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WideOrbit, LLC

Health and Welfare Plan

# Master Summary Plan Description

Amended/Restated Effective January 1, 2022

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This document, together with the additional documents provided along with it, constitute the written plan document required by ERISA § 402 and the Summary Plan Description required by ERISA § 102.

**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 see the notice reproduced in Appendix B for more details.**

**This Wrap Summary Plan Document (SPD) has been formally modified through the Summary of Material Modification document(s) attached at the back of this document.**

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## 1. Definitions

Capitalized terms used in this document have the following meanings:

**"AD&D"** means accidental death and dismemberment insurance.

**"Affordable Care Act"** means the Patient Protection and Affordable Care Act, as amended.

**"COBRA"** means certain provisions of federal law that permit employees and covered dependents to extend health plan coverage in certain circumstances when it otherwise would be lost.

**"Code"** means the Internal Revenue Code of 1986, as amended.

**"Company"** means WideOrbit, LLC or any successor thereto, and any affiliated entity within the same controlled group, as that term is defined under section 414(b) of the Internal Revenue Code, that participates in the plan.

**"DCAP"** means a dependent care assistance program that may be established by the Company under a separate document. The DCAP is a benefit program under the Plan. It may allow you to use pre-tax dollars to pay for the care of your eligible dependents while you are at work. It is not subject to ERISA.

**"Employee"** means any common-law employee of the Company who satisfies the eligibility provisions of in this document and is not excluded from participation by the terms of an applicable benefit program. Individuals who are classified or treated by the Company as independent contractors (regardless of any subsequent reclassification), or as an employee of an employment agency are not eligible employee under the Plan. The Company, in its sole discretion may otherwise define classes or groups of employees who may be excluded from participation under certain benefit programs, such as temporary employees or interns.

**"ERISA"** means the Employee Retirement Income Security Act of 1974, as amended.

**"Health FSA"** means a health flexible spending account plan that may be established by the Company under a separate document. The health FSA is a benefit program under the Plan. It allows you to use before-tax dollars to pay for most medical and dental expenses not reimbursed under other programs.

**"HIPAA"** means the Health Insurance Portability and Accountability Act of 1996, as amended.

**"NMHPA"** means the Newborns' and Mothers' Health Protection Act of 1996, as amended.

**"Plan"** means the WideOrbit, LLC Health and Welfare Plan and includes this document, written amendments and updates to this document, and the terms of all policies and component benefit programs listed in Section 15.

**"Plan Administrator"** means the Company.

**"SPD"** means the Summary Plan Description required by ERISA § 102 summarizing this Plan and includes this document, information booklets supplied by insurance carriers, and other benefits descriptions provided to participants with this document or at any other period as appropriate to provide updates to the document, such as during open enrollment.

**"WHCRA"** means the Women's Health and Cancer Rights Act of 1998, as amended.

## 2. Introduction

The Company maintains the Plan for the exclusive benefit of eligible Employees and eligible family members or "dependents." It is important that you share this document and the materials referenced herein with your covered dependents. The Plan provides health and welfare benefits through the benefit programs listed in Section 15. See Section 15 for a listing of benefit programs and the entities that help administer the programs.

Each of these benefit programs is summarized in a certificate of insurance booklet issued by an insurance company, a summary plan description or another document (a "Benefit Description"). A Benefit Description will be available from the insurer (if the benefit is fully-insured) or Plan Administrator (if the benefit is self-funded). Whether a benefit program is fully-insured or self-funded is noted in Section 15.

This document and its attachments constitute the plan document required by ERISA § 402. This document and its attachments, coupled with the information booklets and other descriptive materials provided for benefits as described in Section 15 constitutes the wrap Summary Plan Description as required by ERISA § 102.

## 3. General Information about the Plan

<b>Plan Name:</b>	WideOrbit, LLC Health and Welfare Plan.
<b>Type of Plan:</b>	Health and Welfare plan providing coverages listed in Section 15. The Plan also includes funding through a cafeteria plan under Code § 125.
<b>Plan Year:</b>	January 1 to December 31.
<b>Plan Number:</b>	501
<b>Effective Date:</b>	January 1, 2008. The Plan has been amended several times since its original effective date, most recently as of January 1, 2022.
<b>Funding Medium and Type of Plan Administration:</b>	Some benefits under the Plan are self-funded, and some are fully insured. See Section 15 for a description of the benefit programs and whether they are self-funded or fully insured.

For benefit programs which are fully insured, benefits are insured under a group contract entered into between the Company and insurance companies or HMO.

The insurance companies and/or HMO, not the Company, are responsible for paying claims with respect to these programs. The Company shares responsibility with the insurance companies and/or HMO for administering these program benefits, as described below.

For benefit programs which are self-funded, the Company is responsible for processing and paying appropriate claims. The Company may hire a third party administrator (a "TPA") to process claims.

Premiums for Employees and their eligible family members may be paid in part by the Company out of its general assets and in part by Employees' pre-tax and/or post-tax payroll deductions. The Plan Administrator provides a schedule of the applicable premiums during the initial and subsequent open enrollment periods and on request for each of the benefit programs, as applicable.

The Company provides Employees the opportunity to pay for benefits on a pre-tax basis through a cafeteria plan. Appendix C provides information with regard to such a plan.

**Plan Sponsor:**

The employer is the Plan Sponsor.

WideOrbit, LLC  
1160 Battery Street East, Suite 300  
San Francisco, CA 94111  
1-415-675-6700

**Plan Sponsor's Employer  
Identification Number:**

94-3339060

**Insurance Companies/HMO:**

See a complete list under the heading Plan Provider Information later in this document.

**Plan Administrator:**

Attention: Human Resources  
WideOrbit, LLC  
1160 Battery Street East, Suite 300  
San Francisco, CA 94111  
1-415-675-6700

**Named Fiduciary:**

WideOrbit, LLC  
1160 Battery Street East, Suite 300  
San Francisco, CA 94111  
1-415-675-6700

**Agent for Service of Legal Process:**

General Counsel

WideOrbit, LLC  
1160 Battery Street East, Suite 300  
San Francisco, CA 94111

1-415-675-6700

Service for legal process may also be made on the Plan Administrator.

Language assistance is available. If you have difficulty understanding any part of this Summary Plan Description, contact the Plan Administrator at 415-675-6700.

Benefits hereunder may be provided pursuant to an insurance contract or pursuant to a governing document adopted by the Company. If so, these contracts are made a part of this Plan document, and the contracts and Plan document should be construed as consistent, if possible. If the terms of this Plan document conflict with the terms of such insurance contract or other governing document, then the terms of the insurance contract or governing document will control, with the exception of defining eligible employees and dependents, which is determined by the Company, unless otherwise required by law.

## 4. Eligibility and Participation Requirements

### Eligibility and Participation

An eligible Employee with respect to the Plan will be an Employee who is eligible to participate in and receive benefits under one or more of the benefit programs. To determine whether you or your family members are eligible to participate in a benefit program, please see Section 15. Reclassification from non-employee to employee status by a court or any agency or by the Company will not create any retroactive right to coverage. In addition, prospective coverage under any benefit program will apply to a reclassified employee only if the Company takes action to extend that benefit program coverage to that employee.

Certain benefit programs require that you make an annual election to enroll for coverage.

**Generally, you cannot enroll, drop coverage, or change your or your dependents coverage under the plan except during annual Open Enrollment.** However, you may be able to add or drop coverage for yourself or a dependent during the plan year if you experience an event that triggers a HIPAA Special Enrollment Right (see discussion below) or if you have a Status Change Event (see Appendix C for an explanation of Status Change Events). Please review the rules for changing your benefits elections described in Appendix C very carefully as the rules regarding making benefits changes mid-year must be strictly enforced.

Information about enrollment procedures is provided by the Company. Information about when your participation begins in various benefit programs is found under Section 15. You must follow any required enrollment procedures. **Always make sure the Company has your current**

***home address and other contact information for you and your covered dependent to correctly administer your benefits and to send you important benefits information.***

### **Eligible Dependent Status**

Section 15 describes whether your spouse and or child can participate in a particular benefit program. Section 15 also describes any limits on such participation. For example, children covered under the medical benefit program generally can be covered until the end of the month during which they reach age 26. However, coverage may end earlier for other benefits (or may not be available at all). For specifics on eligibility for each benefit offered refer to Section 15. Note that the definition of a child or definition of a dependent may be different for the different benefits offered under the Plan.

You cannot be covered both as an employee and as a dependent under the plan.

### **Full Time Status and the ACA**

Under the ACA, employers are required to report specific benefits information to IRS on “full-time” employees as defined by the ACA. A “full-time” employee is generally an employee who works on average 130 hours per month. Employers may also face penalties if they do not offer major medical coverage to substantially all full-time employees or if the coverage they offer is unaffordable or does not meet a minimum value standard. The Company determines full-time status using the “Monthly” method. ACA full-time status is not a guarantee of major medical benefits eligibility. Benefits eligibility is described in Section 15.

### **Special Enrollment Provisions under HIPAA**

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a special enrollment period for the Medical benefit program (or similar benefit programs providing medical benefits) may be available, usually if you lose medical coverage under certain conditions or when you acquire a new dependent by marriage, birth, or adoption.

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

In addition, if you declined enrollment in the Plan for yourself or your dependents (including a spouse) because of coverage under Medicaid or a State Children’s Health Insurance Program, there may be a right to enroll in this Plan if there is a loss of eligibility for the government-provided coverage. However, a request for enrollment must be made within 60 days after the government-provided coverage ends.

Finally, if you declined enrollment in the Plan for yourself or your dependents (including a spouse), and you or a dependent later becomes eligible for state “premium assistance” through Medicaid or a State Children’s Health Insurance Program which provides help with paying for Plan coverage, then there may be a right to enroll in this Plan. However, a request for enrollment must be made within 60 days after the determination of eligibility for the state

assistance. ***Medicaid and State Children’s Health Insurance Program premium assistance are not available with respect to coverage under a health FSA or a high-deductible health plan. Thus, this special enrollment event will not apply to such plans.***

## **Coverage during Certain Leaves of Absence**

Certain Federal (and State) statutes like the Family and Medical Leave Act (FMLA) require that eligibility for medical benefits continue for employees on those protected leaves of absence under the same terms as active employees. When wages continue during such a leave, your contributions will be deducted from those wages on a pre-tax basis. When such a leave is unpaid, you are still required to pay your portion of the premium. Your portion of the premium may be paid as regular monthly intervals during the leave on a post-tax basis.

You may also generally discontinue coverage at the beginning of such an unpaid leave and when you return your benefits will either be reinstated, or you may re-enroll for the remainder of the coverage period or plan year.

Human Resources must determine whether or not you are eligible for a statutory or other leave of absence.

## **Terms of Participation**

Your participation and the participation of your spouse and dependents in a benefit program will terminate according to the terms of the specific benefit program. Generally, coverage for most benefit programs terminates on the last day of the month in which you terminate employment, but certain benefit programs may provide coverage only through the date your employment terminates. Please see Section 15 for further information on the date participation in a specific benefit program will terminate.

Coverage may also terminate if you fail to pay your share of an applicable premium, if your hours drop below the required hourly threshold for the particular benefit, if you engage in fraud or make an intentional misrepresentation of a material fact, or for any other reason as set forth in the attached documents. You should consult Section 15 for a general summary and the attached documents for specific termination events and information.

Coverage may be terminated retroactively in the normal course of business due to a participant’s termination of employment, nonpayment of premiums, loss of dependent eligibility or other, similar factors. When you or a dependent lose eligibility for benefits, regardless of whether or not you timely report that loss of eligibility, a change to any existing salary reduction election will be made automatically. To the extent that the coverage at issue does not allow for retroactive termination of that coverage and election to the date of the loss of eligibility, such changes will be prospective. If coverage can be terminated retroactively to the date of the loss of eligibility, or sometime thereafter, excess salary reduction contributions will be refunded on a post-tax basis to the date the termination of coverage can be made effective.

Any person claiming benefits under the Plan shall furnish the Company, any insurance company or other entity working on behalf of the Plan or a benefit program with such information and documentation as may be necessary to verify eligibility for and/or entitlement to benefits under the Plan or a benefit program. This may include but is not limited to providing social security numbers, birth certificates, marriage certificates, or proof of dependent eligibility. Failure to cooperate and provide such information will lead to a loss of eligibility for benefits.

Knowingly enrolling an ineligible dependent in plan benefits constitutes fraud and is considered a material misrepresentation that will result in termination of coverage as well as other disciplinary action up to and including termination of employment. Eligibility for benefits is described in Section 15. If you have questions about whether a dependent is eligible you must contact Human Resources before enrolling that dependent.

## **COBRA Rights**

You may be eligible for COBRA continuation coverage or conversion policies when your coverage for a medical or other health benefit program under this Plan terminates.

Information about COBRA continuation coverage or conversion is contained in Appendix A. If you have questions about this law or these rights, please contact the Plan Administrator (for benefit programs that are self-funded) or the insurance carrier (if the benefit is fully insured). You can determine whether a benefit program is self-funded or fully insured by consulting Section 15.

For the Health FSA benefit program, COBRA continuation coverage is available if your account is underspent (if the COBRA premium for the account (the monthly salary reduction election + 2%) for the remainder of the coverage period is less than the account's balance) but generally cannot extend beyond the end of the Plan Year (including any 2½ month grace period). COBRA continuation coverage will not be offered with respect to the Health FSA benefit program if your Health FSA is overspent, unless otherwise required by applicable law.

## **5. Summary of Plan Benefits**

### **Benefits and Contribution**

The Plan provides you and your eligible spouse and dependents with the benefit programs listed in Section 15. A summary of each benefit program provided under the Plan may be provided in the attached documents (such as a certificate of insurance booklet, summary plan description for a specific benefit program or other governing document). Note that some of the attached documents may be labeled as a “summary plan description.” If so, that document will only be a summary of the specific benefit program to which it relates. Notwithstanding any of the terms of such a document, that document is not the formal, single “Summary Plan Description” for this Plan. Rather, this document constitutes the formal, single “Summary Plan Description.”

The cost of the benefits provided through the benefit programs may be funded in part by Company contributions and in part by pre-tax and/or post-tax employee contributions. The Company will determine and periodically communicate your share of the cost, if any, of the benefit programs. The Company reserves the right to change that determination.

The Company will make its contributions, if any, in an amount that (in the Company's sole discretion) is at least sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by your contributions. The Company will pay its contribution and your contributions to any insurance carrier or, with respect to benefits that are self-insured, will use these contributions to pay benefits directly to, or on behalf of, you or

your eligible family members from the Company's general assets. Your contributions toward the cost of a particular benefit program will be used in their entirety prior to using Company contributions to pay for the cost of such benefit program.

Medical benefits under this Plan may be subject to cost-sharing provisions, premiums, deductibles, co-insurance, copayment amounts, annual or lifetime limits, pre-authorization requirements or utilization review. There may also be limitations on the selection of primary care or network providers, limits on emergency medical care, or limited coverage for preventive services, drugs, medical tests, medical devices or medical procedures. These limitations are set forth in the attached documents.

Certain prescription drug benefits are considered "Creditable Coverage" under Medicare Part D. The attached documents provide details regarding this coverage and an annual notice (attached and incorporated by reference in Appendix B) explains how this creditable coverage works for these prescription drug benefit programs.

The Plan will provide benefits in accordance with the requirements of all applicable Federal laws regulating group health plans, such as COBRA, HIPAA, NMHPA, WHCRA, the Affordable Care Act and the No Surprises Act. A brief summary of some of these laws is below.

#### **Newborns' and Mothers' Health Protection Act (NMHPA) of 1996**

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

#### **Women's Health and Cancer Rights Act (WHCRA) of 1998**

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan.

### **Qualified Medical Child Support Orders**

Group health plans and health insurance issuers generally must provide benefits as required by any qualified medical child support order, or “QMCSO.” The Plan has detailed procedures for determining whether an order qualifies as a QMCSO.

Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

### **Lifetime and Annual Limits**

Lifetime or annual limit on the dollar value of “essential health benefits” are no longer permitted under the major medical plans offered by the Plan. For more information on “essential health benefits” refer to the terms of policies and benefit program materials listed in Section 15. These documents are provided to you during enrollment and are available from Human Resources, the insurer (if the benefit is fully-insured), or Plan Administrator (if the benefit is self-funded).

## **6. Grandfathered Status under the Affordable Care Act**

### **Non-Grandfathered Benefit Programs under the Affordable Care Act**

The following benefit programs that provide health benefits are not “grandfathered health plans” under the Affordable Care Act:

- Blue Cross Blue Shield of AL PPO
- Blue Cross Blue Shield of AL HDHP
- Cigna PPO
- Cigna HDHP
- Kaiser DHMO
- Kaiser HDHP

These benefit programs must, under the Affordable Care Act, provide additional protections. The protections provided by the Affordable Care Act include the following:

#### **Preventive Services covered at 100%**

In-network preventive care services will be covered at 100% with no cost sharing (e.g., copayment, coinsurance percentage, deductible, etc.). Preventive services include those services outlined in the US Preventive Services Taskforce recommendations (services rated “A” or “B”). Please see the attached documents for the preventive services included at no cost share.

#### **Non-Network Emergency Services covered as In-Network**

Emergency services must be covered without the need for prior authorization, regardless of the participating status of the provider or facility, and at the in-network cost sharing level.

**Access to Primary Care Physicians**

The Affordable Care Act generally allows participants the right to designate any primary care provider who participates in the network and who is available to accept the participant and his or her family members. If the benefit program requires that a primary care provider be designated, but one is not designated, the benefit program or a health insurance issuer will designate one until the participant or family member makes such a designation.

- For children, you may designate a pediatrician as the primary care provider.
- You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

## 7. How the Plan Is Administered

**Plan Administration**

The administration of the Plan is under the supervision of the Plan Administrator. The Plan Administrator is a named fiduciary within the meaning of ERISA § 402 and has full discretionary authority to administer the Plan, to interpret the Plan, and to determine eligibility for participation and for benefits under the terms of the Plan. However, insurers and parties that have entered into administrative service agreements (Third Party Service Providers or TPAs) assume sole responsibility for their performance under applicable policies or administrative services agreements and, under ERISA, may be fiduciaries with respect to their performance.

The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan. The administrative duties of the Plan Administrator include, but are not limited to, interpreting the Plan, prescribing applicable procedures, determining eligibility for and the amount of benefits, and authorizing benefit payments and gathering information necessary for administering the Plan. (However, as noted below, one or more insurance companies may have these responsibilities with respect to fully insured benefits.)

The Plan Administrator may delegate any of these administrative duties among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegate(s) and expressly describes the nature and scope of the delegated responsibility. The Plan Administrator has the discretionary authority to interpret the Plan in order to make eligibility and benefit determinations as it may determine in its sole discretion. The Plan Administrator also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the Plan.

**Power and Authority of Insurance Company**

As detailed in Section 15, certain benefits under the Plan may be fully insured. The insurance companies are responsible for: (1) determining eligibility for and the amount of any benefits

payable under their respective benefit programs, and (2) prescribing claims procedures to be followed and the claims forms to be used by employees pursuant to their respective benefit programs.

## **Questions**

If you have any general questions regarding the Plan, or your eligibility for or the amount of any benefit payable under any benefit program, please contact the Plan Administrator or the appropriate insurance company as applicable.

## **8. Circumstances Which May Affect Benefits**

### **Denial or Loss of Benefits**

Your benefits (and the benefits of your eligible spouse and dependents) will cease when your participation in the Plan terminates. See Section 15. Your benefits will also cease on termination of the Plan.

### **Right to Recover Benefit Overpayments and Other Erroneous Payments**

The Plan and its benefit programs (including any insurance company on behalf of a benefit program) have all necessary or helpful rights to subrogation or reimbursement of benefits. If, for any reason, any benefit under the Plan is erroneously paid or exceeds the amount appropriately payable under the Plan, the recipient of such benefit (the “Recipient”) shall be responsible for refunding the overpayment to the Plan or insurance company to the fullest extent permitted by law. In addition, if the Plan or insurance company makes any payment that, according to the terms of the Plan, policy or contract should not have been made, the insurance company, the Plan Administrator, or the Plan Sponsor (or designee) may, to the fullest extent permitted by law, recover that incorrect payment, whether or not it was made due to the insurance company’s or Plan Administrator’s (or its designee’s) own error, from the person to whom it was made or from any other appropriate party.

As may be permitted in the sole discretion of the Plan Administrator or insurance company, the refund or repayment may be made in one or a combination of the following methods: (a) as a single lump-sum payment, (b) as a reduction of the amount of future benefits otherwise payable under the Plan, (c) as automatic deductions from pay, or (d) any other method as may be required or permitted in the sole discretion of the Plan Administrator or the insurance company. The Plan may also seek recovery of the erroneous payment or benefit overpayment from any other appropriate party.

Any benefit payments or reimbursements made by check must be cashed or deposited within one year after the check is issued. If any check or other payment for a benefit is not cashed or deposited within one year of the date of issue, the Plan will have no liability for the benefit payment and the amount of the check will be deemed a forfeiture. No funds will escheat to any state.

## **9. Amendment or Termination of the Plan**

### **Amendment or Termination**

The Plan and any benefit program under the Plan may be amended or terminated at any time, in the sole discretion of the Company as Plan sponsor. Some benefit programs may also be amended or terminated by an insurance carrier, as more fully described in any attached documents from an insurance carrier. The policies and agreements may also be amended or terminated at any time in accordance with their terms. No individual (including a retired employee) shall have a right to continuing benefits except to the extent required by law.

## **10. No Contract of Employment**

The Plan is not intended to be, and may not be construed as, constituting a contract or other arrangement between you and the Company to the effect that you will be employed for any specific period of time.

## **11. No Assignment**

Except as may otherwise be specifically provided in this Plan, the benefit programs, or applicable law, an individual's rights, interests or benefits under this Plan or the benefit programs shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution or levy of any kind, either voluntary or involuntary, prior to being received by the persons entitled thereto under the terms of the benefit programs, and any such attempt shall be void.

Specifically, participants and beneficiaries covered under this plan cannot assign their rights to medical providers to pursue direct payment of claims either as the participant or beneficiaries' agent or under power of attorney. Under the terms of this plan, medical providers cannot take action enforcing a patient's right to recover benefits under ERISA or assert any claims under ERISA on behalf of patients, even where the patient(s) have assigned their rights to their medical providers.

## **12. Claims Procedure**

### **Claims for Fully-Insured Benefits**

For purposes of determining of the amount of, and entitlement to, benefits of the benefit programs provided under insurance contracts or policies, the respective insurer is the named fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to benefits.

To obtain benefits from the insurer of a benefit program, you must follow the claims procedures under the applicable insurance contract, which may require you to complete, sign and submit a written claim on the insurer's form.

The insurance company will decide your claim in accordance with its reasonable claims procedures as required by ERISA.

See the appropriate certificate of insurance or booklet for details regarding the insurance company's claims procedures. You must fully follow and exhaust these claims procedures before you can file a lawsuit in state or federal court. You may have a right to seek external review of your claims, if so noted in the applicable insurance contract or policy.

### **Claims for Self-Funded Benefits**

For purposes of determining the amount of, and entitlement to, benefits under the benefit programs which are self-funded, the Plan Administrator is the named fiduciary under the Plan, with the full power to make factual determinations and to interpret and apply the terms of the Plan.

To obtain benefits from a benefit program which is self-funded you must complete, execute, and submit to the Plan Administrator a written claim on the form available from the Plan Administrator. The Plan Administrator has the right to secure independent medical advice and to require such other evidence, as it deems necessary to decide your claim.

The Plan Administrator will decide your claim in accordance with reasonable claims procedures, as required by ERISA. You may have a right to seek external review of your claims, if so noted in the applicable attached document for the self-funded benefit program.

See the appropriate benefits description for information about how to file a claim and for details regarding the claims procedures applicable to your claim. You must fully follow and exhaust these claims procedures before you can file a lawsuit in court.

### **The Role of Authorized Representatives**

Under ERISA and the ACA participants and beneficiaries have the right to designate an Authorized Representative for certain purposes. These purposes are generally limited to requesting documents or other information on behalf of a participant or beneficiary or acting on their behalf during claims and appeals procedures that can follow an adverse benefits determination. In any situation that does not constitute an urgent care claim, to designate any third party as an Authorized Representative a participant or beneficiary must use the signed statement included as an appendix of this document with the required witness signature. A medical provider will not become a participant or beneficiary's Authorized Representative as a result of an attempt to secure an assignment of benefits. The Plan does not guarantee that any purported assignment will be valid under the terms of the Plan.

## **13. Statement of ERISA Rights**

This Statement of ERISA Rights applies to those benefit programs which are subject to ERISA. Not all benefit programs which are part of this Plan will be subject to ERISA. The following benefit programs are not subject to ERISA: HSA, EAP.

## **Your Rights**

As a participant in an ERISA plan you are entitled to certain rights and protections under ERISA. ERISA provides that, as a participant, you are entitled to:

- examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan documents, including insurance contracts, and copies of all documents filed by the Plan with the U.S. Department of Labor (if any) such as annual reports and Plan descriptions;
- obtain copies of the benefit program documents and other program information on written request to the Plan Administrator (the Plan Administrator may make a reasonable charge for the copies);
- receive a summary of the Plan's annual financial report, if any (the Plan Administrator is required by law to furnish each participant with a copy of this summary annual report);
- continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

## **Fiduciary Obligations**

In addition to creating rights for participants, ERISA imposes duties on the people who are responsible for the operation of the benefit program. These people, called "fiduciaries" of the program, have a duty to operate the program prudently and in the interest of you and other program participants. Fiduciaries who violate ERISA may be removed and may be required to reimburse the Plan for any losses they have caused the program.

## **No Discrimination**

No one, including the Company or any other person, may fire you or discriminate against you in any way with the purpose of preventing you from obtaining welfare benefits or exercising your rights under ERISA.

## **Right to Review**

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan Administrator review and reconsider your claim.

## **Filing Suit**

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, and if you have exhausted the claims procedures available to you under the Plan, you may file suit in a court.

Any lawsuit must be filed within 36 months of the final decision on the claim. Exhaustion of the internal claims and appeals procedure is required prior to filing suit.

If it should happen that benefit program fiduciaries misuse the Program's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous), the court may order you to pay these costs and fees.

## **Questions**

If you have any questions about this statement or your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

## **14. General Information**

### **COBRA**

Benefit programs which provide health benefits generally are subject to the federal law known as COBRA. COBRA generally allows covered participants and beneficiaries to continue in the benefit program, even after a "qualifying event" occurs. For more information about COBRA please see Appendix A. You may also have state law continuation or conversion rights.

### **Subrogation and Reimbursement**

If an individual has a claim for benefits under this Plan or any benefit program, and that individual acquires any right or action against a third party for the person's injury, sickness or other illness which is so covered, then: (a) the Plan shall be entitled to reimbursement for such benefits from such third party up to 100% of the benefits paid by the Plan; and (b) the Plan is automatically subrogated to all such rights or claims of the covered person. The covered person shall cooperate fully with the Plan in the enforcement of the Plan's subrogation and reimbursement rights. In addition, the person shall permit suit to be brought in the person's name under the direction of and at the expense of the Company if the Company so chooses. The Plan shall not be liable for such a person's attorney's fees absent prior written approval from the Plan. The Plan Administrator may require the receipt of a signed and dated subrogation and reimbursement agreement from the person before advancing any monies.

The failure or refusal of a covered person to fully cooperate with the Plan in the enforcement of the Plan's subrogation and reimbursement rights shall result in a forfeiture of all benefits payable to that person, even if such benefits have already been paid, in which event the Company shall retain a right to recover paid benefits which are forfeited in such a manner.

The Company, on behalf of this Plan, shall have a first priority right to recover from and a lien against any payment, whether designated as a payment for medical benefits or any other type of damages, from the proceeds of any recovery, including but not limited to any settlement,

award or judgment which results from a claim or lawsuit by or on behalf of a covered person who received benefits under this Plan (even if such covered person is not made whole). The plan is not required to contribute to any expenses or fees (including attorney's fees or costs) incurred in obtaining the funds. The plan's recovery will not be limited or reduced by doctrines (equitable or other) including but not limited to, the make-whole doctrine, contributory or comparative negligence, or the common fund doctrine. The plan's right to full recovery is not reduced if settlement funds or other payments to you are spent or no longer in an individual's possession or control. Notice of the Plan's claim shall be sufficient to establish this Plan's lien against the third party or insurance carrier. The Company shall be entitled to deduct the amount of the lien from any future claims payable to or on behalf of the covered person or payee if the covered person or payee fails to promptly notify the Plan Administrator of a payment received from a third party or insurance carrier that is subject to this Plan's subrogation and reimbursement rights.

In the event that the Plan obtains a recovery against a third party in excess of payments made to or on behalf of the covered person and reasonable out of pocket expenses of the recovery, then the Plan shall pay to the covered person that excess amount recovered by the Plan.

In the event of any direct conflict between this Section 13 and the subrogation and reimbursement provisions in any benefit program, the subrogation and reimbursement provisions in the benefit program shall control. Otherwise, the provisions of this Section 13 shall apply and may supplement those contained in any benefit program.

The above provisions of this "Subrogation and Reimbursement" section apply with respect to a benefit program that is self-funded and does not, in its governing documents (but excluding this Plan document) have a subrogation and reimbursement section. If the benefit program does have such a section that section shall control. With respect to a fully insured benefit program, the contract or policy from the insurer shall control with respect to subrogation and reimbursement matters.

### **No Vesting of Benefits**

Nothing in the Plan, nor anything in any benefit program, shall be construed as creating any vested rights to benefits in favor of any employee, former employee or covered person.

### **Waiver and Estoppel**

No term, condition, or provision of this Plan or any benefit program shall be deemed to be waived, and there shall be no estoppel against enforcing any provision of the Plan or benefit program, except through a writing of the party to be charged by the waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless explicitly made so and shall operate only with regard to the specific term or condition waived and shall not be deemed to waive such term or condition in the future, or as to any act other than as specifically waived. No covered person other than as named or described by class in the waiver shall be entitled to rely on the waiver for any purposes.

### **Effect on Other Benefit Plans**

Amounts credited or paid under this Plan, or any benefit program shall not be considered to be compensation for purposes of any benefit program hereunder or any qualified or nonqualified pension plan maintained by the Company unless expressly provided in such benefit program or

qualified or nonqualified pension plan, as applicable, or if required by applicable law. The treatment of amounts paid under this Plan or any benefit program for purposes of any other employee benefit plan maintained by the Company shall be determined under the provisions of the applicable employee benefit plan.

### **Severability**

If any provision of this Plan or any benefit program is held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions hereof shall continue to be fully effective.

### **Rebates**

In some situations, a rebate may be paid by an insurance company which provides coverage under the Plan. For example, a rebate may be provided under the Medical Loss Ratio ("MLR") rules, which are part of the Affordable Care Act. Except as specifically and unambiguously provided in a Benefit Description, or as otherwise required by applicable law, any rebate from any source will be:

- Considered an asset of the Company, not the Plan. The Company does not need to use such a rebate to benefit Employees, participants or beneficiaries. The Company can use such a rebate for the Company's own purposes
- An asset of the Plan in proportion to how much of the rebate relates to Employee, participant, or beneficiary contributions. The portion relating to Company contributions shall not be considered a Plan asset. The Company will have the ability to make certain assumptions or minor changes (such as rounding to the nearest \$1 or \$10) when determining the amount which is considered a plan asset. The Company shall have discretion to determine how to use all amounts. Amounts which are plan assets will be used to benefit individuals selected by the Company. This group of individuals may not be identical to the group which relates to the rebate. In addition, certain individuals can receive the rebate (or the benefit of the rebate) even if the rebate related to a different benefit, to the extent allowed by applicable law.
- The entire amount shall be an asset of the Plan, to be used for the benefit of individuals covered by the Plan.

In all situations where ERISA applies the use of any ERISA-covered plan assets will be governed by applicable law, including but not limited to U.S. Department of Labor Technical Release 2011-04.

### **Controlling Law**

This Plan shall be administered, construed, and enforced according to the federal law and the laws of the State of California, to the extent not preempted by federal law. However, with respect to a fully insured benefit program, the applicable insurance policy or contract will control with respect to which state's laws apply.

## 15. Benefit Program Information

### Summary of Eligibility and Participation Provisions

Note: If you have any questions about eligibility or participation, contact the Plan Administrator

<b>Benefit Program</b>	<b>Fully insured or self-funded? if fully-insured, carrier name</b>	<b>Policy or Group #, if fully-insured</b>	<b>Who is eligible</b>	<b>When Participation begins</b>	<b>When Participation Ends<sup>1</sup></b>	<b>To File a Claim, Contact:</b>
<b>Medical PPO &amp; HDHP</b>	Fully-Insured / Blue Cross Blue Shield of AL	97764	Regular Full-Time and Regular Part-Time employees working 20+ hours per week Spouses and children generally are covered	First day of month immediately after hire date and proper election	At the end of the month in which coverage is dropped or employment is terminated. Continuation coverage usually is available.	Blue Cross Blue Shield of AL at: Customer Service 450 Riverchase Parkway East Birmingham, AL 35244 (800) 292-8868
<b>Medical PPO &amp; HDHP</b>	Self-Funded / Cigna	630947	Regular Full-Time and Regular Part-Time employees working 20+ hours per week. Spouses, domestic partners, and children generally are covered	First day of month immediately after hire date and proper election	At the end of the month in which coverage is dropped or employment is terminated. Continuation coverage usually is available.	Cigna at: PO Box 188061 Chattanooga, TN 37422-8061 (866) 494-2111
<b>Medical HMO &amp; HDHP</b>	Fully-Insured / Kaiser	603774	Regular Full-Time and Regular Part-Time employees working 20+ hours per week Spouses, domestic partners, and children generally are covered	First day of month immediately after hire date and proper election	At the end of the month in which coverage is dropped or employment is terminated. Continuation coverage usually is available.	Kaiser Permanente at: PO Box 24010 Oakland, CA 94623 (800) 464-4000
<b>Dental</b>	Self-Funded / Aetna	138366	Regular Full-Time and Regular Part-Time	First day of month immediately after	At the end of the month in which	Aetna at: PO Box 14094

<sup>1</sup> Other Events (such as fraud or intentional misrepresentation of a material fact) can also terminate coverage -- see the benefit program details.

<b>Benefit Program</b>	<b>Fully insured or self-funded? if fully-insured, carrier name</b>	<b>Policy or Group #, if fully-insured</b>	<b>Who is eligible</b>	<b>When Participation begins</b>	<b>When Participation Ends<sup>1</sup></b>	<b>To File a Claim, Contact:</b>
			employees working 20+ hours per week Spouses, domestic partners, and children generally are covered	hire date and proper election	coverage is dropped or employment is terminated. Continuation coverage usually is available.	Lexington, KY 40512-4094 (877) 238-6200
<b>Vision</b>	Self-Funded / Guardian (VSP)	00472074	Regular Full-Time and Regular Part-Time employees working 20+ hours per week. Spouses, domestic partners, and children generally are covered	First day of month immediately after hire date and proper election	At the end of the month in which coverage is dropped or employment is terminated. Continuation coverage usually is available.	Guardian (VSP) at: PO Box 385018 Birmingham, AL 35238-0518 (800) 877-7195
<b>Health and Dependent Care FSA</b>	Self-Funded / WEX, Inc.	28119	Regular Full-Time and Regular Part-Time employees working 20+ hours per week. Expenses of spouses and children generally can be reimbursed at employee election	Immediately upon hire, after proper election filed	Immediately upon termination of employment. Continuation coverage usually is available unless Health FSA is "overspent"	Plan Administrator (see Section 2 for address) WEX, Inc. at: PO Box 2926 Fargo, ND 58108-2926 (866) 451-3399
<b>Basic Life, AD&amp;D, Short Term Disability, Long Term Disability</b>	Fully-Insured / Mutual of Omaha	G000BS83	Regular Full-Time and Regular Part-Time employees working 20+ hours per week.	Immediately upon hire, after proper election filed	Immediately upon termination of employment. Continuation coverage usually is available.	Mutual of Omaha at: 3300 Mutual of Omaha Plaza Omaha, NE 68175 Life: (800) 775-8805 Disability: (800) 877-5172
<b>Supplemental Life and AD&amp;D</b>	Fully-Insured / Mutual of Omaha	G000BS83	Regular Full-Time and Regular Part-Time employees working 20+ hours per week.	Immediately upon hire, after proper election filed	Immediately upon termination of employment. Continuation coverage usually is available.	Mutual of Omaha at: 3300 Mutual of Omaha Plaza Omaha, NE 68175 (800) 775-8805

<b>Benefit Program</b>	<b>Fully insured or self-funded? if fully-insured, carrier name</b>	<b>Policy or Group #, if fully-insured</b>	<b>Who is eligible</b>	<b>When Participation begins</b>	<b>When Participation Ends<sup>1</sup></b>	<b>To File a Claim, Contact:</b>
			Spouses, domestic partners, and children generally are eligible.			
<b>Accident, Critical Illness</b>	Fully-Insured / Mutual of Omaha	G000BS83	Regular Full-Time and Regular Part-Time employees working 20+ hours per week	Immediately upon hire, after proper election filed	Immediately upon termination of employment. Continuation coverage usually is available.	Mutual of Omaha at: 3300 Mutual of Omaha Plaza Omaha, NE 68175 (800) 877-5172
<b>Health Savings Account (HSA)</b>	Not Applicable / Payflex	147606	Regular Full-Time and Regular Part-Time employees working 20+ hours per week.	First day of month immediately after hire date and proper election	Immediately upon termination of employment. Account transitions to individually held account.	Payflex at: (844) 729-3539 Payflex.com
<b>Employee Assistance Program (EAP)</b>	Fully-Insured / Mutual of Omaha	N/A	All employees. Spouses, domestic partners, and children generally are covered.	Immediately upon hire, after proper election filed	Immediately upon termination of employment. Continuation coverage usually is available.	Mutual of Omaha at: 3300 Mutual of Omaha Omaha, NE 68175 (800) 775-6000
<b>Commuter Benefits</b>	Self-Funded / WEX, Inc.	28119	All employees.	Immediately upon hire, after proper election filed	Immediately upon termination of employment.	Plan Administrator (see Section 2 for address) WEX, Inc. at: PO Box 2926 Fargo, ND 58108-2926 (866) 451-3399

## **Appendix A: COBRA General Rights Notice**

**GENERAL NOTICE OF YOUR RIGHTS  
GROUP HEALTH CONTINUATION COVERAGE UNDER COBRA**

**THIS LETTER IS FOR YOUR INFORMATION ONLY. PLEASE RETAIN FOR FUTURE REFERENCE.  
THERE HAS NOT BEEN A CHANGE IN YOUR STATUS WITH YOUR COMPANY.**

This letter contains important information about your employee benefits plan(s). Please read the entire letter.

On April 7, 1986, a federal law called COBRA was enacted (Public Law 99-272, Title X), requiring that most employers sponsoring group health plans offer employees and their families (qualified beneficiary/ies) the opportunity for a temporary extension of health coverage at group rates in certain instances where coverage under the plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights as a qualified beneficiary and obligations under COBRA. Both you and your spouse, if applicable, should take the time to read this notice carefully. This notice does not fully describe COBRA or other rights under the WideOrbit, LLC group health plan ("Group Health Plan"). For additional information you should review the Group Health Plan's Summary Plan Description or contact the WideOrbit, LLC Plan Administrator at (701) 555-1212. Also, you may visit the Department of Labor website ([www.dol.gov](http://www.dol.gov)) for more information on COBRA.

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

**QUALIFYING EVENTS**

If you are an employee of WideOrbit, LLC covered by the Group Health Plan, you have a right to choose COBRA if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

If you are the spouse of an employee covered by the Group Health Plan, you have the right to choose COBRA for yourself if you lose group health coverage under the Group Health Plan for any of the following reasons:

1. The death of your spouse;
2. A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment with WideOrbit, LLC;
3. Divorce or legal separation from your spouse; or
4. Your spouse becomes entitled to Medicare.

In the case of a dependent child of an employee covered by the Group Health Plan, he or she has the right to choose COBRA if the Group Health Plan is lost for any of the following reasons:

1. The death of the parent-employee;
2. A termination of the parent-employee's employment (for reasons other than gross misconduct) or reduction in the parent-employee's hours of employment with WideOrbit, LLC;
3. The parent-employee's divorce or legal separation;

4. The parent-employee became entitled to Medicare prior to his/her qualifying event; or
5. The dependent child ceases to be a dependent child under the Group Health Plan.



Children born to or adopted by a covered employee during the continuation coverage period may also elect continuation coverage, provided that the covered employee has elected COBRA coverage for himself or herself. The coverage period will be determined according to the date of the qualifying event that resulted in the covered employee's COBRA coverage.

Sometimes, filing a bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to WideOrbit, LLC and that bankruptcy results in the loss of coverage of any retired employee under the Group Health Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Group Health Plan.

### **COVERAGE PROVIDED**

Under COBRA, the employee or a family member has the responsibility to inform the WideOrbit, LLC Plan Administrator at (701) 555-1212 of a divorce, legal separation, or a child losing dependent status under the Group Health Plan within 60 days of the later of (1) the date of the qualifying event or (2) the date on which coverage would be lost as a result of the qualifying event.

**If notification is not made within 60 days after the applicable qualifying event occurs or if you do not timely provide any additional documentation or information (if requested) in a timely manner, your notification will be rejected and COBRA coverage will not be offered.**

WideOrbit, LLC has the responsibility to notify the COBRA administrator of the employee's death, termination, and reduction in hours of employment or Medicare entitlement. Once the plan receives notice that a qualifying event has occurred, COBRA coverage will be offered to each qualified beneficiary. Each qualified beneficiary will have an independent right to elect COBRA coverage for 60 days from the later of the date coverage is lost under the plan or the date of notification to elect COBRA coverage. Covered employees may elect COBRA coverage on behalf of their spouse, and parents may elect COBRA coverage on behalf of their eligible dependent children. If a qualified beneficiary does not elect COBRA/continuation coverage within this period, the right to COBRA/continuation coverage will terminate.

If you elect COBRA, WideOrbit, LLC is required to give you and your covered dependents, if any, coverage that is identical to the coverage provided under the plan to similarly situated employees or family members. Under COBRA, you may have to pay all or part of the premium for your continuation coverage.

### **PERIOD OF COVERAGE**

COBRA requires that you be afforded the opportunity to maintain coverage for 36 months unless you lost group health coverage because of a termination of employment or reduction in hours. In that case, the required COBRA period is 18 months.

The 18-month period may be extended to 29 months if an individual is determined by the Social Security Administration (SSA) to be disabled (for Social Security purposes) at any time during the first 60 days of COBRA coverage or before COBRA coverage began and you are still disabled at the end of the original maximum continuation period of coverage (generally 18 months). To benefit from this extension, a qualified beneficiary must notify WEX Health, Inc. at (866) 451-3399 of that determination within 60 days of the later of (1) the date the qualified beneficiary is determined to be disabled by the Social Security Administration; (2) the date of the qualifying event; and (3) the date on which the qualified beneficiary would lose coverage because of the qualifying event, and before the end of the original 18-month period.

If the above notification is not made within 60 days of the date of the disability determination made by the Social Security Administration and before the end of the 18-month period of COBRA/continuation coverage, or if you do not provide the additional documentation or information (if requested) in a timely manner, your notification will be rejected and any additional COBRA/continuation coverage beyond the original 18-month period will not be offered.

The affected individual must also notify the WEX Health, Inc. within 30 days of any final determination that the individual is no longer disabled.

## SECOND QUALIFYING EVENT EXTENSION

If the original event causing the loss of coverage was a termination (other than for gross misconduct) or a reduction in hours, another extension of the 18-month continuation period may occur, if during the 18 months of COBRA coverage, a qualified beneficiary experiences certain secondary qualifying events:



1. Divorce or legal separation
2. Death
3. Medicare entitlement
4. Dependent child ceasing to be a dependent

You will be required to have certain information available about your qualifying event, including: the type of qualifying event (divorce, legal separation, losing dependent coverage); the date of the divorce, legal separation or dependent losing coverage; the name and Social Security number of the covered employee; and the name, address and Social Security number of the covered spouse or dependent who is losing coverage.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA coverage for his spouse and eligible dependents can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA coverage can be extended.

