

A Guide to Your 2025 Benefits



IMPORTANT:

The Hospital Bridge, Critical Illness, Accident, Hospital Indemnity and Major Expense Protection Plans described in this guide are fixed indemnity policies, NOT health insurance.

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- ▶ The payment you get isn't based on the size of your medical bill.
- ▶ There might be a limit on how much this policy will pay each year.
- ▶ This policy isn't a substitute for comprehensive health insurance.
- ▶ Since this policy isn't health insurance, it doesn't have to include most federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- ▶ Visit [HealthCare.gov](https://www.healthcare.gov) or call 1-800-318-2596 (TTY: 1-855-889-4325) to find health coverage options.
- ▶ To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- ▶ For questions or complaints about this policy, contact your state Department of Insurance. Find their number on the National Association of Insurance Commissioners' website ([naic.org](https://www.naic.org)) under "Insurance Departments."
- ▶ If you have this policy through your job, or a family member's job, contact the employer.

People. Service. Performance.

At Populus Group, we believe everyone should have the opportunity to succeed. We understand that having the benefits you need is a part of that. The Populus Group benefit program gives access to plans that help you protect the health and security of you and your family. We realize benefit needs vary from person to person so we provide a range of plans that allows you to choose the level of coverage and the combination of benefits you want and need. This guide highlights the benefits available to you and explains how to enroll. In this guide, you will find:

- Your Benefits-at-a-Glance
- Who is eligible and how to enroll
- Summaries of each benefit plan

Your Benefits At a Glance

Medical (with prescription drug benefit)¹ | page 13-20

- BlueCross BlueShield Basic Medical Plan (EPO Minimum Essential Coverage Plan)
 - EPO plan that features the national BlueCross BlueShield network
 - Plan pays 100% with no deductible for most preventive care in-network
 - Plan pays 100% of basic services, such as in-network office visits and in-network generic drugs (no coverage for major services such as hospitalization and surgery)
 - Includes prescription drug coverage through CVS Caremark
- BlueCross BlueShield Bronze Medical Plan (BlueChoice Advantage)
 - PPO plan that features the national BlueCross BlueShield network
 - Annual individual deductible of \$5,000 and annual family deductible of \$10,000
 - Includes prescription drug coverage through CVS Caremark
- BlueCross BlueShield HSA Eligible Medical Plan (BlueChoice Advantage HDHP)
 - High Deductible Health Plan (HDHP) plan that features the national BlueCross BlueShield network
 - Annual individual deductible of \$4,500 and annual family deductible of \$9,000
 - Includes prescription drug coverage through CVS Caremark
 - Health Savings Account Eligible
- Health Savings Account³
 - Allows you to set aside pre-tax dollars to pay for current or future medical expenses
 - Keep your HSA account even if you end employment with Populus Group (No "Use It or Lose It")
 - Only available if you elect the HSA Eligible High Deductible Medical Plan
- Symetra Life Insurance Company
 - Choice of three fixed indemnity medical insurance plans (Essential Plan, Enhanced Plan, Advanced Plan)
 - Access to the Multiplan network of providers
 - Benefits are paid at a fixed amount regardless of the actual cost of service
 - Plans include prescription drug coverage

Hospital Bridge Insurance Plan¹ | page 21-22

- Pays a daily benefit for medical services such as hospitalization, major diagnostic testing, emergency room visits, and more, up to the annual maximum
- Three options available, with different maximum benefits per covered person per year: Traditional– \$25,000; Enhanced– \$35,000; and Premium– \$45,000
- Designed to be used in combination with Basic Medical Plan, or coverage can be purchased separately

Critical Illness Insurance¹ | page 23

- Pays a fixed dollar amount if you or a covered family member is diagnosed for the first time with a serious illness or condition
- Two options available, with different lump sum benefits: Option 1 – \$10,000; or Option 2 – \$20,000
- Benefits for the employee or spouse are 100% of the lump sum benefit you enrolled for; benefits for children are 25% of the adult benefit
- Coverage can be purchased separately or in addition to a medical plan

Accident Insurance¹ | page 24

- Covers any type of accidental injury not incurred at work (up to three accidents per calendar year per covered person) and pays your actual billed expenses up to the maximum benefit for the option you purchased; can help you meet your deductible or pay other expenses that are not covered by a comprehensive medical plan
- Two options available, with different benefit levels: Option 1 – Up to \$3,500 per accident; or Option 2 – Up to \$10,000 per accident

Hospital Indemnity¹ | page 25

- Provides direct payment to the insured for inpatient hospitalization
- Coverage can be purchased separately to any one of the three medical options
- If hospitalized, plan pays \$1,000 for three hospital stays per covered person per calendar year, and \$300 per day (at least 24 hours in a hospital) for up to 30 days per year
- Includes a Prescription Drug Discount Program

Major Expense Protection Plan¹ | page 26

- Provides direct payment to the insured for emergency room and inpatient hospital benefits which includes substance abuse and mental health
- Coverage can be purchased separately or in addition to any one of the medical options or the Hospital Indemnity plan
- If hospitalized, the plan pays \$1,500 per day up to 30 days per plan year

Health Advocate | page 27

- Health Advocay Services – Access to a Personal Health Advocate, typically a registered nurse, supported by a team of physicians and administrative experts, who will help in handling health care and insurance related issues. You, your spouse, children, parents and the parents of your spouse are eligible to use this service. Automatically receive this benefit when you enroll in a BlueCross medical plan or one of the three Symetra fixed indemnity medical insurance plans.
- Employee Assistance Program (EAP) & Work/Life Benefit – Confidential counseling for emotional, legal, financial, and other personal issues. Company paid, automatically enrolled at hire.

Dental¹ | page 28

- Pays 100% for preventive and diagnostic care; 50% to 80% for other services. \$50 deductible per person

Vision¹ | page 29

- In and out-of-network option (eye exam every 12 months; lenses/frames/contacts every 24 months)
- Interim Benefits for lenses and frames

Flexible Spending Accounts¹ | page 30

- Health Care FSA – allows you to set aside tax free dollars for certain medical expenses
- Dependent Care FSA – allows you to set aside tax free dollars for certain child care expenses

Disability² | page 31-32

- Short Term Disability
 - Plan pays 60% of pre-disability weekly pay up to a maximum benefit of \$600 per week
 - Benefits begin on the 8th day of total disability and will be paid for up to 13 weeks
 - Weekly premiums are based on age and weekly benefit amount
- Long Term Disability
 - Two plan options: five-year option or to age 65 option
 - Plan pays 60% of pre-disability monthly base pay after 90 days of disability. Maximum monthly benefit is \$5,000
 - Weekly premiums are based on age, monthly earnings, and plan option

Voluntary Life and AD&D² | page 33-34

- Life Insurance
 - Employee Voluntary Life: \$10,000 increments up to \$150,000– cost is based on age and level of coverage
 - Spouse Voluntary Life: \$10,000 increments up to \$30,000– cost is based on age and level of coverage
 - Child Voluntary Life: Benefits amounts in either \$1,000, \$2,500, \$5,000, \$7,500 or \$10,000 – cost is based on level of coverage
- Accidental Death & Dismemberment (AD&D)
 - Employee Voluntary AD&D: increments of \$10,000 up to \$500,000 (subject to 10x earnings over \$150,000)
 - Family AD&D: spouse's benefit is 60-100% (depending on dependents) of employee's, dependent children's benefit is 15% of employee's

Enhanced Benefits¹ | page 35-36

- AllState Identity Theft – Provides financial monitoring, fraud alerts, credit reporting, etc.
- MetLife Pet Insurance – Coverage for dogs and cats including accidental injuries, surgeries, exam fees, medications, x-rays, and more!

(1) You may elect or change these benefits during the annual open enrollment period or anytime during the year with a qualifying status change.

(2) You may elect or change these benefits anytime during the year with medical underwriting requirements.

(3) You may elect to open an HSA through Populus during the annual Open Enrollment period or anytime during the year with a qualifying status change provided you elect the HSA Eligible Medical plan offered by Populus. You may change your contribution level to your HSA at any time during the year.

Eligibility

In order to qualify for benefits coverage, you must maintain a minimum of 20 hours per week, each week, in order to qualify for enrollment and to maintain your coverage throughout the calendar year. Falling below 20 hours for 4 consecutive weeks will result in a termination of benefits coverage, please connect with the benefits team at pqbenefits@populusgroup.com if you feel that you'll be running this risk throughout the plan year. The following individuals are also eligible:

Spouse

A spouse is an individual who is recognized as the employee's spouse under applicable state law, excluding, however, a common law spouse unless the individual qualifies as the employee's domestic partner.

Domestic Partner

Same-sex and opposite-sex couples who have registered with any state or local government agency authorized by state or local law to perform such registrations. In other words, you must have filed with the authorized agency and the agency must maintain a record of your domestic partnership.

A civil union partner is neither a spouse nor a domestic partner, unless otherwise registered on a state or local government agency's domestic partner registry.

Populus Group may request documentation of relationships, including marriage certificates, domestic partner registry certificates, and birth certificates. Any requirements for proof of relationship for domestic partnerships are also applied to marriages. For example, domestic partner registry certificates are recognized as fully equivalent to marriage certificates.

Please note, if you are adding a dependent with a last name that is different than yours, you will be required to provide proof of relationship, such as birth certificate or adoption certificate.

Dependent Children

- Is under the age of 26 or is permanently and totally disabled (and meets the eligibility requirements described below); and
- Is related to you in one of the following ways:
 - You or your spouse's child by birth or legal adoption;
 - Under testamentary or court appointed guardianship, other than temporary guardianship of less than 12 months duration, and who resides with, and is the dependent of you or your spouse;
 - A child who is the subject of a Medical Child Support Order or a Qualified Medical Support Order that creates or recognizes the right of the child to receive benefits under a parent's health insurance coverage;
 - A grandchild who is in the court-ordered custody, and who resides with, and is the dependent of you or your spouse.

Examples of Ineligible Dependents

Children whose relationship to you is not listed above, including, but not limited to grandchildren (except as provided above), foster children or children whose only relationship is one of legal guardianship (except as provided above) are not eligible, even though the child may live with you and be dependent upon you for support.

If you and your spouse both work for Populus Group, each family member—you, your spouse, and your eligible children— can be covered only once for medical, dental and vision. One of you can enroll in a plan and cover all eligible children, and the other can waive coverage, or you can both enroll. Children cannot be covered by each parent separately.

Disabled Dependents

Coverage may be available to your disabled child who is over age 26, provided the child is financially dependent on you, is unmarried and was enrolled in the plan prior to attaining age 26. If you have an over age disabled dependent child, documentation of the disability may be required to continue coverage under the plan.

Note: Enrolling an individual that is not eligible for Populus' plans is a fraudulent act and could result in disciplinary action up to and including termination.



When Benefits Begin

If you are a new hire, your benefit coverage begins on the first of the month following your hire date if you are on active service. Active service means you are doing your regular duties in the usual manner on a scheduled work day at one of the places of business where you normally work or where your work sends you.

Coverage for your dependents begins when yours does, unless you add them to your coverage later. You have 30 days from your effective hire date.

Please Note: The Identity Theft Protection plan is effective for new hires 30 days after your date of hire. This differs from all other benefits being effective the first of the month following your date of hire.

	Example 1	Example 2
Date of Hire	2/4/2025	4/1/2025
Date Coverage Begins	3/1/2025	5/1/2025
Enroll by Date	12 Midnight EST, 3/30/2025	12 Midnight EST, 5/30/2025

Please keep in mind, you pay for benefits through weekly payroll deductions and if you miss deductions, payment will automatically be made up with double deductions. Please see the “Paying for Your Benefits” section of the guide for more detailed information.



