This is *Alpha & Omega Building Services Insurance Open Enrollment 2/17/2021 thru 3/23/2021*
This is a time you can make changes to your current plans by adding or deleting benefits. This is also the time you can enroll if you did not earlier. If you do not want to make any changes, there is nothing you need to do as you will be map to the 2021 like plan. Any changes to your benefits must be made on the website Portal and completed prior to the deadline date of 3/23/2020.

If you want to add, delete, or enroll you will need to update your personal information on the Alpha & Omega Building Services Employee Portal. This will be used to either enroll for benefits or waiving benefits.

Section 1 Please review to confirm your information is correct.

Section 2 This is where you will put Dependent information if you want them to be covered with you.
Note Dependents coverage is 100% your cost!

Section 3 Please review the New Employee Benefits packets For Health, Dental, and Vision.
These plans will start 4/1/20201. Here you will select your benefit choices and who will be covered.

There are 2 Plan Groups.

United HealthCare Plans		American Worker Limited Fixed Indemnity Plans	
Plan 1 A	United Health Care HSA Base	Plan 2 A	American Worker Value
Plan 1 B	United Health Care Premier	Plan 2 B	American Worker Premier
Plan 1 C	United Health Care Dental	Plan 2 C	American Worker Dental
Plan 1 D	United Health Care Vision	Plan 2 D	American Worker Vision
If you currently have any of the UHC plans medical, dental, or vision they will remain the same. The UHC prescription co-pays have changes (see benefit sheet). If you have either of the American Worker Value or Premier, there have been enhancements to the pay-outs and the weekly rates have gone down (see benefit sheets). The American Worker dental and vision are the same have no changes to coverage or cost.			

You will need to put your Plan choices in the appropriate box / boxes for all that you want covered.

Section 4 If and only if you take either United Health Care Medical (Plan 1 A or Plan 1 B) or either American Worker Limited Fixed Indemnity (Plan 2 A or Plan 2 B) you will need to put in your beneficiary information for the life insurance.

Section 5 If you do not want/need coverage put you initials in the boxes of the coverage you do not want and all that this may apply. **If you do not want any coverage from either Plan 1 or Plan 2 put Waive All Coverage with reason why.**

Section 6 Here you need to Sign and date.

If you have any questions best way to reach me 513-602-6563.
Thanks,
Bob

Robert L. Cooney
EMPLOYEE BENEFITS PLUS
3386 Socialville Foster Rd.
Maineville, OH 45039
Office 513-459-2255
Cell 513-602-6563
Fax 866-593-4212
rlcooney1@gmail.com

UnitedHealthcare

Medical Proposed Rates for ALPHA & OMEGA BUILDING SERVICES INC

Effective Date: 4/01/2021 | Customer Number 009S9107

Plan 1 A

NEW PHARMACY BENEFITS

Plan Name	ANEQ (HSA) Rx Plan: C24-HSA
Product	Choice HMO *
Check on Doctors & Hospitals	www.Welcometouhc.com
	Click on Find Doctor (Don't select "Currently a Member")
Pick your Network	Select Choice HMO (Network Plan)
	Click on Change Location (Put in your zip Code)
	Select People or Places to verify who is in network
HRA or HSA	HSA
Benefits*	**Network Single/Family**
Office Copay (PCP/SPC)	PCP D&C, SPC D&C
Hospital Copays	OP D&C, IP D&C
UC/ER/Major Diag Copay	UC D&C, ER D&C, MD D&C
Other	N/A
Deductible	$5,000/$10,000 (Emb)
Coinsurance	80%
Out-of-Pocket	$6,550/$13,100
Pharmacy	$10/40/85/250, 2.5x MO (Essential PDL)
	Out of Network Single/Family
Deductible	N/A
Coinsurance	N/A
Out of Pocket	N/A
Weekly Rates	**Weekly** Rates
Employee	**$64.78**
Employee + Spouse	**$207.31**
Employee + Child(ren)	**$181.40**
Employee + Family	**$323.92**

*High level benefit summary. Please see your plan summary for more detailed benefit description.