If a second qualifying event does take place, COBRA provides that the qualified beneficiary may be eligible to extend COBRA up to 36 months from the date of the original qualifying event. If a second qualifying event occurs, it is the qualified beneficiary's responsibility to inform the WideOrbit, LLC Plan Administrator within 60 days of the event. In no event, however, will COBRA last beyond three years from the date of the event that originally made the qualified beneficiary eligible for COBRA. If COBRA coverage is elected, the coverage previously in effect will generally be continued. From time to time, some changes in coverage are possible. For example, benefits and cost will be modified as regular changes are made to the plan. Once you make your election, you will have up to 45 days to pay your first COBRA coverage premium, which will include any make-up premiums you missed. COBRA coverage will be effective the day after the qualifying event or the last day of active coverage, whichever is later. Premiums will be equal to the entire cost of the coverage, with an additional two percent to cover administrative expenses.

If the above notification is not made within 60 days after the second qualifying event occurs or if you do not provide any additional documentation or information (if requested) in a timely manner, your notification will be rejected and any additional COBRA coverage beyond the original 18- (or 29-) month period will not be offered.

### SPECIAL RULE FOR HEALTH FSAs

COBRA coverage under the WideOrbit, LLC Health FSA will be offered only to qualified beneficiaries losing coverage that have under-spent accounts. A qualified beneficiary has an under-spent account if the annual limit elected by the covered employee, reduced by reimbursable claims submitted up to the time of the qualifying event, is equal to or more than the amount of the premiums for the WideOrbit, LLC Health FSA COBRA coverage that will be charged for the remainder of the plan year. COBRA coverage will consist of the WideOrbit, LLC Health FSA coverage in force at the time of the qualifying event. The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the plan year, and the COBRA coverage for the FSA plan will terminate at the end of the plan year.

Unless otherwise elected, all qualified beneficiaries who were covered under the WideOrbit, LLC Health FSA will be covered together for Health FSA COBRA coverage. However, each qualified beneficiary could alternatively elect separate COBRA coverage to cover that beneficiary only with a separate Health FSA annual limit and a separate premium. If you are interested in this alternative, contact WEX Health, Inc. at (866) 451-3399 during business hours for more information.

### SPECIAL RULE FOR EMPLOYEES IN THE UNIFORMED SERVICES

If you are an employee and your coverage under the plan terminates due to your service in the uniformed services, you may elect special continuation coverage under the Uniformed Services Employment and Reemployment Rights Act (USERRA) for yourself and your covered spouse and covered dependents. This special continuation of coverage may extend for up to 24 months beginning from the date your plan coverage would otherwise terminate due to your service in the uniformed services. Service in the uniformed services includes your performance of duty on a voluntary or involuntary basis in the Armed Forces (including the Coast Guard and the Reserves), the Army National Guard, the Air National Guard, and the commissioned corps of the Public Health Service. If you believe this special continuation of coverage rule applies to you, please contact your human resources contact at your employer.



### **ALTERNATE RECIPIENTS UNDER QMCSOs**

A child of the covered employee who is receiving benefits under the Plan pursuant to a qualified medical child support order (QMCSO) received by ABC Holding Co during the covered employee's period of employment with ABC Holding Co is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

### **PLAN CONTACT INFORMATION**

To ensure that all covered individuals receive information properly and timely, it is important that you notify our Customer Service Department at (866) 451-3399 of any change in dependent status or any address change of any family member as soon as possible. Certain changes must be submitted to us in writing. You should keep a copy, for your records, of any notices you send. Failure on your part to notify us of any changes may result in delayed notification or loss of continuation of coverage options.

### **OTHER COVERAGE OPTIONS**

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

### **ENROLLMENT IN MEDICARE**

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of the month after your employment ends or the month after group health plan coverage based on current employment ends. For more information visit <https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods>.

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

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

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

For more information about your rights under ERISA, including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit [www.dol.gov/ebsa](http://www.dol.gov/ebsa). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov).

If you have any questions about COBRA, please contact our Customer Service Department at (866) 451-3399 during business hours.

Sincerely,



## Appendix B: Medicare Part D

### Medicare Part D Notice of Creditable Coverage

Important Notice from WideOrbit, LLC About  
Your Prescription Drug Coverage and Medicare

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

Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. WideOrbit has determined that the prescription drug coverage offered by the WideOrbit, Inc. Health and Welfare Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

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#### When Can You Join A Medicare Drug Plan?

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

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

#### What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your WideOrbit coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under WideOrbit is creditable (e.g. as good as Medicare coverage), you can retain your existing prescription drug

coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

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

#### [When Will You Pay A Higher Premium \(Penalty\) To Join A Medicare Drug Plan?](#)

You should also know that if you drop or lose your current coverage with WideOrbit and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

#### [For More Information About This Notice Or Your Current Prescription Drug Coverage:](#)

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

#### [For More Information About Your Options Under Medicare Prescription Drug Coverage:](#)

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

For more information about Medicare prescription drug coverage:

- Visit [www.medicare.gov](http://www.medicare.gov)
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

Date:	January 1 <sup>st</sup> , 2022
Name of Entity/Sender:	WideOrbit
Contact – Position/Office:	Human Resources
Address:	11600 Battery Street E., Suite 300, San Francisco, CA 94111
Phone Number:	415-675-6700

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**XI  
SUMMARY**

**WIDEORBIT  
CAFETERIA PLAN**

**INTRODUCTION**

We have amended the "Flexible Benefits Plan" that we previously established for you and other eligible employees. Under this Plan, you will be able to choose among certain benefits that we make available. The benefits that you may choose are outlined in this Summary Plan Description. We will also tell you about other important information concerning the amended Plan, such as the rules you must satisfy before you can join and the laws that protect your rights.

One of the most important features of our Plan is that the benefits being offered are generally ones that you are already paying for, but normally with money that has first been subject to income and Social Security taxes. Under our Plan, these same expenses will be paid for with a portion of your pay before Federal income or Social Security taxes are withheld. This means that you will pay less tax and have more money to spend and save.

Read this Summary Plan Description carefully so that you understand the provisions of our amended Plan and the benefits you will receive. This SPD describes the Plan's benefits and obligations as contained in the legal Plan document, which governs the operation of the Plan. The Plan document is written in much more technical and precise language. If the non-technical language in this SPD and the technical, legal language of the Plan document conflict, the Plan document always governs. Also, if there is a conflict between an insurance contract and either the Plan document or this Summary Plan Description, the insurance contract will control. If you wish to receive a copy of the legal Plan document, please contact the Administrator.

This SPD describes the current provisions of the Plan which are designed to comply with applicable legal requirements. The Plan is subject to federal laws, such as the Internal Revenue Code and other federal and state laws which may affect your rights. The provisions of the Plan are subject to revision due to a change in laws or due to pronouncements by the Internal Revenue Service (IRS) or other federal agencies. We may also amend or terminate this Plan. If the provisions of the Plan that are described in this SPD change, we will notify you.

We have attempted to answer most of the questions you may have regarding your benefits in the Plan. If this SPD does not answer all of your questions, please contact the Administrator (or other plan representative). The name and address of the Administrator can be found in the Article of this SPD entitled "General Information About the Plan."

**I  
ELIGIBILITY**

**1. When can I become a participant in the Plan?**

Before you become a Plan member (referred to in this Summary Plan Description as a "Participant"), there are certain rules which you must satisfy. First, you must meet the eligibility requirements and be an active employee. After that, the next step is to actually join the Plan on the "entry date" that we have established for all employees. The "entry date" is defined in Question 3 below. You will also be required to complete certain application forms before you can enroll in the Health Flexible Spending Account or Dependent Care Flexible Spending Account.

**2. What are the eligibility requirements for our Plan?**

You will be eligible to join the Plan once you have satisfied the conditions for coverage under our group medical plan. Of course, if you were already a participant before this amendment, you will remain a participant.

**3. When is my entry date?**

You can join the Plan on the same day you can enter our group medical plan.

**4. What must I do to enroll in the Plan?**

Before you can join the Plan, you must complete an application to participate in the Plan. The application includes your personal choices for each of the benefits which are being offered under the Plan. You must also authorize us to set some of your earnings aside in order to pay for a portion of the benefits you have elected.

However, if you are already covered under any of the insured benefits, you will automatically participate in this Plan to the extent of your premiums unless you elect not to participate in this Plan.

**II  
OPERATION**

**1. How does this Plan operate?**

Before the start of each Plan Year, you will be able to elect to have some of your upcoming pay contributed to the Plan. These amounts will be used to pay for the benefits you have chosen. The portion of your pay that is paid to the Plan is not subject to Federal income or Social Security taxes. In other words, this allows you to use tax-free dollars to pay for certain kinds of benefits and expenses which you normally pay for with out-of-pocket, taxable dollars. Also, we will make additional Employer contributions to the

Plan that you may use to increase the amounts used to pay benefits. However, if you receive a reimbursement for an expense under the Plan, you cannot claim a Federal income tax credit or deduction on your return. (See the Article entitled "General Information About Our Plan" for the definition of "Plan Year.")

### III CONTRIBUTIONS

#### 1. How much of my pay may the Employer redirect?

Each year, we will automatically contribute on your behalf enough of your compensation to pay for the insurance coverage provided unless you elect not to receive any or all of such coverage. You may also elect to have us contribute on your behalf enough of your compensation to pay for any other benefits that you elect under the Plan. These amounts will be deducted from your pay over the course of the year.

#### 2. How much will the Employer contribute each year?

We may contribute a discretionary amount which we will determine prior to the beginning of each Plan Year. This contribution can be used for the Health Savings Account and will be made on a pro rata basis during the year. If you elect not to participate, the Employer will not contribute to the Plan on your behalf.

#### 3. What happens to contributions made to the Plan?

Before each Plan Year begins, you will select the benefits you want and how much of the contributions should go toward each benefit. It is very important that you make these choices carefully based on what you expect to spend on each covered benefit or expense during the Plan Year. Later, they will be used to pay for the expenses as they arise during the Plan Year.

#### 4. When must I decide which accounts I want to use?

You are required by Federal law to decide before the Plan Year begins, during the election period (defined below). You must decide two things. First, which benefits you want and, second, how much should go toward each benefit.

If you are already covered by any of the insured benefits offered by this Plan, you will automatically become a Participant to the extent of the premiums for such insurance unless you elect, during the election period (defined below), not to participate in the Plan.

#### 5. When is the election period for our Plan?

You will make your initial election on or before your entry date. (You should review Section I on Eligibility to better understand the eligibility requirements and entry date.) Then, for each following Plan Year, the election period is established by the Administrator and applied uniformly to all Participants. It will normally be a period of time prior to the beginning of each Plan Year. The Administrator will inform you each year about the election period. (See the Article entitled "General Information About Our Plan" for the definition of Plan Year.)

#### 6. May I change my elections during the Plan Year?

Generally, you cannot change the elections you have made after the beginning of the Plan Year. However, there are certain limited situations when you can change your elections. You are permitted to change elections if you have a "change in status" and you make an election change that is consistent with the change in status. Currently, Federal law considers the following events to be a change in status:

- Marriage, divorce, death of a spouse, legal separation or annulment;
- Change in the number of dependents, including birth, adoption, placement for adoption, or death of a dependent;
- Any of the following events for you, your spouse or dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, a change in worksite, or any other change in employment status that affects eligibility for benefits;
- One of your dependents satisfies or ceases to satisfy the requirements for coverage due to change in age, student status, or any similar circumstance; and
- A change in the place of residence of you, your spouse or dependent that would lead to a change in status, such as moving out of a coverage area for insurance.

In addition, if you are participating in the Dependent Care Flexible Spending Account, then there is a change in status if your dependent no longer meets the qualifications to be eligible for dependent care.

However, with respect to the Health Flexible Spending Account, you may only increase your benefit election as the result of a change in status.

However, with respect to the Health Savings Account, you may modify or revoke your elections without having to have a change in status.

There are detailed rules on when a change in election is deemed to be consistent with a change in status. In addition, there are laws that give you rights to change health coverage for you, your spouse, or your dependents. If you change coverage due to rights you have under the law, then you can make a corresponding change in your elections under the Plan. If any of these conditions apply to you, you should contact the Administrator.

If the cost of a benefit provided under the Plan increases or decreases during a Plan Year, then we will automatically increase or decrease, as the case may be, your salary redirection election. If the cost increases significantly, you will be permitted to either make corresponding changes in your payments or revoke your election and obtain coverage under another benefit package option with similar coverage, or revoke your election entirely.

If the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, then you may revoke your elections and elect to receive on a prospective basis coverage under another plan with similar coverage. In addition, if we add a new coverage option or eliminate an existing option, you may elect the newly-added option (or elect another option if an option has been eliminated) and make corresponding election changes to other options providing similar coverage. If you are not a Participant, you may elect to join the Plan. There are also certain situations when you may be able to change your elections on account of a change under the plan of your spouse's, former spouse's or dependent's employer.

These rules on change due to cost or coverage do not apply to the Health Flexible Spending Account, and you may not change your election to the Health Flexible Spending Account if you make a change due to cost or coverage for insurance or if you decide to participate in the Health Savings Account.

You may not change your election under the Dependent Care Flexible Spending Account if the cost change is imposed by a dependent care provider who is your relative.

You may revoke your coverage under the employer's group health plan outside of our open enrollment period, if your employment status changes from working at least 30 hours per week to less than 30 hours. This is regardless of whether the reduction in hours has resulted in loss of eligibility. You must show intent to enroll in another health plan.

You may also revoke your coverage under our Employer sponsored group health plan if you are eligible to obtain coverage through the health exchanges.

## **7. May I make new elections in future Plan Years?**

Yes, you may. For each new Plan Year, you may change the elections that you previously made. You may also choose not to participate in the Plan for the upcoming Plan Year. If you do not make new elections during the election period before a new Plan Year begins, we will assume you want your elections for insured benefits only to remain the same and you will not be considered a Participant for the non-insured benefit options under the Plan for the upcoming Plan Year.

## **IV BENEFITS**

### **1. Health Flexible Spending Account**

The Health Flexible Spending Account enables you to pay for expenses allowed under Sections 105 and 213(d) of the Internal Revenue Code which are not covered by our insured medical plan and save taxes at the same time. The Health Flexible Spending Account allows you to be reimbursed by the Employer for expenses incurred by you and your dependents.

Drug costs, including insulin, may be reimbursed.

You may be reimbursed for "over the counter" drugs only if those drugs are prescribed for you. You may not, however, be reimbursed for the cost of other health care coverage maintained outside of the Plan, or for long-term care expenses. A list of covered expenses is available from the Administrator.

The most that you can contribute to your Health Flexible Spending Account each Plan Year is set by the IRS the dollar limit may increase annually to adjust for the cost of living. In addition, you will be eligible to carryover amounts left in your Health Flexible Spending Account, up to the IRS maximum. This means that amounts you do not use during a Plan Year can be carried over to the next Plan Year and used for expenses incurred in the next Plan Year.

In order to be reimbursed for a health care expense, you must submit to the Administrator an itemized bill from the service provider. We will also provide you with a debit or credit card to use to pay for medical expenses. The Administrator will provide you with further details. Amounts reimbursed from the Plan may not be claimed as a deduction on your personal income tax return. Reimbursement from the fund shall be paid at least once a month. Expenses under this Plan are treated as being "incurred" when you are provided with the care that gives rise to the expenses, not when you are formally billed or charged, or you pay for the medical care.

You may be reimbursed for expenses for any child until the end of the calendar year in which the child reaches age 26. A child is a natural child, stepchild, foster child, adopted child, or a child placed with you for adoption. If a child gains or regains eligibility due to these new rules, that qualifies as a change in status to change coverage.

Newborns' and Mothers' Health Protection Act: Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's

attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act: This plan, as required by the Women's Health and Cancer Rights Act of 1998, will reimburse up to plan limits for benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). Contact your Plan Administrator for more information.

## **2. Dependent Care Flexible Spending Account**

The Dependent Care Flexible Spending Account enables you to pay for out-of-pocket, work-related dependent day-care cost with pre-tax dollars. If you are married, you can use the account if you and your spouse both work or, in some situations, if your spouse goes to school full-time. Single employees can also use the account.

An eligible dependent is someone for whom you can claim expenses on Federal Income Tax Form 2441 "Credit for Child and Dependent Care Expenses." Children must be under age 13. Other dependents must be physically or mentally unable to care for themselves. Dependent Care arrangements which qualify include:

- (a) A Dependent (Day) Care Center, provided that if care is provided by the facility for more than six individuals, the facility complies with applicable state and local laws;
- (b) An Educational Institution for pre-school children. For older children, only expenses for non-school care are eligible; and
- (c) An "Individual" who provides care inside or outside your home: The "Individual" may not be a child of yours under age 19 or anyone you claim as a dependent for Federal tax purposes.

You should make sure that the dependent care expenses you are currently paying for qualify under our Plan. We will also provide you with a debit or credit card to use to pay for dependent care expenses. The Administrator will provide you with further details.

The law places limits on the amount of money that can be paid to you in a calendar year from your Dependent Care Flexible Spending Account. Generally, your reimbursements may not exceed the lesser of: (a) the IRS maximums (there are different maximums if you are married filing a joint return or the head of a household; or if you are married filing separate returns); (b) your taxable compensation; (c) your spouse's actual or deemed earned income (a spouse who is a full time student or incapable of caring for himself/herself has a monthly earned income of \$250 for one dependent or \$500 for two or more dependents).

Also, in order to have the reimbursements made to you from this account be excludable from your income, you must provide a statement from the service provider including the name, address, and in most cases, the taxpayer identification number of the service provider on your tax form for the year, as well as the amount of such expense as proof that the expense has been incurred. In addition, Federal tax laws permit a tax credit for certain dependent care expenses you may be paying for even if you are not a Participant in this Plan. You may save more money if you take advantage of this tax credit rather than using the Dependent Care Flexible Spending Account under our Plan. Ask your tax adviser which is better for you.

## **3. Premium Expense Account**

A Premium Expense Account allows you to use tax-free dollars to pay for certain premium expenses under various insurance programs that we offer you. These premium expenses include:

- Health care premiums under our insured group medical plan.
- Group term life insurance premiums.
- Dental insurance premiums.
- Vision insurance premiums.
- Accidental death and dismemberment insurance premiums.

Under our Plan, we will establish sub-accounts for you for each different type of insurance coverage that is available. Also, certain limits on the amount of coverage may apply.

The Administrator may terminate or modify Plan benefits at any time, subject to the provisions of any insurance contracts providing benefits described above. We will not be liable to you if an insurance company fails to provide any of the benefits described above. Also, your insurance will end when you leave employment, are no longer eligible under the terms of any insurance policies, or when insurance terminates.

Any benefits to be provided by insurance will be provided only after (1) you have provided the Administrator the necessary information to apply for insurance, and (2) the insurance is in effect for you.

If you cover your children up to age 26 under your insurance, you can pay for that coverage through the Plan.

#### **4. May I direct Plan contributions to my Health Savings Account?**

Yes. Any monies that you do not apply toward available benefits can be contributed to your Health Savings Account, which enables you to pay for expenses which are not covered by our insured medical plan and save taxes at the same time. Please see your Plan Administrator for further details.

### **V BENEFIT PAYMENTS**

#### **1. When will I receive payments from my accounts?**

During the course of the Plan Year, you may submit requests for reimbursement of expenses you have incurred. Expenses are considered "incurred" when the service is performed, not necessarily when it is paid for. The Administrator will provide you with acceptable forms for submitting these requests for reimbursement. If the request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement payment soon thereafter. Remember, these reimbursements which are made from the Plan are generally not subject to federal income tax or withholding. Nor are they subject to Social Security taxes. Requests for payment of insured benefits should be made directly to the insurer. You will only be reimbursed from the Dependent Care Flexible Spending Account to the extent that there are sufficient funds in the Account to cover your request.

#### **2. What happens if I don't spend all Plan contributions during the Plan Year?**

If you have not spent all the amounts in your Dependent Care Flexible Spending Account by the end of the Plan Year, you may continue to incur claims for expenses during the "Grace Period." The "Grace Period" extends 2 1/2 months after the end of the Plan Year, during which time you can continue to incur claims and use up all amounts remaining in your Dependent Care Flexible Spending Account.

Any monies left at the end of the Plan Year and the Grace Period will be forfeited, except for amounts contributed to your Health Savings Account. Obviously, qualifying expenses that you incur late in the Plan Year or during the Grace Period for which you seek reimbursement after the end of such Plan Year and Grace Period will be paid first before any amount is forfeited. For the Health Flexible Spending Account, you must submit claims no later than 90 days after the end of the Plan Year. For the Dependent Care Flexible Spending Account, you must submit claims no later than 90 days after the end of the Plan Year. Because it is possible that you might forfeit amounts in the Plan if you do not fully use the contributions that have been made, it is important that you decide how much to place in each account carefully and conservatively. Remember, you must decide which benefits you want to contribute to and how much to place in each account before the Plan Year begins. You want to be as certain as you can that the amount you decide to place in each account will be used up entirely.

#### **3. Family and Medical Leave Act (FMLA)**

If you take leave under the Family and Medical Leave Act, you may revoke or change your existing elections for health insurance, group-term life insurance and the Health Flexible Spending Account. If your coverage in these benefits terminates, due to your revocation of the benefit while on leave or due to your non-payment of contributions, you will be permitted to reinstate coverage for the remaining part of the Plan Year upon your return. For the Health Flexible Spending Account, you may continue your coverage or you may revoke your coverage and resume it when you return. You can resume your coverage at its original level and make payments for the time that you are on leave. For example, if you elect \$1,200 for the year and are out on leave for 3 months, then return and elect to resume your coverage at that level, your remaining payments will be increased to cover the difference - from \$100 per month to \$150 per month. Alternatively your maximum amount will be reduced proportionately for the time that you were gone. For example, if you elect \$1,200 for the year and are out on leave for 3 months, your amount will be reduced to \$900. The expenses you incur during the time you are not in the Health Flexible Spending Account are not reimbursable.

If you continue your coverage during your unpaid leave, you may pre-pay for the coverage, you may pay for your coverage on an after-tax basis while you are on leave, or you and your Employer may arrange a schedule for you to "catch up" your payments when you return.

#### **4. Uniformed Services Employment and Reemployment Rights Act (USERRA)**

If you are going into or returning from military service, you may have special rights to health care coverage under your Health Flexible Spending Account under the Uniformed Services Employment and Reemployment Rights Act of 1994. These rights can include extended health care coverage. If you may be affected by this law, ask your Administrator for further details.

#### **5. What happens if I terminate employment?**

If you terminate employment during the Plan Year, your right to benefits will be determined in the following manner:

- (a) You will remain covered by insurance, but only for the period for which premiums have been paid prior to your termination of employment.
- (b) You will still be able to request reimbursement for qualifying dependent care expenses incurred prior to your date of termination from the balance remaining in your dependent care account at the time of termination of employment. However, no further salary redirection and Employer contributions will be made on your behalf after you terminate. You must submit claims within 90 days after termination.

(c) Your Health Savings Account amounts will remain yours even after your termination of employment.

(d) For health benefit coverage and Health Flexible Spending Account coverage on termination of employment, please see the Article entitled "Continuation Coverage Rights Under COBRA." Upon your termination of employment, your participation in the Health Flexible Spending Account will cease, and no further salary redirection and Employer contributions will be contributed on your behalf. However, you will be able to submit claims for health care expenses that were incurred before the end of the period for which payments to the Health Flexible Spending Account have already been made. Your further participation will be governed by "Continuation Coverage Rights Under COBRA."

**6. Will my Social Security benefits be affected?**

Your Social Security benefits may be slightly reduced because when you receive tax-free benefits under our Plan, it reduces the amount of contributions that you make to the Federal Social Security system as well as our contribution to Social Security on your behalf.

**VI  
HIGHLY COMPENSATED AND KEY EMPLOYEES**

**1. Do limitations apply to highly compensated employees?**

Under the Internal Revenue Code, highly compensated employees and key employees generally are Participants who are officers, shareholders or highly paid. You will be notified by the Administrator each Plan Year whether you are a highly compensated employee or a key employee.

If you are within these categories, the amount of contributions and benefits for you may be limited so that the Plan as a whole does not unfairly favor those who are highly paid, their spouses or their dependents. Federal tax laws state that a plan will be considered to unfairly favor the key employees if they as a group receive more than 25% of all of the nontaxable benefits provided for under our Plan.

Plan experience will dictate whether contribution limitations on highly compensated employees or key employees will apply. You will be notified of these limitations if you are affected.

**VII  
PLAN ACCOUNTING**

**1. Periodic Statements**

The Administrator will provide you with a statement of your account periodically during the Plan Year that shows your account balance. It is important to read these statements carefully so you understand the balance remaining to pay for a benefit. Remember, you want to spend all the money you have designated for a particular benefit by the end of the Plan Year.

**VIII  
GENERAL INFORMATION ABOUT OUR PLAN**

This Section contains certain general information which you may need to know about the Plan.

**1. General Plan Information**

WideOrbit Cafeteria Plan is the name of the Plan.

Your Employer has assigned Plan Number 501 to your Plan.

The provisions of your amended Plan become effective on 1/1/2019. Your Plan was originally effective on 1/1/2017.

Your Plan's records are maintained on a twelve-month period of time. This is known as the Plan Year. The Plan Year begins on January 1 and ends on December 31.

**2. Employer Information**

Your Employer's name, address, and identification number are:

WideOrbit  
1160 Battery Street Ste 300  
San Francisco, California 94111  
943339060

**3. Plan Administrator Information**

The name, address and business telephone number of your Plan's Administrator are:

WideOrbit  
1160 Battery Street Ste 300  
San Francisco, California 94111  
4155009349

The Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Administrator will also answer any questions you may have about our Plan. You may contact the Administrator for any further information about the Plan.

#### **4. Service of Legal Process**

The name and address of the Plan's agent for service of legal process are:

WideOrbit  
1160 Battery Street Ste 300  
San Francisco, California 94111

#### **5. Type of Administration**

The type of Administration is Employer Administration.

#### **6. Claims Submission**

Claims for expenses should be submitted to:

Discovery Benefits, Inc.

PO Box 2926

Fargo, ND 58108-2926

### **IX ADDITIONAL PLAN INFORMATION**

#### **1. Your Rights Under ERISA**

Plan Participants, eligible employees and all other employees of the Employer may be entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code. For those benefits subject to ERISA, these laws provide that Participants, eligible employees and all other employees are entitled to:

- (a) examine, without charge, at the Administrator's office, all Plan documents, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration;
- (b) obtain copies of all Plan documents and other Plan information upon written request to the Administrator. The Administrator may charge a reasonable fee for the copies;
- (c) continue health coverage for a Participant, Spouse, or other dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Employees or dependents may have to pay for such coverage; and
- (d) review this summary plan description and the documents governing the plan on the rules governing COBRA continuation rights.

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of an employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the best interest of you and other Plan Participants.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may request the Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

If you have any questions about the Plan, you should contact the Administrator. If you have any questions about this statement, or about your rights under ERISA or the Health Insurance Portability and Accountability Act (HIPAA) or if you need assistance in obtaining documents from the Administrator, you should contact either the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at [www.dol.gov/ebsa/](http://www.dol.gov/ebsa/). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

## 2. Claims Process

You should submit all reimbursement claims during the Plan Year. For the Health Flexible Spending Account, you must submit claims no later than 90 days after the end of the Plan Year. However, if you terminate employment during the Plan Year, you must submit your Health Flexible Spending Account claims within 90 days after your termination of employment. For the Dependent Care Flexible Spending Account, you must submit claims no later than 90 days after the end of the Plan Year. However, if you terminate employment during the Plan Year, you must submit your Dependent Care Flexible Spending Account claims within 90 days after your termination of employment. Any claims submitted after that time will not be considered.

Claims that are insured will be handled in accordance with procedures contained in the insurance policies. All other general requests should be directed to the Administrator of our Plan. If a dependent care claim under the Plan is denied in whole or in part, you or your beneficiary will receive written notification. The notification will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, a description of any additional information needed to process the claim and an explanation of the claims review procedure. Within 60 days after denial, you or your beneficiary may submit a written request for reconsideration of the denial to the Administrator.

Any such request should be accompanied by documents or records in support of your appeal. You or your beneficiary may review pertinent documents and submit issues and comments in writing. The Administrator will review the claim and provide, within 60 days, a written response to the appeal. (This period may be extended an additional 60 days under certain circumstances.) In this response, the Administrator will explain the reason for the decision, with specific reference to the provisions of the Plan on which the decision is based. The Administrator has the exclusive right to interpret the appropriate plan provisions. Decisions of the Administrator are conclusive and binding.

In the case of a claim for medical expenses under the Health Flexible Spending Account, the following timetable for claims applies:

Notification of whether claim is accepted or denied	30 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information to process the claim:	
Notification to Participant	15 days
Response by Participant	45 days
Review of claim denial	60 days

The Plan Administrator will provide written or electronic notification of any claim denial. The notice will state:

- (a) The specific reason or reasons for the denial;
- (b) Reference to the specific Plan provisions on which the denial was based;
- (c) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

- (d) A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of your right to bring a civil action under section 502 of ERISA following a denial on review;
- (e) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim; and
- (f) If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

When you receive a denial, you will have 180 days following receipt of the notification in which to appeal the decision. You may submit written comments, documents, records, and other information relating to the claim. If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a claim if it:

- (a) was relied upon in making the claim determination;
- (b) was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;
- (c) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or
- (d) constituted a statement of policy or guidance with respect to the Plan concerning the denied claim.

The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

### 3. Qualified Medical Child Support Order

A medical child support order is a judgment, decree or order (including approval of a property settlement) made under state law that provides for child support or health coverage for the child of a participant. The child becomes an "alternate recipient" and can receive benefits under the health plans of the Employer, if the order is determined to be "qualified." You may obtain, without charge, a copy of the procedures governing the determination of qualified medical child support orders from the Plan Administrator.

## X CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain employees and their families covered under health benefits under this Plan will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator or its designee is responsible for administering COBRA continuation coverage. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA. While the Plan itself is not a group health plan, it does provide health benefits. Whenever "Plan" is used in this section, it means any of the health benefits under this Plan including the Health Flexible Spending Account.

### 1. What is COBRA continuation coverage?

COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

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

## 2. Who can become a Qualified Beneficiary?

In general, a Qualified Beneficiary can be:

- (a) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.
- (b) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Employee" includes any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan. However, this provision does not establish eligibility of these individuals. Eligibility for Plan coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

## 3. What is a Qualifying Event?

A Qualifying Event is any of the following if the Plan provided that the Plan participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

- (a) The death of a covered Employee.
- (b) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.
- (c) The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.
- (d) A covered Employee's enrollment in any part of the Medicare program.
- (e) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event, the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993, as amended ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

## 4. What factors should be considered when determining to elect COBRA continuation coverage?

When considering options for health coverage, Qualified Beneficiaries should consider:

- **Premiums:** This plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive. Qualified Beneficiaries have special enrollment rights

under federal law (HIPAA). They have the right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by a spouse's employer) within 30 days after Plan coverage ends due to one of the Qualifying Events listed above.

- **Provider Networks:** If a Qualified Beneficiary is currently getting care or treatment for a condition, a change in health coverage may affect access to a particular health care provider. You may want to check to see if your current health care providers participate in a network in considering options for health coverage.
- **Drug Formularies:** For Qualified Beneficiaries taking medication, a change in health coverage may affect costs for medication – and in some cases, the medication may not be covered by another plan. Qualified beneficiaries should check to see if current medications are listed in drug formularies for other health coverage.
- **Severance payments:** If COBRA rights arise because the Employee has lost his job and there is a severance package available from the employer, the former employer may have offered to pay some or all of the Employee's COBRA payments for a period of time. This can affect the timing of coverage available in the Marketplace. In this scenario, the Employee may want to contact the Department of Labor at 1-866-444-3272 to discuss options.
- **Medicare Eligibility:** You should be aware of how COBRA coverage coordinates with Medicare eligibility. If you are eligible for Medicare at the time of the Qualifying Event, or if you will become eligible soon after the Qualifying Event, you should know that you have 8 months to enroll in Medicare after your employment –related health coverage ends. Electing COBRA coverage does not extend this 8-month period. For more information, see [medicare.gov/sign-up-change-plan](http://medicare.gov/sign-up-change-plan).
- **Service Areas:** If benefits under the Plan are limited to specific service or coverage areas, benefits may not be available to a Qualified Beneficiary who moves out of the area.
- **Other Cost-Sharing:** In addition to premiums or contributions for health coverage, the Plan requires participants to pay copayments, deductibles, coinsurance, or other amounts as benefits are used. Qualified beneficiaries should check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

**Are there other coverage options besides COBRA Continuation Coverage?** Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for Qualified Beneficiaries through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at [www.healthcare.gov](http://www.healthcare.gov).

#### **5. What is the procedure for obtaining COBRA continuation coverage?**

The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

#### **6. What is the election period and how long must it last?**

The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

Note: If a covered Employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, as extended by the Trade Preferences Extension Act of 2015, and the employee and his or her covered dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he or she and/or his or her family members may qualify for assistance under this special provision should contact the Plan Administrator or its designee for further information about the special second election period. If continuation coverage is elected under this extension, it will not become effective prior to the beginning of this special second election period.

#### **7. Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event?**

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The Employer (if the Employer is not the Plan Administrator) will notify the Plan Administrator or its designee of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

- (a) the end of employment or reduction of hours of employment,
- (b) death of the employee,

- (c) commencement of a proceeding in bankruptcy with respect to the Employer, or
- (d) entitlement of the employee to any part of Medicare.

**IMPORTANT:**

**For the other Qualifying Events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Administrator or its designee.**

**NOTICE PROCEDURES:**

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

WideOrbit  
1160 Battery Street Ste 300  
San Francisco, California 94111

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include a **copy of the divorce decree or the legal separation agreement**.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives ***timely notice*** that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your spouse or dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

**8. Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights?**

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

**9. Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare?**

Qualified Beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

**10. When may a Qualified Beneficiary's COBRA continuation coverage be terminated?**

During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

- (a) The last day of the applicable maximum coverage period.
- (b) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.
- (c) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.

(d) The date, after the date of the election, that the Qualified Beneficiary first becomes entitled to Medicare (either part A or part B, whichever occurs earlier).

(e) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

(1) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

(2) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

#### **11. What are the maximum coverage periods for COBRA continuation coverage?**

The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

(a) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

(b) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries ends on the later of:

(1) 36 months after the date the covered Employee becomes enrolled in the Medicare program. This extension does not apply to the covered Employee; or

(2) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

(c) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

(d) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

#### **12. Under what circumstances can the maximum coverage period be expanded?**

If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Plan Administrator or its designee in accordance with the procedures above.

#### **13. How does a Qualified Beneficiary become entitled to a disability extension?**

A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice must be sent to the Plan Administrator or its designee in accordance with the procedures above.

#### **14. Does the Plan require payment for COBRA continuation coverage?**

For any period of COBRA continuation coverage under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage may be required to pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. Your Plan Administrator will

inform you of the cost. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

**15. Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments?**

Yes. The Plan is also permitted to allow for payment at other intervals.

**16. What is Timely Payment for COBRA continuation coverage?**

Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered Employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of \$50 or 10% of the required amount.

**17. How is my participation in the Health Flexible Spending Account affected?**

You can elect to continue your participation in the Health Flexible Spending Account for the remainder of the Plan Year, subject to the following conditions. You may only continue to participate in the Health Flexible Spending Account if you have elected to contribute more money including any carryover amounts than you have taken out in claims. For example, if you elected to contribute an annual amount of \$500 and, at the time you terminate employment, you have contributed \$300 but only claimed \$150, you may elect to continue coverage under the Health Flexible Spending Account. If you elect to continue coverage, then you would be able to continue to receive your health reimbursements up to the \$500. However, you must continue to pay for the coverage, just as the money has been taken out of your paycheck, but on an after-tax basis. The Plan can also charge you an extra amount (as explained above for other health benefits) to provide this benefit.

**IF YOU HAVE QUESTIONS**

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator or its designee. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

**KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES**

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator or its designee.

**XI  
SUMMARY**

The money you earn is important to you and your family. You need it to pay your bills, enjoy recreational activities and save for the future. Our flexible benefits plan will help you keep more of the money you earn by lowering the amount of taxes you pay. The Plan is the result of our continuing efforts to find ways to help you get the most for your earnings.

If you have any questions, please contact the Administrator.

## Appendix D: Notice of HIPAA Privacy Practices

Purpose: Privacy notices must be given to individuals covered by the plan. A single notice to a covered employee is effective for all covered dependents. Notices must be provided upon enrollment, and within 60 days of a material change to the notice. Plans must notify participants every 3 years that a privacy notice is available. Consistent with other template forms, this Notice assumes the plan does not, with respect to protected health information: (1) engage in fundraising; (2) engage in marketing, where the plan receives financial remuneration for such marketing; (3) sell protected health information; (4) use genetic information for underwriting purposes; or (5) engage in research. If these assumptions are not correct this Notice should be changed.

### WideOrbit, LLC

#### PRIVACY PRACTICES NOTICE

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

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#### Summary of Our Privacy Practices

We may use and disclose your protected health information ("medical information"), without your permission, for treatment, payment, and health care operations activities. We may use and disclose your medical information, without your permission, when required or authorized by law for public health activities, law enforcement, judicial and administrative proceedings, research, and certain other public benefit functions.

We may disclose your medical information to your family members, friends, and others you involve in your care or payment for your health care. We may disclose your medical information to appropriate public and private agencies in disaster relief situations.

We may disclose to your employer whether you are enrolled or disenrolled in the health plans it sponsors. We may disclose summary health information to your employer for certain limited purposes. We may disclose your medical information to your employer to administer your group health plan if your employer explains the

limitations on its use and disclosure of your medical information in the plan document for your group health plan.

Except for certain legally-approved uses and disclosures, we will not otherwise use or disclose your medical information without your written authorization.

You have the right to examine and receive a copy of your medical information. You have the right to receive an accounting of certain disclosures we may make of your medical information. You have the right to request that we amend, further restrict use and disclosure of, or communicate in confidence with you about your medical information.

You have the right to receive notice of breaches of your unsecured medical information.

Please review this entire notice for details about the uses and disclosures we may make of your medical information, about your rights and how to exercise them, and about complaints

regarding or additional information about our privacy practices.

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### Contact Information

For more information about our privacy practices, to discuss questions or concerns, or to

get additional copies of this notice, please contact our Contact Office.

Contact Office: Human Resources \_\_\_\_\_

Telephone: 415-675-6700 \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail: \_\_\_\_\_

Address: \_\_\_\_\_

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### Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your protected health information ("medical information"). We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your medical information.

We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect September 23, 2013, and will remain in effect unless we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make any change in our privacy practices and the new terms of our notice applicable to all medical information we maintain, including medical information we created or received before we made the change.

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### Uses and Disclosures of Your Medical Information

**Treatment:** We may disclose your medical information, without your permission, to a physician or other health care provider to treat you.

**Payment:** We may use and disclose your medical information, without your permission, to pay claims from physicians, hospitals and other health care providers for services delivered to you that are covered by your health plan, to determine your eligibility for benefits, to coordinate your benefits with other payers, to determine the medical necessity of care delivered to you, to obtain premiums for your health coverage, to issue explanations of benefits to the subscriber of

the health plan in which you participate, and the like. We may disclose your medical information to a health care provider or another health plan for that provider or plan to obtain payment or engage in other payment activities.

**Health Care Operations:** We may use and disclose your medical information, without your permission, for health care operations. Health care operations include:

- health care quality assessment and improvement activities;
- reviewing and evaluating health care provider and health plan performance, qualifications and competence, health care training

programs, health care provider and health plan accreditation, certification, licensing and credentialing activities;

- conducting or arranging for medical reviews, audits, and legal services, including fraud and abuse detection and prevention;
- underwriting and premium rating our risk for health coverage, and obtaining stop-loss and similar reinsurance for our health coverage obligations; and
- business planning, development, management, and general administration, including customer service, grievance resolution, claims payment and health coverage improvement activities, de-identifying medical information, and creating limited data sets for health care operations, public health activities, and research.

We may disclose your medical information to another health plan or to a health care provider subject to federal privacy protection laws, as long as the plan or provider has or had a relationship with you and the medical information is for that plan's or provider's health care quality assessment and improvement activities, competence and qualification evaluation and review activities, or fraud and abuse detection and prevention.

**Your Authorization:** You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we will not use or disclose your medical information for any purpose other than those described in this notice. We generally may use or disclose any psychotherapy notes we hold only with your authorization.

**Family, Friends, and Others Involved in Your Care or Payment for Care:** We may disclose your medical information to a family member, friend or any other person you involve in your care or payment for your health care. We will disclose only the medical information that is relevant to the person's involvement.

We may use or disclose your name, location, and general condition to notify, or to assist an appropriate public or private agency to locate and

notify, a person responsible for your care in appropriate situations, such as a medical emergency or during disaster relief efforts.

We will provide you with an opportunity to object to these disclosures, unless you are not present or are incapacitated or it is an emergency or disaster relief situation. In those situations, we will use our professional judgment to determine whether disclosing medical information related to your care or payment is in your best interest under the circumstances.

Your medical information remains protected by us for at least 50 years after you die. After you die, we may disclose to a family member, or other person involved in your health care prior to your death, the medical information that is relevant to that person's involvement, unless doing so is inconsistent with your preference and you have told us so.

**Your Employer:** We may disclose to your employer whether you are enrolled or disenrolled in a health plan that your employer sponsors.

We may disclose summary health information to your employer to use to obtain premium bids for the health insurance coverage offered under the group health plan in which you participate or to decide whether to modify, amend or terminate that group health plan (this is sometimes called "underwriting"). Summary health information is aggregated claims history, claims expenses or types of claims experienced by the enrollees in your group health plan. Although summary health information will be stripped of all direct identifiers of these enrollees, it still may be possible to identify medical information contained in the summary health information as yours. We are expressly prohibited from using or disclosing any health information containing your genetic information for underwriting purposes.

We may disclose your medical information and the medical information of others enrolled in your group health plan to your employer to administer your group health plan. Before we may do that, your employer must amend the plan document for your group health plan to establish the limited uses and disclosures it may make of your medical information. Please see your group

health plan document for a full explanation of those limitations.

**Health-Related Products and Services:**

We may use your medical information to communicate with you about health-related products, benefits and services, and payment for those products, benefits and services that we provide or include in our benefits plan. We may use your medical information to communicate with you about treatment alternatives that may be of interest to you.

These communications may include information about the health care providers in our networks, about replacement of or enhancements to your health plan, and about health-related products or services that are available only to our enrollees that add value to our benefits plans.

**Public Health and Benefit Activities:** We may use and disclose your medical information, without your permission, when required by law, and when authorized by law for the following kinds of public health and public benefit activities:

- for public health, including to report disease and vital statistics, child

- abuse, and adult abuse, neglect or domestic violence;
- to avert a serious and imminent threat to health or safety;
- for health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities, and fraud prevention agencies;
- for research;
- in response to court and administrative orders and other lawful process;
- to law enforcement officials with regard to crime victims and criminal activities;
- to coroners, medical examiners, funeral directors, and organ procurement organizations;
- to the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; and
- as authorized by state worker's compensation laws.

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**Your Rights**

**Access:** You have the right to examine and to receive a copy of your medical information, with limited exceptions. You should submit your request in writing to our plan administrator.

**We may charge you reasonable, cost-based fees (including labor costs) for a copy of your medical information, for mailing the copy to you, and for preparing any summary or explanation of your medical information you request. Contact our Office for information about our fees.**

Your medical information may be maintained electronically. If so, you can request an electronic copy of your medical information. If you do, we will provide you with your medical information in the electronic form and format you requested, if it is readily producible in such form and format. If

not, we will produce it in a readable electronic form and format as we mutually agree upon.

