2026

Employee Benefits Guide

advantive

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Medicare Part D Notice

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please refer to your Annual Notices for more details.

Welcome to your Benefits!

Whether you're enrolling in benefits for the first time, nearing retirement, or somewhere in between, Advantive supports you with benefit programs and resources to help you thrive today and prepare for tomorrow. Review the coverage and tools available to you to make the most of your benefits package.

This benefits guide highlights the main features of our employee benefits program and provides an overview of your healthcare, life, disability, and retirement benefits, among others. It does not include all plan rules, details, limitations, or exclusions. The terms of your benefit plans are governed by legal documents, including insurance contracts. Should there be an inconsistency between this brochure and the legal plan documents, the plan documents are the final authority. Advantive reserves the right to change or discontinue its employee benefits plans at any time.

Three Steps to Enroll in Your 2026 Benefits!

Open Enrollment is your annual opportunity to make changes to your benefits for the coming year.

1) Learn: Review the annual enrollment materials provided by Advantive.
2) Decide: Determine which plans are right for you and your family next year.
3) Enroll: This year is an "active enrollment," which means that you MUST enroll or waive benefit options in Dayforce by the December 5th deadline, or you will not have benefit coverage beginning January 1, 2026.

Need Help Deciding?

Try our new Nayya Decision Support Tool (through our partnership with Symetra) to compare plans and get personalized recommendations for your 2026 benefits.

Eligibility

If you are a U.S. based, full-time employee working at least 30 hours per week, you are eligible for benefits. Most of your benefits are effective on your date of hire. You may also enroll your eligible dependents for coverage. Eligible dependents could be:

- Your legal married spouse or qualified domestic partner
- Natural, adopted or stepchildren up to age 26
- Children over age 26 who are disabled and depend on you for support
- Children named in a Qualified Medical Child Support Order (QMCSO).

Changing Benefits After Enrollment

During the year, you cannot make changes to your benefits unless you have a qualified life event. If you do not make changes to your benefits within 31 days of the qualified life event, you will have to wait until the next annual open enrollment period to make changes (unless you experience another qualified life event). For additional coverage information, please refer to the benefit booklets for each benefit. Dependents must meet eligibility requirements. Please see "Determining Eligibility" for important information on termination of coverage for ineligible dependents.

Qualified Life Event		Documentation Needed
Change in marital status	Marriage	Copy of marriage certificate
	Divorce/Legal separation	Copy of divorce decree
	Death	Copy of death certificate
Change in number of dependents	Birth or adoption	Copy of birth certificate or copy of legal adoption papers
	Stepchild	Copy of birth certificate plus a copy of the marriage certificate between employee and spouse
	Death	Copy of death certificate
Change in employment	Change in your eligibility status (i.e., full-time to part-time)	Notification of increase or reduction of hours that changes coverage status
	Change in spouse's benefits or employment status	Notification of spouse's employment status that results in a loss or gain of coverage

Decide with Confidence.

Introducing the Nayya Choose Decision Support Tool!

Visit
www.app.nayya.com/users/sign_in
to get started!

NAYYA

Need Help Choosing Plans?

NAYYA explains your benefits options and helps you choose what's best for you. This is an interactive, online tool that works on any computer, tablet, or smartphone. NAYYA is an expert on Advantive's benefits. Using it can help you pick benefits that provide the right level of coverage for your needs without taking too much money out of your paycheck.

How NAYYA Works

- First, NAYYA will ask some questions about your personal situation so it can better understand your needs. (Don't worry—everything you share with NAYYA is completely anonymous and confidential.)
- Then you'll be matched with the plan options that fit you best. You can also see why NAYYA thinks the recommended plan is better for you than your other options.

For First-Time Access

If you're accessing NAYYA for the first time, please use the following steps:

1. Go to the NAYYA sign-up page: https://app.nayya.com/users/sign_up.
2. Make sure to use your employer email address when signing up. This will ensure that you can successfully log in and access your personalized benefits information.
3. Answer a few questions about yourself and your family through NAYYA's secure survey.
4. Get matched with a benefits package customized to your needs a budget.
5. Continue onto Dayforce to complete your benefits enrollment utilizing the recommendations from your survey.

Need Help?

If you encounter any issues or have any questions during this process, The NAYYA Support Team is here to help! You can reach NAYYA at support@nayya.com. They're available Monday through Friday, from 9:00 am to 5:00 pm ET.

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Medical

Medical insurance is essential to your well-being, and our medical coverage provides you and your family the protection you need for everyday health issues or when the unexpected happens.

Parts of Your Medical Plan

- **Preventative care** is always 100% covered when you use in-network providers and includes things like physical exams, flu shots, and screenings.
- **Annual deductibles** are the amount you pay each year for eligible in-network and out-of-network charges before the plan begins to pay.
- **Annual out-of-pocket maximums** are the most you will pay each year for eligible in-network and out-of-network services, including prescriptions. After you reach your out-of-pocket maximum, the plan picks up the full cost of covered medical care for the remainder of the year.
- **Copays** are fixed amounts you pay for healthcare services. Copays do not count toward your deductible, but they do count toward your annual out-of-pocket maximum.
- **Coinsurance** is your share of the cost of care after you've met your deductible.

Domestic Partner Notice

Please note that domestic partner coverage can differ from spouse coverage when Medicare eligibility is a factor. Medicare is the primary payer for domestic partners with large employer group health plan coverage if a domestic partner can get Medicare due to their age and has group health plan coverage through their partner's current employer.

Medical Plan Comparison

You may visit any medical provider you choose, but in-network providers offer the highest level of benefits and lower out-of-pocket costs. In-network providers charge members reduced, contracted fees instead of their typical fees. Providers outside the plan's network set their own rates, so you may be responsible for the difference if a provider's fees are above the reasonable and customary limits.

	Cigna $3,400 HDHP Base Plan		Cigna $1,000 PPO Buy-Up Plan	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
You Pay				
Calendar Year Deductible				
Individual	$3,400	$9,000	$1,000	$5,000
Family	$6,600	$18,000	$3,000	$15,000
Calendar Year Out-of-Pocket Maximum (includes deductible)				
Individual	$5,000	$12,000	$4,000	$10,000
Family	$10,000	$24,000	$8,000	$30,000
Coinsurance/Copays				
Preventive Care	Covered in full	50% after ded.	Covered in full	50% after ded.
PCP	20% after ded.	50% after ded.	$25 copay	50% after ded.
Specialist	20% after ded.	50% after ded.	$50 copay	50% after ded.
Urgent Care	20% after ded.	50% after ded.	$50 copay	50% after ded.
Emergency Room	20% after ded.		$350 copay + 20% after ded.	
In-Network – Retail Rx (up to 31-day supply)				
Tier 1: Generic	$5 copay		$10 copay	
Tier 2: Brand (preferred)	$30 copay		$35 copay	
Tier 3: Brand (non-preferred)	$75 copay		$70 copay	
In-Network – Mail Order Rx (up to 90-day supply)				
Mail Order (Tiers 1, 2, and 3)	3x retail		2.5x retail	

Save on Prescription Drugs

Ask for generics: Generic and brand-name drugs have the same active ingredients, which means they have the same efficacy for treating your condition. The main difference is the cost to you.