POD = Benefit paid as follows: Per Occurrence Deductible, then plan deductible and coinsurance.

LTD # = the number of services covered at that copay, after the limit plan deductible and coinsurance will apply, note PCP and SPC may be combined (see benefit

Day x# = the max number of days the copay will apply

UnitedHealthcare

Medical Proposed Rates for ALPHA & OMEGA BUILDING SERVICES INC

Effective Date: 4/01/2021 | Customer Number 009S9107

Plan 1 B

NEW PHARMACY BENEFITS

Plan Name	AXPG (Premier) Rx Plan: C24
Product	Choice + Insurance *
Check on Doctors & Hospitals	www.Welcometouhc.com
	Click on Find Doctor (Don't select "Currently a Member")
Pick your Network	Select Choice Plus (Network Plan)
	Click on Change Location (Put in your zip Code)
	Select People or Places to verify who is in network
HRA or HSA	No
Benefits*	**Network Single/Family**
Office Copay (PCP/SPC)	PCP $15/$15, SPC $50/$100
Hospital Copays	OP D&C, IP D&C
UC/ER/Major Diag Copay	UC $25, ER $300+D&C, MD D&C
Other	N/A
Deductible	$3,000/$6,000 (Emb)
Coinsurance	80%
Out-of-Pocket	$7,150/$14,300
Pharmacy	$10/40/85/250, 2.5x MO (Essential PDL)
	Out of Network Single/Family
Deductible	$7,500/$15,000 (Emb)
Coinsurance	50%
Out of Pocket	$15,000/$30,000
Weekly Rates	**Weekly** Rates
Employee	**$84.11**
Employee + Spouse	**$247.87**
Employee + Child(ren)	**$218.10**
Employee + Family	**$381.87**

*High level benefit summary. Please see your plan summary for more detailed benefit description.
POD = Benefit paid as follows: Per Occurrence Deductible, then plan deductible and coinsurance.
LTD # = the number of services covered at that copay, after the limit plan deductible and coinsurance will apply, note PCP and SPC may be combined (see benefit
Day x# = the max number of days the copay will apply

PLAN 1 C WEEKLY RATES

Employee $ 6.12 | Employee + Spouse $12.25
Employee + Child(ren) $15.76 | Employee + Family $23.17

UnitedHealthcare® FlexAppeal Enhanced dental plan

Consumer MaxMultiplier Voluntary National Options PPO 20 X9197 /MAC

Network/covered dental services

	NON-ORTHODONTICS		ORTHODONTICS	
	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK
Individual Annual Deductible	$50	$50	$0	$0
Family Annual Deductible	$150	$150	$0	$0
Annual Maximum Benefit* *(The total benefit payable by the plan will not exceed the highest listed maximum amount for either Network or Non-Network services.)*	$1000 per person per Calendar Year	$1000 per person per Calendar Year	$1000 per person per Lifetime	$1000 per person per Lifetime
Annual Deductible Applies to Preventive and Diagnostic Services	No			
Annual Deductible Applies to Orthodontic Services	No			
Waiting Period	No waiting period			
Orthodontic Eligibility Requirement	Child Only Up to Age 19			

