoice or call 1-800-883-2177 for a list of in-network providers.	This plan uses a provider network. You pay the least if you use a provider in Level 1 (Select Tier). You pay more if you use a provider in Level 2 (Standard Tier). You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the in-network specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Level 1 (Select Tier) (You will pay the least)	Level 2 (Standard Tier) (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Primary Office Visit: 0% coinsurance Convenience Care: 0% coinsurance Virtuwell: 0% coinsurance	Primary Office Visit: 0% coinsurance Convenience Care: 0% coinsurance Virtuwell: 0% coinsurance	Primary Office Visit: 50% coinsurance Convenience Care: 50% coinsurance	None
	Specialist visit	0% coinsurance	0% coinsurance	50% coinsurance	None
	Preventive care/screening/ Immunization	No charge	No charge	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	0% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance	0% coinsurance	50% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Level 1 (Select Tier) (You will pay the least)	Level 2 (Standard Tier) (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.healthpartners.com/hp/pharmacy/druglist/preferredrx/index.html	Generic drugs	Formulary: 0% coinsurance Non-preferred: 0% coinsurance	Formulary: 0% coinsurance Non-preferred: 0% coinsurance	Formulary: 50% coinsurance at retail, mail not covered Non-preferred: 50% coinsurance at retail, mail not covered	Days Supply: 31 day supply retail / 93 day supply mail order. Formulary insulin covered with no member cost-sharing after a $25 benefit cap per prescription per month. Preventive Drugs: No charge retail or No charge mail/prescription
	Formulary brand drugs	0% coinsurance	0% coinsurance	50% coinsurance at retail, mail not covered	
	Non-preferred brand drugs	0% coinsurance	0% coinsurance	50% coinsurance at retail, mail not covered	
	Specialty drugs	0% coinsurance	0% coinsurance	50% coinsurance at retail, mail not covered	Formulary oral chemotherapy drugs follow the Specialty drug benefit.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	0% coinsurance	50% coinsurance	None
	Physician/surgeon fees	0% coinsurance	0% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	0% coinsurance	0% coinsurance	0% coinsurance	All services follow the Standard Tier benefits.
	Emergency medical transportation	0% coinsurance	0% coinsurance	0% coinsurance	All services follow the Standard Tier benefits.
	Urgent care	0% coinsurance	0% coinsurance	0% coinsurance	Out-of-network services apply to the in-network deductible.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	0% coinsurance	50% coinsurance	None
	Physician/surgeon fees	0% coinsurance	0% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	0% coinsurance	0% coinsurance	50% coinsurance	None
	Inpatient services	0% coinsurance	0% coinsurance	50% coinsurance	None
If you are pregnant	Office visits	No charge	No charge	50% coinsurance	Depending on the type of services, a copayment, coinsurance, or deductible may apply.
	Childbirth/delivery professional	0% coinsurance	0% coinsurance	50% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Level 1 (Select Tier) (You will pay the least)	Level 2 (Standard Tier) (You will pay more)	Out-of-Network Provider (You will pay the most)	
	services				
	Childbirth/delivery facility services	0% coinsurance	0% coinsurance	50% coinsurance	None
If you need help recovering or have other special health needs	Home health care	0% coinsurance	0% coinsurance	50% coinsurance	In-network: 120 visit maximum; Out-of-network: 60 visit maximum
	Rehabilitation services	0% coinsurance	0% coinsurance	50% coinsurance	Out-of-network: 20 visit limit/year
	Habilitation services	0% coinsurance	0% coinsurance	50% coinsurance	Out-of-network: 20 visit limit/year
	Skilled nursing care	0% coinsurance	0% coinsurance	50% coinsurance	120 days per calendar year
	Durable medical equipment	0% coinsurance	0% coinsurance	50% coinsurance	Limited to one wig per year for Alopecia Areata
	Hospice services	0% coinsurance	0% coinsurance	50% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge	No charge	50% coinsurance	None
	Children's glasses	Not covered	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	Not covered	None

Excluded Services & Other Covered Services:

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

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs

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

- Acupuncture, limit of 15 visits
- Chiropractic care
- Hearing aids
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Your plan at 1-800-883-2177. For insured plans, call the MN Dept. of Commerce at 651-539-1600 / 1-800-657-3602. If your plan is not subject to ERISA, contact the US Dept. of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. If

your plan is subject to ERISA; contact the US Dept. of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272), or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Your plan at 1-800-883-2177. For insured plans, call the MN Dept. of Commerce at 651-539-1600 / 1-800-657-3602. For group health plans subject to ERISA, the US Dept. of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272), or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-866-398-9119.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-883-2177.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-883-2177.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-883-2177.

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

About these Coverage Examples:

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

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

The plan's overall deductible	$3,300
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,300
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,360**

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

The plan's overall deductible	$3,300
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,300
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,320**

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

The plan's overall deductible	$3,300
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

HealthPartners®

Enhanced HSA Preventive Drug List

Preventive drugs are used to help avoid disease and maintain health. If your employer offers a high deductible health plan that is intended to be paired with a Health Savings Account (HSA), you will be able to purchase the medications on the preventive drug list for a copay, rather than having to pay the full cost of the drug up to your plan's deductible. The preventive drug list was developed in accordance with federal guidance and is a subset of the HealthPartners drug formulary. This list is reviewed periodically and is subject to change, so be sure to review the most current list before filling your prescriptions.

Check your plan details or ask Member Services if you have this benefit

Please note: *If there is a difference between this general information and your plan documents, your plan documents will be used to determine your coverage. Please see your plan documents for your specific coverage information.*

How to use this list

- The following list explains which medications are covered as HSA Preventive medications
- Brand medicines are in ALL CAPS (e.g., JARDIANCE TABLET)
- Generic medicines are in lower italics (e.g., furosemide tablet)

Other important information

- Coverage rules may apply and may not be shown here.
  - » Some medications have rules, such as prior authorization, that must be met before the medication is covered.
  - » Please see the "More Details" column below for more information.
  - » Please check the **Pharmacy Drug List (Formulary)** for complete coverage rules.

PA - Prior authorization ST – Step therapy QL – Quantity limit AE – Age Edit

DRUG	MORE DETAILS
ANTI-INFLAMMATORY AGENTS (RESPIRATORY)	
LEUKOTRIENE MODIFIERS	
montelukast sodium (4 mg granules, 4 mg tab chew, 5 mg tab chew, 10 mg tablet)	
ANTIARRHYTHMIC AGENTS	
CLASS IV ANTIARRHYTHMICS	
CARTIA XT (120 MG CAPSULE, 180 MG CAPSULE, 240 MG CAPSULE, 300 MG CAPSULE)	
DILT-XR (120 MG CAPSULE, 180 MG CAPSULE, 240 MG CAPSULE)	
diltiazem 24hr er (24hr er 120 mg cap, 24hr er 180 mg cap, 24hr er 240 mg cap, 24hr er 300 mg cap, 24hr er 360 mg cap, 24hr er 420 mg cap)	
diltiazem 24hr er (cd) (24h 120 mg cp, 24h 180 mg cp, 24h 240 mg cp, 24h 300 mg cp)	
diltiazem 24hr er (xr) (24h 120 mg cp, 24h 180 mg cp, 24h 240 mg cp)	
diltiazem 24hr er 360 mg cap (generic for cardizem cd)	
diltiazem hcl (30 mg tablet, 60 mg tablet, 90 mg tablet, 120 mg tablet)	
TAZTIA XT (120 MG CAPSULE, 180 MG CAPSULE, 240 MG CAPSULE, 300 MG CAPSULE, 360 MG CAPSULE)	
TIADYLT ER (ER 120 MG CAPSULE, ER 180 MG CAPSULE, ER 240 MG CAPSULE, ER 300 MG CAPSULE, ER 360 MG CAPSULE, ER 420 MG CAPSULE)	
verapamil er (er 120 mg capsule, er 120 mg tablet, er 180 mg capsule, er 180 mg tablet, er 240 mg capsule, er 240 mg tablet)	
verapamil hcl (40 mg tablet, 80 mg tablet, 120 mg tablet)	
verapamil sr (sr 120 mg capsule, sr 180 mg capsule, sr 240 mg capsule, sr 360 mg capsule)	
ANTICHOLINERGIC AGENTS	
ANTIMUSCARINICS/ANTISPASMODICS	
ANORO ELLIPTA 62.5-25 MCG INH	
ATROVENT 17 MCG HFA INHALER	QL
COMBIVENT RESPIMAT 20-100 MCG	QL

DRUG	MORE DETAILS
INCRUSE ELLIPTA 62.5 MCG INH	
iprat-albut 0.5-3(2.5) mg/3 ml	
ipratropium br 0.02% soln	
TRELEGY ELLIPTA (100-62.5-25, 200-62.5-25)	
ANTICOAGULANTS	
COUMARIN DERIVATIVES	
jantoven (1 mg tablet, 2 mg tablet, 2.5 mg tablet, 3 mg tablet, 4 mg tablet, 5 mg tablet, 6 mg tablet, 7.5 mg tablet, 10 mg tablet)	
warfarin sodium (1 mg tablet, 2 mg tablet, 2.5 mg tablet, 3 mg tablet, 4 mg tablet, 5 mg tablet, 6 mg tablet, 7.5 mg tablet, 10 mg tablet)	
DIRECT FACTOR XA INHIBITORS	
ELIQUIS (2.5 MG TABLET, 5 MG TABLET, DVT-PE TREAT START 5MG)	QL
XARELTO (2.5 MG TABLET, 10 MG TABLET, 15 MG TABLET, 20 MG TABLET, DVT-PE TREAT START 30D)	QL
DIRECT THROMBIN INHIBITORS	
dabigatran etexilate (75 mg cap, 110 mg cp, 150 mg cp)	QL
ANTIDEPRESSANTS	
ANTIDEPRESSANTS, MISCELLANEOUS	
bupropion hcl (75 mg tablet, 100 mg tablet)	
bupropion hcl sr (sr 100 mg tablet, sr 150 mg tablet, sr 200 mg tablet)	
bupropion xl (150 mg tablet, 300 mg tablet)	
MONOAMINE OXIDASE INHIBITORS	
phenelzine sulfate 15 mg tab	
tranylcypromine sulf 10 mg tab	
SEL.SEROTONIN,NOREPI REUPTAKE INHIBITOR	
desvenlafaxine suc er 100 mg tablet (generic for Pristiq)	
desvenlafaxine suc er 25 mg tablet (generic for Pristiq)	

DRUG	MORE DETAILS
desvenlafaxine suc er 50 mg tablet (generic for Pristiq)	
duloxetine hcl (dr 20 mg cap, dr 30 mg cap, dr 60 mg cap)	
venlafaxine hcl (25 mg tablet, 37.5 mg tablet, 50 mg tablet, 75 mg tablet, 100 mg tablet)	
venlafaxine hcl er (er 37.5 mg cap, er 75 mg cap, er 150 mg cap)	
SELECTIVE-SEROTONIN REUPTAKE INHIBITORS	
citalopram hbr (10 mg tablet, 10 mg/5 ml soln, 20 mg tablet, 20 mg/10 ml cup, 40 mg tablet)	
escitalopram oxalate (5 mg tablet, 10 mg tablet, 20 mg tablet)	
fluoxetine hcl (hcl 10 mg capsule, 20 mg/5 ml soln cup, 20 mg/5 ml solution, hcl 20 mg capsule, hcl 40 mg capsule)	
fluvoxamine maleate (25 mg tab, 50 mg tab, 100 mg tab)	
paroxetine hcl (10 mg tablet, 20 mg tablet, 30 mg tablet, 40 mg tablet)	
sertraline hcl (25 mg tablet, 50 mg tablet, 100 mg tablet)	
SEROTONIN MODULATORS	
mirtazapine (7.5 mg tablet, 15 mg tablet, 30 mg tablet, 45 mg tablet)	
nefazodone hcl (50 mg tablet, 100 mg tablet, 150 mg tablet, 200 mg tablet, 250 mg tablet)	
trazodone hcl (50 mg tablet, 100 mg tablet, 150 mg tablet, 300 mg tablet)	
vilazodone hcl (10 mg tablet, 20 mg tablet, 40 mg tablet)	
TRICYCLICS, OTHER NOREPI-RU INHIBITORS	
amitriptyline hcl (10 mg tab, 25 mg tab, 50 mg tab, 75 mg tab, 100 mg tab, 150 mg tab)	
clomipramine hcl (25 mg capsule, 50 mg capsule, 75 mg capsule)	
desipramine hcl (10 mg tablet, 25 mg tablet, 50 mg tablet, 75 mg tablet, 100 mg tablet, 150 mg tablet)	
doxepin hcl (10 mg capsule, 10 mg/ml oral conc, 25 mg capsule, 50 mg capsule, 75 mg capsule, 100 mg capsule, 150 mg capsule)	
imipramine hcl (10 mg tablet, 25 mg tablet, 50 mg tablet)	

DRUG	MORE DETAILS
nortriptyline hcl (10 mg/5 ml soln, hcl 10 mg cap, hcl 25 mg cap, hcl 50 mg cap, hcl 75 mg cap)	
ANTIDIABETIC AGENTS	
ALPHA-GLUCOSIDASE INHIBITORS	
acarbose (25 mg tablet, 50 mg tablet, 100 mg tablet)	
miglitol (25 mg tablet, 50 mg tablet, 100 mg tablet)	
BIGUANIDES	
metformin hcl 1,000 mg tablet (generic for glucophage)	
metformin hcl 500 mg tablet (generic for glucophage)	
metformin hcl 850 mg tablet	
metformin hcl er (er 500 mg tablet, er 750 mg tablet)	
DIPEPTIDYL PEPTIDASE-4(DPP-4) INHIBITORS	
JENTADUETO (2.5 MG-1000 MG TAB, 2.5 MG-500 MG TAB, 2.5 MG-850 MG TAB)	QL
JENTADUETO XR (2.5 MG, 5 MG TB)	QL
TRADJENTA 5 MG TABLET	QL
INCRETIN MIMETICS	
MOUNJARO (2.5 MG/0.5 ML PEN, 5 MG/0.5 ML PEN, 7.5 MG/0.5 ML PEN, 10 MG/0.5 ML PEN, 12.5 MG/0.5 ML PEN, 15 MG/0.5 ML PEN)	PA, QL
OZEMPIC (0.25-0.5 MG/DOSE PEN, 1 MG/DOSE (4 MG/3 ML), 2 MG/DOSE (8 MG/3 ML))	PA, QL
RYBELSUS (3 MG TABLET, 7 MG TABLET, 14 MG TABLET)	PA, QL
TRULICITY (0.75 MG/0.5 ML PEN, 1.5 MG/0.5 ML PEN, 3 MG/0.5 ML PEN, 4.5 MG/0.5 ML PEN)	PA, QL
VICTOZA 2-PAK 18 MG/3 ML PEN	PA, QL
VICTOZA 3-PAK 18 MG/3 ML PEN	PA, QL
MEGLITINIDES	
nateglinide (60 mg tablet, 120 mg tablet)	

DRUG	MORE DETAILS
repaglinide (0.5 mg tablet, 1 mg tablet, 2 mg tablet)	
SODIUM-GLUC COTRANSPORT 2 (SGLT2) INHIB	
GLYXAMBI (10 MG TABLET, 25 MG TABLET)	QL
JARDIANCE (10 MG TABLET, 25 MG TABLET)	QL
SYNJARDY (5-1,000 MG TABLET, 5-500 MG TABLET, 12.5-1,000 MG TABLET, 12.5-500 MG TABLET)	QL
SYNJARDY XR (5-1,000 MG TABLET, 10-1,000 MG TABLET, 12.5-1,000 MG TAB, 25-1,000 MG TABLET)	QL
TRIJARDY XR (5-2.5-1,000 MG TAB, 10-5-1,000 MG TAB, 12.5-2.5-1,000 MG, 25-5-1,000 MG TAB)	QL
SULFONYLUREAS	
glimepiride (1 mg tablet, 2 mg tablet, 4 mg tablet)	
glipizide (2.5 mg tablet, 5 mg tablet, 10 mg tablet)	
glipizide er (er 2.5 mg tablet, er 5 mg tablet, er 10 mg tablet)	
glipizide xl (2.5 mg tablet, 5 mg tablet, 10 mg tablet)	
glipizide-metformin (2.5-250 mg, 2.5-500 mg, 5-500 mg)	
THIAZOLIDINEDIONES	
pioglitazone hcl (15 mg tablet, 30 mg tablet, 45 mg tablet)	
pioglitazone-glimepiride (30-2, 30-4)	
pioglitazone-metformin (15-500, 15-850)	
ANTIHYPOGLYCEMIC AGENTS	
GLYCOGENOLYTIC AGENTS	
BAQSIMI (3 MG SPRAY, 3 MG SPRAY ONE PACK, 3 MG SPRAY TWO PACK)	QL
glucagon 1 mg emergency kit	QL
glucagon 1 mg emergency kit (generic glucagen)	QL
glucagon 1 mg vial	QL
GVOKE (1 MG/0.2 ML KIT, 1 MG/0.2 ML VIAL)	QL

