2026 Benefits

# EXPLORE YOUR BENEFITS

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## MEDICAL, DENTAL & VISION



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## IMPORTANT PLAN INFORMATION



**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

## 2026 BENEFITS

January 1, 2026 through December 31, 2026

## 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, Brinton Business Ventures Inc 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 full-time employee working 30 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 (you must live together and meet all criteria outlined in the domestic partner definition.
- Natural, adopted or step children up to age 26. Including children of domestic partners.
- 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.

## When you can enroll

- 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 60 days of hire as long as you enroll within 31 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

*Click to play video*


## LIFE HAPPENS

A change in your life may allow you to update your benefit choices. Watch the video for a quick take on your options.

Outside of open enrollment, 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.

# HAVE QUESTIONS ABOUT YOUR BENEFITS?

*Click to play video*


## CONTACT YOUR ALLIANT BENEFIT ADVOCATE

### Email

**benefitsupport@alliant.com**

### Phone

**(800) 489-1390**

### Hours

**Monday - Friday**
**8 a.m. to 8 p.m. ET**
**5 a.m. to 5 p.m. PT**

## 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.


# HEALTHCARE

## MAKE TIME FOR HEALTH

### OUR COMMITMENT

We believe that our employees should have access to healthcare coverage that promotes preventive care and helps cover the cost of illness.

Eligible employees and their eligible dependents can enroll in medical, dental, and vision coverage through the Brinton Business Ventures Inc benefits program.

### Medical

We offer 2 medical plans. Preventive care is fully covered if obtained in-network. Your costs for other services will depend on which plan you choose. Review the network provider information and out-of-pocket costs such as deductible, coinsurance and prescription drugs so you can understand how the plan works.

### Dental

We now offer 2 dental plans. Some people don't like going to the dentist, but no one likes big dental bills. Regular checkups and cleanings are fully covered and can identify issues before they become serious. And if you do need dental services, insurance helps cover the cost for fillings, gum disease, and more.

### Vision

An eye exam can uncover health conditions you may not know you have, such as glaucoma, or even high blood pressure. Our vision plan helps cover the cost of eye exams, eyeglasses, and contact lenses to ensure you're seeing and feeling your best.

# MEDICAL

## OUR PLANS

- Premera Your Future HSA $3,400
- Premera Your Choice PPO $2,500

## 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

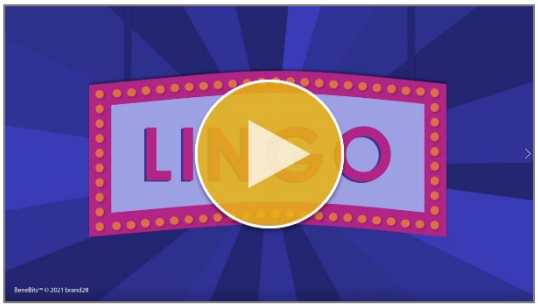
How much is the monthly payroll deduction? Do you have to meet a deductible? What is the out-of-pocket maximum? How much of the cost is covered by the plan? How much are any copayments for office visits, prescriptions, etc. All of these factors together affect your total cost for healthcare.

# MEDICAL

## WORDS TO KNOW

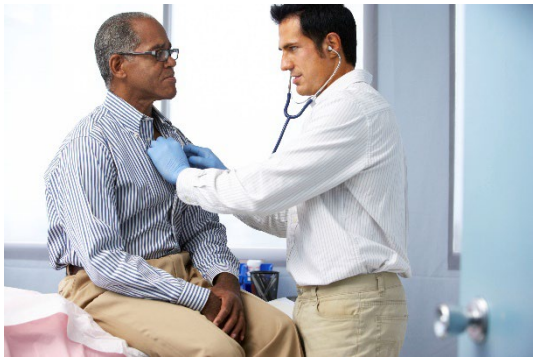
Can you beat the Health Lingo game? Learn the words that will help you understand how your plan works.

*Click to play video*




- **DEDUCTIBLE:** The amount of healthcare costs you have to pay for with your own money before your plan will start to pay anything.
- **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 eligible expenses for the rest of the plan year.
- **COINSURANCE:** After the deductible (if applicable), you and the plan share the cost. For example, if the plan pays 80%, your coinsurance share of the cost is 20%. You are billed for your coinsurance after your visit.
- **COPAY:** A set fee you pay instead of coinsurance for some healthcare services, for example, a doctor's office visit. You pay the copay at the time you receive care.
- **IN-NETWORK / OUT-OF-NETWORK:** In-network services will always be the lowest cost option. Out-of-network services will cost more, or may not be covered. Check your plan's website to find doctors, hospitals, labs, and pharmacies that belong to the network.