Brand-name drugs tend to be more expensive because of the lengthy drug development process. Manufacturers charge more to recoup costs. When a patent expires, other manufacturers can produce the medication and create competition.

Home delivery: Enjoy the convenience and savings of home delivery for medications you take on a regular basis through our mail-order prescription program. The larger 90-day supply is mailed directly to your home—saving you time and money.

Where to Go for Care

Becoming familiar with your options for medical care can save you time and money.

Health Care Provider		Symptoms	Average Cost	Average Wait
NON-EMERGENCY CARE				
Virtual Visits/ Telemedicine	Access to care via phone, online video, or mobile app whether you are home, work or traveling; medications can be prescribed. 24 hours a day, 7 days a week.	• Allergies • Cough / Cold / Flu • Rash • Stomachache	$	2 – 5 minutes
Doctor's Office	Generally, the best place for routine preventive care; established relationship; able to treat based on medical history. Office hours vary.	• Infections • Sore and strep throat • Vaccinations • Minor injuries, sprains, and strains	$	15 – 20 minutes
Retail Clinic	Usually, lower out-of-pocket cost than urgent care; when you can't see your doctor; located in stores and pharmacies. Hours vary based on store hours.	• Common infections • Minor injuries • Pregnancy tests • Vaccinations	$	15 minutes
Urgent Care	When you need immediate attention; walk-in basis is usually accepted. Generally, includes evening, weekend and holiday hours.	• Sprains and strains • Minor broken bones • Small cuts that may require stitches • Minor burns and infections	$$	15-30 minutes
EMERGENCY CARE				
Hospital ER	Life-threatening or critical conditions; trauma treatment; multiple bills for doctor and facility. 24 hours a day, 7 days a week.	• Chest pain • Difficulty breathing • Severe bleeding • Blurred or sudden loss of vision • Major broken bones	$$$$	4+ hours
Freestanding ER	Services do not include trauma care; can look similar to an urgent care center, but medical bills may be 10 times higher	• Most major injures except trauma • Severe pain	$$$$$$	Minimal

Note: Examples of symptoms are not inclusive of all health issues. Wait times described are only estimates. This information is not intended as medical advice. If you have questions, please call the phone number on the back of your medical ID card.

Virtual Care

When you need care—anytime, day or night—or when your primary care provider is not available, virtual care can be a convenient option. With virtual care, you don't have to drive to the doctor's office or sit in a waiting room when you're sick—you can see your doctor from the comfort of your own bed or sofa.

Find the right virtual care, on myCigna®:

Visit myCigna.com. Select the Find Care and Costs tab, or download the myCigna® app.

- **Primary Care**
- **Urgent Care**
- **Dermatology**
- **Women's Health**
- **Nutrition**
- **Physical Therapy**
- **MSK**
- **Speech Therapy**
- **Sleep Apnea**
- **Cardiac Health**
- **Chronic Pain**
- **Gastro Health**

When searching by doctor name, condition or keyword, you can select "virtual" providers or look for pop-up boxes showing relevant virtual care providers. **Register today and be ready when you need care.**

Cigna Programs

myCigna

Register online or download the myCigna app to your mobile device for help staying organized and in control of your health anytime, anywhere. Log in to:

- Track your account balances and deductibles
- Manage and calculate costs
- View, download or email ID card information
- Find doctors, dentists and pharmacies
- Refill Cigna Home Delivery prescriptions and view your order history
- View medication costs based on your plan and search for lower, cost-saving alternatives

The app is also available in Spanish.

Omada

Omada is a personalized program that surrounds you with the tools and support you need to reach your health goals, whether it's losing weight, managing diabetes, lowering your blood pressure, or improving your overall health. If you or your covered adult dependents are enrolled in the company medical plan through Cigna, are at risk for type 2 diabetes or heart disease or are living with diabetes or high blood pressure, you may apply to this program.

Cigna One Guide

Cigna One Guide helps you engage in your health and get the most out of your health plan. Connect with specially trained personal guides that help you:

- Find health care providers
- Locate health facilities (e.g., labs and urgent care centers)
- Refill prescriptions
- Estimate drug costs

Support is available from personal guides by calling or messaging through the app feature. You can use the Click to Chat feature to message a personal guide 9:00 am to 8:00 p.m. Monday – Friday. Or click on the call icon to talk to a personal guide.

Cigna Mental Health Resources

Headspace Care

Headspace Care virtually connects you with a certified coach via texting and app-based programs to help manage anxiety, depression and daily stressors – 24/7/365.

Talkspace

With Talkspace online therapy, you can regularly communicate with a licensed therapist 24/7 safely and securely from a phone or desktop. Download the Talkspace app on your smartphone or visit www.talkspace.com/covered to begin.

Supplemental Medical

Just as it sounds, supplemental medical plans can help you pay for costs you may incur after an accidental injury, illness or hospitalization. These plans offered through Symetra are 100% voluntary.

Accident Insurance

Accident insurance pays out a lump sum if you become injured as a result of an accident. Accident insurance may also complement health insurance if an accident causes you to have medical expenses that your health insurance doesn't cover.

Accident insurance covers qualifying injuries, which might include a broken limb, loss of a limb, burns, lacerations or paralysis. While health insurance companies pay your provider or facility, accident insurance pays you directly.

How Accident Insurance Works

Accident insurance policies can provide you with a lump sum paid directly to you that will help pay for a wide range of situations, including initial care, surgery, transportation and lodging, and follow-up care. Here's how it works:

- A set amount is payable based on the injury you suffer and the treatment you receive.
- Benefits are payable directly to you and can be used as you see fit.
- Coverage is available for you, your spouse and eligible dependent children.
- You do not need to answer medical questions or have a physical exam to get basic coverage.
- Accident insurance covers injuries that happen on the job or off the job.
- Benefit payments are not reduced by any other insurance you may have with other companies.