DRUG	MORE DETAILS
GVOKE HYPOPEN 1-PACK (1-PK 1 MG/0.2 ML, 1PK 0.5MG/0.1 ML)	QL
GVOKE HYPOPEN 2-PACK (2-PK 1 MG/0.2 ML, 2PK 0.5MG/0.1 ML)	QL
GVOKE PFS 1-PACK SYRINGE (1-PK 1 MG/0.2 ML SYR, 1PK 0.5MG/0.1 ML SYR)	QL
GVOKE PFS 2-PACK SYRINGE (2-PK 1 MG/0.2 ML SYR, 2PK 0.5MG/0.1 ML SYR)	QL
ZEGALOGUE 0.6 MG/0.6 ML SYRING	QL
ZEGALOGUE 0.6 MG/0.6ML AUTOINJ	QL
ANTILIPEMIC AGENTS	
BILE ACID SEQUESTRANTS	
cholestyramine (packet, powder)	
cholestyramine light (packet, powder)	
colestipol hcl 1 gm tablet	
PREVALITE (PACKET, POWDER)	
CHOLESTEROL ABSORPTION INHIBITORS	
ezetimibe 10 mg tablet	
FIBRIC ACID DERIVATIVES	
fenofibrate (48 mg tablet, 54 mg tablet, 67 mg capsule, 134 mg capsule, 145 mg tablet, 160 mg tablet, 200 mg capsule)	
fenofibric acid (dr 45 mg cap, dr 135 mg cap)	
gemfibrozil 600 mg tablet	
HMG-COA REDUCTASE INHIBITORS	
atorvastatin calcium (10 mg tablet, 20 mg tablet, 40 mg tablet, 80 mg tablet)	
lovastatin (10 mg tablet, 20 mg tablet, 40 mg tablet)	
pravastatin sodium (10 mg tab, 20 mg tab, 40 mg tab, 80 mg tab)	
rosuvastatin calcium (5 mg tab, 10 mg tab, 20 mg tab, 40 mg tab)	
simvastatin (5 mg tablet, 10 mg tablet, 20 mg tablet, 40 mg tablet, 80 mg tablet)	

DRUG	MORE DETAILS
OMEGA-3-MEDIATED ANTILIPEMICS	
omega-3 ethyl esters 1 gm cap	
ANTIPSYCHOTIC AGENTS	
ATYPICAL ANTIPSYCHOTICS	
aripiprazole (2 mg tablet, 5 mg tablet, 10 mg tablet, 15 mg tablet, 20 mg tablet, 30 mg tablet)	AE
asenapine maleate (2.5 mg tablet, 5 mg tablet, 10 mg tablet)	AE
clozapine (25 mg tablet, 50 mg tablet, 100 mg tablet, 200 mg tablet)	AE
lurasidone hcl (20 mg tablet, 40 mg tablet, 60 mg tablet, 80 mg tablet, 120 mg tablet)	QL, AE
olanzapine (2.5 mg tablet, 5 mg tablet, 7.5 mg tablet, 10 mg tablet, 15 mg tablet, 20 mg tablet)	AE
olanzapine odt (odt 5 mg tablet, odt 10 mg tablet, odt 15 mg tablet, odt 20 mg tablet)	AE
paliperidone er (er 1.5 mg tablet, er 3 mg tablet, er 6 mg tablet, er 9 mg tablet)	AE
quetiapine fumarate (fumarate 25 mg tab, fumarate 50 mg tab, fumarate 100 mg tab, 150 mg tablet, fumarate 200 mg tab, fumarate 300 mg tab, fumarate 400 mg tab)	AE
quetiapine fumarate er (er 50 mg tablet, er 150 mg tablet, er 200 mg tablet, er 300 mg tablet, er 400 mg tablet)	AE
risperidone (0.25 mg tablet, 0.5 mg tablet, 1 mg tablet, 1 mg/ml solution, 2 mg tablet, 3 mg tablet, 4 mg tablet)	AE
ziprasidone hcl (20 mg capsule, 40 mg capsule, 60 mg capsule, 80 mg capsule)	AE
BUTYROPHENONES	
haloperidol (0.5 mg tablet, 1 mg tablet, 2 mg tablet, 5 mg tablet, 10 mg tablet, 20 mg tablet)	AE
haloperidol lactate (2 mg/ml conc, 10 mg/5 ml cup)	AE
DIBENZOXAPINES	
loxapine (5 mg capsule, 10 mg capsule, 25 mg capsule, 50 mg capsule)	AE

DRUG	MORE DETAILS
PHENOTHIAZINES	
fluphenazine hcl (1 mg tablet, 2.5 mg tablet, 2.5 mg/5 ml elix, 5 mg tablet, 5 mg/ml conc, 10 mg tablet)	AE
perphenazine (2 mg tablet, 4 mg tablet, 8 mg tablet, 16 mg tablet)	AE
thioridazine hcl (10 mg tablet, 25 mg tablet, 50 mg tablet, 100 mg tablet)	AE
trifluoperazine hcl (1 mg tablet, 2 mg tablet, 5 mg tablet, 10 mg tablet)	AE
THIOXANTHENES	
thiothixene (1 mg capsule, 2 mg capsule, 5 mg capsule, 10 mg capsule)	AE
ANTITHROMBOTIC AGENTS	
PLATELET-AGGREGATION INHIBITORS	
BRILINTA (60 MG TABLET, 90 MG TABLET)	
cilostazol (50 mg tablet, 100 mg tablet)	
clopidogrel 75 mg tablet	
prasugrel hcl (5 mg tablet, 10 mg tablet)	
AUTONOMIC DRUGS	
SMOKING CESSATION AGENTS	
apo-varenicline 0.5 mg tablet (apotex)	QL
apo-varenicline 1 mg tablet (apotex)	QL
NICORETTE 2 MG LOZENGE	
nicotine gum (2 mg gum, cvs 2 mg gum, cvs 4 mg gum, eq 2 mg gum, eq 4 mg gum, ft 2 mg gum, ft 4 mg gum, gnp 2 mg gum, gnp 4 mg gum, gs 2 mg gum, gs 4 mg gum, hm 2 mg gum, kro 2 mg gum, 4 mg gum, hm 4 mg gum, kro 4 mg gum, ra 2 mg gum, ra 4 mg gum, sm 2 mg gum, sm 4 mg gum, sw 2 mg gum, sw 4 mg gum)	
nicotine lozenge (2 mg lozenge, 2 mg mini lozenge, cvs 2 mg lozenge, 4 mg lozenge, cvs 4 mg lozenge, cvs 4 mg mini lozenge, eq 2 mg lozenge, eq 4 mg lozenge, ft 2 mg lozenge, ft 2 mg mini lozenge, ft 4 mg mini lozenge, gnp 2 mg lozenge, gnp 2 mg mini lozenge, gnp 4 mg lozenge, gnp 4 mg mini lozenge, gs 2 mg mini lozenge, gs 4 mg lozenge, hm 2 mg lozenge, 4 mg mini lozenge, ft 4 mg lozenge, gs 4 mg mini lozenge, hm 2 mg mini lozenge, hm 4 mg lozenge, hm 4 mg mini lozenge, kro 2 mg lozenge, kro 4 mg lozenge, ra 2 mg lozenge, ra 4 mg lozenge, sm 2 mg lozenge, sm 4 mg lozenge, sw 2 mg lozenge, sw 4 mg lozenge)	

DRUG	MORE DETAILS
nicotine patch (7 mg/24hr patch, cvs 7 mg/24hr patch, cvs 14 mg/24hr patch, cvs 21 mg/24hr patch, eq 7 mg/24hr patch, eq 14 mg/24hr patch, eq 21 mg/24hr patch, ft 7 mg/24hr patch, ft 21 mg/24hr patch, hm 7 mg/24hr patch, kro 7 mg/24hr patch, ra 7 mg/24hr patch, 14 mg/24hr patch, ft 14 mg/24hr patch, gnp 7 mg/24hr patch, gnp 14 mg/24hr patch, gnp 21 mg/24hr patch, hm 14 mg/24hr patch, hm 21 mg/24hr patch, kro 14 mg/24hr patch, 21 mg/24hr patch, kro 21 mg/24hr patch, ra 14 mg/24hr patch, ra 21 mg/24hr patch, sm 7 mg/24hr patch, sm 14 mg/24hr patch, sm 21 mg/24hr patch, transdermal system)	
NICOTROL CARTRIDGE INHALER	
NICOTROL NS 10 MG/ML SPRAY	
quit 2 mg lozenge	
quit 4 mg lozenge	
varenicline tartrate (0.5 mg tablet, 1 mg cont month bx, 1 mg tablet, starting month box)	QL
BETA-ADRENERGIC AGONISTS	
SELECTIVE BETA-2-ADRENERGIC AGONISTS	
ADVAIR HFA (HFA 45-21 MCG INHALER, HFA 115-21 MCG INHALER, HFA 230-21 MCG INHALER)	
BREO ELLIPTA (50-25 MCG INHALER, 100-25 MCG INHALR, 200-25 MCG INHALR)	
fluticasone-salmeterol (100-50, 250-50, 500-50)	
STRIVERDI RESPIMAT INHAL SPRAY	
SYMBICORT (80-4.5 MCG INHALER, 160-4.5 MCG INHALER)	
WIXELA INHUB (100-50, 250-50, 500-50)	
BRONCHODILATORS	
ANTICHOLINERGIC AGENTS (RESPIR.TRACT)	
BREZTRI AEROSPHERE INHALER	
CALCIUM-CHANNEL BLOCKING AGENTS	
DIHYDROPYRIDINES	
amlodipine besylate (2.5 mg tab, 5 mg tab, 10 mg tab)	

DRUG	MORE DETAILS
amlodipine besylate-benazepril (2.5-10, 5-10 mg, 5-20 mg, 5-40 mg, 10-20 mg, 10-40 mg)	
amlodipine-valsartan (5-160 mg, 5-320 mg, 10-160 mg, 10-320 mg)	
nifedipine er (er 30 mg tablet, er 60 mg tablet, er 90 mg tablet)	
CARDIOVASCULAR DRUGS	
BETA-ADRENERGIC BLOCKING AGENTS	
atenolol (25 mg tablet, 50 mg tablet, 100 mg tablet)	
atenolol-chlorthalidone (50-25, 100-25)	
bisoprolol fumarate (5 mg tab, 10 mg tab)	
bisoprolol-hydrochlorothiazide (2.5-6.25 mg tb, 5-6.25 mg tab, 10-6.25 mg tab)	
carvedilol (3.125 mg tablet, 6.25 mg tablet, 12.5 mg tablet, 25 mg tablet)	
labetalol hcl (100 mg tablet, 200 mg tablet, 300 mg tablet)	
metoprolol succinate (er 25 mg tab, er 50 mg tab, er 100 mg tab, er 200 mg tab)	
metoprolol tartrate (25 mg tab, 50 mg tab, 100 mg tab)	
metoprolol-hydrochlorothiazide (50-25 mg tab, 100-25 mg tab, 100-50 mg tab)	
nadolol (20 mg tablet, 40 mg tablet, 80 mg tablet)	
propranolol hcl (10 mg tablet, 20 mg tablet, 40 mg tablet, 60 mg tablet, 80 mg tablet)	
propranolol hcl er (er 60 mg capsule, er 80 mg capsule, er 120 mg capsule, er 160 mg capsule)	
CENTRAL ALPHA-AGONISTS (25:24)	
clonidine hcl (0.1 mg tablet, 0.2 mg tablet, 0.3 mg tablet)	
guanfacine hcl (1 mg tablet, 2 mg tablet)	
methyldopa (250 mg tablet, 500 mg tablet)	

DRUG	MORE DETAILS
CENTRAL NERVOUS SYSTEM AGENTS	
ANTIMANIC AGENTS	
lithium carbonate (150 mg cap, 300 mg cap, 300 mg tab, 600 mg cap)	
lithium carbonate er (er 300 mg tb, er 450 mg tb)	
lithium citrate (8 meq/5 ml soln cup, 8 meq/5 ml solution)	
DEVICES	
DEVICES	
1ST TIER UNIFINE PENTIPS (PENTP 5MM 31G, PNTIP 4MM 32G, PNTIP 6MM 31G, PNTIP 8MM 31G, PNTP 12MM 29G, PNTP 29GX1/2", PNTP 31GX1/4")	
1ST TIER UNIFINE PENTIPS PLUS (PNTIP 8MM 31G, PNTP 31GX3/16, PNTP 31GX5/16, PNTP 32GX5/32)	
ACCU-CHEK AVIVA PLUS METER	QL
ACCU-CHEK AVIVA SOLUTION	
ACCU-CHEK FASTCLIX LANCING DEV	
ACCU-CHEK GUIDE L1-L2 CTRL SOL	
ACCU-CHEK GUIDE ME GLUCOSE MTR	QL
ACCU-CHEK GUIDE MONITOR SYSTEM	QL
ACCU-CHEK SMARTVIEW CONTRL SOL	
ACCU-CHEK SOFTCLIX (LANCET KIT, LANCETS)	
ADVOCATE PEN NEEDLE 4MM 33G	
ADVOCATE PEN NEEDLES (PEN NDL 12.7MM 29G, PEN NEEDLES 5MM 31G, PEN NEEDLES 8MM 31G)	
ADVOCATE SAFETY LANCET (21G, 23G, 28G)	
ASSURE ID PEN NEEDLE (PEN NEEDLE 30GX3/16", PEN NEEDLE 30GX5/16", PEN NEEDLE 31GX3/16")	
ASSURE LANCE 28G SAFETY LANCET	
BD AUTOSHIELD DUO NDL 5MMX30G	
BD NANO 2 GEN PEN NDL 32G 4MM	

DRUG	MORE DETAILS
BD UF MICRO PEN NEEDLE 6MMX32G	
BD UF MINI PEN NEEDLE 5MMX31G	
BD UF NANO PEN NEEDLE 4MMX32G	
BD UF ORIG PEN NDL 12.7MMX29G	
BD UF SHORT PEN NEEDLE 8MMX31G	
BUTTERFLY TOUCH 30-36G LANCET	
CAREFINE PEN NEEDLE (PEN NEEDLE 4MM 32G, PEN NEEDLE 5MM 32G, PEN NEEDLE 6MM 31G, PEN NEEDLE 8MM 30G, PEN NEEDLE 12.7MM 29G, PEN NEEDLES 6MM 32G, PEN NEEDLES 8MM 31G)	
CARESENS 30G LANCET	
CARETOUCH PEN NEEDLE (PEN NEEDLE 31GX1/4", PEN NEEDLE 31GX3/16", PEN NEEDLE 31GX5/16", PEN NEEDLE 32GX3/16", PEN NEEDLE 32GX5/32")	
CARETOUCH SAFETY LANCETS (26G, 28G)	
CARETOUCH TWIST LANCET (28G, 30G)	
CHOSEN 30G LANCET	
CHOSEN SAFETY 28G LANCET	
CLICKFINE (31G X 1/4" NEEDLES, 31G X 5/16" NEEDLES, GNP 31G X 1/4" NDL, GNP 31G X 5/16" NDL, PEN NEEDLE 32GX5/32", UNIVERSAL 31G X 1/4", UNIVERSAL 31GX5/16")	
COMFORT EZ PEN NEEDLE (PEN NEEDLE 12MM 29G, PEN NEEDLES 4MM 32G, PEN NEEDLES 4MM 33G, PEN NEEDLES 5MM 31G, PEN NEEDLES 5MM 32G, PEN NEEDLES 5MM 33G, PEN NEEDLES 6MM 31G, PEN NEEDLES 6MM 32G, PEN NEEDLES 6MM 33G, PEN NEEDLES 8MM 31G, PEN NEEDLES 8MM 32G, PEN NEEDLES 8MM 33G)	
COMFORT EZ PRESSURE ACTIVT 28G	
COMFORT TOUCH ULT THIN 31G LAN	
COMFORTTOUCH PLUS SAF 30G LANC	
DROPLET 30G LANCETS	
DROPLET PEN NEEDLE (PEN NEEDLE 29GX1/2", PEN NEEDLE 29GX3/8", PEN NEEDLE 31GX1/4", PEN NEEDLE 31GX3/16", PEN NEEDLE 31GX5/16", PEN NEEDLE 32GX1/4", PEN NEEDLE 32GX3/16", PEN NEEDLE 32GX5/16", PEN NEEDLE 32GX5/32")	

