

2022 Employee Benefits Guide



CONTACT INFORMATION



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ACCOUNT MANAGERS

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MEDICAL

UnitedHealthcare

800.842.8000

www.myuhc.com

DENTAL

Humana

800.457.4708

www.humana.com

COMPREHENSIVE VISION PLAN

EyeMed Vision

866.939.3633

www.eyemedvisioncare.com

BASIC LIFE / AD&D /

VOL TERM LIFE / DISABILITIES

Mutual of Omaha

800.775.6000

www.mutualofomaha.com

COLONIAL LIFE PRODUCTS

Beth Mitchell

843.388.6308

www.coloniallife.com

Thorne Ambulance Service takes pride in offering a comprehensive benefits program to help employees and their families better prepare for planned and unplanned life events. In addition to the medical plan, Thorne Ambulance Service will continue to offer comprehensive benefit options including dental, vision, basic life/AD&D, voluntary term life, short-term disability and long-term disability to all eligible employees. Accident, critical illness and whole life are offered through Colonial Life. Please review this guide to help you understand the benefit plans available to you and your family.

ARE YOU ELIGIBLE FOR BENEFITS?

All full-time employees working at least 30 hours per week are eligible for benefits as of the first of the month following 60 days of your employment date. Available benefits include health, dental, vision and basic life insurance.

You may also elect coverage for your dependents including:

- Your legal spouse or domestic partner
- Your dependent children up to the age of 26 (regardless of student or marital status)
- Children, regardless of age, who are mentally or physically handicapped and incapable of self-care

OPEN ENROLLMENT

Each year during open enrollment you have the opportunity to enroll in, or make changes to, your benefit elections. Full-time Employees who wish to make changes to their coverage options must do so during the company designated 'Open Enrollment Period.'

Plan Effective October 1, 2021.

Please note: You are required to enroll through Employee Navigator during Open Enrollment.

WHEN CAN I MAKE CHANGES?

During each annual enrollment period, you have the opportunity to review your benefit elections and make changes for the coming plan year. For most benefits, you may only make changes to your elections during the year if you have a qualifying event. Life events include:

- Marriage / Divorce
- Gain or loss of an eligible dependent for reasons such as birth, adoption, court order, disability, death, marriage, or reaching the dependent child age limit

- Change in your spouse's employment affecting benefit eligibility
- Change in your spouse's benefit coverage with another employer that affects benefit eligibility
- Change in Employee work status

The change to your benefit elections must be consistent with the life event. You have 30 days from the date of the life event to submit an enrollment change form and documentation of the event to Human Resources. In most cases, your election will become effective the first day of the month following the life event once the paperwork is received. Birth of a child or adoption is an exception and would begin on the day of birth or adoption. Otherwise, you must wait until the next annual enrollment period to make a change to your elections.

ENROLLMENT PROCEDURES

The following steps will guide you through the enrollment/change process.

1. Carefully review the plan information in this benefit enrollment guide and all other plan materials included in your enrollment package. The insurance carriers' websites also provide important information and tools that can help you make enrollment decisions.
2. Consider the needs of any dependents you may have. If you are married, review any coverage offered through your spouse's employer to avoid costly duplicate coverage.
3. All eligible employees are required to enroll through Employee Navigator. As a new hire, should you decide to decline/waive coverage, you will need to do so through Employee Navigator.
4. Any new enrollment changes must be received no later than thirty days prior to your coverage effective date.
5. See page 14 for Employee Navigator instructions.



SUMMARY HEALTH BENEFITS: BASE PLAN / HDHP



| PLAN NAME: CKV2 UHC GROUP# 925267 | | IN-NETWORK | OUT-OF-NETWORK |
|---|--|--|--|
| CALENDAR YEAR DEDUCTIBLE <i>(Embedded*)</i> | | Individual \$5,000 / Family \$10,000 | Individual \$10,000 / Family \$20,000 |
| MAXIMUM OUT-OF-POCKET | | Individual \$6,750 / Family \$13,500 <i>Includes deductible & coinsurance</i> | Individual \$15,000 / Family \$30,000 |
| PHYSICIAN SERVICES IN THE OFFICE <i>Excluding obstetrical delivery, dialysis treatment, second surgical opinion, office surgery, allergy injections, radiation and chemotherapy</i> | | Primary Care Visit / Specialist Visit / Urgent Care Visit Services subject to Deductible, 80% | Deductible, 50% |
| OTHER PHYSICIAN SERVICES <i>Inpatient/Outpatient hospital, anesthesia services, radiology, pathology, diagnostic testing, obstetrical delivery, initial newborn pediatric exam, all other outpatient/office services</i> | | Deductible, 80% | Deductible, 50% |
| Pathology Labs – Services provided at a Hospital Based Lab or Outpatient Hospital-Based Diagnostic Center | | Deductible, 60% | Not Covered |
| Pathology Labs – Services Provided at a Freestanding Lab, Freestanding Diagnostic Center or in a Physician’s Office | | Deductible, 80% | Not Covered |
| Major Diagnostic and Imaging – Services Provided at a Freestanding Diagnostic Center or in a Physician’s Office | | Deductible, 80% | Deductible, 50% |
| Major Diagnostic and Imaging – Services Provided at an Outpatient Hospital based Diagnostic Center | | You Pay a \$500 Per Occurrence Deductible per Service prior to and in addition to paying any Annual Deductible and Coinsurance (20%) | You Pay a \$500 Per Occurrence Deductible per Service prior to and in addition to paying any Annual Deductible and Coinsurance (50%) |
| WELLNESS BENEFITS – Based on the Health Care Reform Guidelines, refer to www.healthcare.gov | | 100% | Not Covered |
| Mammograms – Must see a provider in Mammography Network and follow specified age guidelines) | | 100% | |
| Pap Smear / Prostate Screening / Colonoscopy – Age Based | | 100% | |
| Preventive Care (In-Network Only) Benefits Payable at 100% if Coded as Preventive | | | |
| INPATIENT / OUTPATIENT FACILITY CHARGES | | Deductible, 80% | Deductible, 50% |
| SKILLED NURSING / HOME HEALTH CARE (60 days per year) | | Deductible, 80% | Deductible, 50% |
| REHABILITATION SERVICES (20 Visits per year) <i>Manipulative Treatments (Chiro), Physical Therapy, Occupational Therapy, Speech Therapy</i> | | Deductible, 80% | Deductible, 50% |
| EMERGENCY ROOM CHARGES | | Deductible, 80% | Deductible, 80% |
| Out-of-Network True Emergency Facility and Professional charges are subject to In-Network coinsurance and/or copay and Out-of-Network Benefit Year Deductible and Out of Pocket. | | | |
| MENTAL HEALTH BENEFITS | | | |
| INPATIENT / OUTPATIENT FACILITY CHARGES | | Deductible, 80% | Deductible, 50% |
| PHARMACY BENEFITS | | | |
| PHARMACY | | Deductible, 80%, then Copay once Deductible is Satisfied Tier 1 / Tier 2 / Tier 3 / Tier 4 \$10 / \$35 / \$75 / \$150 \$25 / \$87.50 / \$187.50 / \$375 | Deductible, 50%, then Copay once Deductible is Satisfied Tier 1 / Tier 2 / Tier 3 / Tier 4 \$10 / \$35 / \$75 / \$150 If you use an Out-of-Network Pharmacy (including a mail order pharmacy), you may be responsible for any amount over the <u>allowed amount</u> . |
| Retail (31-day supply) Mail Order (90-day supply) | | | |
| BENEFIT MAXIMUMS | | | |
| ANNUAL / LIFETIME MAXIMUM | | Unlimited | Unlimited |

