ASAC
Area Substance Abuse Council

Prevent • Treat • Recover

AREA SUBSTANCE ABUSE COUNCIL

01.01.26 - 12.31.26

Enrollment & Eligibility

Am I eligible for benefits?

If you are classified as a full-time or part-time benefit eligible employee (working 30 or more hours per week) you are eligible to enroll in the benefits described in this guide. Also eligible are your spouse and child(ren) as long as the child is under age 26, an unmarried full-time student enrolled in accredited educational institution, or an unmarried child who is totally and permanently disabled (see coverage manual for further qualifications to cover disabled children).

When am I eligible for benefits?

Newly Eligible Employees: You have 30 days from your eligibility date to enroll in coverage and your coverage will be effective the first of the month coinciding with or following your date of hire. If you do not enroll at this time, see below for when you can make changes.

Annual Open Enrollment: You may make changes to your benefit elections during your open enrollment period. Your open enrollment period begins with your open enrollment meeting and ends when forms are due to be turned in. The benefits you elect during open enrollment will be effective from January 1, 2026 - December 31, 2026.

Qualified Change in Status: If you experience a qualifying event, you may be eligible to enroll in coverage. Examples of qualifying events include: loss of other coverage, marriage, divorce, birth or adoption, death, change in employment status or change in coverage under another employer sponsored plan. To make a change due to a qualifying event, you must notify HR of any changes within 30 days.

How do I enroll in benefits and when are my benefit elections due?

Newly Eligible Employees: If you are enrolling as a newly eligible employee, you will receive an email notification from HR when it is time to make your elections. You will need to complete your benefit elections within 30 days of your effective date.

Annual Open Enrollment: If you are enrolling or making a change at open enrollment, you will receive an email notification from HR when it is time to make your elections.
Your open enrollment period is November 11, 2025 - November 25, 2025. The annual open enrollment deadline is **November 25, 2025.** Remember, unless you have a qualified change in status, you cannot make changes to the benefits you elect until the next open enrollment period. Therefore, now is the time to review your current benefit elections and make any necessary changes.

Qualified Change in Status: If you experience a qualifying event, please contact HR. They will open your enrollment and provide further instruction on how to change your election online.

Benefits Enrollment and Information

Our company is currently offering the opportunity to make your annual benefit choices and to enroll in those benefits. For your convenience, we are utilizing a website that allows you to complete your enrollment online:

Team Name: asac.ease.com

You will receive an email when it is time to enroll.

Please note: passwords are case sensitive and you will be required to change your password the first time you login.

The website will present you with your enrollment options. Then, you need to select your benefits for the upcoming plan year and verify your personal information. Complete as much as you can initially – this information will be saved and you will be able to return to complete your enrollment choices within your enrollment timeframe.

After completing your enrollment for this plan year, you may login at any time throughout the year to review benefits information. You may also login to make changes should you experience a qualified change in status.

Benefit information only may be accessed via the Ease mobile app. Enrollment and benefit changes must be completed via the Ease website as described above.

To access the Ease mobile app:
For iOS:
1. Search for and install the Ease (formerly EaseCentral) app from the App Store.
2. Access the app by entering the URL shown above under Team name.

3. Enter your username and password used to login to the OwlLink powered by Ease website.

For Android:
4. Search for and install the Ease app from the Play Store.
5. Access the app by entering the URL shown above under Team name.
6. Enter your username and password used to login to the OwlLink powered by Ease website

Carrier Contact Information

Medical and Prescription:
Provider Name: Wellmark
Provider Phone Number: 800-524-9242
Provider Website: www.wellmark.com

Third Party Administrator:
Provider Type: Partial Self-Fund (PSF)
Provider Name: Auxiant
Provider Phone Number: 800-475-2232
Provider Website: www.auxiant.com

Dental:
Provider Name: Wellmark
Provider Phone Number: 877-333-0164
Provider Website: www.wellmark.com

Vision:
Provider Name: Principal Financial Group
Provider Phone Number: 800-986-3343
Provider Website: www.principal.com