You may request that we transmit your medical information directly to another person you designate. If so, we will provide the copy to the designated person. Your request must be in writing, signed by you and must clearly identify the designated person and where we should send the copy of your medical information.

**Disclosure Accounting:** You have the right to a list of instances from the prior six years in which we disclose your medical information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities.

You should submit your request to the contact at the end of this notice. We will provide

you with information about each accountable disclosure that we made during the period for which you request the accounting, except we are not obligated to account for a disclosure that occurred more than 6 years before the date of your request and never for a disclosure that occurred before the plan's effective date (if the plan was created less than six years ago).

**Amendment.** You have the right to request that we amend your medical information. You should submit your request in writing to the contact at the end of this notice.

We may deny your request only for certain reasons. If we deny your request, we will provide you a written explanation. If we accept your request, we will make your amendment part of your medical information and use reasonable efforts to inform others of the amendment who we know may have and rely on the unamended information to your detriment, as well as persons you want to receive the amendment.

**Restriction:** You have the right to request that we restrict our use or disclosure of your medical information for treatment, payment or health care operations, or with family, friends or others you identify. We are not required to agree to your request, except for certain required restrictions, described below. If we do agree, we will abide by our agreement, except in a medical emergency or as required or authorized by law. You should submit your request to the contact at the end of this notice. We will agree to (and not terminate) a restriction request if:

1. the disclosure is to a health plan for purposes of carrying out payment or health care operations and is not otherwise required by law; and
2. the medical information pertains solely to a health care item or service for which the individual, or person other than the health plan on behalf of the individual, has paid the covered entity in full.

**Confidential Communication:** You have the right to request that we communicate with you about your medical information in confidence by means or to locations that you specify. You should make your request in writing, and your request must represent that the information could endanger you if it is not communicated in confidence as you request. You should submit your request in writing to the contact at the end of this notice.

We will accommodate your request if it is reasonable, specifies the means or location for communicating with you, and continues to permit us to collect premiums and pay claims under your health plan. Please note that an explanation of benefits and other information that we issue to the subscriber about health care that you received for which you did not request confidential communications, or about health care received by the subscriber or by others covered by the health plan in which you participate, may contain sufficient information to reveal that you obtained health care for which we paid, even though you requested that we communicate with you about that health care in confidence.

**Breach Notification:** You have the right to receive notice of a breach of your unsecured medical information. Notification may be delayed or not provided if so, required by a law enforcement official. You may request that notice be provided by electronic mail. If you are deceased and there is a breach of your medical information, the notice will be provided to your next of kin or personal representatives if the plan knows the identity and address of such individual(s).

**Electronic Notice:** If you receive this notice on our web site or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact our Contact Office to obtain this notice in written form.

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## Complaints

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, about amending your medical

information, about restricting our use or disclosure of your medical information, or about how we communicate with you about your medical information (including a breach notice

communication), you may complain to our Contact Office.

You also may submit a written complaint to the Office for Civil Rights of the United States Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201. You may contact the Office for Civil Rights' Hotline at 1-800-368-1019.

We support your right to the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

# Appendix E: Authorized Representatives

## Appointment of Authorized Representative

I, \_\_\_\_\_

[name of claimant]

hereby appoint \_\_\_\_\_ to act on my behalf

[name of Authorized Representative]

or on behalf of \_\_\_\_\_

[name of patient: plan participant or beneficiary]

in connection with any claim for coverage or benefits, including receipt of any approvals or authorizations that are required before medical services are provided under the plan named above ("Plan"). I authorize my representative to receive any and all information that is provided to me, and to act for me and for my covered spouse or dependent, if named above as the patient, in providing any information to the Plan that relates to any claim for coverage or benefits under the Plan.

This form does not constitute an assignment of rights for direct payment.

Distribute to me and to my Authorized Representative: All information and notifications should be distributed to me and to my Authorized Representative.

\_\_\_\_\_

Claimant's signature

\_\_\_\_\_

Date

Accepted: \_\_\_\_\_

Authorized Representative's signature

\_\_\_\_\_

Date

Witness: \_\_\_\_\_

Witness signature

\_\_\_\_\_

Date

A high-angle, wide shot of the Golden Gate Bridge in San Francisco. The bridge's iconic orange-red towers and suspension cables are prominent on the left, extending across the frame towards the right. The bridge spans across a deep blue-green bay, with a small white ferry boat visible in the lower right. In the background, the city of San Francisco is visible on the hills under a clear blue sky. A dark blue horizontal bar is overlaid on the top right of the image, containing the title text.

# 2023 BENEFITS GUIDE

**WIDEORBIT**

Say hello to a Wider World™

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**This guide is an overview** and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your plan benefit booklets or summary plan descriptions (SPDs). The plan benefit booklets determine how all benefits are paid.



## GETTING STARTED

### 2023 Benefits

January 1, 2023 through December 31, 2023

### 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 see the *Important Notices* section for more details.

Whether you're enrolling in benefits for the first time, nearing retirement, or somewhere in between, WideOrbit supports you with benefit programs and resources to help you thrive today and prepare for tomorrow.

This guide provides an overview of your healthcare coverage, life, disability, retirement benefits, and more.

You'll find tips to help you understand your medical coverage, save time and money on healthcare, reduce taxes, and balance your work and home life. Review the coverage and tools available to you to make the most of your benefits package.

# WHO'S ELIGIBLE FOR BENEFITS?

## Employees

You are eligible if you are a regular full-time employee working 20 or more hours per week. Employees with variable hours and seasonal schedules may be considered eligible for benefits. Refer to "Determining Eligibility" later in this guide for details.

## Eligible dependents

- Legally married spouse or same or opposite gender domestic partner
- Natural, adopted or stepchildren up to age 26. Domestic partner's child(ren) are eligible.
- Children over age 26 who are disabled and depend on you for support
- Children named in a Qualified Medical Child Support Order (QMCSO).

For additional information, please refer to the benefit booklets for each benefit.

## Domestic Partner eligibility criteria

If you are enrolling a domestic partner or domestic partner children, you are required to have met all eligibility requirements listed below for the previous 6 months:

- You maintain the same principal place of residence and intend to do so in the future
  - You agree to be responsible for each other's basic living expenses in the event that either of you are unable to provide such expenses for yourself
  - You are both 18 or older and neither of you are married
  - You are not related by blood to such a degree that you would be prevented from marrying in the state in which you reside
  - Neither of you has maintained coverage for another Domestic Partner under any health plan within the last six months. (This excludes any domestic partner that has died within the last six months)
  - You agree to notify WideOrbit immediately upon your failure to satisfy any of the criteria of Domestic Partnership
  - You understand that it is fraudulent act to obtain health coverage by misrepresenting any facts stated herein
- Or -
- You are Registered Domestic Partners

You may be required to provide proof of dependent status. Any falsification of this information will result in disciplinary action, up to and including termination.

For additional information, please refer to the full certificate of coverage for each benefit.

**Note:** WideOrbit extends coverage to same gender and opposite gender Domestic Partners (DPs) and their dependents who meet the policy requirement. Keep in mind that due to IRS regulations, your cost for domestic partner coverage must be paid with after-tax dollars. In addition, the company's cost for domestic partner coverage is considered "imputed cost," and is subject to income and Social Security taxes, unless your domestic partner qualifies as your tax dependent.

# WHEN CAN YOU ENROLL



## New Hire & Open Enrollment

You can enroll in benefits as a new hire or during the annual open enrollment period. New hire coverage begins on the First of Month Following Date of Hire if you enroll within 30 days of becoming eligible.

If you miss the enrollment deadline, you'll need to wait until the next open enrollment (the one time each year that you can make changes to your benefits for any reason).

## Changing Your Benefits

Outside of open enrollment and your new hire window, you may be able to enroll or make changes to your benefit elections if you have a big change in your life, including:

- Change in legal marital status
- Change in number of dependents or dependent eligibility status
- Change in employment status that affects eligibility for you, your spouse, or dependent child(ren)
- Change in residence that affects access to network providers
- Change in your health coverage or your spouse's coverage due to your spouse's employment
- Change in an individual's eligibility for Medicare or Medicaid
- Court order requiring coverage for your child
- "Special enrollment event" under the Health Insurance Portability and Accountability Act (HIPAA), including a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan
- Event allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act (you have 60 days to request enrollment due to events allowed under CHIP).

You must submit your change within 31 days after the event.

# THE EASY WAY TO GET BENEFITS INFO

Click to play video



## GET MYBENEFITS.LIFE®

**On the web:**  
**wideorbit.mybenefits.life**

**On your smartphone**



Download from the  
App Store or  
Google Play.

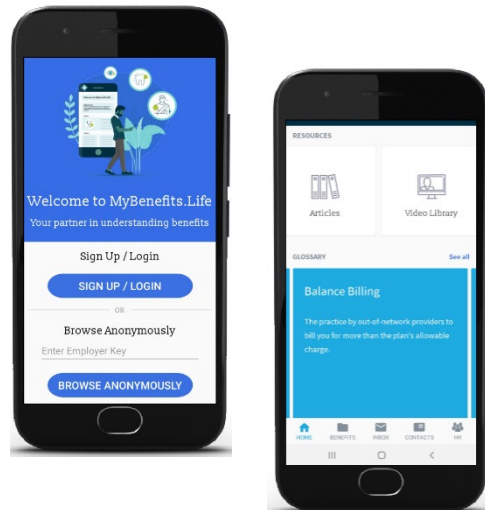
**Login With Employer Key**  
**WIDEORBIT**

MyBenefits.Life® gives you all your benefits information in one place

You can bank online, book a vacation online, and read the news online. Why should your benefits information be any different? MyBenefits.Life® is both a website and a mobile app that gives you access to the benefits information you need, when you need it.

Here's what you'll find on MyBenefits.Life®

<b>Benefits</b>	See benefit details and costs—for all plans you're eligible for, such as healthcare, disability, life insurance, and more
<b>Search</b>	Can't find it? Just search the site
<b>Articles &amp; Video Library</b>	Have 2 minutes? Increase your benefits IQ with short explainer articles and videos
<b>Financial Wellness</b>	Want to understand your finances better? Learn how in the Digital Financial Wellness Center, powered by Prudential
<b>Glossary</b>	HDHP? EOB? Coinsurance? Get the definitions in plain English
<b>Documents</b>	Important benefit plan notices ("the fine print")
<b>Contacts</b>	Find HR, benefits, and carrier contacts
<b>Get Help</b>	Need help? Reach helpful resources



# HAVE QUESTIONS ABOUT YOUR BENEFITS?

*Click to play video*



## CONTACT YOUR ALLIANT BENEFIT ADVOCATE

**Sarah Magaoay**

### Email

**wideorbit@alliant.com**

### Phone

**925-287-7248**

### Hours

**M-Th, 8am to 5pm PST**

**Fri, 8am to 4:30pm PST**

## Get help from a Benefit Advocate

Are you getting married and not sure how and 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 Advocates are trained benefits expert who can help you understand and use your healthcare and other coverage. Contact your Benefit Advocate for issues such as:

- General benefit questions
- Eligibility and coverage
- Finding a network provider
- Health care claim or billing issues, when warranted
- Coverage changes due to life events (marriage, new child, divorce, etc.).

## Claims assistance

If you need claims assistance, you'll 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 time basis to only the individuals listed on the form. The form is revocable at any time. Your Benefit Advocate will provide the form to you when needed.



# MEDICAL

## OUR PLANS

2023 Cigna HDHP

2023 Cigna PPO

2023 BCBS of AL HDHP (AL Only)

2023 BCBS of AL PPO (AL Only)

2023 Kaiser HDHP (CA Only)

2023 Kaiser DHMO (CA Only)

## WHICH PLAN IS RIGHT FOR YOU?

That depends on your healthcare needs, favorite doctors, and budget. Here are some considerations.

### Do you prefer specific doctors or hospitals?

If you want to stay with your favorite doctors and facilities, check whether they are in the plan's network. If they are not, but you are comfortable paying a bit more to see them, consider a plan with both in-network and out-of-network benefits.

### What are your usual healthcare needs?

Do you have frequent doctor or urgent care visits? Do you have a condition that requires a specialist? Do you take prescription medications? Compare how each plan covers the services you need most often.

### Consider the bottom line

How much is the monthly payroll deduction? Do you have to meet a deductible? What is the out-of-pocket maximum? How much of the cost is covered by the plan? How much are any copayments for office visits, prescriptions, etc. All of these factors together affect your total cost for healthcare.

# 2023 Cigna HDHP

You always pay the deductible and copayment (\$). The coinsurance (%) shows what you pay after the deductible.

Beginning in 2023, you will be able to reimburse qualified lodging and travel expenses under [IRS Publication 502](#). Travel and lodging expenses are covered for specific services with restricted geographic access to care, including abortion, gender affirmation, behavioral inpatient and outpatient, bariatric surgery, and congenital heart disease treatment. Be sure to save your travel and lodging receipts and contact Cigna with any questions. The care must be received 60 miles or farther from your home.

	In-Network	Out-of-Network
Annual Deductible	\$2,250 (combined with out-of-network); \$3,000 per individual, up to \$4,500 per family (combined with out-of-network)	\$2,250 (combined with in-network); \$3,000 per individual, up to \$4,500 per family (combined with in-network)
Accumulation Period	Time period to incur eligible expenses toward the deductible: Calendar Year	
Annual Out-of-Pocket Maximum	\$3,000 (combined with out-of-network); \$3,000 per individual, up to \$6,000 per family (combined with out-of-network)	\$6,000 (combined with in-network); \$6,000 per individual, up to \$12,000 per family (combined with in-network)
Office Visit	20% after deductible	50% after deductible
Chiropractic	20% after deductible (up to 20 visits per calendar year combined with out-of-network)	50% after deductible (up to 20 visits per calendar year combined with in-network)
Lab and X-ray	20% after deductible	50% after deductible
Urgent Care	20% after deductible	50% after deductible
Emergency Room	20% after deductible	20% after deductible
Hospitalization	20% after deductible	50% after deductible
Outpatient Surgery	20% after deductible	50% after deductible
<b>PRESCRIPTION DRUGS</b>		
Deductible	Combined with medical deductible	N/A
Out-of-Pocket Maximum	Combined with medical out of pocket	N/A
Generic	<b>Pharmacy:</b> \$10 copay after deductible <b>Mail Order:</b> \$20 copay after deductible	<b>Pharmacy:</b> Not covered <b>Mail Order:</b> N/A
Preferred Brand Name	<b>Pharmacy:</b> \$25 copay after deductible <b>Mail Order:</b> \$50 copay after deductible	<b>Pharmacy:</b> Not covered <b>Mail Order:</b> N/A
Non-Preferred Brand Name	<b>Pharmacy:</b> \$40 copay after deductible <b>Mail Order:</b> \$80 copay after deductible	<b>Pharmacy:</b> Not covered <b>Mail Order:</b> N/A
Specialty	<b>Pharmacy:</b> You pay 30% after deductible <b>Mail Order:</b> You pay 30% after deductible	<b>Pharmacy:</b> Not covered <b>Mail Order:</b> N/A
Supply	<b>Pharmacy:</b> 30 days <b>Mail Order:</b> 90 days	<b>Pharmacy:</b> Not covered <b>Mail Order:</b> N/A

# 2023 Cigna PPO

You always pay the deductible and copayment (\$). The coinsurance (%) shows what you pay after the deductible.

Beginning in 2023, you will be able to reimburse qualified lodging and travel expenses under [IRS Publication 502](#). Travel and lodging expenses are covered for specific services with restricted geographic access to care, including abortion, gender affirmation, behavioral inpatient and outpatient, bariatric surgery, and congenital heart disease treatment. Be sure to save your travel and lodging receipts and contact Cigna with any questions. The care must be received 60 miles or farther from your home

	In-Network	Out-of-Network
Annual Deductible	\$500; \$500 per individual, up to \$1,000 per family	\$500; \$500 per individual, up to \$1,000 per family
Accumulation Period	Time period to incur eligible expenses toward the deductible: Calendar Year	
Annual Out-of-Pocket Maximum	\$3,500; \$3,500 per individual, up to \$7,000 per family	\$7,000; \$7,000 per individual, up to \$14,000 per family
Office Visit	\$20 copay	40% after deductible
Chiropractic	\$20 copay (limited to 20 visits per calendar year, combined with out-of-network)	40% after deductible (limited to 20 visits per calendar year, combined with in-network)
Lab and X-ray	20% after deductible	40% after deductible
Urgent Care	\$25 copay	40% after deductible
Emergency Room	\$100 copay, + 20% coinsurance (copay waived if admitted)	\$100 copay, + 20% coinsurance (copay waived if admitted)
Hospitalization	\$250 copay, + 20% after deductible	40% after deductible
Outpatient Surgery	20% after deductible	40% after deductible
<b>PRESCRIPTION DRUGS</b>		
Deductible	\$0	N/A
Out-of-Pocket Maximum	Combined with medical out of pocket	N/A
Generic	<b>Pharmacy:</b> \$5 copay <b>Mail Order:</b> \$10 copay	<b>Pharmacy:</b> Not covered <b>Mail Order:</b> N/A
Preferred Brand Name	<b>Pharmacy:</b> \$10 copay <b>Mail Order:</b> \$20 copay	<b>Pharmacy:</b> Not covered <b>Mail Order:</b> N/A
Non-Preferred Brand Name	<b>Pharmacy:</b> \$25 copay <b>Mail Order:</b> \$50 copay	<b>Pharmacy:</b> Not covered <b>Mail Order:</b> N/A
Specialty	<b>Pharmacy:</b> You pay 30% <b>Mail Order:</b> You pay 30%	<b>Pharmacy:</b> Not covered <b>Mail Order:</b> N/A
Supply	<b>Pharmacy:</b> 30 days <b>Mail Order:</b> 90 days	<b>Pharmacy:</b> Not covered <b>Mail Order:</b> N/A

## 2023 BCBS of AL HDHP – *Alabama Only*

You always pay the deductible and copayment (\$). The coinsurance (%) shows what you pay after the deductible.

	In-Network	Out-of-Network
Annual Deductible	\$2,250; \$3,000 per individual, up to \$4,500 per family	\$2,250; \$3,000 per individual, up to \$4,500 per family
Accumulation Period	Time period to incur eligible expenses toward the deductible: Calendar Year	
Annual Out-of-Pocket Maximum	\$3,000; \$3,000 per individual, up to \$6,000 per family	There is no out-of-pocket maximum for out-of-network services
Office Visit	20% after deductible	50% after deductible
Chiropractic	20% after deductible (limited to 20 visits per calendar year combined with out-of-network)	50% after deductible; <b>In Alabama:</b> Not covered (limited to 20 visits per calendar year combined with in-network)
Lab and X-ray	20% after deductible	50% after deductible
Urgent Care	20% after deductible	50% after deductible
Emergency Room	20% after deductible	20% after deductible
Hospitalization	20% after deductible	50% after deductible
Outpatient Surgery	20% after deductible	50% after deductible <b>In Alabama:</b> Not Covered
<b>PRESCRIPTION DRUGS</b>		
Deductible	Combined with medical deductible	N/A
Out-of-Pocket Maximum	Combined with medical out of pocket	N/A
Generic	<b>Pharmacy:</b> \$10 copay after deductible <b>Mail Order:</b> \$25 copay after deductible	<b>Pharmacy:</b> Not covered <b>Mail Order:</b> N/A
Preferred Brand Name	<b>Pharmacy:</b> \$25 copay after deductible <b>Mail Order:</b> \$62.50 copay after deductible	<b>Pharmacy:</b> Not covered <b>Mail Order:</b> N/A
Non-Preferred Brand Name	<b>Pharmacy:</b> \$40 copay after deductible <b>Mail Order:</b> \$100 copay after deductible	<b>Pharmacy:</b> Not covered <b>Mail Order:</b> N/A
Specialty	<b>Pharmacy:</b> You pay 30% after deductible <b>Mail Order:</b> You pay 30% after deductible	<b>Pharmacy:</b> Not covered <b>Mail Order:</b> N/A
Supply	<b>Pharmacy:</b> 30 days <b>Mail Order:</b> 90 days	<b>Pharmacy:</b> Not covered <b>Mail Order:</b> N/A

## 2023 BCBS of AL PPO – *Alabama Only*

You always pay the deductible and copayment (\$). The coinsurance (%) shows what you pay after the deductible.

	In-Network	Out-of-Network
Annual Deductible	\$500; \$500 per individual, up to \$1,000 per family	\$500; \$500 per individual, up to \$1,000 per family
Accumulation Period	Time period to incur eligible expenses toward the deductible: Calendar Year	
Annual Out-of-Pocket Maximum	\$3,500; \$3,500 per individual, up to \$7,000 per family	There is no out-of-pocket maximum for out-of-network services
Office Visit	\$20 copay	40% after deductible; <b>In Alabama:</b> 50% after deductible
Chiropractic	20% after deductible (limited to 12 visits per calendar year combined with out-of-network)	40% after deductible; <b>In Alabama:</b> Not Covered (limited to 12 visits per calendar year combined with in-network)
Lab and X-ray	20% after deductible	40% after deductible
Urgent Care	\$20 copay	40% after deductible
Emergency Room	\$100 copay	\$100 copay
Hospitalization	20% after deductible	40% after deductible
Outpatient Surgery	20% after deductible	40% after deductible <b>In Alabama:</b> Not Covered
<b>PRESCRIPTION DRUGS</b>		
Deductible	\$0	N/A
Out-of-Pocket Maximum	Combined with medical out of pocket	N/A
Generic	<b>Pharmacy:</b> \$5 copay <b>Mail Order:</b> \$12.50 copay	<b>Pharmacy:</b> Not covered <b>Mail Order:</b> N/A
Preferred Brand Name	<b>Pharmacy:</b> \$10 copay <b>Mail Order:</b> \$25 copay	<b>Pharmacy:</b> Not covered <b>Mail Order:</b> N/A
Non-Preferred Brand Name	<b>Pharmacy:</b> \$25 copay <b>Mail Order:</b> \$62.50 copay	<b>Pharmacy:</b> Not covered <b>Mail Order:</b> N/A
Specialty	<b>Pharmacy:</b> You pay 30% <b>Mail Order:</b> You pay 30%	<b>Pharmacy:</b> Not covered <b>Mail Order:</b> N/A
Supply	<b>Pharmacy:</b> 30 days <b>Mail Order:</b> 90 days	<b>Pharmacy:</b> Not covered <b>Mail Order:</b> N/A

## 2023 Kaiser HDHP – *California Only*

	In-Network
Annual Deductible	\$2,000; \$3,000 per individual, up to \$4,000 per family
Accumulation Period	Time period to incur eligible expenses toward the deductible: Plan Year
Annual Out-of-Pocket Maximum	\$3,500; \$3,500 per individual up to \$7,000 per family
Office Visit	\$30 copay after deductible; \$50 copay after deductible for specialist
Chiropractic	Not covered
Lab and X-ray	X-Ray and Lab Tests: \$10 copay after deductible; Imaging (CT/PET & MRI's): \$150 copay after deductible
Urgent Care	\$30 copay after deductible
Emergency Room	\$100 copay after deductible
Hospitalization	\$250 copay after deductible
Outpatient Surgery	\$150 copay after deductible
<b>PRESCRIPTION DRUGS</b>	
Deductible	Combined with medical deductible
Out-of-Pocket Maximum	Combined with medical out of pocket
Generic	<b>Pharmacy:</b> \$10 copay after deductible <b>Mail Order:</b> \$20 copay after deductible
Preferred Brand Name	<b>Pharmacy:</b> \$30 copay after deductible <b>Mail Order:</b> \$60 copay after deductible
Non-Preferred Brand Name	<b>Pharmacy:</b> \$30 copay after deductible <b>Mail Order:</b> \$60 copay after deductible
Specialty	<b>Pharmacy:</b> You pay 20% after deductible (not to exceed \$200) <b>Mail Order:</b> N/A
Supply	<b>Pharmacy:</b> 30 days <b>Mail Order:</b> 100 days

## 2023 Kaiser DHMO – *California Only*

	In-Network (California Only)
Annual Deductible	\$1,000; \$1,000 per individual, up to \$2,000 per family
Accumulation Period	Time period to incur eligible expenses toward the deductible: Plan Year
Annual Out-of-Pocket Maximum	\$3,000; \$3,000 per individual up to \$6,000 per family
Office Visit	\$20 copay; \$20 copay for specialist
Chiropractic	Not covered
Lab and X-ray	X-Ray and Lab Tests: \$10 copay; Imaging (CT/PET & MRI's): \$150 copay
Urgent Care	\$20 copay
Emergency Room	20% after deductible
Hospitalization	20% after deductible
Outpatient Surgery	20% after deductible
Telehealth (Online)	No charge
<b>PRESCRIPTION DRUGS</b>	
Deductible	\$0
Out-of-Pocket Maximum	Combined with medical out of pocket
Generic	<b>Pharmacy:</b> \$10 copay <b>Mail Order:</b> \$20 copay
Preferred Brand Name	<b>Pharmacy:</b> \$30 copay <b>Mail Order:</b> \$60 copay
Non-Preferred Brand Name	<b>Pharmacy:</b> \$30 copay <b>Mail Order:</b> \$60 copay
Specialty	<b>Pharmacy:</b> You pay 20% (not to exceed \$150) <b>Mail Order:</b> N/A
Supply	<b>Pharmacy:</b> 30 days <b>Mail Order:</b> 100 days

# HEALTH SAVINGS ACCOUNT (HSA)

Click to play video



## ARE YOU ELIGIBLE?

The HSA is not for everyone. You're eligible only if you are:

1. Enrolled in the 2023 PayFlex HSA.
2. Not enrolled in other non-HDHP medical coverage, including Medicare, Medicaid, or Tricare.
3. Not a tax dependent.
4. Not enrolled in a healthcare Flexible Spending Account (FSA), unless it's a "limited purpose" FSA for dental and vision expenses.

## A personal savings account for healthcare

A Health Savings Account (HSA) is an easy way to pay for healthcare expenses that you have today and save for expenses you may have in the future.

## How the HSA works

- Your HSA account is set up automatically after you enroll.
- To help you get started, WideOrbit contributes to your HSA:  
Cigna and BCBS of AL HDHP:

**Individual:** \$281.25 per quarter

**Family:** \$562.50 per quarter

Kaiser HDHP:

**Individual:** \$250 per quarter

**Family:** \$500 per quarter

- You can contribute up to the limit set by the IRS (includes company amount).

Individual: \$3,850 per year

Family: \$7,750 per year

Are you age 55 +? You can contribute an additional \$1,000 per year

- You can use your HSA debit card to pay for eligible expenses like office visits, lab tests, prescriptions, dental and vision care, and even some drugstore items.

## Four reasons to love an HSA

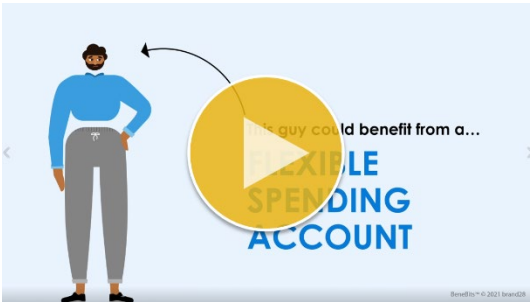
1. **Tax-free.** No federal tax on contributions, or state tax in most states. Withdrawals are also tax-free as long as they're for eligible healthcare expenses.
2. **No "use it or lose it."** Your balance rolls over from year to year. You own the account and can continue to use it even if you change medical plans or leave the company.
3. **Use it now or later.** Use your HSA for healthcare expenses you have today or save it to use in the future.
4. **Boosts retirement savings.** After you retire, you can use your HSA for healthcare expenses tax-free, or for regular living expenses, taxable but no penalties.

## Find out more

- [Eligible Expenses](#)
- [Ineligible Expenses](#)

# HEALTHCARE FLEXIBLE SPENDING ACCOUNT (FSA)

Click to play video



## ARE YOU ELIGIBLE?

You don't have to enroll in one of our medical plans to participate in the healthcare FSA. However, if you or your spouse are enrolled in a high deductible health plan (like our 2023 PayFlex HSA, you can only participate in the **Limited Purpose FSA** for dental and vision expenses.

### Find out more

- [WEXInc.com](https://www.wexinc.com)
- [Eligible Expenses](#) – now include more over-the-counter items!
- [Ineligible Expenses](#)

### Do you pay for dependent care?

Look in the Financial Wellness section for information on tax savings through the Dependent Care FSA.

## Set aside healthcare dollars for the coming year

A healthcare FSA allows you to set aside tax-free money to pay for healthcare expenses you expect to have over the coming year.

## How the 2023 WEX Flexible Spending Account works

- You estimate what you and your family's out-of-pocket costs will be for the coming year. Think about what out-of-pocket costs you expect to have for eligible expenses such as office visits, surgery, dental and vision expenses, prescriptions, even eligible drugstore items.
- You can contribute up to \$3,050, the annual limit set by the IRS. Contributions are deducted from your pay pre-tax, meaning no federal or state tax on that amount.
- During the year, you can use your FSA debit card to pay for services and products. Withdrawals are tax-free as long as they're for eligible healthcare expenses.

## Estimate carefully!

If you don't spend all the money in your account, you can roll over up to \$610 to use the following year. Any additional remaining balance will be forfeited.

### FSA TAX SAVINGS EXAMPLE

#### \$60,000 Annual Pay, with \$1,500 FSA Contribution

<b>\$330</b>	<b>\$115</b>	<b>\$445</b>
22% Federal income tax	7.65% FICA tax	Annual FSA tax savings

#### \$120,000 Annual Pay, with \$3,050 FSA Contribution

<b>\$732</b>	<b>\$233</b>	<b>\$965</b>
24% Federal income tax	7.65% FICA tax	Annual FSA tax savings

*Your tax savings may vary depending on tax filing status and other variables*



# DENTAL

## OUR PLAN

2023 Aetna Dental PPO

## Why sign up for Dental coverage?

It's important to go to the dentist regularly. Brushing and flossing are great, but regular exams catch dental issues early before they become more expensive and difficult to treat.

That's where dental insurance comes in. Dental insurance makes it easier and less expensive to get the care you need to maintain good oral health.

Dental insurance covers three types of treatments:

- **Preventive** care includes exams, cleanings and x-rays
- **Basic** care focuses on repair and restoration with services such as fillings, root canals, and gum disease treatment
- **Major** care goes further than basic and includes bridges, crowns and dentures
- **Orthodontia** treatment to properly align teeth within the mouth.

# 2023 Aetna Dental PPO

You always pay the deductible and copayment (\$). The coinsurance (%) shows what you pay after the deductible.

	In-Network	Out-of-Network
Annual Deductible	\$50 (in and out-of-network combined); \$50 per individual, up to \$150 per family (in and out-of-network combined)	\$50 (in and out-of-network combined); \$50 per individual, up to \$150 per family (in and out-of-network combined)
Annual Plan Maximum	\$2,500 (in and out-of-network combined)	\$2,500 (in and out-of-network combined)
Diagnostic & Preventive	No charge (deductible waived)	No charge (deductible waived)
Basic Services	20% after deductible	20% after deductible
Major Services	50% after deductible	50% after deductible
Orthodontia	50% Children: Covered Adults: Covered	50% Children: Covered Adults: Covered
Ortho Lifetime Max	\$1,500 (in and out-of-network combined)	\$1,500 (in and out-of-network combined)



## VISION

### OUR PLAN

2023 VSP Vision

#### Why sign up for Vision coverage?

Vision coverage helps with the cost of eyeglasses or contacts. But even if you don't need vision correction, an annual eye exam checks the health of your eyes and can even detect more serious health issues such as diabetes, high blood pressure, high cholesterol, and thyroid disease.

You'll even find discounts on services like LASIK and PRK, rebates on contact lenses, and money off on hearing aids and other related services. Visit the plan's website to check out these extra savings.

## 2023 VSP Vision

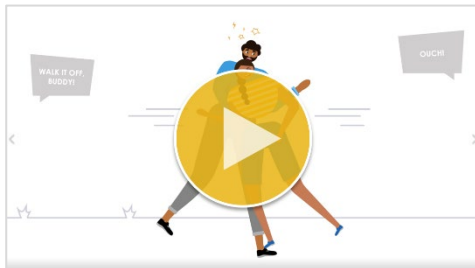
Your vision checkup is fully covered after your Exam copay. After any Materials copay, the plan covers frames, lenses, and contacts as described below.

	In-Network	Out-of-Network
Copay	<b>Exam:</b> \$10 copay <b>Materials:</b> \$25 copay	<b>Exam:</b> \$10 copay (reimbursed up to \$50) <b>Materials:</b> \$25 copay
Frames	Coverage up to \$130, 20% discount over \$130 after materials copay	Reimbursed up to \$48 after materials copay
Lenses	<b>Single Vision:</b> No charge after applicable copay <b>Bifocal:</b> No charge after applicable copay <b>Trifocal:</b> No charge after applicable copay	<b>Single Vision:</b> Reimbursed up to \$48 after materials copay <b>Bifocal:</b> Reimbursed up to \$67 after materials copay <b>Trifocal:</b> Reimbursed up to \$86 after materials copay
Contacts (Elective)	Coverage up to \$130 (in lieu of frames)	Reimbursed up to \$120 (in lieu of frames)
Frequency	<b>Exam:</b> 12 months <b>Frames:</b> 24 months <b>Lenses:</b> 12 months <b>Contacts (Elective):</b> 12 months (in lieu of frames)	<b>Exam:</b> 12 months <b>Frames:</b> 24 months <b>Lenses:</b> 12 months <b>Contacts (Elective):</b> 12 months (in lieu of frames)



# ENGAGE

*Click to play video*



PCP vs Urgent Care vs ER






## Maximize Your Healthcare

Knowing how to best use your healthcare coverage can help you improve your health and reduce your expenses. In this section you'll find tips on:

- Finding the right care at the right cost
- Alternatives to hospital care
- Understanding preventive care benefits
- Saving money on prescription drugs





# KNOW WHERE TO GO

Where you get medical care can have a significant impact on the cost. Here's a quick guide to help you know where to go, based on your condition, budget, and time.

Type	Appropriate for	Examples	Access	Cost
<b>Nurseline</b> 	Quick answers from a trained nurse	<ul style="list-style-type: none"> <li>Identifying symptoms</li> <li>Decide if immediate care is needed</li> <li>Home treatment options and advice</li> </ul>	24/7	\$0
<b>Online visit</b> 	Many non-emergency health conditions	<ul style="list-style-type: none"> <li>Cold, flu, allergies</li> <li>Headache, migraine</li> <li>Skin conditions, rashes</li> <li>Minor injuries</li> <li>Mental health concerns</li> </ul>	24/7	\$
<b>Office visit</b> 	Routine medical care and overall health management	<ul style="list-style-type: none"> <li>Preventive care</li> <li>Illnesses, injuries</li> <li>Managing existing conditions</li> </ul>	Office Hours	\$\$
<b>Urgent care, walk-in clinic</b> 	Non-life-threatening conditions requiring prompt attention	<ul style="list-style-type: none"> <li>Stitches</li> <li>Sprains</li> <li>Animal bites</li> <li>Ear-nose-throat infections</li> </ul>	Office Hours, or up to 24/7	\$\$\$
<b>Emergency room</b> 	Life-threatening conditions requiring immediate medical expertise	<ul style="list-style-type: none"> <li>Suspected heart attack or stroke</li> <li>Major bone breaks</li> <li>Excessive bleeding</li> <li>Severe pain</li> <li>Difficulty breathing</li> </ul>	24/7	\$\$\$\$\$

# ALTERNATIVE FACILITIES

If you have time to evaluate your options for non-emergency health treatments, these alternative facilities can provide the same results as a hospital at a fraction of the cost.

Need	Alternative	Features	Savings
<b>Surgery</b> 	Ambulatory Surgery Center (ASC)	<ul style="list-style-type: none"> <li>Specializes in same-day surgeries</li> <li>Cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery and more</li> <li>Held to same safety standards as hospitals</li> </ul>	Up to 50% over hospital stay*
<b>Physical therapy</b> 	Free-standing physical therapy center	<ul style="list-style-type: none"> <li>Important part of the recovery process after an injury or surgery</li> </ul>	40 to 60% over a hospital setting*
<b>Sleep study</b> 	Home testing	<ul style="list-style-type: none"> <li>Diagnoses sleep apnea and other conditions</li> <li>Cost is often covered by insurance if considered medically necessary</li> </ul>	Approx. \$4,500*
<b>Infusion therapy</b> 	Home or outpatient infusion therapy	<ul style="list-style-type: none"> <li>For drugs that must be delivered by intravenous injections, or epidurals</li> <li>Delivered by licensed infusion therapy provider</li> <li>Maintain normal lifestyle and comfort of home or outpatient center</li> </ul>	Up to 90% over hospital stay*

*\*in-network*

## How to find an alternative treatment facility

Ask your doctor if your treatment must be delivered in the hospital. You can also search for surgical centers, physical therapy, etc. on your plan's website; or call member services for assistance.

Online tools such as [healthcarebluebook.com](https://www.healthcarebluebook.com) and [healthgrades.com](https://www.healthgrades.com) help you compare costs and doctor ratings. Some alternative services include a facility fee to cover overhead costs. To avoid a surprise on your bill, ask about facility fees before you schedule your appointment.

# TURNING 65? UNDERSTAND YOUR MEDICARE OPTIONS



**Alliant Medicare Solutions is a no cost service available to you, your family members, and friends nearing age 65.**

*Alliant Medicare Solutions is provided by Insuractive LLC, a Nebraska resident insurance agency. Insuractive LLC is wholly owned by Alliant Insurance Services, Inc.*

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

If, like most people, you become eligible for Medicare at age 65, you have a seven-month window to enroll, starting three months before you turn age 65 and ending three months after your birthday month.

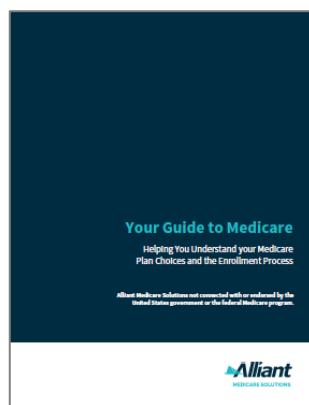
## Introducing Alliant Medicare Solutions

Choosing a Medicare plan – and understanding how it can affect your employer-provided medical coverage – can be confusing. That’s why we are offering Alliant Medicare Solutions to 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 **(866) 279-3195** 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.

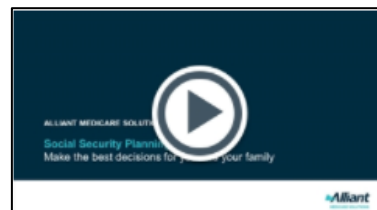
## Find Out More



*Your Guide to Medicare*



*Medicare 101 Video*



*Social Security Planning Video*

# PREVENTIVE CARE SCREENING BENEFITS



## TYPICAL SCREENINGS FOR ADULTS

- Blood pressure
- Cholesterol
- Diabetes
- Colorectal cancer screening
- Depression
- Mammograms
- OB/GYN screenings
- Prostate cancer screening
- Testicular exam

You take your car in for maintenance. Why not do the same for yourself?

Annual preventive checkups can help you and your doctor identify your baseline level of health and detect issues before they become serious.

### What is Preventive Care?

The Affordable Care Act (ACA) requires health insurers to cover a set of preventive services at no cost to you, even if you haven't met your yearly deductible. The preventive care services you'll need to stay healthy vary by age, sex, and medical history.

Visit [health.gov/myhealthfinder](https://www.health.gov/myhealthfinder) for recommended guidelines.

**Preventive care is covered in full  
only when obtained from an  
IN-NETWORK provider.**

### Not all exams and tests are considered preventive

Exams performed by specialists are generally not considered preventive and may not be covered at 100 percent.

Additionally, certain screenings may be considered diagnostic, not preventive, based on your current medical condition. You may be responsible for paying all or a share of the cost for those services.

If you have a question about whether a service will be covered as preventive care, contact your medical plan.

# PRESCRIPTIONS BREAKING YOUR BUDGET?



## THE FORMULARY DRUG TIERS DETERMINE YOUR COST

---

\$ Generic Drug

---

\$\$ Brand Name Drug

---

\$\$\$ Specialty Drug

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## Understanding the formulary can save you money

If your doctor prescribes medicine, especially for an ongoing condition, don't forget to check your health plan's drug formulary. It's a powerful tool that can help you make informed decisions about your medication options and identify the lowest cost selection.

## What is a formulary?

A drug formulary is a list of prescription drugs covered by your medical plan. Most prescription drug formularies separate the medications they cover into four or five drug categories, or "tiers." These groupings range from least expensive to most expensive cost to you. "Preferred" drugs generally cost you less than "non-preferred" drugs.

## Get the most from your coverage

To get the most out of your prescription drug coverage, note where your prescriptions fall within your plan's drug formulary tiers and ask your doctor for advice. Generic drugs are usually the lowest cost option. Generics are required by the Food and Drug Administration (FDA) to perform the same as brand-name drug equivalents.

**To find out if a drug is on your plan's formulary, visit the plan's website or call the customer service number on your ID card.**



## LIFE & DISABILITY

### **YOUR BENEFICIARY = WHO GETS PAID**

If the worst happens, your beneficiary—the person (or people) on record with the life insurance carrier—receives the benefit. Make sure that you name at least one beneficiary for your life insurance benefit, and change your beneficiary as needed if your situation changes.

### **Is your family protected?**

Life, AD&D and disability insurance can fill a number of financial gaps due to a temporary or permanent reduction of income. Consider what your family would need to cover day-to-day living expenses and medical bills during a pregnancy or illness-related disability leave, or how you would manage large expenses (rent or mortgage, children's education, student loans, consumer debt, etc.) after the death of a spouse or partner.

We provide short and long-term disability benefits and a base amount of life and AD&D insurance to help you recover from financial loss.

### **If you need additional coverage**

We offer voluntary coverage that you can purchase for yourself, your spouse, and your children. See the Voluntary Benefits section for details.

# COMPANY- PROVIDED LIFE AND AD&D INSURANCE



## WHAT'S GUARANTEED ISSUE?

If you select coverage above a certain limit (the "guaranteed issue") or after your initial eligibility, you will need to provide additional information about your health status in order to qualify for the requested amount of coverage.

## A NOTE ABOUT TAXES

Company-provided life insurance coverage over \$50,000 is considered a taxable benefit. The value of the benefit over \$50,000 will be reported as taxable income on your annual W-2 form.

## Basic Life and AD&D

Basic Life Insurance pays your beneficiary a lump sum if you die. AD&D (Accidental Death & Dismemberment) coverage provides a benefit to you if you suffer from loss of a limb, speech, sight, or hearing, or to your beneficiary if you have a fatal accident. The cost of coverage is paid in full by the company.

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## 2023 Mutual of Omaha Life and AD&D

Up to \$100,000. Guaranteed issue of \$100,000.

---

*The benefit amounts above will be reduced if you are age 65 or older. Refer to the plan document for details.*

# SHORT-TERM DISABILITY INSURANCE (STD)



## EXPECT THE UNEXPECTED

Most people underestimate the likelihood of being disabled at some point in their life. Disability insurance replaces part of your pay while you are unable to work so you have a continuing income for living expenses.

## STD Benefits

Short-Term Disability (STD) insurance replaces part of your income for limited duration issues such as:

- Pregnancy issues and childbirth recovery
- Prolonged illness or injury
- Surgery and recovery time

STD payments may be reduced if you receive other benefits such as sick pay, workers' compensation, Social Security, or state disability. WideOrbit pays the cost of this coverage.

---

### 2023 Mutual of Omaha STD

<b>Weekly benefit amount</b>	67% up to a maximum of \$2,900
<b>Benefits begin</b>	After 7 days of disability due to accident or 7 days due to sickness
<b>Maximum payment period</b>	12 weeks (based on first day benefits begin)

---

# LONG-TERM DISABILITY INSURANCE (LTD)



## 3 THINGS TO KNOW ABOUT LTD INSURANCE

1. It can protect you from having to tap into your retirement savings.
2. You can use LTD benefits however you need, for housing, food, medical bills, etc.
3. Benefits can last a long time—from weeks to even years—if you remain eligible.