***Embedded Deductible:** An individual deductible “embedded” within the family deductible. Before the insurance benefits begin the **individual** must meet the embedded individual deductible amount, which is equal to the single coverage deductible.

► For information about UnitedHealthcare Motion™, please see page 7.

► For information about SimplyEngaged®, please see page 8.

SUMMARY HEALTH BENEFITS: MID PLAN



| PLAN NAME: CKWB UHC GROUP# 925267 | | IN-NETWORK | OUT-OF-NETWORK |
|---|--|--|--|
| CALENDAR YEAR DEDUCTIBLE <i>(Embedded*)</i> | | Individual \$2,000 / Family \$4,000 | Individual \$10,000 / Family \$20,000 |
| MAXIMUM OUT-OF-POCKET | | Individual \$8,500 / Family \$17,000 <i>Includes deductible, copays & coinsurance</i> | Individual \$20,000 / Family \$40,000 <i>Includes deductible & coinsurance</i> |
| PHYSICIAN SERVICES IN THE OFFICE <i>Excluding obstetrical delivery, dialysis treatment, second surgical opinion, office surgery, allergy injections, radiation and chemotherapy</i> | | \$25 Copay – Primary Care Visit \$100 copay – Specialist Visit \$50 copay – Urgent Care Visit | Deductible, 50% |
| OTHER PHYSICIAN SERVICES <i>Inpatient/Outpatient hospital, anesthesia services, radiology, pathology, diagnostic testing, obstetrical delivery, initial newborn pediatric exam, all other outpatient/office services</i> | | Deductible, 50% | Deductible, 50% |
| Pathology Labs – Services provided at a Hospital Based Lab or Outpatient Hospital-Based Diagnostic Center | | Deductible, 50% | Not Covered |
| Pathology Labs – Services Provided at a Freestanding Lab, Freestanding Diagnostic Center or in a Physician's Office | | No Copay | Not Covered |
| Major Diagnostic and Imaging – Services Provided at a Freestanding Diagnostic Center or in a Physician's Office | | Deductible, 50% | Deductible, 50% |
| Major Diagnostic and Imaging – Services Provided at an Outpatient Hospital based Diagnostic Center | | You Pay a \$500 Per Occurrence Deductible per Service prior to and in addition to paying any Annual Deductible and Coinsurance (50%) | You Pay a \$500 Per Occurrence Deductible per Service prior to and in addition to paying any Annual Deductible and Coinsurance (50%) |
| WELLNESS BENEFITS – Based on the Health Care Reform Guidelines, refer to www.healthcare.gov | | 100% | Not Covered |
| Mammograms – Must see a provider in Mammography Network and follow specified age guidelines) | | 100% | |
| Pap Smear / Prostate Screening / Colonoscopy – Age Based | | 100% | |
| Preventive Care (In-Network Only) Benefits Payable at 100% if Coded as Preventive | | | |
| INPATIENT / OUTPATIENT FACILITY CHARGES | | Deductible, 50% | Deductible, 50% |
| SKILLED NURSING / HOME HEALTH CARE (60 days per year) | | Deductible, 50% | Deductible, 50% |
| REHABILITATION SERVICES (20 Visits per year) <i>Manipulative Treatments (Chiro), Physical Therapy, Occupational Therapy, Speech Therapy</i> | | \$25 Copay | Deductible, 50% |
| EMERGENCY ROOM CHARGES | | Deductible, 50% | Deductible, 50% |
| Out-of-Network True Emergency Facility and Professional charges are subject to In-Network coinsurance and/or copay and Out-of-Network Benefit Year Deductible and Out of Pocket. | | | |
| MENTAL HEALTH BENEFITS | | | |
| INPATIENT / OUTPATIENT FACILITY CHARGES | | Deductible, 50% | Deductible, 50% |
| PHARMACY BENEFITS | | | |
| PHARMACY Retail (31-day supply) Mail Order (90-day supply) | | Tier 1 / Tier 2 / Tier 3 / Tier 4 \$10 / \$35 / \$75 / \$150 \$25 / \$87.50 / \$187.50 / \$375 | Tier 1 / Tier 2 / Tier 3 / Tier 4 \$10 / \$35 / \$75 / \$150 If you use an Out-of-Network Pharmacy (including a mail order pharmacy), you may be responsible for any amount over the <u>allowed amount</u> . |
| BENEFIT MAXIMUMS | | | |
| ANNUAL / LIFETIME MAXIMUM | | Unlimited | Unlimited |

***Embedded Deductible:** An individual deductible “embedded” within the family deductible. Before the insurance benefits begin the **individual** must meet the embedded individual deductible amount, which is equal to the single coverage deductible.

► For information about SimplyEngaged®, please see page 8.

