XCLUSIVE® SERVICES

2025 Benefits Enrollment Guide
External Team Members

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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 pages 23-24 where Notice of Creditable Coverage begin for more details.

This document is an outline of the coverage proposed by the carrier (s), based on information provided by your company. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request.

The intent of this document is to provide you with general information regarding the status of, and/or potential concerns related to, your current Team Member benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be addressed by your general counsel or an attorney who specializes in this practice area.

TERMS TO KNOW

Qualified Life Event	A major life change that allows you to make changes to your health plan. Some major changes include marriage, divorce, the birth of a child, loss of a job, or dependent child turns 26. Qualifying life events MUST be completed within 30 days of the event.
Coinsurance	The percentage of costs of a covered health care service you pay after you've paid your deductible.
Deductible	An amount you must pay out of pocket for your healthcare before your insurance company begins to kick in for certain covered healthcare services.
Copays	A fixed amount you pay to see your doctor or specialist when you are rendered a service.
Network	The facilities, providers and suppliers your insurer or plan is contracted with to provide services.
Insurance Premium	The amount you are deducted from your paycheck every pay period for your health and welfare benefits.
Prescription Tiers	The different cost levels you pay for a medication. Each tier is assigned a cost. This is how much you will pay when you fill a prescription, if applicable.
Out Of Pocket Maximum	The most you will pay for covered services in a plan year. After you spend this amount, your health plan pays 100% of the costs of covered benefits.
Preferred Provider	A provider who has a contract with your insurer or plan to provide services to you at a discount.

Medical Benefits

Administered by Aetna and Kaiser Permanente

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. A little prevention usually goes a long way— especially in healthcare. Routine exams and regular preventive care provide an inexpensive review of your health. Small problems can potentially develop into large expenses. By identifying the problems early, often they can be treated at little cost.

XCLUSIVE SERVICES **Medical Insurance Options EXTERNAL EMPLOYEES – Effective January 1, 2025**

There are several plans to choose from. **Aetna** plans provide day-to-day coverage, Dental and Vision, **Kaiser** plan will provide full Health insurance coverage.

	DAY TO DAY COVERAGE			STANDARD COVERAGE
Insurance Provider	**Aetna Network** **Aetna offers Day to Day coverage, Dental and Vision plans**			**Kaiser Permanente** **HDHP 5000 20% in Colorado** **PPO 3000 30% outside of Colorado**
Who is eligible? **How to enroll?**	**All External employees are eligible, employees can apply anytime. Employees have coverage only when they work. If they don't, there will be no coverage and no deduction** **To enroll, follow the link sent via email to create a profile in Employee Navigator**			**External team members are eligible after 1 year of service, if the average number of hours worked averaged 30 hours per week.**
Does this plan qualify as Minimum Essential Coverage?	***No, not ACA approved, these plans do not protect you from a Penalty***			**Yes, ACA (Affordable Care Act) Approved**
How does this plan work?	Employees can go to the doctor, urgent care facility or emergency room. If the provider is in-network, he will reduce what he charges and bill the insurance company. The insurance company will send the provider a payment for the service and the provider will bill Employee for any balance owed. If the provider is not in-network, Employee will not receive a discount and may have to file a claim themselves.			Preventive care is free. Employees pay for all other covered services until the annual deductible is reached, up to the out-of-Pocket Maximum.
Locate network providers	**Call AETNA, 1-888-772-9682, Code 1095, Group# 802189** **Or Email,** www.aetna.com/docfind/custom/avp			**KAISER, 1-855-364-3184** **Group#35989, or Email,** www.kp.org
In-Network Benefits	**PLAN 1**	**PLAN 3**	**PLAN 5**	
Prescription Drugs	The plan will pay **$20** up to **8 Times a year.**	The plan will pay **$30** up to **12 Times a year.**	The plan will pay **$45** up to **12 Times a year.**	Routine Exams, Diagnostic Lab, Immunizations, **100%** Covered **No referrals are required for specialty care.** ▪ **In Colorado** **HDHP Plan, Employee $5,000** (Deductible) Once the deductible is reached, Employee responsible for 20%, Kaiser will pay 80% ▪ **Outside of Colorado** **PPO Plan, Employee $3,000** (Deductible) Once the deductible is reached, Employee responsible for 30%, Kaiser will pay 70%
Doctor's Office Visit, Urgent Care Facility or Walk-in Clinic	The plan will pay **$50** for each **Visit, up to 5 visits a year.**	The plan will pay **$60** for each **Visit, up to 5 visits a year.**	The plan will pay **$70** for each **Visit, up to 7 visits a year.**	
Outpatient Lab/X-ray	The plan will pay **$50** for **Testing twice a year.**	The plan will pay **$70** for **Testing three times a year.**	The plan will pay **$90** for **Testing three times a year.**	
Emergency Room	The plan will pay **$100** for an **ER visit twice a year.**	The plan will pay **$175** for an **ER visit twice a year.**	The plan will pay **$275** for an **ER visit twice a year.**	
Outpatient Surgery	The plan will pay **$200.** **Once a year.**	The plan will pay **$300.** **Twice a year.**	The plan will pay **$450.** **Twice a year.**	
Hospital Care	The plan will pay **$200** per day+ **$200** for surgery +**$100** for an accident – **Twice a year.**	The plan will pay **$350** per day+ **$300** for surgery +**$200** for an accident –**Twice a year.**	The plan will pay **$500** per day+ **$450** for surgery +**$300** for an accident – **Twice a year.**	
Weekly Cost – Per paycheck				
Employee only	**$11.99**	**$16.47**	**$20.56**	
Employee + one Dependent	**$24.99**	**$36.40**	**$45.60**	
Employee & two or more	**$34.99**	**$52.34**	**$65.63**	