## LTD benefits cushion the financial impact of a disability

Long-Term Disability (LTD) insurance replaces part of your income for longer term issues such as:

- Debilitating illness (cancer, heart disease, etc.)
- Serious injuries (accident, etc.)
- Heart attack, stroke
- Mental disorders.

If you qualify, LTD benefits begin after short-term disability benefits end. Payments may be reduced by state, federal, or private disability benefits you receive while disabled. WideOrbit pays the cost of this coverage.

---

## 2023 Mutual of Omaha LTD

<b>Monthly benefit amount</b>	60% up to a maximum of \$12,000
<b>Benefits begin</b>	After 90 days of disability
<b>Maximum payment period</b>	Social Security Normal Retirement Age or Maximum Benefit Duration

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# VOLUNTARY LIFE INSURANCE

## Protecting those you leave behind

Voluntary Life Insurance allows you to purchase additional life insurance to protect your family's financial security. Coverage is available for your spouse and/or child(ren) if you purchase coverage for yourself.

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### 2023 Mutual of Omaha Voluntary Life

- Employee** \$10,000 Increments up to Lesser of 5x salary or \$500,000. Guaranteed issue of Lesser of 5x salary or \$150,000.
  - Spouse** \$5,000 Increments up to Lesser of 100% of employee benefit or \$250,000. Guaranteed issue of Lesser of 100% employee benefit or \$25,000.
  - Child(ren)** \$10,000. Guaranteed issue of \$10,000.
- 



### GUARANTEED ISSUE

If you purchase life insurance coverage above a certain limit (the "guaranteed issue" amount) or after your initial eligibility period, you will need to submit Evidence of Insurability with additional information about your health in order for the insurance company to approve the amount of coverage.



## FINANCIAL WELLNESS

### PLANS TO HELP YOU SAVE

- Dependent Care Flexible Spending Account (DC FSA)
- Transportation & Parking Benefits
- 401(k) Retirement Savings Plan

### Is it time for a “financial wellness” checkup?

Are you worried about money—making your paycheck last? Paying down debt? Making a big purchase like a car or home? And can you even think about preparing for retirement?

Ignoring your financial health can take a toll on your quality of life today and block opportunities for the future. And worrying about money matters can make you stressed, even to the point of physical illness.

We offer benefits and resources to help you make the most of your money now and in the future. You can increase your take-home pay by saving on taxes; and work toward your retirement goals.

# PAYING FOR DAYCARE? MAKE IT TAX-FREE!



## EVERY OPPORTUNITY TO SAVE

The biggest deduction from your paycheck is likely federal income tax. Why not take a bite out of taxes while paying for necessary expenses with tax-free dollars?

## Dependent Care FSA—up to \$5,000 per year tax-free

A dependent care Flexible Spending Account (FSA) can help families save potentially hundreds of dollars per year on day care. This program is administered by WEX Inc.

## Here's how the 2023 WEX Inc. Flexible Spending Account works

You set aside money from your paycheck, before taxes, to pay for work-related day care expenses. Eligible expenses include not only childcare, but also before and after school care programs, preschool, and summer day camp for children under age 13. The account can also be used for day care for a spouse or other adult dependent who lives with you and is physically or mentally incapable of self-care.

You can set aside up to \$5,000 per household per year. You can pay your dependent care provider directly from your FSA account, or you can submit claims to get reimbursed for eligible dependent care expenses you pay out of pocket.



**Estimate carefully!** You can't change your FSA election amount mid-year unless you experience a qualifying event. Money contributed to a dependent care FSA must be used for expenses incurred during the same plan year. Unspent funds will be forfeited.

# SAVE ON COMMUTE EXPENSES



## Transportation Savings Account—up to \$600 per month tax-free

Do you have out-of-pocket commuting expenses for public transportation, van pooling, or for worksite parking? If so, you can save on taxes by enrolling in our transportation savings account, administered by WEX Inc.

The account lets you set aside money—before it's taxed—through payroll deduction. You may enroll in or stop this program at any time. Money in the account can be used in future months or plan years.

Set aside up to \$300 per month for work-related parking expenses and up to \$300 per month for work-related commute expenses.

## CAN I OPT OUT OR CHANGE MY ELECTION IF MY WORK SCHEDULE OR LOCATION CHANGES?

Yes, contributions can be updated monthly but do require time before they are posted to your account as payroll must deduct the funds on your next pay period, then transmit the election to WEX.

You must place your order by the 10<sup>th</sup> of the month prior to when the funds will be used. For example, if you wish to contribute funds for December, your order must be placed by November 10<sup>th</sup>.

# 401(k) PROGRAM

WideOrbit's retirement savings plan lets you save for the future while taking advantage of company matching contributions and a full range of investment options.

We encourage you to take an active role in your account. Review the contribution amount and investment strategy to ensure they meet your needs. If you would like to make changes to any elections, prefer not to participate, or have questions about the Plan's provisions, log on to Fidelity at <http://www.401k.com> or call 800-835-5095.

## WideOrbit Match

**WideOrbit matches 50% of your deferrals up to 6% of your income (subject to IRS income cap).**

For example, to receive full match, defer 6% of your income; in this case WO will match 3%. WO contributions made quarterly.

## Summary

- **Automatic contributions.** All employees are auto enrolled at 6% within 30 days. Fidelity will mail materials to you directly about the account, including information to opt out.
- **Traditional pre-tax contributions.** This money is not taxed when it is put into your account, leaving you more money to work for you.
- **ROTH 401(k) after-tax contributions.** You can also choose to make ROTH contributions, but you won't pay income tax on contributions or earnings when you make withdrawals from your ROTH 401(k) balance, provided you have turned age 59.5 and have held your ROTH 401(k) account for at least five years.
- **Traditional after-tax contributions.** After-tax contributions offer an alternative to the pre-tax and ROTH 401(k) after-tax contributions that are already available.
- **The ROTH in-plan conversion.** Allows you to convert all or a portion of your pre-tax and traditional after-tax savings to ROTH money within the plan.
- **Brokerage Account.** Gives you expanded investment choices and the opportunity to actively manage your retirement contributions.

## 2023 contributions maximum (per IRS) limits

You can contribute a percentage of your pay to either option or both up to an annual IRS limit, which is \$22,500\* in 2023. Employees age 50 and older can contribute an additional \$7,500\* in "catch-up" contributions.

\*These amounts are evaluated annually by the IRS and are subject to change.



## WELLBEING & BALANCE

**“ THE KEY TO KEEPING YOUR BALANCE IS KNOWING WHEN YOU'VE LOST IT. ”**

### A Happier, Healthier You

Creating a healthy balance between work and play is a major factor in leading a happy and productive lifestyle, but it's not always easy.

We offer programs to help you:

- Manage stress, chemical dependency, mental health and family issues
- Maximize your physical well-being
- Take time to spend with family and friends, take care of personal business, or just have a little extra “me time”.

Taking care of yourself will help you be more effective in all areas of your life. Be sure to take advantage of these programs to stay at your best.

# EMPLOYEE ASSISTANCE PROGRAM (EAP)



## CONTACT THE EAP

### Phone

**(800) 344-4222**

### Website

[Employees.concernhealth.com](https://employees.concernhealth.com)

**Employer code: wide**

## Help for you and your household members

There are times when everyone needs a little help or advice, or assistance with a serious concern. The EAP through Concern can help you handle a wide variety of personal issue such as emotional health and substance abuse; parenting and childcare needs; financial coaching; legal consultation; and eldercare resources.

Best of all, contacting the EAP is completely confidential, free and available to any member of your immediate household.

## No cost EAP resources

The EAP is available around the clock to ensure you get access to the resources you need:

- Unlimited phone access 24/7
- In-person or video counseling for short-term issues; up to 5 visits per issue per year
- Unlimited web access to helpful articles, resources, and self-assessment tools.

### COUNSELING BENEFITS

- Difficulty with relationship
- Emotional distress
- Job stress
- Communication/ conflict issues
- Alcohol or drug problems
- Loss and death

### PARENTING & CHILDCARE

- Referrals to quality providers
- Family day care homes
- Infant centers and preschools
- Before/after school care
- 24-hour care

### FINANCIAL COACHING

- Money management
- Debt management
- Identity theft resolution
- Tax issues

### LEGAL CONSULTATION

- Referral to a local attorney
- Family issues (marital, child custody, adoption)
- Estate planning
- Landlord/tenant
- Immigration
- Personal Injury
- Consumer protection
- Real estate
- Bankruptcy

### ELDERCARE RESOURCES

- Help with finding appropriate resources to care for an elderly or disabled relative

### ONLINE RESOURCES

- Self-help tools to enhance resilience and well-being
- Useful information and links to various services and topics

# ADDITIONAL PROGRAMS



### Life Event Benefit

WideOrbit offers a Life Events Benefit to recognize major life events in your immediate family. WideOrbit will reimburse up to \$500 in receipts surrounding these events:

- Birth or adoption
- Marriage or ‘legal’ partnership
- Death in your immediate family
- Retirement

This is a taxable benefit and receipts should be submitted within 30 days of the life event. Please contact [hr@wideorbit.com](mailto:hr@wideorbit.com) with any questions. Note: Immediate family is defined as: Spouse, child (step), parent (step), grandparent (step).

### New Parent Benefit

SNOO from Happiest Baby

For parents of new babies (0 - 6 months), WideOrbit subsidizes six months of rental of the Snoo Baby Bassinet from Happiest Baby. This product improves rest and well-being for baby and family. Rested, supported coworkers return to work. Rested coworkers are more productive. Rent directly from Happiest Baby via WideOrbit portal. Subject to a refundable security deposit. Product recommended from birth to six months of age. Please contact HR if you may qualify for this benefit.

### Telemedicine

Have you ever needed to see a doctor but couldn’t because of scheduling, holidays, weekends, travel or even bad weather? Cigna, BCBS of AL and Kaiser save you time and money by connecting you to a doctor via video chat from any location, 24/7, no appointment needed. You’ll be connected to a board-certified doctor who can diagnose and treat many common medical problems such as colds and flu, ear infections, skin problems, allergies, sinus problems, and more. General telemedicine visits are charged the same as general in office physician visits, consult your plan documents for further information on coverage levels.

Carrier	Website	Phone Number/App
Cigna (MD Live)	<a href="https://myCigna.com">myCigna.com</a>	(888) 726-3171
Kaiser	<a href="https://kp.org/mydoctor/videovisits">kp.org/mydoctor/videovisits</a>	KP Preventive Care App (Apple and Android)
BCBS of AL	<a href="https://Teladoc.com/Alabama">Teladoc.com/Alabama</a>	(855) 477-4549

### Travel Assistance

When you travel overseas for purposes other than work, you can rely on Mutual of Omaha. This program offers access to an international network of participating doctors, and hospitals for a broad range of medical care services. The center is available by phone 24/7 and is staffed with multilingual representatives who can help coordinate your medical care. Call (800) 856-9947 within the US or (312) 935-3658 outside of the US.

# TIME AWAY FROM WORK



## Time off

### **Vacation Days**

From date of hire, vacation is granted at a rate of 3 weeks (15 business days) per year. Hours are accrued at a rate of 10 hours per month from your date of hire. After your fourth (4) year of continuous employment, you will receive 4 weeks (20 business days) of vacation per year, accrued at a rate of 13.33 hours per month.

Part-time employees accrue vacation on a pro-rata basis based on the number of hours they are regularly scheduled to work each week. For example, an employee who is regularly scheduled to work 30 hours will earn vacation at 75% of the accrual rate for full-time employees. Temporary employees do not accrue vacation.

### **Vacation Accrual Caps**

An accrual cap is the total balance of unused, accrued vacation days you can accumulate. In the event an employee's accrued but unused vacation reaches the maximum accrual that is allowed, the employee will not earn any additional vacation benefits. Vacation benefits will cease to accrue until the employee takes enough time off to fall below the maximum accrual. Once the accrual balance is below the maximum, vacation benefits will begin accruing again.

### **Vacation Carryover**

All employees are encouraged to use their vacation benefits each year. Because vacation is accrued based on one's hire date, employees may carry over accrued but unused vacation from one calendar year to the next.

### **Sick and Kin Care Time Off**

Full time employees accrue 9 sick days per year, available for use at the beginning of each calendar year while they are actively employed at WideOrbit. Unused accrued paid sick leave will not be paid out upon separation of employment. Employees who start after January 1st will be able to use a prorated amount based on their projected accrual of one hour sick time per 30 hours worked.

# TIME AWAY FROM WORK - *continued*



## 2023 paid holidays

These holidays are recognized by WideOrbit as paid holidays for the calendar year 2023

New Year's Day (observed)	January 2 <sup>nd</sup>
MLK Day	January 16 <sup>th</sup>
Presidents' Day	February 20 <sup>th</sup>
Memorial Day	May 29 <sup>th</sup>
Juneteenth	June 19 <sup>th</sup>
Independence Day	July 3 <sup>rd</sup> – 4 <sup>th</sup>
Labor Day	September 4 <sup>th</sup>
Veterans' Day (veterans only)	November 10 <sup>th</sup>
Thanksgiving	November 23 <sup>rd</sup> – 24 <sup>th</sup>
Christmas	December 25 <sup>th</sup> – 27 <sup>th</sup>

## Time off

### Volunteer Time Off (VTO)

WideOrbit encourages employees to volunteer up to 8 hours (1 day) per calendar year (pro-rated for part-time employee); to become involved in their communities, lending their voluntary support to programs that positively impact the quality of life within these communities. Employees can volunteer up to 8 hours (1 day) per calendar year (pro-rated for part-time employee).

### Sabbatical Leave

The purpose of a sabbatical is to allow employees time to explore outside areas of interest, spend additional time with family or some other purpose without the responsibility of work.

WideOrbit offers two options for an extended Sabbatical leave.

- Option 1: After four years of continuous employment with WideOrbit, an employee receives the option of taking four weeks off at half pay.
- Option 2: After five years of continuous employment with WideOrbit, an employee receives the option of taking five weeks off at half pay.

Employees may use earned Vacation to receive full pay during their Sabbatical. To receive full pay during a Sabbatical, 4 hours of Vacation time (or .5 of a vacation day) will be debited for each business day out on Sabbatical.

WideOrbit respects the religious beliefs of its employees and will make every effort to accommodate absences for religious holidays providing they don't cause hardship to WideOrbit. Absences for religious holidays can be taken as vacation or as unpaid time off if you don't have vacation accrued.

For more information on Time Off, please refer to Employee Handbook.



# VOLUNTARY PLANS

## OUR VOLUNTARY PLANS

- Mutual of Omaha Voluntary Accident Insurance
- Mutual of Omaha Voluntary Critical Illness Insurance
- LegalShield Legal Assistance
- IDShield Identity Theft Protection
- Nationwide Pet Insurance

## You're unique—and so are your benefit needs

Voluntary benefits are optional coverages that help you customize your benefits package to your individual needs.

WideOrbit offers plans to help:

- replace income if you're injured or ill
- bridge the gap for special healthcare needs
- secure your identity, and help you manage legal issues
- save money on protection for your pets

You pay the entire cost for these plans, but rates may be more affordable than individual coverage. And you get the added convenience of paying through payroll deduction.

Voluntary benefits are just that: voluntary. You have the freedom and flexibility to choose the benefits that make sense for you and your family. Or, you don't have to sign up for voluntary benefits at all. The choice is yours.

# VOLUNTARY HEALTH-RELATED PLANS



## 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.

## Accident Insurance

Accident Insurance from Mutual of Omaha helps you pay for unexpected costs that can add up due to common injuries such as fractures, dislocations, burns, emergency room or urgent care visits, and physical therapy. If you or a covered family member has an accident, this plan pays a lump-sum, tax-free benefit. The amount of money depends on the type and severity of your injury and can be used any way you choose. You may even be eligible for a benefit if you receive a covered wellness screening such as blood tests, stress tests, or a chest x-ray.

## Critical Illness Insurance

Critical illness insurance from Mutual of Omaha can help fill a financial gap if you experience a serious illness such as cancer, heart attack or stroke. Upon diagnosis of a covered illness, a lump-sum, tax-free benefit is immediately paid to you. Use it to help cover medical costs, transportation, childcare, lost income, or any other need following a critical illness. You choose a benefit amount that fits your paycheck and can cover yourself and your family members if needed. You may even be eligible for a benefit if you receive a covered wellness screening such as blood tests, stress tests, or a chest x-ray.

If you and/or your family are enrolled in Critical Illness insurance, you are each eligible for a \$50 benefit for receiving a general health screening, such as your annual physical.

# PLANS TO KEEP YOU AND YOUR FAMILY SECURE



## CONTACT INFORMATION

See the Plan Contacts section of this guide or log on to MyBenefits.Life® for contact information.

## Identity Theft Protection

Identity theft is serious. Victims can spend hundreds, even thousands of dollars, and weeks of their own time to repair the damage done to their good names and credit records. The longer identity fraud goes undetected, the more expensive and difficult it becomes to resolve. For an affordable monthly premium, identity theft protection from IDShield helps protect your personal information through proactive monitoring, identity restoration, and resolution.

## Legal Program

Do you have an attorney on retainer? Most people don't, so our legal program offers you access to legal advice and even representation for an affordable monthly premium. Whether you need assistance reviewing a rental agreement, fighting a traffic ticket, creating a will, buying a house or navigating an IRS audit, legal coverage from LegalShield offers reputable attorney assistance for you and your family.

## Pet Insurance

Pets are members of the family too. When your pet gets sick, bills can add up faster than expected. Pet insurance prevents you from needing to weigh your pet's health against your bank account. Most plans offer coverage for costs associated with both accidents and illnesses—even medications. Nationwide provides coverage for this program. You can enroll in this program at any time.



## IMPORTANT PLAN INFORMATION

In this section, you'll find important plan information, including:

- Your medical, dental and vision benefit contributions for 2023
- Contact information for our benefit carriers and vendors
- A summary of the health plan notices you are entitled to receive annually, and where to find them
- A Benefits Glossary to help you understand important insurance terms.

# YOUR MONTHLY BENEFIT COSTS

The total amount that you pay for your benefits coverage depends on the plans you choose, how many dependents you cover, and for medical coverage, how much you earn. Your healthcare costs are deducted from your pay on a pre-tax basis — before federal, state, and social security taxes are calculated — so you pay less in taxes.

## MEDICAL, DENTAL & VISION

	Cigna PPO	Cigna HDHP	BCBS of AL PPO	BCBS of AL HDHP	Kaiser HMO	Kaiser HDHP	Aetna Dental PPO	VSP Vision
<b>EMPLOYEE ONLY</b>	\$180.68	\$111.24	\$180.68	\$111.24	\$101.82	\$90.48	\$13.73	\$3.22
<b>EMPLOYEE + SPOUSE</b>	\$377.31	\$283.03	\$377.31	\$283.03	\$293.64	\$281.78	\$30.35	\$5.91
<b>EMPLOYEE + CHILDREN</b>	\$379.24	\$274.95	\$379.24	\$274.95	\$266.95	\$259.99	\$36.17	\$6.04
<b>EMPLOYEE + FAMILY</b>	\$666.18	\$436.79	\$666.18	\$436.79	\$400.42	\$368.89	\$51.53	\$9.53

*Please note that unless your domestic partner is your tax dependent as defined by the IRS, contributions for domestic partner coverage must be made after-tax. Similarly, the company contribution toward coverage for your domestic partner and his/her dependents will be reported as taxable income on your W-2. Contact your tax advisor for more details on how this tax treatment applies to you. Notify WideOrbit if your domestic partner is your tax dependent.*

# VOLUNTARY LIFE & AD&D INSURANCE COSTS

If you elect voluntary coverage, your monthly premium rate is calculated based on your age and the amount of coverage. Use the tables below to estimate the premium amount that will be deducted from your paycheck. Spouse rates are based on the employee age.

## VOLUNTARY LIFE INSURANCE – MONTHLY RATE PER \$1,000 OF COVERAGE

AGE	EMPLOYEE	SPOUSE
<25	\$0.039	\$0.039
25-29	\$0.039	\$0.039
30-34	\$0.049	\$0.049
35-39	\$0.069	\$0.069
40-44	\$0.100	\$0.100
45-49	\$0.150	\$0.150
50-54	\$0.230	\$0.230
55-59	\$0.430	\$0.430
60-64	\$0.660	\$0.660
65-69	\$1.137	\$1.137
70-74	\$1.842	\$1.842
75-79	\$2.060	\$2.060
80+	\$3.254	\$3.254

## VOLUNTARY AD&D – MONTHLY RATE PER \$1,000 OF COVERAGE

Employee & Spouse	\$0.029
Child(ren)	\$0.029

To calculate your per paycheck AD&D cost, follow the same steps as the table above.

## CALCULATE YOUR LIFE INSURANCE COST

### 1. Desired Coverage (\$1,000 Increments)

You:	Spouse:
------	---------

### 2. Divide Step 1 by 1,000 =

You:	Spouse:
------	---------

### 3. Multiply Step 2 by Rate from Table =

You:	Spouse:
------	---------

### 4. Multiply Step 3 by 12 and divide by 24 =

You:	Spouse:
------	---------

### 5. Add You + Spouse from Step 4:

TOTAL COST PER PAYCHECK:
--------------------------

## CHILD LIFE INSURANCE

COVERAGE AMOUNT	Rate per \$1,000 of coverage	Total Cost Per Paycheck
\$1,000	\$0.157	\$0.08
\$10,000	\$0.157	\$0.80

**Premium includes all eligible children.** Eligible children include dependent children under age 26 as long as you apply for and are approved for coverage for yourself.

# PLAN CONTACTS

## HELPFUL RESOURCES

### Benefits Portal/App

MyBenefits.Life®

[wideorbit.mybenefits.life](https://wideorbit.mybenefits.life)

Employer code: WideOrbit

### Enrollment Website (ADP)

[workforcenow.adp.com](https://workforcenow.adp.com)

Or via WideOrbit [SSO](#)

### Benefit Advocate

[wideorbit@alliant.com](mailto:wideorbit@alliant.com)

(925) 287-7248

## MEDICAL, DENTAL & VISION

### Cigna PPO & HDHP

Policy # 630947

[Mycigna.com](https://mycigna.com)

[Find a Provider](#)

(866) 494-2111

### Kaiser DHMO & HDHP

Policy # 603774

[Kp.org](https://kp.org)

[Find a Provider](#)

(800) 464-4000

### BCBS of AL PPO & HDHP

Policy # 97764

[Bcbsal.org](https://bcbsal.org)

[Find a Provider](#)

(800) 464-4000

### Aetna Dental

Policy # 138366

[Aetna.com](https://aetna.com)

[Find a Provider](#)

(877) 238-6200

### Guardian (VSP)

Policy # 00472074

[vsp.com](https://vsp.com)

[Find a Provider](#)

800) 877-7195

## HEALTH SAVINGS ACCOUNT (HSA)

### PayFlex

Policy # 147606

Cigna & BCBS of AL

[Payflex.com](https://payflex.com)

(844) 729-3539

### Kaiser HSA

[Kp.org/healthexpense](https://kp.org/healthexpense)

Health Payment Services

(877) 761-3399

## LIFE, AD&D, SHORT-TERM, & LONG-TERM DISABILITY

### Mutual of Omaha

Policy # G000BS83

[Mutualofomaha.com](https://mutualofomaha.com)

(800) 775-6000

## EMPLOYEE ASSISTANCE PROGRAM EAP

### Concern

[Employees.concernhealth.com](https://employees.concernhealth.com)

Company code: wide

(800) 344-4222

## FLEXIBLE SPENDING ACCOUNTS (FSA)

### WEX, Inc.

Policy # 28119

[Wexinc.com](https://wexinc.com)

(866) 451-3399

## TRANSIT / PARKING ADMINISTRATION

### WEX, Inc.

Policy # 28119

[Wexinc.com](https://wexinc.com)

(866) 451-3399

## VOLUNTARY ACCIDENT & CRITICAL ILLNESS

### Mutual of Omaha

Policy # G000BS83

[Mutualofomaha.com](https://mutualofomaha.com)

(800) 775-6000

## PET INSURANCE

### Nationwide

Policy # G000BS83

[Benefits.petinsurance.com](https://benefits.petinsurance.com)

(877) 738-7874

### 401(k)

### Fidelity

Policy # 29346

[401k.com](https://401k.com)

(800) 835-5095

## VOLUNTARY LEGAL AND IDENTITY THEFT PROTECTION

### LegalShield / IDShield

[Benefits.legalshield.com](https://benefits.legalshield.com)

# 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).

### **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.

**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.

# GLOSSARY

## -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.

# PLAN DOCUMENTS

Important documents for our health plan and retirement plan are available at the end of this brochure. Paper copies of these documents and notices are available if requested. If you would like a paper copy, please contact the Plan Administrator.

## **SUMMARY PLAN DESCRIPTIONS (SPD)**

The legal document for describing benefits provided under the plan as well as plan rights and obligations to participants and beneficiaries.

- WideOrbit, LLC Health and Welfare Plan

## **SUMMARY OF BENEFITS AND COVERAGE (SBC)**

A document required by the Affordable Care Act (ACA) that presents benefit plan features in a standardized format. SBC documents are available through MyBenefits.Life.

- Cigna PPO
- Cigna HDHP
- BCBS of AL PPO
- BCBS of AL HDHP
- Kaiser DHMO
- Kaiser HDHP

## **STATEMENT OF MATERIAL MODIFICATIONS**

This enrollment guide constitutes a Summary of Material Modifications (SMM) to the WideOrbit, Inc. Health and Welfare Plan. It is meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.

# IMPORTANT PLAN INFORMATION

## HEALTH PLAN NOTICES

These notices must be provided to plan participants on an annual basis and are available in the Annual Notices document, located at the end of this document:

- **Medicare Part D Notice:** Describes options to access prescription drug coverage for Medicare eligible individuals
- **Women's Health and Cancer Rights Act:** Describes benefits available to those that will or have undergone a mastectomy
- **Newborns' and Mothers' Health Protection Act:** Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery
- **HIPAA Notice of Special Enrollment Rights:** Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment
- **HIPAA Notice of Privacy Practices:** Describes how health information about you may be used and disclosed
- **Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP):** Describes availability of premium assistance for Medicaid eligible dependents.

## COBRA CONTINUATION COVERAGE

You and/or your dependents may have the right to continue coverage after you lose eligibility under the terms of our health plan. Upon enrollment, you and your dependents receive a COBRA Initial Notice that outlines the circumstances under which continued coverage is available and your obligations to notify the plan when you or your dependents experience a qualifying event. Please review this notice carefully to make sure you understand your rights and obligations.

# Medicare Part D Notice

## Important Notice from WideOrbit, LLC About Your Prescription Drug Coverage and Medicare

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. WideOrbit, LLC has determined that the prescription drug coverage offered by the WideOrbit, LLC Health and Welfare Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

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## When Can You Join A Medicare Drug Plan?

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

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

## What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your WideOrbit, LLC coverage **will not** be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under WideOrbit, LLC Health and Welfare Plan is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your WideOrbit, LLC prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

## When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with WideOrbit, LLC and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

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

## For More Information About Your Options Under Medicare Prescription Drug Coverage...

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

For more information about Medicare prescription drug coverage:

- Visit [medicare.gov](https://www.medicare.gov)
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at [socialsecurity.gov](https://www.socialsecurity.gov), or call them at 800-772-1213 (TTY 800-325-0778).

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

**Date:** January 1, 2023  
**Name of Entity/Sender:** WideOrbit, LLC  
**Contact-Position/Office:** Human Resources  
**Address:** 1160 Battery Street Suite 300, San Francisco, CA 94111  
**Phone Number:** 415-675-6700

## Women's Health and Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, deductibles and coinsurance apply per your formal plan documents. If you would like more information on WHCRA benefits, call your plan administrator 415-675-6700.

## Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator at 415-675-6700.

## HIPAA Notice of Special Enrollment Rights

If you decline enrollment in WideOrbit, LLC's health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in WideOrbit, LLC's health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 31 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 31-day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in WideOrbit, LLC's health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan. Any other currently covered dependents may also switch to the new plan in which you enroll.

## Availability of Privacy Practices Notice

We maintain the HIPAA Notice of Privacy Practices for WideOrbit, LLC describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting 415-675-6700.

## Premium Assistance under Medicaid and the Children’s Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit [www.healthcare.gov](http://www.healthcare.gov).

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or [www.insurekidsnow.gov](http://www.insurekidsnow.gov) to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at [www.askebsa.dol.gov](http://www.askebsa.dol.gov) or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2022. Contact your State for more information on eligibility—

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

**COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)**

Health First Colorado Website: <https://www.healthfirstcolorado.com/>

Health First Colorado Member Contact Center: 1-800-221-3943 | State Relay 711

CHP+: <https://www.colorado.gov/pacific/hcpf/child-health-plan-plus>

CHP+ Customer Service: 1-800-359-1991 | State Relay 711

Health Insurance Buy-In Program (HIBI): <https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program>

HIBI Customer Service: 1-855-692-6442

**FLORIDA – Medicaid**

Website: <https://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html>

Phone: 1-877-357-3268

**GEORGIA – Medicaid**

GA HIPP Website: <https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp>

Phone: 678-564-1162, press 1

GA CHIPRA Website: <https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra> | Phone: 678-564-1162, press 2

**INDIANA – Medicaid**

Healthy Indiana Plan for low-income adults 19-64 Website: <http://www.in.gov/fssa/hip/> | Phone: 1-877-438-4479

All other Medicaid Website: <https://www.in.gov/medicaid/> | Phone 1-800-457-4584

**IOWA – Medicaid and CHIP (Hawki)**

Medicaid Website: <https://dhs.iowa.gov/ime/members> | Medicaid Phone: 1-800-338-8366

Hawki Website: <http://dhs.iowa.gov/Hawki> | Hawki Phone: 1-800-257-8563

HIPP Website: <https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp> | HIPP Phone: 1-888-346-9562

**KANSAS – Medicaid**

Website: <https://www.kancare.ks.gov/> | Phone: 1-800-792-4884

**KENTUCKY – Medicaid**

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)

Website: <https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx> | Phone: 1-855-459-6328

Email: [KIHIPPPROGRAM@ky.gov](mailto:KIHIPPPROGRAM@ky.gov) | KCHIP Website: <https://kidshealth.ky.gov/Pages/index.aspx>

Phone: 1-877-524-4718 | Kentucky Medicaid Website: <https://chfs.ky.gov>

**LOUISIANA – Medicaid**

Website: [www.medicicaid.la.gov](http://www.medicicaid.la.gov) or [www.ldh.la.gov/lahipp](http://www.ldh.la.gov/lahipp)

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

**MAINE – Medicaid**

Enrollment Website: <https://www.maine.gov/dhhs/ofi/applications-forms>

Phone: 1-800-442-6003 | TTY: Maine relay 711

Private Health Insurance Premium Webpage: <https://www.maine.gov/dhhs/ofi/applications-forms>

Phone: 800-977-6740 | TTY: Maine relay 711

**MASSACHUSETTS – Medicaid and CHIP**

Website: <https://www.mass.gov/masshealth/pa> | Phone: 1-800-862-4840 | TTY: 617-886-8102

**MINNESOTA – Medicaid**

Website: <https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp> | Phone: 1-800-657-3739

**MISSOURI – Medicaid**

Website: <http://www.dss.mo.gov/mhd/participants/pages/hipp.htm> | Phone: 573-751-2005

**MONTANA – Medicaid**

Website: <http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>

Phone: 1-800-694-3084 | email: [HSHIPPPProgram@mt.gov](mailto:HSHIPPPProgram@mt.gov)

#### **NEBRASKA – Medicaid**

Website: <http://www.ACCESSNebraska.ne.gov>

Phone: 1-855-632-7633 | Lincoln: 402-473-7000 | Omaha: 402-595-1178

#### **NEVADA – Medicaid**

Medicaid Website: <http://dhcfp.nv.gov> | Medicaid Phone: 1-800-992-0900

#### **NEW HAMPSHIRE – Medicaid**

Website: <https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program>

Phone: 603-271-5218 | Toll free number for the HIPP program: 1-800-852-3345, ext. 5218

#### **NEW JERSEY – Medicaid and CHIP**

Medicaid Website: <http://www.state.nj.us/humanservices/dmahs/clients/medicaid/> | Phone: 609-631-2392

CHIP Website: <http://www.njfamilycare.org/index.html> | CHIP Phone: 1-800-701-0710

#### **NEW YORK – Medicaid**

Website: [https://www.health.ny.gov/health\\_care/medicaid/](https://www.health.ny.gov/health_care/medicaid/) | Phone: 1-800-541-2831

#### **NORTH CAROLINA – Medicaid**

Website: <https://medicaid.ncdhhs.gov/> | Phone: 919-855-4100

#### **NORTH DAKOTA – Medicaid**

Website: <http://www.nd.gov/dhs/services/medicalserv/medicaid/> | Phone: 1-844-854-4825

#### **OKLAHOMA – Medicaid and CHIP**

Website: <http://www.insureoklahoma.org> | Phone: 1-888-365-3742

#### **OREGON – Medicaid**

Website: <http://healthcare.oregon.gov/Pages/index.aspx> or <http://www.oregonhealthcare.gov/index-es.html>

Phone: 1-800-699-9075

#### **PENNSYLVANIA – Medicaid**

Website: <https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx> | Phone: 1-800-692-7462

#### **RHODE ISLAND – Medicaid and CHIP**

Website: <http://www.eohhs.ri.gov/> | Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)

#### **SOUTH CAROLINA – Medicaid**

Website: <https://www.scdhhs.gov> | Phone: 1-888-549-0820

#### **SOUTH DAKOTA – Medicaid**

Website: <http://dss.sd.gov> | Phone: 1-888-828-0059

#### **TEXAS – Medicaid**

Website: <http://gethipptexas.com/> | Phone: 1-800-440-0493

#### **UTAH – Medicaid and CHIP**

Medicaid Website: <https://medicaid.utah.gov/> | CHIP Website: <http://health.utah.gov/chip>

Phone: 1-877-543-7669

#### **VERMONT – Medicaid**

Website: <http://www.greenmountaincare.org/> | Phone: 1-800-250-8427

#### **VIRGINIA – Medicaid and CHIP**

Website: <https://www.coverva.org/en/famis-select> or <https://www.coverva.org/en/hipp>

Medicaid Phone: 1-800-432-5924 | CHIP Phone: 1-800-432-5924

#### **WASHINGTON – Medicaid**

Website: <https://www.hca.wa.gov/> | Phone: 1-800-562-3022

#### **WEST VIRGINIA – Medicaid and CHIP**

Website: <https://dhhr.wv.gov/bms/> or <http://mywvhipp.com/>

Medicaid Phone: 304-558-1700 | CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

#### **WISCONSIN – Medicaid and CHIP**

Website: <https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm> | Phone: 1-800-362-3002

#### **WYOMING – Medicaid**

Website: <https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/> | Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

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

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

## ACA Disclaimer

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 9.12% in 2023 of your modified adjusted household income.



Rev. November 3, 2022

WIDEORBIT

Say hello to a Wider World™

# 2024 BENEFITS GUIDE



**WIDEORBIT**

Say hello to a Wider World™

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**This guide is an overview** and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your plan benefit booklets or summary plan descriptions (SPDs). The plan benefit booklets determine how all benefits are paid.



# GETTING STARTED

## 2024 Benefits

January 1, 2024 through December 31, 2024

### 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 see the *Important Notices* section for more details.

Whether you're enrolling in benefits for the first time, nearing retirement, or somewhere in between, WideOrbit supports you with benefit programs and resources to help you thrive today and prepare for tomorrow.

This guide provides an overview of your healthcare coverage, life, disability, retirement benefits, and more.

You'll find tips to help you understand your medical coverage, save time and money on healthcare, reduce taxes, and balance your work and home life. Review the coverage and tools available to you to make the most of your benefits package.

# WHO'S ELIGIBLE FOR BENEFITS?

## Employees

You are eligible if you are a regular full-time employee working 20 or more hours per week. Employees with variable hours and seasonal schedules may be considered eligible for benefits. Refer to "Determining Eligibility" later in this guide for details.

## Eligible dependents

- Legally married spouse or same or opposite gender domestic partner
- Natural, adopted or stepchildren up to age 26. Domestic partner's child(ren) are eligible.
- Children over age 26 who are disabled and depend on you for support
- Children named in a Qualified Medical Child Support Order (QMCSO).

For additional information, please refer to the benefit booklets for each benefit.

## Domestic Partner eligibility criteria

If you are enrolling a domestic partner or domestic partner children, you are required to have met all eligibility requirements listed below for the previous 6 months:

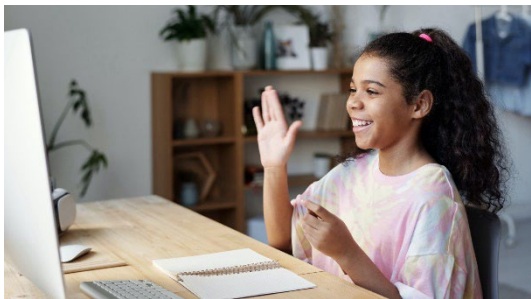
- You maintain the same principal place of residence and intend to do so in the future
  - You agree to be responsible for each other's basic living expenses in the event that either of you are unable to provide such expenses for yourself
  - You are both 18 or older and neither of you are married
  - You are not related by blood to such a degree that you would be prevented from marrying in the state in which you reside
  - Neither of you has maintained coverage for another Domestic Partner under any health plan within the last six months. (This excludes any domestic partner that has died within the last six months)
  - You agree to notify WideOrbit immediately upon your failure to satisfy any of the criteria of Domestic Partnership
  - You understand that it is fraudulent act to obtain health coverage by misrepresenting any facts stated herein
- Or -
- You are Registered Domestic Partners

You may be required to provide proof of dependent status. Any falsification of this information will result in disciplinary action, up to and including termination.

For additional information, please refer to the full certificate of coverage for each benefit.

**Note:** WideOrbit extends coverage to same gender and opposite gender Domestic Partners (DPs) and their dependents who meet the policy requirement. Keep in mind that due to IRS regulations, your cost for domestic partner coverage must be paid with after-tax dollars. In addition, the company's cost for domestic partner coverage is considered "imputed cost," and is subject to income and Social Security taxes, unless your domestic partner qualifies as your tax dependent.

# WHEN CAN YOU ENROLL



## New Hire & Open Enrollment

You can enroll in benefits as a new hire or during the annual open enrollment period. New hire coverage begins on the First of Month Following Date of Hire if you enroll within 30 days of becoming eligible.

If you miss the enrollment deadline, you'll need to wait until the next open enrollment (the one time each year that you can make changes to your benefits for any reason).

## Changing Your Benefits

Outside of open enrollment and your new hire window, you may be able to enroll or make changes to your benefit elections if you have a big change in your life, including:

- Change in legal marital status
- Change in number of dependents or dependent eligibility status
- Change in employment status that affects eligibility for you, your spouse, or dependent child(ren)
- Change in residence that affects access to network providers
- Change in your health coverage or your spouse's coverage due to your spouse's employment
- Change in an individual's eligibility for Medicare or Medicaid
- Court order requiring coverage for your child
- "Special enrollment event" under the Health Insurance Portability and Accountability Act (HIPAA), including a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan
- Event allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act (you have 60 days to request enrollment due to events allowed under CHIP).

You must submit your change within 31 days after the event.

# THE EASY WAY TO GET BENEFITS INFO

Click to play video



## GET MYBENEFITS.LIFE®

**On the web:**  
**wideorbit.mybenefits.life**

**On your smartphone**



Download from the App Store or Google Play.

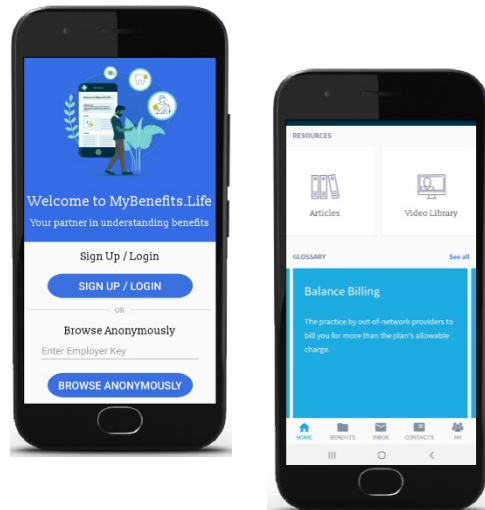
**Login With Employer Key**  
**WIDEORBIT**

MyBenefits.Life® gives you all your benefits information in one place

You can bank online, book a vacation online, and read the news online. Why should your benefits information be any different? MyBenefits.Life® is both a website and a mobile app that gives you access to the benefits information you need, when you need it.

Here's what you'll find on MyBenefits.Life®

<b>Benefits</b>	See benefit details and costs—for all plans you're eligible for, such as healthcare, disability, life insurance, and more
<b>Search</b>	Can't find it? Just search the site
<b>Articles &amp; Video Library</b>	Have 2 minutes? Increase your benefits IQ with short explainer articles and videos
<b>Financial Wellness</b>	Want to understand your finances better? Learn how in the Digital Financial Wellness Center, powered by Prudential
<b>Glossary</b>	HDHP? EOB? Coinsurance? Get the definitions in plain English
<b>Documents</b>	Important benefit plan notices ("the fine print")
<b>Contacts</b>	Find HR, benefits, and carrier contacts
<b>Get Help</b>	Need help? Reach helpful resources



# HAVE QUESTIONS ABOUT YOUR BENEFITS?



## CONTACT YOUR ALLIANT BENEFIT ADVOCATE

### Email

[wideorbit@alliant.com](mailto:wideorbit@alliant.com)

### Phone

925-287-7248

### Hours

M-Th, 8am to 5pm PST

Fri, 8am to 4:30pm PST

## Get help from a Benefit Advocate

Are you getting married and not sure how and 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 Advocates are trained benefits expert who can help you understand and use your healthcare and other coverage.

Contact your Benefit Advocate for issues such as:

- General benefit questions
- Eligibility and coverage
- Finding a network provider
- Health care claim or billing issues, when warranted
- Coverage changes due to life events (marriage, new child, divorce, etc.).

## Claims assistance

If you need claims assistance, you'll 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 time basis to only the individuals listed on the form. The form is revocable at any time. Your Benefit Advocate will provide the form to you when needed.



## MEDICAL

### OUR PLANS

2024 Cigna HDHP

2024 Cigna PPO

2024 BCBS of AL HDHP (AL Only)

2024 BCBS of AL PPO (AL Only)

2024 Kaiser HDHP (CA Only)

2024 Kaiser DHMO (CA Only)

### WHICH PLAN IS RIGHT FOR YOU?

That depends on your healthcare needs, favorite doctors, and budget. Here are some considerations.

#### Do you prefer specific doctors or hospitals?

If you want to stay with your favorite doctors and facilities, check whether they are in the plan's network. If they are not, but you are comfortable paying a bit more to see them, consider a plan with both in-network and out-of-network benefits.

#### What are your usual healthcare needs?

Do you have frequent doctor or urgent care visits? Do you have a condition that requires a specialist? Do you take prescription medications? Compare how each plan covers the services you need most often.

#### Consider the bottom line

How much is the monthly payroll deduction? Do you have to meet a deductible? What is the out-of-pocket maximum? How much of the cost is covered by the plan? How much are any copayments for office visits, prescriptions, etc. All of these factors together affect your total cost for healthcare.

# 2024 Cigna HDHP

You always pay the deductible and copayment (\$). The coinsurance (%) shows what you pay after the deductible.

You can reimburse qualified lodging and travel expenses under [IRS Publication 502](#). Travel and lodging expenses are covered for specific services with restricted geographic access to care, including abortion, gender affirmation, behavioral inpatient and outpatient, bariatric surgery, and congenital heart disease treatment. Be sure to save your travel and lodging receipts and contact Cigna with any questions. The care must be received 60 miles or farther from your home.

