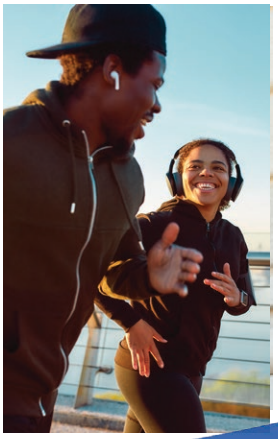
BURNS McDONNELL



OWN YOUR HEALTH

BENEFITS GUIDE '25

Here's Where to Find ...

2025 OPEN ENROLLMENT HIGHLIGHTS

It is our priority to offer a robust, competitive and comprehensive benefits package. Please see below for an overview of some enhancements and changes happening in the 2025 plan year.

NEW: Women's Health Chapter of My Health Novel!

My Health Novel is a benefit available to those enrolled in the medical plan. The new Women's Health chapter is aimed at improving and supporting women's health and well-being throughout various stages of life from pelvic pain to fertility and post-partum support to menopause. This benefit provides specialized support, virtual coaching, physical therapy and more.

Preferred Care Blue QHDHP Deductible Increase

In order to remain compliant with IRS regulations and continue allowing pre-tax HSA contributions, we must increase the deductibles for the Qualified High Deductible Health Plan. The new deductibles under this plan will be $1,650 for individual only coverage and $3,300 for family coverage.

New HSA Administrator: HealthEquity

Effective 01/01/25 Further will transition to HealthEquity's portal. Existing accounts with Further will move over automatically and you will receive a new HealthEquity Visa card and gain access to the new HealthEquity app. Communications about this transition will be sent directly to those impacted starting in October.

New Wellness Vendor in 2025: Navigate

We are excited to partner with Navigate, our new wellness vendor for 2025. Be on the lookout for more information coming your way soon.

OPEN ENROLLMENT EVENTS

These educational opportunities are available to assist with this year's Open Enrollment.

Benefits Overview Presentation

Tuesday, Oct. 29, 2024
11:30 am CT
Live Webcast Presentation

Attend this presentation to get an overview of the benefits we offer as well as the changes and enhancements coming in 2025.

In-Person Benefits Fair (KC Office Location)

Thursday, Nov. 7, 2024
11:00 am-1:00 pm CT
Cafeteria Atrium

Virtual Benefits Fair

Oct. 28-Nov 15

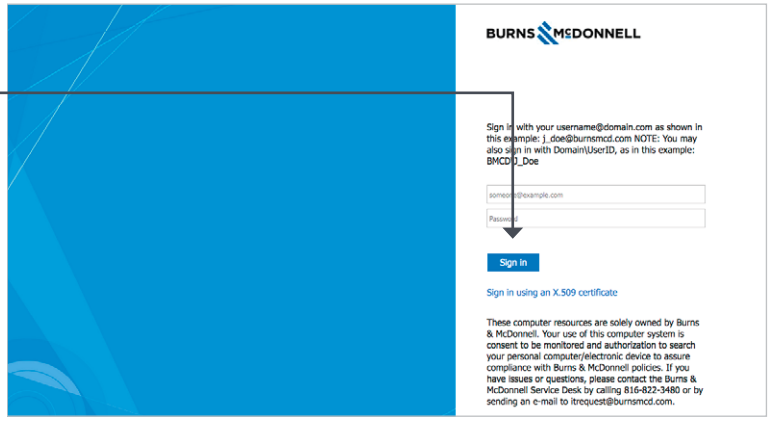
Want to learn more about our various benefit offerings? Stop by the Virtual Benefits Fair at burnsmcdbenefits.com/oe2025 starting Oct. 25 to view plan summaries, calculators and more.

HOW TO ENROLL

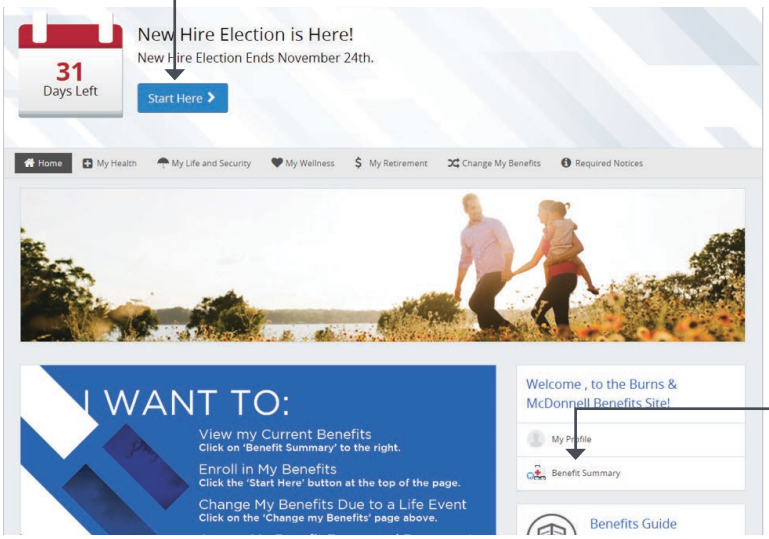
Online Enrollment

Get Started

Visit benefitsolver.burnsmcd.com, and if you are on the company network, you will be logged in automatically. If you are visiting the site from outside the company network, please log in using your standard network username and password.



Begin Enrollment



Click "Start Here" and follow the instructions to enroll in your benefits or waive coverage. You must make your elections by the deadline shown on the calendar. If you miss the deadline, your current elections will remain the same, with the exception of Flexible Spending Accounts, which must be re-elected each year.

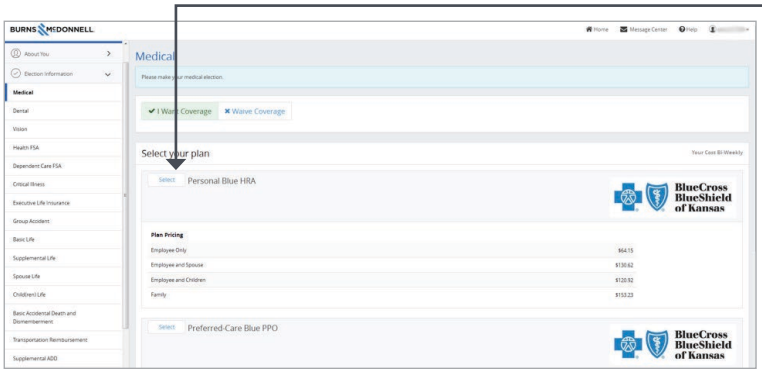
Want to Review Your Current Benefits?

You have year-round access to your benefit summary and specific benefit elections at benefitsolver.burnsmcd.com. Click "Benefits Summary" on the homepage to review your current benefits.

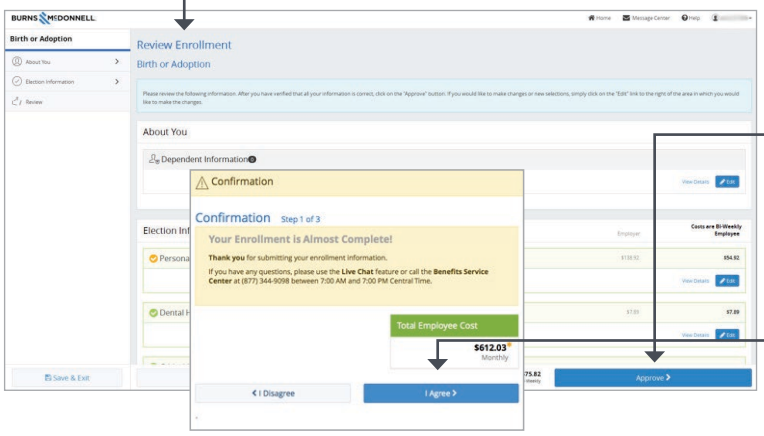
Looking for more information?