# WHICH PLAN IS RIGHT FOR YOU?



## Consider a PPO (Preferred Provider Organization) if:

- You want to be able to see any provider, even a specialist, without a referral
- You are willing to pay more to see out-of-network providers.

### Plans To Consider

- Premera Your Choice PPO $2,500

## Consider a High Deductible Health Plan (HDHP) if:

- You want to be able to see any provider, even a specialist, without a referral
- You are willing to pay more to see out-of-network providers
- You want tax-free savings on your healthcare costs
- You want to build a savings account for future healthcare costs for you and your eligible family members
- You want an extra way to add to your retirement savings.

### Plans To Consider

- Premera Your Future HSA $3,400

# Premera Blue Cross
## YOUR FUTURE HSA $3,400

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

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Annual Deductible** *(embedded)* | $3,400 employee coverage<br>$6,800 family coverage | $6,800 employee coverage<br>$13,600 family coverage |
| | *Offset by HSA Contributions* | |
| **Annual Out-of-Pocket Maximum** | $6,550 employee coverage<br>$13,100 family coverage | $13,100 employee coverage<br>$26,200 family coverage |
| **OFFICE VISIT** | | |
| Primary Provider | Plan pays 70% after deductible | Plan pays 50% after deductible |
| Specialist | Plan pays 70% after deductible | Plan pays 50% after deductible |
| Virtual Visit | Plan pays 70% after deductible | Not Covered |
| **Preventive Services** | Plan pays 100% | Not Covered |
| Seasonal Immunization | Plan pays 100% | Plan pays 100% |
| **Chiropractic** | Plan pays 70% after deductible<br>*(up to 20 visits per calendar year)* | Plan pays 50% after deductible<br>*(in-network limitations apply)* |
| **Lab and X-ray** | Plan pays 70% after deductible | Plan pays 50% after deductible |
| **Urgent Care** | Plan pays 70% after deductible | Plan pays 50% after deductible |
| **Emergency Room** | Plan pays 70% after deductible | |
| **Inpatient Hospitalization** | Plan pays 70% after deductible | Plan pays 50% after deductible |
| **Outpatient Surgery** | Plan pays 70% after deductible | Plan pays 50% after deductible |
| **PRESCRIPTION DRUGS** | | |
| Generic | $15 after deductible | $15 after deductible |
| Brand Name | $35 after deductible | $35 after deductible |
| Non-preferred Brand | $70 after deductible | $70 after deductible |
| Supply Limit | Up to 90 days, copay per 30 day supply | |
| **Mail Order** | | |
| Generic | $37.50 after deductible | Not Covered |
| Brand Name | $87.50 after deductible | Not Covered |
| Non-preferred Brand | $175 after deductible | Not Covered |
| Supply Limit | 90 days | |

# Premera Blue Cross
## YOUR CHOICE PPO $2,500

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

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Annual Deductible** *(embedded)* | $2,500 per individual<br>$5,000 family limit | $5,000 per individual<br>$10,000 family limit |
| **Annual Out-of-Pocket Maximum** | $7,000 per individual<br>$14,000 family limit | $14,000 per individual<br>$28,000 family limit |
| **OFFICE VISIT** | | |
| PCP/Specialist | 1st 3 visits: 100%<br>Thereafter: 80% after deductible | Plan pays 50% after deductible |
| Virtual Visit | $10 copay then plan pays 100% | Not Covered |
| **Preventive Services** | Plan pays 100% | Not Covered |
| Seasonal Immunization | Plan pays 100% | Plan pays 100% |
| **Chiropractic** | Shared with Office Visit<br>*(up to 20 visits per calendar year)* | Plan pays 50% after deductible<br>*(in-network limitations apply)* |
| **Lab and X-ray** | Plan pays 80% after deductible | Plan pays 50% after deductible |
| **Urgent Care** | Freestanding Center: 1st 2 visits: 100%<br>Thereafter: 80% after deductible<br>Hospital-based: $250 copay/visit, then 80% after deductible | Freestanding Center: Plan pays 50% after deductible<br>Hospital-based: $250 copay/visit, then 80% after deductible |
| **Emergency Room** | $250 copay then plan pays 80% after deductible *(copay waived if admitted)* | |
| **Inpatient Hospitalization** | $250 copay then 100%; facility fee<br>Plan pays 80% after deductible; provider services | Plan pays 50% after deductible |
| **Outpatient Surgery** | Plan pays 80% after deductible | Plan pays 50% after deductible |
| **PRESCRIPTION DRUGS** | | |
| Generic | $25 copay then plan pays 100% | $25 copay then plan pays 60% |
| Brand Name | $50 copay then plan pays 100% | $50 copay then plan pays 60% |
| Non-preferred Brand | $100 copay then plan pays 100% | $100 copay then plan pays 60% |
| Supply Limit | 30 days | |
| **Mail Order** | | |
| Generic | $62.50 copay then plan pays 100% | Not Covered |
| Brand Name | $125 copay then plan pays 100% | |
| Non-preferred Brand | $250 copay then plan pays 100% | |
| Supply Limit | 90 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 Premera HSA $3,400 Plan.
2. Not enrolled in other non-HDHP medical coverage, including Medicare, Medicaid, or Tricare.
3. Not a tax dependent.