COVERED SERVICES**	NETWORK PLAN PAYS***	NON-NETWORK PLAN PAYS****	BENEFIT GUIDELINES
PREVENTIVE & DIAGNOSTIC SERVICES			
Periodic Oral Evaluation	100%	100%	Limited to 2 times per consecutive 12 months.
Radiographs - Bitewing	100%	100%	Bitewing: Limited to 1 series of films per calendar year. Complete/Panorex: Limited to 1 time per consecutive 36 months.
Radiographs - Intraoral/Extraoral	100%	100%	Limited to 2 films per calendar year.
Lab and Other Diagnostic Tests	100%	100%	
Dental Prophylaxis (Cleanings)	100%	100%	Benefit is not to exceed in combination with periodontal maintenance 4 per consecutive 12 months.
Fluoride Treatments	100%	100%	Limited to covered persons under the age of 16 years and limited to 2 times per consecutive 12 months.
Sealants	100%	100%	Limited to covered persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.
Space Maintainers	100%	100%	For covered persons under the age of 16 years, limit 1 per consecutive 60 months.
BASIC DENTAL SERVICES			
Restorations; Amalgam or Composite (Anterior & Posterior)	80%	80%	Multiple restorations on one surface will be treated as a single filling.
General Services - Emergency Treatment	80%	80%	Covered as a separate benefit only if no other service was done during the visit other than X-rays.
General Services - Occlusal Guards	80%	80%	Limited to 1 guard every consecutive 36 months.
General Services - Anesthesia	80%	80%	When clinically necessary.
Simple Extractions	80%	80%	Limited to 1 time per tooth per lifetime.
MAJOR DENTAL SERVICES			
Oral Surgery - Brush Biopsy	50%	50%	
Oral Surgery - Surgical Extractions	50%	50%	
Oral Surgery - Partial/Bony	50%	50%	
Oral Surgery - Other	50%	50%	
Endodontics - Pulpotomy	50%	50%	Root Canal Therapy: Limited to 1 time per tooth per lifetime.
Endodontics - Other	50%	50%	
Periodontal Maintenance	50%	50%	Benefit is not to exceed in combination with dental prophylaxis 4 per consecutive 12 months.
Periodontics - Non Surgical	50%	50%	Scaling and Root Planing: Limited to 1 time per quadrant per consecutive 24 months.
Periodontics - Surgical	50%	50%	Limited to 1 quadrant or site per consecutive 36 months per surgical area.
Periodontics - Osseous Surgery	50%	50%	Limited to 1 quadrant or site per consecutive 36 months per surgical area.
Inlays/Onlays/Crowns**	50%	50%	Limited to 1 time per tooth per consecutive 60 months.
Dentures and other Removable Prosthetics	50%	50%	Full Denture/Partial Denture: Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.
Fixed Partial Dentures (Bridges)**	50%	50%	Limited to 1 time per tooth per consecutive 60 months.
Implant Services	50%	50%	Limited to 1 time per tooth per consecutive 60 months.
ORTHODONTIC SERVICES			
Diagnose or correct misalignment of the teeth or bite	50%	50%	

* This plan includes a maximum benefit award program. Some of the unused portion of your annual maximum benefit may be available in future benefit periods.

** Your dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exist, your plan bases reimbursement on the least costly treatment alternative. If you and your dentist have agreed on a treatment which is more costly than the treatment on which the plan benefit is based, you will be responsible for the difference between the fee for service rendered and the fee covered by the plan. In addition, a pre-treatment estimate is recommended for any service estimated to cost over $500; please consult your dentist.

*** The network percentage of benefits is based on the discounted fee negotiated with the provider.

**** The non-network percentage of benefits is based on the allowable amount applicable for the same service that would have been rendered by a network provider.

In accordance with the Illinois state requirement, a partner in a Civil Union is included in the definition of Dependent. For a complete description of Dependent Coverage, please refer to your Certificate of Coverage.

The Prenatal Dental Care (not available in WA) and Oral Cancer Screening programs are covered under this plan. The material contained in the above table is for informational purposes only and is not an offer of coverage. Please note that the above provides only a brief, general description of coverage and does not constitute a contract. For a complete listing of your coverage, including exclusions and limitations relating to your coverage, please refer to your Certificate of Coverage or contact your benefits administrator. If differences exist between this Summary Benefits and your Certificate of Coverage/benefits administrator, the Certificate/benefits administrator will govern. All terms and conditions of coverage are subject to applicable state and federal laws. State mandates regarding benefit levels and age limitations may supersede plan design features.