Basic Life/AD&D, Voluntary Term Life/AD&D, Short-Term and Long-Term Disability:
Provider Name: Principal Financial Group
Provider Phone Number: 800-986-3343
Provider Website: www.principal.com

Health and Dependent Care FSA:
Provider Name: iSolved Benefit Services (Kabel)
Contact: Melinda Pollmeier / HR@asac.us
Website: www.isolvedbenefitservices.com/wdm

Other Voluntary Coverages:
Provider Name: Ware Group / Assurity (Matt Rednour)
Provider Phone Number: 563-265-0122
Provider Email: Matt@waregroupga.com

Area Substance Abuse Council
Medical Benefit Summary
January 1, 2026 - December 31, 2026

Plan Name	Wellmark / Auxiant OBS 230178-73 / 230188-65 Plan A		Wellmark / Auxiant OBS 230178-72 / 230188-64 Plan B		Wellmark / Auxiant OBS 230178-72 / 230188-64 Plan C	
Network	Wellmark Blue PPO		Wellmark Blue POS (Point of Service)		Wellmark Blue POS (Point of Service)	
	In	Out	In	Out	In	Out
Deductible						
Individual	$1,000	$6,350	$1,000	$6,350	$2,500	$6,350
Family	$2,000	$12,700	$2,000	$12,700	$5,000	$12,700
Coinsurance	30%	40%	30%	40%	30%	40%
Out of Pocket Maximum						
Individual	$2,000	$7,900	$2,000	$6,350	$5,000	$7,900
Family	$4,000	$15,800	$4,000	$15,800	$10,000	$15,800
Copays						
Preventive Care	$0	Ded / 40%	$0	Ded / 40%	$0	Ded / 40%
Office/Virtual Visit - Designated PCP	$25	Ded / 40%	$20	Ded / 40%	$20	Ded / 40%
Office/Virtual Visit - Non-Designated PCP	$25	Ded / 40%	$25	Ded / 40%	$25	Ded / 40%
Office/Virtual Visit - Specialist	$50	Ded / 40%	$50	Ded / 40%	$50	Ded / 40%
Doctor on Demand	$25		$25		$25	
Urgent Care	$25	Ded / 40%	$25	Ded / 40%	$25	Ded / 40%
ER	Ded / 30%		Ded / 30%		Ded / 30%	
Prescription Drugs (In Network)						
Tier 1	$8		$8		$8	
Tier 2	$35		$35		$35	
Tier 3	$50		$50		$50	
Biosimilar & Generic Specialty	$75		$75		$75	
Preferred Specialty	$100		$100		$100	
Non-Preferred Specialty	$150		$150		$150	
Deductible	$100 / $200		$100 / $200		$100 / $200	
	Monthly	Per Pay Period	Monthly	Per Pay Period	Monthly	Per Pay Period
Employee	$211.84	$105.92	$145.78	$72.89	$54.51	$27.25
Employee / Spouse*	$516.15	$258.07	$381.09	$190.54	$194.65	$97.32
Employee / Child(ren)	$483.20	$241.60	$358.29	$179.14	$182.16	$91.08
Family*	$691.55	$345.77	$490.01	$245.00	$236.16	$118.08
	*Spousal Surcharge Affidavit Required - $150 per month / $75 per pay period surcharge may apply					

Electing Plan A: The Wellmark Blue PPO Network includes statewide & national network of providers.

Electing Plan B or Plan C: The Wellmark Blue POS Network includes providers in Iowa & bordering counties in the network of providers. You are encouraged to designate a primary care provider for yourself and any family members. Not only will your preventive care be covered, but your office visit copay is reduced when seeing your designated PCP for a sick visit. To designate or change your Designated PCP or OB/GYN you will need to login to your myWellmark.com account online or via the mobile app or call Wellmark Customer Services at 1-800-990-1106.

Infertility Treatment ($15,000 Lifetime Maximum) included on all plan options

This proposal is an outline of the coverages proposed by the carrier(s) based upon the information provided by your company. It does not include all the terms, coverages, exclusions, limitations, and conditions of the actual contract language. See the policies and contracts for actual language. This proposal is not a contract and offers no contractual obligation on behalf of GBS. Policy forms for your reference will be made available upon request.