## 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 CMS HSA works

Your HSA account is set up automatically after you enroll.

To help you get started, Brinton Business Ventures Inc makes a contribution to your HSA:

**Individual**: $600 annually
**Family**: $1,200 annually

You can contribute up to the limit set by the IRS:

**Individual**: $4,400* per year (2026)
**Family**: $8,750* per year (2026)

**includes BBV Inc. contributions*

**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

# DENTAL

## OUR PLANs

- Premera Dental $50/$150
- PPO 50D/1500 w/ Ortho

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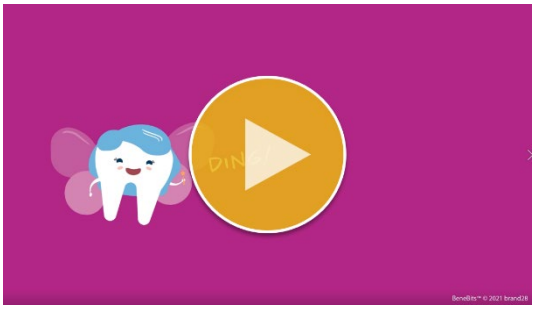


## Why sign up for Dental coverage?

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** for children and adults

# Premera Blue Cross
## Dental PPO $50/$1,000 Plan

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

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Annual Deductible** | $50 per individual<br>$150 per family | Combined with In-Network |
| **Annual Plan Maximum** | $1,000 | Combined with In-Network |
| **Waiting Period** | None | |
| **Diagnostic & Preventive** | Plan pays 100% | Plan pays 100% |
| **BASIC SERVICES** | | |
| Fillings | Plan pays 90% after deductible | Plan pays 80% after deductible |
| Root Canals | Plan pays 90% after deductible | Plan pays 80% after deductible |
| Periodontics | Plan pays 90% after deductible | Plan pays 80% after deductible |
| **Major Services** | Plan pays 60% after deductible | Plan pays 50% after deductible |
| **Orthodontia** | Not Covered | Not Covered |
| Adults | Not Covered | Not Covered |
| Dependent Children | Not Covered | Not Covered |
| Full-time Students | Not Covered | Not Covered |

***Provider Choice:*** *You may seek care from any licensed provider. However, when you visit an in-network dentist, you can maximize your benefit plan with access to lower out-of-pocket expenses. If you visit an out-of-network dentist you may be responsible for additional costs if the provider's usual & customary levels.*

# Premera Blue Cross

## Dental PPO $50/$1500 with Orthodontia Plan

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

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Annual Deductible** | $50 per individual<br>$150 per family | Combined with In-Network |
| **Annual Plan Maximum** | $1,500 | Combined with In-Network |
| **Waiting Period** | None | |
| **Diagnostic & Preventive** | Plan pays 100% | Plan pays 100% |
| **BASIC SERVICES** | | |
| Fillings | Plan pays 90% after deductible | Plan pays 80% after deductible |
| Root Canals | Plan pays 90% after deductible | Plan pays 80% after deductible |
| Periodontics | Plan pays 90% after deductible | Plan pays 80% after deductible |
| **Major Services** | Plan pays 60% after deductible | Plan pays 50% after deductible |
| **Orthodontia** | Plan pays 100% up to $1,000 Lifetime Maximum | Plan pays 100% up to $1,000 Lifetime Maximum |
| Adults | Covered | Covered |
| Dependent Children | Covered | Covered |
| Full-time Students | Covered | Covered |

***Provider Choice:*** *You may seek care from any licensed provider. However, when you visit an in-network dentist, you can maximize your benefit plan with access to lower out-of-pocket expenses. If you visit an out-of-network dentist you may be responsible for additional costs if the provider's charges exceed the plan's usual & customary levels.*