DRUG	MORE DETAILS
DROPSAFE PEN NEEDLE (PEN NEEDLE 31GX1/4", PEN NEEDLE 31GX5/16")	
EASY COMFORT PEN NEEDLE (PEN NDL 31GX3/16", PEN NDL 31GX5/16", PEN NDL 33G 4MM, PEN NDL 33G 5MM, PEN NDL 33G 6MM)	
EASY COMFORT PEN NEEDLES (PEN NDL 31GX1/4", PEN NDL 31GX3/16", PEN NDL 31GX5/16", PEN NDL 32GX5/32")	
EASY GLIDE PEN NEEDLE 4MM 33G	
EASY TOUCH PEN NEEDLE (PEN NEEDLE 29GX1/2", PEN NEEDLE 30GX5/16, PEN NEEDLE 31GX1/4", PEN NEEDLE 31GX3/16, PEN NEEDLE 31GX5/16, PEN NEEDLE 32GX1/4", PEN NEEDLE 32GX3/16, PEN NEEDLE 32GX5/32)	
EMBRACE SAFETY LANCET (21G, 28G)	
EZ-LETS 26G LANCETS	
GOJJI LANCETS 30G	
HEALTHWISE PEN NEEDLE (PEN NEEDLE 31G 5MM, PEN NEEDLE 31G 8MM, PEN NEEDLE 32G 4MM)	
HEALTHY ACCENTS UNIFINE PENTIP (PENTIP 4MM 32G, PENTIP 5MM 31G, PENTIP 6MM 31G, PENTIP 8MM 31G, PENTP 12MM 29G)	
INCONTROL PEN NEEDLE (PEN NEEDLE 4MM 32G, PEN NEEDLE 5MM 31G, PEN NEEDLE 6MM 31G, PEN NEEDLE 8MM 31G, PEN NEEDLE 12MM 29G)	
INSULIN PEN NEEDLE (PEN NDL 29GX1/2", PEN NDL 31GX1/3", PEN NDL 31GX1/4", PEN NDL 31GX1/6")	
INSUPEN (30G ULTRAFIN NEEDLE, 31G ULTRAFIN NEEDLE, 32G 6MM PEN NEEDLE, 32G 8MM PEN NEEDLE, PEN NEEDLE 32GX5/32")	
INSUPEN PEN NEEDLE (PEN NEEDLE 29GX1/2", PEN NEEDLE 29GX12MM, PEN NEEDLE 30GX8MM, PEN NEEDLE 31GX3/16", PEN NEEDLE 31GX5/16", PEN NEEDLE 31GX6MM, PEN NEEDLE 31GX8MM, PEN NEEDLE 32GX4MM, PEN NEEDLE 32GX5/32", PEN NEEDLE 32GX6MM, PEN NEEDLE 32GX8MM, PEN NEEDLE 33GX4MM)	
LANCING DEVICE	
LITE TOUCH (PEN NEEDLE 29G, 31GX1/4" PEN NEEDLE, PEN NEEDLE 31G)	
MAXICOMFORT II PEN NDL 31GX6MM	
MAXICOMFORT SAFETY PEN NEEDLE (MAICOMFORT PEN NDL 5MM, MAICOMFORT PEN NDL 8MM)	
MICRO THIN LANCET (, PUB)	

DRUG	MORE DETAILS
MICRODOT INSULIN PEN NEEDLE (PEN NEEDLE 31GX6MM, PEN NEEDLE 32GX4MM, PEN NEEDLE 33GX4MM)	
MICRODOT SAFETY 28G LANCET	
MICROLET LANCETS	
MINI ULTRA-THIN II PEN NDL 31G	
MOBILE 30G LANCETS	
NOVOFINE 32G NEEDLES	
NOVOFINE AUTOCOVER 30G NEEDLE	
NOVOFINE PLUS PEN NDL 32GX1/6"	
NOVOTWIST NEEDLE 32G 5MM	
ONETOUCH DELICA PLUS LANC DEV	
ONETOUCH DELICA PLUS LANCET (30G, 33G)	
ONETOUCH DELICA SAF 30G LANCET	
ONETOUCH ULTRASOFT2 30G LANCET	
PEN NEEDLE (FIFTY50 PEN 31G X 3/16" NEEDLE, FIFTY50 PEN 31G X 5/16" NEEDLE, FIFTY50 PEN NEEDLE 32G X 1/4", FIFTY50 PEN NEEDLE 32G X 5/32", GNP CLICKFINE PEN NDL 31GX1/4", GNP CLICKFINE PEN NDL 31GX5/16, GS PEN NEEDLE 31G X 1/4", GS PEN NEEDLE 31G X 5/16", GS PEN NEEDLE 31G X 5MM, GS PEN NEEDLE 31G X 6MM, GS PEN NEEDLE 31G X 8MM, GS PEN NEEDLE 32G X 4MM, GS PEN NEEDLE 32G X 6MM, KROGER PEN NEEDLES 31G X 5/16", LIVE BETTER PEN NEEDLES 8MM, MS PEN NEEDLE 6MM 31G, PEN NEEDLE 4MM 32G, PEN NEEDLE 5MM 31G, PEN NEEDLE 6MM 31G, PEN NEEDLE 12MM 29G, PEN NEEDLE 30G X 5/16", PEN NEEDLE 31G 8MM, PEN NEEDLE 31G X 1/4", PEN NEEDLE 31G X 3/16", PEN NEEDLE 31G X 5/16", PEN NEEDLE 32G X 1/4", PEN NEEDLE 32G X 3/16", PEN NEEDLE 32G X 5/32", PUB PEN 8MM 31G NEEDLES, PUB PEN 12MM 29G NEEDLES, PUB PEN NEEDLE 6MM 31G, RA PEN NEEDLE 31GX3/16", RA PEN NEEDLE 31GX5/16", RELION MINI PEN 31G X 1/4" NDL, RELION PEN 29G NEEDLE, RELION PEN 31G NEEDLE, RELION PEN NEEDLE 29GX1/2", RELION PEN NEEDLE 31GX1/4", RELION PEN NEEDLE 31GX5/16", RELION PEN NEEDLE 32GX5/32", TODAY'S HLTH PN NEEDLE 6MM 31G)	
PEN NEEDLES (PEN 4MM 32G, PEN 5MM 31G, PEN 6MM 31G, PEN 8MM 31G, PEN 12MM 29G)	
PENTIPS (PEN NEEDLE 29GX1/2", PEN NEEDLE 31GX3/16", PEN NEEDLE 31GX5/16", PEN NEEDLE 32GX5/32")	

DRUG	MORE DETAILS
PENTIPS PEN NEEDLE (PEN NEEDLE 29G 1/2", PEN NEEDLE 29GX1/2", PEN NEEDLE 31G 1/4", PEN NEEDLE 31G 3/16", PEN NEEDLE 31G 5/16", PEN NEEDLE 31GX1/4", PEN NEEDLE 31GX3/16", PEN NEEDLE 31GX5/16", PEN NEEDLE 32G 5/32", PEN NEEDLE 32GX5/32")	
PERFECT POINT SAFETY LANCETS (28G, 30G)	
PIP LANCET (28G, 30G)	
PREVENT DROPSAFE PEN NEEDLE (PEN NEEDLE 31GX1/4", PEN NEEDLE 31GX5/16")	
PRO COMFORT 30G SAFETY LANCET	
PRO COMFORT PEN NEEDLE (PEN NDL 4MM 32G, PEN NDL 5MM 32G, PEN NDL 31GX5/16", PEN NDL 32G X 1/4")	
PURE COMFORT 30G SAFETY LANCET	
PURE COMFORT LANCETS (SAFETY, TWIST)	
PUSH BUTTON SAFETY 28G LANCET	
PV UNILET MICRO THIN 33G LANCT	
RELI ON 31G X 1/4" NEEDLES	
RELION 2-IN-1 LANCET DEVICE	
RELION PEN NEEDLES 32GX5/32"	
SAFESNAP INSULIN SYRINGE (SYRINGE 0.3 ML, SYRINGE 0.5 ML)	
SAFETY PEN NEEDLE 5MM X 31G	
SAPS TWIST TOP 30G LANCET	
STERILE LANCETS (, GNP)	
SUPER THIN 30G LANCET	
SURE COMFORT (PEN NDL 29GX1/2", 30G PEN NEEDLE)	
SURE COMFORT PEN NEEDLE (PEN NDL 31G 5MM, PEN NDL 31G 8MM, PEN NDL 32G 4MM, PEN NDL 32G 6MM)	
SURE-FINE PEN NEEDLES (PEN 5MM, PEN 8MM, PEN 12.7MM)	
SYRINGE WITH NEEDLE	
TECHLITE 26G LANCETS	

DRUG	MORE DETAILS
TECHLITE PEN NEEDLE (PEN NEEDLE 29GX1/2", PEN NEEDLE 29GX3/8", PEN NEEDLE 31GX1/4", PEN NEEDLE 31GX3/16", PEN NEEDLE 31GX5/16", PEN NEEDLE 32GX1/4", PEN NEEDLE 32GX5/16", PEN NEEDLE 32GX5/32")	
TEMPO REFILL KIT	
TEMPO REFILL KIT (WITH GAUZE)	
TEMPO SMART BUTTON	
TEMPO WELCOME KIT	
THIN 26G LANCET	
THIN 26G LANCETS	
TOPCARE CLICKFINE (1/4", 5/16")	
TRUE COMFORT 30G SAFETY LANCET	
TRUE COMFORT 30G TWIST LANCET	
TRUE COMFORT PEN NEEDLE (PEN NDL 31GX5MM, PEN NDL 31GX6MM, PEN NDL 32GX4MM)	
TRUEPLUS PEN NEEDLE (PEN NEEDLE 29G 12MM, PEN NEEDLE 29GX1/2", PEN NEEDLE 31G 5MM, PEN NEEDLE 31G 8MM, PEN NEEDLE 31G X 1/4", PEN NEEDLE 31GX3/16", PEN NEEDLE 31GX5/16", PEN NEEDLE 32GX5/32")	
TWIST TOP LANCET (, SWI)	
ULTICARE PEN NEEDLE (HM PEN NEEDLE 4MM 32G, HM PEN NEEDLE 6MM 31G, HM PEN NEEDLE 8MM 31G, PEN NDL 12.7 MM 29G, PEN NEEDLE 4MM 32G, PEN NEEDLE 6MM 31G, PEN NEEDLE 8 MM 31G, PEN NEEDLE 8MM 31G, PEN NEEDLE 31GX3/16", PEN NEEDLES 4MM 32G, PEN NEEDLES 6MM 31G, PEN NEEDLES 6MM 32G, PEN NEEDLES 8MM 31G, PEN NEEDLES 12MM 29G, YOURX PEN NDL 4MM 32G, YOURX PEN NDL 6MM 31G, YOURX PEN NDL 8MM 31G)	
ULTIGUARD SAFEPACK 32G 4MM	
ULTILET PEN NEEDLE (PEN NEEDLE, PEN NEEDLE 4MM 32G)	
ULTRA FLO PEN NEEDLE 31G 5MM	
ULTRA THIN 31G LANCET	
ULTRA-THIN II (PEN NDL 29GX1/2", PEN NDL 31GX5/16)	
ULTRACARE PEN NEEDLE (PEN NEEDLE 31GX1/4", PEN NEEDLE 31GX3/16", PEN NEEDLE 31GX5/16", PEN NEEDLE 32GX1/4", PEN NEEDLE 32GX3/16", PEN NEEDLE 32GX5/32", PEN NEEDLE 33GX5/32")	

DRUG	MORE DETAILS
UNIFINE PENTIPS (CAREONE PENTIP 4MM 32G, CAREONE PENTIP 5MM 31G, CAREONE PENTIP 6MM 31G, CAREONE PENTIP 8MM 31G, CAREONE PNTP 12MM 29G, PC PENTIPS 6MM NEEDLE, PC PENTIPS 8MM NEEDLE, PC PENTIPS 12MM NEEDLE, PENTIPS 6MM 31G, PENTIPS 6MM NEEDLE, PENTIPS 8MM 31G, PENTIPS 8MM NEEDLE, PENTIPS 12MM 29G, PENTIPS 31GX3/16", PENTIPS 32GX1/4", PENTIPS 32GX5/32", PENTIPS 33GX5/32", PENTIPS NEEDLES 29G, QC PENTIPS 4MM 32G, QC PENTIPS 32GX5/32", SHOPKO PENTIPS 4MM 32G, SHOPKO PENTIPS 5MM 31G, SHOPKO PENTIPS 8MM 31G, SHOPKO PNTIPS 12MM 29G)	
UNIFINE PENTIPS PLUS (CAREONE PENTP 29GX1/2", CAREONE PENTP 31GX1/4", CAREONE PNTP 31GX3/16", CAREONE PNTP 31GX5/16", CAREONE PNTP 32GX5/32", HEB PNTP PLUS 31GX3/16, HEB PNTP PLUS 32GX5/32, PENTIPS PLUS 29GX1/2", PENTIPS PLUS 31G 5MM, PENTIPS PLUS 31GX1/4", PENTIPS PLUS 31GX3/16", PENTIPS PLUS 31GX5/16", PENTIPS PLUS 32GX5/32", PENTIPS PLUS 33GX5/32", PUB PNTP PLUS 31GX3/16, SHOPKO PENTIPS 4MM 32G, SHOPKO PENTIPS 5MM 31G, SHOPKO PENTIPS 8MM 31G, SHOPKO PNTIPS 12MM 29G, WM PENTIP PLUS 4MM 32G, WM PENTIP PLUS 5MM 31G, WM PENTIP PLUS 6MM 31G, WM PENTIP PLUS 8MM 31G)	
VERIFINE PEN NEEDLE (PEN NEEDLE 31G 6MM, PEN NEEDLE 31G 8MM, PEN NEEDLE 32G 4MM, PEN NEEDLE 32G 5MM)	
VERIFINE SAFETY LANCET MINI (21G MINI, 23G MINI, 28G MINI, 30G MINI)	
VERIFINE UNIVERSAL LANCET (28G, 30G, 33G)	
VIVAGUARD 30G LANCET	
VIVAGUARD SAFETY 28G LANCET	
DIAGNOSTIC AGENTS	
CARDIAC FUNCTION	
dipyridamole (25 mg tablet, 50 mg tablet, 75 mg tablet)	
DIABETES MELLITUS	
ACCU-CHEK AVIVA PLUS TEST STRP	QL
ACCU-CHEK GUIDE TEST STRIP	QL
ACCU-CHEK SMARTVIEW TEST STRIP	QL
DIURETICS	
LOOP DIURETICS (40:28)	
bumetanide (0.5 mg tablet, 1 mg tablet, 2 mg tablet)	