View plan details, carrier specifics and benefit guides by clicking "Reference Center" in the main navigation.

Make Your Elections



Review your options as you complete the steps of the enrollment process. Click "Select" on the plan(s) you would like to choose. Track your choices along the left side, which update with your total cost. If you have any questions as you go through enrollment, call 816-822-3400 or email benefits@burnsmcd.com. Use the "Reference Center" to access additional plan details and help you make the right elections.



Review Your Elections

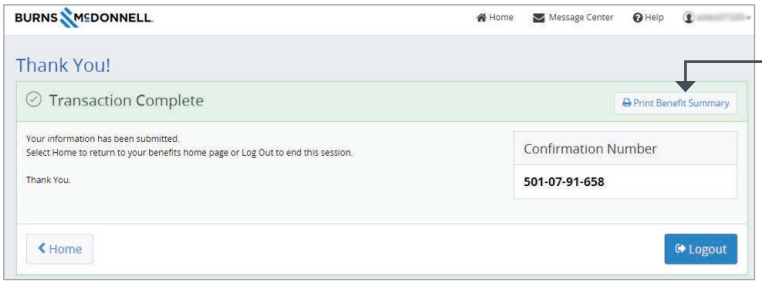
Review, edit and approve your personal information, elections, dependents and beneficiaries.

Approve

Once you have reviewed your elections and confirmed they are accurate, click “Approve” to continue.

Confirm Your Choices

Your enrollment isn’t complete until you confirm your benefit elections and cost.

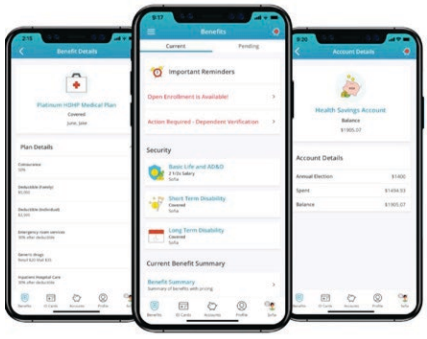


Print

Print your election information and confirmation number for future reference or save it to your Message Center.

MyChoice Mobile App

House all of your most important benefit information in one easily downloadable mobile app. View current benefit plans, beneficiaries, virtual ID cards and important benefit deadlines all from the palm of your hand. Download MyChoice Mobile from your device’s app store, and then log in to benefitsolver.burnsmcd.com to receive your access code.



Hard Copy Enrollment

If you cannot access the Benefitsolver portal, contact benefits@burnsmcd.com to discuss other options for completing your enrollment.

IMPORTANT

If you are unable to open the online enrollment forms due to technical difficulties, please call 816-822-3480. If hard copies of the necessary forms are needed, please contact Benefits at benefits@burnsmcd.com.

MEDICAL INSURANCE

The following is a summary of our offered benefit plans. Refer to the full plan summaries within the Reference Center on the Benefitsolver portal for specific plan details and to help determine which plans are best suited to your needs. Each election is for the 2025 plan year and cannot be changed until the next annual enrollment period unless the change is due to and consistent with qualifying changes in family or job status. Any midyear benefit change must occur within 31 days of the qualifying event.

Blue Cross and Blue Shield of Kansas City Medical Plans

Under all the medical plans, you have the freedom to use any physician, located in any area; however, to receive the maximum benefits under the plan, physicians should be chosen from a network of participating providers. You may also use a doctor that is not in the network and receive reduced, out-of-network benefits. Primary care physicians do not need to be designated, and no referrals are needed to visit specialists.

Preferred Care Blue PPO

If you visit an in-network provider, most services can be performed by a primary care physician for a $25 copay or a specialist for a $40 copay. Most additional services are covered at 80 percent coinsurance after a deductible is met, up to the maximum annual out-of-pocket limit. If you visit a provider that is not in the network, under most circumstances services will be covered at 60 percent coinsurance after the deductible is met, up to the maximum annual out-of-pocket limit. Once the out-of-pocket limit is met, the plan pays 100 percent of all remaining charges.

Personal Blue HRA

This plan provides an employer-funded health reimbursement account (HRA), which pays a portion of eligible healthcare expenses, excluding prescription costs. Claims that are submitted through insurance are reimbursed directly to the member by the HRA account. If the HRA is depleted, you are responsible for meeting the remaining deductible. Once the deductible is satisfied, you will pay coinsurance up to the maximum annual out-of-pocket limit. Once the out-of-pocket limit is met, the plan pays 100 percent of all remaining eligible charges. If a balance remains in your HRA in any given year, the remaining amount is rolled over to the next year's account balance, up to a maximum of two years' worth of contributions, plus the upcoming year's normal contribution amount.

BlueSaver QHDHP

The QHDHP plan requires you to meet a deductible each year before benefits begin (except for preventive services, which are always covered at 100 percent). Once you meet the deductible, the plan pays 80 percent of your covered expenses and you pay 20 percent. Once your share of expenses reaches the out-of-pocket limit, the plan pays benefits at 100 percent for the rest of the plan year. To help with your out-of-pocket expenses in this plan, Burns & McDonnell provides an employer contribution, and you are able to make tax-free contributions to a Health Savings Account (HSA). More details about HSAs can be found on page 19.

If enrolled in employee + spouse, child(ren) or family coverage, the full family deductible must be met before the plan will begin paying for any individual. In addition, if you are enrolled in employee + spouse, child(ren) or family coverage, the full family out-of-pocket maximum must be met before the out-of-pocket maximum will be considered satisfied for any individual.

The benefits available under the Preferred Care Blue PPO, Personal Blue HRA and BlueSaver QHDHP plans are each described in greater detail in the benefit summary within the Benefitsolver portal.

TELADOC VIRTUAL VISIT

Why wait for the care you need now? Teladoc virtual care gives you 24/7/365 access to a board-certified physician through the convenience of phone or video consults.

Teladoc provides telehealth consultation services on behalf of our medical plan to all enrolled employees, spouses, and dependents. Find the treatment you need for many of the most common medical conditions, including colds, allergies, sinus problems and more. Register for Teladoc by calling 866-789-8155 or start by logging in to your My Health Toolkit member portal and navigating to the "Resources" tab.

MY HEALTH NOVEL WITH BCBS

THE MUSCULOSKELETAL (MSK) PROGRAM provides a convenient way to stay in shape or address pain that's kept you from activities you love. The BCBS plans now include online programs for fitness and physical therapy with targeted exercises and helpful tools, such as wearable sensors, at no additional cost to you. To enroll, complete the health quiz on the My Health Toolkit portal or call 866-400-8941.

THE WOMEN'S HEALTH CHAPTER OF MY HEALTH NOVEL This care program is designed just for women and tackles issues women face throughout their lives. It includes access to mobile apps and tools customized to meet your needs. And there's no cost to you. Whether you're dealing with pelvic pain, fertility issues, breastfeeding or menopause, you'll find help and solutions. When you sign up, you'll get access to online help, including virtual coaching, physical therapy advice and support from health care experts.

Access these programs by logging into your My Health Toolkit, selecting "Wellness & Care Management, Wellness Programs," then "My Health Novel". You will be asked to take a quick, one minute assessment and you'll then be able to see your recommended program and resources.