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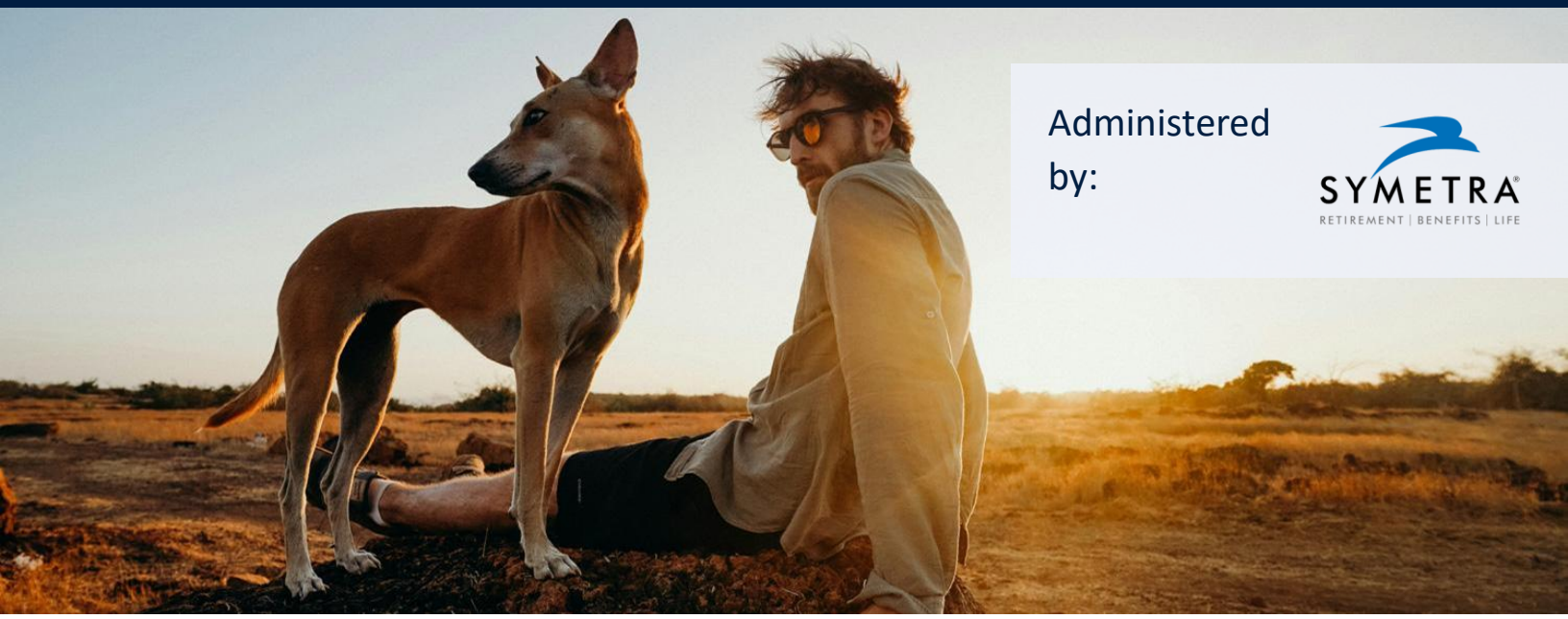

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Critical Illness Insurance

Even with major medical coverage, suffering a serious illness like cancer, heart attack or stroke comes with out-of-pocket expenses. Critical illness insurance will help ease the financial strain and help you worry while you recover.

How do claims get paid?

If you suffer from one of the serious illnesses covered by your policy, you'll be paid in a lump sum. The payment will go directly to you instead of to a medical provider. The payment you receive can be used however you see fit, for things like:

- Childcare costs
- Medical expenses
- Travel expenses for you and your family
- Lost wages from missed time at work
- Living expenses

Hospital Indemnity Insurance

A hospital stay can be costly, even if you have medical coverage. Hospital indemnity coverage can help cover your medical deductible or coinsurance if you are hospitalized by paying a lump-sum benefit directly to you. The plan covers employees who are admitted to a hospital or ICU for a covered sickness or injury.

Even if your medical insurance covers most of your hospitalization, you can use this benefit to pay extra expenses while you recover.

How does it work?

You pay monthly premiums for hospital indemnity insurance. If you are admitted to the hospital for an injury or illness, you'll need to file a claim to receive the benefit.

You can use your benefit however you see fit. That may include paying for your deductible, copays and coinsurance. Or you can use the benefit for personal costs, like childcare expenses or ordering takeout while you are in the hospital—the choice is yours!

Things to Consider

Your medical plan helps cover the cost of illness, but a serious or long-lasting medical crisis often involves additional expenses and may affect your ability to bring home a full paycheck. These plans provide you with resources to help you get by while there are additional strains on your finances.

See the Symetra documents for additional plan details, including the schedule of benefits.

Dental

Taking care of your oral health is not a luxury; it is a necessity for long-term optimal health. With a focus on prevention, early diagnosis and treatment, dental insurance can greatly reduce your costs when it comes to restorative and emergency procedures. Advantive's dental plans through Cigna cover preventive services—like exams and cleanings—at no cost to you. You'll pay only a small deductible and coinsurance for basic and major services.

When you visit a dentist in the **Cigna DPPO network**, you will maximize your savings. These dentists have agreed to reduced fees, which means you won't get charged more than you expected.

	Cigna DPPO Plan	
	IN-NETWORK	OUT-OF-NETWORK*
Calendar Year Plan Maximum		
Per Individual	$1,500 per individual (Preventive, Basic, and Major Services combined)	
You Pay		
Calendar Year Deductible		
Individual	$50	
Family	$150	
Preventive Care		
Exams, Cleanings, X-rays, etc.	Covered in full	
Basic Services		
Fillings, Sealants, Extractions, Emergency Exams	20%	
Major Procedures		
Crowns, Inlays/Onlays, Dentures and Bridgework, Repairs	50%	
Orthodontia		
Children (up to 19th birthday)	50%	

*Out-of-Network reimbursement is based on the 90th percentile of prevailing charges for the geographic area.