How To Enroll: PopulusBenefits.com

PopulusBenefits.com is an online benefits service that puts benefits information and enrollment at your fingertips, 24 hours a day, seven days a week. **PopulusBenefits.com** lets you look at your personal benefits record, including current coverage, dependents, and costs. You can also find details about all the available plans, so you can choose benefits that will work best for you and your family. In addition:

- You can enroll online and print a confirmation. You **do not** have to fill out a paper enrollment form. **You cannot enroll over the phone.**
- **PopulusBenefits.com** is private and accessible via the internet, anywhere, anytime.
- You can print a Temporary Benefit Confirmation to present to your providers in the event you have not received your ID cards.
- You can access **PopulusBenefits.com** after the enrollment period whenever you have questions about your benefits.
- You have from your date of hire through the end of your first full calendar month of employment to enroll. If you wait until the latter part of your effective month to enroll, your benefits will still begin on the first of the month and you will be responsible for all missed premiums.

Mobile App

Download the KTBSonline app (look for the lion icon) to access your benefits on the go. With the app, you will have quick access to information and services, including:

- Benefits enrollment
- Plan details
- Employee/dependent information
- Ability to email proof of coverage directly from the app
- Ability to reach out to customer service for assistance

Search for KTBSonline and download on any mobile device today!

The Enrollment Process

Once you log in, just follow these steps:

- Review your personal information:
 - Demographic (if you need to make changes, you may do so at this screen. If you need to change a field you do not have access to, please contact your local office)
 - Employment information (if this information is incorrect, please contact your local office)
 - Dependent review. If you need to add or remove a dependent, you should do so from this screen. Please note, adding a dependent here DOES NOT enroll them in benefits. You must add them to each plan you wish to enroll them in.
- Review your current benefits and details of your 2025 options.
- Elect your benefits or waive those you do not wish to elect. Choose your coverage level (Employee, Employee + Child(ren), Employee + Spouse, Family) or waive medical coverage. If you choose coverage other than employee only, you must add your dependents to the plan.
 - Medical
 - Health Savings Account (only if you are enrolled in the HSA Eligible High Deductible medical plan)
 - Hospital Bridge Insurance Plan
 - Critical Illness Insurance
 - Accident Insurance
 - Hospital Indemnity Plan
 - Major Expense Protection Plan (MEPP)
 - Dental
 - Vision
 - Life Insurance (If you enroll outside of your eligibility period or increase your existing coverage you will be subject to approval by Reliance).
 - AD&D
 - Short Term Disability (STD)
 - Long Term Disability (LTD)
 - Identity Theft Protection
 - Pet Insurance (This benefit will not be elected on the enrollment portal. If you are interested in electing Pet Insurance, please contact MetLife directly at: 1-800-438-6388)
- Review all of your elections and continue through the enrollment process.
- Review the Online Enrollment User Acknowledgment and complete the online enrollment process.
- Print your online Enrollment Election form and keep this copy for your records.



Beneficiaries

Many people overlook and underestimate the importance of designating a beneficiary. In many cases, people don't designate a beneficiary at all, and in other cases, the information is outdated. Taking the time to designate or update your beneficiaries today can eliminate many challenges for your family in the event of your death.

How To Designate Or Update Your Beneficiaries

Below is a list of the benefits that need a beneficiary as well as step-by-step instructions on how to check and update your beneficiaries.

- **Life Insurance and AD&D:** Log on to **PopulusBenefits.com**. Click My Benefits & Personal Information at the top of the page. Under the Benefits section on the left side of the page, click Beneficiaries.
- **Health Savings Account (HSA):** From the Health Equity employee portal click on the help link in the upper right-hand corner of the page. This will direct you to the HQY help center. In the search bar labeled "get answers" type in Beneficiary. The topic "add a beneficiary" will appear below. Click on the that and it will provide detailed instructions on how to add a beneficiary.

Benefit Identification (ID) Cards

Your medical and hospital bridge insurance plan ID cards will arrive at your home approximately three weeks from the time your enrollment is received at Symetra or BCBS. You will not receive ID cards for the critical illness, accident, hospital indemnity, major expense protection plan, dental and vision plans, as Symetra, MetLife and VSP do not require you to have an ID card for these plans.

You may retrieve a Temporary Benefit Confirmation if you have not received your medical ID card or if you would prefer to have your dental and vision information on hand when you visit your provider. To access your Temporary Benefit Confirmation, log on to **PopulusBenefits.com** and select My Benefits & Personal Information at the top of the Homepage. Under the Benefits Information column, select Temporary Benefit Confirmation. Select the benefits you would like a temporary confirmation for.

If You Do Not Enroll

If you do not enroll during your initial eligibility period (generally 30 days from the first day of the month following your date of hire), you cannot enroll or make changes to your coverage until the next Open Enrollment period, or unless you have a qualifying status change, described later in this guide.

Paying For Your Benefits

You pay for your benefits through weekly payroll deductions. Your premiums for your medical, hospital bridge plan, critical illness insurance, accident insurance, hospital indemnity, major expense protection plan, dental, and vision coverage will be deducted from your paycheck on a pre-tax or post-tax basis, depending on the option you choose. However, according to federal law, premiums for a same-sex spouse and his/her children cannot be paid on a pre-tax basis unless, the spouse or child qualifies as your dependent as defined under the Internal Revenue Code.

Under Section 125 of the Internal Revenue Code, if you choose pre-tax contributions, you may not change or cancel your benefits unless you incur a qualifying life status change, described later in this guide.

If you choose post-tax contributions you may completely cancel all of the benefit plans you are enrolled in at any time during the year without restriction, or you may just cancel one benefit plan and keep the others (subject to any policy rules).

Deductions for Disability, Life, and AD&D insurance are made on a post-tax basis. Please keep in mind:

- Weekly payroll deductions begin the first full week of benefit coverage;
- If you wait until the latter part of your effective month to enroll, your benefits will still begin on the first of the month and you be responsible for all missed premiums. ***It is your responsibility for all missed premiums owed for the plans that you elect into while on assignment. Populus Group has the right to recoup deductions in the form of double deductions if any weeks are not recouped throughout the calendar year such as from a vacation, client shutdown, etc.***
- Missed deductions will be made up with double deductions in subsequent weeks.
- You must pay for your benefits every week, regardless of how often you use them.

	Example 1	Example 2
Date of Hire	2/5/2025	4/1/2025
Date Coverage Begins	3/1/2025	5/1/2025
Enroll by Date	12 Midnight EST, 3/31/2025	12 Midnight EST, 5/30/2025
Date you physically enrolled	3/17/2025	5/19/2025
Weeks of arrears/missed premiums owed	1 week at double deductions	2 weeks at double deductions

If You Have Questions

If you have questions about your benefit choices or the enrollment process, contact the Benefits Service Center at **888-858-6310**. Phone numbers and web addresses for the various benefit plan providers are found in the back of this guide.

Medical & Prescription Benefits

Basic Plan (EPO Minimum Essential Coverage Plan)	In-Network
Benefit Period ¹ Maximum ²	Unlimited
Lifetime Maximum	Unlimited
Benefit Period ¹ Deductible ²	\$0.00
Benefit Period ¹ Out-of-Pocket Maximum ³	\$0.00
Office Visits	
PCP Visit	Covered at 100%
Specialist Visit	Covered at 100%
Preventive Care⁴	
Well Child Care & Immunizations (through age 17)	Covered at 100%
Annual Physicals	Covered at 100%
Routine GYN Exam	Covered at 100%
Mammography	Covered at 100%
Hospitalization	
Inpatient & Outpatient	Not covered
Labs, and Testing	
X-Ray & Diagnostic Imaging	Not covered
Outpatient Lab Work	Covered at 100%
Mental Health and Substance Abuse	
Inpatient ⁴ & Outpatient	Not covered
Prescription Drug	
Deductible	\$0.00
Generic Drugs	\$0.00 copay
Preferred Brand Drugs	\$0.00 copay
Non-Preferred Brand and Specialty Drugs	Not Covered

(1) Benefit Period is January through December of each calendar year.

(2) Per covered member for all medical services.

(3) Includes deductible, coinsurance and copayments.

(4) As defined under the Affordable Care Act.

Note: The Basic Medical Plan does not provide the minimum creditable coverage that adults who file taxes in Massachusetts need to have in order to avoid penalties. Employees residing in Massachusetts who select the Basic Medical Plan may be subject to penalties. **The Basic Medical Plan option is a Minimum Essential Coverage plan, and is not subject to any state benefit requirements.**

The contents of this chart are for informational purposes only. If there is any conflict between the information in this chart and the official plan document, the official plan document will govern.

Weekly Premiums	Basic Plan	Bronze Plan	HSA Eligible Plan
Employee	\$48.80	\$126.92	\$130.55
Employee & Child(ren)*	\$78.91	\$234.79	\$241.51
Employee & Spouse*	\$89.36	\$291.91	\$300.26
Family	\$123.60	\$385.82	\$396.87

*Please see the Eligibility section of this guide for the definition of an eligible dependent.

The Bronze Plan is considered affordable under the Affordable Care Act (ACA). Therefore, you will not qualify for a tax credit or subsidy if you purchase health insurance through Federal or State run exchanges. You may be eligible for a subsidy which would result in a per paycheck deduction lower than the cost listed in this guide for Individual coverage on the Bronze Plan, based on the requirements of the ACA. For more information, contact the Populus Group Benefits Team at PGBenefits@PopulusGroup.com.

Benefit	HSA Eligible High Deductible Health Plan (BlueChoice Advantage HDHP)		Bronze Plan (BlueChoice Advantage)	
	In-Network ^{1,2}	Out-of Network ^{1,3}	In-Network ^{1,2}	Out-of Network ^{1,3}
Annual Deductible ⁴	\$4,500 Individual \$9,000 Family	\$9,000 Individual \$18,000 Family	\$5,000 Ind \$10,000 Fam	\$10,000 Ind \$20,000 Fam
Annual Out-of-Pocket Maximum ⁵	\$6,550 Individual \$13,100 Family (Combined medical & Rx out of pocket max)	\$12,700 Individual \$25,400 Family	\$6,350 Ind \$12,700 Fam	\$12,700 Ind \$25,400 Fam
Lifetime Maximum Benefit	None	None	None	None
Preventive Services				
Well Child Care (including exams & immunizations)	Covered at 100%	You pay 50% of AB	Covered at 100%	You pay 50% of AB
Adult Physical Exam (including routine GYN visit)	Covered at 100%	You pay 50% of AB*	Covered at 100%	You pay 50% of AB*
Breast Cancer Screening	Covered at 100%	You pay 50% of AB	Covered at 100%	You pay 50% of AB
Pap Test, Prostate/ Colorectal Cancer Screening	Covered at 100%	You pay 50% of AB*	Covered at 100%	You pay 50% of AB*
Office Visits, Labs and Testing				
Office Visits for Illness	You pay 20% of AB*	You pay 50% of AB*	You pay \$40 per visit*	You pay 50% of AB*
Imaging, Labs and X-ray ⁷	You pay 20% of AB*	You pay 50% of AB*	You pay \$40 per visit*	You pay 50% of AB*
Physical/Speech/Occupational Therapy ^{8,9}	You pay 20% of AB*	You pay 50% of AB*	You pay \$40 per visit*	You pay 50% of AB*
Chiropractic ^{8,10}	You pay 20% of AB*	You pay 50% of AB*	You pay \$40 per visit*	You pay 50% of AB*
Emergency Services				
Urgent Care Center	You pay 20% of AB*	You pay 20% of AB**	You pay \$50 per visit*	You pay \$50 per visit**
Emergency Room – Facility Services	You pay 20% of AB*	You pay 20% of AB**	You pay \$250 per visit* ¹¹	You pay \$250 per visit** ¹¹
Emergency Room – Physician Services	You pay 20% of AB*	You pay 20% of AB**	Covered at 100%*	Covered at 100%**
Ambulance (if medically necessary)	You pay 20% of AB*	You pay 20% of AB**	You pay 20% of AB*	You pay 20% of AB**
Hospitalization—(Members are responsible for applicable physician and facility fees)				
Inpatient/Outpatient Facility Services	You pay 20% of AB*	You pay 50% of AB*	You pay 20% of AB*	You pay 50% of AB*
Inpatient/Outpatient Physician Services	You pay 20% of AB*	You pay 50% of AB*	You pay 20% of AB*	You pay 50% of AB*
Maternity				
Preventive Prenatal and Postnatal Office Visits	Covered at 100%	You pay 50% of AB*	Covered at 100%	You pay 50% of AB*
Delivery and Facility Services	You pay 20% of AB*	You pay 50% of AB*	You pay 20% of AB*	You pay 50% of AB*
Nursery Care of Newborn	You pay 20% of AB*	You pay 50% of AB*	You pay 20% of AB*	You pay 50% of AB*
Mental Health and Substance Abuse				
Inpatient/Outpatient Facility Services	You pay 20% of AB*	You pay 50% of AB*	You pay 20% of AB*	You pay 50% of AB*
Inpatient/Outpatient Physician Services	You pay 20% of AB*	You pay 50% of AB*	You pay 20% of AB*	You pay 50% of AB*
Prescription Drugs ⁶				
Deductible & Out-of-Pocket Maximum	See Medical Summary			
Up to a 34-day supply	Generic: You pay \$15 per prescription Preferred: You pay \$50 per prescription Non-preferred: You pay \$100 per prescription			
Maintenance Drugs: Up to a 90-day supply	Generic: You pay \$30 per prescription Preferred: You pay \$100 per prescription Non-preferred: You pay \$200 per prescription			

Not all services and procedures are covered by your benefits contract. This summary is for comparison purposes only and does not create rights not given through the benefit plan. The contents of this chart are for informational purposes only. If there is any conflict between the information in this chart and the official plan document, the official plan document will govern.