MEDICAL AND PRESCRIPTION DRUG PLANS

2025 Medical/Prescription Plan Highlights

Network	Preferred Care Blue PPO Plan		Preferred Care Blue HRA Plan		Preferred Care Blue QHDHP	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Employer Funding	N/A		$500 for individual, $750 for Employee and Spouse, $1,000 for other tiers		$250 for individual, $500 for other tiers	
Annual Deductible/ Individual	$750	$3,000	$1,750	$3,000	$1,650	$2,500
Annual Deductible/Family	$2,250	$9,000	$3,500	$6,000	$3,300	$5,000
Member Coinsurance	20%	40%	20%	40%	20%	40%
Annual Out-of-Pocket Limit/Individual	$2,000	$6,000	$3,750	$7,500	$3,500	$7,000
Annual Out-of-Pocket Limit/Family	$6,000	$18,000	$7,500	$15,000	$7,000	$14,000
Primary Care Office Visit	$25 copay	40% after ded.	20% after ded.	40% after ded.	20% after ded.	40% after ded.
Specialist Office Visit	$40 copay	40% after ded.	20% after ded.	40% after ded.	20% after ded.	40% after ded.
Teladoc Virtual Visit	$40 copay		20% after deductible		20% after deductible	
Premise On-Site	$10 visit fee	N/A	$10 visit fee	N/A	$35 visit fee before deductible $10 visit fee after deductible $0 visit fee after OOP max	N/A
Preventive Care	100%	40% after ded.	100%	40% after ded.	100%	40% after ded.
Routine Eye Exam	$15 copay	N/A	$15 copay	N/A	20% after ded.	N/A
Inpatient Hospital	20% after ded.	40% after ded.	20% after ded.	40% after ded.	20% after ded.	40% after ded.
Outpatient Hospital/ Surgeries	20% after ded.	40% after ded.	20% after ded.	40% after ded.	20% after ded.	40% after ded.
Urgent Care	$40 copay	40% after ded.	20% after ded.	40% after ded.	20% after ded.	40% after ded.
Emergency Room	$75 copay, then ded., then 20%		20% after ded.		20% after ded.	
Prescription Drug Tier 1	$12 copay	50% after copay	$12 copay	50% after copay	20% after ded.	40% after ded.
Prescription Drug Tier 2	$35 copay	50% after copay	$35 copay	50% after copay	20% after ded.	40% after ded.
Prescription Drug Tier 3	$60 copay	50% after copay	$60 copay	50% after copay	20% after ded.	40% after ded.

*Premise fees will not apply to plan accumulators except for the QHDHP plan.

PPO and HRA Plans: Each member on the plan has their own individual deductible and individual out-of-pocket maximum, up to a family maximum limit. Once the individual or family out-of-pocket maximum has been satisfied, benefits will be paid at 100 percent.

QHDHP: If enrolled in employee + spouse, child(ren) or family coverage, the family deductible must be met before the plan will begin paying for an individual. In addition, if enrolled in employee + spouse, child(ren) or family coverage, the full family out-of-pocket maximum must be met before the out-of-pocket maximum will be considered satisfied.

Preferred Care Blue QHDHP Deductible Increase

To remain compliant with IRS regulations and continue allowing pre-tax Health Savings Account (HSA) contributions, Burns & McDonnell must increase the deductibles for the Qualified High Deductible Health Plan. The new deductibles under this plan will be $1,650 for individual only coverage and $3,300 for family coverage.

Blue Cross and Blue Shield Prescription Benefits

PPO & HRA Plans

Prescription benefits are identical under the PPO and HRA plans. Medications are divided into three tiers. Prescriptions for medications on the Tier 1 drug list are covered with a $12 copayment. Medications listed on the Tier 2 list will require a $35 copayment, while Tier 3 medications require a $60 copayment. Prescription copayments accumulate toward your out-of-pocket maximum but do not count toward your annual deductible.

QHDHP Plan

Under the QHDHP, there are no copayments and prescription costs accumulate toward your deductible. Once your deductible is met, you pay 20 percent of prescription costs until you meet your out-of-pocket maximum.

A list of medications and their corresponding tiers (for the PPO and HRA plans only) can be found on your My Health Toolkit portal, myhealthtoolkitkc.com, or by calling the customer service line.

Mail-Order Prescription Benefits

All medical plans also offer prescriptions through Optum's mail-order service, allowing you to order a three-month supply of any drug at the cost of only a two-month supply. The mail-order prescription service allows you and the company to save on the high cost of prescription benefits.

Medical Plan Cost Estimator

Picking the right plan can be complicated. Utilize the cost estimator, found in the Reference Center of the Benefitsolver portal to see how each plan fits unique healthcare needs.

Being a Smart Healthcare Consumer

Preventive Care

- **MEDICAL:** In-network preventive care is 100 percent covered on our medical plan.
- **ENHANCED ORAL HEALTH AND PREVENTION:** Through Delta Dental's Healthy Smiles, Healthy Lives® benefits, eligible covered members gain access to additional services to help reduce the risks associated with periodontal disease and certain existing medical conditions.
- **YOUR HEART LOVES REGULAR EYE EXAMS.** The eye is one of the only areas of the body where doctors have an unobstructed view of blood vessels. A full eye examination may reveal the first signs of serious heart conditions, including high blood pressure, before symptoms show up elsewhere in the body.

Generic Drugs vs. Brand Name

Pharmacies offer a wide range of generic drugs at much lower costs than brand-name drugs. Generic medications have the same active ingredients and follow the same FDA quality standards, but you pay a fraction of the brand-name medication cost. The average person pays $25 more for a brand-name medication than a generic medication.

Urgent Care vs. Emergency Room

Generally, urgent care centers offer walk-in services and are open after regular business hours and on weekends. Urgent care visits cost less out of your pocket, and wait times are shorter than ER visits. Remember that a community hospital visit is still an ER visit. Unnecessary emergency room visits raise premiums, copayments and overall costs for everyone. On average, 13.8 percent of ER visits are not emergent.

Telehealth vs. Office Visit

Common medical issues can often be diagnosed through a virtual visit, which costs less than a standard doctor's appointment. For more information about Teladoc, visit teladoc.com.

In-Network vs. Out-of-Network

Make sure your doctor is in-network. You receive the greatest discounts when your services are from in-network providers. Remember to review the differences between the PPO and Premier Networks now available with Delta Dental of Missouri and the Surency Vision Insight Network.

Health Savings Account or FSA

Set aside a portion of your paycheck tax-free to spend on future medical, dental or vision expenses.

Healthcare Navigation and Additional Resources

My Health Novel for Musculoskeletal (MSK) & Womens Health

Blue Cross Blue Shield's My Health Novel offers great support for both Musculoskeletal concerns and now for Women's Health! Both programs are free and available to those enrolled in a Burns medical plan with BCBS. Please reference page 7 of the guide to learn more details surrounding these great benefits.

BCBS Behavioral Health Support

The Blue Cross Blue Shield plans include three programs available to virtually supplement the Burns & McDonnell SupportLinc EAP program at no additional cost to you.

- Meru Health, digital therapy program: meruhealth.com/cba
- NOCD, OCD-specific support: nocd.com
- YouturnHealth, substance use support: youturnhealth.com; Registration code: CBA
- Within Health, eating disorder support: wthn.health/cba

Livongo Diabetes Management

Livongo provides members living with diabetes a personalized experience that helps them understand their blood sugar, develop sustainable healthy lifestyle habits, and improve glycemic control.