Plan details (including limitations & exclusions) are available.

Medical Insurance Plans for EXTERNAL TEAM MEMBERS IN COLORADO – Effective January 1, 2025

- The insurance company is **Kaiser Permanente**. The provider network is **Colorado Permanente Medical Group Network** in Colorado. This plan will provide catastrophic coverage.
- **External team members** are eligible after 1 year of service, if the average number of hours worked averaged 30 hours per week.
- Team Member may also enroll spouse and dependent children **at Full price, up to age 26**.
- Pre-existing conditions will be covered.
- Please complete the enrollment email and return it to Stephane Jimenez at benefits@xclusiveservices.com **or Call (303)430-1700, Ext. 713**
- **This form confirms that you were offered an opportunity to enroll and will let Corporate know what choice you make.**

Kaiser Permanente	HSA 5000 EMB 20%
Features of this plan	HDHP plan – in network care is covered. **No referrals are required for specialty care** Prior authorization is required for Hospitalization & Surgery (unless an emergency) Deductibles & out of pocket maximums are per calendar year **Unlimited lifetime benefits**
In-Network Benefits	
Preventive Care	**100% Covered (includes routine Exams, associated diagnostic Lab, Immunizations)**
Prescription Drugs Tier 1 **RX, Generic** Tier 2 **RX, Brand** Tier 3 **RX Nonpreferred** Tier 4 **RX, Specialty** Mail Order	Retail Pharmacy – 30 day supply **$20 Copay** **$40** Copay **$60** Copay 20% $40/$80/$120/20%– 90 day supply
Office Visit Primary Care (**PCP**) Specialist Chiropractic Care **Urgent Care Facility Visit** **Emergency Room Outpatient Lab/X-ray** **Maternity Care** **Emergency Room** **Hospital Admission** **Outpatient Surgery** **Advanced Imaging** **Outpatient Rehab**	**Employee Only $5,000 (Deductible),** **Family $10,000 (Deductible)** Once the deductible is reached, the Co-insurance will pay **80% for the balance of the year** Up to Annual out of Pocket Maximum of **$6,050 (Employee only)**
Annual Out of Pocket Maximum	Copays, deductible & coinsurance **Employee only Cap is $6,050**, (This is your Out-of Pocket Limit) **Family Cap is $12,100**
Out-Network Benefits	**Limited Benefits (10 visits or services)**

Medical Plan Rates - HSA 5000 EMB 20%	
Weekly Rates (52)	
Employee Only	$30.45
Employee & Spouse	$118.25
Employee & Children	$94.60
Family	$141.90

Health Savings Account

A **Health Savings Account (HSA)** is a savings plan that can be used to pay for qualified medical expenses with pretax dollars. Both the employer and Team Member can contribute to the account.

There are several advantages of participating in a Health Savings Account (HSA):

1. You can set aside money in a Health Savings Account (HSA) before taxes to pay for eligible medical, dental and vision expenses (through payroll deduction or other means). An HSA is similar to a flexible spending account in that you are allowed to pay for eligible expenses with pretax dollars, but it does not have the same limitations.
2. Unused money in an HSA account is NOT forfeited at the end of the year and is carried forward. There is NO "use it or lose it" policy.
3. The HSA account is yours to keep which means that you can take it with you if you change jobs or retire. If you have any money remaining in your HSA after retirement, you may withdraw the money as cash (after age 65) with no penalty. If you should choose not to participate in an HSA plan again next year, you can still use the funds in the account for qualified expenses. However, you are no longer eligible to put money in the account if you do not have a high deductible health plan that meets the IRS requirements.
4. You can use the HSA funds for any immediate family member, even if they are not covered on your medical plan. However, if you have a spouse or dependents covered on a plan with copays, they can NOT be enrolled as a dependent on the HSA plan.
5. Per IRS regulations, you are NOT eligible to contribute to an HSA pretax if you are currently enrolled in a traditional Flexible Spending Account (FSA) or if you are eligible for or enrolled in Medicare.