	In-Network	Out-of-Network
<b>Annual Deductible</b>	\$2,250 employee only (combined with out-of-network); \$3,200 per individual in a family, up to \$4,500 per family (combined with out-of-network)	\$4,000 employee only (combined with in-network); \$4,000 per individual in a family, up to \$8,000 per family (combined with in-network)
<b>Accumulation Period</b>	Time period to incur eligible expenses toward the deductible: Calendar Year	
<b>Annual Out-of-Pocket Maximum</b>	\$4,000 employee only (combined with out-of-network); \$4,000 per individual in a family, up to \$8,000 per family (combined with out-of-network)	\$8,000 employee only (combined with in-network); \$8,000 per individual in a family, up to \$16,000 per family (combined with in-network)
<b>Office Visit</b>	20% after deductible	50% after deductible
<b>Chiropractic</b>	20% after deductible (up to 20 visits per calendar year combined with out-of-network)	50% after deductible (up to 20 visits per calendar year combined with in-network)
<b>Lab and X-ray</b>	20% after deductible	50% after deductible
<b>Urgent Care</b>	20% after deductible	50% after deductible
<b>Emergency Room</b>	20% after deductible	20% after deductible
<b>Hospitalization</b>	20% after deductible	50% after deductible
<b>Outpatient Surgery</b>	20% after deductible	50% after deductible
<b>PRESCRIPTION DRUGS</b>		
<b>Deductible</b>	Combined with medical deductible	N/A
<b>Out-of-Pocket Maximum</b>	Combined with medical out of pocket	N/A
<b>Generic</b>	<b>Pharmacy:</b> \$15 copay after deductible <b>Mail Order:</b> \$30 copay after deductible	Not covered
<b>Preferred Brand Name</b>	<b>Pharmacy:</b> \$30 copay after deductible <b>Mail Order:</b> \$60 copay after deductible	Not covered
<b>Non-Preferred Brand Name</b>	<b>Pharmacy:</b> \$50 copay after deductible <b>Mail Order:</b> \$100 copay after deductible	Not covered
<b>Specialty</b>	<b>Pharmacy:</b> You pay 30% after deductible <b>Mail Order:</b> You pay 30% after deductible	Not covered
<b>Supply</b>	<b>Pharmacy:</b> 30 days <b>Mail Order:</b> 90 days	Not covered

# 2024 Cigna PPO

You always pay the deductible and copayment (\$). The coinsurance (%) shows what you pay after the deductible.

You can reimburse qualified lodging and travel expenses under [IRS Publication 502](#). Travel and lodging expenses are covered for specific services with restricted geographic access to care, including abortion, gender affirmation, behavioral inpatient and outpatient, bariatric surgery, and congenital heart disease treatment. Be sure to save your travel and lodging receipts and contact Cigna with any questions. The care must be received 60 miles or farther from your home

	In-Network	Out-of-Network
<b>Annual Deductible</b>	\$500 per individual, up to \$1,000 per family	\$1,000 per individual, up to \$2,000 per family
<b>Accumulation Period</b>	Time period to incur eligible expenses toward the deductible: Calendar Year	
<b>Annual Out-of-Pocket Maximum</b>	\$3,500 per individual, up to \$7,000 per family	\$7,000 per individual, up to \$14,000 per family
<b>Office Visit</b>	\$20 copay, \$30 copay for Specialist	40% after deductible
<b>Chiropractic</b>	\$30 copay (limited to 20 visits per calendar year, combined with out-of-network)	40% after deductible (limited to 20 visits per calendar year, combined with in-network)
<b>Lab and X-ray</b>	20% after deductible	40% after deductible
<b>Urgent Care</b>	\$30 copay	40% after deductible
<b>Emergency Room</b>	\$150 copay, + 20% coinsurance (copay waived if admitted)	\$150 copay, + 20% coinsurance (copay waived if admitted)
<b>Hospitalization</b>	\$250 copay, + 20% after deductible	40% after deductible
<b>Outpatient Surgery</b>	20% after deductible	40% after deductible
<b>PRESCRIPTION DRUGS</b>		
<b>Deductible</b>	None	N/A
<b>Out-of-Pocket Maximum</b>	Combined with medical out of pocket	N/A
<b>Generic</b>	<b>Pharmacy:</b> \$15 copay <b>Mail Order:</b> \$30 copay	Not covered
<b>Preferred Brand Name</b>	<b>Pharmacy:</b> \$30 copay <b>Mail Order:</b> \$60 copay	Not covered
<b>Non-Preferred Brand Name</b>	<b>Pharmacy:</b> \$50 copay <b>Mail Order:</b> \$100 copay	Not covered
<b>Specialty</b>	<b>Pharmacy:</b> You pay 30% <b>Mail Order:</b> You pay 30%	Not covered
<b>Supply</b>	<b>Pharmacy:</b> 30 days <b>Mail Order:</b> 90 days	Not covered

## 2024 BCBS of AL HDHP – *Alabama Only*

You always pay the deductible and copayment (\$). The coinsurance (%) shows what you pay after the deductible.

	In-Network	Out-of-Network
<b>Annual Deductible</b>	\$2,250 employee only; \$3,200 per individual in a family, up to \$4,500 per family	\$4,000 employee only; \$4,000 per individual in a family, up to \$8,000 per family
<b>Accumulation Period</b>	Time period to incur eligible expenses toward the deductible: Calendar Year	
<b>Annual Out-of-Pocket Maximum</b>	\$4,000 employee only; \$4,000 per individual in a family, up to \$8,000 per family	There is no out-of-pocket maximum for out-of-network services
<b>Office Visit</b>	20% after deductible	50% after deductible
<b>Chiropractic</b>	20% after deductible (limited to 20 visits per calendar year combined with out-of- network)	50% after deductible; <b>In Alabama:</b> Not covered (limited to 20 visits per calendar year combined with in-network)
<b>Lab and X-ray</b>	20% after deductible	50% after deductible
<b>Urgent Care</b>	20% after deductible	50% after deductible
<b>Emergency Room</b>	20% after deductible	20% after deductible
<b>Hospitalization</b>	20% after deductible	50% after deductible
<b>Outpatient Surgery</b>	20% after deductible	50% after deductible <b>In Alabama:</b> Not Covered
<b>PRESCRIPTION DRUGS</b>		
<b>Deductible</b>	Combined with medical deductible	N/A
<b>Out-of-Pocket Maximum</b>	Combined with medical out of pocket	N/A
<b>Generic</b>	<b>Pharmacy:</b> \$15 copay after deductible <b>Mail Order:</b> \$37.50 copay after deductible	Not covered
<b>Preferred Brand Name</b>	<b>Pharmacy:</b> \$30 copay after deductible <b>Mail Order:</b> \$75 copay after deductible	Not covered
<b>Non-Preferred Brand Name</b>	<b>Pharmacy:</b> \$50 copay after deductible <b>Mail Order:</b> \$125 copay after deductible	Not covered
<b>Specialty</b>	<b>Pharmacy:</b> You pay 30% after deductible <b>Mail Order:</b> You pay 30% after deductible	Not covered
<b>Supply</b>	<b>Pharmacy:</b> 30 days <b>Mail Order:</b> 90 days	Not covered

## 2024 BCBS of AL PPO – *Alabama Only*

You always pay the deductible and copayment (\$). The coinsurance (%) shows what you pay after the deductible.

	In-Network	Out-of-Network
<b>Annual Deductible</b>	\$500 per individual, up to \$1,000 per family	\$1,000 per individual, up to \$2,000 per family
<b>Accumulation Period</b>	Time period to incur eligible expenses toward the deductible: Calendar Year	
<b>Annual Out-of-Pocket Maximum</b>	\$3,500 per individual, up to \$7,000 per family	There is no out-of-pocket maximum for out-of-network services
<b>Office Visit</b>	\$20 copay, \$30 copay for Specialist	40% after deductible; <b>In Alabama:</b> 50% after deductible
<b>Chiropractic</b>	20% after deductible (limited to 12 visits per calendar year combined with out-of-network)	40% after deductible; <b>In Alabama:</b> Not Covered (limited to 12 visits per calendar year combined with in-network)
<b>Lab and X-ray</b>	20% after deductible	40% after deductible
<b>Urgent Care</b>	\$30 copay	40% after deductible
<b>Emergency Room</b>	\$150 copay	\$150 copay
<b>Hospitalization</b>	20% after deductible	40% after deductible
<b>Outpatient Surgery</b>	20% after deductible	40% after deductible <b>In Alabama:</b> Not Covered
<b>PRESCRIPTION DRUGS</b>		
<b>Deductible</b>	None	N/A
<b>Out-of-Pocket Maximum</b>	Combined with medical out of pocket	N/A
<b>Generic</b>	<b>Pharmacy:</b> \$15 copay <b>Mail Order:</b> \$37.50 copay	Not covered
<b>Preferred Brand Name</b>	<b>Pharmacy:</b> \$30 copay <b>Mail Order:</b> \$75 copay	Not covered
<b>Non-Preferred Brand Name</b>	<b>Pharmacy:</b> \$50 copay <b>Mail Order:</b> \$125 copay	Not covered
<b>Specialty</b>	<b>Pharmacy:</b> You pay 30% <b>Mail Order:</b> You pay 30%	Not covered
<b>Supply</b>	<b>Pharmacy:</b> 30 days <b>Mail Order:</b> 90 days	Not covered

## 2024 Kaiser HDHP – *California Only*

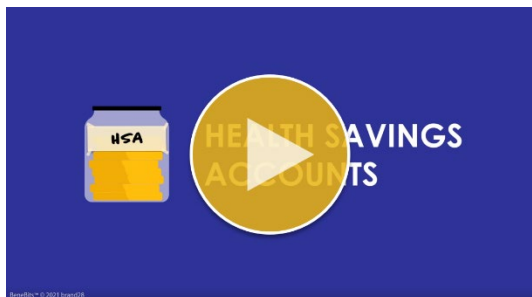
	In-Network
<b>Annual Deductible</b>	\$2,000 employee only; \$3,200 per individual in a family, up to \$4,000 per family
<b>Accumulation Period</b>	Time period to incur eligible expenses toward the deductible: Plan Year
<b>Annual Out-of-Pocket Maximum</b>	\$3,500 employee only; \$3,500 per individual in a family, up to \$7,000 per family
<b>Office Visit</b>	\$30 copay after deductible; \$50 copay after deductible for specialist
<b>Chiropractic</b>	Not covered
<b>Lab and X-ray</b>	X-Ray and Lab Tests: \$10 copay after deductible; Imaging (CT/PET & MRI's): \$150 copay after deductible
<b>Urgent Care</b>	\$30 copay after deductible
<b>Emergency Room</b>	\$100 copay after deductible
<b>Hospitalization</b>	\$250 copay after deductible
<b>Outpatient Surgery</b>	\$150 copay after deductible
<b>PRESCRIPTION DRUGS</b>	
<b>Deductible</b>	Combined with medical deductible
<b>Out-of-Pocket Maximum</b>	Combined with medical out of pocket
<b>Generic</b>	<b>Pharmacy:</b> \$10 copay after deductible <b>Mail Order:</b> \$20 copay after deductible
<b>Preferred Brand Name</b>	<b>Pharmacy:</b> \$30 copay after deductible <b>Mail Order:</b> \$60 copay after deductible
<b>Non-Preferred Brand Name</b>	<b>Pharmacy:</b> \$30 copay after deductible <b>Mail Order:</b> \$60 copay after deductible
<b>Specialty</b>	<b>Pharmacy:</b> You pay 20% after deductible (not to exceed \$200) <b>Mail Order:</b> N/A
<b>Supply</b>	<b>Pharmacy:</b> 30 days <b>Mail Order:</b> 100 days

## 2024 Kaiser DHMO – *California Only*

	In-Network (California Only)
<b>Annual Deductible</b>	\$1,000 per individual, up to \$2,000 per family
<b>Accumulation Period</b>	Time period to incur eligible expenses toward the deductible: Plan Year
<b>Annual Out-of-Pocket Maximum</b>	\$3,000 per individual up to \$6,000 per family
<b>Office Visit</b>	\$20 copay; \$20 copay for specialist
<b>Chiropractic</b>	Not covered
<b>Lab and X-ray</b>	X-Ray and Lab Tests: \$10 copay; Imaging (CT/PET & MRI's): \$150 copay
<b>Urgent Care</b>	\$20 copay
<b>Emergency Room</b>	20% after deductible
<b>Hospitalization</b>	20% after deductible
<b>Outpatient Surgery</b>	20% after deductible
<b>Telehealth (Online)</b>	No charge
<b>PRESCRIPTION DRUGS</b>	
<b>Deductible</b>	\$0
<b>Out-of-Pocket Maximum</b>	Combined with medical out of pocket
<b>Generic</b>	<b>Pharmacy:</b> \$10 copay <b>Mail Order:</b> \$20 copay
<b>Preferred Brand Name</b>	<b>Pharmacy:</b> \$30 copay <b>Mail Order:</b> \$60 copay
<b>Non-Preferred Brand Name</b>	<b>Pharmacy:</b> \$30 copay <b>Mail Order:</b> \$60 copay
<b>Specialty</b>	<b>Pharmacy:</b> You pay 20% (not to exceed \$150) <b>Mail Order:</b> N/A
<b>Supply</b>	<b>Pharmacy:</b> 30 days <b>Mail Order:</b> 100 days

# HEALTH SAVINGS ACCOUNT (HSA)

Click to play video



## ARE YOU ELIGIBLE?

The HSA is not for everyone. You're eligible only if you are:

1. Enrolled in the 2024 Cigna, Blue Cross Blue Shield of Alabama, or Kaiser High Deductible Health Plan.
2. Not enrolled in other non-HDHP medical coverage, including Medicare, Medicaid, or Tricare.
3. Not a tax dependent.
4. Not enrolled in a healthcare Flexible Spending Account (FSA), unless it's a "limited purpose" FSA for dental and vision expenses.

## A personal savings account for healthcare

A Health Savings Account (HSA) is an easy way to pay for healthcare expenses that you have today and save for expenses you may have in the future.

## How the HSA works

- Your HSA account is set up automatically after you enroll.

- To help you get started, WideOrbit contributes to your HSA:

Cigna and BCBS of AL HDHP:

**Individual:** \$281.25 per quarter

**Family:** \$562.50 per quarter

Kaiser HDHP:

**Individual:** \$250 per quarter

**Family:** \$500 per quarter

- You can contribute up to the limit set by the IRS (includes company amount).

Individual: \$4,150 per year

Family: \$8,300 per year

Are you age 55 +? You can contribute an additional \$1,000 per year

- You can use your HSA debit card to pay for eligible expenses like office visits, lab tests, prescriptions, dental and vision care, and even some drugstore items.

## Four reasons to love an HSA

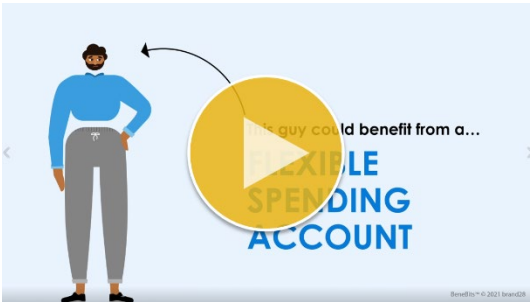
1. **Tax-free.** No federal tax on contributions, or state tax in most states. Withdrawals are also tax-free as long as they're for eligible healthcare expenses.
2. **No "use it or lose it."** Your balance rolls over from year to year. You own the account and can continue to use it even if you change medical plans or leave the company.
3. **Use it now or later.** Use your HSA for healthcare expenses you have today or save it to use in the future.
4. **Boosts retirement savings.** After you retire, you can use your HSA for healthcare expenses tax-free, or for regular living expenses, taxable but no penalties.

## Find out more

- [Eligible Expenses](#)
- [Ineligible Expenses](#)

# HEALTHCARE FLEXIBLE SPENDING ACCOUNT (FSA)

Click to play video



## ARE YOU ELIGIBLE?

You don't have to enroll in one of our medical plans to participate in the healthcare FSA. However, if you or your spouse are enrolled in a high deductible health plan (like our 2024 Inspira Financial HSA, you can only participate in the **Limited Purpose FSA** for dental and vision expenses.

### Find out more

- [WEXInc.com](https://www.wexinc.com)
- [Eligible Expenses](#) – now include more over-the-counter items!
- [Ineligible Expenses](#)

### Do you pay for dependent care?

Look in the Financial Wellness section for information on tax savings through the Dependent Care FSA.

## Set aside healthcare dollars for the coming year

A healthcare FSA allows you to set aside tax-free money to pay for healthcare expenses you expect to have over the coming year.

## How the 2024 WEX Flexible Spending Account works

- You estimate what you and your family's out-of-pocket costs will be for the coming year. Think about what out-of-pocket costs you expect to have for eligible expenses such as office visits, surgery, dental and vision expenses, prescriptions, even eligible drugstore items.
- You can contribute up to \$3,200, the annual limit set by the IRS. Contributions are deducted from your pay pre-tax, meaning no federal or state tax on that amount.
- During the year, you can use your FSA debit card to pay for services and products. Withdrawals are tax-free as long as they're for eligible healthcare expenses.

## Estimate carefully!

If you don't spend all the money in your account, you can roll over up to \$640 to use the following year. Any additional remaining balance will be forfeited.

### FSA TAX SAVINGS EXAMPLE

#### \$60,000 Annual Pay, with \$1,500 FSA Contribution

<b>\$330</b>	<b>\$115</b>	<b>\$445</b>
22% Federal income tax	7.65% FICA tax	Annual FSA tax savings

#### \$120,000 Annual Pay, with \$3,050 FSA Contribution

<b>\$732</b>	<b>\$233</b>	<b>\$965</b>
24% Federal income tax	7.65% FICA tax	Annual FSA tax savings

*Your tax savings may vary depending on tax filing status and other variables*



## DENTAL

### OUR PLAN

2024 Cigna Dental Buy Up PPO

2024 Cigna Dental Base PPO

### Why sign up for Dental coverage?

It's important to go to the dentist regularly. Brushing and flossing are great, but regular exams catch dental issues early before they become more expensive and difficult to treat.

That's where dental insurance comes in. Dental insurance makes it easier and less expensive to get the care you need to maintain good oral health.

Dental insurance covers three types of treatments:

- **Preventive** care includes exams, cleanings and x-rays
- **Basic** care focuses on repair and restoration with services such as fillings, root canals, and gum disease treatment
- **Major** care goes further than basic and includes bridges, crowns and dentures
- **Orthodontia** treatment to properly align teeth within the mouth.

## 2024 Cigna Dental Buy Up PPO and Base PPO

Beginning in 2024, WideOrbit’s dental coverage will be moving from Aetna to Cigna. Be sure to check for in-network dentists under Cigna’s “Total Cigna DPPO” network by navigating to [Cigna’s website](#), selecting “Find a Doctor, Dentist, or Facility”, following the prompts to search by type of dentist or dentist name, and when prompted to select a plan choose “DPPO/EPO > Total Cigna DPPO”. You will also have the option to enroll in the Buy Up Dental PPO offering you higher dental and orthodontic maximums as well as other improved benefits.

You always pay the deductible and copayment (\$). The coinsurance (%) shows what you pay after the deductible.

	Cigna Buy Up PPO		Cigna Base PPO	
	In-Network “Total Cigna DPPO”	Out-of-Network	In-Network: “Total Cigna DPPO”	Out-of-Network
<b>Annual Deductible</b>	\$50 per individual, up to \$150 per family (in and out-of-network combined)	\$50 per individual, up to \$150 per family (in and out-of-network combined)	\$50 per individual, up to \$150 per family (in and out-of-network combined)	\$50 per individual, up to \$150 per family (in and out-of-network combined)
<b>Annual Plan Maximum</b>	\$5,000 (in and out-of-network combined)	\$2,500 (in and out-of-network combined)	\$2,500 (in and out-of-network combined)	\$2,500 (in and out-of-network combined)
<b>Diagnostic &amp; Preventive</b>	No charge (deductible waived)	No charge (deductible waived)	No charge (deductible waived)	No charge (deductible waived)
<b>Basic Services</b>	No charge after deductible	20% after deductible	20% after deductible	20% after deductible
<b>Major Services</b>	40% after deductible	50% after deductible	50% after deductible	50% after deductible
<b>Orthodontia</b>	50%  Children: Covered Adults: Covered	50%  Children: Covered Adults: Covered	50%  Children: Covered Adults: Covered	50%  Children: Covered Adults: Covered
<b>Ortho Lifetime Max</b>	\$2,500 (in and out-of-network combined)	\$1,500 (in and out-of-network combined)	\$1,500 (in and out-of-network combined)	\$1,500 (in and out-of-network combined)



## VISION

### OUR PLAN

2024 Guardian (VSP) Vision

### Why sign up for Vision coverage?

Vision coverage helps with the cost of eyeglasses or contacts. But even if you don't need vision correction, an annual eye exam checks the health of your eyes and can even detect more serious health issues such as diabetes, high blood pressure, high cholesterol, and thyroid disease.

You'll even find discounts on services like LASIK and PRK, rebates on contact lenses, and money off on hearing aids and other related services. Visit the plan's website to check out these extra savings.

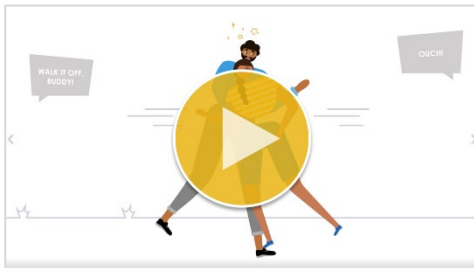
# 2024 Guardian (VSP) Vision

Your vision checkup is fully covered after your Exam copay. After any Materials copay, the plan covers frames, lenses, and contacts as described below.

	In-Network	Out-of-Network
<b>Copay</b>	<b>Exam:</b> \$10 copay <b>Materials:</b> \$25 copay	<b>Exam:</b> \$10 copay (reimbursed up to \$50) <b>Materials:</b> \$25 copay
<b>Frames</b>	Coverage up to \$130, 20% discount over \$130 after materials copay	Reimbursed up to \$48 after materials copay
<b>Lenses</b>	<b>Single Vision:</b> No charge after applicable copay <b>Bifocal:</b> No charge after applicable copay <b>Trifocal:</b> No charge after applicable copay	<b>Single Vision:</b> Reimbursed up to \$48 after materials copay <b>Bifocal:</b> Reimbursed up to \$67 after materials copay <b>Trifocal:</b> Reimbursed up to \$86 after materials copay
<b>Contacts (Elective)</b>	Coverage up to \$130 (in lieu of frames)	Reimbursed up to \$120 (in lieu of frames)
<b>Frequency</b>	<b>Exam:</b> 12 months <b>Frames:</b> 24 months <b>Lenses:</b> 12 months <b>Contacts (Elective):</b> 12 months (in lieu of frames)	<b>Exam:</b> 12 months <b>Frames:</b> 24 months <b>Lenses:</b> 12 months <b>Contacts (Elective):</b> 12 months (in lieu of frames)

# ENGAGE

*Click to play video*



PCP vs Urgent Care vs ER






## Maximize Your Healthcare

Knowing how to best use your healthcare coverage can help you improve your health and reduce your expenses. In this section you'll find tips on:

- Finding the right care at the right cost
- Alternatives to hospital care
- Understanding preventive care benefits
- Saving money on prescription drugs





# KNOW WHERE TO GO

Where you get medical care can have a significant impact on the cost. Here's a quick guide to help you know where to go, based on your condition, budget, and time.

Type	Appropriate for	Examples	Access	Cost
<b>Nurseline</b> 	Quick answers from a trained nurse	<ul style="list-style-type: none"> <li>Identifying symptoms</li> <li>Decide if immediate care is needed</li> <li>Home treatment options and advice</li> </ul>	24/7	\$0
<b>Online visit</b> 	Many non-emergency health conditions	<ul style="list-style-type: none"> <li>Cold, flu, allergies</li> <li>Headache, migraine</li> <li>Skin conditions, rashes</li> <li>Minor injuries</li> <li>Mental health concerns</li> </ul>	24/7	\$
<b>Office visit</b> 	Routine medical care and overall health management	<ul style="list-style-type: none"> <li>Preventive care</li> <li>Illnesses, injuries</li> <li>Managing existing conditions</li> </ul>	Office Hours	\$\$
<b>Urgent care, walk-in clinic</b> 	Non-life-threatening conditions requiring prompt attention	<ul style="list-style-type: none"> <li>Stitches</li> <li>Sprains</li> <li>Animal bites</li> <li>Ear-nose-throat infections</li> </ul>	Office Hours, or up to 24/7	\$\$\$
<b>Emergency room</b> 	Life-threatening conditions requiring immediate medical expertise	<ul style="list-style-type: none"> <li>Suspected heart attack or stroke</li> <li>Major bone breaks</li> <li>Excessive bleeding</li> <li>Severe pain</li> <li>Difficulty breathing</li> </ul>	24/7	\$\$\$\$\$

# ALTERNATIVE FACILITIES

If you have time to evaluate your options for non-emergency health treatments, these alternative facilities can provide the same results as a hospital at a fraction of the cost.

Need	Alternative	Features	Savings
<b>Surgery</b> 	Ambulatory Surgery Center (ASC)	<ul style="list-style-type: none"> <li>Specializes in same-day surgeries</li> <li>Cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery and more</li> <li>Held to same safety standards as hospitals</li> </ul>	Up to 50% over hospital stay*
<b>Physical therapy</b> 	Free-standing physical therapy center	<ul style="list-style-type: none"> <li>Important part of the recovery process after an injury or surgery</li> </ul>	40 to 60% over a hospital setting*
<b>Sleep study</b> 	Home testing	<ul style="list-style-type: none"> <li>Diagnoses sleep apnea and other conditions</li> <li>Cost is often covered by insurance if considered medically necessary</li> </ul>	Approx. \$4,500*
<b>Infusion therapy</b> 	Home or outpatient infusion therapy	<ul style="list-style-type: none"> <li>For drugs that must be delivered by intravenous injections, or epidurals</li> <li>Delivered by licensed infusion therapy provider</li> <li>Maintain normal lifestyle and comfort of home or outpatient center</li> </ul>	Up to 90% over hospital stay*

*\*in-network*

## How to find an alternative treatment facility

Ask your doctor if your treatment must be delivered in the hospital. You can also search for surgical centers, physical therapy, etc. on your plan's website; or call member services for assistance.

Online tools such as [healthcarebluebook.com](https://www.healthcarebluebook.com) and [healthgrades.com](https://www.healthgrades.com) help you compare costs and doctor ratings. Some alternative services include a facility fee to cover overhead costs. To avoid a surprise on your bill, ask about facility fees before you schedule your appointment.

# TURNING 65? UNDERSTAND YOUR MEDICARE OPTIONS



**Alliant Medicare Solutions is a no cost service available to you, your family members, and friends nearing age 65.**

*Alliant Medicare Solutions is provided by Insuractive LLC, a Nebraska resident insurance agency. Insuractive LLC is wholly owned by Alliant Insurance Services, Inc.*

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

If, like most people, you become eligible for Medicare at age 65, you have a seven-month window to enroll, starting three months before you turn age 65 and ending three months after your birthday month.

## Introducing Alliant Medicare Solutions

Choosing a Medicare plan – and understanding how it can affect your employer-provided medical coverage – can be confusing. That’s why we are offering Alliant Medicare Solutions to 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 **(866) 279-3195** 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.

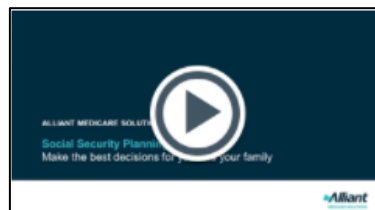
## Find Out More



[Your Guide to Medicare](#)



[Medicare 101 Video](#)



[Social Security Planning Video](#)

# PREVENTIVE CARE SCREENING BENEFITS



## TYPICAL SCREENINGS FOR ADULTS

- Blood pressure
- Cholesterol
- Diabetes
- Colorectal cancer screening
- Depression
- Mammograms
- OB/GYN screenings
- Prostate cancer screening
- Testicular exam

You take your car in for maintenance. Why not do the same for yourself?

Annual preventive checkups can help you and your doctor identify your baseline level of health and detect issues before they become serious.

### What is Preventive Care?

The Affordable Care Act (ACA) requires health insurers to cover a set of preventive services at no cost to you, even if you haven't met your yearly deductible. The preventive care services you'll need to stay healthy vary by age, sex, and medical history.

Visit [health.gov/myhealthfinder](https://www.health.gov/myhealthfinder) for recommended guidelines.

**Preventive care is covered in full  
only when obtained from an  
IN-NETWORK provider.**

### Not all exams and tests are considered preventive

Exams performed by specialists are generally not considered preventive and may not be covered at 100 percent.

Additionally, certain screenings may be considered diagnostic, not preventive, based on your current medical condition. You may be responsible for paying all or a share of the cost for those services.

If you have a question about whether a service will be covered as preventive care, contact your medical plan.

# PRESCRIPTIONS BREAKING YOUR BUDGET?



## THE FORMULARY DRUG TIERS DETERMINE YOUR COST

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\$ Generic Drug

---

\$\$ Brand Name Drug

---

\$\$\$ Specialty Drug

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## Understanding the formulary can save you money

If your doctor prescribes medicine, especially for an ongoing condition, don't forget to check your health plan's drug formulary. It's a powerful tool that can help you make informed decisions about your medication options and identify the lowest cost selection.

## What is a formulary?

A drug formulary is a list of prescription drugs covered by your medical plan. Most prescription drug formularies separate the medications they cover into four or five drug categories, or "tiers." These groupings range from least expensive to most expensive cost to you. "Preferred" drugs generally cost you less than "non-preferred" drugs.

## Get the most from your coverage

To get the most out of your prescription drug coverage, note where your prescriptions fall within your plan's drug formulary tiers and ask your doctor for advice. Generic drugs are usually the lowest cost option. Generics are required by the Food and Drug Administration (FDA) to perform the same as brand-name drug equivalents.

**To find out if a drug is on your plan's formulary, visit the plan's website or call the customer service number on your ID card.**



## LIFE & DISABILITY

### **YOUR BENEFICIARY = WHO GETS PAID**

If the worst happens, your beneficiary—the person (or people) on record with the life insurance carrier—receives the benefit. Make sure that you name at least one beneficiary for your life insurance benefit, and change your beneficiary as needed if your situation changes.

### **Is your family protected?**

Life, AD&D and disability insurance can fill a number of financial gaps due to a temporary or permanent reduction of income. Consider what your family would need to cover day-to-day living expenses and medical bills during a pregnancy or illness-related disability leave, or how you would manage large expenses (rent or mortgage, children’s education, student loans, consumer debt, etc.) after the death of a spouse or partner.

We provide short and long-term disability benefits and a base amount of life and AD&D insurance to help you recover from financial loss.

### **If you need additional coverage**

We offer voluntary coverage that you can purchase for yourself, your spouse, and your children. See the Voluntary Benefits section for details.

# COMPANY- PROVIDED LIFE AND AD&D INSURANCE



## Basic Life and AD&D

Basic Life Insurance pays your beneficiary a lump sum if you die. AD&D (Accidental Death & Dismemberment) coverage provides a benefit to you if you suffer from loss of a limb, speech, sight, or hearing, or to your beneficiary if you have a fatal accident. The cost of coverage is paid in full by the company.

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### 2024 Mutual of Omaha Life and AD&D

Up to \$100,000. Guaranteed issue of \$100,000.

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*The benefit amounts above will be reduced if you are age 65 or older. Refer to the plan document for details.*

## WHAT'S GUARANTEED ISSUE?

If you select coverage above a certain limit (the "guaranteed issue") or after your initial eligibility, you will need to provide additional information about your health status in order to qualify for the requested amount of coverage.

## A NOTE ABOUT TAXES

Company-provided life insurance coverage over \$50,000 is considered a taxable benefit. The value of the benefit over \$50,000 will be reported as taxable income on your annual W-2 form.

# SHORT-TERM DISABILITY INSURANCE (STD)



## EXPECT THE UNEXPECTED

Most people underestimate the likelihood of being disabled at some point in their life. Disability insurance replaces part of your pay while you are unable to work so you have a continuing income for living expenses.

## STD Benefits

Short-Term Disability (STD) insurance replaces part of your income for limited duration issues such as:

- Pregnancy issues and childbirth recovery
- Prolonged illness or injury
- Surgery and recovery time

STD payments may be reduced if you receive other benefits such as sick pay, workers' compensation, Social Security, or state disability. WideOrbit pays the cost of this coverage.

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### 2024 Mutual of Omaha STD

<b>Weekly benefit amount</b>	67% up to a maximum of \$2,900
<b>Benefits begin</b>	After 7 days of disability due to accident or 7 days due to sickness
<b>Maximum payment period</b>	12 weeks (based on first day benefits begin)

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# LONG-TERM DISABILITY INSURANCE (LTD)



## 3 THINGS TO KNOW ABOUT LTD INSURANCE

1. It can protect you from having to tap into your retirement savings.
2. You can use LTD benefits however you need, for housing, food, medical bills, etc.
3. Benefits can last a long time—from weeks to even years—if you remain eligible.

## LTD benefits cushion the financial impact of a disability

Long-Term Disability (LTD) insurance replaces part of your income for longer term issues such as:

- Debilitating illness (cancer, heart disease, etc.)
- Serious injuries (accident, etc.)
- Heart attack, stroke
- Mental disorders.

If you qualify, LTD benefits begin after short-term disability benefits end. Payments may be reduced by state, federal, or private disability benefits you receive while disabled. WideOrbit pays the cost of this coverage.

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### 2024 Mutual of Omaha LTD

<b>Monthly benefit amount</b>	60% up to a maximum of \$12,000
<b>Benefits begin</b>	After 90 days of disability
<b>Maximum payment period</b>	Social Security Normal Retirement Age or Maximum Benefit Duration

---

# VOLUNTARY LIFE INSURANCE

## Protecting those you leave behind

Voluntary Life Insurance allows you to purchase additional life insurance to protect your family's financial security. Coverage is available for your spouse and/or child(ren) if you purchase coverage for yourself.

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### 2024 Mutual of Omaha Voluntary Life

- Employee**      \$10,000 Increments up to Lesser of 5x salary or \$500,000. Guaranteed issue of Lesser of 5x salary or \$150,000.
  - Spouse**        \$5,000 Increments up to Lesser of 100% of employee benefit or \$250,000. Guaranteed issue of Lesser of 100% employee benefit or \$25,000.
  - Child(ren)**    \$10,000. Guaranteed issue of \$10,000.
- 



### GUARANTEED ISSUE

If you purchase life insurance coverage above a certain limit (the "guaranteed issue" amount) or after your initial eligibility period, you will need to submit Evidence of Insurability with additional information about your health in order for the insurance company to approve the amount of coverage.



## FINANCIAL WELLNESS

### PLANS TO HELP YOU SAVE

- Dependent Care Flexible Spending Account (DC FSA)
- Transportation & Parking Benefits
- 401(k) Retirement Savings Plan

### Is it time for a “financial wellness” checkup?

Are you worried about money—making your paycheck last? Paying down debt? Making a big purchase like a car or home? And can you even think about preparing for retirement?

Ignoring your financial health can take a toll on your quality of life today and block opportunities for the future. And worrying about money matters can make you stressed, even to the point of physical illness.

We offer benefits and resources to help you make the most of your money now and in the future. You can increase your take-home pay by saving on taxes; and work toward your retirement goals.

# PAYING FOR DAYCARE? MAKE IT TAX-FREE!



## EVERY OPPORTUNITY TO SAVE

The biggest deduction from your paycheck is likely federal income tax. Why not take a bite out of taxes while paying for necessary expenses with tax-free dollars?

## Dependent Care FSA—up to \$5,000 per year tax-free

A dependent care Flexible Spending Account (FSA) can help families save potentially hundreds of dollars per year on day care. This program is administered by WEX Inc.

## Here's how the 2024 WEX Inc. Flexible Spending Account works

You set aside money from your paycheck, before taxes, to pay for work-related day care expenses. Eligible expenses include not only childcare, but also before and after school care programs, preschool, and summer day camp for children under age 13. The account can also be used for day care for a spouse or other adult dependent who lives with you and is physically or mentally incapable of self-care.

You can set aside up to \$5,000 per household per year. You can pay your dependent care provider directly from your FSA account, or you can submit claims to get reimbursed for eligible dependent care expenses you pay out of pocket.



**Estimate carefully!** You can't change your FSA election amount mid-year unless you experience a qualifying event. Money contributed to a dependent care FSA must be used for expenses incurred during the same plan year. Unspent funds will be forfeited.

# SAVE ON COMMUTE EXPENSES



## Transportation Savings Account—up to \$630 per month tax-free

Do you have out-of-pocket commuting expenses for public transportation, van pooling, or for worksite parking? If so, you can save on taxes by enrolling in our transportation savings account, administered by WEX Inc.

The account lets you set aside money—before it's taxed—through payroll deduction. You may enroll in or stop this program at any time. Money in the account can be used in future months or plan years.

Set aside up to \$315 per month for work-related parking expenses and up to \$315 per month for work-related commute expenses.

## CAN I OPT OUT OR CHANGE MY ELECTION IF MY WORK SCHEDULE OR LOCATION CHANGES?

Yes, contributions can be updated monthly but do require time before they are posted to your account as payroll must deduct the funds on your next pay period, then transmit the election to WEX.

You must place your order by the 10<sup>th</sup> of the month prior to when the funds will be used. For example, if you wish to contribute funds for December, your order must be placed by November 10<sup>th</sup>.

# 401(k) PROGRAM

WideOrbit's retirement savings plan lets you save for the future while taking advantage of company matching contributions and a full range of investment options.

We encourage you to take an active role in your account. Review the contribution amount and investment strategy to ensure they meet your needs. If you would like to make changes to any elections, prefer not to participate, or have questions about the Plan's provisions, log on to Fidelity at <http://www.401k.com> or call 800-835-5095.

## WideOrbit Match

**WideOrbit matches 50% of your deferrals up to 6% of your income (subject to IRS income cap).**

For example, to receive full match, defer 6% of your income; in this case WO will match 3%. WO contributions made quarterly.

## Summary

- **Automatic contributions.** All employees are auto enrolled at 6% within 30 days. Fidelity will mail materials to you directly about the account, including information to opt out.
- **Traditional pre-tax contributions.** This money is not taxed when it is put into your account, leaving you more money to work for you.
- **ROTH 401(k) after-tax contributions.** You can also choose to make ROTH contributions, but you won't pay income tax on contributions or earnings when you make withdrawals from your ROTH 401(k) balance, provided you have turned age 59.5 and have held your ROTH 401(k) account for at least five years.
- **Traditional after-tax contributions.** After-tax contributions offer an alternative to the pre-tax and ROTH 401(k) after-tax contributions that are already available.
- **The ROTH in-plan conversion.** Allows you to convert all or a portion of your pre-tax and traditional after-tax savings to ROTH money within the plan.
- **Brokerage Account.** Gives you expanded investment choices and the opportunity to actively manage your retirement contributions.

## 2024 contributions maximum (per IRS) limits

You can contribute a percentage of your pay to either option or both up to an annual IRS limit, which is \$23,000 in 2024. Employees age 50 and older can contribute an additional \$7,500 in "catch-up" contributions.



## WELLBEING & BALANCE

**“ THE KEY TO KEEPING YOUR BALANCE IS KNOWING WHEN YOU'VE LOST IT. ”**

### A Happier, Healthier You

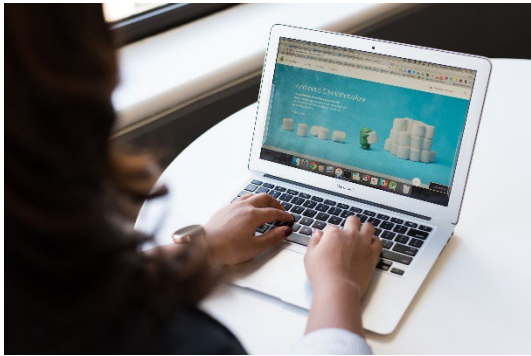
Creating a healthy balance between work and play is a major factor in leading a happy and productive lifestyle, but it's not always easy.

We offer programs to help you:

- Manage stress, chemical dependency, mental health and family issues
- Maximize your physical well-being
- Take time to spend with family and friends, take care of personal business, or just have a little extra “me time”.

Taking care of yourself will help you be more effective in all areas of your life. Be sure to take advantage of these programs to stay at your best.

# EMPLOYEE ASSISTANCE PROGRAM (EAP)



## CONTACT THE EAP

### Phone

**(800) 344-4222**

### Website

**[Employees.concernhealth.com](https://employees.concernhealth.com)**

**Employer code: wide**

## Help for you and your household members

There are times when everyone needs a little help or advice, or assistance with a serious concern. The EAP through Concern can help you handle a wide variety of personal issue such as emotional health and substance abuse; parenting and childcare needs; financial coaching; legal consultation; and eldercare resources.

Best of all, contacting the EAP is completely confidential, free and available to any member of your immediate household.

## No cost EAP resources

The EAP is available around the clock to ensure you get access to the resources you need:

- Unlimited phone access 24/7
- In-person or video counseling for short-term issues; up to 5 visits per issue per year
- Unlimited web access to helpful articles, resources, and self-assessment tools.

### COUNSELING BENEFITS

- Difficulty with relationship
- Emotional distress
- Job stress
- Communication/ conflict issues
- Alcohol or drug problems
- Loss and death

### PARENTING & CHILDCARE

- Referrals to quality providers
- Family day care homes
- Infant centers and preschools
- Before/after school care
- 24-hour care

### FINANCIAL COACHING

- Money management
- Debt management
- Identity theft resolution
- Tax issues

### LEGAL CONSULTATION

- Referral to a local attorney
- Family issues (marital, child custody, adoption)
- Estate planning
- Landlord/tenant
- Immigration
- Personal Injury
- Consumer protection
- Real estate
- Bankruptcy

### ELDERCARE RESOURCES

- Help with finding appropriate resources to care for an elderly or disabled relative

### ONLINE RESOURCES

- Self-help tools to enhance resilience and well-being
- Useful information and links to various services and topics

# ADDITIONAL PROGRAMS



### Life Event Benefit

WideOrbit offers a Life Events Benefit to recognize major life events in your immediate family. WideOrbit will reimburse up to \$500 in receipts surrounding these events:

- Birth or adoption
- Marriage or ‘legal’ partnership
- Death in your immediate family
- Retirement

This is a taxable benefit and receipts should be submitted within 30 days of the life event. Please contact [hr@wideorbit.com](mailto:hr@wideorbit.com) with any questions. Note: Immediate family is defined as: Spouse, child (step), parent (step), grandparent (step).

### Telemedicine

Have you ever needed to see a doctor but couldn’t because of scheduling, holidays, weekends, travel or even bad weather? Cigna, BCBS of AL and Kaiser save you time and money by connecting you to a doctor via video chat from any location, 24/7, no appointment needed. You’ll be connected to a board-certified doctor who can diagnose and treat many common medical problems such as colds and flu, ear infections, skin problems, allergies, sinus problems, and more. General telemedicine visits are charged the same as general in office physician visits, consult your plan documents for further information on coverage levels.

Carrier	Website	Phone Number/App
Cigna (MD Live)	<a href="https://myCigna.com">myCigna.com</a>	(888) 726-3171
Kaiser	<a href="https://kp.org/mydoctor/videovisits">kp.org/mydoctor/videovisits</a>	KP Preventive Care App (Apple and Android)
BCBS of AL	<a href="https://Teladoc.com/Alabama">Teladoc.com/Alabama</a>	(855) 477-4549

### Travel Assistance

When you travel overseas for purposes other than work, you can rely on Mutual of Omaha. This program offers access to an international network of participating doctors, and hospitals for a broad range of medical care services. The center is available by phone 24/7 and is staffed with multilingual representatives who can help coordinate your medical care. Call (800) 856-9947 within the US or (312) 935-3658 outside of the US.

# TIME AWAY FROM WORK



## Time off

### **Vacation Days**

From date of hire, vacation is granted at a rate of 3 weeks (15 business days) per year. Hours are accrued at a rate of 10 hours per month from your date of hire. After your fourth (4) year of continuous employment, you will receive 4 weeks (20 business days) of vacation per year, accrued at a rate of 13.33 hours per month.