Program benefits:

- Free advanced blood glucose meter, unlimited testing strips and lancets right to your door
- 24/7 real-time support for out-of-range readings
- One-on-one coaching with personalized tips and action plans

There is no cost for this program for employees and dependents with diabetes who are enrolled in the medical plan. To learn more and join the program, text "GO BMCD" to 85240, visit join.livongo.com/BMCD/register, or call 800-945-4355 and use the registration code: BMCD.

Lockton Nurse Advocate

Good mental and physical health play an integral role in creating a happy, productive life. Our Lockton Nurse Advocate offers clinical concierge services to help you improve your health and achieve your personal and professional goals by learning about your health and lifestyle, discussing best practice medical care, connecting you with appropriate resources, and more.

Contact the Lockton Nurse Advocate by phone and/or email.

Ana Hensey
Phone: 833-518-1630
Email: membersupport@lockton.com

Premise Health Coaching

Visit the Premise Health Coach for wellness and condition management support. Set SMART goals to work towards improving overall health (management of weight, stress, nutrition, tobacco cessation, exercise, work-life balance and general health) and improving chronic conditions (high cholesterol, high blood pressure, diabetes, asthma/COPD, migraine, heart failure, GERD, low back pain, osteoarthritis). 1-hour sessions and telehealth available.

Coaching is available to all employee-owners. Call 816-823-6000 to set up an in-person or virtual appointment.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Life can be a juggling act. It takes time and energy to manage your work, family and personal wellbeing. Burns & McDonnell is pleased to provide the SupportLinc Employee Assistance Program (EAP) to help you manage life's daily challenges. SupportLinc offers confidential, professional support for emotional health and work-life balance concerns at no cost to you or your family. The EAP provides up to six sessions of counseling for a wide variety of concerns, such as:

- Anxiety
- Depression
- Marriage and relationship problems
- Grief and loss
- Substance use
- Anger management
- Stress
- Financial assistance
- Legal assistance
- Family assistance

What is an EAP?

An Employee Assistance Program (EAP) is a free and confidential mental health benefit offered by your employer, separate from your medical insurance.

Who is eligible?

This program is available to you, your spouse or domestic partner and your immediate family members. This includes dependent children under the age of 26, whether they live in the household or not. For children under the age of 18, a custodial parent or legal guardian should contact the program first to establish the most appropriate plan of action.

What is included?

- **Confidentiality:** Strict confidentiality standards ensure no one will know you have accessed the program without your written permission except as required by law.
- **In-the-moment support:** A licensed clinician answers 24/7/365 when you call for assistance with emotional health concerns.
- **Web platform:** Your one-stop shop for SupportLinc support, resources, information and more. Discover on-demand training to boost wellbeing, search engines, financial calculators, tip sheets and more.
- **eConnect® mobile app:** Get confidential support and guidance on the go from a licensed counselor via live chat, as well as expert content and resources – all from the convenience of your phone or tablet. Use the QR code below to download the eConnect® app.
- **Textcoach®:** Personalized coaching with a licensed counselor on mobile or desktop.
- **Virtual Support Connect:** Moderated group support sessions on an anonymous, chat-based platform.
- **Financial expertise:** Consultation and planning with a financial counselor.
- **Legal consultation:** By phone or in-person with a local attorney.
- **Convenience resources:** Referrals for child or elder care, adoption, pet care, home repair, education, housing needs and so much more.
- **Animo Online Learning Modules:** Access self-guided resources to improve focus, wellbeing and emotional fitness.

SupportLinc

Phone: 1-888-881-LINC (5462)
Web: supportlinc.com | Code: bmcd

Download the mobile app today!

WELLNESS PROGRAM

Burns & McDonnell is excited to introduce Navigate as our new wellbeing partner in 2025.

Just as we approach every project with integrity, grit, and determination, we are committed to providing the same level of support to each of you when it comes to your wellbeing. Navigate shares our passion for empowering individuals to achieve their best, with a platform that brings innovation, purpose, and personalization to your wellbeing journey. With our refreshed program coming soon, you'll soon have access to a platform designed to help you thrive in every area, whether it's physical fitness, mental health, financial wellness, nutrition, sleep, mindfulness, balance, or purpose and career.

Be on the lookout for more details on how to set up your account, participate in upcoming challenges, and explore the full suite of wellbeing tools designed to support you.

DENTAL INSURANCE

Your dental benefits will be provided through Delta Dental, the nation's leading provider of dental insurance. You will have a choice of two benefit plans: a low plan and a high plan. On both plans you will have access to the two Delta Dental networks: Delta Dental PPO™ and Delta Dental Premier®. You will have the freedom to choose from any dental provider, understanding the benefits under each provider network is important and allows you to maximize your benefit.

Reminder

Be sure to register your member portal here where you can view your claims, print or request a new ID cards, and access a suite of member tools and resources.

- **DELTA DENTAL PPO™:** Offers the highest negotiated discounted rates
- **DELTA DENTAL PREMIER®:** Offers negotiated rates, but not as discounted as the PPO discounts
- **OUT-OF-NETWORK:** Does not have negotiated rates and is able to balance bill for service above and beyond the in-network allowable charges.

Finding a Provider Is Easy

Quickly find a dentist by using any of these options:

- **ONLINE:** Visit deltadentalmo.com and click "Find a Dentist"
- **MOBILE APP:** To download, visit the App Store (Apple) or Google Play (Android) and search for Delta Dental.
- **CUSTOMER SERVICE:** Our customer care team can assist via phone at 800-335-8266 or via email at service@deltadentalmo.com.

Plan Highlights to Remember

MAXADVANTAGE: Claims paid for cleanings, exams, X-rays and fluoride treatments do not apply towards the annual plan maximum.

FLUORIDE: All participants are eligible to receive fluoride treatments twice per benefit year.

SEALANTS: All participants are eligible for sealants on caries-free 1st and 2nd permanent molars.

COMPOSITE FILLINGS: Composite (white) fillings are covered for all teeth.

ORTHODONTIA: Orthodontia will only be covered on the high plan, to a maximum of $2,000 per person. Please refer to the flyer, in the Reference Center on Benefitsolver if enrolled on the low plan with orthodontia in progress.

HEALTHY SMILES, HEALTHY LIVES: Two additional cleanings for participants who are pregnant, have periodontal disease, have suppressed immune system, or organ transplant. A self-report form is available on the Delta Dental microsite here. For members who have periodontal disease, your periodontal claim will auto-report this benefit for you.

	Low Plan PPO MAC[1]		High Plan PPO[2]	
	Delta Dental PPO™	Delta Dental Premier® or non-participating	Delta Dental PPO™	Delta Dental Premier® or non-participating
Diagnostic and Preventive Services Healthy Smiles, Healthy Lives, sealants for all participants, fluoride 2x/year for all participants	100%	100%[1]	100%	100%[2]
Basic Services Composite fillings	50%	50%[1]	80%	80%[2]
Major Services	50%	50%[1]	50%	50%[2]
Orthodontia Services	N/A		50%	50%[2]
Annual deductible	$100 per person		$50 per person/$150 family limit	
Annual Plan Maximum	$1,000 per person + **MAXAdvantage**		$1,500 per person + **MAXAdvantage**	
Lifetime Orthodontic Plan Maximum	N/A		**$2,000 per person**	

[1]Low Plan
All benefit payments under the Low Plan are based on the lesser of the dentist's usual fees or the PPO fee schedule.
PPO™ providers: agree to accept contractual reimbursement as payment in full and will not balance bill
Premier® providers: may collect the difference between the Delta Dental contract amount and the PPO fee schedule.
Out-of-network: are not contracted with Delta Dental and therefore may balance bill the difference between the out-of-network payment and the billed charges.