The HSA bank account is offered in conjunction with the HSA medical plan ONLY:

EMPLOYER CONTRIBUTION

- $600 annually for Employee Only
- $1,200 annually towards Employee & Spouse, Employee & Children and Family

TEAM MEMBER CONTRIBUTIONS

- Completely voluntary
- Contributions are made via payroll deduction into your HSA account

HSA Limits for 2025

The following Health Savings Account (HSA) limits apply:

HSA Maximum Contribution Amount**	2025
Individual	$4,300
Family	$8,550
Catch-Up Contributions (age 55 and older)	$1,000

**Max contributions include both employee and employer contributions.

Account Management

You manage your own HSA account through WEX as if it were your own bank account.

Medical Insurance Plans for EXTERNAL TEAM MEMBERS OUTSIDE COLORADO – Effective January 1, 2025

- The insurance company is **Kaiser Permanente**. The provider network is CIGNA for Team Members outside of Colorado. This plan will provide catastrophic coverage.
- **External team members** are eligible after 1 year of service, if the average number of hours worked averaged 30 hours per week.
- Employee may also enroll spouse and dependent children **at Full price, up to age 26**.
- Pre-existing conditions will be covered.
- For PPO participants living in Colorado or Georgia, visit https://www.myfirsthealth.com/LocateProvider/SelectNetworkType
- Please complete the enrollment email and return it to Team Member at ***benefits@xclusiveservices.com***, **or Call (303) 430-1700, Ext. 713**
- **This form confirms that you were offered an opportunity to enroll and will let Corporate know what choice you make.**

	PPO 3000 30%	
	In-Network	Out-of-Network
Lifetime Benefit Maximum	**Unlimited**	
Calendar Year Deductible	**$3,000 single $6,000 family**	**$8,000 single $24,000 family**
Annual Out-of-Pocket Maximum (includes deductible)	**$6,000 single $12,000 family**	**$13,500 single $27,000 family**
Coinsurance	**30%**	**50%**
Doctor's Office		
Primary Care Office Visit	**$30 copay + (30% coinsurance for other covered services)**	**CYD/50%**
Specialist	**$60 copay + (30% coinsurance for other covered services)**	**CYD/50%**
Urgent Care	**CYD/30%**	**CYD/70%**
Preventative Services (routine exams, immunizations, well baby care and mammograms)	**Covered at 100%**	**CYD/50%**
Prescription Drugs		
Retail—Generic Drug	**$20**	**CYD/50%**
Retail—Preferred brand	**$40**	**CYD/50%**
Retail—Nonformulary Drug	**$60**	**CYD/50%**
Retail—Specialty drugs	**20% coinsurance up to $250 per drug**	**CYD/50%**
Mail Order Available (90-day supply)	**$40 / $80 / $120**	**NOT COVERED**
Hospital Services		
Emergency Room	**CYD/30%**	**CYD/70%**
Inpatient	**CYD/30%**	**CYD5/0%**
Outpatient Surgery	**CYD/30%**	**CYD/50%**
Bariatric Surgery	**Not Included**	

Medical Plan Rates - PPO 3000 30%	
Weekly Rates (52)	
Employee Only	$30.45
Employee & Spouse	$118.25
Employee & Children	$94.60
Family	$141.90