# VISION

## OUR PLAN

- VSP Vision Care

*Click to play video*


## 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.

# VSP Vision Care
## VSP Signature Plan

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

| | DESCRIPTION |
|---|---|
| **COPAYS** | |
| Exam | $10 copay then plan pays 100% |
| Materials | $25 copay then plan pays 100% |
| **EYEGLASS LENSES** | |
| Single Vision Lens | Plan pays 100% of basic lens<br>*(materials copay applies)* |
| Bifocal Lens | Plan pays 100% of basic lens<br>*(materials copay applies)* |
| Trifocal Lens | Plan pays 100% of basic lens<br>*(materials copay applies)* |
| **Frames** | Up to **$150 (Increased Benefit!)** |
| **Contacts (Elective)** | Reimbursed up to $130<br>*(copay waived; instead of eyeglasses)* |
| **FREQUENCY** | |
| Exam | 1 x every 12 months from last date of service |
| Lenses | 1 x every 12 months from last date of service |
| Frames | 1 x every **12** months from last date of service **(Increased Benefit!)** |
| Contracts (Elective) | 1 x every 12 months from last date of service |

# 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 |
|---|---|---|---|---|
| **Nurseline**  | Quick answers from a trained nurse | • Identifying symptoms<br>• Decide if immediate care is needed<br>• Home treatment options and advice | 24/7 | **$0** |
| **Online visit**  | Many non-emergency health conditions | • Cold, flu, allergies<br>• Headache, migraine<br>• Skin conditions, rashes<br>• Minor injuries<br>• Mental health concerns | 24/7 | **$** |
| **Office visit**  | Routine medical care and overall health management | • Preventive care<br>• Illnesses, injuries<br>• Managing existing conditions | Office Hours | **$$** |
| **Urgent care, walk-in clinic**  | Non-life-threatening conditions requiring prompt attention | • Stitches<br>• Sprains<br>• Animal bites<br>• Ear-nose-throat infections | Office Hours, or up to 24/7 | **$$$** |
| **Emergency room**  | Life-threatening conditions requiring immediate medical expertise | • Suspected heart attack or stroke<br>• Major bone breaks<br>• Excessive bleeding<br>• Severe pain<br>• Difficulty breathing | 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.

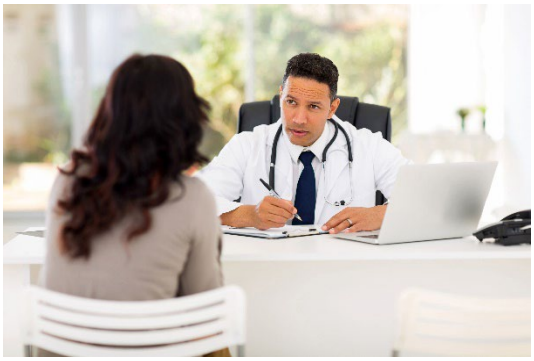
| Need | Alternative | Features | Savings |
|---|---|---|---|
| **Surgery**  | Ambulatory Surgery Center (ASC) | • Specializes in same-day surgeries<br>• Cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery and more<br>• Held to same safety standards as hospitals | Up to 50% over hospital stay* |
| **Physical therapy**  | Free-standing physical therapy center | • Important part of the recovery process after an injury or surgery | 40 to 60% over a hospital setting* |
| **Sleep study**  | Home testing | • Diagnoses sleep apnea and other conditions<br>• Cost is often covered by insurance if considered medically necessary | Approx. $4,500* |
| **Infusion therapy**  | Home or outpatient infusion therapy | • For drugs that must be delivered by intravenous injections, or epidurals<br>• Delivered by licensed infusion therapy provider<br>• Maintain normal lifestyle and comfort of home or outpatient center | Up to 90% over hospital stay*<br><br>**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 and 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.

# 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.

**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?

*Click to play video*


## THE FORMULARY DRUG TIERS DETERMINE YOUR COST

| | |
|---|---|
| $ | Generic Drug |
| $$ | Brand Name Drug |
| $$$ | Specialty Drug |

## 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

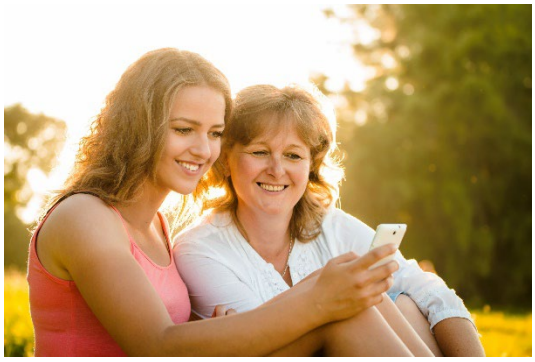
If the worst happens, your beneficiary—the person (or people) on record with the life insurance carrier—receives the benefit. Make sure that you name at least one beneficiary for your life insurance benefit, and change your beneficiary as needed if your situation changes.