Plan 1 D

Plan S109V

Employee	$1.48
Employee + Spouse	$2.81
Employee + Child(ren)	$3.30
Employee + Family	$4.64

UnitedHealthcare®

Vision Benefit Summary

Customer Service and Provider Locator: (800) 638-3120

myuhcvision.com

UnitedHealthcare vision has been trusted for more than 50 years to deliver affordable, innovative vision care solutions to the nation's leading employers through experienced, customer-focused people and the nation's most accessible, diversified vision care network.
In-network, covered-in-full benefits (up to the plan allowance and after applicable copay) include a comprehensive exam, eyeglasses with standard single vision, lined bifocal, lined trifocal, or lenticular lenses, standard scratch-resistant coating and the frame, or contact lenses in lieu of eyeglasses. Members age 0-12 are eligible for a 2nd exam. Members age 0-12 are also eligible for a replacement frame and lenses if they have a prescription change of 0.5 diopter or more. The 2nd exam and replacement benefits are the same as the initial exam, frame and lens benefits.

	Exam with Materials
Benefit Frequency	
Comprehensive Exam(s)	Once every 12 months
Comprehensive Exam(s) for diabetics only	Twice every 12 months
Spectacle Lenses	Once every 12 months
Frames	Once every 24 months
Contact Lenses in Lieu of Eyeglasses	Once every 12 months
In-Network Services	
Copays	
Exam(s)	$ 10.00
Materials	$ 25.00
Retinal Screening for Diabetics	$ 0.00
Frame Benefit (for frames that exceed the allowance, an additional 30% discount may be applied to the overage)[1]	
Private Practice Provider	$130.00 retail frame allowance
Retail Chain Provider	$130.00 retail frame allowance
Lens Options	
Standard Scratch-resistant Coating,Polycarbonate Lenses for Dependent Children (up to age 19) - covered in full. Other optional lens upgrades may be offered at a discount. Based on state guidelines, lens materials and options may not be available at these discounted prices at all provider locations. Please ask your provider for details. The Lens Options list can be found at myuhcvision.com.	
Contact Lens Benefit[2]	
Elective contact lenses Allowance is applied toward the purchase of contact lenses. Materials copay is waived.	$125.00
Elective contact lens fitting and evaluation Allowance is applied toward the contact lens fitting/evaluation fees.	$30.00
Necessary contact lenses[3]	Covered in full after copay (if applicable).
Out-of-Network Reimbursements (Copays do not apply)	
Exam(s)	Up to $40.00
Frames	Up to $45.00
Single Vision Lenses	Up to $40.00
Lined Bifocal Lenses	Up to $60.00
Lined Trifocal Lenses	Up to $80.00
Lenticular Lenses	Up to $80.00
Elective Contacts in Lieu of Eyeglasses[2]	Up to $100.00
Contact Lens Fitting and Evaluation	Up to $0.00
Necessary Contacts in Lieu of Eyeglasses[3]	Up to $210.00

Discounts	
	Laser vision UnitedHealthcare offers members access to discounted laser vision correction providers. Members can receive discounts on laser vision correction procedures. For more information, visit myuhcvision.com.
	Additional Material At a participating in-network provider you will receive up to a 20% discount on an additional pair of eyeglasses or contact lenses. This program is available after your vision benefits have been exhausted. Please note that this discount shall not be considered insurance, and that UnitedHealthcare shall neither pay nor reimburse the provider or member for any funds owed or spent. Additional materials do not have to be purchased at the time of initial material purchase.
	Hearing Aids As a UnitedHealthcare vision plan member, you can save on custom-programmed hearing aids when you buy them from UnitedHealthcare Hearing. To find out more go to UHCHearing.com. When placing your order use promo code MYVISION to get the special price discount.

[1]30% discount available at most participating in-network provider locations. May exclude certain frame manufacturers. Please verify all discounts with your provider.
[2]Contact lenses are in lieu of eyeglass lenses and/or eyeglass frames.
[3]Necessary contact lenses are determined at the provider's discretion for one or more of the following conditions: Following cataract surgery without intraocular lens implant; to correct extreme vision problems that cannot be corrected with eyeglass lenses and/or frames; with certain conditions such as anisometropia, keratoconus, irregular corneal/astigmatism, aphakia, pathological myopia, aniseikonia, aniridia, facial deformity, or corneal deformity. If your provider considers your contacts necessary, you should ask your provider to contact UnitedHealthcare vision confirming the reimbursement that UnitedHealthcare will make before you purchase such contacts.