Finding a Provider – Out Of State Plan

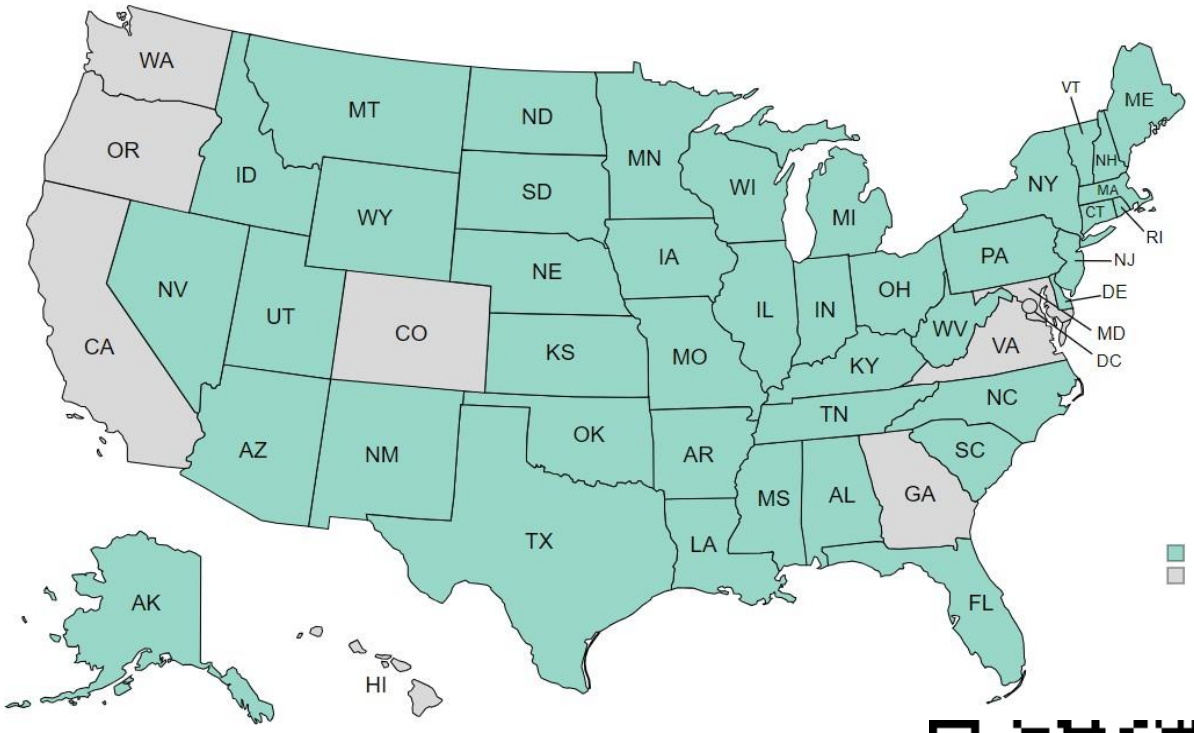
Cigna PPO Network

Since January 1, 2024, the Cigna PPO Network has replaced the First Health Network outside KP states. The First Health Network will continue to remain part of KPIC's Participating Provider Network within Colorado and in the KP states.

Cigna's collaboration with Kaiser creates a broader network that gives Team Members options to find care closer to where they live or travel. Cigna's brand recognition makes accessing care easier. Kaiser's negotiated contracted rates with Cigna Payer Solution may lower members' out-of-pocket costs for services with a deductible or coinsurance cost share.

To locate Cigna Healthcare SM PPO Network providers, call Customer Service at **1-855-364-3184** or use the QR Code below. Members who call in should indicate they have coverage through an employer in Colorado but have an out-of-state PPO plan or ask to speak to someone in "Choice Product line" department.

To locate MedImpact Pharmacies (part of Cigna's PPO Network), call **1-800-788- 2949** or visit visit **kp.org/ppo-colorado.**



Aetna – Fixed Benefits Plans

Extra financial help when you need it most

Would you have enough money to help pay for any unexpected medical expenses? Do you skip going to the doctor's office for minor illnesses like a common cold because of the cost?

The Aetna Fixed Benefits Plan can help.

It pays daily fixed cash benefits for covered services. You can use that cash to help pay some of the costs that pop up, like doctor visits, hospital stays or prescriptions.

It is a good partner with medical plans, since it pays regardless of any other insurance you have. It can help you afford a big deductible- common in many of today's major medical plans.

So, what do you get?

You get handy features, like:

- Guaranteed enrollment, with no doctor exam
- Access to our large network of discounted hospitals, physicians, and pharmacies
- Coverage at affordable group rates

The result? You can be healthier, happier and more focused on enjoying life.

Your dollar goes further

You can reduce your out-of-pocket medical costs when you visit a hospital, physician, pharmacy and/or other provider in our nationwide network.

Just use our provider search* to find in-network doctors and medical specialists in your area: **aetna.com/dse/custom/avp.**

Coverage when it counts

78% of workers are living paycheck to paycheck. And, more than 1 in 4 workers do not set aside any savings each month.[1]

Don't miss out. Enroll today.

This policy, alone, does not meet Massachusetts Minimum Creditable Coverage standards.

*If you see a provider that participates in the Aetna network affiliated with this program, the amount you owe the provider is reduced because Aetna has already negotiated a discount. If the provider also participates in your underlying health plan's network, the provider may bill you for the rate the provider has negotiated with the health plan and the Aetna discounted rate cannot be guaranteed.

[1] Friedman, Zack. Forbes. 78% of workers live paycheck to paycheck. forbes.com. January 11, 2019. Available at: https://www.forbes.com/sites/zackfriedman/2019/01/11/live-paycheck-to-paycheck-government-shutdown/#5a5c32b14f10. Accessed May, 1, 2019.