## Is your family protected?

Life and AD&D insurance can fill 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 a base amount of life and AD&D insurance to help you recover from financial loss.

# 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 or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing in the event of an accident. **The cost of coverage is paid in full by Brinton Business Ventures Inc.**

### Lincoln Financial Group
### Basic Life and AD&D Insurance

$20,000 benefit provided by Brinton Business Ventures

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

Make sure that you have named a beneficiary for your life insurance benefit, and update it if your family or marital status changes.

# VOLUNTARY PLANS

## OUR VOLUNTARY PLANS

- Accident Insurance
- Critical Illness Insurance
- Hospital Indemnity 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.

Brinton Business Ventures Inc. offers plans to help:

- provide income for survivors
- replace income if you're injured or ill
- bridge the gap for special healthcare needs

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.

# ACCIDENT INSURANCE

## A Financial Cushion when Accidents Happen

Accident insurance pays cash benefits for the treatments and injuries associated with an accidental injury such as fractures, dislocations, burns, emergency room, or urgent care visit, and physical therapy. If you or a covered family member suffers an accident, the plan will pay a lump sum benefit based on a predetermined schedule of benefits.

The below list is a selection of covered benefits. Please refer to the plan documents for a comprehensive list of covered benefits and eligible wellness tests.

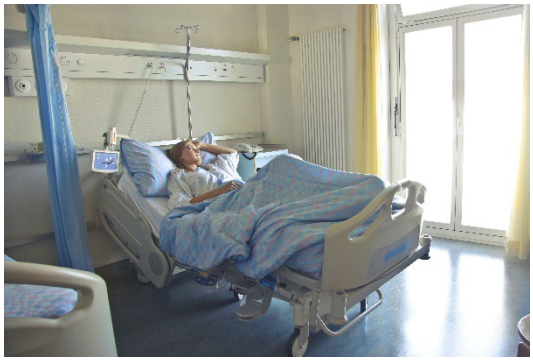
## EXAMPLE

Kyle injured himself while playing in the yard and suffered a serious concussion. Although Christine, his mom, had good medical coverage, the out-of-pocket costs kept adding up. Thankfully, she and her family were enrolled the Accident plan. She was able to use the money she received under the plan to offset her medical deductible and applicable copays.

| CHRISTINE'S BENEFIT PAYOUT | |
|---|---|
| Ambulance | $450 |
| Emergency Room | $300 |
| Major Diagnostic Testing | $300 |
| Concussion | $400 |
| **TOTAL BENEFIT** | **$1,450** |

| BENEFIT TYPE | BENEFIT AMOUNT |
|---|---|
| Ambulance | $450 ground, $2,000 air |
| Burn | Schedule up to $20,000 |
| Child Sports Injury Benefit | Additional 25% of benefit payout |
| Coma | $10,000 |
| Concussion | $400 |
| Diagnostic Testing (Major) | $300 |
| Dislocation | Schedule up to $8,000 |
| Emergency Room Treatment | $300 |
| Follow-up Treatment | $155 per visit, up to 2 visits |
| Fracture | Schedule up to $8,000 |
| Hospital Admission | $1,500 |
| Hospital Confinement | $300 per day, up to 365 days |
| Laceration | Schedule up to $1,500 |
| Physical Therapy | $80 per visit, up to 6 visits |
| Surgery | Schedule up to $2,000 |
| Urgent Care | $150 |
| X-ray | $300 (at initial visit only) |

# CRITICAL ILLNESS INSURANCE



The below list is a selection of covered benefits. Please refer to the plan documents for a comprehensive list of covered benefits and eligible wellness tests.

## Fill Financial Gaps Due to Serious Illness

Critical Illness insurance 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 benefit is paid directly to you. By enrolling in the Critical Illness plan, you and your enrolled dependents are also eligible to receive an annual $50 Wellness Benefit for keeping up with your preventive care.