SUMMARY HEALTH BENEFITS: HIGH PLAN



| PLAN NAME: CKU6 UHC GROUP# 925267 | | IN-NETWORK | OUT-OF-NETWORK |
|---|--|--|--|
| CALENDAR YEAR DEDUCTIBLE <i>(Embedded*)</i> | | Individual \$1,500 / Family \$3,000 | Individual \$5,000 / Family \$10,000 |
| MAXIMUM OUT-OF-POCKET | | Individual \$8,500 / Family \$17,000 <i>Includes deductible, copays & coinsurance</i> | Individual \$14,000 / Family \$28,000 <i>Includes deductible & coinsurance</i> |
| PHYSICIAN SERVICES IN THE OFFICE <i>Excluding obstetrical delivery, dialysis treatment, second surgical opinion, office surgery, allergy injections, radiation and chemotherapy</i> | | \$35 Copay – Primary Care Visit \$100 copay – Specialist Visit \$50 copay – Urgent Care Visit | Deductible, 50% |
| OTHER PHYSICIAN SERVICES <i>Inpatient/Outpatient hospital, anesthesia services, radiology, pathology, diagnostic testing, obstetrical delivery, initial newborn pediatric exam, all other outpatient/office services</i> | | Deductible, 80% | Deductible, 50% |
| Pathology Labs – Services provided at a Hospital Based Lab or Outpatient Hospital-Based Diagnostic Center | | Deductible, 60% | Not Covered |
| Pathology Labs – Services Provided at a Freestanding Lab, Freestanding Diagnostic Center or in a Physician’s Office | | No Copay | Not Covered |
| Major Diagnostic and Imaging – Services Provided at a Freestanding Diagnostic Center or in a Physician’s Office | | Deductible, 80% | Deductible, 50% |
| Major Diagnostic and Imaging – Services Provided at an Outpatient Hospital based Diagnostic Center | | You Pay a \$500 Per Occurrence Deductible per Service prior to and in addition to paying any Annual Deductible and Coinsurance (20%) | You Pay a \$500 Per Occurrence Deductible per Service prior to and in addition to paying any Annual Deductible and Coinsurance (50%) |
| WELLNESS BENEFITS – Based on the Health Care Reform Guidelines, refer to www.healthcare.gov | | 100% | Not Covered |
| Mammograms – Must see a provider in Mammography Network and follow specified age guidelines) | | 100% | |
| Pap Smear / Prostate Screening / Colonoscopy – Age Based | | 100% | |
| Preventive Care (In-Network Only) Benefits Payable at 100% if Coded as Preventive | | | |
| INPATIENT / OUTPATIENT FACILITY CHARGES | | Deductible, 80% | Deductible, 50% |
| SKILLED NURSING / HOME HEALTH CARE (60 days per year) | | Deductible, 80% | Deductible, 50% |
| REHABILITATION SERVICES (20 Visits per year) <i>Manipulative Treatments (Chiro), Physical Therapy, Occupational Therapy, Speech Therapy</i> | | \$35 Copay | Deductible, 50% |
| EMERGENCY ROOM CHARGES | | Deductible, 80% | Deductible, 80% |
| Out-of-Network True Emergency Facility and Professional charges are subject to In-Network coinsurance and/or copay and Out-of-Network Benefit Year Deductible and Out of Pocket. | | | |
| MENTAL HEALTH BENEFITS | | | |
| INPATIENT / OUTPATIENT FACILITY CHARGES | | Deductible, 80% | Deductible, 50% |
| PHARMACY BENEFITS | | | |
| PHARMACY Retail (31-day supply) Mail Order (90-day supply) | | Tier 1 / Tier 2 / Tier 3 / Tier 4 \$10 / \$35 / \$75 / \$150 \$25 / \$87.50 / \$187.50 / \$375 | Tier 1 / Tier 2 / Tier 3 / Tier 4 \$10 / \$35 / \$75 / \$150 If you use an Out-of-Network Pharmacy (including a mail order pharmacy), you may be responsible for any amount over the <u>allowed amount</u> . |
| BENEFIT MAXIMUMS | | | |
| ANNUAL / LIFETIME MAXIMUM | | Unlimited | Unlimited |

***Embedded Deductible:** An individual deductible “embedded” within the family deductible. Before the insurance benefits begin the **individual** must meet the embedded individual deductible amount, which is equal to the single coverage deductible.

► For information about SimplyEngaged®, please see page 8.

TO SEARCH FOR PARTICIPATING NETWORK UHC PROVIDERS:

“Choice Plus Advanced” plan – Visit www.welcometouhc.com/choiceplusadvanced. Within the site, for pharmacy PDL, scroll down the home page or under the Benefits Link is a pharmacy benefits page – then select Advantage 4 tier PDL.

MEDICAL BI-WEEKLY RATES

| | <u>BASE PLAN / HDHP</u> | <u>MID PLAN</u> | <u>HIGH PLAN</u> |
|-----------------------|-------------------------|-----------------|------------------|
| EMPLOYEE | \$65.00 | \$109.28 | \$140.31 |
| EMPLOYEE & SPOUSE | \$367.99 | \$467.14 | \$544.71 |
| EMPLOYEE & CHILD(REN) | \$288.42 | \$371.71 | \$436.87 |
| EMPLOYEE & FAMILY | \$467.45 | \$586.43 | \$679.51 |



Virtual Health* can help you save time and money by giving you access to:

- On-demand virtual doctor visits with **\$0** consultation fees
- Your benefits plan information and ID cards in one place
- Telebehavioral health for ongoing visits with behavioral professionals
- Wellness coaching and seasonal healthcare tips
- Money-saving tools to help with Rx costs and out-of-pocket expenses ...and more!

**Access is available for your entire household.*

CALL A HEALTH ADVOCATE

When you have a question about your medical plan, a recent claim, or how to reduce your healthcare costs, call a Concierge!

Dedicated Subject Matter Experts can help you:

- Understand your benefits
- Review medical bills
- Get a second opinion

TELEMEDICINE

Instead of taking time out of your busy schedule to go to the doctor's office, speak to a licensed doctor over the phone. Some examples of common symptoms that can be treated include:

- Cold or Flu
- Sinus Infection
- Pink Eye
- Poison Ivy

This benefit is provided at NO COST to you!

Visit www.VirtualHealth4U.com and click on **New Members – Register Here.**
(Website is supported by Google Chrome)

Customer Service: 866.763.9202



HEALTH SAVINGS ACCOUNT

If you are a participant in the High Deductible Health Plan, you are eligible for a Health Savings Account (HSA)*. An HSA is a tax-exempt trust or custodial account created exclusively to pay for medical expenses for you, your spouse and eligible dependents. You may contribute to an HSA if you are enrolled in a HDHP, not enrolled in any other major medical plan including Medicare and not claimed as a dependent on another person's tax return.

For Participants Enrolled in the UnitedHealthcare HDHP ONLY

HSA 2021 Annual Maximum: \$3,600 Individual | \$7,200 Family

HSA 2022 Annual Maximum: \$3,650 Individual | \$7,300 Family

Ages 55 or older can contribute an additional \$1,000 annually

Increased physical activity and rewards go hand in hand and may help you earn Health Savings Account credits

As UnitedHealthcare plan members, you and your enrolled spouse can use UnitedHealthcare Motion to help take greater control of your health while, at the same time, **earning up to \$3 per day in HSA credits** for meeting specific FIT goals. These credits are deposited quarterly into your HSA.

TRY TO HIT YOUR FIT GOALS EVERY DAY

- F** Frequency, or the number of times you are physically active.
- I** Intensity, or periods of time of high physical activity.
- T** Tenacity, or achieving total daily activity goals.

ALL YOU HAVE TO DO IS MEET THE WALKING GOALS AND REVIEW YOUR PROGRESS TO HELP YOURSELF EARN CREDITS.