AB= Allowed Benefit

*After deductible is met.

**After In-Network deductible is met.

(1)When multiple services are rendered on the same day by more than one provider, Member payments are required for each provider.

- (2) *In-Network: When covered services are rendered in Maryland, Washington D.C. and/or Northern Virginia, collectively known as the CareFirst BlueChoice service area, by a provider in the CareFirst BlueChoice Provider network, care is reimbursed at the in-network level. In-network benefits are based on the CareFirst BlueChoice Allowed Benefit. The CareFirst BlueChoice Allowed Benefit is generally the contracted rates or fee schedules that CareFirst BlueChoice providers have agreed to accept as payment for covered services. These payments are established by CareFirst BlueChoice, Inc., however, in certain circumstances, an allowance may be established by law. Outside of the CareFirst BlueChoice service area, when covered services are rendered by a provider in the preferred provider network, care is also covered at the in-network level. These in-network benefits are based on the contracted rates or fee schedules that preferred providers have agreed to accept as payment for covered services that are established by the local Blue Cross and Blue Shield Plan, however, in certain circumstances, an allowance may be established by law.*
- (3) *Out-of-Network: When covered services are rendered by a provider that is not in the CareFirst BlueChoice network in Maryland, Washington D.C. or Northern Virginia, or is not in the preferred provider network outside of CareFirst BlueChoice service area, the care is reimbursed as out-of-network. Out-of-network benefits are based on the Allowed Benefit. The Allowed Benefit is generally the contracted rates or fee schedules that are established by CareFirst BlueChoice, or the local Blue Cross and Blue Shield Plan, however, in certain circumstances, an allowance may be established by law.*
- (4) *For family coverage only: When one family member meets the individual deductible, they can start receiving benefits. Each family member cannot contribute more than the individual deductible amount. The family deductible must be met before the remaining family members can start receiving benefits.*
- (5) *For family coverage only: When one family member meets the individual out-of-pocket maximum, their services will be covered at 100% up to the Allowed Benefit. Each family member cannot contribute more than the individual out-of-pocket maximum amount. The family out-of-pocket maximum must be met before the services for all remaining family members will be covered at 100% up to the Allowed Benefit. The out-of-pocket maximum includes deductibles, copays and coinsurance.*
- (6) *Plan has an integrated medical and prescription drug out-of-pocket maximum. The HSA plan is subject to the deductible before prescription copays apply.*
- (7) *If you receive laboratory services inside the CareFirst Service area (Maryland, D.C., Northern Virginia) members should use LabCorp to receive In-Network benefits. Services performed by any other provider, while inside the CareFirst Service area will be considered out-of-network. If you receive laboratory services outside of Maryland, D.C. or Northern Virginia, you may use any participating BlueCard PPO laboratory and receive in-network benefits.*
- (8) *There are no limits for children until the end of the month in which the insured or enrollee turns 19 years of age when Physical, Speech or Occupational Therapy is included as part of Habilitative Services.*
- (9) *Limited to 30 visits per injury per benefit period*
- (10) *Limited to 20 visits per injury per benefit period*
- (11) *Waived if admitted*



Health Savings Account (HSA)

To be eligible to open an HSA, you must be covered by a qualified high deductible health plan such as the Populus Group BlueCross BlueShield HSA Eligible High Deductible Medical Plan. You are not eligible if:

- You can be claimed as a tax dependent of another individual;
- You are currently enrolled in Medicare; or
- You have medical plan coverage other than a high deductible health plan, including secondary coverage under your spouse/domestic partner's plan. There cannot be coordination of benefits with another plan.

An HSA is a tax-advantaged savings account that allows you to put aside pre-tax income, invest your savings, and use your tax-free savings for eligible medical expenses. Unlike other medical savings accounts, any money you do not use stays in your account.

An HSA helps you save for health care expenses over your lifetime. If you use the account to pay for eligible medical expenses, (a list can be found at www.irs.gov/pub/irs-pdf/p502.pdf), you will not have to pay federal income taxes on your savings. You may choose to use the funds for ineligible expenses, but you will be taxed on the amount, and if you are under age 65, you will also be subject to an additional 20% tax penalty. **Please note, you may want to keep your receipts for IRS purposes.**

In addition to being an excellent way to put money aside for current expenses, an HSA is a tax-free way to save for future expenses—such as the need to cover retiree health premiums (excluding Medicare Supplement plans) or to pay for uncovered healthcare expenses at some time in the future.

Your HSA is your personal account and is entirely portable. This means if you leave Populus Group, you can take the account with you. Populus Group has partnered with Optum Bank to manage your Health Savings Account. Once you set up your HSA, you will receive a welcome package from Optum (which will include your healthcare payment card), quarterly Health Savings Account statements and other information pertaining to your HSA.

You may contribute to your HSA through pre-tax payroll deductions or through post-tax contributions of your own, up to the amount allowed by the IRS. If you choose to contribute through post-tax contributions, you will adjust your gross income when filing your income tax return the following year.

It is important to note although some expenses are eligible for reimbursement from your HSA, they may not count toward your annual deductible or annual out-of-pocket maximum (such as certain over-the-counter medications or long term care insurance premiums). For additional information about eligible and ineligible expenses, please refer to IRS Publication 502 www.irs.gov/pub/irs-pdf/p502.pdf.

HSA Contributions

You determine how much you want to contribute to your HSA on an annual basis. You may contribute up to the following IRS maximums:

- **Employee Only:** \$4,300
- **Two Person or Family:** \$8,550

If you are age 55 or older you are also eligible to make an additional contribution of \$1,000 to your HSA. You can add this amount by logging on to the enrollment site at PopulusBenefits.com.

How To Set Up Your HSA

You will set up your HSA with Optum via PopulusBenefits.com at the time you enroll in the BlueCross BlueShield HSA High Deductible Medical Plan. After enrolling in your medical benefits, you will be asked to enter an annual election amount you wish to contribute to your HSA. Once you complete this step, choose your other benefits and submit your enrollment, your information will be sent to Optum and your HSA will be established.

HSA Changes

You may change your HSA contributions at any time during the year by logging on to PopulusBenefits.com. A voluntary HSA contribution change will take effect on the following week's paycheck (subject to the annual limit).

States Not Recognizing The Tax-Free Status Of HSA Contributions

While the pre-tax contributions to your HSA made through payroll always provide tax savings on the federal level, the following states do not currently recognize those contributions for state income tax purposes: **California and New Jersey**. Please note, this is the most current list at the time this guide was created.

Account Balance

Depending on your health care expenses in a given year, you may not need to use all of the funds in your HSA. In this event, the remaining balance in your HSA will be available for your use in future years.

Interest And Earnings On Your Account Balance

Initially, the contributions made by you through payroll are deposited into an FDIC insured interest bearing account.

Once your account balance reaches \$1,000, you may choose to invest your HSA savings in a variety of mutual funds. Please keep in mind mutual funds carry a certain level of risk and return. You should consult a financial advisor when making investment decisions.

Please note: If you fail to open/register your Optum HSA account within the 90 day deadline, you run the possibility of getting your funds refunded as taxable income.

Fixed Indemnity Medical & Prescription Benefits

You may choose one of three fixed indemnity medical plans coverage options. The plans offer access to the MultiPlan national network of providers. For a network provider near you, visit **PopulusBenefits.com** for a direct link to the MultiPlan website or go to **www.multiplan.com**. The following charts highlights commonly covered services under the Symetra Life Insurance Company Fixed Indemnity Medical Insurance Plans.

Due to state regulations, this plan is not available to employees who live in New Hampshire.

Essential Plan	Basic Plan Benefits	Per Provision Limit	Collective Benefit Limit
Doctor Office Visits	\$80 per day	none	15 visits*; \$1,200
Outpatient Diagnostic X-Ray	\$80 per day	none	
Preventive Care	\$80 per day	none	
Emergency Room (outpatient DXL benefits may also apply)	\$200 per day	\$600*	\$600*
Hospital Admission	\$1,500 per first day	1*	\$1,500*
Ambulance Transportation			
Ground Transport	\$250 per day	5 days*	
Air Transport	\$500 per day	5 days*	
Hospital Stay¹			
Regular Room	\$500 per day	10 days*	\$5,000*
ICU	\$1,000 per day	10 days*	\$10,000*
Substance Abuse Facility	\$500 per day	10 days*	\$5,000*
Mental Health (180 day lifetime limit)	\$250 per day	10 days*	\$2,500*
Post-Hospital Nursing Facility Stay ¹	\$250 per day	60 days per stay* ³	\$15,000*
Surgery (based upon site of service) maximum¹ surgical benefit per day			
Outpatient Doctor's Office	\$75 per day	\$3,000 maximum benefit*	\$3,000 maximum benefit*
Outpatient Surgical Facility	\$550 per day		
Inpatient	\$2,000 per day		
Prescriptions			
Preferred generic Rx ⁵	\$10 copay	\$5,000*; \$10,000 family benefit	\$5,000*
Non-preferred generic and brand Rx ⁵	Discount	none	n/a
In-Network Discounts	when services are received through a MultiPlan PPO Network provider ²	none	n/a
Non-Network Penalties	none	none	none

*Per covered person per calendar year

The contents of this chart are for informational purposes only. If there is any conflict between the information in this chart and the official plan document, the official plan document will govern.

(1) 500 days per lifetime maximum except that mental health facility stay is limited to 180 days' lifetime maximum.

(2) Access to the MultiPlan PPO Network is included. There is a \$4 PEPM fee included in the monthly premiums shown for this access. Benefits are payable per policy without regard to network status of provider.

(3) This benefit is paid only if following a covered hospital stay of at least 3 consecutive days and the insured is under age 65.

(4) This collective benefit could be higher if more than one confinement in a single calendar year.

(5) Program insured by PRAM Insurance Services, Inc., Brea, CA, administered by RxEDO.

This discount program is not an insured benefit. Insurance benefits are provided under the Select Benefits Indemnity Policy, form number LGC-8786 2/03, and/or Critical Illness Policy, form number LGC-9095 2/07. they are insured by Symetra Life Insurance Company, 777 108th Ave NE, Suite 1200, Bellevue, WA 98004. The coverage is not a substitute for major medical or other comprehensive coverage. Benefits are subject to exclusions, limitations, reductions and termination of benefits provisions. Please review the description of benefits for additional details. For more information, contact your Symetra agent.