## EXAMPLE

Cindy has a history of cancer in her family, so she enrolled in the Critical Illness plan and elected $20,000 in benefits. A few months later, Cindy was diagnosed with invasive breast cancer. After filing a claim, Cindy was able to use her benefit to help cover her medical costs, pay for additional childcare and cover some of her lost income.

| CINDY'S BENEFIT PAYOUT | |
|---|---|
| Cancer | 100% |
| **TOTAL BENEFIT** | **$20,000** |

| BENEFIT TYPE | BENEFIT AMOUNT |
|---|---|
| Employee | $10,000, $20,000 or $30,000 |
| Spouse | Up to 50% of employee's election (in $5,00 increments) |
| Child | 50% of employee's election (automatic) |
| **BENEFIT TYPE** | **PERCENTAGE OF BENEFIT PROVIDED** |
| ALS, Alzheimer's Disease or Parkinson's Disease | 100% |
| Benign Brain Tumor | 50% |
| Cancer | 100% (Skin Cancer: $500, once per lifetime) |
| Carcinoma in Situ | 25% |
| Chronic Obstructive Pulmonary Disease (COPD) | 100% |
| Coronary Artery Disease w/ Bypass | 25% |
| Covered Childhood Illnesses | 100% |
| End Stage Renal Failure | 100% |
| Heart Attack or Sudden Cardiac Arrest | 100% |
| Major Organ Failure | 100% |
| Multiple Sclerosis (MS) | 25% |
| Stroke | 100% |
| **PROVISIONS** | |
| % of Benefit Paid: Additional Occurrence | Yes, 3 month wait, at 100% |
| % of Benefit Paid: Recurrence | Yes, 6 month wait, at 100% |

# HOSPITAL INDEMNITY INSURANCE New!


Please refer to the plan documents for a comprehensive list of covered benefits.

## Help Cover Out-of-Pocket Costs

A hospital stay can be costly, even if you have medical coverage. Hospital Indemnity insurance can help cover your medical deductible or coinsurance if you are hospitalized by paying a lump-sum benefit directly to you. By enrolling in the Hospital Indemnity plan, you and your insured are also eligible to receive an annual $50 Wellness Benefit for keeping up with your preventive care.

## EXAMPLE

Alexis and her husband eagerly awaited the birth of their child. Alexis was enrolled in the Hospital Indemnity plan, which provided benefits for her hospital admission and stay. The money she received under the plan allowed her to take an extra week of unpaid maternity leave to bond with her little boy.

| ALEXIS' BENEFIT PAYOUT | |
|---|---|
| Hospital Admission | $1,000 |
| Hospital Stay (2 days) | $200 ($100 per day) |
| Newborn Nursery | $500 |
| **TOTAL BENEFIT** | **$1,700** |

| BENEFIT TYPE | BENEFIT AMOUNT |
|---|---|
| Hospital Admission | $1,000 per admission, up to 4 times, per year |
| Hospital Confinement | $100 per day, up to 30 days, per year |
| Hospital ICU Admission | $2,000 per admission, up to 1 time, per year |
| Hospital ICU Confinement | $200 per day, up to 30 days |
| Newborn Nursery | $500, 1 time per year |
| Hospital NICU Admission and Confinement | Additional 25% of benefit |
| **Wellness Benefit** | **$50 per insured, per year** |

| HOSPITAL INDEMNITY INSURANCE | Monthly Premium |
|---|---|
| EMPLOYEE ONLY | $20.34 |
| EMPLOYEE + SPOUSE | $43.43 |
| EMPLOYEE + CHILDREN | $30.88 |
| EMPLOYEE + FAMILY | $56.22 |

# UTILIZING YOUR WELLNESS BENEFIT

Your Critical Illness and Hospital Indemnity benefits offer an annual $50 Wellness Benefit – available to each enrolled member!

Lincoln will pay this benefit when you receive services that you're likely already accessing as part of your preventive care routines. By simply filing a claim after receiving these benefits, you will receive $50 per insured, per year, so be sure to leverage this benefit when looking at your out-of-pocket premium costs for these plans.

## EXAMPLE

Terry is 35 years old and wants to enroll in the Critical Illness plans for the coming year. He sees that he can get a $50 benefit paid for receiving care that he already has scheduled with his doctor! Using that money to offset the cost of annual premium, he realizes he only needs to pay $20.56 annually to provide a financial safety net when he might need it the most.

**CRITICAL ILLNESS**

Based on Terry's age, his $10,000 coverage is $5.88 per month, or $70.56 annually. After his qualifying preventive services, Terry submits a Wellness Benefit claim and receives his $50.

**After factoring in this benefit, his annual premium is only $20.56, which is less than $2 per month!**

## COVERING FAMILY MEMBERS?

Wellness Benefit claims are paid out **per insured member** – if Terry enrolls his spouse and child, he could receive up to $150 in benefits if each family member received qualifying services.

For the **Critical Illness** plan, this would adjust Terry's annual premium to **$101.76** (based on $5k spouse and $5k child benefits).