THIS PLAN DOES NOT COUNT AS MINIMUM ESSENTIAL COVERAGE UNDER THE AFFORDABLE CARE ACT. THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE.

The Aetna Fixed Benefits Plan is underwritten by Aetna Life Insurance Company (Aetna). The Aetna Fixed Benefits Plan is a hospital confinement indemnity insurance plan with other fixed indemnity benefits. This plan provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses. This plan pays you fixed dollar amounts regardless of the amount that the provider charges. You are responsible for making sure the provider's bills get paid. These benefits are paid in addition to any other health coverage you may have. This disclosure provides a very brief description of the important features of the benefits being considered. It is not an insurance contract and only the actual policy provisions will control. This material is for information only. Insurance plans contain exclusions and limitations. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Policies may not be available in all states, and rates and benefits may vary by location. Policies are subject to United States economic and trade sanctions. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice and is subject to change. Aetna does not provide care or guarantee access to health services. Information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna plans, refer to **aetna.com.**

Policy forms issued in Oklahoma include: GR-96172, GR-96173.
Policy forms issued in Missouri include GR-96172 01 or AL VOL HPOL-Hosp 01.

Aetna – Fixed Benefits Plan 1

Fixed Benefits Plan:	
Inpatient Hospital Stay -- daily benefit	
(Includes maternity)	
Plan pays per day in a private or semi-private room	$200
Plan pays per day in Intensive Care Unit (ICU)	$400
Maximum number of stays per coverage year	2 stays
Inpatient Hospital Stay - lump-sum benefit	
(Includes maternity)	
Plan pays per initial day of an inpatient stay	$200
Maximum number of days per coverage year	2 days
Inpatient surgical procedure	
Plan pays per day on which a surgical procedure is performed	$200
Maximum number of days per coverage year	1 day
Accident - additional benefit	
Plan pays per initial day of treatment for an accident	$100
Maximum number of days per coverage year	1 day
Emergency room	
Plan pays per day on which an emergency room visit occurs	$100
Maximum number of days per coverage year	2 days
Outpatient surgical procedure	
Plan pays per day on which a surgical procedure is performed	$200
Maximum number of days per coverage year	1 day
Outpatient doctors' office visits	
Includes doctors' service in the office, home, walk-in clinic, and urgent care clinic.	
Plan pays per day on which doctors' services are provided	$50
Maximum number of days per coverage year	5 days
Outpatient laboratory and x-ray services	
Plan pays per day on which lab or x-ray services are provided	$50
Maximum number of days per coverage year	2 days
Prescription drugs, equipment and supplies	
Plan pays per day on which a prescription drug, equipment or supply is obtained	$20
Maximum number of days per coverage year	8 days

To use your prescription benefit:

A) Present your Aetna identification (ID) card to the pharmacist.
B) Participating pharmacies will apply a discount.
C) You pay the amount charged by the pharmacy.
D) Submit a medical claim form to Aetna Voluntary to receive your fixed benefit payment.

To find a participating pharmacy, call toll-free **1-888-772-9682** or visit **www.aetna.com/dse/custom/avp.**

Services to prevent illness are covered under the applicable benefit (Outpatient doctors' office visits or Outpatient laboratory and x-ray services) listed in this Benefit Summary, the same as services to treat illness.

Aetna – Fixed Benefits Plan 3

Fixed Benefits Plan:	
Inpatient Hospital Stay -- daily benefit	
(Includes maternity)	
Plan pays per day in a private or semi-private room	$350
Plan pays per day in Intensive Care Unit (ICU)	$700
Maximum number of stays per coverage year	2 stays
Inpatient Hospital Stay - lump-sum benefit	
(Includes maternity)	
Plan pays per initial day of an inpatient stay	$500
Maximum number of days per coverage year	2 days
Inpatient surgical procedure	
Plan pays per day on which a surgical procedure is performed	$300
Maximum number of days per coverage year	2 days
Accident - additional benefit	
Plan pays per initial day of treatment for an accident	$200
Maximum number of days per coverage year	2 days
Emergency room	
Plan pays per day on which an emergency room visit occurs	$175
Maximum number of days per coverage year	2 days
Outpatient surgical procedure	
Plan pays per day on which a surgical procedure is performed	$300
Maximum number of days per coverage year	2 days
Outpatient doctors' office visits	
Includes doctors' service in the office, home, walk-in clinic, and urgent care clinic.	
Plan pays per day on which doctors' services are provided	$60
Maximum number of days per coverage year	5 days
Outpatient laboratory and x-ray services	
Plan pays per day on which lab or x-ray services are provided	$70
Maximum number of days per coverage year	3 days
Prescription drugs, equipment and supplies	
Plan pays per day on which a prescription drug, equipment or supply is obtained	$30
Maximum number of days per coverage year	12 days

To use your prescription benefit:

A) Present your Aetna identification (ID) card to the pharmacist.
B) Participating pharmacies will apply a discount.
C) You pay the amount charged by the pharmacy.
D) Submit a medical claim form to Aetna Voluntary to receive your fixed benefit payment.