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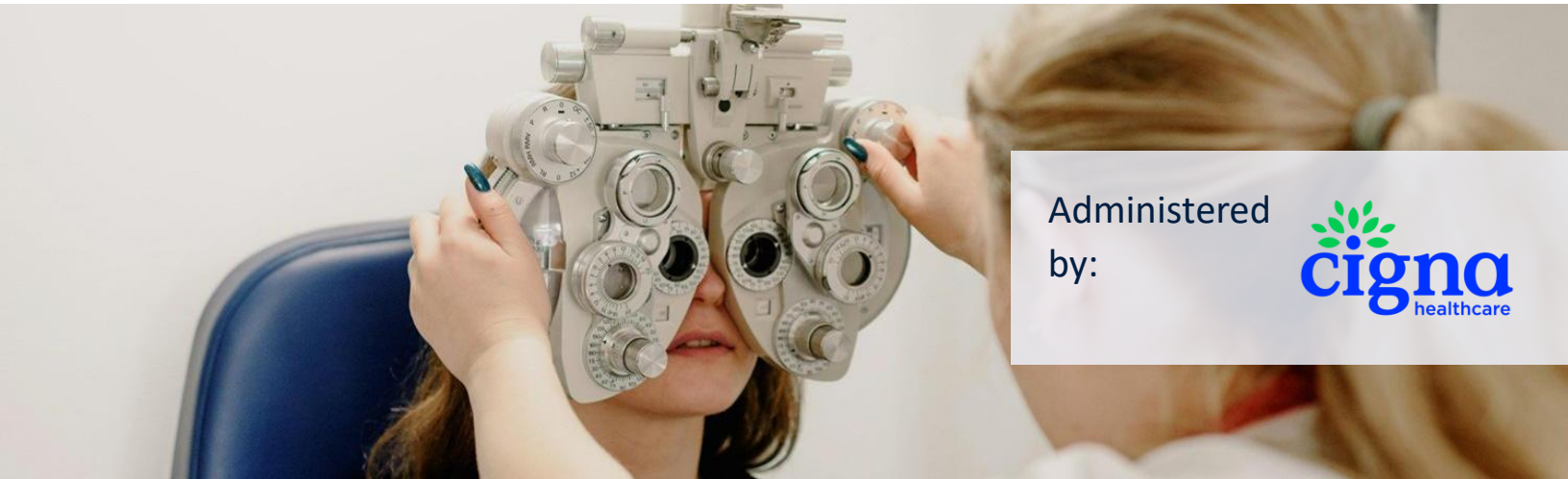
Vision

Healthy eyes and clear vision are important parts of your overall health and quality of life. You may enroll yourself and your eligible dependents, or you may waive vision coverage. You do not have to be enrolled in medical coverage to elect vision coverage, nor do you have to cover the same dependents under medical and vision.

The table below summarizes the key features of the vision plan. Please refer to the official plan documents for additional information on coverage and exclusions.

	Cigna Vision Plan serviced by EyeMed	
	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
	You Pay	**Reimbursement**
Exam	$10 copay	Up to $45
Single Lenses	$25 copay	Up to $32
Bifocals	$25 copay	Up to $55
Trifocals	$25 copay	Up to $65
Frames	Balance over $150 allowance (20% discount off balance over allowance)	Up to $83
Contacts in lieu of Frames/Lenses	Balance over $150 allowance Medically Necessary – 100% covered	Up to $210
Benefit Frequency		
Exams	Once every 12 months	
Lenses	Once every 12 months	
Frames	Once every 24 months	
Contacts	Once every 12 months	



Flexible Spending Accounts (FSA)

To help you pay for certain expenses using pretax dollars, you can participate in a healthcare or dependent-care reimbursement account, also known as a flexible spending account (FSA). There are two types of FSAs: the healthcare FSA and the dependent-care FSA.

When you enroll in an FSA, you choose to contribute a certain amount, through pretax payroll deductions during the year, to the account. Because your contributions are deducted before federal and Social Security taxes are withdrawn, you save money on your taxable income.

Think of an FSA as a personal checking account. You make regular deposits to your account through pretax payroll deductions. You are reimbursed when you incur eligible expenses.

Your contributions will be deducted from your paycheck in equal installments over the course of the calendar year. For example, if you choose to contribute $1,200 to your healthcare FSA, $50 would be withdrawn each pay period. Note that the entire contribution amount is available for reimbursement on Jan. 1.

Healthcare FSA

When you open a healthcare FSA, you can set aside pretax dollars to pay for the medical, dental and vision expenses not covered under your other benefit plans. You have until March 31 of the following year to submit claims for expenses incurred between January 1 and December 31 of the current plan year. Any unused funds from the current plan year will roll over to the next plan year, up to the maximum rollover amount of $680.

You will receive a debit card that will allow you to access funds from your healthcare FSA, if you choose to use one. You can use your debit card for prescription medications, as long as the funds are available.

Note: If you are a participant in an HSA, you are not eligible for the healthcare FSA.

Limited-Purpose Healthcare FSA

The limited-purpose healthcare FSA is for employees enrolled in the Cigna HDHP Plan. The limited-purpose healthcare FSA works the same way as the standard healthcare FSA: pretax contributions, "use it or lose it" elections and expenses must occur within the plan year. However, with the limited-purpose healthcare FSA, you can only submit claims for eligible vision and dental expenses.

Dependent-Care FSA

When you open a dependent-care FSA, you can set aside pretax dollars to pay for dependent-care costs. The money in your dependent-care FSA cannot be used to pay for your dependents' healthcare expenses. Healthcare expenses can be reimbursed only from your healthcare FSA (if you have elected one).

Please note: The rollover or debit card does not apply to the dependent-care FSA.

How much can I contribute?

Because these are tax-free accounts, the IRS limits how much you can contribute to these accounts annually. The 2026 limits are outlined below.

	Healthcare FSA	Dependent Care FSA
Annual Limit	$3,400	$7,500 per household

Remember: FSA accounts are "use it or lose it". All unused funds exceeding the rollover amount at the end of the calendar year will be forfeited so you should plan carefully.

Health Savings Account (HSA)

A health savings account (HSA) is a personal savings account you can use to pay for qualified out-of-pocket medical expenses with pretax dollars—now or in the future. Once you're enrolled in the HSA, you'll receive a debit card to help manage your HSA reimbursements. Your HSA can also be used for your expenses and those of your spouse and dependents, even if they are not covered by the HDHP medical plan.

How a Health Savings Account Works

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Eligibility

You must be enrolled in the Cigna HDHP Plan.

Contributions

For every dollar you contribute to your HSA, Advantive will match it up to the annual maximum amounts shown —helping you double your savings. Advantive will match up to **$600** (employee only) | **$1,200** (family) per year.

You contribute on a pretax basis and can change how much you contribute from each paycheck up to the annual IRS maximum (includes Advantive's contributions) of **$4,400**, or **$8,750** if you enroll in family coverage. You can make an additional catch-up contribution of $1,000 if you are 55 or older.

Eligible Expenses

You may use your HSA funds to cover medical, dental, vision and prescription drug expenses incurred by you and your eligible family members (List of Eligible Expenses).

Using Your Account

Use the debit card linked to your HSA to cover eligible expenses or pay for expenses out of your own pocket and save your HSA money for future healthcare expenses.

Always Yours—No Matter What

One of the best features of an HSA is that any money left in your account at the end of the year rolls over so you can use it next year or sometime in the future. And if you leave Advantive or retire, your HSA goes with you so you can continue to pay for or save for future eligible healthcare expenses.