[2]High Plan
PPO™ providers: agree to accept contractual reimbursement as payment in full and will not balance bill
Premier® providers: agree to accept contractual reimbursement as payment in full and will not balance bill
Out-of-network: are not contracted with Delta Dental and therefore may balance bill the difference between the out-of-network payment and the billed charges.

VISION INSURANCE

Your vision benefits are provided by Surency Vision, utilizing the Eyemed Insight vision network. Your Surency Vision plan provides enhanced benefits when you visit a PLUS Provider — a select group of providers within the Eyemed Insight vision network, which includes Target Optical and LensCrafters.

Benefit Summary	In-Network		Out-of-Network
	PLUS Provider	Non-PLUS Provider	
Exam with Dilation as Necessary	$0 copay	$15 copay	$35 allowance
Retinal Imaging	$10 copay		N/A
Frequencies			
Exams	Once every calendar year		
Frames	Once every two calendar years		
Lenses/Contacts	Once every calendar year		
Frames	$225 allowance	$175 allowance	$75 allowance
Standard Plastic Lenses			
Single Vision	$25 copay		$25 allowance
Bifocal	$25 copay		$40 allowance
Trifocal/Lenticular	$25 copay		$55 allowance
Standard Progressive	$80 copay		$40 allowance
Contact Lenses			
Fitting Exam	Up to $40 copay		N/A
Conventional/ Disposable	$175 allowance		$90 allowance
Medically Necessary	$0 copay		$200 allowance

Your plan has enhanced benefits for children, pregnant and postpartum mothers, and individuals with Type 1 or Type 2 diabetes. Examples of these enhancements are two eye exams during the year, reduced copay for retinal imaging services, additional lenses with a prescription change mid-year, and more.

Reminder

You can use the allowance for both contact lenses and frames in the same calendar year.

Visit surency.com/burnsmcd to view your benefit summary, find a provider, and learn more about your coverage. Download the Surency Vision mobile app to find a provider, use your mobile ID card, view your eligibility and more.

FLEXIBLE SPENDING ACCOUNTS (FSAs)

FSAs allow you to save money by deducting your elected FSA contributions from your paychecks on a pre-tax basis. This means FSA dollars will be deducted from your paycheck before federal, state and social security taxes are calculated. Your amount of savings will depend on your individual tax bracket and the amount of money being withheld from your paychecks.

Additional details on allowable FSA expenses can be found by calling the Navia customer service line or by visiting the Navia website, naviabenefits.com.

Dependent Care FSA

A Dependent Care FSA allows you to put money aside for dependent care for children up to age 13, a disabled dependent of any age or a disabled spouse. To be eligible for a Dependent Care FSA, you and your spouse (if applicable) must work, be looking for work or be full-time students. You can be enrolled in both an HSA and Dependent Care FSA. The 2025 contribution limit is $5,000 ($2,500 if you are married and file separate tax returns).

Examples of eligible expenses include preschool and after-school care, day care providers and summer day camps.

Limited Purpose FSA

If you are participating in a QHDHP and an HSA, you are eligible to enroll in a Limited Purpose FSA alongside your HSA to maximize savings. These funds can be used for qualifying dental and vision expenses only. Medical expenses must utilize the HSA, not the Limited Purpose FSA. If your spouse is already enrolled in a Medical FSA at their workplace, you are not eligible to participate in this plan. The current contribution limit is $3,200.

Examples of eligible expenses include dental exams, vision exams, prescription glasses, laser eye surgeries, contact lenses, orthodontics and dentures.

Medical FSA

Pair a PPO or HRA health plan with a Medical FSA, which covers eligible medical, dental and vision expenses. Note: If you or your spouse is enrolled in a Health Savings Account (HSA), you're not eligible for a Medical FSA. The current contribution limit is $3,200.

Examples of eligible expenses include doctor visits, physical therapy, speech therapy, surgeries, hearing aids, ambulance costs, acupuncture and more. For a full list of eligible expenses, visit the Benefitsolver portal.

When making your 2025 election, keep in mind that you will have until March 31, 2026, to submit expenses incurred in 2025. Up to $640 of unused funds may be carried over to be used in 2026. As required by the IRS, any funds left in your account in excess of $640 will be forfeited.

Important

If you wish to participate in a Flexible Spending Account for 2025, you must re-enroll.

HEALTH SAVINGS ACCOUNT (HSA)

If you enroll in the QHDHP, you can participate in a Health Savings Account (HSA). An HSA is a savings account that allows you to set aside pre-tax money to pay for qualified out-of-pocket medical, dental and vision expenses.

An HSA can help offset the higher deductible associated with the QHDHP. If you have no medical expenses, the money in your HSA builds, and once it reaches a certain limit, you can invest those dollars much as you can with your 401(k).

The IRS HSA contribution limits for 2025 are $4,300 for individual coverage and $8,550 for all other tiers. Please note: These amounts include the $250 individual/$500 other tier employer contribution amounts provided by Burns & McDonnell.

HSA Triple Tax Benefit

Tax-free contributions by employer and employee	Investing available for balances $1,000+ and **tax-free investment growth**	**Tax-free spending** on eligible medical, dental and vision expenses

In order to participate in an HSA, you:

- Must be enrolled in an IRS Qualified High Deductible Health Plan
- Cannot be enrolled in Medicare, Medicaid, TRICARE or VA benefits (if you are collecting social security, you are automatically enrolled in Medicare Part A, which disqualifies you from enrolling in an HSA)
- Cannot be covered by any other traditional health plan
- Cannot have access to your spouse's Healthcare FSA
- Cannot participate in traditional Flexible Spending Accounts (FSAs) and Health Reimbursement Arrangements (HRAs)

Please note that once you open an HSA, that account belongs to you. Therefore, any unused dollars at the end of the year remain in your account for future use. This is different than an FSA, in which you lose any money above the carryover limit that is left in your FSA at the end of the year.

Additional details on allowable HSA expenses can be found by calling the HealthEquity customer service line or by visiting the HealthEquity website at healthequity.com.

IMPORTANT: For Open Enrollment elections, if you have a balance remaining in your 2024 Medical FSA and you are moving to the QHDHP, your FSA balance will automatically be converted to a Limited Purpose FSA. If your spouse has a 2024 FSA, the balance must be depleted before making contributions to an HSA in 2025.

LIFE AND AD&D INSURANCE

Supplemental, Spousal and Child(ren) Life Insurance

Through The Hartford, employees receive a basic life insurance policy equal to the greater of the prior year's total gross compensation or current base salary, up to the maximum of $300,000. You may purchase additional supplemental coverage in increments of $25,000 up to $750,000 and spousal life insurance coverage in increments of $5,000 up to $250,000. You must enroll in employee supplemental life insurance in order to elect spousal life insurance. The amount of spousal life insurance you elect may not exceed 50 percent of the employee supplemental life insurance coverage you carry.

Child(ren) life insurance may be elected for children from birth to age 26 years old in increments of $2,000 to a maximum of $10,000 in coverage. You must enroll in employee supplemental life insurance coverage to enroll in child(ren) life insurance.

Guaranteed Issue

If you are newly eligible and elect an amount that exceeds the GI ($200,000 for employee and $50,000 for spouse), then Evidence of Insurability will be required.

If you were previously eligible and are electing coverage for the first time or electing to increase your current coverage, then Evidence of Insurability will be required.

If you would like to enroll in or increase your supplemental, spousal and/or child(ren) life insurance coverage past the guaranteed issue amount, you must complete an Evidence of Insurability Health Questionnaire for approval of your coverage. Instructions for completion of this questionnaire are provided during the online enrollment process or by contacting Benefits.