To find a participating pharmacy, call toll-free **1-888-772-9682** or visit **www.aetna.com/dse/custom/avp.**

Services to prevent illness are covered under the applicable benefit (Outpatient doctors' office visits or Outpatient laboratory and x-ray services) listed in this Benefit Summary, the same as services to treat illness.

Aetna – Fixed Benefits Plan 5

Fixed Benefits Plan:	
Inpatient Hospital Stay -- daily benefit	
(Includes maternity)	
Plan pays per day in a private or semi-private room	$500
Plan pays per day in Intensive Care Unit (ICU)	$1,000
Maximum number of stays per coverage year	2 stays
Inpatient Hospital Stay - lump-sum benefit	
(Includes maternity)	
Plan pays per initial day of an inpatient stay	$700
Maximum number of days per coverage year	2 days
Inpatient surgical procedure	
Plan pays per day on which a surgical procedure is performed	$450
Maximum number of days per coverage year	2 days
Accident - additional benefit	
Plan pays per initial day of treatment for an accident	$300
Maximum number of days per coverage year	2 days
Emergency room	
Plan pays per day on which an emergency room visit occurs	$275
Maximum number of days per coverage year	2 days
Outpatient surgical procedure	
Plan pays per day on which a surgical procedure is performed	$450
Maximum number of days per coverage year	2 days
Outpatient doctors' office visits	
Includes doctors' service in the office, home, walk-in clinic, and urgent care clinic.	
Plan pays per day on which doctors' services are provided	$70
Maximum number of days per coverage year	7 days
Outpatient laboratory and x-ray services	
Plan pays per day on which lab or x-ray services are provided	$90
Maximum number of days per coverage year	3 days
Prescription drugs, equipment and supplies	
Plan pays per day on which a prescription drug, equipment or supply is obtained	$45
Maximum number of days per coverage year	12 days

To use your prescription benefit:

A) Present your Aetna identification (ID) card to the pharmacist.
B) Participating pharmacies will apply a discount.
C) You pay the amount charged by the pharmacy.
D) Submit a medical claim form to Aetna Voluntary to receive your fixed benefit payment.

To find a participating pharmacy, call toll-free **1-888-772-9682** or visit **www.aetna.com/dse/custom/avp.**

Services to prevent illness are covered under the applicable benefit (Outpatient doctors' office visits or Outpatient laboratory and x-ray services) listed in this Benefit Summary, the same as services to treat illness.

DENTAL BENEFITS

Voluntary dental Insurance

Administered by Reliance Matrix

Good oral care enhances overall physical health, appearance and mental well-being. Problems with the teeth and gums are common and easily treated health problems. Keep your teeth healthy and your smile bright with the Reliance Matrix dental benefit plan.

	Low Plan	High Plan
Services	**In-Network and Out-of-Network**	
Annual Deductible	$100 per person $300 family limit	$50 per person $150 family limit
Calendar Year Maximum	$750 per person	$1,000 per person
Preventive Dental Services (Routine Exam, Bitewing X-rays, Full Mouth/Panoramic X-rays, Periapical X-rays, Cleaning, Fluoride for Children 13 and under, Sealants)	100%	100%
Basic Dental Services (Space Maintainers, Fillings for Cavities, Restorative Composites, (anterior and posterior teeth), Simple Extractions, Anesthesia)	80% after deductible	80% after deductible
Major Dental Services (Onlays, Crowns, Crown Repair, Endodontics (nonsurgical), Endodontics (surgical), Periodontics (nonsurgical), Periodontics (surgical), Denture Repair, Prosthodontics (fixed bridge; removable complete/partial dentures), Complex Extractions)	50% after deductible	50% after deductible
Orthodontia (Coverage for Adults)	50% up to $750 Lifetime Maximum	50% up to $1,000 Lifetime Maximum
Out-of-Network Reimbursement	MAC	90th U&C

Voluntary Dental – High Plan	
Weekly Rates (52)	
Employee Only	$5.89
Employee & Spouse	$11.57
Employee & Children	$16.34
Family	$22.02

VISION BENEFITS

Voluntary Vision Insurance

Administered by Reliance Matrix

Regular eye examinations can not only determine your need for corrective eyewear but also may detect general health problems in their earliest stages. Protection for the eyes should be a major concern to everyone.