Partial Self-Funding

how it works

Your employer has entered into a Partial Self-Funded arrangement in order to better manage the cost of the Health Insurance Plan.

What does that mean?

The plan provided to the employees and their dependents and the plan purchased from the Insurance Company are different.

Your employer has elected to self-fund portions of the deductible, coinsurance & out of pocket maximum. Your employer has contracted with a Third Party Administrator (TPA) to process the claims that fall between the benefits you receive and the benefit plan that is purchased from the Insurance Company.

Refer to the attached Frequently Asked Questions for additional information.

Generally, the Partially Self-Funded plan only applies to the deductible, coinsurance & out of pocket maximum.

Do not make a payment to your provider based upon any EOB. These are not bills. They are simply Explanations of Benefits.

You will receive a bill from your health care provider based upon the adjusted EOB from the TPA. If you have any questions about your EOBs or bills, please contact:

1. Insurance Company – Refer to your ID Card
2. The Third Party Administrator (TPA)

To the right is a flow chart to help better explain this new process.

The Participant visits a Health Care Provider who provides the services and then codes the claim and submits it to the Insurance Company for processing.

The Insurance Company processes the claim and sends an Explanation of Benefits (EOB) to the Provider, TPA and participant reflecting the higher deductible, coinsurance and out of pocket maximum.

When the TPA receives the EOB from the Insurance Company, they reprocess that EOB and adjust the EOB to reflect the lower deductible, coinsurance and out of pocket maximum.

The TPA sends the revised EOB to the provider and the participant. The Participant should retain both the Insurance Company EOB & TPA EOB.

The provider may receive payment from both the Insurance Company & TPA. The Provider will then send a bill to the participant for their portion of the deductible and/or coinsurance.

Frequently Asked Questions

regarding partial self-funding

Why would an employer use this strategy to fund a health plan?

There are several reasons an employer uses this strategy. First, it should generate cost savings over time. Second, it allows for more flexibility in plan design & third, it allows the employer to capture relevant data about the total cost, utilization trends, and distribution of claims which can be used in negotiating renewals.

How does the process work?

You will go to your medical provider and present your card just as you always have. If a copay is due, you'll pay that. If the claim is applied to the deductible, then the Insurance Company will pay their share, the self-funded plan (administered through a TPA) will pay their share, and you pay the difference.

How will I know everything is being processed correctly?

When you have a claim that applies to the deductible, you'll get an Explanation of Benefits (EOB) from the Insurance Company. Shortly following, you will receive another EOB from the TPA explaining how the self-funded plan processed the claim.

Who determines how the claim is processed?

Claims are processed according to the language in your Insurance Company Plan Document. If you have a question about how a claim was handled, you should contact the Insurance Company.

After the Insurance Company has made a determination on a claim, then the TPA will process the claim according to the self-funded portion of the plan. If you have a question on how the TPA processed a claim, please contact them.

Will this be confusing?

This is a different process than what you are used to and there will certainly be questions.

To contact your Insurance Company-refer to your ID Card or contact the Third Party Administrator (TPA).

My provider is asking for payment for services because Wellmark shows my deductible as higher than what is reduced by the self-funded portion of the plan. What do I tell them?

You can share with your provider that there is a buy-down plan that makes additional payments toward claims to lower your deductible and out of pocket maximum. They can confirm this with Auxiant by calling them directly at 800-475-2232 and use the policy holder's social security number as the ID number.

Auxiant®

VISIT US ON THE WEB
auxiant.com

With AuxiantHealth you can:

- Link to network providers
- Contact customer service through Auxiant Live Chat
- View enrollment and claim information, print EOB's, and track claims
- View deductibles and out-of-pocket amounts
- Access plan documents and amendments
- Link to Prescription Benefit Manager
- Get information on the go via our mobile app

At Auxiant.com you have 24/7 access to your personal health care account information

Questions? Contact Auxiant at 1.800.475.2232

Live chat with Auxiant customer service, click Online Chat to begin

Auxiant®

Member Services

Wellmark

Wellmark offers several services to members. Some of the services listed below may not be available to all members, depending on the details of each employer's health plan.