DRUG	MORE DETAILS
furosemide (10 mg/ml solution, 20 mg tablet, 40 mg tablet, 40 mg/5 ml soln, 80 mg tablet)	
torsemide (5 mg tablet, 10 mg tablet, 20 mg tablet, 100 mg tablet)	
POTASSIUM-SPARING DIURETICS	
amiloride hcl 5 mg tablet	
amiloride hcl-hctz 5-50 mg tab	
triamterene-hydrochlorothiazid (37.5-25 mg cp, 37.5-25 mg tb, 75-50 mg tab)	
THIAZIDE DIURETICS	
hydrochlorothiazide (12.5 mg cp, 12.5 mg tb, 25 mg tab, 50 mg tab)	
THIAZIDE-LIKE DIURETICS	
chlorthalidone (25 mg tablet, 50 mg tablet)	
indapamide (1.25 mg tablet, 2.5 mg tablet)	
metolazone (2.5 mg tablet, 5 mg tablet, 10 mg tablet)	
ESTROGENS AND ANTIESTROGENS	
ESTROGEN AGONIST-ANTAGONISTS	
tamoxifen citrate (10 mg tablet, 20 mg tablet)	
HORMONES AND SYNTHETIC SUBSTITUTES	
ADRENALS	
ARNUITY ELLIPTA (50 MCG, 100 MCG, 200 MCG)	
ASMANEX (TWISTHALER 110 MCG #30, TWISTHALER 220 MCG #30, TWISTHALER 220 MCG #60, TWISTHALR 220 MCG #120)	
ASMANEX HFA (HFA 50 MCG INHALER, HFA 100 MCG INHALER, HFA 200 MCG INHALER)	
budesonide (0.25 mg/2 ml susp, 0.5 mg/2 ml susp, 1 mg/2 ml inh susp)	
fluticasone propionate (50 mcg diskus, 100mcg diskus, 250 mcg disk)	
fluticasone propionate hfa (hfa 44 mcg, hfa 110 mcg, hfa 220 mcg)	
QVAR REDIHALER (40 MCG, 80 MCG)	

DRUG	MORE DETAILS
INSULINS	
INTERMEDIATE-ACTING INSULINS	
HUMULIN 70-30 VIAL	
HUMULIN 70/30 KWIKPEN	
HUMULIN N 100 UNIT/ML KWIKPEN	
HUMULIN N 100 UNIT/ML VIAL	
relion novolin 70-30 flexpen	
relion novolin 70-30 vial	
relion novolin n 100 unit/ml	
relion novolin n u-100 flexpen	
LONG-ACTING INSULINS	
insulin glargine 100 unit/ml	
insulin glargine max solo u300	
insulin glargine solostar (u100, u300)	
LANTUS 100 UNIT/ML VIAL	
LANTUS SOLOSTAR 100 UNIT/ML	
LEVEMIR 100 UNIT/ML VIAL	PA
LEVEMIR FLEXPEN 100 UNIT/ML	PA
LEVEMIR FLEXTOUCH 100 UNIT/ML	PA
SOLIQUA 100 UNIT-33 MCG/ML PEN	
TOUJEO MAX SOLOSTR 300 UNIT/ML	
TOUJEO SOLOSTAR 300 UNIT/ML	
XULTOPHY 100 UNIT-3.6MG/ML PEN	
RAPID-ACTING INSULINS	
HUMALOG 100 UNIT/ML CARTRIDGE	
HUMALOG 200 UNIT/ML KWIKPEN	

DRUG	MORE DETAILS
HUMALOG MIX 50-50 KWIKPEN	
HUMALOG MIX 50-50 VIAL	
HUMALOG MIX 75-25 VIAL	
HUMALOG TEMPO PEN 100 UNIT/ML	
insulin aspart 100 unit/ml crt	PA
insulin aspart 100 unit/ml pen	PA
insulin aspart 100 unit/ml vl	PA
insulin lispro 100 unit/ml pen	
insulin lispro 100 unit/ml vl	
insulin lispro jr 100 unit/ml	
insulin lispro mix 75-25 kwkpn	
SHORT-ACTING INSULINS	
HUMULIN R 100 UNIT/ML VIAL	
HUMULIN R 500 UNIT/ML KWIKPEN	
HUMULIN R 500 UNIT/ML VIAL	
relion novolin r 100 unit/ml	
relion novolin r u-100 flexpen	
MINERALOCORTICOID (ALDOSTERONE) ANTAGNTS	
STEROIDAL MINERALOCORTICOID RECEPTOR ANT	
eplerenone (25 mg tablet, 50 mg tablet)	
spironolactone (25 mg tablet, 50 mg tablet, 100 mg tablet)	
spironolactone-hctz 25-25 tab	
MISCELLANEOUS THERAPEUTIC AGENTS	
BONE RESORPTION INHIBITORS	
alendronate sodium (5 mg tablet, 10 mg tab, 35 mg tab, 70 mg tab)	

DRUG	MORE DETAILS
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS	
SALICYLATES	
aspirin-dipyridam er 25-200 mg	
RENIN-ANGIOTENSIN-ALDOSTERONE SYS. INHIB	
ANGIOTENSIN II RECEPTOR ANTAGONISTS	
candesartan cilexetil (4 mg tab, 8 mg tab, 16 mg tb, 32 mg tb)	
irbesartan (75 mg tablet, 150 mg tablet, 300 mg tablet)	
irbesartan-hydrochlorothiazide (150-12.5 mg tb, 300-12.5 mg tb)	
losartan potassium (25 mg tab, 50 mg tab, 100 mg tab)	
losartan-hydrochlorothiazide (50-12.5 mg tab, 100-12.5 mg tab, 100-25 mg tab)	
olmesartan medoxomil (5 mg tab, 20 mg tab, 40 mg tab)	
olmesartan-hydrochlorothiazide (20-12.5 mg tab, 40-12.5 mg tab, 40-25 mg tab)	
telmisartan (20 mg tablet, 40 mg tablet, 80 mg tablet)	
valsartan (40 mg tablet, 80 mg tablet, 160 mg tablet, 320 mg tablet)	
valsartan-hydrochlorothiazide (80-12.5 mg tab, 160-12.5 mg tab, 160-25 mg tab, 320-12.5 mg tab, 320-25 mg tab)	
ANGIOTENSIN-CONVERTING ENZYME INHIBITORS	
benazepril hcl (5 mg tablet, 10 mg tablet, 20 mg tablet, 40 mg tablet)	
benazepril-hydrochlorothiazide (5-6.25 mg tab, 10-12.5 mg tab, 20-12.5 mg tab, 20-25 mg tab)	
enalapril maleate (2.5 mg tab, 5 mg tablet, 10 mg tab, 20 mg tab)	
enalapril-hydrochlorothiazide (5-12.5 mg tab, 10-25 mg tablet)	
fosinopril sodium (10 mg tab, 20 mg tab, 40 mg tab)	
lisinopril (2.5 mg tablet, 5 mg tablet, 10 mg tablet, 20 mg tablet, 30 mg tablet, 40 mg tablet)	
lisinopril-hydrochlorothiazide (10-12.5 mg tab, 20-12.5 mg tab, 20-25 mg tab)	

DRUG	MORE DETAILS
metformin hcl 1,000 mg tablet (generic for glucophage)	
moexipril hcl (7.5 mg tablet, 15 mg tablet)	
perindopril erbumine (2 mg tab, 4 mg tab, 8 mg tab)	
quinapril hcl (5 mg tablet, 10 mg tablet, 20 mg tablet, 40 mg tablet)	
ramipril (1.25 mg capsule, 2.5 mg capsule, 5 mg capsule, 10 mg capsule)	
trandolapril (1 mg tablet, 2 mg tablet, 4 mg tablet)	
URINE AND FECES CONTENTS	
KETONES	
KETONE TEST STRIP (RELION STRIP, STRIP)	
KETOSTIX REAGENT STRIP	
TRUEPLUS KETONE TEST STRIP	
SUGAR	
DIASTIX REAGENT STRIPS	
VASODILATING AGENTS	
DIRECT VASODILATORS	
hydralazine hcl (10 mg tablet, 25 mg tablet, 50 mg tablet, 100 mg tablet)	
minoxidil (2.5 mg tablet, 10 mg tablet)	
VITAMINS	
MULTIVITAMIN PREPARATIONS	
m-natal plus tablet	
mynatal plus captab	
mynatal-z captab	
pnv prenatal plus multivit tab	
PRENATABS FA TABLET	
prenatal vitamin plus low iron	
westab plus tablet	


Your partner for good℠
We're 26,000 partners strong, working together to support your health every day. You can rely on a top-rated Member Services team – here to help you understand your plan and answer your questions. It's a plan you can trust, benefits that benefit you and a commitment to lower costs. We're your partner for all of it. Your partner for good.
HealthPartners®
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HSA Plus plan

Set aside pretax money in a health savings account (HSA) to pay medical bills. Plus, get lower costs on select medicines and care.

How to get more info

- **See plan details** in your **Summary of Benefits and Coverage (SBC)** in your enrollment materials
- **Call us** with questions at **952-883-5000 or 800-883-2177**

TIP: Put some of the money you're saving on premiums into your HSA on your own or through direct deposit.

What you'll pay

Deductible, then coinsurance

This plan has a deductible – a set amount you pay before your plan helps cover costs for most kinds of care. After that, you may pay coinsurance, which is a percent of the bill.

Out-of-pocket maximum

Once you reach the max, your plan pays for in-network care the rest of the year.

What your plan pays for

Even before you reach your deductible, your plan helps cover the things you need most to stay healthy.

In-network preventive care

Your plan pays 100% of the bill.

Preventive drugs

For prescriptions on our HSA Enhanced preventive drug list, your plan pays some and you'll pay a set amount (a copay). See the list at **healthpartners.com/enhancedhsa**.

Preventive care for chronic conditions

Your plan helps pay for certain services and equipment, such as lab work to monitor diabetes or liver disease.

Empower℠ HSA plan highlights

This plan allows you to contribute money to an HSA before taxes are taken out. Add up what you spent on health care expenses last year to get an idea of how much to put in next year.

Use your HSA to pay for things like:

- Doctor visits and lab fees
- Prescription and select over-the-counter medicines
- Dental care and braces
- Vision care and LASIK surgery

HSA money can:

- Earn interest or be invested
- Pay for medical expenses before or after you reach your deductible
- Stay with you year after year, even if you switch jobs – you own the account

TieredChoice

Benefit tiers make it easy for you to choose a high-quality doctor at the lowest cost.

Care in your community from doctors you trust

Doctors in the TieredChoice network are grouped into two benefit levels: Select and Standard.

We coordinate with Select Tier doctors to provide better care at lower cost. Providers at this level include doctors from HealthPartners, Park Nicollet and Children's Minnesota. Standard Tier providers generally offer a greater number of options at a slightly higher cost.

Choose your favorite doctor from any provider in the TieredChoice network – no referral needed.

Benefit Level	Cost
Select Tier	$
Standard Tier	$$

How to get more info

- **See plan details** in your **Summary of Benefits and Coverage (SBC)** in your enrollment materials
- **Call us** with questions at **952-883-5000 or 800-883-2177**

Fast, easy, affordable care

Life is busy. Save time and money by using telemedicine care for many common conditions. Your plan includes options for treatment from your phone or computer.

Virtuwell®

Your 24/7 online clinic

Start your visit any time with any device – no appointments, video or downloads needed. Answer a few questions online to get same-day treatment for more than 60 common conditions. Nurse practitioners give you a diagnosis, treatment plan and prescription (if needed). You'll usually pay less than an in-person visit, and you're only charged if Virtuwell can treat you. Plus follow-up care about your treatment is free.

Get better faster at **virtuwell.com**.*

Doctor On Demand

Live video visits with a doctor include assessment, diagnosis and prescriptions for urgent care like cold & flu, skin conditions and allergies. When you create a free member account, your visit price is always shown up front, without any surprise bills later.

Register at **doctorondemand.com**.

Teladoc

Fill out a brief medical history to connect with medical experts by phone, video or mobile app. Whether it's a prescription sent to the pharmacy of your choice, the guidance to move forward or a review of a preexisting condition, they're ready to help.

Get started at **teladoc.com**.

Questions about benefits?

We can help. Call Member Services at **952-883-5000 or 800-883-2177**

The next time you're sick, your health plan has affordable options to help you get better, faster.
Julie, RN, Nurse Navigator

*Available anywhere in the U.S. to residents of AZ, CA, CO, CT, IA, MI, MN, NY, ND, PA, SD, VA and WI.

Get the most from your meds

Use these tools and resources to learn important information about your prescriptions, including cost and coverage, and how to make sure they're working properly.

Questions about benefits?

We can help. Call Member Services at **952-883-5000 or 800-883-2177**

Check your formulary

A formulary, also called a drug list, tells you what medicines are covered by your health plan and generally how much you'll pay. You'll also learn what steps you may need to take before you can start a medicine, such as submitting prior authorization from your doctor or meeting quantity limits.

1. Get started at **healthpartners.com/preferredrx**.
2. Search by the name or type of medicine.
3. Use your Summary of Benefits and Coverage (SBC) in your enrollment materials to learn more about your coverage, copay or cost share.

Try generics

Generics are as safe and effective as brand-name medicines and made with the same active ingredients, but they cost a lot less. They also might come in a different size, shape or color than the brand-name version. Talk to your doctor or pharmacist about switching to a generic medicine.

Search for the lowest cost

Medicine prices can change from pharmacy to pharmacy. Use our prescription shopping tool to compare prices at nearby pharmacies. You'll find real-time prices, including all available discounts so you can be sure you're getting the best possible price. Get started at **healthpartners.com/pharmacy**.

Talk with a pharmacy navigator

One call will give you answers to your questions around benefits, coverage, costs, formularies and more. Call Member Services at the number on the back of your member ID card. Ask to talk with a pharmacy navigator.

Meet with a pharmacist

If you or a family member are managing multiple or complex medicines, or if you have questions about interactions or side effects, we can help. Our specially trained pharmacists are experts at looking at your medications holistically. At a one-on-one appointment, they'll review your medicines to make sure they're working and right for your lifestyle. Learn more at **healthpartners.com/mtminfo**.

Pharmacy solutions in the palm of your hand

Use our prescription shopping tool to save both time and money.

Compare prices at nearby pharmacies

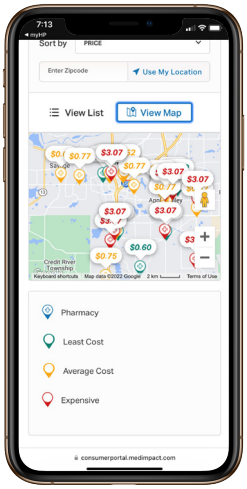
You'll find real-time prices, including all available discounts, so you can be sure you're getting the best possible price. You can also use it to transfer prescriptions to a lower-cost pharmacy and see what's covered by your health plan. Get started at **healthpartners.com/pharmacy** and scan the code below to view a short video highlighting how to use the tool.

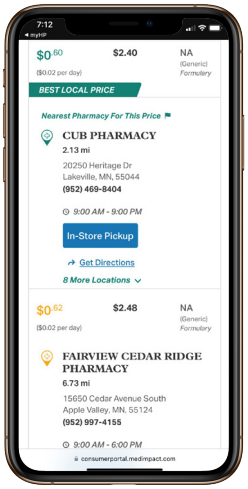
healthpartners.com/viewrxtoolvideo

Sign in to your account

Manage your health and your plan at **healthpartners.com** or the **HealthPartners** mobile app.

Don't have an account yet? It's quick and easy to sign up– you'll just need your member ID card.





You can also use the prescription shopping tool to:

- See available refills
- Check the status of prior authorizations
- Download tax reports of what you spent in the last year

Medicine delivered to your door

Skip the trip to the pharmacy. Get your prescriptions mailed to your home with WellDyne.

How to get started

- Call **800-591-0011**
- Visit **healthpartners.com/mailorder**

5 great things about mail order

1. It's easy to refill your medicine online or with our mobile app
2. Track your package every step of the way, your way – by text, email, phone or online
3. Save money with 90-day supplies and free standard shipping
4. Get your package delivered safely and discreetly in 7-10 days
5. We are available 24/7 to help you with your order – just call the dedicated phone line

TIP: You can track the status of your order at each step, from receipt and processing to shipping and delivery.

To check the status of your order, sign in to your online account or call our responsive phone system.

It's hard to get to the pharmacy each month. Mail order pharmacy delivers your meds quickly and easily to you, just like your favorite stores.
Dave, Pharmacist

Here for you, 24/7

Call us at one of these numbers if you have questions about your health or what your plan covers. We're ready to help.