Service	In-Network	Out-of-Network
Eye Exam — once every 12 months	$10 copay	Up to $45
Lenses — once every 12 months		
Single Vision Lenses	$25 copay (Deductible applies to a complete pair of glasses or to frames, whichever is selected)	Up to $30
Lined Bifocal Lenses		Up to $50
Lined Trifocal Lenses		Up to $65
Lenticular Lenses		Up to $100
Frames — once every 12 months	$130 allowance (The Costco and Walmart allowance will be the wholesale equivalent)	Up to $70
Contact Lenses — once every 12 months		
Fit & Follow Up Exams	Member cost $60 allowance	No benefit
Medically Necessary	Covered in full	Up to $210
Elective	$130 allowance	Up to $105

No need for an ID card. To take advantage of your Reliance Matrix vision benefit, simply contact a VSP provider and let them know you have VSP coverage—they handle the paperwork for you.

There are four ways to find an in-network doctor:

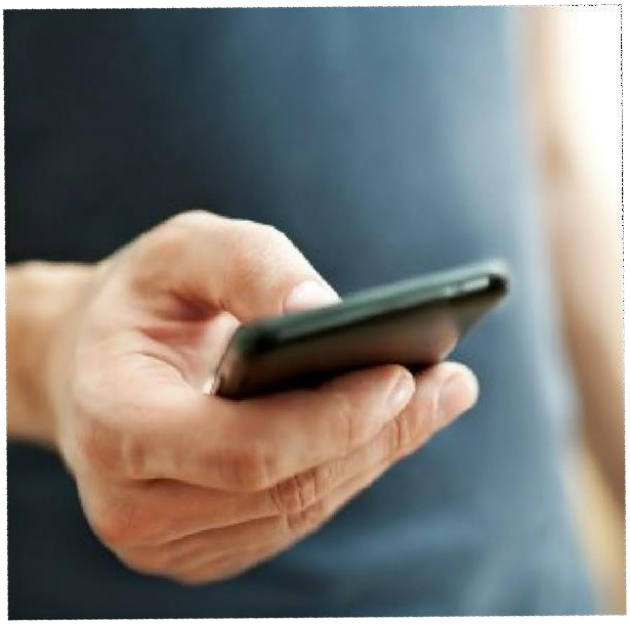
- Visit www.vsp.com and select the VSP Choice Network + Affiliates Network
- Scan the QR code in this page
- Call VSP at 800.877.7195
- Download our mobile app, benefit tools and search for a doctor near you

Voluntary Vision Plan	
Weekly Rates (52)	
Employee Only	$2.20
Employee & Spouse	$4.27
Employee & Children	$3.74
Family	$5.82

CONTACT INFORMATION

If you have specific questions about a benefit plan, please contact the administrator listed below, or your local human resources department.

Benefit	Administrator	Group Number	Phone	Website/Email
Employee Benefits	Aetna	802189	(888) 772-9682 Code: 1095 Customer Service 9 languages	www.myaenasupplemental.com
Medical	Kaiser Permanente	35989	(855) 384-3184	www.kp.org/kpic-colorado
Gallagher	Adam Kinyicky		(830) 221-6250	adam_kinyicky@ajg.com
Human Resources	Stephane Jimenez		(303) 430-1700 ext 713 (303) 726-4863	Benefits@xclusiveservices.com
Coverage2Care—Medicare	Kimberly Rodriguez		(210) 392-0312	kimberly@coverage2care.com



LEGAL NOTICES

Patient Protections Disclosure

The Xclusive Services Health Plan generally requires 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. Until you make this designation, Kaiser Permanente designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Kaiser Permanente at (855) 384-3184 or www.kp.org/kpic-colorado.

For children, you may designate a pediatrician as the primary care provider.
You do not need prior authorization from Kaiser Permanente 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 the Kaiser Permanente at (855) 384-3184 or www.kp.org/kpic-colorado.

Women's Health & 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 the plan. Therefore, the following deductibles and coinsurance apply:

Plan 1: HSA 5000 EMB 20% (Individual: 20% coinsurance and $5,000 deductible; Family: 20% coinsurance and $10,000 deductible)

Plan 2: PPO 3000 30% (Team Members Outside of Colorado) (Individual: 30% coinsurance and $3,000 deductible; Family: 30% coinsurance and $6,000 deductible)

If you would like more information on WHCRA benefits, please call your Plan Administrator at (303) 430-1700 Ext. 713 or benefits@xclusiveservices.com.

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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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**.