Part-time employees accrue vacation on a pro-rata basis based on the number of hours they are regularly scheduled to work each week. For example, an employee who is regularly scheduled to work 30 hours will earn vacation at 75% of the accrual rate for full-time employees. Temporary employees do not accrue vacation.

### **Vacation Accrual Caps**

An accrual cap is the total balance of unused, accrued vacation days you can accumulate. In the event an employee's accrued but unused vacation reaches the maximum accrual that is allowed, the employee will not earn any additional vacation benefits. Vacation benefits will cease to accrue until the employee takes enough time off to fall below the maximum accrual. Once the accrual balance is below the maximum, vacation benefits will begin accruing again.

### **Vacation Carryover**

All employees are encouraged to use their vacation benefits each year. Because vacation is accrued based on one's hire date, employees may carry over accrued but unused vacation from one calendar year to the next.

### **Sick and Kin Care Time Off**

Full time employees accrue 9 sick days per year, available for use at the beginning of each calendar year while they are actively employed at WideOrbit. Unused accrued paid sick leave will not be paid out upon separation of employment. Employees who start after January 1st will be able to use a prorated amount based on their projected accrual of one hour sick time per 30 hours worked.

# TIME AWAY FROM WORK - *continued*



## 2024 paid holidays

These holidays are recognized by WideOrbit as paid holidays for the calendar year 2024

New Year's Day	January 1 <sup>st</sup>
MLK Day	January 15 <sup>th</sup>
Presidents' Day	February 19 <sup>th</sup>
Memorial Day	May 27 <sup>th</sup>
Juneteenth	June 19 <sup>th</sup>
Independence Day	July 4 <sup>th</sup> – 5 <sup>th</sup>
Labor Day	September 2 <sup>nd</sup>
Veterans' Day (veterans only)	November 10 <sup>th</sup>
Thanksgiving	November 28 <sup>th</sup> – 29 <sup>th</sup>
Christmas	December 25 <sup>th</sup> – 26 <sup>th</sup>
New Year's Eve	December 31 <sup>st</sup>

## Time off

### Volunteer Time Off (VTO)

WideOrbit encourages employees to volunteer up to 8 hours (1 day) per calendar year (pro-rated for part-time employee); to become involved in their communities, lending their voluntary support to programs that positively impact the quality of life within these communities. Employees can volunteer up to 8 hours (1 day) per calendar year (pro-rated for part-time employee).

### Sabbatical Leave

The purpose of a sabbatical is to allow employees time to explore outside areas of interest, spend additional time with family or some other purpose without the responsibility of work.

WideOrbit offers two options for an extended Sabbatical leave.

- Option 1: After four years of continuous employment with WideOrbit, an employee receives the option of taking four weeks off at half pay.
- Option 2: After five years of continuous employment with WideOrbit, an employee receives the option of taking five weeks off at half pay.

Employees may use earned Vacation to receive full pay during their Sabbatical. To receive full pay during a Sabbatical, 4 hours of Vacation time (or .5 of a vacation day) will be debited for each business day out on Sabbatical.

WideOrbit respects the religious beliefs of its employees and will make every effort to accommodate absences for religious holidays providing they don't cause hardship to WideOrbit. Absences for religious holidays can be taken as vacation or as unpaid time off if you don't have vacation accrued.

For more information on Time Off, please refer to Employee Handbook.



# VOLUNTARY PLANS

## OUR VOLUNTARY PLANS

- Mutual of Omaha Voluntary Accident Insurance
- Mutual of Omaha Voluntary Critical Illness Insurance
- LegalShield Legal Assistance
- IDShield Identity Theft Protection
- Nationwide Pet Insurance

## You're unique—and so are your benefit needs

Voluntary benefits are optional coverages that help you customize your benefits package to your individual needs.

WideOrbit offers plans to help:

- replace income if you're injured or ill
- bridge the gap for special healthcare needs
- secure your identity, and help you manage legal issues
- save money on protection for your pets

You pay the entire cost for these plans, but rates may be more affordable than individual coverage. And you get the added convenience of paying through payroll deduction.

Voluntary benefits are just that: voluntary. You have the freedom and flexibility to choose the benefits that make sense for you and your family. Or, you don't have to sign up for voluntary benefits at all. The choice is yours.

# VOLUNTARY HEALTH-RELATED PLANS



## 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.

## Accident Insurance

Accident Insurance from Mutual of Omaha helps you pay for unexpected costs that can add up due to common injuries such as fractures, dislocations, burns, emergency room or urgent care visits, and physical therapy. If you or a covered family member has an accident, this plan pays a lump-sum, tax-free benefit. The amount of money depends on the type and severity of your injury and can be used any way you choose. You may even be eligible for a benefit if you receive a covered wellness screening such as blood tests, stress tests, or a chest x-ray.

## Critical Illness Insurance

Critical illness insurance from Mutual of Omaha can help fill a financial gap if you experience a serious illness such as cancer, heart attack or stroke. Upon diagnosis of a covered illness, a lump-sum, tax-free benefit is immediately paid to you. Use it to help cover medical costs, transportation, childcare, lost income, or any other need following a critical illness. You choose a benefit amount that fits your paycheck and can cover yourself and your family members if needed. You may even be eligible for a benefit if you receive a covered wellness screening such as blood tests, stress tests, or a chest x-ray.

If you and/or your family are enrolled in Critical Illness insurance, you are each eligible for a \$50 benefit for receiving a general health screening, such as your annual physical.

# PLANS TO KEEP YOU AND YOUR FAMILY SECURE



## CONTACT INFORMATION

See the Plan Contacts section of this guide or log on to MyBenefits.Life® for contact information.

## Identity Theft Protection

Identity theft is serious. Victims can spend hundreds, even thousands of dollars, and weeks of their own time to repair the damage done to their good names and credit records. The longer identity fraud goes undetected, the more expensive and difficult it becomes to resolve. For an affordable monthly premium, identity theft protection from IDShield helps protect your personal information through proactive monitoring, identity restoration, and resolution.

## Legal Program

Do you have an attorney on retainer? Most people don't, so our legal program offers you access to legal advice and even representation for an affordable monthly premium. Whether you need assistance reviewing a rental agreement, fighting a traffic ticket, creating a will, buying a house or navigating an IRS audit, legal coverage from LegalShield offers reputable attorney assistance for you and your family.

## Pet Insurance

Pets are members of the family too. When your pet gets sick, bills can add up faster than expected. Pet insurance prevents you from needing to weigh your pet's health against your bank account. Most plans offer coverage for costs associated with both accidents and illnesses—even medications. Nationwide provides coverage for this program. You can enroll in this program at any time.



## IMPORTANT PLAN INFORMATION

In this section, you'll find important plan information, including:

- Your medical, dental and vision benefit contributions for 2024
- Contact information for our benefit carriers and vendors
- A summary of the health plan notices you are entitled to receive annually, and where to find them
- A Benefits Glossary to help you understand important insurance terms.

# YOUR MONTHLY BENEFIT COSTS

The total amount that you pay for your benefits coverage depends on the plans you choose, how many dependents you cover, and for medical coverage, how much you earn. Your healthcare costs are deducted from your pay on a pre-tax basis — before federal, state, and social security taxes are calculated — so you pay less in taxes.

## MEDICAL, DENTAL & VISION

	Cigna PPO	Cigna HDHP	BCBS of AL PPO	BCBS of AL HDHP	Kaiser HMO	Kaiser HDHP	Cigna Dental Buy Up PPO	Cigna Dental Base PPO	VSP Vision
<b>EMPLOYEE ONLY</b>	\$234.37	\$126.96	\$234.37	\$126.96	\$121.88	\$111.18	\$23.26	\$14.49	\$3.31
<b>EMPLOYEE + SPOUSE</b>	\$489.42	\$323.04	\$489.42	\$323.04	\$357.53	\$350.37	\$49.81	\$32.04	\$6.07
<b>EMPLOYEE + CHILDREN</b>	\$491.93	\$313.80	\$491.93	\$313.80	\$325.03	\$323.41	\$59.36	\$38.18	\$6.21
<b>EMPLOYEE + FAMILY</b>	\$864.15	\$498.51	\$864.15	\$498.51	\$487.55	\$458.14	\$84.58	\$54.40	\$9.79

*Please note that unless your domestic partner is your tax dependent as defined by the IRS, contributions for domestic partner coverage must be made after-tax. Similarly, the company contribution toward coverage for your domestic partner and his/her dependents will be reported as taxable income on your W-2. Contact your tax advisor for more details on how this tax treatment applies to you. Notify WideOrbit if your domestic partner is your tax dependent.*

# VOLUNTARY LIFE & AD&D INSURANCE COSTS

If you elect voluntary coverage, your monthly premium rate is calculated based on your age and the amount of coverage. Use the tables below to estimate the premium amount that will be deducted from your paycheck. Spouse rates are based on the employee age.

## VOLUNTARY LIFE INSURANCE – MONTHLY RATE PER \$1,000 OF COVERAGE

AGE	EMPLOYEE	SPOUSE
<25	\$0.037	\$0.037
25-29	\$0.037	\$0.037
30-34	\$0.047	\$0.047
35-39	\$0.066	\$0.066
40-44	\$0.095	\$0.095
45-49	\$0.143	\$0.143
50-54	\$0.219	\$0.219
55-59	\$0.409	\$0.409
60-64	\$0.627	\$0.627
65-69	\$1.080	\$1.080
70-74	\$1.750	\$1.750
75-79	\$1.957	\$1.957
80+	\$3.091	\$3.091

## VOLUNTARY AD&D – MONTHLY RATE PER \$1,000 OF COVERAGE

Employee & Spouse	\$0.028
Child(ren)	\$0.028

To calculate your per paycheck AD&D cost, follow the same steps as the table above.

## CALCULATE YOUR LIFE INSURANCE COST

### 1. Desired Coverage (\$1,000 Increments)

You:	Spouse:
------	---------

### 2. Divide Step 1 by 1,000 =

You:	Spouse:
------	---------

### 3. Multiply Step 2 by Rate from Table =

You:	Spouse:
------	---------

### 4. Multiply Step 3 by 12 and divide by 24 =

You:	Spouse:
------	---------

### 5. Add You + Spouse from Step 4:

TOTAL COST PER PAYCHECK:
--------------------------

## CHILD LIFE INSURANCE

COVERAGE AMOUNT	Rate per \$1,000 of coverage	Total Cost Per Paycheck
\$1,000	\$0.149	\$0.07
\$10,000	\$0.149	\$0.07

**Premium includes all eligible children.** Eligible children include dependent children under age 26 as long as you apply for and are approved for coverage for yourself.

# PLAN CONTACTS

## HELPFUL RESOURCES

### Benefits Portal/App

MyBenefits.Life®

[wideorbit.mybenefits.life](https://wideorbit.mybenefits.life)

Employer code: WideOrbit

### Enrollment Website (ADP)

[workforcenow.adp.com](https://workforcenow.adp.com)

Or via WideOrbit [SSO](#)

### Benefit Advocate

[wideorbit@alliant.com](mailto:wideorbit@alliant.com)

(925) 287-7248

## MEDICAL, DENTAL & VISION

### Cigna PPO & HDHP

Policy # 00630947

[Mycigna.com](https://mycigna.com)

[Find a Provider](#)

(866) 494-2111

### Kaiser DHMO & HDHP

Policy # 603774

[Kp.org](https://kp.org)

[Find a Provider](#)

(800) 464-4000

### BCBS of AL PPO & HDHP

Policy # 97764

[Bcbsal.org](https://bcbsal.org)

[Find a Provider](#)

(800) 292-8868

### Cigna Dental Base & Buy Up PPO

Policy # 0630947

[Mycigna.com](https://mycigna.com)

[Find a Provider](#)

(866) 494-2111

### Guardian (VSP)

Policy # 00472074

[vsp.com](https://vsp.com)

[Find a Provider](#)

800) 877-7195

## HEALTH SAVINGS ACCOUNT (HSA)

### Inspira Financial

Policy # 147606

[Inspirafinancial.com](https://inspirafinancial.com)

(844) 729-3539

### Kaiser HSA

[Kp.org/healthexpense](https://kp.org/healthexpense)

Health Payment Services

(877) 761-3399

## LIFE, AD&D, SHORT-TERM, & LONG-TERM DISABILITY

### Mutual of Omaha

Policy # G000BS83

[Mutualofomaha.com](https://mutualofomaha.com)

(800) 775-6000

## EMPLOYEE ASSISTANCE PROGRAM EAP

### Concern

[Employees.concernhealth.com](https://employees.concernhealth.com)

Company code: wide

(800) 344-4222

## FLEXIBLE SPENDING ACCOUNTS (FSA)

### WEX, Inc.

Policy # 28119

[Wexinc.com](https://wexinc.com)

(866) 451-3399

## TRANSIT / PARKING

## ADMINISTRATION

### WEX, Inc.

Policy # 28119

[Wexinc.com](https://wexinc.com)

(866) 451-3399

## VOLUNTARY ACCIDENT & CRITICAL ILLNESS

### Mutual of Omaha

Policy # G000BS83

[Mutualofomaha.com](https://mutualofomaha.com)

(800) 775-6000

## PET INSURANCE

### Nationwide

Policy # G000BS83

[Benefits.petinsurance.com](https://benefits.petinsurance.com)

(877) 738-7874

## 401(k)

### Fidelity

Policy # 29346

[401k.com](https://401k.com)

(800) 835-5095

## VOLUNTARY LEGAL AND IDENTITY THEFT PROTECTION

### LegalShield / IDShield

[Benefits.legalshield.com](https://benefits.legalshield.com)

# 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).

### **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.

**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.

# GLOSSARY

## -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.

# PLAN DOCUMENTS

Important documents for our health plan and retirement plan are available at the end of this brochure. Paper copies of these documents and notices are available if requested. If you would like a paper copy, please contact the Plan Administrator.

## **SUMMARY PLAN DESCRIPTIONS (SPD)**

The legal document for describing benefits provided under the plan as well as plan rights and obligations to participants and beneficiaries.

- WideOrbit, LLC Health and Welfare Plan

## **SUMMARY OF BENEFITS AND COVERAGE (SBC)**

A document required by the Affordable Care Act (ACA) that presents benefit plan features in a standardized format. SBC documents are available through MyBenefits.Life.

- Cigna PPO
- Cigna HDHP
- BCBS of AL PPO
- BCBS of AL HDHP
- Kaiser DHMO
- Kaiser HDHP

## **STATEMENT OF MATERIAL MODIFICATIONS**

This enrollment guide constitutes a Summary of Material Modifications (SMM) to the WideOrbit, Inc. Health and Welfare Plan. It is meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.

# IMPORTANT PLAN INFORMATION

## HEALTH PLAN NOTICES

These notices must be provided to plan participants on an annual basis and are available in the Annual Notices document, located at the end of this document:

- **Medicare Part D Notice:** Describes options to access prescription drug coverage for Medicare eligible individuals
- **Women's Health and Cancer Rights Act:** Describes benefits available to those that will or have undergone a mastectomy
- **Newborns' and Mothers' Health Protection Act:** Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery
- **HIPAA Notice of Special Enrollment Rights:** Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment
- **HIPAA Notice of Privacy Practices:** Describes how health information about you may be used and disclosed
- **Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP):** Describes availability of premium assistance for Medicaid eligible dependents.

## COBRA CONTINUATION COVERAGE

You and/or your dependents may have the right to continue coverage after you lose eligibility under the terms of our health plan. Upon enrollment, you and your dependents receive a COBRA Initial Notice that outlines the circumstances under which continued coverage is available and your obligations to notify the plan when you or your dependents experience a qualifying event. Please review this notice carefully to make sure you understand your rights and obligations.

# Medicare Part D Notice

## Important Notice from WideOrbit LLC About Your Prescription Drug Coverage and Medicare

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. WideOrbit LLC has determined that the prescription drug coverage offered by the WideOrbit, LLC Health and Welfare Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

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## When Can You Join A Medicare Drug Plan?

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

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

## What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your WideOrbit LLC coverage **will not** be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under WideOrbit, LLC Health and Welfare Plan is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your WideOrbit LLC prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

## When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with WideOrbit LLC and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

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

## For More Information About Your Options Under Medicare Prescription Drug Coverage...

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

For more information about Medicare prescription drug coverage:

- Visit [medicare.gov](https://www.medicare.gov)
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at [socialsecurity.gov](https://www.socialsecurity.gov), or call them at 800-772-1213 (TTY 800-325-0778).

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

**Date:** January 1, 2024  
**Name of Entity/Sender:** WideOrbit LLC  
**Contact-Position/Office:** Human Resources  
**Address:** 1160 Battery Street Suite 300, San Francisco, CA 94111  
**Phone Number:** (415) 675-6700

## Women's Health and Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply per your formal plan documents. If you would like more information on WHCRA benefits, call your plan administrator at (415) 675-6700.

## Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator at (415) 675-6700.

## HIPAA Notice of Special Enrollment Rights

If you decline enrollment in WideOrbit LLC's health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in WideOrbit LLC's health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 31 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 31 day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in WideOrbit LLC's health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan. Any other currently covered dependents may also switch to the new plan in which you enroll.

## Availability of Privacy Practices Notice

We maintain the HIPAA Notice of Privacy Practices for WideOrbit LLC describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting (415) 675-6700.

## Notice of Choice of Providers

The Kaiser HMO generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Kaiser at (800) 464-4000.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Kaiser or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Kaiser at (800) 464-4000.

## Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit [www.healthcare.gov](http://www.healthcare.gov).

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or [www.insurekidsnow.gov](http://www.insurekidsnow.gov) to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at [www.askebsa.dol.gov](http://www.askebsa.dol.gov) or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility—

<b>ALABAMA – Medicaid</b>
Website: <a href="http://myalhipp.com/">http://myalhipp.com/</a>   Phone: 1-855-692-5447
<b>ALASKA – Medicaid</b>
The AK Health Insurance Premium Payment Program   Website: <a href="http://myakhipp.com/">http://myakhipp.com/</a>   Phone: 1-866-251-4861 Email: <a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a> Medicaid Eligibility: <a href="https://health.alaska.gov/dpa/Pages/default.aspx">https://health.alaska.gov/dpa/Pages/default.aspx</a>
<b>ARKANSAS – Medicaid</b>
Website: <a href="http://myarhipp.com/">http://myarhipp.com/</a>   Phone: 1-855-MyARHIPP (855-692-7447)
<b>CALIFORNIA – Medicaid</b>
Health Insurance Premium Payment (HIPP) Program website: <a href="http://dhcs.ca.gov/hipp">http://dhcs.ca.gov/hipp</a> Phone: 916-445-8322   Fax: 916-440-5676   Email: <a href="mailto:hipp@dhcs.ca.gov">hipp@dhcs.ca.gov</a>
<b>COLORADO – Health First Colorado (Colorado’s Medicaid Program) &amp; Child Health Plan Plus (CHP+)</b>
Health First Colorado Website: <a href="https://www.healthfirstcolorado.com/">https://www.healthfirstcolorado.com/</a> Health First Colorado Member Contact Center: 1-800-221-3943   State Relay 711 CHP+: <a href="https://www.colorado.gov/pacific/hcpf/child-health-plan-plus">https://www.colorado.gov/pacific/hcpf/child-health-plan-plus</a> CHP+ Customer Service: 1-800-359-1991   State Relay 711 Health Insurance Buy-In Program (HIBI): <a href="https://www.mycohibi.com/">https://www.mycohibi.com/</a> HIBI Customer Service: 1-855-692-6442
<b>FLORIDA – Medicaid</b>
Website: <a href="https://www.flmedicaidtplecovery.com/flmedicaidtplecovery.com/hipp/index.html">https://www.flmedicaidtplecovery.com/flmedicaidtplecovery.com/hipp/index.html</a> Phone: 1-877-357-3268
<b>GEORGIA – Medicaid</b>
GA HIPP Website: <a href="https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp">https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp</a> Phone: 678-564-1162, press 1 GA CHIPRA Website: <a href="https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra">https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra</a>   Phone: 678-564-1162, press 2
<b>INDIANA – Medicaid</b>
Healthy Indiana Plan for low-income adults 19-64 Website: <a href="http://www.in.gov/fssa/hip/">http://www.in.gov/fssa/hip/</a>   Phone: 1-877-438-4479 All other Medicaid Website: <a href="https://www.in.gov/medicaid/">https://www.in.gov/medicaid/</a>   Phone 1-800-457-4584
<b>IOWA – Medicaid and CHIP (Hawki)</b>
Medicaid Website: <a href="https://dhs.iowa.gov/ime/members">https://dhs.iowa.gov/ime/members</a>   Medicaid Phone: 1-800-338-8366 Hawki Website: <a href="http://dhs.iowa.gov/Hawki">http://dhs.iowa.gov/Hawki</a>   Hawki Phone: 1-800-257-8563 HIPP Website: <a href="https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp">https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp</a>   HIPP Phone: 1-888-346-9562
<b>KANSAS – Medicaid</b>
Website: <a href="https://www.kancare.ks.gov/">https://www.kancare.ks.gov/</a>   Phone: 1-800-792-4884   HIPP Phone: 1-800-967-4660
<b>KENTUCKY – Medicaid</b>
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: <a href="https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx">https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx</a>   Phone: 1-855-459-6328 Email: <a href="mailto:KIHIPP.PROGRAM@ky.gov">KIHIPP.PROGRAM@ky.gov</a> KCHIP Website: <a href="https://kidshealth.ky.gov/Pages/index.aspx">https://kidshealth.ky.gov/Pages/index.aspx</a>   Phone: 1-877-524-4718 Kentucky Medicaid Website: <a href="https://chfs.ky.gov/agencies/dms">https://chfs.ky.gov/agencies/dms</a>
<b>LOUISIANA – Medicaid</b>

<p>Website: <a href="http://www.medicaid.la.gov">www.medicaid.la.gov</a> or <a href="http://www.ldh.la.gov/lahipp">www.ldh.la.gov/lahipp</a>  Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>
<p><b>MAINE – Medicaid</b></p> <p>Enrollment Website: <a href="https://www.mymaineconnection.gov/benefits/s/?language=en_US">https://www.mymaineconnection.gov/benefits/s/?language=en_US</a>  Phone: 1-800-442-6003   TTY: Maine relay 711  Private Health Insurance Premium Webpage: <a href="https://www.maine.gov/dhhs/ofi/applications-forms">https://www.maine.gov/dhhs/ofi/applications-forms</a>  Phone: 800-977-6740   TTY: Maine relay 711</p>
<p><b>MASSACHUSETTS – Medicaid and CHIP</b></p> <p>Website: <a href="https://www.mass.gov/masshealth/pa">https://www.mass.gov/masshealth/pa</a>   Phone: 1-800-862-4840   TTY: 711  Email: <a href="mailto:masspreassistance@accenture.com">masspreassistance@accenture.com</a></p>
<p><b>MINNESOTA – Medicaid</b></p> <p>Website: <a href="https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp">https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp</a>  Phone: 1-800-657-3739</p>
<p><b>MISSOURI – Medicaid</b></p> <p>Website: <a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a>   Phone: 573-751-2005</p>
<p><b>MONTANA – Medicaid</b></p> <p>Website: <a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP">http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP</a>  Phone: 1-800-694-3084   email: <a href="mailto:HSHIPPPProgram@mt.gov">HSHIPPPProgram@mt.gov</a></p>
<p><b>NEBRASKA – Medicaid</b></p> <p>Website: <a href="http://www.ACCESSNebraska.ne.gov">http://www.ACCESSNebraska.ne.gov</a>  Phone: 1-855-632-7633   Lincoln: 402-473-7000   Omaha: 402-595-1178</p>
<p><b>NEVADA – Medicaid</b></p> <p>Medicaid Website: <a href="http://dhcfp.nv.gov">http://dhcfp.nv.gov</a>   Medicaid Phone: 1-800-992-0900</p>
<p><b>NEW HAMPSHIRE – Medicaid</b></p> <p>Website: <a href="https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program">https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program</a>  Phone: 603-271-5218   Toll-free number for the HIPP program: 1-800-852-3345, ext. 5218</p>
<p><b>NEW JERSEY – Medicaid and CHIP</b></p> <p>Medicaid Website: <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a>   Phone: 609-631-2392  CHIP Website: <a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a>   Phone: 1-800-701-0710</p>
<p><b>NEW YORK – Medicaid</b></p> <p>Website: <a href="https://www.health.ny.gov/health_care/medicaid/">https://www.health.ny.gov/health_care/medicaid/</a>   Phone: 1-800-541-2831</p>
<p><b>NORTH CAROLINA – Medicaid</b></p> <p>Website: <a href="https://medicaid.ncdhhs.gov/">https://medicaid.ncdhhs.gov/</a>   Phone: 919-855-4100</p>
<p><b>NORTH DAKOTA – Medicaid</b></p> <p>Website: <a href="https://www.hhs.nd.gov/healthcare">https://www.hhs.nd.gov/healthcare</a>   Phone: 1-844-854-4825</p>
<p><b>OKLAHOMA – Medicaid and CHIP</b></p> <p>Website: <a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a>   Phone: 1-888-365-3742</p>
<p><b>OREGON – Medicaid</b></p> <p>Website: <a href="http://healthcare.oregon.gov/Pages/index.aspx">http://healthcare.oregon.gov/Pages/index.aspx</a>   Phone: 1-800-699-9075</p>
<p><b>PENNSYLVANIA – Medicaid and CHIP</b></p> <p>Website: <a href="https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx">https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx</a>   Phone: 1-800-692-7462  CHIP Website: <a href="http://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx">Children's Health Insurance Program (CHIP) (pa.gov)</a>   CHIP Phone: 1-800-986-KIDS (5437)</p>
<p><b>RHODE ISLAND – Medicaid and CHIP</b></p>

Website: <a href="http://www.eohhs.ri.gov/">http://www.eohhs.ri.gov/</a>   Phone: 1-855-697-4347 or 401-462-0311 (Direct Rite Share Line)
<b>SOUTH CAROLINA – Medicaid</b>
Website: <a href="https://www.scdhhs.gov">https://www.scdhhs.gov</a>   Phone: 1-888-549-0820
<b>SOUTH DAKOTA – Medicaid</b>
Website: <a href="http://dss.sd.gov">http://dss.sd.gov</a>   Phone: 1-888-828-0059
<b>TEXAS – Medicaid</b>
Website: <a href="#">Health Insurance Premium Payment (HIPP) Program   Texas Health and Human Services</a> Phone: 1-800-440-0493
<b>UTAH – Medicaid and CHIP</b>
Medicaid Website: <a href="https://medicaid.utah.gov/">https://medicaid.utah.gov/</a>   CHIP Website: <a href="http://health.utah.gov/chip">http://health.utah.gov/chip</a> Phone: 1-877-543-7669
<b>VERMONT – Medicaid</b>
Website: <a href="#">Health Insurance Premium Payment (HIPP) Program   Department of Vermont Health Access</a> Phone: 1-800-250-8427
<b>VIRGINIA – Medicaid and CHIP</b>
Website: <a href="https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select">https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select</a> or <a href="https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs">https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs</a> Medicaid/CHIP Phone: 1-800-432-5924
<b>WASHINGTON – Medicaid</b>
Website: <a href="https://www.hca.wa.gov/">https://www.hca.wa.gov/</a>   Phone: 1-800-562-3022
<b>WEST VIRGINIA – Medicaid and CHIP</b>
Website: <a href="https://dhhr.wv.gov/bms/">https://dhhr.wv.gov/bms/</a> or <a href="http://mywvhipp.com/">http://mywvhipp.com/</a> Medicaid Phone: 304-558-1700   CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
<b>WISCONSIN – Medicaid and CHIP</b>
Website: <a href="https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm">https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm</a>   Phone: 1-800-362-3002
<b>WYOMING – Medicaid</b>
Website: <a href="https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/">https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/</a>   Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

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

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

## ACA Disclaimer

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 9.12% in 2023 (8.39% in 2024) of your modified adjusted household income.

# Illinois Consumer Coverage Disclosure Act

The Consumer Coverage Disclosure Act requires employers to notify Illinois employees which of the Essential Health Benefits listed below are and are not covered by their employer-provided group health insurance coverage. Refer to the [Access to Care and Treatment Benchmark Plan](#) and the [Pediatric Dental Plan](#) to reference the pages listed below.

<b>Employer Name:</b>	WideOrbit
<b>Employer State of Situs:</b>	California
<b>Name of Issuer:</b>	Cigna
<b>Plan Marketing Name:</b>	Cigna Medical PPO Plan
<b>Plan Year:</b>	2024

- Ten (10) Essential Health Benefit (EHB) Categories:**
- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
  - Emergency services
  - Hospitalization (like surgery and overnight stays)
  - Laboratory services
  - Mental health and substance use disorder (MH/SUD) services, including behavioral health treatment (this includes counseling and psychotherapy)
  - Pediatric services, including oral and vision care (but adult dental and vision coverage aren't essential health benefits)
  - Pregnancy, maternity, and newborn care (both before and after birth)
  - Prescription drugs
  - Preventive and wellness services and chronic disease management
  - Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)

<b>2020-2023 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)</b>				<b>Employer Plan Covered Benefit?</b>
<b>Item</b>	<b>EHB Benefit</b>	<b>EHB Category</b>	<b>Benchmark Page # Reference</b>	
1	Accidental Injury—Dental	Ambulatory	Pgs. 10 & 17	Yes
2	Allergy Injections and Testing	Ambulatory	Pg. 11	Yes
3	Bone anchored hearing aids	Ambulatory	Pgs. 17 & 35	No
4	Durable Medical Equipment	Ambulatory	Pg. 13	Yes
5	Hospice	Ambulatory	Pg. 28	Yes
6	Infertility (Fertility) Treatment	Ambulatory	Pgs. 23–24	No
7	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Ambulatory	Pg. 21	Yes
8	Outpatient Surgery Physician/Surgical Services (Ambulatory Patient Services)	Ambulatory	Pgs. 15–16	Yes
9	Private-Duty Nursing	Ambulatory	Pgs. 17 & 34	No
10	Prosthetics/Orthotics	Ambulatory	Pg. 13	Yes
11	Sterilization (vasectomy men)	Ambulatory	Pg. 10	Yes
12	Temporomandibular Joint Disorder (TMJ)	Ambulatory	Pgs. 13 & 24	No
13	Emergency Room Services (Includes MH/SUD Emergency)	Emergency services	Pg. 7	Yes
14	Emergency Transportation/ Ambulance	Emergency services	Pgs. 4 & 17	Yes
15	Bariatric Surgery (Obesity)	Hospitalization	Pg. 21	Yes
16	Breast Reconstruction After Mastectomy	Hospitalization	Pgs. 24–25	Yes
17	Reconstructive Surgery	Hospitalization	Pgs. 25–26 & 35	Yes

18	Inpatient Hospital Services (e.g., Hospital Stay)	Hospitalization	Pg. 15	Yes
19	Skilled Nursing Facility	Hospitalization	Pg. 21	Yes
20	Transplants—Human Organ Transplants (Including transportation & lodging)	Hospitalization	Pgs. 18 & 31	Yes
21	Diagnostic Services	Laboratory services	Pgs. 6 & 12	Yes
22	Intranasal opioid reversal agent associated with opioid prescriptions	MH/SUD	Pg. 32	Yes
23	Mental (Behavioral) Health Treatment (Including Inpatient Treatment)	MH/SUD	Pgs. 8–9, 21	Yes
24	Opioid Medically Assisted Treatment (MAT)	MH/SUD	Pg. 21	Yes
25	Substance Use Disorders (Including Inpatient Treatment)	MH/SUD	Pgs. 9 & 21	Yes
26	Tele-Psychiatry	MH/SUD	Pg. 11	Yes
27	Topical Anti-Inflammatory acute and chronic pain medication	MH/SUD	Pg. 32	Yes
28	Pediatric Dental Care	Pediatric Oral and Vision Care	See AllKids Pediatric Dental Document	No
29	Pediatric Vision Coverage	Pediatric Oral and Vision Care	Pgs. 26–27	No
30	Maternity Service	Pregnancy, Maternity, and Newborn Care	Pgs. 8 & 22	Yes
31	Outpatient Prescription Drugs	Prescription drugs	Pgs. 29–34	Yes
32	Colorectal Cancer Examination and Screening	Preventive and Wellness Services	Pgs. 12 & 16	Yes
33	Contraceptive/Birth Control Services	Preventive and Wellness Services	Pgs. 13 & 16	Yes
34	Diabetes Self-Management Training and Education	Preventive and Wellness Services	Pgs. 11 & 35	Yes
35	Diabetic Supplies for Treatment of Diabetes	Preventive and Wellness Services	Pgs. 31–32	No
36	Mammography—Screening	Preventive and Wellness Services	Pgs. 12, 15 & 24	Yes
37	Osteoporosis—Bone Mass Measurement	Preventive and Wellness Services	Pgs. 12 & 16	Yes
38	Pap Tests/ Prostate—Specific Antigen Tests/ Ovarian Cancer Surveillance Test	Preventive and Wellness Services	Pg. 16	Yes
39	Preventive Care Services	Preventive and Wellness Services	Pg. 18	Yes
40	Sterilization (women)	Preventive and Wellness Services	Pgs. 10 & 19	Yes
41	Chiropractic & Osteopathic Manipulation	Rehabilitative and Habilitative Services and Devices	Pgs. 12–13	Yes
42	Habilitative and Rehabilitative Services	Rehabilitative and Habilitative Services and Devices	Pgs. 8, 9, 11, 12, 22 & 35	Yes

*Special Note: Under Pub. Act 102-0104, eff. July 22, 2021, any EHBs listed above that are clinically appropriate and medically necessary to deliver via telehealth services must be covered in the same manner as when those EHBs are delivered in person.*

<b>Employer Name:</b>	WideOrbit
<b>Employer State of Situs:</b>	California
<b>Name of Issuer:</b>	Cigna
<b>Plan Marketing Name:</b>	Cigna Medical HDHP Plan
<b>Plan Year:</b>	2024

**Ten (10) Essential Health Benefit (EHB) Categories:**

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services
- Hospitalization (like surgery and overnight stays)
- Laboratory services
- Mental health and substance use disorder (MH/SUD) services, including behavioral health treatment (this includes counseling and psychotherapy)
- Pediatric services, including oral and vision care (but adult dental and vision coverage aren't essential health benefits)
- Pregnancy, maternity, and newborn care (both before and after birth)
- Prescription drugs
- Preventive and wellness services and chronic disease management
- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)

**2020-2023 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)**

Item	EHB Benefit	EHB Category	Benchmark Page # Reference	Employer Plan Covered Benefit?
1	Accidental Injury—Dental	Ambulatory	Pgs. 10 & 17	Yes
2	Allergy Injections and Testing	Ambulatory	Pg. 11	Yes
3	Bone anchored hearing aids	Ambulatory	Pgs. 17 & 35	No
4	Durable Medical Equipment	Ambulatory	Pg. 13	Yes
5	Hospice	Ambulatory	Pg. 28	Yes
6	Infertility (Fertility) Treatment	Ambulatory	Pgs. 23–24	No
7	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Ambulatory	Pg. 21	Yes
8	Outpatient Surgery Physician/Surgical Services (Ambulatory Patient Services)	Ambulatory	Pgs. 15–16	Yes
9	Private-Duty Nursing	Ambulatory	Pgs. 17 & 34	No
10	Prosthetics/Orthotics	Ambulatory	Pg. 13	Yes
11	Sterilization (vasectomy men)	Ambulatory	Pg. 10	Yes
12	Temporomandibular Joint Disorder (TMJ)	Ambulatory	Pgs. 13 & 24	No
13	Emergency Room Services (Includes MH/SUD Emergency)	Emergency services	Pg. 7	Yes
14	Emergency Transportation/ Ambulance	Emergency services	Pgs. 4 & 17	Yes
15	Bariatric Surgery (Obesity)	Hospitalization	Pg. 21	No
16	Breast Reconstruction After Mastectomy	Hospitalization	Pgs. 24–25	Yes
17	Reconstructive Surgery	Hospitalization	Pgs. 25–26 & 35	Yes
18	Inpatient Hospital Services (e.g., Hospital Stay)	Hospitalization	Pg. 15	Yes
19	Skilled Nursing Facility	Hospitalization	Pg. 21	Yes
20	Transplants—Human Organ Transplants (Including transportation & lodging)	Hospitalization	Pgs. 18 & 31	Yes
21	Diagnostic Services	Laboratory services	Pgs. 6 & 12	Yes
22	Intranasal opioid reversal agent associated with opioid prescriptions	MH/SUD	Pg. 32	Yes

23	Mental (Behavioral) Health Treatment (Including Inpatient Treatment)	MH/SUD	Pgs. 8–9, 21	Yes
24	Opioid Medically Assisted Treatment (MAT)	MH/SUD	Pg. 21	Yes
25	Substance Use Disorders (Including Inpatient Treatment)	MH/SUD	Pgs. 9 & 21	Yes
26	Tele-Psychiatry	MH/SUD	Pg. 11	Yes
27	Topical Anti-Inflammatory acute and chronic pain medication	MH/SUD	Pg. 32	Yes
28	Pediatric Dental Care	Pediatric Oral and Vision Care	See AllKids Pediatric Dental Document	No
29	Pediatric Vision Coverage	Pediatric Oral and Vision Care	Pgs. 26–27	No
30	Maternity Service	Pregnancy, Maternity, and Newborn Care	Pgs. 8 & 22	Yes
31	Outpatient Prescription Drugs	Prescription drugs	Pgs. 29–34	Yes
32	Colorectal Cancer Examination and Screening	Preventive and Wellness Services	Pgs. 12 & 16	Yes
33	Contraceptive/Birth Control Services	Preventive and Wellness Services	Pgs. 13 & 16	Yes
34	Diabetes Self-Management Training and Education	Preventive and Wellness Services	Pgs. 11 & 35	Yes
35	Diabetic Supplies for Treatment of Diabetes	Preventive and Wellness Services	Pgs. 31–32	No
36	Mammography—Screening	Preventive and Wellness Services	Pgs. 12, 15 & 24	Yes
37	Osteoporosis—Bone Mass Measurement	Preventive and Wellness Services	Pgs. 12 & 16	Yes
38	Pap Tests/ Prostate—Specific Antigen Tests/ Ovarian Cancer Surveillance Test	Preventive and Wellness Services	Pg. 16	Yes
39	Preventive Care Services	Preventive and Wellness Services	Pg. 18	Yes
40	Sterilization (women)	Preventive and Wellness Services	Pgs. 10 & 19	Yes
41	Chiropractic & Osteopathic Manipulation	Rehabilitative and Habilitative Services and Devices	Pgs. 12–13	Yes
42	Habilitative and Rehabilitative Services	Rehabilitative and Habilitative Services and Devices	Pgs. 8, 9, 11, 12, 22 & 35	Yes
<i>Special Note: Under Pub. Act 102-0104, eff. July 22, 2021, any EHBs listed above that are clinically appropriate and medically necessary to deliver via telehealth services must be covered in the same manner as when those EHBs are delivered in person.</i>				

## The ‘No Surprises’ Rules

The “No Surprises” rules protect you from surprise medical bills in situations where you can’t easily choose a provider who’s in your health plan network. This is especially common in an emergency situation, when you may get care from out-of-network providers. Out-of-network providers or emergency facilities may ask you to sign a notice and consent form before providing certain services after you’re no longer in need of emergency care. These are called “post-stabilization services.” You shouldn’t get this notice and consent form if you’re getting emergency services other than post-stabilization services. You may also be asked to sign a notice and consent form if you schedule certain non-emergency services with an out-of-network provider at an in-network hospital or ambulatory surgical center.

The notice and consent form informs you about your protections from unexpected medical bills, gives you the option to give up those protections and pay more for out-of-network care, and provides an estimate of what your out-of-network care might cost. You aren’t required to sign the form and shouldn’t sign the form if you didn’t have a choice of health care provider or facility before scheduling care. If you don’t sign, you may have to reschedule your care with a provider or facility in your health plan’s network.

[View a sample notice and consent form \(PDF\).](#)

This applies to you if you're a participant, beneficiary, enrollee, or covered individual in a group health plan or group or individual health insurance coverage, including a Federal Employees Health Benefits (FEHB) plan.

WIDEORBIT

Say hello to a Wider World™

# 2025 BENEFITS GUIDE

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**This guide is an overview** and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your plan benefit booklets or summary plan descriptions (SPDs). The plan benefit booklets determine how all benefits are paid.



# GETTING STARTED

## 2025 Benefits

January 1, 2025 through December 31, 2025

### 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 see the *Important Notices* section for more details.

Whether you're enrolling in benefits for the first time, nearing retirement, or somewhere in between, WideOrbit supports you with benefit programs and resources to help you thrive today and prepare for tomorrow.

This guide provides an overview of your healthcare coverage, life, disability, retirement benefits, and more.

You'll find tips to help you understand your medical coverage, save time and money on healthcare, reduce taxes, and balance your work and home life. Review the coverage and tools available to you to make the most of your benefits package.

# WHO'S ELIGIBLE FOR BENEFITS?

## Employees

You are eligible if you are a regular full-time employee working 20 or more hours per week. Employees with variable hours and seasonal schedules may be considered eligible for benefits. Refer to "Determining Eligibility" later in this guide for details.

## Eligible dependents

- Legally married spouse or same or opposite gender domestic partner
- Natural, adopted or stepchildren up to age 26. Domestic partner's child(ren) are eligible.
- Children over age 26 who are disabled and depend on you for support
- Children named in a Qualified Medical Child Support Order (QMCSO).

For additional information, please refer to the benefit booklets for each benefit.

## Domestic Partner eligibility criteria

If you are enrolling a domestic partner or domestic partner children, you are required to have met all eligibility requirements listed below for the previous 6 months:

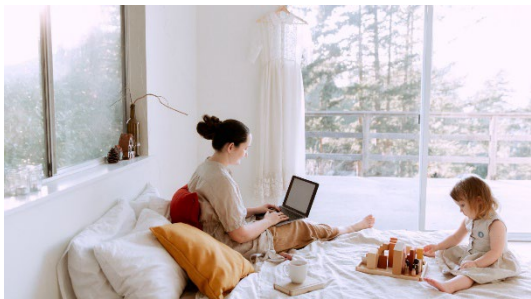
- You maintain the same principal place of residence and intend to do so in the future
  - You agree to be responsible for each other's basic living expenses in the event that either of you are unable to provide such expenses for yourself
  - You are both 18 or older and neither of you are married
  - You are not related by blood to such a degree that you would be prevented from marrying in the state in which you reside
  - Neither of you has maintained coverage for another Domestic Partner under any health plan within the last six months. (This excludes any domestic partner that has died within the last six months)
  - You agree to notify WideOrbit immediately upon your failure to satisfy any of the criteria of Domestic Partnership
  - You understand that it is fraudulent act to obtain health coverage by misrepresenting any facts stated herein
- Or -
- You are Registered Domestic Partners

You may be required to provide proof of dependent status. Any falsification of this information will result in disciplinary action, up to and including termination.

For additional information, please refer to the full certificate of coverage for each benefit.

**Note:** WideOrbit extends coverage to same gender and opposite gender Domestic Partners (DPs) and their dependents who meet the policy requirement. Keep in mind that due to IRS regulations, your cost for domestic partner coverage must be paid with after-tax dollars. In addition, the company's cost for domestic partner coverage is considered "imputed cost," and is subject to income and Social Security taxes, unless your domestic partner qualifies as your tax dependent.

# WHEN CAN YOU ENROLL



## New Hire & Open Enrollment

You can enroll in benefits as a new hire or during the annual open enrollment period. New hire coverage begins on the First of Month Following Date of Hire if you enroll within 30 days of becoming eligible.

If you miss the enrollment deadline, you'll need to wait until the next open enrollment (the one time each year that you can make changes to your benefits for any reason).