The Triple Tax Advantage

In addition to saving money on premiums, HSAs offer you tax advantages like no other:

1) Use your HSA funds to cover qualified medical expenses – tax free.
2) Unused funds grow and can earn interest over time – tax free.
3) Save your HSA funds to use for your health care when you leave Advantive or retire – tax free.

If you like the idea of paying less per paycheck and saving tax-free money for future medical expenses, consider enrolling in an HDHP.

Income Protection

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Basic and Voluntary Life and AD&D

Life insurance pays a lump-sum benefit to your beneficiaries to help meet expenses in the event of your death. Accidental death & dismemberment (AD&D) insurance pays a benefit if you die or suffer certain serious injuries as the result of a covered accident. In the case of a covered accidental injury (e.g., loss of sight, loss of a limb), the benefit you receive is a percentage of your total AD&D coverage based on the severity of the accidental injury.

Imputed Income

Under IRS rules, employees are allowed to receive up to $50,000 of basic life insurance coverage without it being considered taxable income. Any amount more than the $50,000 threshold is considered taxable or imputed income.

In general, voluntary life coverage can also be subject to imputed income. If voluntary life premiums are paid with pre-tax dollars, the IRS considers that coverage to be employer-provided for tax purposes. This means that if your total life insurance coverage (basic + voluntary) is more than $50,000, the value of the coverage over that amount is considered imputed income and is subject to federal, Social Security, and state taxes (if applicable). The imputed income amount will appear in your paycheck and will also be reported on your W-2 each year.

Basic Life and AD&D Insurance: For You		
COVERAGE LEVEL	COVERAGE AMOUNT	EVIDENCE OF INSURABILITY/ PROOF OF GOOD HEALTH
Basic Life and AD&D	1 times annual earnings, up to $500,000	None
Voluntary Life and AD&D Insurance: For You and Your Dependents		
COVERAGE LEVEL	COVERAGE AMOUNT	EVIDENCE OF INSURABILITY/ PROOF OF GOOD HEALTH
Employee Only	Increments of $10,000 not to exceed 5 times your annual earnings or $500,000	Required for amounts greater than $100,000
Spouse	Increments of $5,000 up to $250,000—not to exceed 50% of employee coverage	Required for amounts greater than $20,000
Child(ren)	Increments of $2,000 up to $10,000	None

Guaranteed Issue and Evidence of Insurability

For 2026, new hires can elect up to the GI amount without completing an EOI. For those not currently enrolled, any new election would require an EOI. The same is true for those currently enrolled and looking to increase coverage in excess of the guaranteed issue amount.

See Dayforce for plan pricing and options.

Disability

Disability insurance can keep you financially stable should you experience a qualifying disability and become unable to work. A qualifying disability is a sickness or injury that causes you to be unable to perform any other work.

Short-Term Disability Benefits at a Glance	
Coverage	60% of your weekly earnings, to a $2,000 maximum for 12 weeks.
When Benefits Begin	Benefit begins after 7 days of disability.
Election Required	No election needed – Advantive provides this coverage at no cost to you.

Long-Term Disability Benefits at a Glance	
Coverage	60% of your pre-disability earnings, up to a maximum benefit of $10,000 per month until you recover or reach your Social Security normal retirement age, whichever is sooner.
When Benefits Begin	Benefit begins after 90 days of disability.
Election Required	No election needed – Advantive provides this coverage at no cost to you.

How STD and LTD Work Together

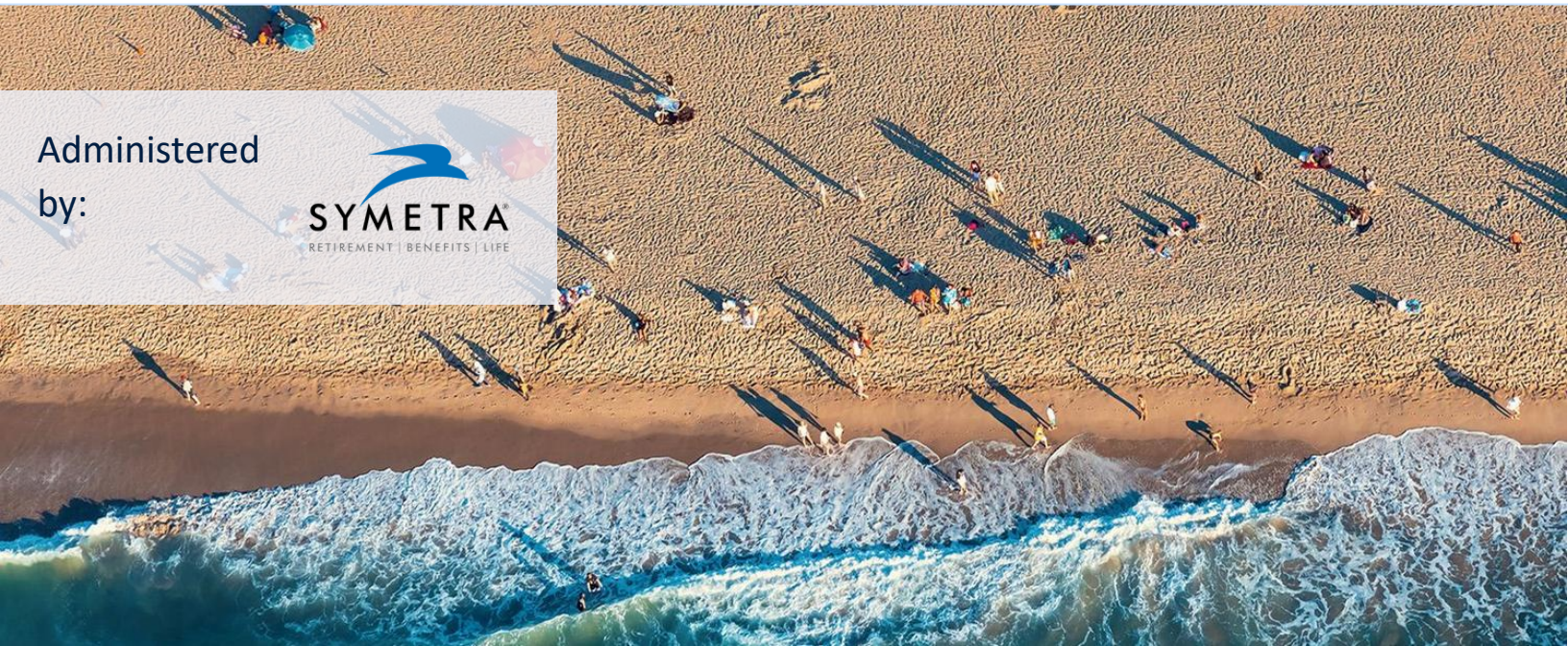
PTO pays 100% of your pay until STD begins.