UnitedHealthcare Motion promotes physical activity through the use of a compatible activity/fitness tracker.

| | | |
|--------------------------------------|--|---------------|
| FREQUENCY | 500 steps in 7 minutes – 6 times a day at least 1 hour apart | \$1.00 |
| INTENSITY | 3,000 steps in 30 minutes | \$1.00 |
| TENACITY | 10,000+ total daily steps | \$1.00 |
| TOTAL DAILY REWARDS AVAILABLE | | \$3.00 |

HIT ALL OF THE DAILY GOALS AND YOU CAN EARN UP TO \$1,095* PER YEAR.

Incentives are processed quarterly and will be available in your HSA. Since the money in your HSA is yours, you can carry over all the money from year to year.

QUICK START REGISTRATION CREDIT.

To make sure you're off to a great start, we'll give you a **\$55 credit** right away -- just for getting set up. You can then use your credit toward the purchase of a compatible activity tracker, some of which are offered at no additional cost to you.

**Not to exceed federal maximum incentive guidelines.*



Available to all UnitedHealthcare plan members.

EARN UP TO \$200* FOR COMPLETING HEALTH AND WELLNESS ACTIVITIES.

With SimplyEngaged, you can get rewarded for taking healthier actions.

HERE'S HOW SIMPLYENGAGED WORKS.

With Rally®, you can access the SimplyEngaged® health and wellness activities available to you. For each Health Action you complete, you'll earn Rally Coins**, which you can redeem for rewards. Plus, you can earn financial incentives provided through gift cards, health account deposits or premium reductions. Rally's digital experience gives you one place to track your activities and rewards.



To get started, go to myuhc.com > Health Resources > Rally.

HEALTH ACTIONS

REWARD

Complete the Health Survey and watch the video.

The Health Survey takes about 15 minutes and upon completion you'll receive personalized suggestions to help you set health goals. Pair this with a short Health Actions video to see your opportunities to earn rewards.

\$25 + Rally Coins



Complete a coaching program.

The results of your Health Survey will provide recommendations for coaching programs that may help improve your health and wellness. These programs are available at no additional cost as part of your health plan benefits. Complete one of the following programs to earn more rewards:

\$100 + Rally Coins



- **Wellness Coaching** provides access to expert coaches and digital tools to help you reach your health goals. It's all about getting and staying healthy – your way – anytime. Choose from a variety of programs, like sleeping better, eating smarter and getting fit.
- **Real Appeal®** may help you start living a healthier life with online weight loss tools to help you achieve lifelong results, one small step at a time. Real Appeal delivers the support to help you lose weight through online coaching, a Success Kit delivered to your door and a community of members to keep you motivated.
- **Quit For Life®** has helped 4 million members quit smoking or using tobacco. It provides the tools, 1-on-1 support and a personalized plan to help you quit your way.

Complete a Biometric screening.

A Biometric health screening may help you and your doctor make more informed decisions about your health.

\$75 + Rally Coins



Get screened for:

- Total cholesterol
- Blood pressure
- Tobacco attestation
- Body mass index (BMI)

You have 3 options to participate in the Biometric health screening:

- ① Employer on-site event, if available
- ② Doctor's office or convenience care clinic
(Provider Results form must be completed.)
- ③ Participating Quest Diagnostics® provider

Complete a Virtual Visit.

Virtual Visits may be a convenient option when you need care. You can talk to a doctor – 24/7 – by phone or video for conditions like the flu, allergies, rashes, migraines and many more.

\$25 + Rally Coins



Complete a Gym Check-In.

Check in to a participating fitness center at least 12 days per month on the Rally Health app. Select from a network of leading fitness centers, where you'll find boxing, climbing, cycling, yoga, Pilates, traditional gyms and more.

\$20 + Rally Coins



*Earnings are per person and include covered spouse or domestic partner.

**Rally Coins can be earned under Rally Health. A reward can only be earned once per incentive year per health action, with the exception of the Fitness Action, up to the maximum incentive amount. Rally Coins may be used to enter sweepstakes for additional rewards.

| TRADITIONAL PREFERRED – HIGH PLAN | IN-NETWORK | OUT-OF-NETWORK (Payable at 90th percentile) |
|--|---|---|
| TYPE A – PREVENTIVE SERVICES | 100% - No Deductible | 100% - No Deductible |
| TYPE B – BASIC SERVICES | 90% after Deductible | 90% after Deductible |
| TYPE C – MAJOR SERVICES | 60% after Deductible | 60% after Deductible |
| TYPE D – ORTHODONTIA (Dependent children up to age 19) | 50% - No Deductible | 50% - No Deductible |
| DEDUCTIBLE (Applies to both Basic and Major Services) | \$50 Individual / \$150 Family | \$50 Individual / \$150 Family |
| ANNUAL MAXIMUM BENEFIT (Per Individual – All services combined) | Unlimited | Unlimited |
| ORTHODONTIA LIFETIME MAXIMUM (Dependent Child to age 19) | \$1,000 per Person | \$1,000 per Person |
| DEPENDENT AGE | Eligible for benefits until the day he/she turns 26 | Eligible for benefits until the day he/she turns 26 |

| TRADITIONAL PREFERRED – LOW PLAN | IN-NETWORK | OUT-OF-NETWORK (Payable at 90th percentile) |
|--|---|---|
| TYPE A – PREVENTIVE SERVICES | 100% - No Deductible | 100% - No Deductible |
| TYPE B – BASIC SERVICES | 80% after Deductible | 80% after Deductible |
| TYPE C – MAJOR SERVICES | 50% after Deductible | 50% after Deductible |
| TYPE D – ORTHODONTIA (Dependent children up to age 19) | 50% - No Deductible | 50% - No Deductible |
| DEDUCTIBLE (Applies to both Basic and Major Services) | \$50 Individual / \$150 Family | \$50 Individual / \$150 Family |
| ANNUAL MAXIMUM BENEFIT (Per Individual – All services combined) | \$1,000 + extended 30% | \$1,000 + extended 30% |
| ORTHODONTIA LIFETIME MAXIMUM (Dependent Child to age 19) | \$1,000 per Person | \$1,000 per Person |
| DEPENDENT AGE | Eligible for benefits until the day he/she turns 26 | Eligible for benefits until the day he/she turns 26 |

TYPE A – PREVENTIVE SERVICES

Routine oral examinations (3 per year); Bitewing x-rays (2 films under age 10, up to 4 films ages 10 and older); Routine cleanings (3 per year); Periodontal cleanings (4 per year); Fluoride treatment (1 per year, through age 16); Sealants (permanent molars, through age 16); Space maintainers (primary teeth, through age 15); Oral Cancer Screening (1 per year, ages 40 and older)