**If all three members' claims are submitted, Terry's annual premium is fully offset for the year! He'll pocket just under $50 for submitting the three Wellness claims.**

# 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 an Employee Assistance Program (EAP) to help you:

- Manage stress, chemical dependency, mental health and family issues

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

# EMPLOYEE ASSISTANCE PROGRAM (EAP)

## CONTACT THE EAP

### Company Username

**bbv**

### Phone

**888-881-5462**

### Website

**supportlinc.com**

## 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 Curalinc 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.
- Unlimited web access to helpful articles, resources, and self-assessment tools.

### COUNSELING BENEFITS

- Difficulty with relationship
- Emotional distress
- Job stress
- 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)
- Landlord/tenant
- 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

# IMPORTANT PLAN INFORMATION

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

- Your medical, dental and vision benefit contributions for 2026
- 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, and how many dependents you cover. 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

### Premera Blue Cross Your Future HSA $3,400

| | Total Cost | Employer Contribution | Employee Cost |
|---|---|---|---|
| EMPLOYEE ONLY | $485.89 | $417.89 | **$68.00** |
| EMPLOYEE + SPOUSE | $1,093.24 | $517.38 | **$575.86** |
| EMPLOYEE + CHILDREN | $947.43 | $467.54 | **$479.89** |
| EMPLOYEE + FAMILY | $1,559.71 | $733.24 | **$826.47** |

### Premera Blue Cross Your Choice PPO $2,500

| | Total Cost | Employer Contribution | Employee Cost |
|---|---|---|---|
| EMPLOYEE ONLY | $560.10 | $420.10 | **$140.00** |
| EMPLOYEE + SPOUSE | $1,260.20 | $547.08 | **$713.12** |
| EMPLOYEE + CHILDREN | $1,092.12 | $497.96 | **$594.16** |
| EMPLOYEE + FAMILY | $1,797.89 | $847.99 | **$949.90** |

*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 Brinton Business Ventures Inc if your domestic partner is your tax dependent.*

# YOUR MONTHLY BENEFIT COSTS

## DENTAL

### Premera Blue Cross Dental Base $1,000

| | Total Cost | Employer Contribution | Employee Cost |
|---|---|---|---|
| EMPLOYEE ONLY | $40.28 | $20.14 | **$20.14** |
| EMPLOYEE + SPOUSE | $80.56 | $20.14 | **$60.42** |
| EMPLOYEE + CHILDREN | $84.29 | $20.14 | **$64.15** |
| EMPLOYEE + FAMILY | $130.45 | $20.14 | **$110.31** |

### Premera Blue Cross Dental Buy Up $1,500 with Ortho

| | Total Cost | Employer Contribution | Employee Cost |
|---|---|---|---|
| EMPLOYEE ONLY | $46.82 | $21.39 | **$25.43** |
| EMPLOYEE + SPOUSE | $93.64 | $21.39 | **$72.25** |
| EMPLOYEE + CHILDREN | $97.98 | $21.39 | **$76.59** |
| EMPLOYEE + FAMILY | $151.63 | $21.39 | **$130.24** |

## VISION

### VSP Signature Voluntary Vision Plan

| | Total Cost |
|---|---|
| EMPLOYEE ONLY | **$8.18** |
| EMPLOYEE + SPOUSE | **$13.09** |
| EMPLOYEE + CHILDREN | **$13.37** |
| EMPLOYEE + FAMILY | **$21.55** |

# YOUR BENEFIT COSTS

You cover the full cost of coverage of your voluntary benefits. These premiums are deducted post-tax, providing a tax-free benefit.

## ACCIDENT INSURANCE

| | Monthly Premium |
|---|---|
| EMPLOYEE ONLY | $21.03 |
| EMPLOYEE + SPOUSE | $33.25 |
| EMPLOYEE + CHILDREN | $34.85 |
| EMPLOYEE + FAMILY | $53.49 |

## HOSPITAL INDEMNITY INSURANCE

| | Monthly Premium |
|---|---|
| EMPLOYEE ONLY | $20.34 |
| EMPLOYEE + SPOUSE | $43.43 |
| EMPLOYEE + CHILDREN | $30.88 |
| EMPLOYEE + FAMILY | $56.22 |

## CRITICAL ILLNESS INSURANCE

Rates shown per $1,000 of coverage. The employee's age is used to determine spouse rates. Attained age rating applies, meaning rates will increase at policy anniversary if you change age brackets.
Child(ren) are included in the employee rate if coverage is elected.