→

After 7 days of sickness or injury, approved STD pays a portion of your income.

→

After 90 days, LTD begins if approved.



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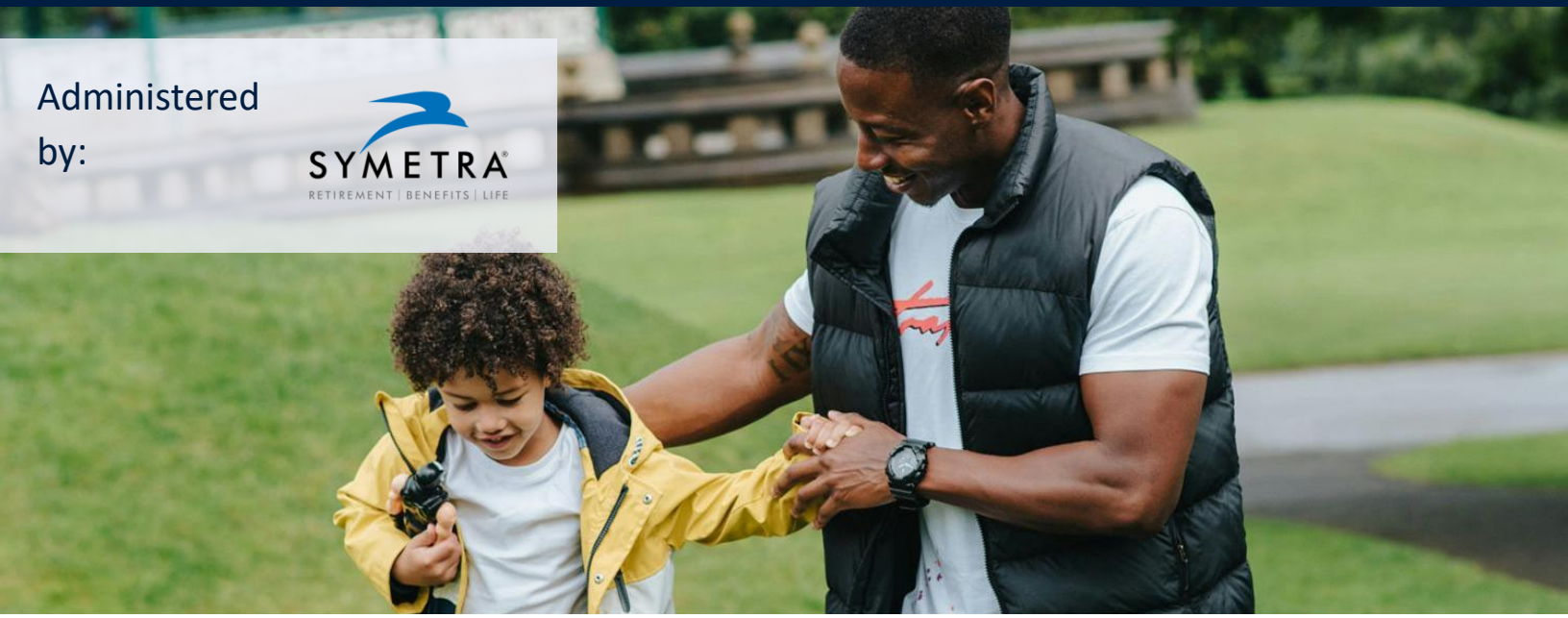


Employee Assistance Program

You automatically have access to the employee assistance program (EAP). This program provides up to five professional, confidential telephonic or face-to-face counseling services to you and your household members at no cost. The EAP can help you resolve personal issues and problems before they affect your health, relationships and work performance.

It's important to note that all EAP conversations are voluntary and strictly confidential. If you and your counselor determine that additional assistance is needed, you'll be referred to the most appropriate and affordable resource available. Although you're responsible for the cost of referrals, these costs are often covered under your medical plan.

This program is available 24 hours a day, 365 days a year for confidential counseling, referral and follow-up services for issues such as:

- Stress
- Marital or family problems
- Anxiety and depression
- Substance use (alcohol and/or drugs)
- Financial issues
- Childcare issues—including identifying schools, daycare and tutors
- Aging parents

Accessing Services

Employees can call toll-free: **1-888-327-9573**. The website, www.guidanceresources.com, provides access to self-assessment tools; tailored searches for child and elder care, attorneys and CPAs; and other helpful services.

Use SYMETRA in the Organization Web ID field to login.

Note: In California, counseling sessions are limited to three sessions in a six-month period.

Additional Benefits

Advantive's Benefit Website

Visit www.advantive.mybenefits.life for your one-stop for all our benefits plans, including the retirement 401(k) plan. You can access helpful links, educational videos, benefit highlights, official carrier documents, plan pricing, important notices, and more from our website!

Legal Program

You have access to legal advice and representation through LegalShield.

Get protection with access to a dedicated provider law firm for legal advice and services or assistance with legal issues like:

- Creating a will
- Reviewing rental agreements
- Traffic tickets
- Buying a house
- IRS audit
- and more

Identity Theft Protection

You also have access to identity consultation services and advice through IDShield. Services include but are not limited to:

- Dedicated licensed private investigator
- Identity, credit, and financial account monitoring
- Child monitoring (family plan only)
- Full-service ID restoration
- Real-time alerts
- 24/7 emergency access
- Social media monitoring and online privacy reputation management

Nationwide Pet Insurance

Let's not forget about our furry friends! Pet insurance helps offset the cost of caring for your pet with a wide range of covered medical treatments. With Nationwide Pet Insurance, you can get:

- Flexible insurance plans that can cover the entire pet family - all pets are welcome (dogs, cats, birds, rabbits, ferrets, reptiles, and exotic pets) with no age limits
- Visit any vet, anywhere, anytime
- Access to 24/7 Vet helpline
- Discounts and additional offers on pet care, when available
- Optional Preventive Care coverage
- And more!

Pricing is on an individual-basis and is based on your pet(s) animal type and age.

Alliant Benefit Advocates

Are you getting married and you're not sure how or when to add your new spouse to your plan? Is your stepchild eligible for your healthcare plan? Do you need help understanding the difference between an HSA and an FSA? A Benefit Advocate can help answer these questions and more!

Benefit Advocate Support

Your Benefit Advocate can help with:

- Medical, dental, vision, EAP, life/AD&D, and disability benefits
- General benefit questions
- Claims and appeals questions
- Prescription problems
- Questions covering HSA and FSA accounts
- Enrollment and eligibility questions
- COBRA inquires
- Medicare questions
- And more!