TYPE B – BASIC SERVICES

Emergency care for pain relief; Amalgam fillings (1 per tooth every 2 years, composite for anterior/front teeth); Oral surgery (tooth extractions including impacted teeth); Stainless steel crowns; Harmful habit appliances for children (1 per lifetime, through age 14)

TYPE C – MAJOR SERVICES

Crowns (1 per tooth every 5 years); Inlays/onlays (1 per tooth every 5 years); Bridges (1 per tooth every 5 years); Dentures (1 per tooth every 5 years); Denture relines/rebases (1 every 3 years, following 6 months of denture use); Denture repair and adjustments (following 6 months of denture use); Implant Related Services (crowns, bridges, and dentures each limited to 1 per tooth every five years. Coverage limited to equivalent cost of a non-implant service. Implant placement itself is not covered.); Periodontics (scaling/root planing and surgery 1 per quadrant every 3 years); Endodontics (root canals 1 per tooth per lifetime and 1 re-treatment)

To Search for In-Network Providers: Visit www.humana.com. Find a Provider: Member Resources/Find a Doctor, Click on Dentist

DENTAL RATES (PER 26 PAY PERIODS)

| | HIGH PLAN | LOW PLAN |
|----------------------------------|-----------|----------|
| EMPLOYEE | \$16.13 | \$11.25 |
| EMPLOYEE & SPOUSE | \$32.25 | \$22.50 |
| EMPLOYEE & CHILD(REN) | \$44.00 | \$31.56 |
| EMPLOYEE & FAMILY | \$60.71 | \$43.39 |



SUMMARY VISION BENEFITS – GROUP #5000156



| | IN-NETWORK (INSIGHT NETWORK) | OUT-OF-NETWORK (REIMBURSEMENT) |
|---|---|-----------------------------------|
| EXAM AT PLUS PROVIDERS | \$0 copay | Up to \$40 |
| EXAM | \$10 copay | Up to \$40 |
| FRAMES | | |
| Any available frame at PLUS Providers | \$0 copay; 20% off balance over \$210 allowance | Up to \$112 |
| Frame | \$0 copay; 20% off balance over \$160 allowance | Up to \$112 |
| CONTACT LENSES <i>(Contact Lens allowance includes materials only)</i> | | |
| Conventional | \$0 copay; 15% off balance over \$160 allowance | Up to \$112 |
| Disposable | \$0 copay; 100% of balance over \$160 allowance | Up to \$112 |
| Medically Necessary | \$0 copay; paid-in-full | Up to \$210 |
| STANDARD PLASTIC LENSES | | |
| Single Vision | \$10 copay | Up to \$30 |
| Bifocal | \$10 copay | Up to \$50 |
| Trifocal | \$10 copay | Up to \$70 |
| Lenticular | \$10 copay | Up to \$70 |
| Progressive - Standard | \$65 copay | Up to \$50 |
| Progressive - Premium Tier 1 | \$95 copay | Up to \$50 |
| Progressive - Premium Tier 2 | \$105 copay | Up to \$50 |
| Progressive - Premium Tier 3 | \$120 copay | Up to \$50 |
| Progressive - Premium Tier 4 | \$185 copay | Up to \$50 |
| LENS OPTIONS | | |
| Anti Reflective Coating - Standard | \$45 copay | Up to \$23 |
| Anti Reflective Coating - Premium Tier 1 | \$57 copay | Up to \$23 |
| Anti Reflective Coating - Premium Tier 2 | \$68 copay | Up to \$23 |
| Anti Reflective Coating - Premium Tier 3 | \$85 copay | Up to \$23 |
| Polycarbonate - Std < 19 years of age | \$0 copay | Up to \$20 |

FREQUENCY: Examination, Lenses (in lieu of contacts), Contacts (in lieu of lenses) and Frames: **Once every plan year**

To Search for In-Network Providers: Visit www.eyemedvisioncare.com. Click on “Find an Eye Doctor,” then select “Insight Network,” add Zip Code and Search.

VISION RATES (PER 26 PAY PERIODS)

| | |
|-----------------------|--------|
| EMPLOYEE | \$2.63 |
| EMPLOYEE & SPOUSE | \$5.00 |
| EMPLOYEE & CHILD(REN) | \$5.26 |
| EMPLOYEE & FAMILY | \$7.74 |



GROUP TERM LIFE INSURANCE: GROUP #G000-BVCV



Thorne Ambulance Service provides employees with an **Employer-Paid** Basic Life / AD&D benefit in the amount of \$50,000.

Benefits reduce 65% at age 65 and 50% at age 70.



VOLUNTARY SHORT-TERM DISABILITY INSURANCE: GROUP #G000-BVCV

| | |
|------------------------|-----------------------------------|
| WEEKLY BENEFIT AMOUNT* | 60% |
| MAXIMUM WEEKLY BENEFIT | \$1,000 |
| ELIMINATION PERIOD | 7 Days Accident / 7 Days Sickness |
| PRE-EXISTING CONDITION | 3/6 |
| BENEFIT DURATION | 12 Weeks |

*The minimum weekly benefit is subject to overpayment situations and any applicable rehabilitation incentives.

BI-WEEKLY PREMIUM CALCULATION

EXAMPLE:

(42-year-old employee
earning \$40,000 a year)

| | | | | |
|--|----|-----------|----|-----------|
| List your weekly earnings (Max. is \$1,666.67) | \$ | | \$ | 769.23 |
| Multiply by the Premium Factor | | 0.0207692 | | 0.0207692 |
| Your <u>Estimated</u> Bi-Weekly Premium* | \$ | | \$ | 15.98 |

*This is an estimate of premium cost. Actual deductions may vary slightly due to rounding and payroll frequency.

VOLUNTARY LONG-TERM DISABILITY INSURANCE: GROUP #G000-BVCV

| | |
|--------------------------------|---|
| COVERAGE | 60% of Pre-disability Earnings |
| MONTHLY MAXIMUM | \$6,000 |
| ELIMINATION PERIOD | 90 Days |
| BENEFIT DURATION | SSNRA (Social Security Normal Retirement Age) |
| PRE-EXISTING CONDITION CLAUSE* | 12/12 |

| AGE BAND | PREMIUM FACTOR |
|----------|----------------|
| <20 | \$0.0016615 |
| 20-24 | \$0.0018000 |
| 25-29 | \$0.0025385 |
| 30-34 | \$0.0038308 |
| 35-39 | \$0.0048000 |
| 40-44 | \$0.0058154 |
| 45-49 | \$0.0078923 |
| 50-54 | \$0.0115385 |
| 55-59 | \$0.0137077 |
| 60-64 | \$0.0145846 |
| 65-69 | \$0.0153231 |
| 70+ | \$0.0161077 |

BI-WEEKLY PREMIUM CALCULATION

EXAMPLE:

(42-year-old employee
earning \$40,000 a year)

| | | | | |
|---|----|--|----|-----------|
| List your monthly earnings (Max. is \$10,000) | \$ | | \$ | 3,333.33 |
| Multiply by the Premium Factor | | | | 0.0058154 |
| Your <u>Estimated</u> Bi-Weekly Premium* | \$ | | \$ | 19.38 |

*This is an estimate of premium cost.
Actual deductions may vary slightly
due to rounding and payroll frequency.