Enhanced Plan	Basic Plan Benefits	Per Provision Limit	Collective Benefit Limit
Doctor Office Visits	\$80 per day	none	20 visits*; \$1,600
Outpatient Diagnostic X-Ray	\$80 per day	none	
Preventive Care	\$80 per day	none	
Emergency Room (outpatient DXL benefits may also apply)	\$200 per day	\$600*	\$600*
Hospital Admission	\$1,000 per first day	2*	\$2,000*
Ambulance Transportation			
Ground Transport	\$250 per day	5 days*	
Air Transport	\$500 per day	5 days*	
Hospital Stay¹			
Regular Room	\$1,200 per day	none	\$15,000*
ICU	\$2,400 per day	none	
Substance Abuse Facility	\$1,200 per day	none	
Mental Health (180 day lifetime limit)	\$600 per day	none	
Post-Hospital Nursing Facility Stay ¹	\$600 per day	60 days per stay* ³	
Surgery (based upon site of service) maximum¹ surgical benefit per day			
Outpatient Doctor's Office	\$65 per day	none	
Outpatient Surgical Facility	\$1,500 per day		
Inpatient	\$3,500 per day		
Surgical Anesthesia	\$400 per surgery with anesthesia		
Outpatient Surgical Facility (OPSF)	\$900 per surgery with OPSF		
Prescriptions			
Generic Rx ⁵	\$10 copay	\$5,000*; \$10,000 family benefit	\$5,000*
Brand Rx ⁵	Discount	none	n/a
In-Network Discounts	when services are received through a MultiPlan PPO Network provider ²	none	n/a
Non-Network Penalties	none	none	none

*Per covered person per calendar year

The contents of this chart are for informational purposes only. If there is any conflict between the information in this chart and the official plan document, the official plan document will govern.

(1) 500 days per lifetime maximum except that mental health facility stay is limited to 180 days' lifetime maximum.

(2) Access to the MultiPlan PPO Network is included. There is a \$4 PEPM fee included in the monthly premiums shown for this access. Benefits are payable per policy without regard to network status of provider.

(3) This benefit is paid only if following a covered hospital stay of at least 3 consecutive days and the insured is under age 65.

(4) This collective benefit could be higher if more than one confinement in a single calendar year.

(5) Program insured by PRAM Insurance Services, Inc., Brea, CA, administered by RxEDO.

This discount program is not an insured benefit. Insurance benefits are provided under the Select Benefits Indemnity Policy, form number LGC-8786 2/03, and/or Critical Illness Policy, form number LGC-9095 2/07. they are insured by Symetra Life Insurance Company, 777 108th Ave NE, Suite 1200, Bellevue, WA 98004. The coverage is not a substitute for major medical or other comprehensive coverage. Benefits are subject to exclusions, limitations, reductions and termination of benefits provisions. Please review the description of benefits for additional details. For more information, contact your Symetra agent.

Advantage Plan	Basic Plan Benefits	Per Provision Limit	Collective Benefit Limit
Doctor Office Visits	\$80 per visit	none	\$150,000*
Outpatient Major Diagnostic Tests	\$375 per day	none	
Emergency Room (outpatient DXL benefits may also apply)	\$200 per day	none	
Hospital Stay¹			
Regular Room	\$2,000 per day	none	
ICU	\$4,000 per day	none	
Substance Abuse Facility	\$2,000 per day	none	
Mental Health (180 day lifetime limit)	\$1,000 per day	none	
Post-Hospital Nursing Facility Stay ¹	\$1,000 per day	60 days per stay* ³	
Surgery (based upon site of service) maximum¹ surgical benefit per day			
Outpatient Doctor's Office	\$75 per day	none	
Outpatient Surgical Facility	\$1,500 per day		
Inpatient	\$3,500 per day		
Surgical Anesthesia	\$550 per surgery with anesthesia		
Outpatient Surgical Facility (OPSF)	\$900 per surgery with OPSF		
Preventive Care	\$100 per day	\$100*	\$100*
Hospital Admission	\$1,000 per admission	3*	\$3,000*
Ambulance Transportation			
Ground Transport	\$250 per day	5 days*	
Air Transport	\$500 per day	5 days*	
Prescriptions			
Generic Rx ⁵	\$10 copay	\$5,000*; \$10,000 family benefit	
Non-preferred generic and brand Rx ⁵	Discount	none	
In-Network Discounts	when services are received through a MultiPlan PPO Network provider ²		
Non-Network Penalties	none		

*Per covered person per calendar year

The contents of this chart are for informational purposes only. If there is any conflict between the information in this chart and the official plan document, the official plan document will govern.

Weekly Premiums	Essential Plan	Enhanced Plan	Advantage Plan
Employee	\$27.10	\$36.31	\$67.11
Employee & Child(ren)*	\$67.25	\$90.98	\$169.89
Employee & Spouse*	\$67.25	\$90.98	\$169.89
Family	\$96.58	\$130.43	\$243.86

*Please see the Eligibility section of this guide for the definition of an eligible dependent.

Hospital Bridge Insurance Plan

Offered through Symetra, the Hospital Bridge Insurance Plan is designed to supplement the Basic Medical Plan, but can also be purchased on a stand-alone basis or as a supplement to another medical plan. The Hospital Bridge Insurance Plan pays a fixed daily benefit directly to you for medical services such as hospitalization, major diagnostic testing, emergency room visits, outpatient surgical facility, mental healthcare room, and more, up to the annual maximum.

When you are admitted to the hospital, you may “assign” your benefits to the hospital or you may choose not to.

This is your choice regardless of any major medical or other coverage you may have, but if you do not have major medical coverage the hospital may require you to assign your benefits as a condition of admittance. If you assign benefits, the hospital should file the claim and payment will be made by Symetra directly to the hospital up to the amount the hospital shows due or up to the limit of the plan. Excess benefits, if any, will be paid directly to you. If you do not assign your benefits, you will need to file the claim with Symetra yourself and benefits will be paid directly to you. Paid benefits are not taxed.

Coverage is guaranteed issue, which means you cannot be denied coverage, regardless of current or prior personal or family health history, and there are no pre-existing limitations.

You may choose from three plan options:

- **Traditional:** \$25,000 maximum benefit per covered person per year
- **Enhanced:** \$35,000 maximum benefit per covered person per year
- **Premium:** \$45,000 maximum benefit per covered person per year

Due to state restrictions, this plan is not available to employees who live in New Hampshire.

Personalize Your Coverage

Consider the Basic Medical Plan + Hospital Bridge Insurance Plan

The Basic Medical Plan features low premiums and no deductible while providing you with 100% coverage for unlimited sick and well visits to doctors and coverage for generic and preferred brand name prescription drugs. However, ***the Basic Medical Plan does not cover surgery, hospitalization, emergency room services, x-ray/diagnostic imaging or non-preferred brand name or specialty prescription drugs.*** Combining the Basic Medical Plan with a Hospital Bridge Plan allows you to expand your coverage and build a personalized program that suits your needs and is budget friendly. Any one of the Hospital Bridge Plans can supplement the Basic Medical Plan or any other coverage you may have. You can also further expand your coverage by choosing Critical Illness Protection and/or Accident Protection Plans.

Basic Medical Plan	
Benefit Period Maximum, Lifetime Maximum	Unlimited
Deductible, Out-of-Pocket Maximum, Coinsurance (per calendar year)	\$0
Office Visits	Covered at 100% in-network
Preventive Care (annual physical, well- child care/immunizations, routine GYN exam)	Covered at 100% in-network
Labs and Testing	
X-Ray/Imaging	Not covered
Outpatient Lab Work	Covered at 100%
Hospitalization	Not covered
Prescription Drug	
Generic and Preferred Brand Drugs	Covered at 100% in-network
Non-Preferred Brand and Specialty Drugs	Not Covered

The contents of this chart are for informational purposes only. If there is any conflict between the information in this chart and the official plan document, the official plan document will govern.

Hospital Bridge Insurance Plan	Traditional	Enhanced	Premium
Benefit Period Maximum	\$25,000 per Covered Person per Year	\$35,000 per Covered Person per Year	\$45,000 per Covered Person per Year
Hospital Inpatient Admission (3 day max)	\$1,000/first day (\$3,000 limit)	\$1,500/first day (\$4,500 limit)	\$2,000/first day (\$6,000 limit)
Ambulance Transportation	5 day combined calendar year max per person		
Ground Transport	\$250/day	\$500/day	\$1,000/day
Air Transport	\$500/day	\$1,000/day	\$2,000/day
Hospital Stay	\$25,000 limit	\$35,000 limit	\$45,000 limit
Regular Room	\$1,200/day	\$1,200/day	\$1,500/day
ICU	\$2,400/day	\$2,400/day	\$3,000/day
Substance Abuse Facility	\$1,200/day	\$1,200/day	\$1,500/day
Mental Health (180 day lifetime limit)	\$600/day	\$600/day	\$750/day
Post Hospital Nursing Facility Stay (60 day max per stay)	\$600/day	\$600/day	\$750/day
Outpatient Surgical Facility	\$300/day	\$400/day	\$500/day
Outpatient Major Diagnostic Testing	\$300/day	\$400/day	\$500/day
Outpatient Diagnostic X-ray and Lab	\$30/day	\$40/day	\$50/day
Emergency Room	\$150/day	\$200/day	\$200/day

The contents of this chart are for informational purposes only. If there is any conflict between the information in this chart and the official plan document, the official plan document will govern.

Hospital Bridge Weekly Premiums	Traditional	Enhanced	Premium
Employee	\$27.18	\$32.88	\$40.57
Employee & Child*	\$52.59	\$63.81	\$78.94
Employee & Child(ren)*	\$75.42	\$91.59	\$113.40
Employee & Spouse*	\$52.59	\$63.81	\$78.94
Family	\$75.42	\$91.59	\$113.40

*Please see the Eligibility section of this guide for the definition of an eligible dependent.

Critical Illness Insurance

Critical Illness Insurance pays you a fixed dollar amount if you or a covered family member is diagnosed for the first time with a serious illness or condition such as invasive cancer, heart attack, stroke, end-stage renal failure, major organ transplant, paralysis, and coma. The plan is “guaranteed issue” coverage, which means you cannot be denied coverage, regardless of current or prior personal or family health history. (Please note: while you cannot be denied for your prior personal or family history, you cannot obtain coverage for a specific covered critical illness if you have previously been diagnosed with that critical illness.) You may elect \$10,000 (Option 1) or \$20,000 (Option 2) worth of coverage for yourself and your spouse. Benefits for children are 25% of the adult benefit.

Critical Illness Insurance is intended to supplement a comprehensive medical plan. It provides a lump sum cash benefit for expenses that may not be covered by a traditional medical plan.

Critical Illness Insurance can be purchased as a stand-alone plan or in addition to any of the medical plan options, Hospital Bridge Insurance Plans, Accident Insurance, Hospital Indemnity Plan and Major Expense Protection Plan.

The benefits of critical illness insurance include:

- Helps you have money for deductibles, copays, lost income, experimental treatment, spousal income when using FMLA, etc.
- Benefits are paid directly to you in addition to the major medical insurance you may already have in place
- Benefits for the employee or spouse are always 100% of the lump sum benefit you enrolled for (\$10,000 or \$20,000); benefits for children are 25% of the adult benefit
- With this “first occurrence ever” policy, each condition is independent. So, if you have your first ever heart attack while covered and a year later you are diagnosed with invasive cancer, then you get paid the full benefit amount twice.
- Payroll deductions can be taken pre-tax and paid benefits are not taxed (except for domestic partners and same- sex civil unions).

Critical Illness Weekly Premiums	Option 1 - \$10,000	Option 2 - \$20,000
Employee	\$4.06	\$8.12
Employee & Child(ren)*	\$5.42	\$10.83
Employee & Spouse*	\$8.12	\$16.24
Family	\$9.47	\$18.95

*Please see the Eligibility section of this guide for the definition of an eligible dependent.

Accident Insurance

Accident Insurance is another option for supplementing a comprehensive medical plan. When accidents happen, out-of-pocket costs for things such as doctor visits, x-rays and physical therapy can add up fast. This plan can help.