## Changing Your Benefits

Outside of open enrollment and your new hire window, you may be able to enroll or make changes to your benefit elections if you have a big change in your life, including:

- Change in legal marital status
- Change in number of dependents or dependent eligibility status
- Change in employment status that affects eligibility for you, your spouse, or dependent child(ren)
- Change in residence that affects access to network providers
- Change in your health coverage or your spouse's coverage due to your spouse's employment
- Change in an individual's eligibility for Medicare or Medicaid
- Court order requiring coverage for your child
- "Special enrollment event" under the Health Insurance Portability and Accountability Act (HIPAA), including a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan
- Event allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act (you have 60 days to request enrollment due to events allowed under CHIP).

You must submit your change within 31 days after the event.

# THE EASY WAY TO GET BENEFITS INFO

MyBenefits.Life® gives you all your benefits information in one place

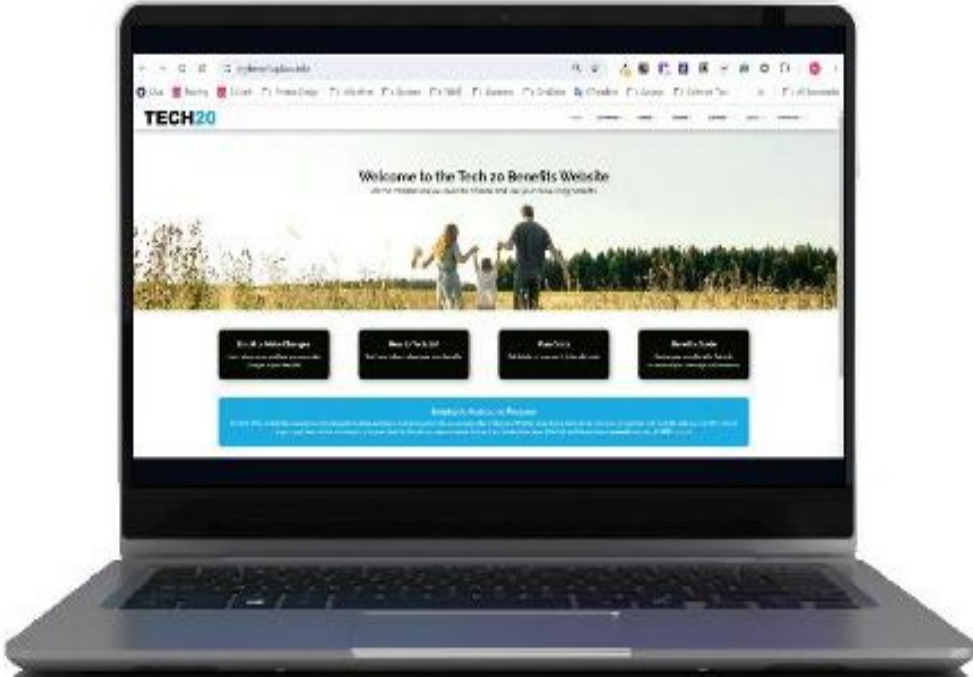
You can bank online, book a vacation online, and read the news online. Why should your benefits information be any different? MyBenefits.Life® is both a website and a mobile app that gives you access to the benefits information you need, when you need it.

## Here’s what you’ll find on MyBenefits.Life®

### GET MYBENEFITS.LIFE®

On the web:  
wideorbit.mybenefits.life

<b>Benefits</b>	See benefit details and costs—for all plans you’re eligible for, such as healthcare, disability, life insurance, and more
<b>Search</b>	Can’t find it? Just search the site
<b>Documents</b>	Important benefit plan notices (“the fine print”)
<b>Contacts</b>	Find HR, benefits, and carrier contacts
<b>Get Help</b>	Need help? Reach helpful resources



# HAVE QUESTIONS ABOUT YOUR BENEFITS?



## CONTACT YOUR ALLIANT BENEFIT ADVOCATE

### Email

wideorbit@alliant.com

### Phone

925-287-7248

### Hours

M-Th, 8am to 5pm PST

Fri, 8am to 4:30pm PST

## Get help from a Benefit Advocate

Are you getting married and not sure how and 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 Advocates are trained benefits expert who can help you understand and use your healthcare and other coverage. Contact your Benefit Advocate for issues such as:

- General benefit questions
- Eligibility and coverage
- Finding a network provider
- Health care claim or billing issues, when warranted
- Coverage changes due to life events (marriage, new child, divorce, etc.).

## Claims assistance

If you need claims assistance, you'll 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 time basis to only the individuals listed on the form. The form is revocable at any time. Your Benefit Advocate will provide the form to you when needed.



## MEDICAL

### OUR PLANS

2025 Cigna HDHP

2025 Cigna PPO

2025 BCBS of AL HDHP (AL Only)

2025 BCBS of AL PPO (AL Only)

2025 Kaiser HDHP (CA Only)

2025 Kaiser DHMO (CA Only)

### WHICH PLAN IS RIGHT FOR YOU?

That depends on your healthcare needs, favorite doctors, and budget. Here are some considerations.

#### Do you prefer specific doctors or hospitals?

If you want to stay with your favorite doctors and facilities, check whether they are in the plan's network. If they are not, but you are comfortable paying a bit more to see them, consider a plan with both in-network and out-of-network benefits.

#### What are your usual healthcare needs?

Do you have frequent doctor or urgent care visits? Do you have a condition that requires a specialist? Do you take prescription medications? Compare how each plan covers the services you need most often.

#### Consider the bottom line

How much is the monthly payroll deduction? Do you have to meet a deductible? What is the out-of-pocket maximum? How much of the cost is covered by the plan? How much are any copayments for office visits, prescriptions, etc. All of these factors together affect your total cost for healthcare.

# 2025 Cigna HDHP

You always pay the deductible and copayment (\$). The coinsurance (%) shows what you pay after the deductible.

You can reimburse qualified lodging and travel expenses under [IRS Publication 502](#). Travel and lodging expenses are covered for specific services with restricted geographic access to care, including abortion, gender affirmation, behavioral inpatient and outpatient, bariatric surgery, and congenital heart disease treatment. Be sure to save your travel and lodging receipts and contact Cigna with any questions. The care must be received 60 miles or farther from your home.

	In-Network	Out-of-Network
<b>Annual Deductible</b>	\$2,250 employee only (combined with out-of-network); \$3,300 per individual in a family, up to \$4,500 per family (combined with out-of-network)	\$6,500 employee only (combined with in-network); \$6,600 per individual in a family, up to \$13,000 per family (combined with in-network)
<b>Accumulation Period</b>	Time period to incur eligible expenses toward the deductible: Calendar Year	
<b>Annual Out-of-Pocket Maximum</b>	\$6,000 employee only (combined with out-of-network); \$6,000 per individual in a family, up to \$12,000 per family (combined with out-of-network)	\$10,000 employee only (combined with in-network); \$10,000 per individual in a family, up to \$20,000 per family (combined with in-network)
<b>Office Visit</b>	20% after deductible	50% after deductible
<b>Chiropractic</b>	20% after deductible (up to 20 visits per calendar year combined with out-of-network)	50% after deductible (up to 20 visits per calendar year combined with in-network)
<b>Lab and X-ray</b>	20% after deductible	50% after deductible
<b>Urgent Care</b>	20% after deductible	50% after deductible
<b>Emergency Room</b>	20% after deductible	20% after deductible
<b>Hospitalization</b>	20% after deductible	50% after deductible
<b>Outpatient Surgery</b>	20% after deductible	50% after deductible
<b>PRESCRIPTION DRUGS</b>		
<b>Deductible</b>	Combined with medical deductible	N/A
<b>Out-of-Pocket Maximum</b>	Combined with medical out of pocket	N/A
<b>Generic</b>	<b>Pharmacy:</b> \$15 copay after deductible <b>Mail Order:</b> \$30 copay after deductible	Not covered
<b>Preferred Brand Name</b>	<b>Pharmacy:</b> \$30 copay after deductible <b>Mail Order:</b> \$60 copay after deductible	Not covered
<b>Non-Preferred Brand Name</b>	<b>Pharmacy:</b> \$50 copay after deductible <b>Mail Order:</b> \$100 copay after deductible	Not covered
<b>Specialty</b>	<b>Pharmacy:</b> You pay 30% after deductible <b>Mail Order:</b> You pay 30% after deductible	Not covered
<b>Supply</b>	<b>Pharmacy:</b> 30 days <b>Mail Order:</b> 90 days	Not covered

# 2025 Cigna PPO

You always pay the deductible and copayment (\$). The coinsurance (%) shows what you pay after the deductible.

You can reimburse qualified lodging and travel expenses under [IRS Publication 502](#). Travel and lodging expenses are covered for specific services with restricted geographic access to care, including abortion, gender affirmation, behavioral inpatient and outpatient, bariatric surgery, and congenital heart disease treatment. Be sure to save your travel and lodging receipts and contact Cigna with any questions. The care must be received 60 miles or farther from your home

	In-Network	Out-of-Network
<b>Annual Deductible</b>	\$500 per individual, up to \$1,000 per family	\$3,000 per individual, up to \$6,000 per family
<b>Accumulation Period</b>	Time period to incur eligible expenses toward the deductible: Calendar Year	
<b>Annual Out-of-Pocket Maximum</b>	\$6,000 per individual, up to \$12,000 per family	\$9,000 per individual, up to \$18,000 per family
<b>Office Visit</b>	\$20 copay, \$30 copay for Specialist	40% after deductible
<b>Chiropractic</b>	\$30 copay (limited to 20 visits per calendar year, combined with out-of-network)	40% after deductible (limited to 20 visits per calendar year, combined with in-network)
<b>Lab and X-ray</b>	20% after deductible	40% after deductible
<b>Urgent Care</b>	\$30 copay	40% after deductible
<b>Emergency Room</b>	\$150 copay, + 20% coinsurance (copay waived if admitted)	\$150 copay, + 20% coinsurance (copay waived if admitted)
<b>Hospitalization</b>	\$250 copay, + 20% after deductible	40% after deductible
<b>Outpatient Surgery</b>	20% after deductible	40% after deductible
<b>PRESCRIPTION DRUGS</b>		
<b>Deductible</b>	None	N/A
<b>Out-of-Pocket Maximum</b>	Combined with medical out of pocket	N/A
<b>Generic</b>	<b>Pharmacy:</b> \$15 copay <b>Mail Order:</b> \$30 copay	Not covered
<b>Preferred Brand Name</b>	<b>Pharmacy:</b> \$30 copay <b>Mail Order:</b> \$60 copay	Not covered
<b>Non-Preferred Brand Name</b>	<b>Pharmacy:</b> \$50 copay <b>Mail Order:</b> \$100 copay	Not covered
<b>Specialty</b>	<b>Pharmacy:</b> You pay 30% <b>Mail Order:</b> You pay 30%	Not covered
<b>Supply</b>	<b>Pharmacy:</b> 30 days <b>Mail Order:</b> 90 days	Not covered

## 2025 BCBS of AL HDHP – *Alabama Only*

You always pay the deductible and copayment (\$). The coinsurance (%) shows what you pay after the deductible.

	In-Network	Out-of-Network
<b>Annual Deductible</b>	\$2,250 employee only; \$3,300 per individual in a family, up to \$4,500 per family	\$6,500 employee only, \$6,500 per individual in a family, up to \$13,000 per family
<b>Accumulation Period</b>	Time period to incur eligible expenses toward the deductible: Calendar Year	
<b>Annual Out-of-Pocket Maximum</b>	\$6,000 employee only, \$6,000 per individual in a family, up to \$12,000 per family	\$10,000 employee only; up to \$20,000 per family (combined with in-network)
<b>Office Visit</b>	20% after deductible	50% after deductible
<b>Chiropractic</b>	20% after deductible (limited to 20 visits per calendar year combined with out-of- network)	50% after deductible; <b>In Alabama:</b> Not covered (limited to 20 visits per calendar year combined with in-network)
<b>Lab and X-ray</b>	20% after deductible	50% after deductible
<b>Urgent Care</b>	20% after deductible	50% after deductible
<b>Emergency Room</b>	20% after deductible	20% after deductible
<b>Hospitalization</b>	20% after deductible	50% after deductible
<b>Outpatient Surgery</b>	20% after deductible	50% after deductible <b>In Alabama:</b> Not Covered
<b>PRESCRIPTION DRUGS</b>		
<b>Deductible</b>	Combined with medical deductible	N/A
<b>Out-of-Pocket Maximum</b>	Combined with medical out of pocket	N/A
<b>Generic</b>	<b>Pharmacy:</b> \$15 copay after deductible <b>Mail Order:</b> \$37.50 copay after deductible	Not covered
<b>Preferred Brand Name</b>	<b>Pharmacy:</b> \$30 copay after deductible <b>Mail Order:</b> \$75 copay after deductible	Not covered
<b>Non-Preferred Brand Name</b>	<b>Pharmacy:</b> \$50 copay after deductible <b>Mail Order:</b> \$125 copay after deductible	Not covered
<b>Specialty</b>	<b>Pharmacy:</b> You pay 30% after deductible <b>Mail Order:</b> You pay 30% after deductible	Not covered
<b>Supply</b>	<b>Pharmacy:</b> 30 days <b>Mail Order:</b> 90 days	Not covered

## 2025 BCBS of AL PPO – *Alabama Only*

You always pay the deductible and copayment (\$). The coinsurance (%) shows what you pay after the deductible.

	In-Network	Out-of-Network
<b>Annual Deductible</b>	\$500 per individual, up to \$1,000 per family	\$3,000 per individual, up to \$6,000 per family
<b>Accumulation Period</b>	Time period to incur eligible expenses toward the deductible: Calendar Year	
<b>Annual Out-of-Pocket Maximum</b>	\$6,000 per individual, up to \$12,000 per family	\$9,000 per individual, up to \$18,000 per family
<b>Office Visit</b>	\$20 copay, \$30 copay for Specialist	40% after deductible; <b>In Alabama:</b> 50% after deductible
<b>Chiropractic</b>	20% after deductible (limited to 12 visits per calendar year combined with out-of-network)	40% after deductible; <b>In Alabama:</b> Not Covered (limited to 12 visits per calendar year combined with in-network)
<b>Lab and X-ray</b>	20% after deductible	40% after deductible
<b>Urgent Care</b>	\$30 copay	40% after deductible
<b>Emergency Room</b>	\$150 copay	\$150 copay
<b>Hospitalization</b>	20% after deductible	40% after deductible
<b>Outpatient Surgery</b>	20% after deductible	40% after deductible <b>In Alabama:</b> Not Covered
<b>PRESCRIPTION DRUGS</b>		
<b>Deductible</b>	None	N/A
<b>Out-of-Pocket Maximum</b>	Combined with medical out of pocket	N/A
<b>Generic</b>	<b>Pharmacy:</b> \$15 copay <b>Mail Order:</b> \$37.50 copay	Not covered
<b>Preferred Brand Name</b>	<b>Pharmacy:</b> \$30 copay <b>Mail Order:</b> \$75 copay	Not covered
<b>Non-Preferred Brand Name</b>	<b>Pharmacy:</b> \$50 copay <b>Mail Order:</b> \$125 copay	Not covered
<b>Specialty</b>	<b>Pharmacy:</b> You pay 30% <b>Mail Order:</b> You pay 30%	Not covered
<b>Supply</b>	<b>Pharmacy:</b> 30 days <b>Mail Order:</b> 90 days	Not covered

## 2025 Kaiser HDHP – *California Only*

	In-Network
<b>Annual Deductible</b>	\$2,000 employee only; \$3,300 per individual in a family, up to \$4,000 per family
<b>Accumulation Period</b>	Time period to incur eligible expenses toward the deductible: Plan Year
<b>Annual Out-of-Pocket Maximum</b>	\$3,600 employee only; \$3,600 per individual in a family, up to \$7,200 per family
<b>Office Visit</b>	\$30 copay after deductible; \$50 copay after deductible for specialist
<b>Chiropractic</b>	Not covered
<b>Lab and X-ray</b>	X-Ray and Lab Tests: \$10 copay after deductible; Imaging (CT/PET & MRI's): \$150 copay after deductible
<b>Urgent Care</b>	\$30 copay after deductible
<b>Emergency Room</b>	\$200 copay after deductible
<b>Hospitalization</b>	\$250 copay after deductible
<b>Outpatient Surgery</b>	\$150 copay after deductible
<b>PRESCRIPTION DRUGS</b>	
<b>Deductible</b>	Combined with medical deductible
<b>Out-of-Pocket Maximum</b>	Combined with medical out of pocket
<b>Generic</b>	<b>Pharmacy:</b> \$10 copay after deductible <b>Mail Order:</b> \$20 copay after deductible
<b>Preferred Brand Name</b>	<b>Pharmacy:</b> \$30 copay after deductible <b>Mail Order:</b> \$60 copay after deductible
<b>Non-Preferred Brand Name</b>	<b>Pharmacy:</b> \$30 copay after deductible <b>Mail Order:</b> \$60 copay after deductible
<b>Specialty</b>	<b>Pharmacy:</b> You pay 20% after deductible (not to exceed \$250) <b>Mail Order:</b> N/A
<b>Supply</b>	<b>Pharmacy:</b> 30 days <b>Mail Order:</b> 100 days

## 2025 Kaiser DHMO – *California Only*

	In-Network (California Only)
<b>Annual Deductible</b>	\$1,000 per individual, up to \$2,000 per family
<b>Accumulation Period</b>	Time period to incur eligible expenses toward the deductible: Plan Year
<b>Annual Out-of-Pocket Maximum</b>	\$3,000 per individual up to \$6,000 per family
<b>Office Visit</b>	\$20 copay; \$20 copay for specialist
<b>Chiropractic</b>	Not covered
<b>Lab and X-ray</b>	X-Ray and Lab Tests: \$10 copay; Imaging (CT/PET & MRI's): 20% up to \$50 copay
<b>Urgent Care</b>	\$20 copay
<b>Emergency Room</b>	20% after deductible
<b>Hospitalization</b>	20% after deductible
<b>Outpatient Surgery</b>	20% after deductible
<b>Telehealth (Online)</b>	No charge
<b>PRESCRIPTION DRUGS</b>	
<b>Deductible</b>	\$0
<b>Out-of-Pocket Maximum</b>	Combined with medical out of pocket
<b>Generic</b>	<b>Pharmacy:</b> \$10 copay <b>Mail Order:</b> \$20 copay
<b>Preferred Brand Name</b>	<b>Pharmacy:</b> \$30 copay <b>Mail Order:</b> \$60 copay
<b>Non-Preferred Brand Name</b>	<b>Pharmacy:</b> \$30 copay <b>Mail Order:</b> \$60 copay
<b>Specialty</b>	<b>Pharmacy:</b> You pay 20% (not to exceed \$150) <b>Mail Order:</b> N/A
<b>Supply</b>	<b>Pharmacy:</b> 30 days <b>Mail Order:</b> 100 days

# HEALTH SAVINGS ACCOUNT (HSA)

Click to play video



## ARE YOU ELIGIBLE?

The HSA is not for everyone. You're eligible only if you are:

1. Enrolled in the 2025 Cigna, Blue Cross Blue Shield of Alabama, or Kaiser High Deductible Health Plan.
2. Not enrolled in other non-HDHP medical coverage, including Medicare, Medicaid, or Tricare.
3. Not a tax dependent.
4. Not enrolled in a healthcare Flexible Spending Account (FSA), unless it's a "limited purpose" FSA for dental and vision expenses.

## A personal savings account for healthcare

A Health Savings Account (HSA) is an easy way to pay for healthcare expenses that you have today and save for expenses you may have in the future.

## How the HSA works

- Your HSA account is set up automatically after you enroll.

- To help you get started, WideOrbit contributes to your HSA:

Cigna and BCBS of AL HDHP:

**Individual:** \$281.25 per quarter

**Family:** \$562.50 per quarter

Kaiser HDHP:

**Individual:** \$250 per quarter

**Family:** \$500 per quarter

- You can contribute up to the limit set by the IRS (includes company amount).

Individual: \$4,300 per year

Family: \$8,550 per year

Are you age 55 +? You can contribute an additional \$1,000 per year

- You can use your HSA debit card to pay for eligible expenses like office visits, lab tests, prescriptions, dental and vision care, and even some drugstore items.

## Four reasons to love an HSA

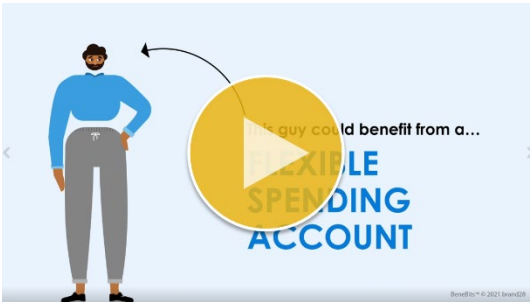
1. **Tax-free.** No federal tax on contributions, or state tax in most states. Withdrawals are also tax-free as long as they're for eligible healthcare expenses.
2. **No "use it or lose it."** Your balance rolls over from year to year. You own the account and can continue to use it even if you change medical plans or leave the company.
3. **Use it now or later.** Use your HSA for healthcare expenses you have today or save it to use in the future.
4. **Boosts retirement savings.** After you retire, you can use your HSA for healthcare expenses tax-free, or for regular living expenses, taxable but no penalties.

## Find out more

- [Eligible Expenses](#)
- [Ineligible Expenses](#)

# HEALTHCARE FLEXIBLE SPENDING ACCOUNT (FSA)

Click to play video



## ARE YOU ELIGIBLE?

You don't have to enroll in one of our medical plans to participate in the healthcare FSA. However, if you or your spouse are enrolled in a high deductible health plan (like our 2025 Inspira Financial HSA, you can only participate in the **Limited Purpose FSA** for dental and vision expenses.

### Find out more

- [WEXInc.com](http://WEXInc.com)
- [Eligible Expenses](#) – now include more over-the-counter items!
- [Ineligible Expenses](#)

### Do you pay for dependent care?

Look in the Financial Wellness section for information on tax savings through the Dependent Care FSA.

## Set aside healthcare dollars for the coming year

A healthcare FSA allows you to set aside tax-free money to pay for healthcare expenses you expect to have over the coming year.

## How the 2025 WEX Flexible Spending Account works

- You estimate what you and your family's out-of-pocket costs will be for the coming year. Think about what out-of-pocket costs you expect to have for eligible expenses such as office visits, surgery, dental and vision expenses, prescriptions, even eligible drugstore items.
- You can contribute up to \$3,300, the annual limit set by the IRS. Contributions are deducted from your pay pre-tax, meaning no federal or state tax on that amount.
- During the year, you can use your FSA debit card to pay for services and products. Withdrawals are tax-free as long as they're for eligible healthcare expenses.

## Estimate carefully!

If you don't spend all the money in your account, you can roll over up to \$660 to use the following year. Any additional remaining balance will be forfeited.

### FSA TAX SAVINGS EXAMPLE

#### \$60,000 Annual Pay, with \$1,500 FSA Contribution

<b>\$330</b>	<b>\$115</b>	<b>\$445</b>
22% Federal income tax	7.65% FICA tax	Annual FSA tax savings

#### \$120,000 Annual Pay, with \$3,050 FSA Contribution

<b>\$732</b>	<b>\$233</b>	<b>\$965</b>
24% Federal income tax	7.65% FICA tax	Annual FSA tax savings

*Your tax savings may vary depending on tax filing status and other variables*



## DENTAL

### OUR PLAN

2025 Cigna Dental Buy Up PPO

2025 Cigna Dental Base PPO

### Why sign up for Dental coverage?

It's important to go to the dentist regularly. Brushing and flossing are great, but regular exams catch dental issues early before they become more expensive and difficult to treat.

That's where dental insurance comes in. Dental insurance makes it easier and less expensive to get the care you need to maintain good oral health.

Dental insurance covers three types of treatments:

- **Preventive** care includes exams, cleanings and x-rays
- **Basic** care focuses on repair and restoration with services such as fillings, root canals, and gum disease treatment
- **Major** care goes further than basic and includes bridges, crowns and dentures
- **Orthodontia** treatment to properly align teeth within the mouth.

## 2025 Cigna Dental Buy Up PPO and Base PPO

Be sure to check for in-network dentists under Cigna’s “Total Cigna DPPO” network by navigating to [Cigna’s website](#), selecting “Find a Doctor, Dentist, or Facility”, following the prompts to search by type of dentist or dentist name, and when prompted to select a plan choose “DPPO/EPO > Total Cigna DPPO”. You will also have the option to enroll in the Buy Up Dental PPO offering you higher dental and orthodontic maximums as well as other improved benefits.

You always pay the deductible and copayment (\$). The coinsurance (%) shows what you pay after the deductible.

	Cigna Buy Up PPO		Cigna Base PPO	
	In-Network “Total Cigna DPPO”	Out-of-Network	In-Network: “Total Cigna DPPO”	Out-of-Network
<b>Annual Deductible</b>	\$50 per individual, up to \$150 per family (in and out-of-network combined)	\$50 per individual, up to \$150 per family (in and out-of-network combined)	\$50 per individual, up to \$150 per family (in and out-of-network combined)	\$50 per individual, up to \$150 per family (in and out-of-network combined)
<b>Annual Plan Maximum</b>	\$5,000 (in and out-of-network combined)	\$2,500 (in and out-of-network combined)	\$2,500 (in and out-of-network combined)	\$2,500 (in and out-of-network combined)
<b>Diagnostic &amp; Preventive</b>	No charge (deductible waived)	No charge (deductible waived)	No charge (deductible waived)	No charge (deductible waived)
<b>Basic Services</b>	No charge after deductible	20% after deductible	20% after deductible	20% after deductible
<b>Major Services</b>	40% after deductible	50% after deductible	50% after deductible	50% after deductible
<b>Orthodontia</b>	50%  Children: Covered Adults: Covered	50%  Children: Covered Adults: Covered	50%  Children: Covered Adults: Covered	50%  Children: Covered Adults: Covered
<b>Ortho Lifetime Max</b>	\$2,500 (in and out-of-network combined)	\$1,500 (in and out-of-network combined)	\$1,500 (in and out-of-network combined)	\$1,500 (in and out-of-network combined)



## VISION

### OUR PLAN

2025 Guardian (VSP) Vision

### Why sign up for Vision coverage?

Vision coverage helps with the cost of eyeglasses or contacts. But even if you don't need vision correction, an annual eye exam checks the health of your eyes and can even detect more serious health issues such as diabetes, high blood pressure, high cholesterol, and thyroid disease.

You'll even find discounts on services like LASIK and PRK, rebates on contact lenses, and money off on hearing aids and other related services. Visit the plan's website to check out these extra savings.

# 2025 Guardian (VSP) Vision

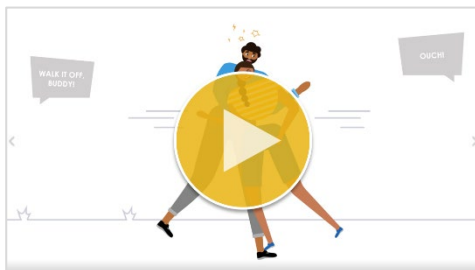
Your vision checkup is fully covered after your Exam copay. After any Materials copay, the plan covers frames, lenses, and contacts as described below.

	In-Network	Out-of-Network
<b>Copay</b>	<b>Exam:</b> \$10 copay <b>Materials:</b> \$25 copay	<b>Exam:</b> \$10 copay (reimbursed up to \$50) <b>Materials:</b> \$25 copay
<b>Frames</b>	Coverage up to \$130, 20% discount over \$130 after materials copay	Reimbursed up to \$48 after materials copay
<b>Lenses</b>	<b>Single Vision:</b> No charge after applicable copay <b>Bifocal:</b> No charge after applicable copay <b>Trifocal:</b> No charge after applicable copay	<b>Single Vision:</b> Reimbursed up to \$48 after materials copay <b>Bifocal:</b> Reimbursed up to \$67 after materials copay <b>Trifocal:</b> Reimbursed up to \$86 after materials copay
<b>Contacts (Elective)</b>	Coverage up to \$130 (in lieu of frames)	Reimbursed up to \$120 (in lieu of frames)
<b>Frequency</b>	<b>Exam:</b> 12 months <b>Frames:</b> 24 months <b>Lenses:</b> 12 months <b>Contacts (Elective):</b> 12 months (in lieu of frames)	<b>Exam:</b> 12 months <b>Frames:</b> 24 months <b>Lenses:</b> 12 months <b>Contacts (Elective):</b> 12 months (in lieu of frames)



# ENGAGE

*Click to play video*



PCP vs Urgent Care vs ER






## Maximize Your Healthcare

Knowing how to best use your healthcare coverage can help you improve your health and reduce your expenses. In this section you'll find tips on:

- Finding the right care at the right cost
- Alternatives to hospital care
- Understanding preventive care benefits
- Saving money on prescription drugs





# KNOW WHERE TO GO

Where you get medical care can have a significant impact on the cost. Here’s a quick guide to help you know where to go, based on your condition, budget, and time.

Type	Appropriate for	Examples	Access	Cost
<b>Nurseline</b> 	Quick answers from a trained nurse	<ul style="list-style-type: none"> <li>Identifying symptoms</li> <li>Decide if immediate care is needed</li> <li>Home treatment options and advice</li> </ul>	24/7	\$0
<b>Online visit</b> 	Many non-emergency health conditions	<ul style="list-style-type: none"> <li>Cold, flu, allergies</li> <li>Headache, migraine</li> <li>Skin conditions, rashes</li> <li>Minor injuries</li> <li>Mental health concerns</li> </ul>	24/7	\$
<b>Office visit</b> 	Routine medical care and overall health management	<ul style="list-style-type: none"> <li>Preventive care</li> <li>Illnesses, injuries</li> <li>Managing existing conditions</li> </ul>	Office Hours	\$\$
<b>Urgent care, walk-in clinic</b> 	Non-life-threatening conditions requiring prompt attention	<ul style="list-style-type: none"> <li>Stitches</li> <li>Sprains</li> <li>Animal bites</li> <li>Ear-nose-throat infections</li> </ul>	Office Hours, or up to 24/7	\$\$\$
<b>Emergency room</b> 	Life-threatening conditions requiring immediate medical expertise	<ul style="list-style-type: none"> <li>Suspected heart attack or stroke</li> <li>Major bone breaks</li> <li>Excessive bleeding</li> <li>Severe pain</li> <li>Difficulty breathing</li> </ul>	24/7	\$\$\$\$\$

# ALTERNATIVE FACILITIES

If you have time to evaluate your options for non-emergency health treatments, these alternative facilities can provide the same results as a hospital at a fraction of the cost.

Need	Alternative	Features	Savings
<b>Surgery</b> 	Ambulatory Surgery Center (ASC)	<ul style="list-style-type: none"> <li>Specializes in same-day surgeries</li> <li>Cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery and more</li> <li>Held to same safety standards as hospitals</li> </ul>	Up to 50% over hospital stay*
<b>Physical therapy</b> 	Free-standing physical therapy center	<ul style="list-style-type: none"> <li>Important part of the recovery process after an injury or surgery</li> </ul>	40 to 60% over a hospital setting*
<b>Sleep study</b> 	Home testing	<ul style="list-style-type: none"> <li>Diagnoses sleep apnea and other conditions</li> <li>Cost is often covered by insurance if considered medically necessary</li> </ul>	Approx. \$4,500*
<b>Infusion therapy</b> 	Home or outpatient infusion therapy	<ul style="list-style-type: none"> <li>For drugs that must be delivered by intravenous injections, or epidurals</li> <li>Delivered by licensed infusion therapy provider</li> <li>Maintain normal lifestyle and comfort of home or outpatient center</li> </ul>	Up to 90% over hospital stay*

*\*in-network*

## How to find an alternative treatment facility

Ask your doctor if your treatment must be delivered in the hospital. You can also search for surgical centers, physical therapy, etc. on your plan's website; or call member services for assistance.

Online tools such as [healthcarebluebook.com](http://healthcarebluebook.com) and [healthgrades.com](http://healthgrades.com) help you compare costs and doctor ratings. Some alternative services include a facility fee to cover overhead costs. To avoid a surprise on your bill, ask about facility fees before you schedule your appointment.

# TURNING 65? UNDERSTAND YOUR MEDICARE OPTIONS



**Alliant Medicare Solutions is a no cost service available to you, your family members, and friends nearing age 65.**

*Alliant Medicare Solutions is provided by Insuractive LLC, a Nebraska resident insurance agency. Insuractive LLC is wholly owned by Alliant Insurance Services, Inc.*

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

If, like most people, you become eligible for Medicare at age 65, you have a seven-month window to enroll, starting three months before you turn age 65 and ending three months after your birthday month.

## Introducing Alliant Medicare Solutions

Choosing a Medicare plan – and understanding how it can affect your employer-provided medical coverage – can be confusing. That’s why we are offering Alliant Medicare Solutions to help you understand Medicare, what is and isn’t covered, and how to choose the best coverage for your situation.

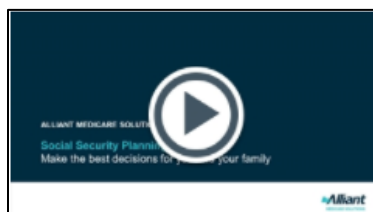
## How does it work?

1. Call Alliant Medicare Solutions at **(866) 279-3195** 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.

## Find Out More



[Medicare 101 Video](#)



[Social Security Planning Video](#)

# PREVENTIVE CARE SCREENING BENEFITS



## TYPICAL SCREENINGS FOR ADULTS

- Blood pressure
- Cholesterol
- Diabetes
- Colorectal cancer screening
- Depression
- Mammograms
- OB/GYN screenings
- Prostate cancer screening
- Testicular exam

You take your car in for maintenance. Why not do the same for yourself?

Annual preventive checkups can help you and your doctor identify your baseline level of health and detect issues before they become serious.

### What is Preventive Care?

The Affordable Care Act (ACA) requires health insurers to cover a set of preventive services at no cost to you, even if you haven't met your yearly deductible. The preventive care services you'll need to stay healthy vary by age, sex, and medical history.

Visit [health.gov/myhealthfinder](https://www.health.gov/myhealthfinder) for recommended guidelines.

**Preventive care is covered in full  
only when obtained from an  
IN-NETWORK provider.**

### Not all exams and tests are considered preventive

Exams performed by specialists are generally not considered preventive and may not be covered at 100 percent.

Additionally, certain screenings may be considered diagnostic, not preventive, based on your current medical condition. You may be responsible for paying all or a share of the cost for those services.

If you have a question about whether a service will be covered as preventive care, contact your medical plan.

# PRESCRIPTIONS BREAKING YOUR BUDGET?



## THE FORMULARY DRUG TIERS DETERMINE YOUR COST

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\$ Generic Drug

---

\$\$ Brand Name Drug

---

\$\$\$ Specialty Drug

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## Understanding the formulary can save you money

If your doctor prescribes medicine, especially for an ongoing condition, don't forget to check your health plan's drug formulary. It's a powerful tool that can help you make informed decisions about your medication options and identify the lowest cost selection.

## What is a formulary?

A drug formulary is a list of prescription drugs covered by your medical plan. Most prescription drug formularies separate the medications they cover into four or five drug categories, or "tiers." These groupings range from least expensive to most expensive cost to you. "Preferred" drugs generally cost you less than "non-preferred" drugs.

## Get the most from your coverage

To get the most out of your prescription drug coverage, note where your prescriptions fall within your plan's drug formulary tiers and ask your doctor for advice. Generic drugs are usually the lowest cost option. Generics are required by the Food and Drug Administration (FDA) to perform the same as brand-name drug equivalents.

**To find out if a drug is on your plan's formulary, visit the plan's website or call the customer service number on your ID card.**



## LIFE & DISABILITY

### **YOUR BENEFICIARY = WHO GETS PAID**

If the worst happens, your beneficiary—the person (or people) on record with the life insurance carrier—receives the benefit. Make sure that you name at least one beneficiary for your life insurance benefit, and change your beneficiary as needed if your situation changes.

### **Is your family protected?**

Life, AD&D and disability insurance can fill a number of financial gaps due to a temporary or permanent reduction of income. Consider what your family would need to cover day-to-day living expenses and medical bills during a pregnancy or illness-related disability leave, or how you would manage large expenses (rent or mortgage, children's education, student loans, consumer debt, etc.) after the death of a spouse or partner.

We provide short and long-term disability benefits and a base amount of life and AD&D insurance to help you recover from financial loss.

### **If you need additional coverage**

We offer voluntary coverage that you can purchase for yourself, your spouse, and your children. See the Voluntary Benefits section for details.

# COMPANY- PROVIDED LIFE AND AD&D INSURANCE



## WHAT'S GUARANTEED ISSUE?

If you select coverage above a certain limit (the "guaranteed issue") or after your initial eligibility, you will need to provide additional information about your health status in order to qualify for the requested amount of coverage.

## Basic Life and AD&D

Basic Life Insurance pays your beneficiary a lump sum if you die. AD&D (Accidental Death & Dismemberment) coverage provides a benefit to you if you suffer from loss of a limb, speech, sight, or hearing, or to your beneficiary if you have a fatal accident. The cost of coverage is paid in full by the company.

Company-provided life insurance coverage over \$50,000 is considered a taxable benefit. The value of the benefit over \$50,000 will be reported as taxable income on your annual W-2 form.

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## 2025 Mutual of Omaha Life and AD&D

Up to \$100,000. Guaranteed issue of \$100,000.

*The benefit amounts above will be reduced if you are age 65 or older. Refer to the plan document for details.*

# SHORT-TERM DISABILITY INSURANCE (STD)



## EXPECT THE UNEXPECTED

Most people underestimate the likelihood of being disabled at some point in their life. Disability insurance replaces part of your pay while you are unable to work so you have a continuing income for living expenses.

## STD Benefits

Short-Term Disability (STD) insurance replaces part of your income for limited duration issues such as:

- Pregnancy issues and childbirth recovery
- Prolonged illness or injury
- Surgery and recovery time

STD payments may be reduced if you receive other benefits such as sick pay, workers' compensation, Social Security, or state disability. WideOrbit pays the cost of this coverage.

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### 2025 Mutual of Omaha STD

<b>Weekly benefit amount</b>	67% up to a maximum of \$2,900
<b>Benefits begin</b>	After 7 days of disability due to accident or 7 days due to sickness
<b>Maximum payment period</b>	12 weeks (based on first day benefits begin)

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# LONG-TERM DISABILITY INSURANCE (LTD)



## 3 THINGS TO KNOW ABOUT LTD INSURANCE

1. It can protect you from having to tap into your retirement savings.
2. You can use LTD benefits however you need, for housing, food, medical bills, etc.
3. Benefits can last a long time—from weeks to even years—if you remain eligible.

## LTD benefits cushion the financial impact of a disability

Long-Term Disability (LTD) insurance replaces part of your income for longer term issues such as:

- Debilitating illness (cancer, heart disease, etc.)
- Serious injuries (accident, etc.)
- Heart attack, stroke
- Mental disorders.

If you qualify, LTD benefits begin after short-term disability benefits end. Payments may be reduced by state, federal, or private disability benefits you receive while disabled. WideOrbit pays the cost of this coverage.

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## 2025 Mutual of Omaha LTD

<b>Monthly benefit amount</b>	60% up to a maximum of \$12,000
<b>Benefits begin</b>	After 90 days of disability
<b>Maximum payment period</b>	Social Security Normal Retirement Age or Maximum Benefit Duration

---

# VOLUNTARY LIFE INSURANCE

## Protecting those you leave behind

Voluntary Life Insurance allows you to purchase additional life insurance to protect your family's financial security. Coverage is available for your spouse and/or child(ren) if you purchase coverage for yourself.

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### 2025 Mutual of Omaha Voluntary Life

- Employee** \$10,000 Increments up to Lesser of 5x salary or \$500,000. Guaranteed issue of Lesser of 5x salary or \$150,000.
  - Spouse** \$5,000 Increments up to Lesser of 100% of employee benefit or \$250,000. Guaranteed issue of Lesser of 100% employee benefit or \$25,000.
  - Child(ren)** \$10,000. Guaranteed issue of \$10,000.
- 



### GUARANTEED ISSUE

If you purchase life insurance coverage above a certain limit (the "guaranteed issue" amount) or after your initial eligibility period, you will need to submit Evidence of Insurability with additional information about your health in order for the insurance company to approve the amount of coverage.



## FINANCIAL WELLNESS

### PLANS TO HELP YOU SAVE

- Dependent Care Flexible Spending Account (DC FSA)
- Transportation & Parking Benefits
- 401(k) Retirement Savings Plan

### Is it time for a “financial wellness” checkup?

Are you worried about money—making your paycheck last? Paying down debt? Making a big purchase like a car or home? And can you even think about preparing for retirement?

Ignoring your financial health can take a toll on your quality of life today and block opportunities for the future. And worrying about money matters can make you stressed, even to the point of physical illness.

We offer benefits and resources to help you make the most of your money now and in the future. You can increase your take-home pay by saving on taxes; and work toward your retirement goals.

# PAYING FOR DAYCARE? MAKE IT TAX-FREE!



## EVERY OPPORTUNITY TO SAVE

The biggest deduction from your paycheck is likely federal income tax. Why not take a bite out of taxes while paying for necessary expenses with tax-free dollars?

## Dependent Care FSA—up to \$5,000 per year tax-free

A dependent care Flexible Spending Account (FSA) can help families save potentially hundreds of dollars per year on day care. This program is administered by WEX Inc.

## Here's how the 2025 WEX Flexible Spending Account works

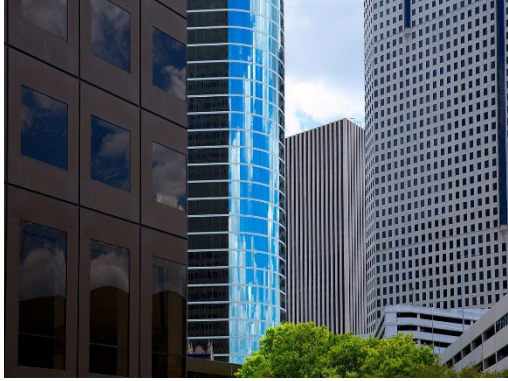
You set aside money from your paycheck, before taxes, to pay for work-related day care expenses. Eligible expenses include not only childcare, but also before and after school care programs, preschool, and summer day camp for children under age 13. The account can also be used for day care for a spouse or other adult dependent who lives with you and is physically or mentally incapable of self-care.

You can set aside up to \$5,000 per household per year. You can pay your dependent care provider directly from your FSA account, or you can submit claims to get reimbursed for eligible dependent care expenses you pay out of pocket.



**Estimate carefully!** You can't change your FSA election amount mid-year unless you experience a qualifying event. Money contributed to a dependent care FSA must be used for expenses incurred during the same plan year. Unspent funds will be forfeited.

# SAVE ON COMMUTE EXPENSES



## Transportation Savings Account—up to \$650 per month tax-free

Do you have out-of-pocket commuting expenses for public transportation, van pooling, or for worksite parking? If so, you can save on taxes by enrolling in our transportation savings account, administered by WEX Inc.

The account lets you set aside money—before it's taxed—through payroll deduction. You may enroll in or stop this program at any time. Money in the account can be used in future months or plan years.

Set aside up to \$325 per month for work-related parking expenses and up to \$325 per month for work-related commute expenses.

## CAN I OPT OUT OR CHANGE MY ELECTION IF MY WORK SCHEDULE OR LOCATION CHANGES?

Yes, contributions can be updated monthly but do require time before they are posted to your account as payroll must deduct the funds on your next pay period, then transmit the election to WEX.

You must place your order by the 10<sup>th</sup> of the month prior to when the funds will be used. For example, if you wish to contribute funds for December, your order must be placed by November 10<sup>th</sup>.

# 401(k) PROGRAM

WideOrbit's retirement savings plan lets you save for the future while taking advantage of company matching contributions and a full range of investment options.

We encourage you to take an active role in your account. Review the contribution amount and investment strategy to ensure they meet your needs. If you would like to make changes to any elections, prefer not to participate, or have questions about the Plan's provisions, log on to Fidelity at <http://www.401k.com> or call 800-835-5095.

## WideOrbit Match

**WideOrbit matches 50% of your deferrals up to 6% of your income (subject to IRS income cap).**

For example, to receive full match, defer 6% of your income; in this case WO will match 3%. WO contributions made quarterly.