► ***STD AND LTD PRE-EXISTING CLAUSE:** The pre-existing period is 3/6 for STD and 12/12 for LTD. This means that any resulting condition from injury or sickness for which the Employee received medical treatment, services or incurred expenses for 3 months for STD or 12 months for LTD prior to the date of his or her coverage that results in disability within the first 12 months of coverage will not be covered.

| | Employee | Spouse | Child |
|---|---------------------------|--|----------|
| INCREMENT AMOUNTS | \$10,000 | \$5,000 | \$10,000 |
| MINIMUM BENEFIT | \$10,000 | \$5,000 | \$10,000 |
| MAXIMUM AMOUNT | \$500,000 EOI Required | \$250,000 not to exceed 50% of employee; EOI Required | \$10,000 |
| GUARANTEE ISSUE AMOUNT (New Hires Only) | \$100,000 | \$50,000 | \$10,000 |

■ Age Reduction: Coverage reduces to 65% at age 70, to 45% at age 75, and to 30% at age 80.

VOLUNTARY TERM LIFE RATES (COMBINED WITH AD&D)

EMPLOYEE: Bi-Weekly Premium Guarantee Issue = \$100,000

| Age | \$10,000 | \$20,000 | \$30,000 | \$40,000 | \$50,000 | \$60,000 | \$70,000 | \$80,000 | \$90,000 | \$100,000 |
|--------------|----------|----------|----------|----------|----------|----------|----------|----------|----------|-----------|
| 0-29 | \$0.46 | \$0.92 | \$1.38 | \$1.85 | \$2.31 | \$2.77 | \$3.23 | \$3.69 | \$4.15 | \$4.62 |
| 30-34 | \$0.65 | \$1.29 | \$1.94 | \$2.58 | \$3.23 | \$3.88 | \$4.52 | \$5.17 | \$5.82 | \$6.46 |
| 35-39 | \$0.74 | \$1.48 | \$2.22 | \$2.95 | \$3.69 | \$4.43 | \$5.17 | \$5.91 | \$6.65 | \$7.38 |
| 40-44 | \$1.15 | \$2.31 | \$3.46 | \$4.62 | \$5.77 | \$6.92 | \$8.08 | \$9.23 | \$10.38 | \$11.54 |
| 45-49 | \$1.89 | \$3.78 | \$5.68 | \$7.57 | \$9.46 | \$11.35 | \$13.25 | \$15.14 | \$17.03 | \$18.92 |
| 50-54 | \$2.86 | \$5.72 | \$8.58 | \$11.45 | \$14.31 | \$17.17 | \$20.03 | \$22.89 | \$25.75 | \$28.62 |
| 55-59 | \$4.25 | \$8.49 | \$12.74 | \$16.98 | \$21.23 | \$25.48 | \$29.72 | \$33.97 | \$38.22 | \$42.46 |
| 60-64 | \$6.88 | \$13.75 | \$20.63 | \$27.51 | \$34.38 | \$41.26 | \$48.14 | \$55.02 | \$61.89 | \$68.77 |
| 65-69 | \$11.40 | \$22.80 | \$34.20 | \$45.60 | \$57.00 | \$68.40 | \$79.80 | \$91.20 | \$102.60 | \$114.00 |
| 70-74 | \$20.31 | \$40.62 | \$60.92 | \$81.23 | \$101.54 | \$121.85 | \$142.15 | \$162.46 | \$182.77 | \$203.08 |
| 75-79 | \$33.37 | \$66.74 | \$100.11 | \$133.48 | \$166.85 | \$200.22 | \$233.58 | \$266.95 | \$300.32 | \$333.69 |
| 80+ | \$67.43 | \$134.86 | \$202.29 | \$269.72 | \$337.15 | \$404.58 | \$472.02 | \$539.45 | \$606.88 | \$674.31 |

SPOUSE: Bi-Weekly Premium Guarantee Issue = \$50,000. Spouse coverage terminates at age 70 and is based on Employee's age.

| Age | \$5,000 | \$10,000 | \$15,000 | \$20,000 | \$25,000 | \$30,000 | \$35,000 | \$40,000 | \$45,000 | \$50,000 |
|--------------|---------|----------|----------|----------|----------|----------|----------|----------|----------|----------|
| 0-29 | \$0.23 | \$0.46 | \$0.69 | \$0.92 | \$1.15 | \$1.38 | \$1.62 | \$1.85 | \$2.08 | \$2.31 |
| 30-34 | \$0.32 | \$0.65 | \$0.97 | \$1.29 | \$1.62 | \$1.94 | \$2.26 | \$2.58 | \$2.91 | \$3.23 |
| 35-39 | \$0.37 | \$0.74 | \$1.11 | \$1.48 | \$1.85 | \$2.22 | \$2.58 | \$2.95 | \$3.32 | \$3.69 |
| 40-44 | \$0.58 | \$1.15 | \$1.73 | \$2.31 | \$2.88 | \$3.46 | \$4.04 | \$4.62 | \$5.19 | \$5.77 |
| 45-49 | \$0.95 | \$1.89 | \$2.84 | \$3.78 | \$4.73 | \$5.68 | \$6.62 | \$7.57 | \$8.52 | \$9.46 |
| 50-54 | \$1.43 | \$2.86 | \$4.29 | \$5.72 | \$7.15 | \$8.58 | \$10.02 | \$11.45 | \$12.88 | \$14.31 |
| 55-59 | \$2.12 | \$4.25 | \$6.37 | \$8.49 | \$10.62 | \$12.74 | \$14.86 | \$16.98 | \$19.11 | \$21.23 |
| 60-64 | \$3.44 | \$6.88 | \$10.32 | \$13.75 | \$17.19 | \$20.63 | \$24.07 | \$27.51 | \$30.95 | \$34.38 |
| 65-69 | \$5.70 | \$11.40 | \$17.10 | \$22.80 | \$28.50 | \$34.20 | \$39.90 | \$45.60 | \$51.30 | \$57.00 |

ALL CHILDREN*: Bi-Weekly Premium Guarantee Issue = \$10,000.

\$10,000

\$0.92

*Regardless of how many children you have, they are included in the "All Children" premium amounts.

EMPLOYEE ASSISTANCE PROGRAM (EAP)



Life's not always easy. Sometimes a personal or professional issue can affect your work, health and general well-being.