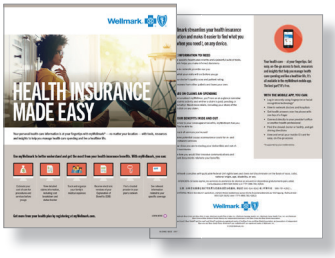
myWellmark
Get the most from your health insurance benefits
- Estimate your cost of care for your procedures and services
- Detailed claims information
- Track and organize your medical expenses
- Receive electronic versions of your Explanation of Benefits (EOB)
- Find a provider in your plan's network
- See the following page for how to register

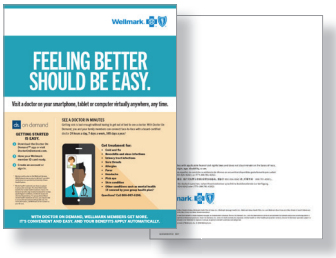
Doctor On Demand
Visit a doctor on your smartphone, tablet or computer from virtually anywhere
- Download the Doctor on Demand app or visit DoctorOnDemand.com
- Have your Wellmark member ID card ready
- Create an account or sign in

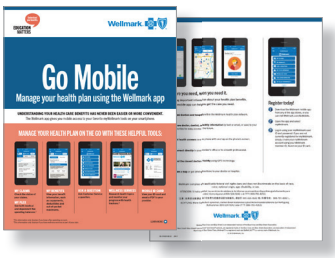
Wellmark Mobile App
Access your favorite myWellmark tools on your smartphone: View benefit information, claims, flex, mobile ID card, wellness services, customer service
- Download the Wellmark mobile app from any of the app stores or visit Wellmark.com/GoMobile
- Open the app and select myWellmark
- Log in using your myWellmark user ID and password. If you are not registered for myWellmark, create an account using your Wellmark member ID, found on your ID card.

Blue365
Exclusive discounts on wellness products and services
- Go to Wellmark.com/Blue365
- Have your email address and the first three characters of your Wellmark ID number ready

IDX Identity
Free access to identity protection services
- Log in to your myWellmark.com account and have your Wellmark insurance card handy
- Click on Identity Protection in the lower left corner of the page
- Write down the enrollment code shown on your screen and then click the Enroll/ Login button
- Enter the Group ID and Subscriber ID from your Wellmark card, register your email and a password
- Enter the enrollment code and follow directions to complete enrollment
- To activate credit monitoring, enter your date of birth, Social Security Number, and answer authentication questions







How to Register for myWellmark.com

Registration takes just 5-10 minutes. You'll need your Wellmark ID card to get started.

1. Go to: authentication.wellmark.com
2. On the right hand side, select your user type
   You are a member on your employer's group sponsored plan.
3. Select Register after choosing your user type.

STEP 1: Personal Information

See your Wellmark ID card and enter the details exactly as shown.

Enter your basic information such as your name, birth date and contact information.

Next, enter the last four digits of your Social Security number and your relationship to the primary member (self, spouse, dependent). This information is safe and confidential when entering it online.

Pick your communication preferences. Choose whether to receive electronic communications from Wellmark, if you're the primary member, to receive explanation of benefits (EOB) statements online.

STEP 2: Create Account

Set up your myWellmark User ID and password. You'll need your User ID and password every time you want to access your myWellmark account.

You'll also choose and answer security questions. These will help identify you if you ever forget your User ID or password.

Next, accept the terms and conditions for using myWellmark

STEP 3: Finish

Confirm your information is accurate and submit your registration

That's it! Next you'll be taken to your myWellmark home page, where you'll learn about how to customize the site to get the most benefit from it.

HealthCare Cost Estimator

Find out how much a service or medical procedure will cost. Click "Find Costs" located on the lower right of your mywellmark page.