Important to Remember:

In-Network

- Always identify yourself as a UnitedHealthcare vision member when making your appointment. This will assist the provider in obtaining your benefit information.
- Patient options such as UV coating, progressive lenses, etc., which are not covered-in-full, may be available at a discount at participating providers. Based on state guidelines, lens materials and options may not be available at these discounted prices at all provider locations. Please ask your provider for details. The Lens Options list can be found at myuhcvision.com.

Choice and Access of Vision Care Providers

UnitedHealthcare offers its vision program through a national network including both private practice and retail chain providers. To access the Provider Locator service or for a printed directory, visit our website myuhcvision.com or call (800) 638-3120, 24 hours a day, seven days a week. You may also view your benefits, search for a provider or print an ID card online at myuhcvision.com.
Retain this UnitedHealthcare vision benefit summary which includes detailed benefit information and instructions on how to use the program. Please refer to your Certificate of Coverage for a full explanation of benefits.
In-Network Provider - Copays and non-covered patient options are paid to provider by program participant at the time of service.
Out-of-Network Provider - Participant pays all billed charges to the provider, and UnitedHealthcare reimburses the participant for services rendered up to the maximum allowance. Copays do not apply to out-of-network benefits. Receipts for payments should be submitted within 90 days after the date of service to the following address: UnitedHealthcare Vision, Attn. Claims Department, P.O. Box 30978, Salt Lake City, UT 84130. If it was not reasonably possible to give written proof in the time required, the Company will not reduce or deny the claim for this reason. However, proof must be filed as soon as reasonably possible, but no later than 1 year after the date of service unless the Covered Person was legally incapacitated.

Customer Service is available toll-free at (800) 638-3120 from 8:00 a.m. to 11:00 p.m. Eastern Time Monday through Friday, and 9:00 a.m. to 6:30 p.m. Eastern Time on Saturday.

This Benefit Summary is intended only to highlight your benefits and should not be relied upon to fully determine coverage. This benefit plan may not cover all of your healthcare expenses. More complete descriptions of benefits and the terms under which they are provided are contained in the certificate of coverage that you will receive upon enrolling in the plan. If this Benefit Summary conflicts in any way with the Policy issued to your employer, the Policy shall prevail.

UnitedHealthcare vision coverage provided by or through UnitedHealthcare Insurance Company, located in Hartford, Connecticut, UnitedHealthcare Insurance Company of New York, located in Islandia, New York, or its affiliates. Administrative services provided by Spectera, Inc., United HealthCare Services, Inc. or their affiliates. Plans sold in Texas use policy form number VPOL.18.TX or VPOL.18TX and associated COC form number VCOC.INT.18.TX or VCOC.CER.18.TX. Plans sold in Virginia use policy form number VPOL.18.VA or VPOL.18.VA and associated COC form number VCOC.INT.18.VA or VCOC.CER.18.VA. If you opt to receive vision care services or vision care materials that are not covered benefits under this plan, a participating vision care provider may charge you their normal fee for such services or materials. Prior to providing you with vision care services or vision care materials that are not covered benefits, the vision care provider will provide you with an estimated cost for each service or material upon your request. This cost may be higher than if you had received only covered vision services and you may incur addition out-of-pocket expenses. Eyewear materials may be ordered through the Spectera Eyecare Networks lab network with which UnitedHealthcare has a business relationship.

The American Worker®

Provided by Fringe Benefit Group

2021 Benefits Enrollment Guide

Alpha & Omega Building Services

Effective Date: April 1, 2021

Alpha & Omega Building Services values the contributions of our employees. In appreciation of your dedicated service, we are pleased to offer The American Worker program. Please carefully review this enrollment guide so you understand the benefits being provided and can make the right choices for you and your family.