## Summary

- **Automatic contributions.** All employees are auto enrolled at 6% within 30 days. Fidelity will mail materials to you directly about the account, including information to opt out.
- **Traditional pre-tax contributions.** This money is not taxed when it is put into your account, leaving you more money to work for you.
- **ROTH 401(k) after-tax contributions.** You can also choose to make ROTH contributions, but you won't pay income tax on contributions or earnings when you make withdrawals from your ROTH 401(k) balance, provided you have turned age 59.5 and have held your ROTH 401(k) account for at least five years.
- **Traditional after-tax contributions.** After-tax contributions offer an alternative to the pre-tax and ROTH 401(k) after-tax contributions that are already available.
- **The ROTH in-plan conversion.** Allows you to convert all or a portion of your pre-tax and traditional after-tax savings to ROTH money within the plan.
- **Brokerage Account.** Gives you expanded investment choices and the opportunity to actively manage your retirement contributions.

## 2025 contributions maximum (per IRS) limits

You can contribute a percentage of your pay to either option or both up to an annual IRS limit, which is \$23,500 in 2025. Employees age 50 and older can contribute an additional \$7,500 in "catch-up" contributions.



## WELLBEING & BALANCE

**“ THE KEY TO KEEPING YOUR BALANCE IS KNOWING WHEN YOU'VE LOST IT. ”**

### A Happier, Healthier You

Creating a healthy balance between work and play is a major factor in leading a happy and productive lifestyle, but it's not always easy.

We offer programs to help you:

- Manage stress, chemical dependency, mental health and family issues
- Maximize your physical well-being
- Take time to spend with family and friends, take care of personal business, or just have a little extra “me time”.

Taking care of yourself will help you be more effective in all areas of your life. Be sure to take advantage of these programs to stay at your best.

# EMPLOYEE ASSISTANCE PROGRAM (EAP)



## CONTACT THE EAP

### Phone

(800) 344-4222

### Website

[Employees.concernhealth.com](https://employees.concernhealth.com)

Employer code: wide

## Help for you and your household members

There are times when everyone needs a little help or advice, or assistance with a serious concern. The EAP through Concern can help you handle a wide variety of personal issue such as emotional health and substance abuse; parenting and childcare needs; financial coaching; legal consultation; and eldercare resources.

Best of all, contacting the EAP is completely confidential, free and available to any member of your immediate household.

## No cost EAP resources

The EAP is available around the clock to ensure you get access to the resources you need:

- Unlimited phone access 24/7
- In-person or video counseling for short-term issues; up to 5 visits per issue per year
- Unlimited web access to helpful articles, resources, and self-assessment tools.

### COUNSELING BENEFITS

- Difficulty with relationship
- Emotional distress
- Job stress
- Communication/ conflict issues
- Alcohol or drug problems
- Loss and death

### PARENTING & CHILDCARE

- Referrals to quality providers
- Family day care homes
- Infant centers and preschools
- Before/after school care
- 24-hour care

### FINANCIAL COACHING

- Money management
- Debt management
- Identity theft resolution
- Tax issues

### LEGAL CONSULTATION

- Referral to a local attorney
- Family issues (marital, child custody, adoption)
- Estate planning
- Landlord/tenant
- Immigration
- Personal Injury
- Consumer protection
- Real estate
- Bankruptcy

### ELDERCARE RESOURCES

- Help with finding appropriate resources to care for an elderly or disabled relative

### ONLINE RESOURCES

- Self-help tools to enhance resilience and well-being
- Useful information and links to various services and topics

# ADDITIONAL PROGRAMS



### Life Event Benefit

WideOrbit offers a Life Events Benefit to recognize major life events in your immediate family. WideOrbit will reimburse up to \$500 in receipts surrounding these events:

- Birth or adoption
- Marriage or ‘legal’ partnership
- Death in your immediate family
- Retirement

This is a taxable benefit and receipts should be submitted within 30 days of the life event. Please contact [hr@wideorbit.com](mailto:hr@wideorbit.com) with any questions. Note: Immediate family is defined as: Spouse, child (step), parent (step), grandparent (step).

### Telemedicine

Have you ever needed to see a doctor but couldn’t because of scheduling, holidays, weekends, travel or even bad weather? Cigna, BCBS of AL and Kaiser save you time and money by connecting you to a doctor via video chat from any location, 24/7, no appointment needed. You’ll be connected to a board-certified doctor who can diagnose and treat many common medical problems such as colds and flu, ear infections, skin problems, allergies, sinus problems, and more. General telemedicine visits are charged the same as general in office physician visits, consult your plan documents for further information on coverage levels.

Carrier	Website	Phone Number/App
Cigna (MD Live)	<a href="https://myCigna.com">myCigna.com</a>	(888) 726-3171
Kaiser	<a href="https://kp.org/mydoctor/videovisits">kp.org/mydoctor/videovisits</a>	KP Preventive Care App (Apple and Android)
BCBS of AL	<a href="https://Teladoc.com/Alabama">Teladoc.com/Alabama</a>	(800) 997-6196

### Travel Assistance

When you travel overseas for purposes other than work, you can rely on Mutual of Omaha. This program offers access to an international network of participating doctors, and hospitals for a broad range of medical care services. The center is available by phone 24/7 and is staffed with multilingual representatives who can help coordinate your medical care. Call (800) 856-9947 within the US or (312) 935-3658 outside of the US.

# TIME AWAY FROM WORK



## Time off

### Vacation Days

From date of hire, vacation is granted at a rate of 3 weeks (15 business days) per year. Hours are accrued at a rate of 10 hours per month from your date of hire. After your fourth (4) year of continuous employment, you will receive 4 weeks (20 business days) of vacation per year, accrued at a rate of 13.33 hours per month.

Part-time employees accrue vacation on a pro-rata basis based on the number of hours they are regularly scheduled to work each week. For example, an employee who is regularly scheduled to work 30 hours will earn vacation at 75% of the accrual rate for full-time employees. Temporary employees do not accrue vacation.

### Vacation Accrual Caps

An accrual cap is the total balance of unused, accrued vacation days you can accumulate. In the event an employee's accrued but unused vacation reaches the maximum accrual that is allowed, the employee will not earn any additional vacation benefits. Vacation benefits will cease to accrue until the employee takes enough time off to fall below the maximum accrual. Once the accrual balance is below the maximum, vacation benefits will begin accruing again.

### Vacation Carryover

All employees are encouraged to use their vacation benefits each year. Because vacation is accrued based on one's hire date, employees may carry over accrued but unused vacation from one calendar year to the next.

### Sick and Kin Care Time Off

Full time employees accrue 9 sick days per year, available for use at the beginning of each calendar year while they are actively employed at WideOrbit. Unused accrued paid sick leave will not be paid out upon separation of employment. Employees who start after January 1st will be able to use a prorated amount based on their projected accrual of one hour sick time per 30 hours worked.

# TIME AWAY FROM WORK - *continued*



## 2025 paid holidays

These holidays are recognized by WideOrbit as paid holidays for the calendar year 2025

New Year's Day	January 1 <sup>st</sup>
MLK Day	January 20 <sup>th</sup>
Presidents' Day	February 17 <sup>th</sup>
Memorial Day	May 26 <sup>th</sup>
Juneteenth	June 19 <sup>th</sup>
Independence Day	July 4 <sup>th</sup>
Labor Day	September 1 <sup>st</sup>
Thanksgiving	November 27 <sup>th</sup> – 28 <sup>th</sup>
Christmas	December 24 <sup>th</sup> – 26 <sup>th</sup>
New Year's Eve	December 31 <sup>st</sup>

## Time off

### Volunteer Time Off (VTO)

WideOrbit encourages employees to volunteer up to 8 hours (1 day) per calendar year (pro-rated for part-time employee); to become involved in their communities, lending their voluntary support to programs that positively impact the quality of life within these communities. Employees can volunteer up to 8 hours (1 day) per calendar year (pro-rated for part-time employee).

### Sabbatical Leave

The purpose of a sabbatical is to allow employees time to explore outside areas of interest, spend additional time with family or some other purpose without the responsibility of work.

WideOrbit offers two options for an extended Sabbatical leave.

- Option 1: After four years of continuous employment with WideOrbit, an employee receives the option of taking four weeks off at half pay.
- Option 2: After five years of continuous employment with WideOrbit, an employee receives the option of taking five weeks off at half pay.

Employees may use earned Vacation to receive full pay during their Sabbatical. To receive full pay during a Sabbatical, 4 hours of Vacation time (or .5 of a vacation day) will be debited for each business day out on Sabbatical.

WideOrbit respects the religious beliefs of its employees and will make every effort to accommodate absences for religious holidays providing they don't cause hardship to WideOrbit. Absences for religious holidays can be taken as vacation or as unpaid time off if you don't have vacation accrued.

For more information on Time Off, please refer to Employee Handbook.



# VOLUNTARY PLANS

## OUR VOLUNTARY PLANS

- Mutual of Omaha Voluntary Accident Insurance
- Mutual of Omaha Voluntary Critical Illness Insurance
- LegalShield Legal Assistance
- IDShield Identity Theft Protection
- Nationwide Pet Insurance

## You're unique—and so are your benefit needs

Voluntary benefits are optional coverages that help you customize your benefits package to your individual needs.

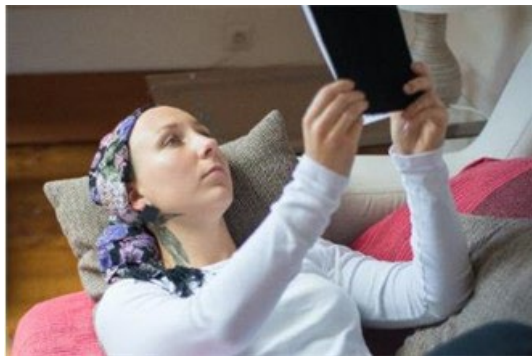
WideOrbit offers plans to help:

- replace income if you're injured or ill
- bridge the gap for special healthcare needs
- secure your identity, and help you manage legal issues
- save money on protection for your pets

You pay the entire cost for these plans, but rates may be more affordable than individual coverage. And you get the added convenience of paying through payroll deduction.

Voluntary benefits are just that: voluntary. You have the freedom and flexibility to choose the benefits that make sense for you and your family. Or, you don't have to sign up for voluntary benefits at all. The choice is yours.

# VOLUNTARY HEALTH-RELATED PLANS



## 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.

## Accident Insurance

Accident Insurance from Mutual of Omaha helps you pay for unexpected costs that can add up due to common injuries such as fractures, dislocations, burns, emergency room or urgent care visits, and physical therapy. If you or a covered family member has an accident, this plan pays a lump-sum, tax-free benefit. The amount of money depends on the type and severity of your injury and can be used any way you choose. You may even be eligible for a benefit if you receive a covered wellness screening such as blood tests, stress tests, or a chest x-ray.

## Critical Illness Insurance

Critical illness insurance from Mutual of Omaha can help fill a financial gap if you experience a serious illness such as cancer, heart attack or stroke. Upon diagnosis of a covered illness, a lump-sum, tax-free benefit is immediately paid to you. Use it to help cover medical costs, transportation, childcare, lost income, or any other need following a critical illness. You choose a benefit amount that fits your paycheck and can cover yourself and your family members if needed. You may even be eligible for a benefit if you receive a covered wellness screening such as blood tests, stress tests, or a chest x-ray.

If you and/or your family are enrolled in Critical Illness insurance, you are each eligible for a \$50 benefit for receiving a general health screening, such as your annual physical.

# PLANS TO KEEP YOU AND YOUR FAMILY SECURE



## CONTACT INFORMATION

See the Plan Contacts section of this guide or log on to MyBenefits.Life® for contact information.

## Identity Theft Protection

Identity theft is serious. Victims can spend hundreds, even thousands of dollars, and weeks of their own time to repair the damage done to their good names and credit records. The longer identity fraud goes undetected, the more expensive and difficult it becomes to resolve. For an affordable monthly premium, identity theft protection from IDShield helps protect your personal information through proactive monitoring, identity restoration, and resolution.

## Legal Program

Do you have an attorney on retainer? Most people don't, so our legal program offers you access to legal advice and even representation for an affordable monthly premium. Whether you need assistance reviewing a rental agreement, fighting a traffic ticket, creating a will, buying a house or navigating an IRS audit, legal coverage from LegalShield offers reputable attorney assistance for you and your family.

## Pet Insurance

Pets are members of the family too. When your pet gets sick, bills can add up faster than expected. Pet insurance prevents you from needing to weigh your pet's health against your bank account. Most plans offer coverage for costs associated with both accidents and illnesses—even medications. Nationwide provides coverage for this program. You can enroll in this program at any time.



## IMPORTANT PLAN INFORMATION

In this section, you'll find important plan information, including:

- Your medical, dental and vision benefit contributions for 2025
- Contact information for our benefit carriers and vendors
- A summary of the health plan notices you are entitled to receive annually, and where to find them
- A Benefits Glossary to help you understand important insurance terms.

# YOUR MONTHLY BENEFIT COSTS

The total amount that you pay for your benefits coverage depends on the plans you choose, how many dependents you cover, and for medical coverage, how much you earn. Your healthcare costs are deducted from your pay on a pre-tax basis — before federal, state, and social security taxes are calculated — so you pay less in taxes.

## MEDICAL, DENTAL & VISION

	Cigna PPO	Cigna HDHP	BCBS of AL PPO	BCBS of AL HDHP	Kaiser HMO	Kaiser HDHP	Cigna Dental Buy Up PPO	Cigna Dental Base PPO	VSP Vision
<b>EMPLOYEE ONLY</b>	\$255.70	\$138.51	\$255.70	\$138.51	\$132.97	\$121.30	\$23.26	\$14.49	\$3.31
<b>EMPLOYEE + SPOUSE</b>	\$533.96	\$352.44	\$533.96	\$352.44	\$340.00	\$340.00	\$49.81	\$32.04	\$6.07
<b>EMPLOYEE + CHILDREN</b>	\$536.70	\$342.36	\$536.70	\$342.36	\$330.00	\$330.00	\$59.36	\$38.18	\$6.21
<b>EMPLOYEE + FAMILY</b>	\$942.79	\$543.87	\$942.79	\$543.87	\$531.92	\$499.83	\$84.58	\$54.40	\$9.79

*Please note that unless your domestic partner is your tax dependent as defined by the IRS, contributions for domestic partner coverage must be made after-tax. Similarly, the company contribution toward coverage for your domestic partner and his/her dependents will be reported as taxable income on your W-2. Contact your tax advisor for more details on how this tax treatment applies to you. Notify WideOrbit if your domestic partner is your tax dependent.*

# VOLUNTARY LIFE & AD&D INSURANCE COSTS

If you elect voluntary coverage, your monthly premium rate is calculated based on your age and the amount of coverage. Use the tables below to estimate the premium amount that will be deducted from your paycheck. Spouse rates are based on the employee age.

## VOLUNTARY LIFE INSURANCE – MONTHLY RATE PER \$1,000 OF COVERAGE

AGE	EMPLOYEE	SPOUSE
<25	\$0.037	\$0.037
25-29	\$0.037	\$0.037
30-34	\$0.047	\$0.047
35-39	\$0.066	\$0.066
40-44	\$0.095	\$0.095
45-49	\$0.143	\$0.143
50-54	\$0.219	\$0.219
55-59	\$0.409	\$0.409
60-64	\$0.627	\$0.627
65-69	\$1.080	\$1.080
70-74	\$1.750	\$1.750
75-79	\$1.957	\$1.957
80+	\$3.091	\$3.091

## VOLUNTARY AD&D – MONTHLY RATE PER \$1,000 OF COVERAGE

Employee & Spouse	\$0.028
Child(ren)	\$0.028

To calculate your per paycheck AD&D cost, follow the same steps as the table above.

## CALCULATE YOUR LIFE INSURANCE COST

### 1. Desired Coverage (\$1,000 Increments)

You:	Spouse:
------	---------

### 2. Divide Step 1 by 1,000 =

You:	Spouse:
------	---------

### 3. Multiply Step 2 by Rate from Table =

You:	Spouse:
------	---------

### 4. Multiply Step 3 by 12 and divide by 24 =

You:	Spouse:
------	---------

### 5. Add You + Spouse from Step 4:

TOTAL COST PER PAYCHECK:
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## CHILD LIFE INSURANCE

COVERAGE AMOUNT	Rate per \$1,000 of coverage	Total Cost Per Paycheck
\$1,000	\$0.149	\$0.07
\$10,000	\$0.149	\$0.75

**Premium includes all eligible children.** Eligible children include dependent children under age 26 as long as you apply for and are approved for coverage for yourself.

# PLAN CONTACTS

## HELPFUL RESOURCES

### Benefits Portal

MyBenefits.Life®  
[wideorbit.mybenefits.life](http://wideorbit.mybenefits.life)

### Enrollment Website (ADP)

[workforcenow.adp.com](http://workforcenow.adp.com)  
Or via WideOrbit [SSO](#)

### Benefit Advocate

[wideorbit@alliant.com](mailto:wideorbit@alliant.com)  
(925) 287-7248

## MEDICAL, DENTAL & VISION

### Cigna PPO & HDHP

Policy # 00630947  
[Mycigna.com](http://Mycigna.com)  
[Find a Provider](#)  
(866) 494-2111

### Kaiser DHMO & HDHP

Policy # 603774  
[Kp.org](http://Kp.org)  
[Find a Provider](#)  
(800) 464-4000

### BCBS of AL PPO & HDHP

Policy # 97764  
[Bcbsal.org](http://Bcbsal.org)  
[Find a Provider](#)  
(800) 292-8868

### Cigna Dental Base & Buy Up PPO

Policy # 0630947  
[Mycigna.com](http://Mycigna.com)  
[Find a Provider](#)  
(866) 494-2111

### Guardian (VSP)

Policy # 00472074  
[vsp.com](http://vsp.com)  
[Find a Provider](#)  
800) 877-7195

## HEALTH SAVINGS ACCOUNT (HSA)

### Inspira Financial

Policy # 147606  
[Inspirafinancial.com](http://Inspirafinancial.com)  
(844) 729-3539

### Kaiser HSA

[Kp.org/healthexpense](http://Kp.org/healthexpense)  
Health Payment Services  
(877) 761-3399

## LIFE, AD&D, SHORT-TERM, & LONG-TERM DISABILITY

### Mutual of Omaha

Policy # G000BS83  
[Mutualofomaha.com](http://Mutualofomaha.com)  
(800) 775-6000

## EMPLOYEE ASSISTANCE PROGRAM EAP

### Concern

[Employees.concernhealth.com](http://Employees.concernhealth.com)  
Company code: wide  
(800) 344-4222

## FLEXIBLE SPENDING ACCOUNTS (FSA)

### WEX, Inc.

Policy # 28119  
[Wexinc.com](http://Wexinc.com)  
(866) 451-3399

## TRANSIT / PARKING ADMINISTRATION

### WEX, Inc.

Policy # 28119  
[Wexinc.com](http://Wexinc.com)  
(866) 451-3399

## VOLUNTARY ACCIDENT & CRITICAL ILLNESS

### Mutual of Omaha

Policy # G000BS83  
[Mutualofomaha.com](http://Mutualofomaha.com)  
(800) 775-6000

## PET INSURANCE

### Nationwide

Policy # G000BS83  
[Benefits.petinsurance.com](http://Benefits.petinsurance.com)  
(877) 738-7874

## 401(k)

### Fidelity

Policy # 29346  
[401k.com](http://401k.com)  
(800) 835-5095

## VOLUNTARY LEGAL AND IDENTITY THEFT PROTECTION

### LegalShield / IDShield

[Benefits.legalshield.com](http://Benefits.legalshield.com)

# 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).

### **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.

### **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.

# GLOSSARY

## -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.

# PLAN DOCUMENTS

Important documents for our health plan and retirement plan are available at the end of this brochure. Paper copies of these documents and notices are available if requested. If you would like a paper copy, please contact the Plan Administrator.

## **SUMMARY PLAN DESCRIPTIONS (SPD)**

The legal document for describing benefits provided under the plan as well as plan rights and obligations to participants and beneficiaries.

- WideOrbit, LLC Health and Welfare Plan

## **SUMMARY OF BENEFITS AND COVERAGE (SBC)**

A document required by the Affordable Care Act (ACA) that presents benefit plan features in a standardized format. SBC documents are available through MyBenefits.Life.

- Cigna PPO
- Cigna HDHP
- BCBS of AL PPO
- BCBS of AL HDHP
- Kaiser DHMO
- Kaiser HDHP

## **STATEMENT OF MATERIAL MODIFICATIONS**

This enrollment guide constitutes a Summary of Material Modifications (SMM) to the WideOrbit, Inc. Health and Welfare Plan. It is meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.

# IMPORTANT PLAN INFORMATION

## HEALTH PLAN NOTICES

These notices must be provided to plan participants on an annual basis and are available in the Annual Notices document, located at the end of this document:

- **Medicare Part D Notice:** Describes options to access prescription drug coverage for Medicare eligible individuals
- **Women's Health and Cancer Rights Act:** Describes benefits available to those that will or have undergone a mastectomy
- **Newborns' and Mothers' Health Protection Act:** Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery
- **HIPAA Notice of Special Enrollment Rights:** Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment
- **HIPAA Notice of Privacy Practices:** Describes how health information about you may be used and disclosed
- **Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP):** Describes availability of premium assistance for Medicaid eligible dependents.

## COBRA CONTINUATION COVERAGE

You and/or your dependents may have the right to continue coverage after you lose eligibility under the terms of our health plan. Upon enrollment, you and your dependents receive a COBRA Initial Notice that outlines the circumstances under which continued coverage is available and your obligations to notify the plan when you or your dependents experience a qualifying event. Please review this notice carefully to make sure you understand your rights and obligations.

# Medicare Part D Notice

## Important Notice from WideOrbit LLC About Your Prescription Drug Coverage and Medicare

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. WideOrbit LLC has determined that the prescription drug coverage offered by the WideOrbit LLC Health and Welfare Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

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### When Can You Join A Medicare Drug Plan?

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

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

### What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your WideOrbit LLC coverage **will not** be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under WideOrbit LLC Health and Welfare Plan is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your WideOrbit LLC prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

## When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with WideOrbit LLC and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

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

## For More Information About Your Options Under Medicare Prescription Drug Coverage...

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

For more information about Medicare prescription drug coverage:

- Visit [medicare.gov](https://www.medicare.gov)
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at [socialsecurity.gov](https://www.socialsecurity.gov), or call them at 800-772-1213 (TTY 800-325-0778).

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

**Date:** January 1, 2025  
**Name of Entity/Sender:** WideOrbit LLC  
**Contact-Position/Office:** Human Resources  
**Address:** 1160 Battery Street Suite 300, San Francisco, CA 94111  
**Phone Number:** (415) 675-6700

## Women's Health and Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, please check your plan documents to see what deductibles and coinsurance apply. If you would like more information on WHCRA benefits, call your plan administrator at (415) 675-6700.

## Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator at (415) 675-6700.

## HIPAA Notice of Special Enrollment Rights

If you decline enrollment in WideOrbit LLC's health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in WideOrbit LLC's health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 31 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 31 day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in WideOrbit LLC's health plan if you become eligible for a state premium assistance program under

Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan. Any other currently covered dependents may also switch to the new plan in which you enroll.

## Availability of Privacy Practices Notice

We maintain the HIPAA Notice of Privacy Practices for WideOrbit LLC describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting your plan administrator at (415) 675-6700.

## Notice of Choice of Providers

The Kaiser HMO generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Kaiser at (800) 464-4000.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Kaiser or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Kaiser at (800) 464-4000.

# Premium Assistance under Medicaid and the Children’s Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit [www.healthcare.gov](http://www.healthcare.gov).

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or [www.insurekidsnow.gov](http://www.insurekidsnow.gov) to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at [www.askebsa.dol.gov](http://www.askebsa.dol.gov) or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility—

<b>ALABAMA – Medicaid</b> Website: <a href="http://myalhipp.com/">http://myalhipp.com/</a>   Phone: 1-855-692-5447
<b>ALASKA – Medicaid</b> The AK Health Insurance Premium Payment Program   Website: <a href="http://myakhipp.com/">http://myakhipp.com/</a>   Phone: 1-866-251-4861 Email: <a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a>   Medicaid Eligibility: <a href="https://health.alaska.gov/dpa/Pages/default.aspx">https://health.alaska.gov/dpa/Pages/default.aspx</a>
<b>ARKANSAS – Medicaid</b> Website: <a href="http://myarhipp.com/">http://myarhipp.com/</a>   Phone: 1-855-MyARHIPP (855-692-7447)
<b>CALIFORNIA – Medicaid</b> Health Insurance Premium Payment (HIPP) Program website: <a href="http://dhcs.ca.gov/hipp">http://dhcs.ca.gov/hipp</a> Phone: 916-445-8322   Fax: 916-440-5676   Email: <a href="mailto:hipp@dhcs.ca.gov">hipp@dhcs.ca.gov</a>
<b>COLORADO – Health First Colorado (Colorado’s Medicaid Program) &amp; Child Health Plan Plus (CHP+)</b> Health First Colorado Website: <a href="https://www.healthfirstcolorado.com/">https://www.healthfirstcolorado.com/</a> Health First Colorado Member Contact Center: 1-800-221-3943   State Relay 711 CHP+: <a href="https://hcpf.colorado.gov/child-health-plan-plus">https://hcpf.colorado.gov/child-health-plan-plus</a> CHP+ Customer Service: 1-800-359-1991   State Relay 711 Health Insurance Buy-In Program (HIBI): <a href="https://www.mycohibi.com/">https://www.mycohibi.com/</a>   HIBI Customer Service: 1-855-692-6442
<b>FLORIDA – Medicaid</b> Website: <a href="https://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html">https://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html</a> Phone: 1-877-357-3268

**GEORGIA – Medicaid**

GA HIPP Website: <https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp>

Phone: 678-564-1162, press 1

GA CHIPRA Website: <https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra> | Phone: 678-564-1162, press 2

**INDIANA – Medicaid**

Health Insurance Premium Payment Program All other Medicaid Website: <https://www.in.gov/medicaid/> | <http://www.in.gov/fssa/dfr/> | Family and Social Services Administration Phone: (800) 403-0864 | Member Services Phone: (800) 457-4584

**IOWA – Medicaid and CHIP (Hawki)**

Medicaid Website: [Iowa Medicaid | Health & Human Services](#) | Medicaid Phone: 1-800-338-8366

Hawki Website: [Hawki - Healthy and Well Kids in Iowa | Health & Human Services](#) | Hawki Phone: 1-800-257-8563

HIPP Website: [Health Insurance Premium Payment \(HIPP\) | Health & Human Services \(iowa.gov\)](#)

HIPP Phone: 1-888-346-9562

**KANSAS – Medicaid**

Website: <https://www.kancare.ks.gov/> | Phone: 1-800-792-4884 | HIPP Phone: 1-800-967-4660

**KENTUCKY – Medicaid**

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)

Website: <https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx> | Phone: 1-855-459-6328

Email: [KIHIPPPROGRAM@ky.gov](mailto:KIHIPPPROGRAM@ky.gov)

KCHIP Website: <https://kynect.ky.gov> | Phone: 1-877-524-4718

Kentucky Medicaid Website: <https://chfs.ky.gov/agencies/dms>

**LOUISIANA – Medicaid**

Website: [www.medicicaid.la.gov](http://www.medicicaid.la.gov) or [www.ldh.la.gov/lahipp](http://www.ldh.la.gov/lahipp)

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

**MAINE – Medicaid**

Enrollment Website: [https://www.mymaineconnection.gov/benefits/s/?language=en\\_US](https://www.mymaineconnection.gov/benefits/s/?language=en_US)

Phone: 1-800-442-6003 | TTY: Maine relay 711

Private Health Insurance Premium Webpage: <https://www.maine.gov/dhhs/ofi/applications-forms>

Phone: 800-977-6740 | TTY: Maine relay 711

**MASSACHUSETTS – Medicaid and CHIP**

Website: <https://www.mass.gov/masshealth/pa> | Phone: 1-800-862-4840 | TTY: 711

Email: [masspremassistance@accenture.com](mailto:masspremassistance@accenture.com)

**MINNESOTA – Medicaid**

Website: <https://mn.gov/dhs/health-care-coverage/> | Phone: 1-800-657-3672

**MISSOURI – Medicaid**

Website: <http://www.dss.mo.gov/mhd/participants/pages/hipp.htm> | Phone: 573-751-2005

**MONTANA – Medicaid**

Website: <http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>

Phone: 1-800-694-3084 | email: [HSHSHIPPPProgram@mt.gov](mailto:HSHSHIPPPProgram@mt.gov)

**NEBRASKA – Medicaid**

Website: <http://www.ACCESSNebraska.ne.gov>

Phone: 1-855-632-7633 | Lincoln: 402-473-7000 | Omaha: 402-595-1178

**NEVADA – Medicaid**

Medicaid Website: <http://dhcfp.nv.gov> | Medicaid Phone: 1-800-992-0900

**NEW HAMPSHIRE – Medicaid**

Website: <https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program>

Phone: 603-271-5218 | Toll-free number for the HIPP program: 1-800-852-3345, ext. 15218

Email: [DHHS.ThirdPartyLiabi@dhhs.nh.gov](mailto:DHHS.ThirdPartyLiabi@dhhs.nh.gov)

**NEW JERSEY – Medicaid and CHIP**

Medicaid Website: <http://www.state.nj.us/humanservices/dmahs/clients/medicaid/> | Phone: 800-356-1561

CHIP Premium Assistance Phone: 609-631-2392 | CHIP Website: <http://www.nifamilycare.org/index.html>

CHIP Phone: 1-800-701-0710 (TTY: 711)

**NEW YORK – Medicaid**

Website: [https://www.health.ny.gov/health\\_care/medicaid/](https://www.health.ny.gov/health_care/medicaid/) | Phone: 1-800-541-2831

**NORTH CAROLINA – Medicaid**

Website: <https://medicaid.ncdhhs.gov/> | Phone: 919-855-4100

**NORTH DAKOTA – Medicaid**

Website: <https://www.hhs.nd.gov/healthcare> | Phone: 1-866-614-6005

**OKLAHOMA – Medicaid and CHIP**

Website: <http://www.insureoklahoma.org> | Phone: 1-888-365-3742

**OREGON – Medicaid and CHIP**

Website: <http://healthcare.oregon.gov/Pages/index.aspx> | Phone: 1-800-699-9075

**PENNSYLVANIA – Medicaid and CHIP**

Website: <https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html> | Phone: 1-800-692-7462

CHIP Website: [Children's Health Insurance Program \(CHIP\) \(pa.gov\)](#) | CHIP Phone: 1-800-986-KIDS (5437)

**RHODE ISLAND – Medicaid and CHIP**

Website: <http://www.eohhs.ri.gov/> | Phone: 1-855-697-4347 or 401-462-0311 (Direct RItE Share Line)

**SOUTH CAROLINA – Medicaid**

Website: <https://www.scdhhs.gov> | Phone: 1-888-549-0820

**SOUTH DAKOTA – Medicaid**

Website: <http://dss.sd.gov> | Phone: 1-888-828-0059

**TEXAS – Medicaid**

Website: [Health Insurance Premium Payment \(HIPP\) Program | Texas Health and Human Services](#)

Phone: 1-800-440-0493

**UTAH – Medicaid and CHIP**

Utah's Premium Partnership for Health Insurance (UPP) Website: <https://medicaid.utah.gov/upp/>

Email: [upp@utah.gov](mailto:upp@utah.gov) | Phone: 1-888-222-2542 |

Adult Expansion Website: <https://medicaid.utah.gov/expansion/>

Utah Medicaid Buyout Program Website: <https://medicaid.utah.gov/buyout-program/>

CHIP Website: <https://chip.utah.gov/>

**VERMONT – Medicaid**

Website: [Health Insurance Premium Payment \(HIPP\) Program | Department of Vermont Health Access](#)

Phone: 1-800-250-8427

**VIRGINIA – Medicaid and CHIP**

Website: <https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select> or

<https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs>

Medicaid/CHIP Phone: 1-800-432-5924

**WASHINGTON – Medicaid**

Website: <https://www.hca.wa.gov/> | Phone: 1-800-562-3022

**WEST VIRGINIA – Medicaid and CHIP**

Website: <https://dhhr.wv.gov/bms/> or <http://mywvhipp.com/>

Medicaid Phone: 304-558-1700 | CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

**WISCONSIN – Medicaid and CHIP**

Website: <https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm> | Phone: 1-800-362-3002

**WYOMING – Medicaid**

Website: <https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/> | Phone: 1-800-251-1269

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

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

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

## ACA Disclaimer

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 8.39% in 2024 (9.02% in 2025) of your modified adjusted household income.

# Illinois Consumer Coverage Disclosure Act

The Consumer Coverage Disclosure Act requires employers to notify Illinois employees which of the Essential Health Benefits listed below are and are not covered by their employer-provided group health insurance coverage. Refer to the [Access to Care and Treatment Benchmark Plan](#) and the [Pediatric Dental Plan](#) to reference the pages listed below.

<b>Employer Name:</b>	WideOrbit
<b>Employer State of Situs:</b>	California
<b>Name of Issuer:</b>	Cigna
<b>Plan Marketing Name:</b>	Cigna Medical PPO Plan
<b>Plan Year:</b>	2025

## Ten (10) Essential Health Benefit (EHB) Categories:

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services
- Hospitalization (like surgery and overnight stays)
- Laboratory services
- Mental health and substance use disorder (MH/SUD) services, including behavioral health treatment (this includes counseling and psychotherapy)
- Pediatric services, including oral and vision care (but adult dental and vision coverage aren't essential health benefits)
- Pregnancy, maternity, and newborn care (both before and after birth)
- Prescription drugs
- Preventive and wellness services and chronic disease management
- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)

## 2020-2023 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)

Item	EHB Benefit	EHB Category	Benchmark Page # Reference	Employer Plan Covered Benefit?
1	Accidental Injury—Dental	Ambulatory	Pgs. 10 & 17	Yes
2	Allergy Injections and Testing	Ambulatory	Pg. 11	Yes
3	Bone anchored hearing aids	Ambulatory	Pgs. 17 & 35	No
4	Durable Medical Equipment	Ambulatory	Pg. 13	Yes
5	Hospice	Ambulatory	Pg. 28	Yes
6	Infertility (Fertility) Treatment	Ambulatory	Pgs. 23–24	No
7	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Ambulatory	Pg. 21	Yes
8	Outpatient Surgery Physician/Surgical Services (Ambulatory Patient Services)	Ambulatory	Pgs. 15–16	Yes
9	Private-Duty Nursing	Ambulatory	Pgs. 17 & 34	No
10	Prosthetics/Orthotics	Ambulatory	Pg. 13	Yes
11	Sterilization (vasectomy men)	Ambulatory	Pg. 10	Yes
12	Temporomandibular Joint Disorder (TMJ)	Ambulatory	Pgs. 13 & 24	No
13	Emergency Room Services (Includes MH/SUD Emergency)	Emergency services	Pg. 7	Yes
14	Emergency Transportation/ Ambulance	Emergency services	Pgs. 4 & 17	Yes
15	Bariatric Surgery (Obesity)	Hospitalization	Pg. 21	Yes
16	Breast Reconstruction After Mastectomy	Hospitalization	Pgs. 24–25	Yes

17	Reconstructive Surgery	Hospitalization	Pgs. 25–26 & 35	Yes
18	Inpatient Hospital Services (e.g., Hospital Stay)	Hospitalization	Pg. 15	Yes
19	Skilled Nursing Facility	Hospitalization	Pg. 21	Yes
20	Transplants—Human Organ Transplants (Including transportation & lodging)	Hospitalization	Pgs. 18 & 31	Yes
21	Diagnostic Services	Laboratory services	Pgs. 6 & 12	Yes
22	Intranasal opioid reversal agent associated with opioid prescriptions	MH/SUD	Pg. 32	Yes
23	Mental (Behavioral) Health Treatment (Including Inpatient Treatment)	MH/SUD	Pgs. 8–9, 21	Yes
24	Opioid Medically Assisted Treatment (MAT)	MH/SUD	Pg. 21	Yes
25	Substance Use Disorders (Including Inpatient Treatment)	MH/SUD	Pgs. 9 & 21	Yes
26	Tele-Psychiatry	MH/SUD	Pg. 11	Yes
27	Topical Anti-Inflammatory acute and chronic pain medication	MH/SUD	Pg. 32	Yes
28	Pediatric Dental Care	Pediatric Oral and Vision Care	See AllKids Pediatric Dental Document	No
29	Pediatric Vision Coverage	Pediatric Oral and Vision Care	Pgs. 26–27	No
30	Maternity Service	Pregnancy, Maternity, and Newborn Care	Pgs. 8 & 22	Yes
31	Outpatient Prescription Drugs	Prescription drugs	Pgs. 29–34	Yes
32	Colorectal Cancer Examination and Screening	Preventive and Wellness Services	Pgs. 12 & 16	Yes
33	Contraceptive/Birth Control Services	Preventive and Wellness Services	Pgs. 13 & 16	Yes
34	Diabetes Self-Management Training and Education	Preventive and Wellness Services	Pgs. 11 & 35	Yes
35	Diabetic Supplies for Treatment of Diabetes	Preventive and Wellness Services	Pgs. 31–32	No
36	Mammography—Screening	Preventive and Wellness Services	Pgs. 12, 15 & 24	Yes
37	Osteoporosis—Bone Mass Measurement	Preventive and Wellness Services	Pgs. 12 & 16	Yes
38	Pap Tests/ Prostate—Specific Antigen Tests/ Ovarian Cancer Surveillance Test	Preventive and Wellness Services	Pg. 16	Yes
39	Preventive Care Services	Preventive and Wellness Services	Pg. 18	Yes
40	Sterilization (women)	Preventive and Wellness Services	Pgs. 10 & 19	Yes
41	Chiropractic & Osteopathic Manipulation	Rehabilitative and Habilitative Services and Devices	Pgs. 12–13	Yes
42	Habilitative and Rehabilitative Services	Rehabilitative and Habilitative Services and Devices	Pgs. 8, 9, 11, 12, 22 & 35	Yes

*Special Note: Under Pub. Act 102-0104, eff. July 22, 2021, any EHBs listed above that are clinically appropriate and medically necessary to deliver via telehealth services must be covered in the same manner as when those EHBs are delivered in person.*

<b>Employer Name:</b>	WideOrbit
<b>Employer State of Situs:</b>	California
<b>Name of Issuer:</b>	Cigna
<b>Plan Marketing Name:</b>	Cigna Medical HDHP Plan
<b>Plan Year:</b>	2025

**Ten (10) Essential Health Benefit (EHB) Categories:**

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
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- Hospitalization (like surgery and overnight stays)
- Laboratory services
- Mental health and substance use disorder (MH/SUD) services, including behavioral health treatment (this includes counseling and psychotherapy)
- Pediatric services, including oral and vision care (but adult dental and vision coverage aren't essential health benefits)
- Pregnancy, maternity, and newborn care (both before and after birth)
- Prescription drugs
- Preventive and wellness services and chronic disease management
- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)

**2020-2023 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)**

<b>Item</b>	<b>EHB Benefit</b>	<b>EHB Category</b>	<b>Benchmark Page # Reference</b>	<b>Employer Plan Covered Benefit?</b>
1	Accidental Injury—Dental	Ambulatory	Pgs. 10 & 17	Yes
2	Allergy Injections and Testing	Ambulatory	Pg. 11	Yes
3	Bone anchored hearing aids	Ambulatory	Pgs. 17 & 35	No
4	Durable Medical Equipment	Ambulatory	Pg. 13	Yes
5	Hospice	Ambulatory	Pg. 28	Yes
6	Infertility (Fertility) Treatment	Ambulatory	Pgs. 23–24	No
7	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Ambulatory	Pg. 21	Yes
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16	Breast Reconstruction After Mastectomy	Hospitalization	Pgs. 24–25	Yes
17	Reconstructive Surgery	Hospitalization	Pgs. 25–26 & 35	Yes
18	Inpatient Hospital Services (e.g., Hospital Stay)	Hospitalization	Pg. 15	Yes
19	Skilled Nursing Facility	Hospitalization	Pg. 21	Yes
20	Transplants—Human Organ Transplants (Including transportation & lodging)	Hospitalization	Pgs. 18 & 31	Yes
21	Diagnostic Services	Laboratory services	Pgs. 6 & 12	Yes

22	Intranasal opioid reversal agent associated with opioid prescriptions	MH/SUD	Pg. 32	Yes
23	Mental (Behavioral) Health Treatment (Including Inpatient Treatment)	MH/SUD	Pgs. 8–9, 21	Yes
24	Opioid Medically Assisted Treatment (MAT)	MH/SUD	Pg. 21	Yes
25	Substance Use Disorders (Including Inpatient Treatment)	MH/SUD	Pgs. 9 & 21	Yes
26	Tele-Psychiatry	MH/SUD	Pg. 11	Yes
27	Topical Anti-Inflammatory acute and chronic pain medication	MH/SUD	Pg. 32	Yes
28	Pediatric Dental Care	Pediatric Oral and Vision Care	See AllKids Pediatric Dental Document	No
29	Pediatric Vision Coverage	Pediatric Oral and Vision Care	Pgs. 26–27	No
30	Maternity Service	Pregnancy, Maternity, and Newborn Care	Pgs. 8 & 22	Yes
31	Outpatient Prescription Drugs	Prescription drugs	Pgs. 29–34	Yes
32	Colorectal Cancer Examination and Screening	Preventive and Wellness Services	Pgs. 12 & 16	Yes
33	Contraceptive/Birth Control Services	Preventive and Wellness Services	Pgs. 13 & 16	Yes
34	Diabetes Self-Management Training and Education	Preventive and Wellness Services	Pgs. 11 & 35	Yes
35	Diabetic Supplies for Treatment of Diabetes	Preventive and Wellness Services	Pgs. 31–32	No
36	Mammography—Screening	Preventive and Wellness Services	Pgs. 12, 15 & 24	Yes
37	Osteoporosis—Bone Mass Measurement	Preventive and Wellness Services	Pgs. 12 & 16	Yes
38	Pap Tests/ Prostate—Specific Antigen Tests/ Ovarian Cancer Surveillance Test	Preventive and Wellness Services	Pg. 16	Yes
39	Preventive Care Services	Preventive and Wellness Services	Pg. 18	Yes
40	Sterilization (women)	Preventive and Wellness Services	Pgs. 10 & 19	Yes
41	Chiropractic & Osteopathic Manipulation	Rehabilitative and Habilitative Services and Devices	Pgs. 12–13	Yes
42	Habilitative and Rehabilitative Services	Rehabilitative and Habilitative Services and Devices	Pgs. 8, 9, 11, 12, 22 & 35	Yes

*Special Note: Under Pub. Act 102-0104, eff. July 22, 2021, any EHBs listed above that are clinically appropriate and medically necessary to deliver via telehealth services must be covered in the same manner as when those EHBs are delivered in person.*

## The ‘No Surprises’ Rules

The “No Surprises” rules protect you from surprise medical bills in situations where you can’t easily choose a provider who’s in your health plan network. This is especially common in an emergency situation, when you may get care from out-of-network providers. Out-of-network providers or emergency facilities may ask you to sign a notice and consent form before providing certain services after you’re no longer in need of emergency care. These are called “post-stabilization services.” You shouldn’t get this notice and consent form if you’re getting emergency services other than post-stabilization services. You may also be asked to sign a notice and consent form if you schedule certain non-emergency services with an out-of-network provider at an in-network hospital or ambulatory surgical center.

The notice and consent form informs you about your protections from unexpected medical bills, gives you the option to give up those protections and pay more for out-of-network care, and provides an estimate of what your out-of-network care might cost. You aren’t required to sign the form and shouldn’t sign the form if you didn’t have a choice of health care provider or facility before scheduling care. If you don’t sign, you may have to reschedule your care with a provider or facility in your health plan’s network.

[View a sample notice and consent form](#) (PDF).

This applies to you if you’re a participant, beneficiary, enrollee, or covered individual in a group health plan or group or individual health insurance coverage, including a Federal Employees Health Benefits (FEHB) plan.

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