Print ID Cards

- Once registered, log in to mywellmark.com
- Under the tab "My Account", select Order ID card.
- Click on "view/Print ID card"
- To print your temporary ID card, click on "Create PDF"
- A new page will appear to print your Temporary ID card. This card looks almost identical to the actual insurance card which includes the information needed for your doctor visit or pharmacy refill.

How to search for a Wellmark provider

1. Go to www.wellmark.com

2. Click on **Member Resources.**

3. Click on **Find a Provider.**.

4. Click **Search Now** to continue to Healthsparq
If you do not know your Member ID number or your three-letter prefix, click on **Browse a List of Plans** and choose your applicable network: PPO, POS, or HMO

OR

If you are currently covered by a Wellmark plan, click **Log in to Find Care** for personalized search results based on your Wellmark plan.

5. Choose your search category: providers by name, providers by specialty, places by name, or places by type - or click Search All or Advanced Search. You may also narrow your search by: PCP-Primary Care, OB/GYN, Mental Health, or Telehealth.

Wellmark®

How to select your **primary care provider on myWellmark®**

Patients who have a strong relationship with their primary care provider (PCP) often benefit from better disease control and improvements in overall health.[1] In addition, building a long-term relationship with your PCP can be associated with lower hospital and emergency room use, saving you money and time. Your PCP should be someone you feel comfortable with, who will listen to and understand your needs and then direct your care appropriately.

Some benefit plans may have a variation in benefit costs when you establish and visit a designated PCP.[2] To receive these benefits, you need to select the provider you'd like as your PCP.[3]

Find digital tools at your fingertips with myWellmark.

Create your myWellmark® account

Go to **mywellmark.com** and click "**Register now**". Enter your email address and select a password. It is recommended you use a non-employer email address. ***Follow the prompts to complete your registration.***

[1] Dean, Kristin. "Why You Should Build a Relationship with Your Doctor." Doctor On Demand, 22 June 2022, doctorondemand.com/blog/health/why-you-should-build-a-relationship-with-your-doctor.

[2] Please review your benefit plan material or visit myWellmark.com for benefit details.

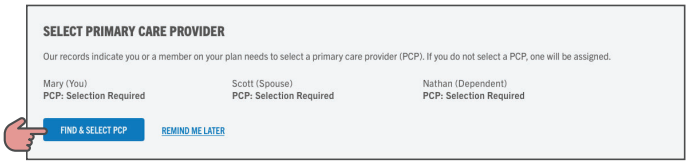
[3] If you do not select a health care provider who can serve as your PCP, one will be assigned for you based on recent visit history and/or location proximity to the home address we have on file for you. You will be notified by mail when this auto-assignment occurs.

Confirm or edit your PCP

Log in to your myWellmark account. Depending on your PCP selection status, you may see the following prompts:

If you need to select a PCP

A pop-up screen will remind you that a PCP needs to be selected for you or other members on your plan. To do this at a later date, click "**Remind me later**". To search for and select a PCP, click "**Find & select PCP**".