Member Services		
For questions about: • Your coverage, claims or plan balances • Finding a doctor, dentist or specialist in your network • Finding care when you're away from home • Health plan services, programs and discounts		Monday – Friday, 7 a.m. to 6 p.m. CT Call the number on the back of your member ID card, **952-883-5000 or 800-883-2177** Interpreters are available if you need one. Español: **866-398-9119** **healthpartners.com**
Member Services can help you reach:		
Nurse Navigator℠ program	**For questions about:** • Understanding your health care and benefits • How to choose a treatment	Monday – Friday, 7:30 a.m. to 5 p.m. CT
Pharmacy navigators	**For questions about:** • Your medicines or how much they cost • Doctor approvals to take a medicine (prior authorization) • Your pharmacy benefits • Transferring medicine to a mail order pharmacy	Monday – Friday, 8 a.m. to 5 p.m. CT
Behavioral health navigators		
For questions about: • Finding a mental or chemical health care professional in your network • Your behavioral health benefits		Monday – Friday, 8 a.m. to 5 p.m. CT **888-638-8787**
CareLine℠ service nurse line		
For questions about: • Whether you should see a doctor • Home remedies • A medicine you're taking		24/7, 365 days a year **800-551-0859**
BabyLine phone service		
For questions about: • Your pregnancy • The contractions you're having • Your new baby		24/7, 365 days a year **800-845-9297**

One thing I love about my job is how my team helps people all day, every day.
Rachel, Registered Nurse, CareLine

Take charge of your health plan

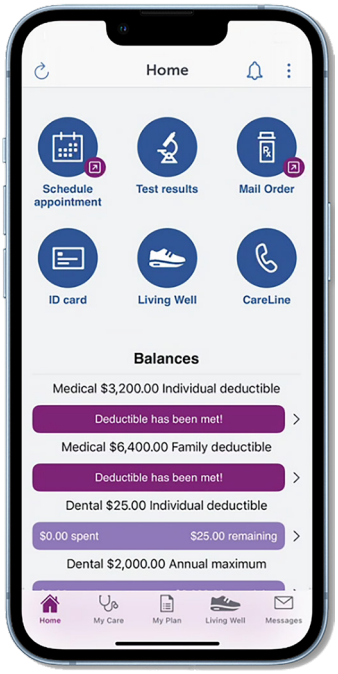
A HealthPartners online account makes it easy to stay on top of your health care and insurance.

Get personalized information when and where you need it

With an online account, you have real-time access to your personal health plan information in one simple place. No more guessing or waiting until business hours to get answers to your questions.

Top 3 ways to use your online account

1. Visit My dashboard through a web browser on your phone or computer for personalized preventive care reminders, helpful tips about your plan and more.
2. Search for in-network doctors, clinics and hospitals and get cost estimates for services specific to your plan using the web or mobile app.
3. Open the HealthPartners mobile app for on-the-go access to claims details, your member ID card and Member Services contact information.



Sign in to your account

Manage your health and your plan at **healthpartners.com** or the **HealthPartners** mobile app.

Don't have an account yet? It's quick and easy to sign up– you'll just need your member ID card.

Scan here for a quick tutorial on creating and using your online account.

healthpartners.com/getconnectedvideo

I love directing members to their online accounts and the mobile app. You can easily get your health plan info, even when I'm not in the office.
Jarria, Member Services

Get the right care at the right price

When you need care, you've got options. Use the chart below to make sure you're making the best choice for your health and your budget. Check online to see what's covered by your plan.

When you need	Go to	Average cost	Average time spent
Health advice from a registered nurse for: • At-home remedies • When to go in for care	CareLine℠ service Call 24/7 at **800-551-0859**	Free	15 minutes
Treatment and prescriptions for minor medical issues, like: • Bladder infection • Pink eye • Upper respiratory infections	Virtual or convenience care	$	15 minutes
A regular checkup or special care during the day for things like: • Diabetes management • Vaccines	Primary care clinics	$$	30 minutes
Care for urgent problems when your doctor's office is closed, like: • Cuts that need stitches • Joint or muscle pain	Urgent care clinics	$$$	45 minutes
Help in an emergency, such as: • Chest pain or shortness of breath • Head injury	Emergency room	$$$$	60 minutes

Find in-network care

Manage your health and your plan at **healthpartners.com** or the **HealthPartners** mobile app.

Don't have an account yet? It's quick and easy to sign up– you'll just need your member ID card.

Still not sure where to go? We'll help you figure out the best place based on the urgency of your care needs. Call CareLine at **800-551-0859**.
Rachel, Registered Nurse, CareLine

A resilient you

We're here to support the whole you – this includes your emotional health. Our resources connect you with information, specialists, and support to get you back on the road to feeling and living better.

Questions about benefits?

Our behavioral health navigators can help you find care in your plan network and answer coverage questions. Call **952-883-5811** or **888-638-8787**.

TIP: Visit **healthpartners.com/resilience** for more information and resources on building emotional resilience.

Self-guided resources included with your plan

Mental Health Hub

Connect to information, tools and support for you and your family. You'll also find resources to explore your plan benefits, get care and more. Visit **healthpartners.com/my/livingwell/mental-health**.

Living Well

Discover personalized activities for building healthier habits, reducing stress and improving your mood. You may need to complete a health assessment to access these activities. Visit **healthpartners.com/livingwell**.

myStrength

Goal-based activities, articles and videos to help you with stress, anxiety, depression and more. This resource will be available to you through your health and well-being experience.

Behavioral health navigators

Get customized resources, guidance and support from an experienced behavioral health specialist – confidentially and at no extra cost. Your behavioral health expert will work with you and your care team to develop a personalized plan focused on your well-being.

Employee Assistance Program (EAP)

Life doesn't always go as planned. When you need extra support, HealthPartners EAP is here to help. Whether it's an issue at work or home, get support and resources to help you with life's challenges. Call or go online anytime – day or night.

- Call **866-326-7194**
- Log on to **hpeap.com** and chat through instant message (ask your employer or call your EAP to get your password)

Living healthier just got a little less expensive

Get special savings from handpicked retailers as a HealthPartners member. There are lots of products and services available to you at a discounted rate – all designed to help you live healthy every day.

See where you can save

Visit **healthpartners.com/discounts** for a list of participating retailers and discounts.

Save big by showing your member ID card at participating retailers

Save money on:

- Eyewear
- Exercise equipment
- Fitness and well-being classes
- Eating well
- Healthy mom and baby products
- Hearing aids
- Pet insurance
- And more!

Discounts on gym memberships

The Active&Fit Direct™ program

Offers access to more than 12,000 fitness centers nationwide and over 9,000 on-demand fitness videos for a flat monthly fee.

Digital workouts

Wellbeats

Get access to free workout videos across all fitness levels, featuring top fitness brands and names. This activity will be available to you through your health and well-being experience.

Making healthy choices is easier when it doesn't break the bank. I always say taking advantage of these discounts is a great way to make the most out of your health plan.
Katie, Member Services

Quit for good

Quitting tobacco and vape may be one of the hardest things you'll ever do. You don't have to do it alone. We're here to help.

How to get started

Call **800-311-1052** to sign up with a health coach.

Get help from a health coach

Work with a health coach to set goals around tobacco use and vaping that fit your lifestyle. You'll get support and encouragement to reach your goals and live nicotine free. Plus, you can schedule phone calls or email your health coach when it works best for you.

Work at your own pace to:

- Beat cravings
- Relieve stress
- Deal with tempting social situations
- Adjust to life without tobacco and vape
- Feel great

Medicine to support quitting

Your health plan might pay for medicines to help you quit. Visit **healthpartners.com/formulary** to view your formulary. Or call our Member Services team at the number on the back of your member ID card.

Digital smoking cessation resources

Pivot is an app-based cessation program to help you quit cigarettes, cigars and all smokeless tobacco products.

- Visit **pivot.co/healthpartners** to get started.

Maybe you've tried to quit on your own – more than once. Don't get down on yourself. Getting support from a coach can be just what you need to quit for good.
Sara, Health Coach

HealthPartners

Employee Assistance Program (EAP)

Find balance with everyday support

Get support and resources to help you in a wide range of stressful situations. It's free and completely confidential.

Your EAP has your back 24/7

Whether you're facing a challenge at work or looking for options to support a sick parent, your EAP is always here to help.

Get support with:

- Emotional well-being, including counseling sessions or life coaching
- Childcare or elder care
- Grief and loss
- Career assistance
- Knowing your legal options
- Budgeting and debt repayment advice
- Job stress
- Parenting, adoption and more!

Members are often surprised how much support is available through their Employee Assistance Program. It's a great benefit I encourage everyone to take advantage of.
Jonathan, Member Services

Use your EAP anytime

Start using your EAP anytime in the way that works best for you:

- Call **866-326-7194**
- Log on to **hpeap.com** and chat through instant message using the password **hpeap**
- Download the iConnectYou mobile app and use passcode **111032**

HealthPartners Employee Assistance Program (EAP) services are provided by Workplace Options.

Improve your health and well-being

Living Well is easy and available to you at no cost.

Learn about your health

Start by taking your health assessment. You'll get a better picture of your current health to help you choose where to focus.

Pick a well-being activity

Want to wake up more refreshed? Bounce back from stress better? Or take control of your weight? You've got lots of options to choose from.

Choose what's best for you

Ask yourself, "What do I want to do to be healthier?" If you want to:

- Eat better – Try *Go for Fruits & Veggies* or *Sugar Smart*.
- Feel less stressed and more in control of your life – *Tackle Stress, Healthy Thinking* or *myStrength* might be your best bet.
- Be more active – Walk it out with the *10,000 Steps*® program.
- Move more – Get on-demand fitness classes with *Wellbeats*.

I know what a difference being healthy can make in your life. Members tell me that a little support from a health professional like me can be a big help.
Sara, Health Coach

Sign in to get started

Manage your health and your plan at **healthpartners.com** or the **HealthPartners** mobile app.

Don't have an account yet? It's quick and easy to sign up– you'll just need your member ID card.

TIP: After you sign in to your HealthPartners online account, go to the *Living Well* tab or select *Living Well* from the HealthPartners mobile app. If you need help, give us a call at **800-311-1052**.

HealthPartners

Build healthy habits that last

Omada is a personalized program that can help you reach your health goals, like managing diabetes, lowering your blood pressure or losing weight.

Build healthy habits

- Discover easy ways to make healthy choices in your daily life by eating healthy, moving more and learning strategies for self-managing your medications

Develop a personalized plan and track your progress

- Regardless of your goals, your professional health coach will help you zero in on your needs and help you monitor your activity to discover what is working

Achieve your goals

- With Omada, your personalized program will help you build problem-solving skills to set and reach your evolving goals

You'll get your own:

- Personalized program
- Professional health coach
- Smart health devices
- Weekly online lessons
- Small peer group

Sign in to get started

Go to www.OmadaHealth.com/HealthPartnersOmada to register. Manage your health and your plan at **healthpartners.com** or the myHP app.

Don't have an account yet? It's quick and easy to sign up – you'll just need your member ID card.

Assist America®

Travel anywhere, worry-free

Whether you're traveling abroad or just out of town for the weekend, you can feel confident you're in good hands when the unexpected happens.

Get 24/7 help

Assist America provides all the support you need when you're more than 100 miles from home.

- Coordinating transport to care facilities or back home
- Filling lost prescriptions
- Finding good doctors
- Getting admitted to the hospital
- Pre-trip info, like immunization and visa requirements
- Tracking down lost luggage
- Translator referrals
- And more!

The Assist America mobile app makes traveling much easier. You can make calls right from the app when you need support.
Jamie, Member Services

How to get started

- Download your **Assist America ID card** at **healthpartners.com/getcareeverywhere**
- Get the **Assist America app** and enter HealthPartners reference number **01-AA-HPT-05133**

Our approach to protecting personal information

HealthPartners® complies with all applicable laws regarding privacy of health and other information about our members and former members. When needed, we get consent or authorization from our members (or an authorized member representative when the member is unable to give consent or authorization) for release of personal information. We give members access to their own information consistent with applicable law and standards. Our policies and practices support compliant, appropriate and effective use of information, internally and externally, and enable us to serve and improve the health of our members, our patients and the community, while being sensitive to privacy. For a copy of our Notice of Privacy Practices, visit our website or call Member Services.

Summary of utilization management programs for medical plans

Our utilization management programs help ensure effective, accessible and high-quality health care. These programs are based on the most up-to-date medical evidence to evaluate appropriate levels of care and establish guidelines for medical practices. Our programs include activities to reduce the underuse, overuse and misuse of health services.

THESE PROGRAMS INCLUDE:

- Progression of care review and care coordination to support safe, timely care and transition from the hospital.
- Outpatient case management to provide member support and coordination of care.
- Evidence-based coverage policy criteria for certain kinds of care.
- Prior authorization of select services – we require prior approval for a small number of services and procedures. For a complete list, visit our website or call Member Services.

Benefit limitations for dental plans

After you enroll, you'll receive plan materials that explain exact coverage terms and conditions. This plan doesn't cover all dental care expenses. In general, services not provided or directed by a licensed provider aren't covered.

HERE IS A SUMMARY OF EXCLUDED OR LIMITED ITEMS (THESE MAY VARY DEPENDING ON YOUR PLAN):

- Coverage for dental exams limited to twice each calendar year.
- Coverage for dental cleanings (prophylaxis or periodontal maintenance) limited to twice each calendar year.
- Sealants limited to one application per tooth once every three years.
- Coverage for professionally applied topical fluoride limited to once each calendar year for members under age 19.
- Coverage for bitewing X-rays limited to once each calendar year.
- Full mouth or panoramic X-rays limited to once every three years.
- Oral hygiene instruction limited to once per enrollee per lifetime.
- Coverage for space maintainers limited to replacement of prematurely lost primary teeth for dependent members under age 19.
- Replacement of crowns and fixed or removable prosthetic appliances limited to once every five years.
- Certain limitations apply to repair, rebase and relining of dentures.
- Dental services related to the replacement of any teeth missing prior to the member's effective date are covered when services are performed by a provider in the HealthPartners dental network.
- Non-surgical and surgical periodontics limited to once every two years.

Appropriate use and coverage of prescription medicines for medical plans

We provide coverage for medicines that are safe, high-quality and cost-effective.

TO HELP US DO THIS, WE USE:

- A formulary (drug list). These prescription medicines are continually reviewed and approved for coverage based on quality, safety, effectiveness and value.
- A free, confidential one-on-one appointment (in person or over the phone) with an experienced clinical pharmacist. Our Medication Therapy Management (MTM) program helps members who use many different medicines get the results they need.
- An opioid management program to support members in managing their pain.
- A transition program that provides a seamless move to our formulary. We allow coverage for a first-time fill of a qualifying non-preferred medicine within the first three months of becoming a member.

The formulary is available at **healthpartners.com/formulary**, along with information on how medicines are reviewed, the criteria used to determine which medicines are added to the list and more. You may also get this information from Member Services.

Important information on provider reimbursement

Our goal in reimbursing providers is to provide affordable care for our members while encouraging quality care through best care practices and rewarding providers for meeting the needs of our members. Several different types of reimbursement arrangements are used with providers. All are designed to achieve that goal. Check with your individual provider to find out how they are paid.

PROVIDER REIMBURSEMENT INFORMATION FOR MEDICAL PLANS

- **Fee-for-service** – Some providers are paid on a "fee-for-service" basis, which means that the health plan pays the provider a certain set amount that corresponds to each type of service furnished by the provider.
- **Discount** – Some providers are paid on a "discount" basis, which means that when a provider sends us a bill, we have negotiated a reduced rate on behalf of our members. We pay a predetermined percentage of the total bill for services.
- **Case rate** – Sometimes we have "case rate" arrangements with providers, which means that for a selected set of services the provider receives a set fee, or a "case rate," for services needed up to an agreed upon maximum amount of services for a designated period of time. Alternatively, we may pay a "case rate" to a provider for all of the selected set of services needed during an agreed upon period of time.
- **Reconciliation** – Sometimes we have withhold arrangements with providers, which means that a portion of the provider's payment is set aside until the end of the year. The year-end reconciliation can happen in a variety of ways.
- **Withhold Arrangements** – Sometimes we use withhold arrangements as part of provider payments which means that a portion of the provider's payment is set aside until the end of the year. The year-end reconciliation can happen in a variety of ways. The provider usually receives all or a portion of the withhold based on performance of agreed upon criteria, which may include patient satisfaction levels, quality of care and/or care management measures. Withhold payment arrangements may apply to primary care, specialty, or hospital providers.
- **Diagnosis** – Some providers — usually hospitals — are paid on the basis of the diagnosis that they are treating; in other words, they are paid a set fee to treat certain kinds of conditions. Sometimes we pay hospitals and other institutional providers a set fee, or "per diem," according to the number of days the patient spent in the facility.
- **APCs** – Some providers — usually hospitals — are paid according to Ambulatory Payment Classifications (APCs) for outpatient services. This means that we have negotiated a payment level based on the resources and intensity of the services provided. In other words, hospitals are paid a set fee for certain kinds of services and that set fee is based on the resources utilized to provide that service.
- **Total Cost of Care** – Some providers — usually primary care medical groups — are paid based on how well they manage the total cost of care associated with a patient, as well as how well they manage the patient experience and the quality of care provided.