Contact your health plan directly for:

- Plan ID cards
- Submitting a new claim
- Verifying that your doctor is currently in-network
- Questions about HSA and FSA debit cards and account balances

HIPAA authorization for claims assistance:

If you need claims assistance, you may need to complete a HIPAA authorization form to grant your Benefit Advocate permission to work with your insurer and/or healthcare provider(s) to resolve your claims issues. Permission is granted on a limited-duration basis, and only to the individuals listed on the form. You can end the permissions granted by the form at any time. Your Benefit Advocate will provide the form to you when needed.

Benefit Questions?	401k Questions?
Contact Your Alliant Benefit Advocate	**Contact Your Alliant Retirement Consultant**
Email: SCR-support@alliant.com	**Email:** SCR-Retirement-Services@Alliant.com
Phone: (855) 889-3713	
Hours:	
› Monday – Thursday: 8 a.m.–5:30 p.m. CT	
› Friday: 8 a.m.–5 p.m. CT	

Administered by: Alliant

Alliant Medicare Solutions

Alliant Medicare Solutions is a no-cost service available to you, your family members, and friends nearing age 65. Visit **alliantmedicaresolutions.com** to learn more!

Turning 65? Understand Your Medicare Options

Whether you retire or continue to work, choosing the right healthcare option is an important decision when you reach age 65.

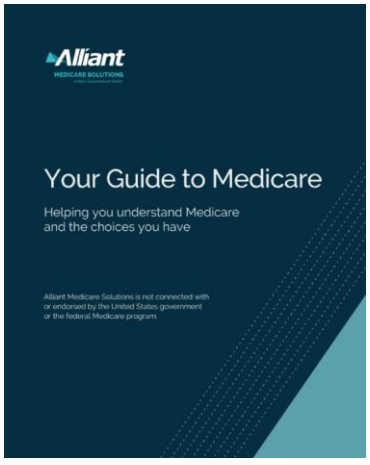
Most people become eligible for Medicare at age 65. When that happens, you'll probably have some time-sensitive decisions to make, based on your individual situation.

Introducing Alliant Medicare Solutions

Medicare can be complicated. Figuring out the rules—not to mention how Medicare works with or compares to your employer-provided medical coverage—can be a headache. That's why we are offering Alliant Medicare Solutions. The licensed insurance agents at AMS can help you understand Medicare, what is and isn't covered, and how to choose the best coverage for your situation.

How Does it Work?

1. Call Alliant Medicare Solutions at to speak to a licensed insurance agent. Have your current medical coverage information available when you call.
2. Discuss with Alliant Medicare Solutions your existing insurance coverage, your Medicare options, and which of those plans might work the best for you.
3. If Medicare is the best option, Alliant Medicare Solutions helps you enroll immediately or emails policy materials for you to review and enroll at a later date.



Your Guide to Medicare

Medicare 101 Video

Social Security Planning Video

Employee Contributions

Medical

Semi-Monthly Rates	Cigna Base $3,400 HDHP	Cigna Buy-Up $1,000 PPO
Employee Only	$0.00	$136.70
Employee + Spouse	$113.06	$330.81
Employee + Child(ren)	$79.10	$246.88
Employee + Family	$155.67	$455.48

Dental

Semi-Monthly Rates	Cigna DPPO Plan
Employee Only	$0.00
Employee + Spouse	$12.50
Employee + Child(ren)	$15.00
Employee + Family	$20.00

Vision

Semi-Monthly Rates	Cigna Vision Plan
Employee Only	$0.00
Employee + Spouse	$1.50
Employee + Child(ren)	$1.80
Employee + Family	$2.50

All Other Benefits

Plan options and rates are housed in the Dayforce Enrollment Portal.

Important Contacts

Carrier/Vendor	Benefit Covered	Website (www.)	Customer Service
Advantive's Benefit Website	All lines of coverage	https://advantive.mybenefits.life/	*HR@advantive.com*
Cigna Insurance	Medical, Dental, Vision	myCigna.com Policy #655815	1-866-494-2111 *(Or call the number on the back of your ID card)*
Symetra Life Insurance	Life, Disability, Worksite	https://www.symetra.com/ Policy #01-020746-00 (Life/DI) Policy #12739000 (Worksite) No ID Cards	1-888-327-9573
Symetra EAP	Employee Assistance Program	https://guidanceresources.com Web ID: SYMETRA	1-888-327-9573
WEX Health	Health Savings Account & Flexible Spending Accounts	Group ID #47802 customerservice@wexhealth.com cobraadmin@wexhealth.com	1-866-451-3399
LegalShield and IDShield	Legal and ID Theft Protection	https://www.legalshield.com/ https://www.idshield.com/identity-theft-protection/	Legal – 1-800-654-7757 ID- 1-888-494-8519
Nationwide	Pet Insurance	https://benefits.petinsurance.com/advantive	1-877-738-7874

GLOSSARY

-A-

AD&D Insurance
An insurance plan that pays a benefit to you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you have a fatal accident.

Allowed Amount
The maximum amount your plan will pay for a covered healthcare service.

Ambulatory Surgery Center (ASC)
A healthcare facility that specializes in same-day surgical procedures such as cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery, and more.

Annual Limit
A cap on the benefits your plan will pay in a year. Limits may be placed on particular services such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service. After an annual limit is reached, you must pay all associated health care costs for the rest of the plan year.

-B-

Balance Billing
In-network providers are not allowed to bill you for more than the plan's allowable charge, but out-of-network providers are. This is called balance billing. For example, if the provider's fee is $100 but the plan's allowable charge is only $70, an out-of-network provider may bill YOU for the $30 difference (the balance).

Note: As of January 1, 2022 the "No Surprises Act" provides protections against surprise billing for emergency services, air ambulance services, and certain services provided by a non-participating provider at a participating facility. For these services, the member's cost are generally limited to what the charge would have been if received in-network, leaving any balance to be settled between the insurer and the out-of-network provider. Consult your health plan documents for details.

Beneficiary
The person (or persons) that you name to be paid a benefit should you die. Beneficiaries are requested for life, AD&D, and retirement plans. You must name your beneficiary in advance.

Brand Name Drug
A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine.

-C-

COBRA
A federal law that may allow you to temporarily continue healthcare coverage after your employment ends, based on certain qualifying events. If you elect COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage, you pay 100% of the premiums, including any share your employer used to pay, plus a small administrative fee.

Claim
A request for payment that you or your health care provider submits to your healthcare plan after you receive services that may be covered.