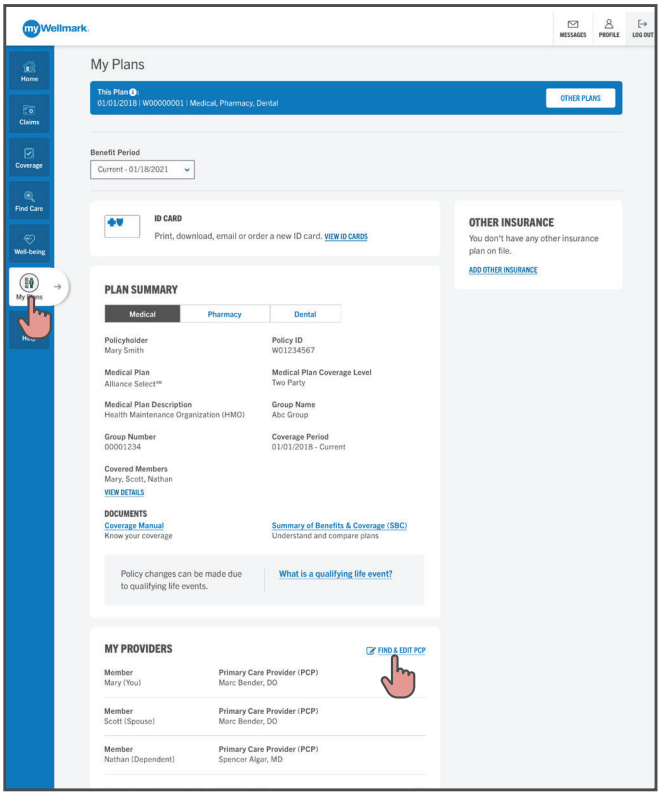


If a PCP has been auto-assigned

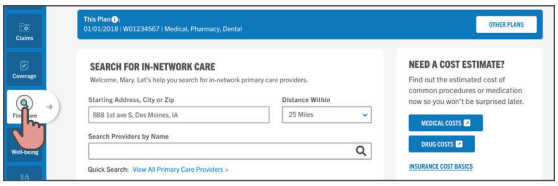
A pop-up screen will display the members on your plan and their PCP assignments. If you need to make updates, click "**Find new PCP**". If you don't need to make changes, click "**Confirm PCP selection**".

Search providers to edit your PCP

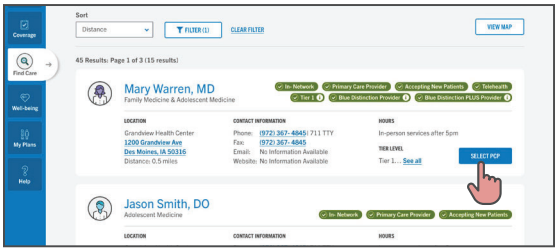
Alternatively, you can navigate to "**My Plans**" and then "**My Providers**". There, you can click on the pencil icon to search for or edit your PCP.



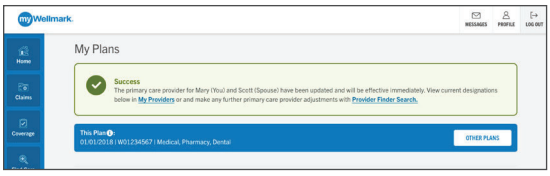
On the "**Find Care**" page you'll be able to search for eligible in-network providers by name or by type. Ensure this provider is accepting new patients.



When you find the PCP you're looking for, click on "**Select PCP**". You'll be prompted to confirm which member will see this PCP.



You will receive a confirmation message when your selection is successful.



Wellmark Blue Cross and Blue Shield of Iowa, Wellmark Health Plan of Iowa, Inc., are independent licensees of the Blue Cross and Blue Shield Association.

Area Substance Abuse Council
Dental Benefit Summary
January 1, 2026 - December 31, 2026

	Wellmark	
Network	Blue Dental	
Member Responsibility		
Deductible	$25 / $75	
Waived for Preventive Services	Yes	
Annual Maximum	$1,000	
Orthodontia Lifetime Maximum (per child, up to age 19)	$750	
Member Coinsurance for Services		
Diagnostic and Preventive	0%	
Basic Restorative / Oral Surgery	20%	
Major Restorative	50%	
Endodontic	50%	
Periodontal	50%	
Prosthetic	50%	
Orthodontic (dependents to age 19)	50%	
	Montlhy	**Per Pay Period**
Employee	$10.85	$5.42
Employee / Spouse	$19.00	$9.50
Employee / Child(ren)	$19.98	$9.99
Family	$45.00	$22.50

This proposal is an outline of the coverages proposed by the carrier(s) based upon the information provided by your company. It does not include all the terms, coverages, exclusions, limitations, and conditions of the actual contract language. See the policies and contracts for actual language. This proposal is not a contract and offers no contractual obligation on behalf of GBS. Policy forms for your reference will be made available upon request.