ARRANGEMENTS USED FOR DENTAL PLANS:

- **Fee-for-service** – the health plan pays the provider a certain set amount that corresponds to each type of service furnished by the provider.
- **Discount** – the provider sends us a bill, and we've already negotiated a reduced rate on behalf of our members. We pay a predetermined percentage of the total bill for services.
- **Salary** – with a possible additional payment made based on performance criteria, such as quality of care and patient satisfaction measures.
- **Capitated** – the provider group receives a set fee for each month for each member enrolled in the provider group's clinic, regardless of how many or what type of services the member actually receives. Provider groups are required to manage the budget for their entire patient panel appropriately.
- **Combination** – more than one of the methods described are used. For example, we may capitate a provider for certain types of care and pay that same provider on a fee-for-service basis for other types of care. We may also pay a provider such as a clinic using one type of reimbursement method, while that clinic may pay its employed providers using another reimbursement method.

Conducting medical necessity reviews

HealthPartners conducts medical necessity reviews for select services. These reviews ensure our members receive safe and effective care that aligns with the coverage outlined in the member's contract. Medical necessity reviews can be conducted pre-service, before the service takes place; post-service, after the service has happened; or concurrently, while the service is taking place. Contracted providers are responsible for obtaining prior authorization from the health plan when it is required. Services that require prior authorization are listed on our website. Prior authorization is not required for emergency services. HealthPartners will inform both you and your provider of the outcome of our review.

This plan may not cover all your health care expenses. Read your plan materials carefully to determine which expenses are covered. For details about benefits and services, go to **healthpartners.com** or call Member Services at **952-883-5000 or 800-883-2177**.

HEALTH SAVINGS ACCOUNT (HSA)

Who is eligible and when:

All active full-time employees working 30 or more hours per week who have elected a High Deductible Health Plan (HDHP) are eligible for a Health Savings Account (HSA) account on the first of the month following 60 days of employment.

Plan Information:

Carrier: **Associated Bank**

Group Number: TBD

2025 Maximum HSA Contributions:
Individual: **$4,300** per calendar year
Family: **$8,550** per calendar year
55+ may contribute an additional $1,000 per calendar year

What is a Health Savings Account?

- A Health Savings Account is a tax favored account which allows you and your employer to make contributions to pay for qualified medical expenses for you and your dependents.
- The account is owned by the member
- Available with a qualified high deductible health plan (HDHP)
- Contributions to the account are made pre-tax via payroll deduction, direct deposit, or lump sum
- Funds roll over from year to year
- Investment opportunities
- Account is portable
- Contributions can be changed throughout the year, subject to the annual contribution limits

Eligible expenses:

- Deductible, coinsurance, prescription drugs, dental and vision services
- COBRA premiums, some Medicare premiums and portions of long-term care insurance premiums
- For additional information regarding health care expenses recognized by Section 213(d) of the Internal Revenue Code can be found at www.irs.gov.

Tax benefits:

- HSA contributions are excluded from federal income tax
- Interest earnings are tax free
- Withdrawals for eligible expenses are exempt from federal income tax

Reimbursements for Qualified Medical Expenses:

- Withdrawals are tax free for the member and their dependents (up to age 23, even if not covered by the health plan)
- Expenses must be incurred after the HSA is established
- Expenses are reimbursed up to the HSA balance
- There's no time limit on when expenses can be reimbursed
- Member must retain documents to support reimbursement

Reimbursements for Non-Qualified Medical Expenses:

- Withdrawal amount is counted as income
- 20% excise tax applies
- Withdrawals for those 65+ are counted as income and no excise tax applies

VOLUNTARY DENTAL

Who is Eligible and When:

All active full-time employees working 30 or more hours per week are eligible for dental on the first of the month following 60 days of employment.

If you are an active employee and elect dental coverage for yourself, you may also cover your eligible dependents. Eligible dependents include your spouse and dependent children under the age of 26.

Dental is voluntary and 100% paid by the employee.

Plan Information:

Carrier: **HealthPartners**

Group Number: 60170

Plan: Distinctions 1

Plan Year: April 1, 2025, through March 31, 2026

Plan Network: Current provider listings are available at healthpartners.com

Dental	HealthPartners		
Benefit Level	**Level 1**	**Level 2**	**Out of Network**
Individual Deductible	$0	$25	$50
Family Deductible	$0	$75	$150
Annual Maximum (per person)	$2,000	$1,500	$1,000
Preventive Services	100%	100%	100%
Basic Services I	80%-100%	80%	50%-80%
Basic Services II	80%	50%	50%
Major Services	50%	50%	50%

Dental Distinctions℠ plan

A healthy mouth may help decrease the risk of diabetes, heart attacks and strokes. That's why our dental plans cover 100% of all in-network preventive care.

How to get more info

- **See plan details** in your **Summary of Benefits (SOB)** in your enrollment materials
- **Call us** with questions at **952-883-5000 or 800-883-2177**
- **Search the network** for your dentist or find a new one at **healthpartners.com/dentaldistinctions**

TIP: By seeing a dentist in benefit level 1, you may get extra care covered by your plan, like more frequent teeth cleanings if you get a lot of cavities.

What your plan pays for

Preventive care is covered at no cost to you when you see a network dentist. It also helps cover:

- HealthPartners MouthWise Matters – extra exams, gum care and cleaning are covered 100% if you're pregnant, or if you have diabetes and are at risk of gum disease
- The cost of other dental care at the amounts shown in your Summary of Benefits

What you'll pay

Deductible or coinsurance

Things like getting a cavity filled might cost a deductible. That's the amount you have to pay before your plan helps with the cost. There's also coinsurance, which is a percent of the bill.

Annual maximum

Your dental plan max is a bit different than your medical plan. It's the most your plan will pay for dental care each year. You're in charge of the rest.

Plan highlights

This plan has two benefit levels. Benefit level 1 is a narrow network where you'll get great care with low out-of-pocket costs. Benefit level 2 is where you'll find more dentists, but your out-of-pocket costs could be higher.

Where you can get care

Pick the care and dentist that's right for your teeth and your wallet.

Benefit level 1

With this narrow network, you may get extra care covered by your plan. It includes HealthPartners Dental Group and other leading clinics in the Twin Cities that provide savings and care to help improve your overall health.

Benefit level 2

Get lots of clinic options so you can choose the dentist who works best for you.

HealthPartners®

Distinctions SM Dental Plan 1

Below is an overview of your HealthPartners dental coverage. If you're looking for more details, please review your plan materials. Need help? Call Member Services at **952-883-5000** or **800-883-2177**.

Plan highlights Partial listing of covered services	**Benefit Level 1** Care from a Benefit Level 1 network provider	**Benefit Level 2** Care from a Benefit Level 2 network provider	**Out-of-Network** Care from an out-of-network provider*
Annual Maximum	**Annual maximums are combined across all tiers**		
The most your plan will pay yearly. It excludes orthodontia. Annual max applies to all services below, including preventive and diagnostic care.	Plan pays $2,000	Plan pays $1,500	Plan pays $1,000
Deductible	**Deductibles are combined across all tiers**		
Applies to Basic Care, Special Care & Prosthetics	$0	$25 per person; $75 per family per calendar year	$50 per person; $150 per family per calendar year
Preventive and Diagnostic Care	**Percentage covered by the plan**		
Teeth cleaning, exams, dental X-rays, fluoride treatments & sealants	100%	100%	100%
Basic Care			
Basic Care I			
Fillings (amalgam and anterior composite)	100%	80%	80%
Posterior composite (white) fillings	80%	80%	50%
Simple extractions	90%	80%	80%
Non-surgical periodontics	80%	80%	50%
Endodontics (root canal therapy)	80%	80%	50%
Basic Care II			
Surgical periodontics	80%	80%	50%
Complex oral surgery	80%	80%	50%
Special Care			
Restorative crowns & onlays	50%	50%	50%
Prosthetics			
Bridges, dentures & partial dentures	50%	50%	50%
Dental implants	50%	50%	50%

** If your out-of-network dentist charges more than the maximum allowable amount, you may be responsible for the difference.*

Little Partners℠ dental benefit

100% dental coverage for kids

Starting healthy habits early in life means fewer cavities, fewer missed school days and more smiles to last a lifetime. The Little Partners dental benefit helps by covering 100% of the cost.

What's covered

Your dental plan includes the Little Partners benefit for kids 12 years old and younger.

- Get dental services covered 100% at an in-network dentist (excludes braces)
- Pay nothing at the dental office – not even a deductible or coinsurance
- Access needed dental care with no annual maximum limit

How it works

Add your kids to your dental plan and make their first appointment with a network dentist. You'll pay nothing for checkups, cavities, X-rays and more (excludes braces). Little Partners makes oral health easy and affordable for your family.

Your kid's smile means everything. We've created Little Partners to remove the financial barrier for parents, ensuring kids can get the care they need to keep their smiles healthy for years to come.
Tom, Dental plan

How to get more info

- **See plan details** in your **Summary of Benefits (SOB)** in your enrollment materials
- **Call us** with questions at **952-883-5000 or 800-883-2177**

HealthPartners MouthWise Matters

Unlock extra dental health benefits

Your dental health has an impact on your overall health. And when your dental health needs extra care, MouthWise Matters provides added benefits for people who are pregnant or living with diabetes.

How to get more info

- **See plan details** in your **Summary of Benefits (SOB)** in your enrollment materials
- **Call us** with questions at **952-883-5000 or 800-883-2177**

What it covers

If you're living with diabetes or are pregnant and at risk of gum disease, MouthWise Matters covers:

- 100% of services to help control gum disease
- Extra dental checkups and cleanings
- Root planing and scaling – a deep cleaning for your teeth

All other services, like fillings and root canals, are covered according to your Summary of Benefits.

How it works

It's easy to get the care you need to stay healthy:

- Visit a network dentist
- Get 100% coverage on medically necessary gum treatment

When gum treatment is needed, there's no coinsurance or deductible. Plus, your plan will pay even if you've reached your annual maximum for the year.

VOLUNTARY VISION

Who is Eligible and When:

All active full-time employees working 30 or more hours per week are eligible for vision on the first of the month following 60 days of employment.

If you are an active employee and elect vision coverage for yourself, you may also cover your eligible dependents. Eligible dependents include your spouse and dependent children under the age of 26.

Vision is voluntary and 100% paid by the employee.

Plan Information:

Carrier: **Lincoln Financial**

Group Number: 000400281900

Plan Year: April 1, 2025, through March 31, 2026

Plan Network: Current provider listings are available at lvc.lfg.com

Vision	In-Network
Eye Examinations (every 12 months)	$10 copay
Frames (every 12 months)	$130 allowance + 30% off the balance
Lenses (every 12 months)	$25 copay
Contacts (every 12 months)	Up to $125 for elective
Members can receive benefit for either glasses OR contacts in a 12-month period, not both.	

Lincoln Financial Group®

Full-Time Employees of Upper River Services, LLC
(Plan Sponsor: Upper River Services, LLC)

Vision Insurance

Lincoln VisionConnect®:

- Provides 100% coverage for annual eye exams and eyeglass lenses after low (or no) copay*
- Maternity Benefit and Children's Eye Care Program*
- Includes a generous allowance for eyeglass frames*
- Offers discounts for certain upgraded lenses*
- Preferred pricing on laser vision correction
- Gives you the option to choose contact lenses instead of eyeglass lenses
- Features group rates for Upper River Services, LLC employees
- Includes an online member portal where you can view your claims, print ID cards, and more

Benefits At-A-Glance

Coverage Amounts	In-Network	Out-of-Network
Eye examination	100% after $10 copay	Up to $40 reimbursement
Eyeglass lenses		
Single vision	100% after $25 copay	Up to $40 reimbursement
Bifocal	100% after $25 copay	Up to $60 reimbursement
Trifocal	100% after $25 copay	Up to $80 reimbursement
Lenticular	100% after $25 copay	Up to $80 reimbursement
Eyeglass frames	Up to $130 allowance	Up to $45 reimbursement
Contact lenses		
Covered Contact Lens Selection	100% after $25 copay	Up to $125 reimbursement
Other contact lens options	Up to $125 allowance	Up to $125 reimbursement
Medically necessary contact lenses	100% after $25 copay	Up to $210 reimbursement

How Often?	
Eye examination	Every 12 months
Eyeglass lenses OR contact lenses	Every 12 months
Eyeglass frames	Every 12 months

Note: *You can choose either eyeglass lenses or contact lenses every 12 months.*

*When you choose an in-network provider.

Lincoln VisionConnect® is underwritten by UnitedHealthcare Insurance Company. UnitedHealthcareInsurance Company is not a Lincoln Financial Group® company.

The Lincoln National Life Insurance Company

Plan Features

In-Network vs. Out-of-Network Coverage

- *Lincoln VisionConnect*® members are supported through the Spectera Vision network. When you visit your eye care provider, **let the office know you are a Spectera customer** to make the most of your in-network provider benefits.

- To find a Spectera vision network provider close to work or home, call 1-800-440-8453 or **locate a provider in a few easy steps:**
  - Visit **lvc.lfg.com**. On the left side of the page, use the **Provider Quick Search**.
  - In the **Provider Quick Search** box, enter a ZIP Code or street address.
  - Click the **Search** button to display a list of providers near you.
- If you choose an out-of-network provider, you pay the provider in full and submit a claim for reimbursement of covered services and products.
- Lincoln's exclusive in-network partnership with Warby Parker lets employees use their annual allowances to purchase eyeglasses and/or contact lenses from this convenient online and retail vendor.

Covered Contact Lens Selection

- *Lincoln VisionConnect*® gives you the option to choose contact lenses instead of eyeglass lenses.
- *Lincoln VisionConnect*® features a Covered Contact Lens Selection benefit.
- This benefit covers fitting and evaluation fees, up to four boxes of contact lenses (depending on the prescription), and two follow-up visits.
- To view your current covered contact lens choices*, visit lvc.lfg.com or call 1-800-440-8453.
- The Covered Contact Lens Selection is not available at 1-800 Contacts, Costco®, LensCrafters, Sam's Club®, Target, Walmart® or Warby Parker locations.

Other Contact Lens Options

- A $125 allowance is provided for all other contact lenses, as well as for contact lenses purchased at 1-800 Contacts, Costco®, LensCrafters, Sam's Club®, Target, Walmart® or Warby Parker with no copay.
  - This allowance does not include the cost of a fitting/evaluation or follow-up.

Medically Necessary Contact Lenses

- Contact lenses are considered "medically necessary" at the discretion of the eye care provider and are covered 100% (after low or no copay) when you choose a network provider.

Eyeglass Frames

- *Lincoln VisionConnect*® provides a $130 retail frame allowance. This covers many of today's popular eyeglass frames.
- If the cost of the frames you choose exceeds $130, you simply pay the remaining balance (which includes a discount of up to 30% at participating providers).

*The Covered Contact Lens Selection is subject to change.
**Discounts subject to change.
Your eye doctor's prescribed wearing schedule may affect replacement frequency.

Plan Discounts

Further maximize your plan with in-network discounts.

Eyeglass Lens Option Discounts**	
Coatings	
Standard scratch coating	No charge
Scratch warranty	$10
Tint	$14
UV coating	$16
Photochromic	$67
Tier I anti-reflective coating	$30
Tier II anti-reflective coating	$50
Tier III anti-reflective coating	$75
Tier IV anti-reflective coating	$95
Lenses	
Roll and polish edges	$13
Tier I progressive	$55
Tier II progressive	$100
Tier III progressive	$150
Tier IV progressive	$200
Tier V progressive	$250
Material	
High index (1.66 or lower)	$53
High index (1.67-1.73)	$63
Polycarbonate	$33
Polycarbonate for dependents under the age of 19	No charge

*The Covered Contact Lens Selection is subject to change.
**Discounts subject to change.
Your eye doctor's prescribed wearing schedule may affect replacement frequency.