When facing life's challenges, you often turn to family or friends for support. But sometimes that's not enough. Sometimes you need an experienced professional to talk with to know you're not alone.

Mutual of Omaha's Employee Assistance Program (EAP) assists employees and their eligible dependents with personal and job-related concerns, including:

- ✓ Emotional well-being
- ✓ Family and relationships
- ✓ Legal and financial
- ✓ Healthy lifestyles
- ✓ Work and life transitions

HIGHLY TRAINED, EXPERIENCED EAP STAFF

Our EAP staff members are all licensed, master's level Employee Assistance Professionals. They provide a solution-focused approach by assessing your situation and referring to the appropriate resources necessary.

WHAT TO EXPECT

When you call, you will speak directly to an EAP professional to receive **immediate support and guidance**.

You can entrust your EAP professional to assess your needs and handle your concerns in a confidential, respectful manner. Our goal is to collaborate with you and find solutions that are responsive to your needs.

Your EAP benefits are provided through your employer. There is **no cost** to you for utilizing EAP services. If additional resources are needed, your EAP professional can assist by locating affordable solutions in your area.

EAP BENEFITS

As an employee, or eligible dependent, of your company your EAP benefits include:

- Access to EAP professionals 24 hours a day, seven days a week
- Information and referral services
- Service for employees and eligible dependents
- Robust network of licensed and/or certified mental health professionals
- Three face-to-face sessions* with a counselor (per household per calendar year)

Legal and financial resources

- Online will preparation
- Legal library and online forms
- Financial tools & resources

Resources for:

- Work/life balance
- Substance use
- Dependent and Elder Care resources

Access to:

- A library of educational articles, handouts and resources via mutualofomaha.com/eap

**Face-to-face visits also can be used toward legal consultations. California Residents: Knox-Keene Statute limits no more than three face-to-face sessions per six-month period per person.*

EAP CONSULTATION

Mutual of Omaha's Employee Assistance Program provides professional, confidential quality consultation, 24 hours a day.

mutualofomaha.com/eap
800.316.2796

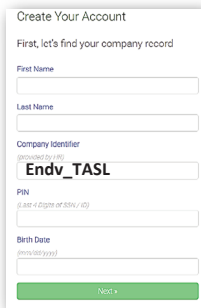


GETTING STARTED WITH YOUR EMPLOYEE BENEFITS ONLINE PORTAL

Welcome to your Online Benefits Portal provided by Endeavor Insurance Services. This guide will walk you through the steps to get started. This is a multi-step process and is designed to ensure the privacy of your sensitive information. You should only need to go through this process once, after which you can simply log in at <https://endeavor.employeeenavigator.com/benefits/account/login>.

FOR NEW USERS:

- 1 Go Online and Visit:
<https://endeavor.employeeenavigator.com/benefits/account/login>
- 2 Click the 'New User Registration' link.
- 3 Enter the information requested on the registration screen. The *Company Identifier* is **"Endv_TASL"**. Click 'Next'.



Create Your Account

First, let's find your company record

First Name

Last Name

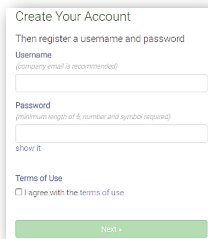
Company Identifier
(company email)
Endv_TASL

PIN
(last 4 digits of SSN or ID)

Birth Date
(month/year)

Next >

- 4 Enter your desired password on the resulting screen. Please note the password requirements. You may also set/change your username here – it will default to your email address if that has already been entered in the system.



Create Your Account

Then register a username and password

Username
(company email is recommended)

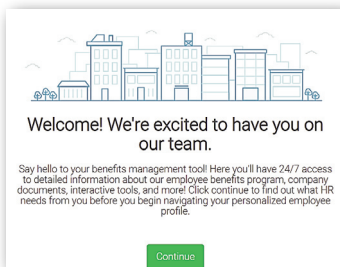
Password
(minimum length of 6, number and symbol required)

show it

Terms of Use
☐ I agree with the terms of use

Next >

- 5 If you have successfully completed the registration, you will receive a notification on the next screen and will be able to log in using your new user name and password.



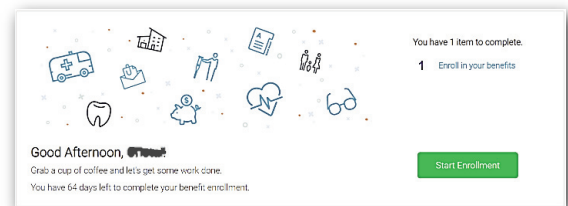
Welcome! We're excited to have you on our team.

Say hello to your benefits management tool! Here you'll have 24/7 access to detailed information about our employee benefits program, company documents, interactive tools, and more! Click continue to find out what HR needs from you before you begin navigating your personalized employee profile.

Continue

READY TO ENROLL IN BENEFITS?

- 1 Go Online and Visit:
<https://endeavor.employeeenavigator.com/benefits/account/login>
- 2 Once logged in, click the 'Start Benefits' link.



Good Afternoon, **Endv_TASL**

Grab a cup of coffee and let's get some work done.

You have 64 days left to complete your benefit enrollment.

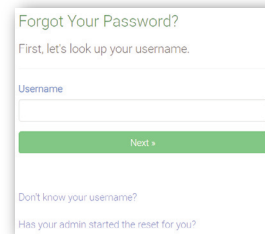
You have 1 item to complete.

- 1 Enroll in your benefits

Start Enrollment

FOR CURRENT USERS (*Forgotten Passwords*):

- 1 Go Online and Visit:
<https://endeavor.employeeenavigator.com/benefits/account/login>
- 2 Click the 'Reset Password' link then 'Click Here' under Employees.
- 3 Enter your username. Click 'Next'. If you do not remember your username, click 'Don't know your username?' to request a reset. The Company Identifier is **"Endv_TASL"**.



Forgot Your Password?

First, let's look up your username.

Username

Next >

Don't know your username?
Has your admin started the reset for you?

- 4 An email will be sent to the one on file. Click the 'Password Reset' link in the email to enter a new password. Accept the Terms and Conditions and you will automatically be logged into the Portal.

For future logins, go to
<https://endeavor.employeeenavigator.com/benefits/account/login>

Please contact **Sumner Fountain** at
864.877.6644 or sfountain@endeavorsc.com.

IMPORTANT NOTICES

INITIAL NOTICE OF YOUR HIPAA SPECIAL ENROLLMENT RIGHTS

Loss of Other Coverage – if you are declining enrollment for yourself and/or your dependents (including your spouse) because of other health insurance coverage or group health plan coverage, you may be able to enroll yourself and/or your dependents in this plan if you or your dependents lose eligibility for that other coverage or if the employer stops contributing towards your or your dependent's coverage. *You will be required to submit a signed statement that this other coverage as the reason for waiving enrollment originally.* To be eligible for this special enrollment opportunity, you must request enrollment **within 31 days** after your other coverage ends or after the employer stops contributing towards the other coverage.