Area Substance Abuse Council
Vision Benefit Summary
January 1, 2026 - December 31, 2026

	Principal	
	VSP Choice Network	
Covered charges	**Benefit**	**Frequency**
Exams	$10 copay	1 per 12 months
Glasses	$25 copay	
Lenses	Single vision, lined bifocal, lined trifocal, and lenticular lenses; polycarbonate lenses for dependent children under age 18	1 pair per 12 months
Frames	$130 allowance for a wide selection of frames; 20% off amount over allowance	1 set per 12 months
Elective contacts	Up to $60 copay for standard and premium elective contact lens exams (fitting and evaluation)	1 per 12 months
	$130 allowance for elective contacts	Instead of lens and frames benefit
Necessary contacts	$25 copay Covered in full for members who have specific conditions. Contact lenses can be chosen instead of glasses.	1 per 12 months
Lens enhancements	$0 copay - standard progressive lenses Most other popular options are covered after a copay, saving members an average of 30%. Members should see their doctor for special pricing on additional lens enhancements.	1 per 12 months
Aditional Benefits	Savings on laser vision correction and additional pairs of prescription glasses and non-prescription sunglasses. See summary for details.	

	Monthly	**Per Pay Period**
Employee	$7.45	$3.73
Employee / Spouse	$16.67	$8.34
Employee / Child(ren)	$18.46	$9.24
Family	$28.80	$14.41

This proposal is an outline of the coverages proposed by the carrier(s) based upon the information provided by your company. It does not include all the terms, coverages, exclusions, limitations, and conditions of the actual contract language. See the policies and contracts for actual language. This proposal is not a contract and offers no contractual obligation on behalf of GBS. Policy forms for your reference will be made available upon request.

Area Substance Abuse Council
Life & Disability Benefit Summary
January 1, 2026 - December 31, 2026

Life and AD&D

Benefit	Principal
Benefit Amount	$100,000
Reduction Schedule	Origianl Amount Reduced: To 65% at Age 65 To 50% at Age 70

Short Term Disability

Benefit	Principal
Benefit Percentage	66.67%
Maximum Weekly Benefit	$1,500
Maximum Benefit Period	12 weeks
Elimination Period	8th day accident / injury 8th day sickness

Long Term Disability

Benefit	Principal
Benefit Percentage	60%
Maximum Monthly Benefit	$6,000
Elimination Period	90 days
Own Occupation Period	2 years
Benefit Duration	Reduced benefit duration to social security normal retirement age

This proposal is an outline of the coverages proposed by the carrier(s) based upon the information provided by your company. It does not include all the terms, coverages, exclusions, limitations, and conditions of the actual contract language. See the policies and contracts for actual language. This proposal is not a contract and offers no contractual obligation on behalf of GBS. Policy forms for your reference will be made available upon request.

Group benefits

Help handling life's ups and downs

Principal®

Life can be unpredictable. And it's not always easy. So it's a big deal to know there's help available when you need it. That's what the employee assistance program (EAP), provided by Magellan Healthcare, is all about.

With an EAP, you and your family have access to **free, confidential** resources to help handle life's everyday—and not so everyday—challenges.

You might use your EAP to help: manage stress, handle relationship issues, balance work and life, work through grief, cope with anxiety, and more. Plus, your EAP gives you access to discounts on major brands and everyday needs.

Services for you and your family

Your EAP offers these services to help you and your family deal with the big and little things.

In-person or virtual counseling

One valuable way to work through personal or work issues is by talking with a professional. You and your family can meet with a licensed, EAP professional in person, via text message, or by live chat, video, or phone sessions. Three counseling sessions per year are included.

Legal, financial, and identity theft services

You and your family have access to these services:

- **Legal services.** Receive a free 60-minute consultation to help deal with issues such as car accidents or family law.
- **Financial wellness.** Receive three free 30-minute consultations. This may include help with budget planning, debt consolidation, or retirement planning.
- **Identity theft resources.** Receive a free 60-minute consultation to help restore your identity if stolen.

Work-life web services

You and your family can access webinars, live talks, and articles on topics such as child and elder care, education, parenting, and more.

Help when and where you need it—day or night

Life's challenges don't always happen during regular business hours. That's why you and your family have 24/7 access to your EAP.

800-450-1327
International: 800-662-4504
TTY: 711

Member.MagellanHealthcare.com
When you create an account, enter **Principal Core** as the program name.