Other Discounts	
Additional eyeglasses and contact lenses	Up to 20%
Mail order contact lenses	10%

Preferred Pricing on Laser Vision Correction

- Free LASIK consultation with in-network providers
- Convenient access to experienced LASIK surgeons at more than 900 locations nationwide
- Flexible 0% financing options available to qualified applicants
- For more information, visit vision.qualsight.com or call 855-250-2020

Covered Family Members

When you choose coverage for yourself, you can also provide coverage for:

- Your spouse.
- Dependent children, up to age 26.

Wellness Benefits — Maternity Benefit and Children's Eye Care Program:

Pregnant or breastfeeding women, and children up to age 13 receive additional coverage for each service frequency period:

- A second eye exam, after any applicable co-pay
- A new pair of glasses including frames and lenses (if the prescription changes .5 diopter or greater)

Questions? Call 800-423-2765 and mention Group ID: 1183884.

This is not intended as a complete description of the insurance coverage offered. While benefit amounts stated in this summary are specific to your coverage, other items may summarize our standard product features and not the specific features of your coverage. Controlling provisions are provided in the policy, and this summary does not modify those provisions or the insurance in any way. This is not a binding contract. A policy will be made available to you that describes the benefits in greater detail. Refer to your certificate for your maximum benefit amounts. Should there be a difference between this summary and the policy, the policy will govern.

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Lincoln VisionConnect® is marketed by The Lincoln National Life Insurance Company (Fort Wayne, IN), which does not solicit business in New York, nor is it licensed to do so. In New York, *Lincoln VisionConnect®* is marketed by Lincoln Life & Annuity Company of New York (Syracuse, NY). Both are Lincoln Financial Group® companies. *Lincoln VisionConnect®* is a registered trademark of Lincoln National Corporation.

Lincoln VisionConnect® coverage is provided by or through UnitedHealthcare Insurance Company, located in Hartford, Connecticut; UnitedHealthcare Insurance Company of New York, located in Islandia, New York; or their affiliates. Administrative services are provided by Spectera, Inc., UnitedHealthCare Services, Inc. or their affiliates. Plans sold in Texas use policy form number VPOL.06.TX or VPOL.13.TX and associated COC form number VCOC.INT.06.TX or VCOC CER.13.TX. Plans sold in Virginia use policy form number VPOL.06.VA or VPOL.13.VA and associated COC form number VCOC.INT.06.VA or VCOC.CER.13.VA. This policy has exclusions, limitations and terms under which the policy may be continued in-force or discontinued. For costs and complete details of the coverage, contact *Lincoln VisionConnect®* at 800-440-8453.

The contracting entity for Spectera Eyecare Networks is Spectera, Inc.

Lincoln Financial Group®

Benefit Exclusions

Like any insurance, this vision insurance plan does have some exclusions. The plan does not cover:

- Post-cataract lenses
- Non-prescription items
- Medical or surgical treatment for eye disease that requires the services of a physician
- Workers' Compensation services or materials
- Services or materials that the patient, without cost, obtained from any governmental organization or program
- Services or materials that are not specifically covered by the plan
- Replacement or repair of lenses and/or frames that have been lost or broken
- Cosmetic extras, except as stated in the policy

A complete list of benefit exclusions is included in the policy. State variations apply.

Questions? Call 800-423-2765 and mention Group ID: 1183884.

This is not intended as a complete description of the insurance coverage offered. While benefit amounts stated in this summary are specific to your coverage, other items may summarize our standard product features and not the specific features of your coverage. Controlling provisions are provided in the policy, and this summary does not modify those provisions or the insurance in any way. This is not a binding contract. A policy will be made available to you that describes the benefits in greater detail. Refer to your certificate for your maximum benefit amounts. Should there be a difference between this summary and the policy, the policy will govern.

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Lincoln VisionConnect® coverage is provided by or through UnitedHealthcare Insurance Company, located in Hartford, Connecticut; UnitedHealthcare Insurance Company of New York, located in Islandia, New York; or their affiliates. Administrative services are provided by Spectera, Inc., UnitedHealthCare Services, Inc. or their affiliates. Plans sold in Texas use policy form number VPOL.06.TX or VPOL.13.TX and associated COC form number VCOC.INT.06.TX or VCOC CER.13.TX. Plans sold in Virginia use policy form number VPOL.06.VA or VPOL.13.VA and associated COC form number VCOC.INT.06.VA or VCOC.CER.13.VA. This policy has exclusions, limitations and terms under which the policy may be continued in-force or discontinued. For costs and complete details of the coverage, contact *Lincoln VisionConnect®* at 800-440-8453.

The contracting entity for Spectera Eyecare Networks is Spectera, Inc.

Lincoln Financial Group®

LIFE AND AD&D AND VOLUNTARY LIFE

Who is Eligible and When:

All active full-time employees working 30 or more hours per week are eligible for life and AD&D and voluntary life on the first of the month following 60 days of employment.

Plan Information:

Carrier: **Lincoln Financial**

Group Number: 000010281897 and 000400281899

Life and AD&D:

Upper River Services provides $50,0000 of Group Term Life (GTL). Eligible employees are automatically enrolled in GTL at no cost and without Evidence of Insurability (EOI). Basic accidental death and dismemberment (AD&D) insurance of $50,000 is also part of the basic coverage package. Eligible employees are automatically enrolled at no cost and without EOI.

Voluntary Life and AD&D:

Upper River Services offers Voluntary Life and Voluntary AD&D through Lincoln Financial.

Voluntary Life and Voluntary AD&D is 100% paid by the employee.

	Employer-Paid Life and AD&D Paid 100% by Upper River Services	Voluntary Life and AD&D Paid 100% by the employee
Employee Benefit	$50,000	$10,000 increments to a max of $300,000 *Not to exceed 5 times annual earnings for amounts over $150,000
Spouse Benefit	N/A	$5,000 increments to a max of $150,000 *Not to exceed 50% of Employee's benefit
Child(ren) Benefit (No AD&D)	N/A	Day 1 to 14 days: No Benefit Day 15 – 6 months: $1,000 or $2,000 6 months to 26 years: $20,000
Accidental Death and Dismemberment (AD&D)	Included	Included
Guarantee Issue	$50,000	Employee: $150,000 Spouse: $50,000 Dependent children: $20,000 (only available at the initial offering or as a new employee)
Age Reduction	65% at age 65 20% at age 70	65% at age 65 50% at age 70

Upper River Services, LLC provides this valuable benefit at no cost to you.
(Plan Sponsor: Upper River Services, LLC)

Full-Time Employees

Term Life and AD&D Insurance

Safeguard the most important people in your life.

Think about what your loved ones may face after you're gone. Term life insurance can help them in so many ways, like covering everyday expenses, paying off debt, and protecting savings. AD&D provides even more coverage if you die or suffer a covered loss in an accident.

AT A GLANCE:

- A cash benefit of $50,000 to your loved ones in the event of your death, plus a matching cash benefit if you die in an accident
- A cash benefit to you if you suffer a covered loss in an accident, such as losing a limb or your eyesight
- *LifeKeys*® services, which provide access to counseling, financial, and legal support
- *TravelConnect*® services, which give you and your family access to emergency medical assistance when you're on a trip 100+ miles from home

You also have the option to increase your cash benefit by securing additional coverage at affordable group rates. See the enclosed life insurance information for details.

ADDITIONAL DETAILS

Conversion: You can convert your group term life coverage to an individual life insurance policy without providing evidence of insurability if you lose coverage due to leaving your job or for another reason outlined in the plan contract. AD&D benefits cannot be converted.

Benefit Reduction: Coverage amounts begin to reduce at age 65 and benefits terminate at retirement. See the plan certificate for details.

For complete benefit descriptions, limitations, and exclusions, refer to the certificate of coverage.

This is not intended as a complete description of the insurance coverage offered. Controlling provisions are provided in the policy, and this summary does not modify those provisions or the insurance in any way. This is not a binding contract. A certificate of coverage will be made available to you that describes the benefits in greater detail. Refer to your certificate for your maximum benefit amounts. Should there be a difference between this summary and the contract, the contract will govern.

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Lincoln Financial Group®

Full-Time Employees of Upper River Services, LLC

(Plan Sponsor: Upper River Services, LLC)

Benefits At-A-Glance

Voluntary Term Life and AD&D Insurance

The Lincoln Term Life and AD&D Insurance Plan:

- Provides a cash benefit to your loved ones in the event of your death
- Provides an additional cash benefit to your loved ones if you die — or to you if you lose a limb or your eyesight — in a covered accident
- Features group rates for Upper River Services, LLC employees
- Includes *LifeKeys*® services, which provide access to counseling, financial, and legal support services
- Also includes *TravelConnect*® services, which give you and your family access to emergency medical assistance when you're on a trip 100+ miles from home

Employee	
Newly hired employee guaranteed coverage amount	$150,000
Continuing employee guaranteed coverage annual increase amount	Choice of $10,000 or $20,000
Maximum coverage amount	5 times your annual salary ($300,000 maximum in increments of $10,000)
Minimum coverage amount	$10,000
AD&D coverage amount	Equal to the life insurance amount chosen
Spouse	
Newly hired employee guaranteed coverage amount	$50,000
Continuing employee guaranteed coverage annual increase amount	Choice of $5,000 or $10,000
Maximum coverage amount	50% of the employee coverage amount ($150,000 maximum in increments of $5,000)
Minimum coverage amount	$5,000
AD&D coverage amount	Equal to the life insurance amount chosen
Dependent Children	
6 months to age 26 (to age 26 if unmarried, & a full-time student) guaranteed coverage amount	$20,000
Age 14 days to 6 months guaranteed coverage amount	$1,000

What your benefits cover

Employee Coverage

Guaranteed Life and AD&D Insurance Coverage Amount

- Initial Open Enrollment: When you are first offered this coverage, you can choose a coverage amount up to $150,000 without providing evidence of insurability.
- Annual Limited Enrollment: If you are a continuing employee, you can increase your coverage amount by $10,000 or $20,000 without providing evidence of insurability . If you submitted evidence of insurability in the past and were declined for medical reasons, you may be required to submit evidence of insurability.
- If you decline this coverage now and wish to enroll later, evidence of insurability may be required and may be at your own expense.
- You can increase this amount by up to $20,000 during the next limited open enrollment period.

Maximum Life Insurance Coverage Amount

- You can choose a coverage amount up to 5 times your annual salary ($300,000 maximum) with evidence of insurability. See the Evidence of Insurability page for details.
- The maximum coverage amount for employees 70 and older who are electing coverage for the first time is $50,000.
- Your coverage amount will reduce by 35% when you reach age 65 and an additional 15% of the original amount when you reach age 70.

Spouse Coverage - You can secure term life and AD&D insurance for your spouse if you select coverage for yourself.

Guaranteed Life and AD&D Insurance Coverage Amount

- Initial Open Enrollment: When you are first offered this coverage, you can choose a coverage amount up to 50% of your coverage amount ($50,000 maximum) for your spouse without providing evidence of insurability.
- Annual Limited Enrollment: If you are a continuing employee, you can increase the coverage amount for your spouse by $5,000 or $10,000 without providing evidence of insurability. If you submitted evidence of insurability in the past and were declined for medical reasons, you may be required to submit evidence of insurability.
- If you decline this coverage now and wish to enroll later, evidence of insurability may be required and may be at your own expense.
- You can increase this amount by up to $10,000 during the next limited open enrollment period.

Maximum Life Insurance Coverage Amount

- You can choose a coverage amount up to 50% of your coverage amount ($150,000 maximum) for your spouse with evidence of insurability.
- Coverage amounts are reduced by 35% when an employee reaches age 65 and an additional 15% when an employee reaches age 70.

Dependent Children Coverage - You can secure term life insurance for your dependent children when you choose coverage for yourself.

Guaranteed Life Insurance Coverage Options: $10,000 and $20,000.

Additional Plan Benefits

Accelerated Death Benefit	Included
Premium Waiver	Included
Conversion	Included
Portability	Included
Seat Belt & Airbag	Included with AD&D
Common Carrier	Included with AD&D

Benefit Exclusions

Like any insurance, this term life and AD&D insurance policy does have exclusions.

For life insurance, a suicide exclusion may apply.

For AD&D, benefits will not be paid if death results from suicide, or death/dismemberment occurs while:

- Inflicting or attempting to inflict injury to one's self
- Participating in a riot or as a result of war or act of war
- Serving as a member of the military, including the Reserves and National Guard
- Committing or attempting to commit a felony
- Deliberately inhaling gas (such as carbon monoxide) or using drugs other than those prescribed by a physician and administered as prescribed
- Flying in a non-commercial airplane or aircraft, such as a balloon or glider
- Driving while intoxicated (with a blood alcohol level of .08 grams or more per 100 milliliters of blood)

In addition, the AD&D insurance policy does not cover sickness or disease, including the medical and surgical treatment of a disease.

A complete list of benefit exclusions is included in the policy. State variations apply.

Questions? Call 800-423-2765 and mention Group ID: 1183884.

Monthly Voluntary Life and AD&D Insurance Premium
Here's how little you pay with group rates.

Employee Age Range	Life & AD&D Premium Rate Factor
0 - 24	0.0001220
25 - 29	0.0001220
30 - 34	0.0001460
35 - 39	0.0001590
40 - 44	0.0001710
45 - 49	0.0002310
50 - 54	0.0003270
55 - 59	0.0005690
60 - 64	0.0008460
65 - 69	0.0015820
70 - 74	0.0025340
75 - 79	0.0025340
80 - 99	0.0025340

Group Rates for You

The estimated monthly premium for life and AD&D insurance is determined by multiplying the desired amount of coverage (in increments of $10,000) by the employee age-range premium factor.

$_____ X _____ = $_____

coverage amount premium factor monthly premium

Note: Rates are subject to change and can vary over time.

Employee | Monthly Premiums for Select Life and AD&D Insurance Coverage Amounts

Employee Age Range	$10,000	$50,000	$100,000	$150,000	$200,000	$300,000
0-24	$1.22	$6.10	$12.20	$18.30	$24.40	$36.60
25-29	$1.22	$6.10	$12.20	$18.30	$24.40	$36.60
30-34	$1.46	$7.30	$14.60	$21.90	$29.20	$43.80
35-39	$1.59	$7.95	$15.90	$23.85	$31.80	$47.70
40-44	$1.71	$8.55	$17.10	$25.65	$34.20	$51.30
45-49	$2.31	$11.55	$23.10	$34.65	$46.20	$69.30
50-54	$3.27	$16.35	$32.70	$49.05	$65.40	$98.10
55-59	$5.69	$28.45	$56.90	$85.35	$113.80	$170.70
60-64	$8.46	$42.30	$84.60	$126.90	$169.20	$253.80

Employee Age Range	$6,500	$32,500	$65,000	$97,500	$130,000	$195,000
65-69	$10.28	$51.42	$102.83	$154.25	$205.66	$308.49

Employee Age Range	$5,000	$25,000
70-74	$12.67	$63.35

Employee Age Range	$5,000	$25,000
75-79	$12.67	$63.35

Employee Age Range	$5,000	$25,000
80-99	$12.67	$63.35

The Lincoln National Life Insurance Company

Please see prior page for product information.

Voluntary Life and AD&D Insurance At-A-Glance

LFE-ENRO-BRC001-MN

Employee Age Range	Life & AD&D Premium Rate Factor
0 - 24	0.0001220
25 - 29	0.0001220
30 - 34	0.0001460
35 - 39	0.0001590
40 - 44	0.0001710
45 - 49	0.0002310
50 - 54	0.0003270
55 - 59	0.0005690
60 - 64	0.0008460
65 - 69	0.0015820
70 - 74	0.0025340
75 - 79	0.0025340
80 - 99	0.0025340

Group Rates for Your Spouse

The estimated monthly premium for life and AD&D insurance is determined by multiplying the desired amount of coverage (in increments of $5,000) by the employee age-range premium factor.

$_____ X _____ = $_____

coverage amount premium factor monthly premium

Note: Rates are subject to change and can vary over time.