You can choose from two options:

- **Option 1:** Coverage of up to \$3,500 per accident
- **Option 2:** Coverage of up to \$10,000 per accident

The Accident Insurance plan covers any type of accidental injury not incurred at work (up to 3 per calendar year per covered person) and pays your actual billed expenses up to the maximum benefit for the option you purchased. As with the other supplementary plans available, this plan can help you meet your deductible or pay other expenses that are not covered by a comprehensive plan.

Accident Insurance can be purchased as a stand-alone plan or in addition to any of the medical plan options, Hospital Bridge Insurance Plans, Critical Illness Insurance, Hospital Indemnity Plan and Major Expense Protection Plan.

Due to state restrictions, this plan is not available to employees who live in New Hampshire.

Here are two examples of how benefits would be paid:

Coverage Level	Option 1	Option 2
Group Accident	Up to \$3,500 per occurrence (3 occurrences per person, per calendar year max)	Up to \$10,000 per occurrence (3 occurrences per person, per calendar year max)
Emergency Room	\$300 per day, \$600 per person, per calendar year max	\$300 per day, \$600 per person, per calendar year max
Ambulance Transportation		
Ground Transport	\$300 (5 days combined calendar year max per person)	\$120 (5 days combined calendar year max per person)
Air Transport	\$500 (5 days combined calendar year max per person)	\$390 (5 days combined calendar year max per person)

The contents of this chart are for informational purposes only. If there is any conflict between the information in this chart and the official plan document, the official plan document will govern.

Accident Insurance Weekly Premiums	Option 1 - \$3,500	Option 2 - \$10,000
Employee	\$6.74	\$8.11
Employee & Child(ren)*	\$11.05	\$13.29
Employee & Spouse*	\$14.37	\$17.27
Family	\$20.00	\$24.05

**Please see the Eligibility section of this guide for the definition of an eligible dependent.*

Premiums are based on the coverage level you choose and whether you cover yourself only or yourself and your dependents.

Hospital Indemnity Plan

If you are hospitalized as an inpatient, the plan will pay you \$1,000 in cash per admission, up to 3 admissions per covered person per calendar year. Each covered person will also receive a benefit for each day (24 hour period) hospitalized as illustrated by the chart below subject to all policy provisions.

The plan also includes a pharmacy discount program at no additional cost. The pharmacy discount program is a benefit for those without prescription drug coverage on a Populus medical plan or another medical plan that includes prescription drug coverage. A discount from usual and customary drug charges will be given to you when prescriptions are purchased through an in-network pharmacy. This is not a prescription drug benefit but a discount program provided through ReStat (www.restat.com). Most national pharmacies are included in the ReStat network as are many regional and local pharmacies. You can verify participation by asking your pharmacy or checking on-line. You should not attempt to use this discount program if you have prescription drug coverage through your medical plan with Populus or another plan. You can use only one pharmacy benefit program. Benefits cannot be duplicated.

This plan can be purchased as a stand-alone plan, or in addition to any one of the three fixed indemnity medical plan options (Essential, Enhanced, or Advantage), the Hospital Bridge Insurance Plan, Critical Illness Insurance, Accident Insurance, and/or the Major Expense Protection Plan.

Benefit	Coverage
Deductible	None
Copay	None
Lifetime Maximum	500 days lifetime maximum for each benefit per person (except for Mental Illness)
Hospital Admission	\$1,000 per admission, per covered person, per calendar year
Hospital Stay ¹ (ICU)	\$600 per day, 30 days maximum per covered person, per calendar year
Hospital Stay ¹ (regular room)	\$300 per day, 30 days maximum per covered person, per calendar year
Hospital Stay ¹ (Substance Abuse Facility)	\$300 per day, 30 days maximum per covered person, per calendar year
Hospital Stay ² (Mental Health Facility)	\$150 per day, 30 days maximum per covered person, per calendar
Post Hospital Nursing Facility Stay ^{1,3}	\$150 per day, 60 days maximum per confinement per covered person under the age of 65

The contents of this chart are for informational purposes only. If there is any conflict between the information in this chart and the official plan document, the official plan document will govern. See policy for details, exclusions and limitations.

(1) 500 days per lifetime maximum

(2) 180 days per lifetime maximum

(3) Following a hospital stay of at least 3 days

Hospital Indemnity Plan Weekly Premiums	HEPP
Employee	\$6.20
Employee & Child*	\$12.20
Employee & Children*	\$17.59
Employee & Spouse*	\$12.20
Family	\$17.59

*Please see the Eligibility section of this guide for the definition of an eligible dependent.

Major Expense Protection Plan

The Major Expense Protection Plan offers you the opportunity to buy additional emergency room and inpatient hospital coverage, which includes inpatient hospitalization for substance abuse, and mental health. This plan can be purchased as a stand-alone plan, or in addition to any one of the three fixed indemnity medical plan options (Essential, Enhanced, or Advantage), the Hospital Bridge Insurance Plan, Critical Illness Insurance, Accident Insurance, and/or the Hospital Indemnity Plan. The MEPP does not issue restrictions on hospitals, meaning there is no requirement to use participating providers. The following chart is a summary of the plan.

Benefit	Coverage
Deductible	None
Copay	None
Lifetime Maximum	500 days lifetime maximum for each benefit per person (except for Mental Illness)
Emergency Room Benefit (Covered events that are the result of an illness or accident are paid at a pre-selected fixed dollar amount per visit up to a calendar year maximum. This benefit will be paid only for procedures received in an emergency room.)	\$200 per visit / \$500 calendar year maximum per person, per calendar year
Inpatient Hospital Benefit Coverage for inpatient hospital stays is provided and benefits are paid at a pre-selected fixed dollar amount per day of confinement up to a maximum number of days per calendar year.	
Daily Hospital (30 days maximum per calendar year)	\$1,500 per daily hospital stay
Substance Abuse (30 days maximum per calendar year)	\$1,500 per day, per person for stays in a substance abuse facility
Intensive Care Unit (30 days maximum per calendar year)	\$3,000 per day, per person for stays in the Intensive Care Unit
Mental Health Facility (30 days maximum per calendar year)	\$750 per day, per person for stays in a mental health facility
Nursing Facility (maximum 60 consecutive days per stay)*	\$750 per day, per person for stays in a nursing facility (only if following a covered hospital stay of at least 3 consecutive days and the person is less than age 65)
Maternity Care	Covered as any other condition
Ambulance Transportation	
Ground Transport	\$250 per day (5 day combined calendar year max per person)
Air Transport	\$500 per day (5 day combined calendar year max per person)

The contents of this chart are for informational purposes only. If there is any conflict between the information in this chart and the official plan document, the official plan document will govern.

*Note: 31 days per person per calendar year for New Hampshire residents

The Major Expense Protection Plan is not a replacement for a major medical policy or other comprehensive policy. It is designed to cover benefits used on a routine basis at a preselected, fixed dollar amount. Coverage may be subject to exclusions, limitation, reductions, and termination of benefit provisions. Exclusions, limitations, definitions, and benefits may vary by state. Please see the policy for details. The Major Expense Protection Plan is insured by Symetra Life Insurance Company, 777 108th Avenue NE, Suite 1200, Bellevue, WA, 98004. SymetraSM is a service mark of Symetra Life Insurance Company.

Major Expense Protection Plan Weekly Premiums	MEPP
Employee	\$22.85
Employee & Child*	\$47.52
Employee & Children*	\$54.41
Employee & Spouse*	\$47.52
Family	\$54.41

*Please see the Eligibility section of this guide for the definition of an eligible dependent.

Advocacy Services through Health Advocate

Health Advocate, the nation's leading health advocacy company, provides confidential, personalized, one-on-one assistance to you and eligible family members to help navigate many aspects of the health care world. You will have access to a Personal Health Advocate, typically a registered nurse, supported by a team of physicians and administrative experts, who will help in handling healthcare and insurance related issues. Eligible family members who can use Health Advocate include you, your spouse, your children, your parents, and your spouse's parents.

- Finding the best doctors, hospitals, dentists, and other leading healthcare providers anywhere in the country. This includes locating providers in your health insurance plan's network.
- Scheduling appointments with providers including hard to reach specialists and critical care providers and arranging for specialized treatments and tests.
- Helping to resolve insurance claims and assisting with negotiating billing and payment arrangements, and related administrative issues.
- Working with our insurance companies to obtain appropriate approvals for needed services often fostering communications between physicians and insurance companies.
- Assisting with eldercare and related healthcare issues facing your parents and parents-in-law. They work with Medicare and other government insurance programs and help make arrangements following discharge from a hospital for in-home or needed institutional service.
- Answering questions about test results, treatment recommendations and medications recommended or prescribed by your physician.
- Obtaining unbiased health information to help make an informed decision.
- Assisting in the transfer of medical records, x-rays and lab results.
- Locating and researching the newest treatments for a medical condition.
- Assisting with finding qualified wellness programs, providers and services.

To utilize the services offered by Health Advocate, simply call **1-866-695-8622** or send an email to **answers@HealthAdvocate.com**. When you request service, you will be asked to complete a Medical Information Release Form.

Please be assured Health Advocate will keep all information strictly confidential and will protect your privacy. For more information about the company and services, visit **www.HealthAdvocate.com**.

Employee Assistance Program (EAP) through Health Advocate

Populus Group is pleased to offer an Employee Assistance Program (EAP) at no cost to you, and you will be automatically enrolled!

What is EAP?

The EAP is designed to help you lead a happier and more productive life at home and at work. Balancing the needs of work, family and personal responsibilities isn't always easy. This program offers the right support at the right time.

The EAP provides a professional counselor to listen and help define the problem clearly, assess the type of help needed, and either provide the required help or make the most appropriate, cost-effective referral for you. Health Advocates EAP experts can:

- Provide confidential help with personal issues, 24/7
- Research and locate legal specialists and financial counselors
- Consult with you in person, by telephone or secure video
- Find local resources for childcare, adult day care and eldercare
- Help with stress, anxiety, depression and family problems
- Direct you to your comprehensive EAP member website
- Support you with grief and loss, anger and substance abuse
- Refer you to more long-term support as needed
- Find local services to help make your life easier

Download the Health Advocate mobile app for free, convenient, on-the-go help! The mobile app offers one-touch calling, quick email contact, online trainings, webinars and much more.

Dental Benefits

The MetLife dental plan covers preventive, basic, and major dental services and supplies for eligible employees. Generally, when you receive care from a MetLife participating dentist, your out-of-pocket expenses will be lower than if you receive services from a non-participating dentist. For a participating dentist near you, visit **PopulusBenefits.com** for a direct link to the MetLife website or go to **www.metlife.com/dental**. You can also call MetLife at **1-800-942-0854**.

This chart provides highlights of some covered services. For a full description of covered services and exclusions, please see the detailed plan description provided on **PopulusBenefits.com**. Please note, deductibles and annual plan limits are per coverage year (January 1 – December 31).

MetLife Dental Plan Benefits	In-Network	Out-of Network
Annual (calendar year) Deductible (for Type B and C Expenses Combined)	\$50 per person	\$50 per person
Annual (calendar year) Plan Limit Maximum Benefit	\$1,000 per person	\$1,000 per person
Type A Expenses		
Preventive Oral Exams, Cleaning, Polishing (once every six months)	Plan pays 100%* no deductible	Plan pays 100%** no deductible
Type B Expenses		
X-rays, Fillings, Minor Oral Surgery	Plan pays 80%* after deductible	Plan pays 80%** after deductible
Type C Expenses		
Crowns, Dentures, Bridgework, Complex oral surgery	Plan pays 50%* after deductible	Plan pays 50%** after deductible
Type D Expenses		
Orthodontia	Not covered	Not covered

Additional Type A, B & C information can be found in the MetLife Dental Plan Certificate of Insurance.

*Plan Benefits subject to the Maximum Allowed Charge for the types of dental services shown in section C of the Plan Certificate of Insurance. The Maximum Allowed Charge is the lower of: a. the amount charged by the Participating Provider for the service or supply; and b. the maximum amount that the Participating Provider agreed with us to charge for that service or supply. This maximum amount is specified or based on the amounts specified in the Preferred Dentist Program Table of Maximum Allowed Charges.