Supplemental Accidental Death & Dismemberment Insurance

Accidental death and dismemberment (AD&D) coverage is provided through Chubb. AD&D insurance provides coverage against any accident that occurs 24 hours a day, at work or at home. Burns & McDonnell provides a basic AD&D benefit of four times annual base salary, up to a maximum of $300,000. You may purchase supplemental coverage in increments of $25,000 up to $500,000 for you and your family.

SHORT-TERM DISABILITY INSURANCE

The Burns & McDonnell short-term disability program provides all full-time and reduced full-time employees with disability pay equal to 100 percent of your regular base pay, paid bi-weekly following satisfaction of the designated waiting period.

Short-term disability benefits may be approved if you and your physician provide proof that you are disabled due to illness or injury, and are under appropriate treatment and care of a physician. This benefit will be paid for the duration of your disability up to a maximum of 11 weeks following satisfaction of the elimination period.

LONG-TERM DISABILITY INSURANCE

You are eligible for long-term disability insurance through The Hartford. Long-term disability allows you to insure a portion of your income in the event you become disabled and are unable to work. This benefit begins after a 90-day elimination period. You have the option to insure either 50 percent or 60 percent of compensation up to a total maximum monthly benefit of $10,000 for the 50 percent option and $15,000 for the 60 percent option. Premiums and benefits are paid based on the greater of your prior year's total gross compensation or current base salary.

You may be subject to pre-existing condition limitations if you are not currently enrolled in long-term disability or if you choose to increase your current coverage from 50 percent to 60 percent. Pre-existing condition limitations are detailed in the Summary Plan Description found on the Benefitsolver portal.

EOI (evidence of insurability) is not required for long-term disability for any instances.

CRITICAL ILLNESS INSURANCE

Critical illness insurance through Voya provides a lump-sum payment directly to you upon diagnosis of a covered critical illness. The critical illness plan only provides payment for illnesses newly diagnosed after the coverage becomes effective.

You have the option to enroll in $10,000 or $20,000 of coverage for yourself and your dependents. If you elect dependent coverage, your dependents will be covered for 100 percent of your elected amount.

This is not health insurance and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.

If you enroll in critical illness coverage, you and each dependent on your policy have access to the $50 wellness benefit, which provides a yearly benefit if you complete a health screening test, whether or not there were any out-of-pocket costs. The wellness benefit is designed to help you maintain a healthy lifestyle with tests that screen for a wide range of potential illnesses and diseases. To learn more or to file a claim, please visit presents.voya.com/EBRC/BurnsMcDonnell.

GROUP ACCIDENT INSURANCE

Group accident insurance through Voya provides payments directly to you for injuries and/or medical services attributed to a covered accident.

What's Covered?

Accident insurance provides a benefit payment after a covered accident that results in specific injuries and treatments. To be eligible, the accident must happen outside of work. You may enroll yourself and eligible family members in this coverage. Some of the most common treatments and conditions eligible for benefits include:

- Emergency room treatment
- X-rays
- Physical therapy
- Stitches
- Follow-up doctor treatment(s)

Sample Payment Amounts

If one of the below events happens to you, and your claim is approved, you will receive a benefit payment in the amount listed below. This post-tax benefit amount can be spent on anything you'd like, whether that be to help pay for medical expenses, transportation, or even a treat on the way home to reward a child for a difficult visit.

Accident-Related Treatment	Benefit Payment
Emergency room treatment	$300
X-ray	$200
Physical or occupational therapy (up to six per accident)	$75
Stitches (for lacerations, up to 2")	$120
Follow-up doctor treatment	$120

The chart above is a sample and is not all-inclusive of the covered accidents under the policy. Specific details regarding covered injuries and/or medical services are provided in the benefits summary on the Benefitsolver portal.

HOSPITAL INDEMNITY INSURANCE

Hospital indemnity insurance through Voya pays a benefit if you have a covered stay in a hospital, critical care unit, or rehabilitation facility on or after your coverage effective date. You can use this money for any expense you'd like. Childcare, groceries, help around the house — it's up to you. You may enroll yourself and eligible family members in this coverage. Specific details regarding covered stays and facilities can be found in the plan certificate located on the Benefitsolver portal.

When your stay begins

When you are admitted to a covered medical facility, you become eligible for an admission benefit for the first day of confinement. This benefit is payable once per confinement, up to a maximum of 8 admission(s) per calendar year:

Type of Admission	Benefit Amount
Hospital Admission	$1,000
Intensive Care Unit* Admission	$2,000

As your stay continues

Beginning on Day 2 of your confinement, for each day that you have a stay in a covered facility, you'll be eligible for a fixed daily benefit payment. The benefit amount and maximum number of days per confinement varies by facility:

Type of Facility	Daily Benefit
Hospital (30 day maximum per confinement)	$100
Intensive Care Unit* (15 day maximum per confinement)	$200
Rehabilitation Facility (30 day maximum per confinement)	$50

If you add a child to your family

Hospital Indemnity Insurance benefits apply if you have employee or spouse coverage and are hospitalized for childbirth. In addition, your newborn child(ren) may be covered as well. See below for more details and for a complete description of your available benefits, exclusions and limitations, see your certificate of insurance and any riders.

IF CHILD COVERAGE IS EFFECTIVE BEFORE THE CHILD IS BORN: Benefits will apply just as they would for any other child.

IF CHILD COVERAGE IS NOT EFFECTIVE BEFORE THE CHILD IS BORN: No benefits are payable.

*An Intensive Care Unit may be referred to as a "Critical Care Unit" in your certificate of coverage. An ICU Transitional Care Unit may be referred to as a "CCU Step-Down Unit" in your policy documentation. Refer to your policy documentation for complete definitions and descriptions of each facility type.

LEGAL SERVICES

The following legal services are available through MetLaw:

- Preparation of wills and trusts
- Real estate matters
- Consumer protection
- Document preparation and review
- Traffic and juvenile matters
- Family law, including adoptions
- Debt matters, including identity theft defense

MetLaw provides easy, direct access to Hyatt Legal's network of more than 12,000 attorneys who provide telephone and office consultations and advice on an unlimited number of personal legal matters. Services are fully covered for most frequently needed personal legal matters. Please refer to the Reference Center on the Benefitsolver portal for more information.

TRANSPORTATION AND PARKING REIMBURSEMENT ACCOUNTS

You are eligible to participate in the transportation and parking reimbursement accounts through Navia. These plans allow you to pay for your work-related mass transit and parking expenses on a pre-tax basis.

Eligible transportation expenses are work-related expenses incurred by you and not your spouse or dependent. To be qualified for reimbursement, the expenses must be incurred because you commute to work on mass transit facilities or for transportation provided by an entity using a highway vehicle with a seating capacity of at least six adults. Eligible expenses include any pass, token, fare card, voucher or similar item purchased for mass transit.

IMPORTANT

If you wish to participate in the transportation and/or parking reimbursement accounts for 2025, you must re-enroll in the plan.

Eligible parking expenses must take place at or near your place of employment, or at a location from which you commute to work.

The maximum contribution and reimbursement amount is $315 per month. Election changes may be made monthly but cannot be made retroactively. You may request reimbursement from Navia only for the amount you have already contributed during the year, less any reimbursements received.

Further details on allowable transportation and parking expenses can be found by calling the Navia customer service line or by visiting the Navia website, naviabenefits.com.