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** 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** 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 –

ALABAMA – Medicaid	**ALASKA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/ flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – 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	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: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
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	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – 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: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: 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: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	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

NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – 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)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: 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	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	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
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

HIPAA Notice of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights

Xclusive Services is committed to the privacy of your health information. The administrators of the Xclusive Services Health Plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Stephane Jimenez - Benefits Manager at (303) 430-1700 Ext. 713 or benefits@xclusiveservices.com.

HIPAA Special Enrollment Rights

Xclusive Services Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the Xclusive Services Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program – If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Stephane Jimenez - Benefits Manager at (303) 430-1700 Ext. 713 or benefits@xclusiveservices.com.

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

Notice of Creditable Coverage

Important Notice from Xclusive Services

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 Xclusive Services 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. **Xclusive Services has determined that the prescription drug coverage offered by the medical 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.**

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 current Xclusive Services coverage may be affected. If you do decide to join a Medicare drug plan and drop your current Xclusive Services coverage, be aware that you and your dependents may or 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 Xclusive Services 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 Xclusive Services 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
- 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, 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 01, 2025**
Name of Entity/Sender:	**Xclusive Services**
Contact—Position/Office:	**Stephane Jimenez - Benefits Manager**
Office Address:	**8774 Yates Dr Ste 210 Westminster, Colorado 80031-6906 United States**
Phone Number:	**(303) 430-1700 Ext. 713**

COBRA General Notice

Model General Notice of COBRA Continuation Coverage Rights
(For use by single-employer group health plans)

**** Continuation Coverage Rights Under COBRA****

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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.

What is COBRA continuation coverage?

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

If you're a Team Member, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of a Team Member, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

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

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the Team Member;
- The Team Member's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the Team Member and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Stephane Jimenez.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives 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 Team Members may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.
There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the Team Member or former Team Member dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), 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/**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

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[1] 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

[1] https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start

If you don't enroll in Medicare 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 continuation coverage 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.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (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. (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.**

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about 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.

Plan contact information

Xclusive Services
Stephane Jimenez - Benefits
Manager 8774 Yates Dr Ste 210
Westminster, Colorado 80031-6906
United States
(303) 430-1700 Ext. 713

Marketplace Notice

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the Team Member, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income. [1] [2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact Stephane Jimenez.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Xclusive Services		4. Employer Identification Number (EIN) 75-2993507	
5. Employer address 8774 Yates Dr Ste 210		6. Employer phone number (303) 430-1700 Ext. 713	
7. City Westminster		8. State Colorado	9. ZIP code 80031-6906
10. Who can we contact about employee health coverage at this job? Stephane Jimenez			
11. Phone number (if different from above)	12. Email address benefits@xclusiveservices.com		

Aetna – Important Payroll Info

What if I miss a payroll deduction?
Your coverage will not begin until you have your first payroll deduction. Each payroll deduction pays for coverage for one payroll period. If you miss a payroll deduction after your coverage begins, you will not have coverage during the time that payroll deduction would cover, unless you pay the full missed premium directly to Aetna Voluntary.

Will my balance be canceled if I don't make up a missed premium?
Once your coverage has begun, it will not be canceled because you do not make up a missed premium. However, no claims will be paid for losses that occur during the period for which the premium is unpaid.

How do I pay my missed premium?
To pay by ***personal check***, ***cashier's check***, or ***money order***, make payable to ***Aetna Life Insurance Company*** and send with a completed copy of the Missed Premium Payment Coupon to: Missed Premiums, P.O. Box 534739, Atlanta, GA, 30353. You can get additional payment coupons by calling **1-888-772-9682**.

Can I pick which premiums I wish to pay?
No. Your missed premium payment will always be applied to the oldest gap in coverage within the last 45 days (from the postmark on your mailed payment). You cannot choose to cover a later gap in coverage if you have an earlier gap in coverage if you have an earlier gap within the past 45 days from the date your payment is postmarked. To find out what gaps in coverage you may have, please call toll free **1-888-772-9682**, Monday through Friday, 8 a.m. to 6 p.m.

How long do I have to pay a missed premium?
You may pay for a gap in coverage that is up to 45 days old, from the date your payment is postmarked. Please note, if you have a gap in coverage of more than 30 days, your 3 to 12 month waiting period for dental services will reset.

Can I just pay part of a missed premium?
No. You must pay the full premium deduction that was missed in your paycheck, for all coverage you have. We cannot accept partial payments.

If I become ineligible or my employment ends, can I continue coverage with missed premium payments?
No. If your coverage terminates, you may not continue coverage by paying missed premiums.

This benefit summary prepared by

Gallagher

Insurance | Risk Management | Consulting