**Plan Benefits subject to Reasonable and Customary (R&C) limits for the types of dental services shown in section C of the Plan Certificate of Insurance. The Reasonable and Customary Charge is the lowest of: a. the usual charge by the Dentist or other provider of the services or supplies for the same or similar services or supplies; or b. the usual charge of most other Dentists or other providers in the same geographic area for the same or similar services or supplies; or c. the actual charge for the services or supplies.

The contents of this chart are for informational purposes only. If there is any conflict between the information in this chart and the official plan document, the official plan document will govern.

Weekly Premiums	Dental
Employee	\$7.93
Employee & Child(ren)*	\$15.93
Employee & Spouse*	\$18.15
Family	\$20.51

*Please see the Eligibility section of this guide for the definition of an eligible dependent.



Vision Benefits

Eligible employees also have the opportunity to enroll in vision benefits through VSP.

VSP Benefits	Frequency*	Vision Service Plan (VSP)	Out-of Network
Eye Exam	Once every 12 months (Well/Vision)	\$15 co-pay, then plan pays 100%	Plan pays up to \$50
Frames	Once every 24 months	Plan pays 100% for selected frames up to \$130	Plan pays up to \$70
Lenses			
Single Vision	Once every 24 months	Combined \$15 co-pay for lenses and frames, then plan pays 100%	Plan pays up to \$50
Bifocal (lined)			Plan pays up to \$75
Trifocal (lined)			Plan pays up to \$100
Lenticular			Plan pays up to \$125
Interim Benefits	For lenses (including contact lenses) and frames every 24 months- If your lens prescription changes before you are eligible for new lenses and those prescriptions meet at least one of the following criteria, lenses & frames will be replaced at a 12 month frequency; a) a new prescription differs from the original by at least a .50 diopter sphere or cylinder; b) an axis change of 15 degrees for more; c) a 5 prism		
Contact Lenses			
Visually Necessary	Once every 24 months	\$15 co-pay, then plan pays 100%	Plan pays up to \$210
Elective		Plan pays up to \$130	Plan pays up to \$105

The contents of this chart are for informational purposes only. If there is any conflict between the information in this chart and the official plan document, the official plan document will govern.

Weekly Premiums	Vision
Employee	\$1.92
Employee & Spouse / Employee & Child*	\$3.02
Employee & Children*	\$3.08
Family	\$4.97

*Please see the Eligibility section of this guide for the definition of an eligible dependent.

Flexible Spending Accounts (FSAs)

For the 2025 plan year, the Flexible Spending Accounts will be administered through Optum Financial. Optum Financial is a different platform vendor than Optum Bank, who handles the Health Savings Accounts (HSA's). FSAs provide a method to pay for qualified expenses partially or not covered by your medical, dental, and vision plans, and for qualified dependent care expenses. Please note that an FSA cannot be used to pay weekly premiums. You may participate in either or both Health Care or Dependent Care Flexible Spending Accounts even if you choose to opt out of the medical coverage. Each type of account is designed to serve different needs. The accounts may not be combined. Please note that an FSA account cannot be used to pay weekly premiums.

- **Health Care FSA** – used for eligible medical, prescription drug, dental or vision expenses, including deductibles, coinsurance and copays. You can allocate up to the IRS limit each year to the Health Care FSA for yourself or your dependents. The Health Care FSA limit for 2025 is projected at \$3,300. After you enroll, you will receive a debit card with detailed instructions on how to use it.
- **Dependent Care FSA** – used for eligible dependent care expenses (children up to age 13), such as childcare, summer day camp or elder care. You can allocate up to \$5,000, per household each year to the Dependent Care FSA.

The IRS requires that all funds set aside each plan year must be used by year end or they will be forfeited and not refunded.

During open enrollment, you decide how much money, if any, you want to deposit in either or both accounts for the year. Money is deducted from your paycheck on a pre-tax basis. Only those employees who elect these accounts will have them. As you incur eligible expenses throughout the plan year (January 1 - December 31), you pay yourself back with the money in your account. You will be reimbursed by submitting your claim to Optum Financial.

Services provided must be incurred during the current plan year. You will have 90 days following the end of the plan year to submit claims for reimbursement of eligible expenses.

Please note, if your health care FSA coverage terminates mid-year (e.g., termination of employment, change in employment status), you will have 60 days from the date of termination to submit claims for reimbursement of eligible expenses.

To elect a Flexible Spending Account for the 2025 plan year, employees will be required to elect during Open Enrollment at **PopulusBenefits.com**. Employees will then visit **www.optumfinancial.com** to register and open their account.

Download the Optum Financial app for an easier way to manage your flexible spending account.

Detailed information on Optum Financial will be available on **PopulusBenefits.com**.

Family and Medical Leave (FMLA)

The company provides Family and Medical Leaves of Absence without pay to eligible employees. Qualified individuals must have worked for the company for at least 12 months in the last seven (7) years, and must also have worked at least 1,250 hours during the 12 months immediately preceding the request. Qualified individuals may be eligible to take up to 12 weeks of unpaid Family and Medical Leave within a rolling 12 month period for the following reasons:

- To care for the employee's child during the first 12 months following birth, adoption or foster care.
- To care for the employee's spouse, child or parent with a serious health condition.
- For incapacity due to the employee's pregnancy or child birth.
- For the employee's own serious health condition.

Furthermore, qualified individuals may be eligible to take up to 26 weeks of unpaid Family and Medical Leave within a rolling 12 - month period for the following reasons:

- To care for the employee's spouse, child, parent or next of kin who is a service member recovering from serious illness or injury sustained in the line of active duty.
- Due to a qualifying exigency arising because the employee's spouse, child or parent is on active duty or has been notified of an impending call to order to active duty in support of a contingency operation.

In addition to FMLA leave, employees may also be eligible for leave under a similar state law. For information about the availability of state leave, please contact the Benefits Department.

Short Term Disability (STD)

The company offers a Short-Term Disability (STD) plan through The Hartford that protects you against loss of income if you cannot work due to a sickness or injury that is not work related. If you become totally disabled, your benefit will be 60% of your pre-disability weekly pay up to a maximum benefit of \$600 a week. Benefits begin on the 8th day of total disability, and will be paid for up to 13 weeks.

- If you enroll during your initial eligibility period, you will not be subject to approval by The Hartford. Late enrollees are subject to approval by The Hartford and medical questions will be required to be answered.
- Deductions are taken on a post-tax basis, so any benefit paid is tax free.
- Coverage ends on your last day of employment.
- If you become disabled in the first 12 months after you enroll for STD coverage, benefits will not be paid for a disability caused by any medical condition for which you have been treated or diagnosed within the six months before joining the STD plan, including pregnancy.

The cost of coverage is based on your age and weekly benefit amount, as shown in the following chart. When completing your new hire enrollment on **PopulusBenefits.com**, you will be able to automatically calculate your weekly STD premium.

Your Age	Weekly Premium Multiplier*
Under 25	\$0.13
25-29	\$0.11
30-34	\$0.11
35-39	\$0.10
40-44	\$0.11
45-49	\$0.12
50-54	\$0.15
55 and over	\$0.18

*The costs shown above are per \$10 of weekly benefit.

Example – An individual age 36 with \$480 in weekly pay, the weekly benefit is \$288 and the weekly cost to the employee is \$3.92. The weekly benefit of \$288 is based on 60% of the \$480 weekly pay. Weekly premiums are calculated for every \$10 of weekly benefit amount (i.e. $\$288/\$10 = 28.80$). Using the age of the employee and the chart above the premium multiplier is determined. In this example the employee is 36 years old therefore the multiplier is \$.10. When the \$.10 is multiplied by 28.80 the employee arrives at their weekly premium of \$2.88.

Long Term Disability (LTD)

The company offers a Long-Term Disability (LTD) plan through MetLife that pays benefits if total disability lasts more than 90 days.

- The monthly LTD benefit is 60% of your pre-disability monthly base pay, reduced by Social Security and other disability income benefits.
- The maximum monthly LTD benefit is \$5,000.
- The minimum monthly benefit is the greater of \$100 or 10% of your monthly benefit before reductions for Social Security and other income benefits.
- Deductions are taken on a post-tax basis.
- Coverage ends on your last day of employment.
- When you enroll, you can choose a five year benefit period or a benefit period to age 65.
- LTD benefits are not paid for more than 24 months for mental or nervous disabilities.
- A work incentive benefit lets you return to work during partial disability.
- If you die while on LTD, three months of benefits will be paid to your survivor.
- If you enroll during your initial eligibility period, you will not be subject to approval by MetLife. Late enrollees are subject to approval by MetLife and medical questions will be required to be answered.
- Conditions existing within three months of your effective date of coverage are considered pre-existing and are not covered until you are continuously insured for 12 months.

The cost of coverage is based on your age, monthly earnings, and benefit period you choose, as shown in the following chart. When completing your new hire enrollment on **PopulusBenefits.com**, you will be able to automatically calculate your weekly LTD premium.

Your Age	LTD Weekly Premium Multiplier*	
	Five-year	To age 65
Under 25	\$0.0346	\$0.0462
25-29	\$0.0415	\$0.0554
30-34	\$0.0554	\$0.0831
35-39	\$0.0738	\$0.1223
40-44	\$0.0992	\$0.1592
45-49	\$0.1569	\$0.2585
50-54	\$0.2585	\$0.3646
55+	\$0.4431	\$0.4638

*The costs shown above are per \$100 of monthly earnings.

Example – for an individual age 36 with \$3,000 in monthly earnings who chooses benefits to age 65, the weekly cost is \$3.67 [$\0.1223 (weekly rate for age 36) times 30 (monthly earnings divided by 100)]. (Please note, the maximum insurable monthly earnings amount is \$8,333.33 (\$100,000 annually).

Life Insurance

The Populus Group Voluntary Term Life Insurance plans through Reliance Standard let you choose coverage for yourself, your spouse, and dependent children under age 19 (26 if full-time student). You may elect coverage for your spouse without buying coverage for yourself. However, in order to buy coverage your child(ren), either you or your spouse must elect coverage. Coverage is portable – you may purchase an individual policy if your Populus Group employment ends.

To enroll or make changes after your initial eligibility period (30 days from effective date), you must complete a medical underwriting questionnaire and have the insurance carrier approve you for any amount elected. This is called providing evidence of insurability (EOI).

- **Employee Life Insurance:** Amounts in \$10,000 benefit units can be elected to a maximum of \$150,000. EOI is not required for any amount if you enroll during your initial eligibility period. Any amount elected after the initial eligibility period including increased amounts, will require EOI. When you enroll you must name a beneficiary. The amount of insurance in effect is subject to automatic reduction beginning at age 75.
- **Life Insurance for your Spouse:** Amounts in \$10,000 benefit units can be elected to a maximum of \$30,000 for your spouse. EOI is not required for any amount if you enroll during your initial eligibility period. Any amount elected after the initial eligibility period including increased amounts, will require EOI. You are the beneficiary for spouse's coverage. One the date of application, your spouse must be under age 70. Insurance on a spouse terminates at age 75.
- **Life Insurance for Dependent Children:** Amounts in \$2,500, \$5,000, \$7,500 or \$10,000 benefit units can be elected. Coverage for newborn children 14 days to 6 months of age begins at \$1,000. Coverage for children age 6 months to age 19 or to age 26 if a full-time student status. One benefit amount is applicable to all eligible children. Coverage up to \$10,000 can be elected at any time, without providing EOI. You are the beneficiary.

The cost of employee and spouse's term life insurance is based on age and the amount of coverage you select. The rates are the same for the employee and spouse's coverage. Weekly Premium Multiplier's are shown on the following chart. When completing your new hire enrollment on **PopulusBenefits.com**, you will be able to automatically calculate your weekly Life Insurance premiums.

Age	Weekly Premium Multiplier*
Under 30	\$0.141
30-34	\$0.171
35-39	\$0.247
40-44	\$0.351
45-49	\$0.653
50-54	\$1.057
55-59	\$1.638
60-64	\$2.993
65-69	\$4.403
70+	\$7.145

*The costs shown above are per \$10,000 of life insurance coverage.