About Your Coverage

FIXED INDEMNITY PLANS

- First dollar coverage for Doctor Office Visits, Diagnostic X-Rays and Lab Work, Hospital Stays and more
- Key features include no deductibles, copays, pre-existing condition limitations or waiting periods
- Prescription Drugs
- National PPO Network, PHCS

FREESTANDING COVERAGE OPTIONS

- Dental Coverage
- Vision Coverage

Take The Next Step

To enroll in benefit coverage, you will need to complete and return an enrollment application to your manager. If you are newly eligible for benefit coverage and do not enroll in coverage now, you will not be able to enroll until the next Open Enrollment period, unless you have a Qualifying Life Event.

Additional Contact Information

PHCS LIMITED BENEFIT NETWORK

Online: www.multiplan.com/awp
Phone: (888) 371-7427

CERPASSRX

Online: www.cerpassrx.com
Phone: (844) 636-7506

FIXED INDEMNITY

The American Worker Fixed Indemnity Plan provides affordable, first dollar coverage. The plan offers coverage for basic healthcare services and prescription drug discounts.

The Fixed Indemnity Plan is underwritten by Nationwide Life Insurance Company. The plan includes additional benefit plan features which are provided by separate vendors. **All benefits pay on a calendar year basis per person, unless stated otherwise.**

Services	Plan 2 A Value Plan	Plan 2 B Select Plan
Physician's Office	$60 per day; 6 days per year	$70 per day; 4 days per year
Outpatient Diagnostic Lab	$75 per testing day; 3 days per year	$75 per testing day; 3 days per year
Outpatient Diagnostic X-Ray	$75 per testing day; 2 days per year	$75 per testing day; 3 days per year
Outpatient Diagnostic Advanced Studies	$200 per testing day; 3 days per year	$300 per testing day; 3 days per year
Preventive Care	$50 per day; 1 day per year	$75 per day; 1 day per year
Emergency Room Sickness	$100 per day; 2 days per year	$150 per day; 2 days per year
Surgical Indemnity Benefit -Daily Inpatient Surgical -Daily Outpatient Surgical -Daily Outpatient Minor -Outpatient Benefit Maximum	N/A	 $3,000 per day, 1 day per year $1,500 per day $300 per day 1 day per year
Outpatient Surgical Facility	$250 per day; 1 day per year	$500 per day; 1 day per year
Anesthesia	30% of Surgical Benefit	30% of Surgical Benefit
Hospital Admission	$500 lump sum per confinement	$1,000 lump sum per confinement
Daily In-Hospital Indemnity Intensive Care Unit Substance Abuse Mental Illness Skilled Nursing (Inpatient)	$200 per day; 500 day lifetime max $400 per day; 30 days per year $100 per day; 30 days per year $100 per day; 30 days per year $100 per day; 60 days per stay	$300 per day; 500 day lifetime max $600 per day; 30 days per year $300 per day; 30 days per year $300 per day; 30 days per year $300 per day; 60 days per stay
*Prescription Drugs	Discount Rx Plan	Copay Rx Plan
*Accident Medical Expense	$5,000 maximum benefit per injury	
*Accidental Death & Dismemberment	$15,000 Employee / $7,500 Spouse / $3,000 Child	
*HealthiestYou	No cost access to doctors by phone or online	
*PHCS Network	Physician and Hospital	
Weekly Rates	**Value Plan**	**Select Plan**
Employee Only	$6.90	$18.35
Employee + Spouse	$17.68	$46.61
Employee + Child(ren)	$13.05	$35.43
Family	$19.94	$54.01

***Services not underwritten by Nationwide Life Insurance Company.**
Fixed Indemnity Plans are not available to residents of NH, VT & WA.

The Fixed Indemnity Plan is (a) not a substitute for minimum essential health coverage under the Affordable Care Act (ACA); and (b) does not qualify as minimum essential coverage under the ACA.

PHCS PPO Limited Benefit Network

All plan designs provide covered individuals access to a PPO Network that allows them to take advantage of network negotiated rates.