Spouse | Monthly Premiums for Select Life & AD&D Insurance Coverage Amounts

Employee Age Range	$5,000	$25,000	$50,000	$750,000	$100,000	$150,000
0 - 24	$0.61	$3.05	$6.10	$91.50	$12.20	$18.30
25 - 29	$0.61	$3.05	$6.10	$91.50	$12.20	$18.30
30 - 34	$0.73	$3.65	$7.30	$109.50	$14.60	$21.90
35 - 39	$0.80	$3.98	$7.95	$119.25	$15.90	$23.85
40 - 44	$0.86	$4.28	$8.55	$128.25	$17.10	$25.65
45 - 49	$1.16	$5.78	$11.55	$173.25	$23.10	$34.65
50 - 54	$1.64	$8.18	$16.35	$245.25	$32.70	$49.05
55 - 59	$2.85	$14.23	$28.45	$426.75	$56.90	$85.35
60 - 64	$4.23	$21.15	$42.30	$634.50	$84.60	$126.90
Employee Age Range	$3,250	$16,250	$32,500	$487,500	$65,000	$97,500
65 - 69	$5.14	$25.71	$51.42	$771.23	$102.83	$154.25
Employee Age Range	$2,500	$12,500	$25,000	$375,000	$50,000	$75,000
70 - 74	$6.34	$31.68	$63.35	$950.25	$126.70	$190.05
Employee Age Range	$2,500	$12,500	$25,000	$375,000	$50,000	$75,000
75 - 79	$6.34	$31.68	$63.35	$950.25	$126.70	$190.05
Employee Age Range	$2,500	$12,500	$25,000	$375,000	$50,000	$75,000
80 - 99	$6.34	$31.68	$63.35	$950.25	$126.70	$190.05

Dependent Children Monthly Premium for Life Insurance Coverage

The Lincoln National Life Insurance Company

Please see prior page for product information.

Voluntary Life and AD&D Insurance At-A-Glance

LFE-ENRO-BRC001-MN

Coverage Amount	Monthly Premium
$10,000	$1.80
$20,000	$3.60

Group Rates for Your Dependent Children

One affordable monthly premium covers all of your eligible dependent children.

Note: You must be an active Upper River Services, LLC employee to select coverage for a spouse and/or dependent children. To be eligible for coverage, a spouse or dependent child cannot be confined to a health care facility or unable to perform the typical activities of a healthy person of the same age and gender.

The Lincoln National Life Insurance Company

Please see prior page for product information.

Voluntary Life and AD&D Insurance At-A-Glance

LFE-ENRO-BRC001-MN

LONG TERM DISABILITY

Who is Eligible and When:

All active full-time employees working 30 or more hours per week are eligible for disability on the first of the month following 60 days of employment.

Plan Information:

Carrier: **Lincoln Financial**

Group Number: 000010281898

Long Term Disability:

Disability insurance is designed to protect employees from income loss and other financial hardship associated with absence from work due to injury, sickness or disease.

Upper River Services offers long term disability for those unscheduled life events. Disability coverage can help you remain financially stable should you become injured or ill and cannot work.

Long term disability is **100% paid by Upper River Services**.

	Long Term Disability
Elimination period	90 days of disability
Percentage of Income Replaced	60% of monthly income
Maximum Benefits Payable	$6,000 per month
Maximum Benefit Duration	Social Security Retirement Age

Lincoln Financial Group®

Upper River Services, LLC provides this valuable benefit at no cost to you.
(Plan Sponsor: Upper River Services, LLC)

All Other Full-Time Employees Excluding Owners

Long-term Disability Insurance

Keep getting a check when you're hurt or sick.

You always have bills to pay, even when you can't get to work due to injury, illness, or surgery. Long-term disability insurance helps you make ends meet during this difficult time.

AT A GLANCE:

- A cash benefit of 60% of your monthly salary (up to $6,000) starting 90 days after you are out of work and continuing up to age 65 or Social Security Normal Retirement Age (SSNRA), whichever is later
- *EmployeeConnect*℠ services, which give you and your family confidential access to counselors as well as personal, legal, and financial assistance.
    - Program Services include:
        - Unlimited, 24/7 access to information and referrals
        - In-person help for short-term issues; up to five sessions with a counselor per person, per issue, per year.
        - One free consultation with a network attorney (with subsequent meetings at a reduced fee)
        - Online tools, tutorials, videos and much more

ADDITIONAL DETAILS

Coverage Period for Your Occupation: 24 months. After this initial period, you may be eligible to continue receiving benefits if your disability prohibits you from performing any employment for which you are reasonably suited through your training, education, and experience. In this case, your benefits may be extended through the end of your maximum coverage period (benefit duration).

Pre-existing Condition: If you have a medical condition that begins before your coverage takes effect, and you receive treatment for this condition within the 3 months leading up to your coverage start date, you may not be eligible for benefits for that condition until you have been covered by the plan for 12 months.

For complete benefit descriptions, limitations, and exclusions, refer to the certificate of coverage.

GLOSSARY

Glossary is for benefit general terms and may not all apply to your plan(s).

Allowed Amount - The highest amount that will cover (pay) a service.

Benefit Period - When services are covered under your plan. It also defines the time when benefit maximums, deductibles and coinsurance limits build up. It has a start and end date. It is often one calendar year for health insurance plans. *Example: You may have a plan with a benefit period of January 1 through December 31 that covers 10 physical therapy visits. The 11th or more session will not be covered.*

Brand - A prescription drug product which is manufactured and marketed under a trademark or name by a specific drug manufacturer, or that is identify as a brand name product.

Coinsurance - A certain percent you must pay each benefit period after you have paid your deductible. This payment is for covered services only. You may still have to pay a copay. *Example: Your plan might cover 80 percent of your medical bill. You will have to pay the other 20 percent. The 20 percent is the coinsurance.*

Coinsurance Limit (or Maximum) - The most you will pay in coinsurance costs during a benefit period.

Condition - An injury, ailment, disease, illness or disorder.

Contract - The agreement between an insurance company and the policyholder.

Copayment (Copay) - The amount you pay to a healthcare provider at the time you receive services. You may have to pay a copay for each covered visit to your doctor, depending on your plan. Not all plans have a copay.

Covered Charges - Charges for covered services that your health plan paid for. There may be a limit on covered charges if you receive services from providers outside your plan's network of providers.

Covered Person - Any person covered under the plan.

Covered Service - A healthcare provider's service or medical supplies covered by your health plan. Benefits will be given for these services based on your plan.

Creditable Coverage - Coverage of a person under any of these:

A group health plan. This includes church and governmental plans.

Health insurance coverage.

Medicare (Part A or Part B of Title XVIII of the Social Security Act).

Medicaid (Title XIX of the Social Security Act, other than coverage consisting only of benefits under Section 1928).

The health plan for active military personnel. This includes TRICARE.

The Indian Health Service or other tribal organization program.

A state health benefits risk pool.

The Federal Employees Health Benefits Program.

A public health plan (as defined in federal regulations).

A health benefit plan under section 5 (c) of the Peace Corps Act.

Any other plan which gives complete hospital, medical and surgical services.

Deductible - The amount you pay for your healthcare services before your health insurer pays. Deductibles are based on your benefit period (typically a year at a time). *Example: If your plan has a $2,000 annual deductible, you will be expected to pay the first $2,000 toward your healthcare services. After you reach $2,000, your health insurer will cover the rest of the costs.*

Dependent Coverage - Coverage for your dependents who qualify.

Emergency Medical Condition - A medical problem with sudden and severe symptoms that must be treated quickly. In an emergency, a person with no medical training and an average knowledge of health/medicine could reasonably expect the problem could:

Put a person's health at serious risk.

Put an unborn child's health at serious risk.

Result in serious damage to the person's body and how his or her body works.

Result in serious damage of a person's organ or any part of the person.

Experimental or Investigational Drug, Device, Medical Treatment or Procedure - These are not approved by the U.S. Food and Drug Administration (FDA) or are not considered the standard of care

Explanation of benefits - the health insurance company's written explanation of how a medical claim was paid. It contains detailed information about what the company paid and what portion of the costs you are responsible for.

Generic - A prescription drug product that is chemically equivalent to a brand-name drug; or that the claims administrator identifies as a generic product based on available data resources.

Health Assessment - A health survey that measures your current health, health risks and quality of life.

Inpatient Services - Services received when admitted to a hospital and a room and board charge is made.

Institution (Institutional) - A hospital or certain other facility.

Legal Guardian - The person who takes care of a child and makes healthcare decision for the child. This person is the natural parent or was made caretaker by a court of law.

Medical Care - Medical services received from a healthcare provider or facility to treat a condition.

Medically Necessary (or Medical Necessity) - Services, supplies or prescription drugs that are needed to diagnose or treat a medical condition. Also, an insurer must decide if this care is:

Accepted as standard practice. It can't be experimental or investigational.

Not just for your convenience or the convenience of a provider.

The right amount or level of service that can be given to you.

Example: Inpatient care is medically necessary if your condition can't be treated properly as an outpatient service.

Medicare - A federal program for people age 65 or older that pays for certain healthcare expenses.

Network Provider/In-network Provider - A healthcare provider who is part of a plan's network.

Non-covered Charges - Charges for services and supplies that are **not** covered under the health plan. Examples of non-covered charges may include things like acupuncture, weight loss surgery or marriage counseling. Consult your plan for more information.

Non-network Provider/Out-of-network Provider - A healthcare provider who is **not** part of a plan's network. Costs associated with out-of-network providers may be higher or not covered by your plan. Consult your plan for more information.

Outpatient Services - Services that do not need an overnight stay in a hospital. These services are often provided in a doctor's office, hospital or clinic.

Out-of-pocket Cost - Cost you must pay. Out-of-pocket costs vary by plan and each plan has a maximum out of pocket (MOOP) cost. Consult your plan for more information.

Per Member Per Month (PMPM) - The average cost or quantity per month based on active membership.

Pre-existing condition - a health problem that has been diagnosed, or for which you have been treated, before buying a health insurance plan.

Preventive Care - Regular care that is generally performed by a primary care physician (e.g. physicals, health screenings).

Primary Care Provider - A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Provider (Healthcare Provider) - A hospital, facility, physician or other licensed healthcare professional.

Urgent Care Provider - A provider of services for health problems that need medical help right away but are not emergency medical conditions.

Specialist - A physician that specializes in a specific area of medicine.

Waiting period - the period of time that an employer makes a new employee wait before he or she becomes eligible for coverage under the company's health plan. Also, the period of time beginning with a policy's effective date during which a health plan may not pay benefits for certain pre-existing conditions.

SPECIAL NOTICES

PLAN YEAR: 2025-2026

KRAUS-ANDERSON® Insurance

CONTACT INFORMATION

PLAN ADMINISTRATOR	
Contact Name:	Bridget Carbary
Phone Number:	651-292-9293
E-mail:	bridget@ursi.net
HEALTH INSURANCE PROVIDER	
Health Insurer:	HealthPartners
Customer Service:	952-883-5000
Website:	www.healthpartners.com
PRIVACY OFFICER	
Contact Name:	Bridget Carbary
Business Address:	40 State St
	St. Paul, MN 55107
Phone Number:	651-292-9293
E-mail:	bridget@ursi.net
Website:	www.ursi.net
MEDICARE PART D	
Creditable:	$4,000-100% HSA Plus Plan

The information in this Special Notices is presented is based on information required by law. While every effort was taken to accurately report your benefits, discrepancies, or errors are always possible. In case of discrepancy between the Special Notices and the actual plan documents the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about this summary, contact your plan administrator.

SPECIAL ENROLLMENT NOTICE

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact our plan administrator.

WHCRA ENROLLMENT NOTICE

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: see your Certificate of Coverage or Summary Plan Description. If you would like more information on WHCRA benefits, call Customer Service at the number on the back of your ID card.

WHCRA ANNUAL NOTICE

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator for more information.

NEWBORN'S ACT DISCLOSURE

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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008

The Genetic Information Nondiscrimination Act of 2008 ("GINA") protects employees against discrimination based on their genetic information. Unless otherwise permitted, your Employer may not request or require any genetic information from you or your family members.

WELLNESS PROGRAM DISCLOSURE NOTICE

Your health plan is committed to helping you achieve your best health and may provide rewards for participating in a wellness program. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact your plan administrator and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

ADA WELLNESS PROGRAM DISCLOSURE NOTICE

Our wellness program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you may be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You may also be asked to complete a biometric screening, which could include a blood test. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program may receive an incentive. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so may receive the incentive.

Additional incentives may be available for employees who participate in certain health-related activities or achieve certain health outcomes. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting the plan administrator.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health potential risks and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

PROTECTIONS FROM DISCLOSURE OF MEDICAL INFORMATION

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and our company may use aggregate information it collects to design a program based on identified health risks in the workplace, we will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is your doctor in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the plan administrator.

MENTAL HEALTH PARITY & ADDICTION EQUITY ACT DISCLOSURE

The Mental Health Parity and Addiction Equity Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co- pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For information regarding the criteria for medical necessity determinations made under the Company's group health plan with respect to mental health or substance use disorder benefits, please contact the plan administrator.

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

General Information

When key parts of the health care law take effect in 2014, there will be a new 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 and employment based health coverage offered by your employer.

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. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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 8.39% of your household income for the year, 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.

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.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

HIPAA NOTICE OF PRIVACY PRACTICES

YOUR INFORMATION, YOUR RIGHTS, OUR RESPONSIBILITIES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of your health and claims record	• You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct health and claims records	• You can ask us to correct your health and claims records if you think they are correct or incomplete. Ask us how to do this. • We may say “no” to your request, but we’ll tell you why in writing within 60 days.
Request confidential communication	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will consider all reasonable requests and must say “yes” if you tell us you would be in danger if we do not.
Ask us to limit what we use or share	• You can ask us not to use or share certain health information for treatment, payment, or our operations. • We are not required to agree to your request, and we may say “no” if it would affect your care.
Get a list of these with whom we’ve shared information	• You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive this notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the Privacy Officer contact information. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint. • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or other involved in payment for your care • Share information in a disaster relief situations • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we never share your information unless you give us written permission:	• Marketing purposes • Sale of your information

Our Uses and Disclosures

How do we typically us or share your health information? We typically use or share your health information in the following ways.

Help manage the health care treatment you receive	• We can use your health information and share it with professionals who are treating you.	*Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*
Run our organization	• We can use and disclose your information to run our organization and contract you when necessary. • **We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage**. This does not apply to long term care plans.	*Example: We use health information about you to develop better services for you.*

Pay for your health services	• We can use and disclose your health information as we pay for your health services	*Example: We share information about you with your dental plan to coordinate payment for your dental work.*
Administer your plan	• We may disclose your health information to your health plan sponsor for plan administration.	*Example: Your company contacts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

How else can we use or share your health information?

We are allowed or required to share your information in other ways—usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues	We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests and work with a medical examiner or funeral director	• We can share health information about you with organ procurement organizations. • We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/oct/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our website, and we will mail a copy to you.

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

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, like a copayment, coinsurance, or deductible. You may have additional 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" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays 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 plan's deductible or 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. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're 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 they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). 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 balanced billed for these post-stabilization services.

For information about state-enacted balance billing protections that might be applicable to you, contact your state's Department of Insurance or Department of Commerce.

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 can 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 types of 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 out-of-network care. You can choose a provider or facility in your plan's network.

For information about state-enacted balance billing protections that might be applicable to you, contact your state's Department of Insurance or Department of Commerce.

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

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, your health plan must:

    - Cover emergency services without requiring you to get approval for services in advance (also known as "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 in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, you may contact:

- The US Department of Health and Human Services at:
  Phone: 800-985-3059
  Website: https://www.cms.gov/nosurprises/consumers

- Your state agency, which can be found at:
  https://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants

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, 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 July 31, 2024. Contact your State for more information on eligibility.

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

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.

OMB Control Number 1210-0137 (expires 1/31/2026)

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS
YOUR CONTINUATION COVERAGE RIGHTS UNDER COBRA

Please note that COBRA applies only to employers with 20 or more employees in the previous year. While you may not have COBRA coverage based on the size of your employer, you may be eligible for state continuation coverage. Check with your local labor department to understand the laws in your state.

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or

- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. Contact the COBRA Administrator immediately or as soon as possible to notify them of this qualification.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers

of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE
CREDITABLE COVERAGE NOTICE

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

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

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

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

When can you join a Medicare drug plan?

- You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

- However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What happens to your current coverage if you decide to join a Medicare drug plan?

- If you decide to join a Medicare drug plan, your current coverage will not be affected. Please see the Insurance Carrier for additional information regarding plan coverage

- If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents will may not be able to get this coverage back.

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 nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this notice or your current prescription drug coverage…

Contact the person listed as the plan administrator for further information NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage changes. You also may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage…

- More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

- For more information about Medicare prescription drug coverage: Visit www.medicare.gov.

- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help Call 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 about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).