Example – for an individual age 46 with \$50,000 in life insurance, the weekly cost is \$3.27 [$\0.653 (weekly rate for age 46) times 5].

The cost of life insurance for dependent children is based on the coverage level you choose, regardless of how many eligible children you have. Weekly Premium Multiplier's are shown on the following chart. When completing your new hire benefits on **PopulusBenefits.com**, you will be able to automatically calculate your weekly life insurance premium.

Amount	Weekly Premium Multiplier
\$2,500*	\$0.136
\$5,000*	\$0.205
\$7,500*	\$0.275
\$10,000*	\$0.344

*Please note, Life Insurance is not a COBRA eligible plan. However, if your employment ends you may elect to continue Life Insurance for yourself and your dependents under the Portability and Conversion terms of the plan. You have 30 days to send your completed application to the Populus Group benefits department. Please refer to the plan certificate, which can be located on www.PopulusBenefits.com for more details.



Accidental Death & Dismemberment (AD&D)

Accidental Death and Dismemberment (AD&D) insurance covers you if you die or suffer serious injury as a result of an accident.

- You may buy AD&D coverage of up to \$500,000 in \$10,000 increments.
- Benefits are paid to your beneficiary if you die, or to you if you suffer certain injuries as a result of an accident.
- AD&D benefits are paid in addition to your life insurance coverage if you die as a result of an accident.
- Proof of good health is not required.
- You may choose employee-only coverage or family coverage (family includes coverage for yourself).
- If you choose family coverage, your spouse's benefit is 60% of yours and dependent children's benefit is 15% of yours. You are the beneficiary for your dependents' AD&D coverage.

The cost of AD&D coverage depends on the coverage level you choose, as shown on the following chart. When completing your new hire enrollment on **PopulusBenefits.com**, you will be able to automatically calculate your weekly AD&D premiums.

Coverage Level	AD&D Weekly Premium Multiplier*
Employee	\$0.009
Family	\$0.021

*The costs shown above are per \$1,000 of coverage.

Example: For an individual who chooses family AD&D coverage of \$50,000, the weekly cost is \$1.05 [$\0.021 (weekly rate for family coverage) times 50].

Please note: AD&D Insurance is not a COBRA eligible plan. However, if your employment ends you may elect to continue AD&D Insurance for yourself and your dependents under the Portability and Conversion terms of the plan. Please refer to the plan certificate, which can be located on www.PopulusBenefits.com for more details.



Identity Theft Protection

Populus Group offers an Identity Theft Protection benefits on a voluntary basis. This benefit is an employee-paid benefit if you wish to elect it. Identity theft protection is provided by Allstate.

Allstate protects millions of American workers from the devastation of identity theft- their monitoring capabilities exceed any others. Allstate uses their proprietary software to proactively monitor various sources. Detection when an identity is at elevated risk for theft allows Allstate to take the necessary precautions, including placing fraud alerts, credit freezes and pulling credit reports. Allstate searches the dark web for compromised credentials and monitor financial transactions members would never hear about otherwise. Should fraud or identity theft occur, their in-house Privacy Advocates are always there to fully restore any employees compromised identity.

While Allstate's Identity Protection's service includes credit monitoring, monthly scores and an annual credit report, they also provide social media monitoring, real time management and alerts, checking the security of your IP addresses, reimbursement for fraud-related losses, protection for your whole family and much more!

Access the entire Allstate Identity Theft Protection portal on the go! Available for iOS and Android.

Please see the chart below for the cost for Identity Theft through Allstate.

Weekly Premiums	
Employee only	\$1.80
All Other Coverage Tiers	\$3.16

Coverage is portable and can be transferred to an individual policy. Further details can be found on your company intranet.

Pet Insurance through MetLife

Populus Group offers Pet insurance through MetLife on a voluntary, employee-paid basis. Pet Insurance is available for dogs and cats only, utilizing the Populus Group discount. Now more than ever, pets are playing a significant role in our lives, and it is important to keep them safe and healthy.

Why is pet insurance important?

More than 6 in 10 pet owners said their pet has had an emergency medical expense. The average cost for a routine vet visit is \$212 for dogs and \$160 for cats. An average annual cost for a surgical vet visit is \$426 for dogs and \$214 for cats. MetLife's Pet Insurance coverage includes:

- Accidental injuries
- Illnesses
- Exam fees
- Surgeries
- Medications
- Ultrasounds
- Hospital stays
- X-rays and other diagnostics
- Hip dysplasia
- Hereditary conditions
- Congenital conditions
- Chronic conditions
- Alternative therapies

Each pet's premium will be unique based on the age, breed, location, and gender—as well as the coverage amount you select.

If an employee wishes to enroll in Pet Insurance, they will not enroll through PopulusBenefits.com. This benefit will not be payroll deducted; it will be direct billed with MetLife. Employees must contact MetLife directly to get a quote, get coverage options, and to enroll. Please call 1-800-438-6388.

Please note: Pet Insurance may not cover pre-existing conditions.

Principal Financial Group- 401k

To help you have the income you need once you reach retirement, it's essential to have access to a pre-tax retirement plan. We are proud to offer our employees access to the Principal Financial Group 401(k) plan, which has many exciting options for you to choose from for your retirement savings. **The Principal 401k plan number is: 346754.**

IMPORTANT: If you don't want to participate in our 401(k) plan, you actively need to change your deferral percentage to 0% by contacting Principal after receiving your first paycheck. If you don't opt-out, you will automatically be enrolled 30 days after your start date at a deferral rate of 6%. To do this you can either visit their website or call 1-800-547-7754.



Get the app at principal.com/onthego or by scanning the QR code. Then, save and plan for the future on the go with the new Principal® app. Available for iOS and Android

It's this easy. Once you've downloaded the app, make sure to follow the prompts and activate 2-factor authentication—this important step helps protect your retirement savings from identity fraud.

Learn more at your own pace. In addition to reviewing and updating your retirement account, you can also view articles, videos, and webinars through Insights that will help to expand your understanding of how to better save for your retirement.

Filing Claims

Below are instructions on filing claims with each of the benefit carriers. All claim forms (where applicable) can be found on **PopulusBenefits.com**.

- For CareFirst Administrators Basic and BlueCross BlueShield HSA Eligible High Deductible and Bronze Medical Plan Claims
 - **In-Network:** provider should submit claims to CareFirst Administrators or BlueCross BlueShield
 - **Out-of-Network:** the employee will pay the claim out-of-pocket and submit the claim to the address located on the Medical Claim Form
- For Prescription Reimbursement Claims

Submit the CVS Caremark claim form, along with your register receipt and the appropriate drug receipt with name of pharmacy, name of the drug etc. to the address located on the claim form.

- For Fixed Indemnity Medical Claims
 - **In-Network Providers:** Present your Select Benefits ID card at the time of service and ask your provider to file the claim with Select Benefits Administrators (SBA) and accept an assignment of benefits. Your provider may or may not agree to accept the assignment. SBA will process the claim and send payment to your provider. Both you and your provider will receive an Explanation of Benefits (EOB) showing what was paid.
 - **Out-of-Network Providers:** Ask the provider to file the claim with Select Benefits Administrators (SBA). If the provider is unwilling to submit the claim, you will need to file the claim with SBA, and they will pay benefits based upon the amount covered by your Select Benefits plan. For faster response, please request a copy of the itemized bill from the provider listing dates of service and procedure and diagnosis codes. Ask for Health Care Financing Administration (HCFA) forms for doctor's office visits and Universal Billing (UB92) forms for hospital care.

All claims must be submitted within 90 days from the date of service. Mail or fax claim forms to: **Attention: Claims Department PO Box 440, Select Benefit Administrators, Ashland, WI 54806 Fax: (715) 68-5919**. A few weeks later you will be mailed an Explanation of Benefits showing what was paid.

- For Hospital Bridge Insurance, Critical Illness, Accident Insurance, Hospital Indemnity or Major Expense Protection Plan Claims

Simply mail a copy of your itemized receipt for services (given to you by your provider) to: **Claims: Select Benefit Administrators of America, Box 440 Ashland, WI 54806**.

Make sure the following information is shown on your service receipt:

- Insured's ID (Social Security Number)
- Patient Name
- Provider name, address and ID
- Diagnosis or ICD-9 code(s) [description of your medical condition]
- Procedure or CPT or revenue codes [that indicate services rendered]
- Associated charges
- Date of service

If any of this information is missing, simply write it in.

➤ For Dental Claims

- **In-Network:** the dentist should submit the claim to MetLife.
- **Out-of-Network:** the employee should submit the Dental Claim form to: MetLife (National), P.O. Box 981282 El Paso, TX 79998

➤ For Vision Claims

- **In-Network:** the employee pays appropriate co-pay, the physician submits the claim to Vision Service Plan.
- **Out-of-Network:** the employee should pay the provider the full amount of the bill and request an itemized copy of the bill that shows the amount of the eye examination, lens type, and frame (if applicable). The employee should send a copy of the itemized bill to: Vision Service Plan, Attention: **Non-Member Doctor Claims, Box 997105 Sacramento, CA 95899-7100**

The following information must be included:

- Member's name and mailing address
- Member's social security number
- Member's employer (Populus Group)
- Patient's name, relationship to member, and date of birth
- Submit the above information on any generic insurance claim form that may be available upon request from your Non-Participating provider. We do not have the claim forms available at Corporate.

All claims must be submitted within 6 months from the date of service.

➤ For Life Insurance and Accidental Death & Dismemberment (AD&D) Claims

The appropriate Reliance Standard Life Insurance Company Claim Form should be completed in full. The form, along the required documentation (listed on the form) should be mailed to: **Populus Group Benefits Department, 3001 W. Big Beaver Road, Suite 400, Troy, MI 48084**

➤ For Short Term Disability (STD) Claims

You may file a claim by calling The Hartford's toll-free number **1-866-945-7781** 8:00am to 8:00pm EST, or you file a claim online at **www.TheHartfordAtWork.com**. You will be asked to provide:

- Your name and social security number
- Department and last day of active full-time work
- Manager's name & phone number
- Nature of claim and whether it's work-related
- Treating physician's name, address, and phone number

➤ For Family and Medical Leave (FMLA) Claims

Complete the following forms:

- Family and Medical Leave of Absence Form
- Certification of Health Provider Form

You must contact your local office to make a request for leave. Both forms must be completed in full and sent together to:

Populus Group Benefits Department, Attention: **Melissa Speck, 3001 W. Big Beaver Rd., Suite 400, Troy, MI 48084**

➤ For Long Term Disability (LTD) Claims

- The physician must complete the Long Term Disability Claim Form-Attending Physician, in full
- The employee must complete the Long Term Disability Claim Form-Employee Statement, in full
- The employer must complete the Long Term Disability Claim Form-Employer Statement, in full

All three fully completed forms must be sent together to: **MetLife, P.O. Box 14590, Lexington, KY 40511-4590**

Changing Your Benefits During The Plan Year

Once you enroll for pre-tax insurance coverage you generally cannot change elections during the plan year unless you have a qualifying life status change as defined by the IRS.

Qualifying Life Status Change Events	What You May Change	Effective Date	documentation required?
Marriage ¹	Add yourself, spouse, child(ren) and/or stepchild(ren) to existing coverage	Date of event	Yes (example: marriage certificate)
Birth or adoption of a child(ren)	Add yourself, spouse, and child(ren)	Date of event	Yes (example: birth certificate)
Divorce/Legal Separation (only in states that recognize legal separation)	Cancel coverage for your spouse and stepchildren if enrolled in your employer's plan/Add coverage for yourself and your children if enrolled in your spouse's plan	The Saturday coinciding with or following event	Only required if adding coverage (example: proof of loss of coverage, birth certificate)
You, spouse or child(ren) loses other coverage ²	Add yourself, spouse or child(ren) who lost coverage	The day coverage ended	Yes (example: proof of loss of coverage)
You, spouse, or child(ren) gains other group coverage	Cancel coverage for yourself, spouse, and/or child(ren) who gain coverage	The Saturday coinciding with or following event	Yes (example: proof of gain of coverage)
You, spouse or child(ren) exhaust COBRA coverage ³	Add yourself, spouse, child(ren) who were covered under COBRA	Date of Event	Yes (example: proof of loss of coverage)
You, your spouse or child(ren) die	Cancel coverage for yourself, spouse or child(ren) who die	Date of Death	Yes (example: death certificate)
Change in dependent's eligibility for benefits, such as age	Cancel coverage for your dependent	The Saturday coinciding with or following event	Yes (example: loss of coverage)
Entering the United States	Add yourself, spouse and child(ren)	Date of Event	Yes (example: travel itinerary, proof of dependents' status to employee and a visa/passport)

**Anyone enrolled in the Bronze and HDHP/HSA will be subject to the carrier rules for Qualifying Life Events.*

(1) Canceling an individual health plan is not ordinarily considered a qualifying change and does not allow you to add coverage with Populus Group.