- **Limited Benefit Network:** www.Multiplan.com/awp
- **Call:** (888) 371-7427

Discount Rx Plan

Employees and their dependents pay the lesser of the pharmacy's usual and customary fee or the contract rate. Discounts are available on both generic and brand name drugs. Contraceptive drugs are included. Receive instant savings of up to 85% based on all FDA approved drugs (brand & generic) at the pharmacy filling the claim. No claim forms required. Prescriptions for 30-day supplies can be filled at more than 58,000 participating pharmacies nationwide including all of the national chains and over 90% of independent pharmacies.

Your discount may also apply to certain over-the-counter medications, diabetic supplies that have an NDC (National Drug Code), and even for certain pet medications that have human equivalent medications. For additional savings, you may also utilize our mail order pharmacy for 90 day supplies.

CERPASSRX

- **Visit:** www.cerpassrx.com
- **Call:** (844) 636-7506

Copay Rx Plan

- **Tier 1 (Most Generics):** $10 Co-Pay
- **Tier 2 (Some Generics & Preferred/Formulary Brand Name):** $50 or 50%; whichever is greater
- **Tier 3 (Non-Preferred / Non-Formulary Brand Name):** Employees pay 100% of the cost after pharmacy discounts

Mail Order option available for 90 day prescription supply.

- **Tier 1:** $25 copay
- **Tier 2:** $125 or 50%
- **Monthly Maximum:** $200 Employee / $400 Family
- No Deductible

CERPASSRX

- **Visit:** www.cerpassrx.com
- **Call:** (844) 636-7506

Ameritas

Dental Insurance

Keep a bright, healthy smile while supporting your overall well-being with affordable dental coverage.

LOCATE NETWORK PROVIDERS

Visit www.Ameritas.com
- Select **"FIND A PROVIDER"**
- Select **"DENTAL"**
- Select **"NETWORK PROVIDER"**
- Select **"CLASSIC PPO" network.**

Call (800) 659-2223
- Select **option 3**

Plan 2 C

Calendar Year Maximum	Up to $1,000 per Covered Member
Deductible	$0 per Visit
Covered Services	**Maximum Covered Expense***
Type 1 - No Waiting Period	
Comprehensive Oral Evaluation	$13.00
Bitewing - Single Radiographic Image	$4.00
Prophylaxis - Adult	$18.00
Sealant - Per Tooth	$10.00
Intraoral - Complete Series of Radiogrpahic Images	$27.00
Panoramic Radiographic Image	$22.00
Space Maintainer - Fixed - Unilateral	$64.00
Type 2 - No Waiting Period	
Amalgam - One Surface, Primary or Permanent	$26.00
Resin-based Composite - One Surface, Anterior	$32.00
Resin-based Composite - One Surface, Posterior	$35.00
Endodontic Therapy - Anterior Tooth	$160.00
Periodontal Scaling & Root planing - Four or More Teeth per quadrant	$54.00
Extractions	$29.00
Protective Restoration	$19.00
Type 3 - 12 Month Waiting Period	
Resin-based Composite - Crown, Anterior	$52.00
Prefabricated Porcelain/Ceramic - Crown - Primary Tooth	$48.00
Prefabricated Stainless Steel - Crown - Primary Tooth	$44.00
Prefabricated Resin Crown	$52.00
Inlay - Metallic - One Surface	$137.00
Onlay - Metallic - Two Surfaces	$178.00
Crown Resin-based Composite (indirect)	$78.00
Complete Denture - Maxillary	$222.00
Orthodontia - 12 Month Waiting Period	
Plan Benefit	50%
Lifetime Maximum (per person)	$500.00**
Coverage for Adults	No
Weekly Rates	
Employee Only	$2.55
Employee + Spouse	$4.46
Employee + Child(ren)	$5.88
Family	$7.78

***Maximum Covered Expense** is the maximum amount considered per procedure.
**Maximum not reduced by prior carrier payment.

Ameritas

Vision Insurance

A regular eye exam won't just help you see better, it can also detect the first signs of serious health conditions. Visit a VSP Choice provider to get the most benefit from the plan.