New Dependent as a Result of Marriage, Birth, Adoption or Placement for Adoption – 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/or your dependent(s). To be eligible for this special enrollment opportunity, you must request enrollment **within 31 days** after the marriage, birth, adoption or placement for adoption.

Medicaid Coverage – Thorne Ambulance Service group health plan will allow an employee or dependent who is eligible, but not enrolled for coverage, to enroll for coverage if either of the following events occur:

1. **TERMINATION OF MEDICAID OR CHIP COVERAGE** – If the employee or dependent is covered under a Medicaid plan or under a State child health plan (SCHIP) and coverage of the employee or dependent under such a plan is terminated as a result of loss of eligibility.
2. **ELIGIBILITY FOR PREMIUM ASSISTANCE UNDER MEDICAID OR CHIP** – If the employee or dependent becomes eligible for premium assistance under Medicaid or SCHIP, including under any waiver or demonstration project conducted under or in relation to such a plan. This is usually a program where the state assists employed individuals with premium payment assistance for their employer's group health plan rather than direct enrollment in a state Medicaid program.

To be eligible for this special enrollment opportunity, you must request coverage under the group health plan **within 60 days** after the date the employee or dependent becomes eligible for premium assistance under Medicaid or SCHIP or the date you or your dependent's Medicaid or state-sponsored CHIP coverage ends.

To request special enrollment or obtain more information, please contact the Benefits Hotline at 1-888-877-6641.

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

If you are eligible for health coverage but are unable to afford the premium, some States have assistance programs that can help pay for coverage.

If you or your dependents are already enrolled in Medicaid or CHIP, you can 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, you can contact your State Medicaid or CHIP office or call 1-877-KIDSNOW or www.insurekidsnow.gov to find out how to apply.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, **you must request coverage within 60 days of being determined eligible for premium assistance.**

For more information on special enrollment rights, you can contact either:

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

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

HIPAA PRIVACY NOTICE

Protecting Your Health Information Privacy Rights

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. Please contact your medical plan carrier to request a copy of the Notice.

WELLNESS PROGRAM – NOTICE OF ALTERNATIVE STANDARD

If it is unreasonably difficult due to a medical condition for you to meet the requirements of our company wellness or smoking cessation program (or if it is medically inadvisable for you to attempt to meet the requirements of this program), we will make available a reasonable alternative standard for you to avoid this surcharge. Please contact Human Resources for more information.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT (NMHPA)

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 insurers may not, under Federal law, require that a provider obtain authorization from the plan or the insurer for prescribing a length of stay not more than 48 hours (or 96 hours).

NOTICE REGARDING THE WOMEN'S HEALTH AND CANCER RIGHTS ACT

On October 21, 1998, Congress passed a bill called the Women's Health and Cancer Rights Act. This new law requires group health plans provide coverage for mastectomy to provide coverage for certain reconstructive services.

These services include:

- ♦ Reconstruction of the breast upon which the mastectomy has been performed,
- ♦ Surgery/reconstruction of the other breast to produce a symmetrical appearance,
- ♦ Prostheses, and
- ♦ Treatment of physical complications during all stages of mastectomy, including lymphedemas.

In addition, the plan may not:

- ♦ Interfere with a woman's rights under the plan to avoid these requirements, or
- ♦ Offer inducements to the health provider, or assess penalties against the health provider, in an attempt to interfere with the requirements of the law.

However, the plan may apply deductibles and copays consistent with other coverage provided by plan.

If you have any questions about the current plan coverage, please contact the Benefits Hotline at 1-888-877-6641.

REPORT ELIGIBILITY CHANGES IN A TIMELY MANNER

It is your responsibility to notify the Benefits Department when a dependent becomes eligible or ceases to be eligible for coverage under our benefit plans. All eligibility changes should be reported within 31 days of the event. Failure to report changes in a timely manner can impact your ability to add newly eligible dependents or discontinue pre-tax premium contributions on ineligible dependents.

In addition, failure to report a loss of eligibility due to legal separation or divorce or a dependent that has otherwise ceased to be eligible, such as a child reaching the maximum dependent child age limit, can impact your dependent's rights for group health plan coverage under the federal law known as COBRA. If you fail to report the loss of eligibility within 60 days of the event, your dependents may be left with not continuation coverage under our plan. Please see your COBRA notice or your group health plan summary plan description for additional information.

IMPORTANT NOTICES (CONTINUED)

IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE & MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Thorne Ambulance Service 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. Thorne Ambulance Service has determined that the prescription drug coverage offered by our Health Plan 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 Thorne Ambulance Service coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current Thorne Ambulance Service coverage, be aware that you and your dependents will not be able to

get this coverage back until the next enrollment period unless you experience a qualified life event. Note that your current coverage pays for other health expenses, in addition to prescription drugs, and you will still be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan and keep your coverage under the Thorne Ambulance Service plan.

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 with Thorne Ambulance Service 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% or 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.

Summary of Options for Medicare Eligible Employees (and/or Dependents)

Medical and prescription drug coverage are offered as a package under the Thorne Ambulance Service plan (you cannot elect medical coverage without prescription drug coverage).

1. Continue medical and prescription drug coverage under the Thorne Ambulance Service Plan and do not elect Medicare D coverage.
Impact – your claims continue to be paid by the Thorne Ambulance Service plan.
2. Continue medical and prescription drug coverage under the Thorne Ambulance Service plan and elect Medicare D coverage.
Impact – As an active employee (or dependent of an active employee) the Thorne Ambulance Service plan continues to pay primary on your claims (pays before Medicare D).
3. Drop the Thorne Ambulance Service plan and elect Medicare D coverage.
Impact – Medicare is your primary coverage. You will not be able to rejoin the Thorne Ambulance Service plan until the next open enrollment period unless you experience a qualified life event.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below 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 through Thorne Ambulance Service 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).

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

Name of Entity/Sender:

Thorne Ambulance Service

Contact-Position/Office:

Endeavor Insurance Services

Address:

218 Trade St, Suite G | Greer, SC 29651

Phone Number: 1-888-877-6641



The information contained in this summary should in no way be constructed as a promise or guarantee of employment or benefits. The company reserves the right to modify, amend, suspend, or terminate any plan at any time for any reason. If there is a conflict between the information in this brochure and the actual plan documents or policies, the documents or policies will always govern. Complete details about the benefits can be obtained by reviewing current plan descriptions, contracts, certificates, policies and plan documents available from Human Resources.