(2) Purchasing an individual health plan is not considered a qualifying change and does not allow you to cancel your coverage with Populus Group

(3) COBRA period must be fully exhausted. Choosing to discontinue COBRA during your COBRA period does not allow you to add coverage with Populus Group, except during the annual open enrollment period.

This is a brief overview of potential qualifying events. Eligible qualifying events are dictated by Internal Revenue Code Section 125.

You have 30 days from the date of the status change to change your benefits. If you or your dependent becomes eligible for a state premium subsidy for Medicaid or through a state children's health insurance program with respect to coverage under this plan, you have 60 days from the date of such eligibility determination to enroll in the plan. If you or your dependent decline to participate in the plan because you have Medicaid coverage or coverage under a state children's health insurance program and you later lose that coverage you have 60 days from the date of such loss of coverage to enroll in the plan.

You may make your change on **PopulusBenefits.com** or submit a change form. In either case, you need to submit hard copy proof of the change, such as a birth or marriage certificate. You can only make changes consistent with the status change. For instance: If you add a child, you may add dependent life insurance and change your medical plan coverage level (i.e. employee plus one or family), but you may not change or cancel your medical plan.

Please note, if you choose post-tax contributions, you generally may cancel one or all of the benefit plans you are enrolled in at any time during the year without restriction, but will be subject to any plan policy rules.

When Coverage Ends

Your coverage under the following plans will end at midnight on the Saturday coinciding with or following your last day of employment: BlueCross BlueShield Basic Medical Plan, BlueCross BlueShield HSA Eligible High Deductible Medical Plan, Bronze Medical Plan, Symetra Fixed Indemnity Medical Insurance Plans, Hospital Bridge Insurance Plan, Critical Illness Insurance, Accident Insurance, Hospital Indemnity Plan, Major Expense Protection Plan, Dental and Vision.

Example: If you work your final day on Thursday, June 5, 2025, then your coverage under any of the plans listed above will end at midnight on Saturday, June 7, 2025. Disability, Life and AD&D coverage end on your last day of work.

Your benefit coverage also ends when you are no longer eligible, when you stop paying premiums, or when the group plan ends, whichever comes first. Coverage for dependents ends when they are no longer eligible, when dependent coverage is no longer offered, or when your coverage ends. Please see the eligibility section of this guide for the definition of an eligible dependent.



Continuation of Coverage Eligible Benefits

While not COBRA eligible, the Fixed Indemnity Medical Plans, Major Expense Protection Plan, and Hospital Indemnity Plan can be continued for up to 18 months after termination. You will receive Continuation of Coverage paperwork from Select Benefits Administrators (SBA).

Fixed Indemnity Medical Plans Monthly Premiums	Essential	Enhanced	Advantage
Employee	\$119.68	\$160.36	\$296.42
Employee & Child(ren)*	\$297.00	\$401.81	\$750.34
Employee & Spouse*	\$297.00	\$401.81	\$750.34
Family	\$426.56	\$576.08	\$1,077.06

Major Expense Protection Plan	Monthly Premiums
Employee	\$100.93
Employee & Child(ren)*	\$209.86
Employee & Spouse*	\$209.86
Family	\$240.30

Hospital Indemnity	Monthly Premiums
Employee	\$27.39
Employee & Child(ren)*	\$53.87
Employee & Spouse*	\$53.87
Family	\$77.67

Please note, the Hospital Bridge Insurance Plan, Critical Illness Insurance, Accident Insurance are not COBRA eligible plans. They are portable, meaning you can elect to continue these plans after your coverage ends with Populus Group. Please contact Symetra directly for instructions.

Please also note, Life Insurance, AD&D Insurance and Disability Insurance are not COBRA or Continuation eligible plans. However, you may elect to continue Life Insurance & AD&D Insurance for yourself and your dependents under the Portability and Conversion terms of the plan, directly through the carrier. You have 30 days to send your completed application to the Populus Group Benefits Department. Please refer to the plan certificate, which can be located on [PopulusBenefits.com](https://www.PopulusBenefits.com) for more details.

COBRA Eligible Benefits

COBRA (Consolidated Omnibus Budget Reconciliation Act) provides for continuation of health care coverage for employees and covered dependents that lose their group coverage for a variety of reasons. It requires employers to offer the same dental and vision coverage as is offered to active employees and their families. You and your eligible dependents covered at the time your company medical coverage ends may elect to continue coverage, but you must pay the full (employee plus company) premium plus an additional administrative fee.

When You Can Elect COBRA Coverage

You can continue your Blue Cross Basic Medical Plan, HSA Eligible High Deductible Bronze Medical Plan, Bronze Medical Plan, dental and vision coverage for yourself and your covered dependents for up to 18 months, if your group coverage ends because:

- You separate from service with the Company (for reasons other than gross misconduct on your part).
- Your hours are reduced so that you are no longer eligible for the company plan.

If you – or a dependent – are determined to be disabled (for Social Security benefit purposes) when the group coverage ends or within the first 60 days of COBRA coverage, coverage for that person may continue for up to a total of 29 months. Your spouse and covered children can elect to continue coverage for up to 36 months if their coverage ends due to:

- Your death
- Divorce or legal separation
- If a termination or reduction of hours occurs less than 18 months after the employee's Medicare entitlement (36 months of COBRA coverage is allowed from the date of the Medicare entitlement).

Applying For COBRA Coverage

When your coverage under the Company Plan ends, you or your dependents have 60 days to elect continued coverage. If you lose coverage due to separation from service or a reduction in work hours, the company will automatically notify you of your COBRA rights. In the case of a divorce, legal separation, or when a child no longer qualifies for dependent coverage, you, your spouse, or dependent child must notify the company within 60 days of the event. You then will be provided with information on your COBRA rights. The company has the right to end your COBRA continued coverage if:

- The company stops providing medical coverage for all employees
- You do not pay your premium on time
- You become covered by another group health plan
- You become covered by Medicare
- You extended COBRA coverage to 29 months due to disability, but are no longer considered disabled

COBRA information will be mailed to you when your COBRA eligible coverage ends. You may want to verify that your address is correct in the benefits system to prevent any delays in receiving your information. For additional information, please contact COBRA Support at **866-696-4548**.

COBRA Monthly Premiums	Basic (Medical)	Bronze (Medical)	High Deductible (Medical)	Dental	Vision
Employee	\$175.00	\$571.76	\$588.12	\$35.71	\$8.66
Employee & Child(ren)*	\$279.00	\$1,057.72	\$1,088.01	\$71.78	\$13.61
Employee & Spouse*	\$350.00	\$1,315.04	\$1,352.67	\$81.76	\$13.87
Family	\$438.00	\$1,738.14	\$1,787.90	\$92.40	\$22.39

*Please see the Eligibility section of this guide for the definition of an eligible dependent.

Please note, Life Insurance, AD&D Insurance and Disability Insurance are not COBRA or Continuation eligible plans. However, you may elect to continue Life Insurance & AD&D Insurance for yourself and your dependents under the Portability and Conversion terms of the plan, directly through the carrier. You have 30 days to send your completed application to the Populus Group Benefits Department. Please refer to the plan certificate, which can be located on PopulusBenefits.com for more details.

Key Contacts, Phone Numbers, & Websites

For Enrollment, Eligibility or Administrative questions, contact the Benefits Service Center:

- 1-888-858-6310 | www.PopulusBenefits.com | pgbenefits@populusgroup.com

For HSA Eligible High Deductible Medical Plan and Bronze Medical Plan questions, contact CareFirst BlueCross BlueShield:

- 1-888-567-9155 | www.carefirst.com

For Basic Medical Plan questions, contact CareFirst Administrators:

- 1-866-945-9839 | www.cfablue.com

For Health Savings Account questions, contact Optum Bank:

- 1-866-234-8913 | www.optumbank.com

For Health Advocate Advocacy & EAP questions, contact Health Advocate:

- 1-866-799-2728 | www.healthadvocate.com/members

For Fixed Indemnity Medical Insurance, Critical Illness, Accident Insurance, Hospital Indemnity and Major Expense Protection Plan (MEPP) questions, contact Symetra:

- 1-800-497-3699

For Dental Benefits, Claim Questions, or Participating Dentists, contact MetLife:

- 1-800-942-0854 | www.metlife.com/dental

For Vision Benefits, Claim Questions, or Participating Eye Care Providers, contact VSP:

- 1-800-877-7195 | www.vsp.com

For Flexible Spending Account questions, contact Optum Financial:

- 1-877-891-1022 | www.optumfinancial.com

For Short Term Disability, contact The Hartford:

- 1-866-945-7781

For Long Term Disability, contact MetLife:

- 1-800-300-4296

For Life and Accidental Death & Dismemberment (AD&D) Insurance, contact Reliance Standard Life Insurance:

- 1-800-351-7500

For Identity Theft Protection questions, contact AllState:

- 1-800-789-2720 | To create an account: privacyarmor.infoarmor.com/signin/signup | To sign in: signin.infoarmor.com

For Pet Insurance quotes or questions, contact MetLife:

- 1-800-438-6388

For 401k questions, contact, Principal Financial Group:

- 1-800-547-7754 | www.principal.com

For More Information

You are entitled to receive a Summary Plan Description (SPD) according to the rights and protections guaranteed under the Employee Retirement Income Security Act of 1974 (ERISA).

An SPD provides details of the benefit plans outlined in this guide. You should find and print out these descriptions from the benefits website at www.PopulusBenefits.com. We assume all employees have access to this website at your worksite, as well as the opportunity to convert the SPD to printed form. If you do not, please contact Human Resources and we will send you SPDs in printed form.

Further Benefit Information

Visit your online benefits portal at www.populusbenefits.com to view:

- Summary of Benefits and Coverage
- Carrier Summaries and Details
- Marketplace and Subsidy Notice
- Important Medicare information about your Prescription Drug Plan
- And other Legal Notices...

You may also request a free paper copy of any of these notices by contacting the Benefits Service Center at the phone number listed on the key contacts page of this guide.

A Final Word

In this guide, we describe your employee benefits in a clear, simple, and concise manner. Complete descriptions of the benefits provided through Populus Group are contained in the corresponding contracts and plan documents. If there is any disagreement between this guide and the wording of the corresponding contract or plan document, the contract or plan document will govern. Populus Group reserves the right to modify, amend, suspend or terminate any plan, in whole or in part, at any time. This guide does not constitute a guarantee of employment.



A Division of Kelly & Associates Insurance Group, Inc. | kellybenefits.com

Kelly & Associates Insurance Group, Inc (Kelly Benefits) provides administrative services that include: billing, enrollment and call center service for insurance benefits. The administration of benefits by Kelly Benefits does not guarantee coverage. Billing and collecting premiums or sending payroll deduction files, does not constitute coverage being bound. Please refer to specific insurance carrier contract for rules requiring evidence of insurability (EOI) or other underwriting requirements regarding final insurance carrier approval. Kelly Benefits is not an insurer and is not responsible for paying insurance benefit claims relative to Kelly Benefits involvement with billing and collecting insurance premiums. *This booklet summary is only intended as a brief summary of your benefits. Benefits are subject to the contractual terms, limitations and exclusions as set forth in the master contracts.