LOCATE NETWORK PROVIDERS

Call (800) 877-7195

Visit www.Ameritas.com

- Select **"FIND A PROVIDER"**
- Select **"VISION: VSP"**
- Select **"LOOK UP VSP PROVIDERS"**

Plan 2 D

Deductible	$10 Exam, $10 Eye Glass Lenses or Frames[1]	
Covered services	**VSP Choice Network**	**Out-of-Network**
Annual Eye Exam	Covered in Full	Up to $45
Lenses (per pair) Single Vision Bifocal Trifocal Lenticular	Covered in Full	 Up to $30 Up to $50 Up to $65 Up to $100
Frame Allowance	$150[2]	Up to $75
Contact Lenses Fit and Follow Up Exams Elective Medically Necessary	 Member cost up to $60 Up to $150 Covered in Full	 No Benefit Up to $120 Up to $210
Frequency Exam / Lens / Frames	Based on Date of Service 12 Months / 12 Months / 24 Months	
Lens Options[3]		
Std. Polycarbonate	Covered in full for dependent children $33.00 for Adults	No Benefit
Scratch Resistant Coating	$17.00 - $33.00	No Benefit
Anti-Reflective Coating	$43.00 - $85.00	No Benefit
Ultraviolet Coating	$16.00	No Benefit
Weekly Rates		
Employee	$2.32	
Employee + Spouse	$3.79	
Employee + Child(ren)	$3.78	
Family	$6.10	

[1]**Deductible applies to a complete pair of glasses or to frames, whichever is selected.**

[2]**The Costco allowance will be the wholesale equivalent.**

[3]**Lens Option member costs vary by prescription, option chosen and retail locations.**

Introduction

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It also can become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description, which will be mailed to you following your enrollment in the plan.

What is COBRA Continuation Coverage?

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

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan due to one of the following qualifying events:

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

If you are the spouse or domestic partner of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan due to any of the following qualifying events:

- Your spouse or domestic partner dies
- Your spouse's or domestic partner's hours of employment are reduced
- Your spouse's or domestic partner's employment ends for any reason other than his or her gross misconduct
- Your spouse or domestic partner's becomes entitled to Medicare benefits (under Part A, Part B, or both)
- You become divorced or legally separated from your spouse or domestic partner

Your dependent children will become qualified beneficiaries if they lose coverage under the plan due to any of the following qualifying events:

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

When is COBRA coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred.

The employer must notify the Plan Record-keeper if any of the following qualifying events occur: the end of employment, a reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

DISCLOSURES

Please refer to official insurance policy and plan documents for more extensive information concerning your benefit plans. In the event of any conflict between this guide and the official plan documents, the plan documents, policy and certificate of coverage will govern.

New Hampshire residents are not eligible for any of the benefit programs offered by The American Worker.

Fixed Indemnity: This program is not intended nor recommended to replace any comprehensive program of insurance in which you currently participate, or intend to participate. This plan is not designed to replace or provide major medical or catastrophic coverage. This brochure is for summary purposes only. The insurance benefits of the fixed indemnity plan are offered by Companion Life Insurance Company. Additional information will be provided upon enrollment in the program. Plan exclusions and limitations apply. **Massachusetts residents** are eligible for the Fixed Indemnity plan, but this plan does NOT meet Minimum Creditable Coverage standards.

The Fixed Indemnity Plan is (a) not a substitute for minimum essential health coverage under the Affordable Care Act (ACA); and (b) does not qualify as minimum essential coverage under the ACA.

Please Note: A separate claim form is needed for the Accident Medical & AD&D benefits. You may access the claim forms at www.TheAmericanWorker.com or by calling Member Services.

Accident Medical Expense: This is a brief summary of the Accident coverage available under this plan. The issued Policy contains the compete limitations, exclusions, definitions and plan provisions. Plan features and availability may vary by state. Full details of the coverage are contained in the Policy on file with the Policyholder. If any conflict should arise between the contents of this summary and the respective Policy, the terms of the Policy will govern in all cases.

NOTES

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