Coinsurance
Your share of the cost of a healthcare visit or service. Coinsurance is expressed as a percentage and always adds up to 100%. For example, if the plan pays 70%, your coinsurance responsibility is 30% of the cost. If your plan has a deductible, you pay 100% of the cost until you meet your deductible amount.

Copayment
A flat fee you pay for some healthcare services, for example, a doctor's office visit. You pay the copayment (sometimes called a copay) at the time you receive care. In most cases, copays do not count toward the deductible.

-D-

Deductible
The amount of healthcare expenses you have to pay for with your own money before your health plan will pay. The deductible does not apply to preventive care and certain other services.

Family coverage may have an *aggregate* or *embedded* deductible. Aggregate means your family must meet the entire family deductible before any individual expenses are covered. Embedded means the plan begins to make payments for an individual member as soon as they reach their individual deductible.

Dental Basic Services
Services such as fillings, routine extractions and some oral surgery procedures.

Dental Diagnostic & Preventive
Generally includes routine cleanings, oral exams, x-rays, and fluoride treatments. Most plans limit preventive exams and cleanings to two times a year.

Dental Major Services
Complex or restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Dependent Care Flexible Spending Account (FSA)
An arrangement through your employer that lets you pay for eligible child and elder care expenses with tax-free dollars. Eligible expenses include day care, before and after-school programs, preschool, and summer day camp for children under age 13. Also included is care for a spouse or other dependent who lives with you and is physically incapable of self-care.

-E-

Eligible Expense
A service or product that is covered by your plan. Your plan will not cover any of the cost if the expense is not eligible.

Excluded Service
A service that your health plan doesn't pay for or cover.

-F-

Formulary
A list of prescription drugs covered by your medical plan or prescription drug plan. Also called a drug list.

-G-

Generic Drug
A drug that has the same active ingredients as a brand name drug, but is sold under a different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor.

Grandfathered
A medical plan that is exempt from certain provisions of the Affordable Care Act (ACA).

-H-

Health Reimbursement Account (HRA)
An account funded by an employer that reimburses employees, tax-free, for qualified medical expenses up to a maximum amount per year. Sometimes called Health Reimbursement Arrangements.

Healthcare Flexible Spending Account (FSA)
A health account through your employer that lets you pay for many out-of-pocket medical expenses with tax-free dollars. Eligible expenses include insurance copayments and deductibles, qualified prescription drugs, insulin, and medical devices, and some over-the-counter items.

GLOSSARY

High Deductible Health Plan (HDHP)
A medical plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but you pay more health care costs (the deductible) before the insurance company starts to pay its share. A high deductible plan (HDHP) may make you eligible for a health savings account (HSA) that allows you to pay for certain medical expenses with money free from federal taxes.

-I-

In-Network
In-network providers and services contract with your healthcare plan and will usually be the lowest cost option. Check your plan's website to find doctors, hospitals, labs, and pharmacies. Out-of-network services will cost more, or may not be covered.

-L-

Life Insurance
An insurance plan that pays your beneficiary a lump sum if you die.

Long Term Disability Insurance
Insurance that replaces a portion of your income if you are unable to work due to a debilitating illness, serious injury, or mental disorder. Long term disability generally starts after a 90-day waiting period.

-M-

Mail Order
A feature of a medical or prescription drug plan where medicines you take routinely can be delivered by mail in a 90-day supply.

-O-

Open Enrollment
The time of year when you can change the benefit plans you are enrolled in and the dependents you cover. Open enrollment is held one time each year. Outside of open enrollment, you can only make changes if you have certain events in your life, like getting married or adding a new baby or child in the family.

Out-of-Network
Out-of-network providers (doctors, hospitals, labs, etc.) cost you more because they are not contracted with your plan and are not obligated to limit their maximum fees. Some plans, such as HMOs and EPOs, do not cover out-of- network services at all.

Out-of-Pocket Cost
A healthcare expense you are responsible for paying with your own money, whether from your bank account, credit card, or from a health account such as an HSA, FSA or HRA.

Out-of-Pocket Maximum
Protects you from big medical bills. Once costs "out of your own pocket" reach this amount, the plan pays 100% of most remaining eligible expenses for the rest of the plan year.

Family coverage may have an *aggregate* or *embedded* maximum. Aggregate means your family must meet the entire family out-of-pocket maximum before the plan pays 100% for any member. Embedded means the plan will cover 100% for an individual member as soon as they reach their individual maximum.

Outpatient Care
Care from a hospital that doesn't require you to stay overnight.

-P-

Participating Pharmacy
A pharmacy that contracts with your medical or drug plan and will usually result in the lowest cost for prescription medications.

Plan Year
A 12-month period of benefits coverage. The 12-month period may or may not be the same as the calendar year.

Preferred Drug
Each health plan has a preferred drug list that includes prescription medicines based on an evaluation of effectiveness and cost. Another name for this list is a "formulary." The plan may charge more for non-preferred drugs or for brand name drugs that have generic versions. Drugs that are not on the preferred drug list may not be covered.

Preventive Care Services
Routine healthcare visits that may include screenings, tests, check-ups, immunizations, and patient counseling to prevent illnesses, disease, or other health problems. Many preventive care services are fully covered. Check with your health plan in advance if you have questions about whether a preventive service is covered.

Primary Care Provider (PCP)
The main doctor you consult for healthcare issues. Some medical plans require members to name a specific doctor as their PCP, and require care and referrals to be directed or approved by that provider.

-S-

Short Term Disability Insurance
Insurance that replaces a portion of your income if you are temporarily unable to work due to surgery and recovery time, a prolonged illness or injury, or pregnancy issues and childbirth recovery.

-T-

Telehealth / Telemedicine / Teledoc
A virtual visit to a doctor using video chat on a computer, tablet or smartphone. Telehealth visits can be used for many common, non-serious illnesses and injuries and are available 24/7. Many health plans and medical groups provide telehealth services at no cost or for much less than an office visit.

-U-

UCR (Usual, Customary, and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care
Care for an illness, injury or condition serious enough that care is needed right away, but not so severe it requires emergency room care. Treatment at an urgent care center generally costs much less than an emergency room visit.

-V-

Vaccinations
Treatment to prevent common illnesses such as flu, pneumonia, measles, polio, meningitis, shingles, and other diseases. Also called immunizations.

Voluntary Benefit
An optional benefit plan offered by your employer for which you pay the entire premium, usually through payroll deduction.

Please note that this guide highlights some of the main features of your benefit programs but does not include all plan rules, features, limitations or exclusions. Legal documents, including insurance contracts, govern the terms of your benefit plans. Should there be any inconsistencies between this summary and the legal plan documents, the plan documents are the final authority.