	Transportation	Parking
Purpose of Account	Pay for qualified work-related transit using public transportation or commuter vehicles	Pay for qualified parking expenses at or near your place of work
Owner of Account	Employee/Employer	Employee/Employer
"Use It or Lose It" Provision	No	No
Annual Contribution Limit	$315 per month	$315 per month
Elections	Monthly	Monthly
Plan Carrier	Navia	Navia

2025 PREMIUMS

Semi-Monthly Contributions

Medical and Prescription Plan

Rates DO NOT reflect the wellness credit for completion of the wellness incentive program.

	PPO Plan Preferred Care Blue	HRA Plan Preferred Care Blue	QHDHP Preferred Care Blue
Employee Only	$138.00	$98.50	$90.00
Employee + Spouse	$317.00	$213.00	$191.50
Employee + Child(ren)	$277.00	$179.50	$164.50
Employee + Family	$371.50	$265.00	$239.00

Dental

	Low Plan	High Plan
Employee Only	$4.71	$9.09
Employee + 1	$9.83	$18.94
Employee + 2 or More	$18.41	$33.72

Vision

Employee Only	$2.84
Employee + Spouse	$5.72
Employee + Child(ren)	$6.19
Employee + Family	$9.48

Supplemental, Spousal & Children Life Insurance

Rate per $1,000 of Coverage

Employee/Spouse*	
Under 25	$0.030
25-29	$0.030
30-34	$0.040
35-39	$0.045
40-44	$0.055
45-49	$0.095
50-54	$0.165
55-59	$0.295
60-64	$0.360
65-69	$0.635
70-74	$1.030
75+	$1.630
Child Optional Life	
Per $1,000 of Benefit	$0.060

*Both Supplemental and Spousal Life Insurance rates are based upon the employee's age.

Supplemental AD&D

Rate per $1,000 of Coverage

Employee Only	Employee + Family
$0.0085	$0.0135

Long-Term Disability

Rate per $100 of Monthly Income

50% Coverage	60% Coverage
$0.096	$0.172

Example: An employee who elects 50 percent coverage and has a total compensation of $50,000 will pay a semi-monthly premium of: $3.99.

Semi-Monthly Contributions

Group Accident Insurance

Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
$5.91	$9.61	$10.32	$14.01

This is not health insurance and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.

Hospital Indemnity

Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
$5.88	$12.93	$11.53	$18.58

This is not health insurance and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.

Legal Services

All Tiers
$9.00

Critical Illness

Rate per $1,000 of Coverage

Non-Tobacco Rates	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
Age Band				
Under 25	$0.10	$0.20	$0.35	$0.45
25-29	$0.15	$0.29	$0.40	$0.54
30-34	$0.19	$0.37	$0.44	$0.62
35-39	$0.24	$0.47	$0.49	$0.72
40-44	$0.30	$0.60	$0.55	$0.85
45-49	$0.52	$1.04	$0.77	$1.29
50-54	$0.65	$1.30	$0.90	$1.55
55-59	$0.93	$1.85	$1.18	$2.10
60-64	$1.20	$2.40	$1.45	$2.65
65-69	$1.71	$3.42	$1.96	$3.67
70 +	$2.26	$4.52	$2.51	$4.77
Tobacco Rates	**Employee Only**	**Employee + Spouse**	**Employee + Child**	**Family**
Age Band				
Under 25	$0.11	$0.21	$0.36	$0.46
25-29	$0.17	$0.34	$0.42	$0.59
30-34	$0.24	$0.48	$0.49	$0.73
35-39	$0.35	$0.69	$0.60	$0.94
40-44	$0.53	$1.05	$0.78	$1.30
45-49	$0.80	$1.60	$1.05	$1.85
50-54	$1.20	$2.40	$1.45	$2.65
55-59	$1.75	$3.50	$2.00	$3.75
60-64	$2.38	$4.75	$2.63	$5.00
65-69	$3.45	$6.90	$3.70	$7.15
70 +	$4.53	$9.05	$4.78	$9.30

Premiums for coverage are based on your age, the coverage amount you have elected and your tobacco use status.

This is not health insurance and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.

2025 PREMIUMS

Weekly Contributions

Medical and Prescription Plan

Rates DO NOT reflect the wellness credit for completion of the wellness incentive program.

	PPO Plan Preferred Care Blue	HRA Plan Preferred Care Blue	HSA Preferred Care Blue
Employee Only	$63.69	$45.46	$41.54
Employee + Spouse	$146.31	$98.31	$88.38
Employee + Child(ren)	$127.85	$82.85	$75.92
Employee + Family	$171.46	$122.31	$110.31

Dental

	Low Plan	High Plan
Employee Only	$2.17	$4.19
Employee + 1	$4.54	$8.74
Employee + 2 or More	$8.49	$15.56

Vision

Employee Only	$1.31
Employee + Spouse	$2.64
Employee + Child(ren)	$2.85
Employee + Family	$4.38

Supplemental, Spousal & Children Life Insurance

Rate per $1,000 of Coverage

Employee/Spouse*	
Under 25	$0.014
25-29	$0.014
30-34	$0.018
35-39	$0.021
40-44	$0.025
45-49	$0.044
50-54	$0.076
55-59	$0.136
60-64	$0.166
65-69	$0.293
70-74	$0.475
75+	$0.752
Child Optional Life	
Per $1,000 of Benefit	$0.014

*Both Supplemental and Spousal Life Insurance rates are based upon the employee's age.

Supplemental AD&D

Rate per $1,000 of Coverage

Employee Only	Employee + Family
$0.004	$0.006

Long-term Disability

Rate per $100 of Monthly Income

50% Coverage	60% Coverage
$0.044	$0.079

Example: An employee who elects 50 percent coverage and has a total compensation of $50,000 will pay a weekly premium of: $1.83.

Weekly Contributions

Group Accident Insurance

Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
$2.73	$4.44	$4.76	$6.47

This is not health insurance and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.

Hospital Indemnity

Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
$2.71	$5.97	$5.32	$8.58

This is not health insurance and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.

Legal Services

All Tiers
$4.15

Critical illness

Rate per $1,000 of Coverage

Non-Tobacco Rates	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
Age Band				
Under 25	$0.05	$0.09	$0.16	$0.21
25-29	$0.07	$0.13	$0.18	$0.25
30-34	$0.09	$0.17	$0.20	$0.29
35-39	$0.11	$0.22	$0.22	$0.33
40-44	$0.14	$0.28	$0.25	$0.39
45-49	$0.24	$0.48	$0.36	$0.60
50-54	$0.30	$0.60	$0.42	$0.72
55-59	$0.43	$0.85	$0.54	$0.97
60-64	$0.55	$1.11	$0.67	$1.22
65-69	$0.79	$1.58	$0.90	$1.69
70 +	$1.04	$2.09	$1.16	$2.20
Tobacco Rates	**Employee Only**	**Employee + Spouse**	**Employee + Child**	**Family**
Age Band				
Under 25	$0.05	$0.10	$0.16	$0.21
25-29	$0.08	$0.16	$0.19	$0.27
30-34	$0.11	$0.22	$0.23	$0.34
35-39	$0.16	$0.32	$0.27	$0.43
40-44	$0.24	$0.48	$0.36	$0.60
45-49	$0.37	$0.74	$0.48	$0.85
50-54	$0.55	$1.11	$0.67	$1.22
55-59	$0.81	$1.62	$0.92	$0.17
60-64	$1.10	$2.19	$1.21	$2.31
65-69	$1.59	$3.18	$1.71	$3.30
70 +	$2.09	$4.18	$2.20	$4.29

Premiums for coverage are based on your age, the coverage amount you have elected and your tobacco use status.

This is not health insurance and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.