| Monthly Premium | EMPLOYEE | SPOUSE |
|---|---|---|
| Under age 24 | $0.230 | $0.162 |
| 25 – 29 | $0.327 | $0.259 |
| 30 – 34 | $0.437 | $0.369 |
| 35 – 39 | $0.588 | $0.519 |
| 40 – 44 | $0.877 | $0.807 |
| 45 – 49 | $1.249 | $1.181 |
| 50 – 54 | $1.810 | $1.742 |
| 55 – 59 | $2.462 | $2.392 |
| 60 – 64 | $3.463 | $3.395 |
| 65 – 69 | $4.770 | $4.701 |
| 70+ | $8.971 | $8.902 |

*Rates will be rounded to the nearest penny and may differ from the above chart.*

## HELPFUL RESOURCES

**Benefit Advocate**
benefitsupport@alliant.com
(800) 489-1390

## MEDICAL/RX & DENTAL

**Premera Blue Cross**
Policy # 4024591
premera.com
Premera Mobile App
Find a Provider
Member Services
(800) 722-1471

## VISION

**Vision Service Plan (VSP)**
Policy # 30065489
vsp.com
Find a Provider
Member Services
(800) 877-7195

## HEALTH SAVINGS ACCOUNT (HSA)

**COBRA Management Services**
cobramanagement.com
Member Services
(866) 517-7580

## LIFE, AD&D, & VOLUNTARY LINES

**Lincoln Financial Group**
Policy # 10273652
LincolnFinancial.com
Member Services
(800) 423-2765

# 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.

# IMPORTANT PLAN INFORMATION

## HEALTH PLAN NOTICES

These notices must be provided to plan participants on an annual basis and are available in the accompanying Annual Notices 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.

# PLAN DOCUMENTS

Important documents for our health plan and retirement plan are available accompanying Annual Notices document. 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.

## SUMMARY OF BENEFITS AND COVERAGE (SBC)

A document required by the Affordable Care Act (ACA) that presents benefit plan features in a standardized format.

- Premera Blue Cross Your Future HSA $3,400
- Premera Blue Cross Your Choice PPO $2,500

## STATEMENT OF MATERIAL MODIFICATIONS

This enrollment guide constitutes a Summary of Material Modifications (SMM) to the Brinton Business Ventures Inc. Health 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.

# DETERMINING ELIGIBILITY

## LOOK-BACK MEASUREMENT METHOD

The information below explains how your eligibility for healthcare coverage is determined, in accordance with the rules of the Affordable Care Act (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 whose works on average 130 hours per month. ACA full-time status can affect or determine major medical benefits eligibility but is not a guarantee of benefits eligibility. Brinton Business Ventures Inc uses the look-back measurement method to determine group health plan eligibility.

**NEW EMPLOYEES HIRED TO WORK FULL-TIME:** If you are hired as a new full-time employee (work on average 130 or more hours a month), you and your dependents are generally eligible for group health plan coverage as of the first of the month following 60 days of employment.

**NEW EMPLOYEES HIRED TO WORK A PART-TIME, VARIABLE HOUR OR SEASONAL SCHEDULE:** If you are hired into a part-time position, a position where your hours vary and Brinton Business Ventures Inc is unable to determine — as of your date of hire — whether you will be a full-time employee, or you are hired as a seasonal employee who will work for six (6) consecutive months or less (regardless of monthly hours worked), you will be placed in an initial measurement period (IMP). Your IMP will begin on the first of the month following the date of hire. If, during your IMP, you average 130 or more hours a month, you will become full-time and, if otherwise eligible for benefits, you will be offered coverage as of the first of the month following your IMP. Your full-time status will remain in effect during an associated stability period that will last 180 days. If your employment is terminated during that stability period, and you were enrolled in benefits, you will be offered coverage under COBRA.

**ONGOING EMPLOYEES:** An ongoing employee is an individual who has been employed for an entire standard measurement period. A standard measurement period is the 180 day period during which Brinton Business Ventures Inc counts employee hours to determine which employees work full-time. Those employees who average 130 or more hours a month over the standard measurement period will be deemed full time and, if otherwise eligible for benefits, offered coverage as of the first day of the stability period associated with the standard measurement period. Full-time status will be in effect during an associated stability period for 180 days. If your employment is terminated during a stability period, and you were enrolled in benefits, you will be offered continued coverage under COBRA.

Brinton Business Ventures Inc uses the standard measurement period and associated stability period annual cycle set forth below:

**MEASUREMENT PERIOD:** STARTS: November 1.  DURATION: October 31. Time to determine if you work 130+ hours per month on average – used to establish if you are "full-time" or "part-time" for medical eligibility.

**STABILITY PERIOD:** STARTS: January 1.  DURATION: December 31. Time during which you will be considered "full-time" or "part-time" for medical plan eligibility - based on hours worked during preceding Measurement Period.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