CONTACTS

Blue Cross Blue Shield

Medical Insurance

Customer Service:
833-578-1131
myhealthtoolkitkc.com

Pharmacy Customer Service

855-811-2218

Teladoc

866-789-8155
teladoc.com

Delta Dental of Missouri

Dental Insurance

800-335-8266
burnsmcd.deltadentalmo.com

Surency

Vision Insurance

866-818-8805
surency.com/burnsmcd

Voya

Group Accident, Critical Illness, and Hospital Indemnity Insurance

877-236-7564
presents.voya.com/EBRC/BurnsMcDonnell

The Hartford

Life and Disability Insurance

877-426-6483
thehartford.com/employee-benefits/employees

MetLaw

Legal Services

800-821-6400
info.legalplans.com
Access Code: GETLAW

Navia Benefits

Flexible Spending Accounts (FSAs) Transportation and Parking Reimbursement Accounts

800-669-3539
naviabenefits.com/contact

HealthEquity (previously Further)

Health Savings Accounts (HSAs)

866-346-5800
healthequity.com

Chubb

Accidental Death and Dismemberment Insurance

866-324-8222
chubb.com

SupportLinc

Employee Assistance Program

888-881-5462
supportlinc.com
Code: bmcd

Livongo

Diabetes Management

800-945-4355
join.livongo.com/BMCD/register

Lockton Nurse Advocate

833-518-1630
Email: bmcdlna@lockton.com

Burns & McDonnell

On-Site Health Center

816-823-6000
mypremisehealth.com

On-Site Pharmacy

816-321-7821

Burns & McDonnell Benefits

Phone: 816-822-3400
Fax: 816-822-3516
Email: benefits@burnsmcd.com

A QUICK GUIDE TO INSURANCE TERMS

BALANCE BILLING: Balance billing is the practice by which out-of-network providers charge fees in excess of negotiated amounts and bill the patient for the portion of the bill that the insurance company or medical plan does not pay. In-network providers do not balance bill for covered services. They must agree to accept the exact amount paid by the plan (plus any member copayment and/or coinsurance) as stipulated in their contracts. Non-network providers, however, are not under contract so they can balance bill.

BENEFIT: Coverage for healthcare services available in accordance with the terms of your healthcare coverage.

BENEFITS-ELIGIBLE EMPLOYEE: Employees regularly scheduled to work 30 hours or more per week.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA): Gives employees and their families who lose their health benefits the right to choose to continue group health benefits provided by the company for limited periods of time under certain circumstances such as voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce and other life events.

COORDINATION OF BENEFITS (COB): A program that coordinates your health benefits when you have coverage under more than one group health plan (e.g., spouse's plan).

COINSURANCE: The designated portion of the approved amount you are required to pay for covered services. This amount is typically a percentage of the service cost.

CONVERSION AND PORTABILITY RIGHTS: If your life insurance ceases due to termination of employment or reduction of hours, you may convert or port your group life insurance into an individual life insurance policy.

COPAYMENT: A flat fee you pay for office visits to network providers at the time services are delivered. Also, a flat fee you pay for prescription drugs under the PPO or HRA plans.

COVERED SERVICES: Services, treatments or supplies identified as payable in the plan certificate. Covered services must be medically necessary to be payable, unless otherwise specified.

DEDUCTIBLE: The amount you owe for covered expenses before coinsurance begins.

EXPLANATION OF BENEFITS (EOB): A document sent by an insurer to a member explaining what was covered for a medical service, how they arrived at the insurance payment amount and patient responsibility amount.

EVIDENCE OF INSURABILITY (EOI): The application process in which you provide information on the condition of your health, or your dependent's health, in order to be approved for coverage.

FLEXIBLE SPENDING ACCOUNT (FSA): An FSA allows an employee to set aside a portion of his or her earnings to pay for expenses considered tax-deductible by the IRS, including healthcare, dependent care, and transportation expenses for commuting to and from work. Money contributed into an FSA is not subject to payroll taxes, resulting in a payroll tax savings.

HEALTH SAVINGS ACCOUNT (HSA): A medical savings account that allows employees to save for medical expenses on a pre-tax basis. You must be enrolled in a qualified high deductible health plan (QHDHP) to qualify for an HSA.

HSA CATCH-UP CONTRIBUTIONS: Employees 55 and older enrolled in the HSA may contribute an additional $1,000 (in 2023) to the maximum yearly contribution. These contributions must end when the individual enrolls in Medicare.

IMPUTED INCOME: The addition of the value of noncash benefit compensation to an employee's taxable wages in order to properly withhold income and employment taxes from the wages. Imputed income is taxable to the employee.

IN-NETWORK PROVIDERS/SERVICES: In-network providers are doctors who are contracted with the insurance company. In-network providers do not balance bill for covered services. They must accept the amount paid by the plan (plus any member copayment and/or coinsurance) as stipulated in their contracts. Out-of-network providers, however, are not under contracts so they can balance bill.

OUT-OF-NETWORK PROVIDERS/SERVICES: Out-of-network providers are doctors that are not contracted with an insurance company and may balance bill the member for covered services. If you choose to use an out-of-network doctor, services will not be provided at a discounted rate.

OUT-OF-POCKET MAXIMUM: This is the maximum amount of covered expenses the member will pay in a plan year. The out-of-pocket maximum is dependent on the medical plan you choose. After you have paid the annual out-of-pocket maximum (deductible included), the plan usually pays the full cost of covered expenses: for the remainder of the plan year.

PREFERRED PROVIDER ORGANIZATION (PPO) PLANS: Allow you to choose any provider in or out-of-network; however, you receive greater benefits and discounts when you use in-network providers.

PRESCRIPTION DRUG TIERS:

- **GENERIC DRUGS (TIER 1):** A prescription drug approved by the federal FDA that is produced and sold without patent protection. A generic equivalent drug contains the same active ingredient as a brand-name version. Since the major difference between brand-name and generic drugs is price, your prescription will automatically be filled with the generic equivalent when medically appropriate. Generic drugs also require the lowest copayment, making them the most cost-effective option for treatment.
- **PREFERRED BRAND (TIER 2):** Products are typically lower-costing brands or brands without generic equivalents within the drug classification.
- **NONPREFERRED BRAND (TIER 3):** Products are usually higher-costing, newer drugs that have good generic or significantly lower-costing brand alternatives available within the drug classification. However, nonpreferred drugs also include specialty drugs that may only be available in the nonpreferred brand tier, as the drugs are used to treat complex and rare conditions and have no generic alternatives.

PRIOR AUTHORIZATION: Prior authorization helps ensure that safe, high-quality, cost-effective medical services and drug therapy are prescribed prior to the use of more expensive options that may not have proven value over current services or formulary medications. Please visit the My Health Toolkit portal for a list of drugs in which your doctor needs to request prior authorization before prescribing.

PROVIDER: A person (such as a physician) or a facility (such as a hospital) that provides services or supplies related to healthcare.

STEP THERAPY: Step therapy requires a member try lower cost medications before "stepping up" to drugs that cost more. The insurance company wants to know that less expensive options did not work before the plan covers the more costly drug. If you have tried alternative drugs with no success, your drug will be covered. If not, the drug may cost more or not be covered at all.

USUAL, CUSTOMARY AND REASONABLE (UCR): This is the rate paid within a range of common charges for a specific geographic region. The insurance company determines the UCR rates for all services offered and does not pay benefits or charges that exceed the UCR level. In other words, this is a "going rate" for services or procedures.

Description of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may be eligible to enroll yourself or your dependents in these plans in the future, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be eligible to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

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The descriptions of the benefits are not guarantees of current or future employment or benefits. If there is any conflict between this guide and the official plan documents, the official documents will govern.