Area Substance Abuse Council
Voluntary Life and AD&D Benefit Summary
January 1, 2026 - December 31, 2026

	Principal
Employee	
Increments	$10,000
Benefit Maximum	$500,000
Guarantee Issue	$200,000
**Annual Increase Option	2 Increments, not to exceed the benefit maximum, without EOI
AD&D	Matches voluntary life benefit
Spouse	
Increments	$5,000
Benefit Maximum	100% of Employee's Benefit, up to $200,000
Guarantee Issue	100% of Employee's Benefit, up to $30,000
**Annual Increase Option	2 Increments, not to exceed the benefit maximum, without EOI
Child	
Increments	$2,000; $4,000; $10,000
Benefit Max	100% of Employee's Benefit, up to $10,000
Guarantee Issue	$10,000

Effective 1/1/2026 - you can enroll elect to enroll up to the guarantee issue amount without providing proof of good health.

**Annually, you can request to add or increase existing life insurance coverage for yourself or eligible dependents up two benefit increments without providingproof of good health, not to exceed the maximum life insurance benefit allowed. Higher amounts of coverage can be requested, but will require approval of proof of good health.

This proposal is an outline of the coverages proposed by the carrier(s) based upon the information provided by your company. It does not include all the terms, coverages, exclusions, limitations, and conditions of the actual contract language. See the policies and contracts for actual language. This proposal is not a contract and offers no contractual obligation on behalf of GBS. Policy forms for your reference will be made available upon request.

Area Substance Abuse Council Inc
Flexible Spending Benefit Summary
January 1, 2026 - December 31, 2026

Medical FSA

	iSolved
Maximum Contribution Amount	**$3,400**
Employer Contribution	N/A
Maximum Carryover*	$680

At the end of the 2025 Plan Year, if you have unspent dollars up to $660 will be automaticlly carried over to your 2026 plan year.

*For the 2026 Plan Year, If you have unspent dollars remaining at the end of 2026, up to $680 can be carried over to 2027.

Dependent Care FSA

	iSolved
Maximum Contribution Amount	**$7,500**
Maximum Carryover / Grace Period	N/A

This proposal is an outline of the coverages proposed by the carrier(s) based upon the information provided by your company. It does not include all the terms, coverages, exclusions, limitations, and conditions of the actual contract language. See the policies and contracts for actual language. This proposal is not a contract and offers no contractual obligation on behalf of GBS. Policy forms for your reference will be made available upon request.

isolved Benefit Services

Flexible Spending Accounts.

Real Savings. Real Simple.

Using a Flexible Spending Account (FSA) is a great way to stretch your benefit dollars. You use pre-tax dollars in your FSA to reimburse yourself for eligible out-of-pocket medical and dependent care expenses. That means you can enjoy tax savings with the convenience of a prepaid benefits card. And that makes real sense.

What is an FSA?

With an FSA, you elect to have your annual contribution (up to the annual limit set by the IRS) deducted from your paycheck each pay period in equal installments throughout the year. The amount of your pay that goes into an FSA will not count as taxable income, so you will have immediate tax savings. FSA dollars can be used during the plan year to pay for qualified expenses and services. Please check with your employer to see what plans are offered.

A Health FSA allows reimbursement of qualifying out-of-pocket medical expenses.

A Dependent Care FSA allows reimbursement of dependent care expenses, such as day care, incurred by eligible dependents.

A Limited Purpose Health FSA is compatible with a Health Savings Account (HSA). A limited FSA only allows reimbursement for preventive care, vision and dental expenses, keeping the employee eligible to contribute to an HSA.

With all FSA account types, you'll receive access to a secure, easy-to-use web portal where you can track your account balance, view your investment accounts and submit requests for reimbursements.

In addition, your plan might offer a convenient prepaid benefits card to make it easy to pay for eligible services and products. When you use the card, payments are automatically withdrawn from your account, so there are no out-of-pocket costs and you likely won't have to submit receipts to verify the purchase. Just swipe the card and go. **It's that easy!**

Throughout the year, you'll likely incur expenses for yourself and your family that insurance won't cover. By taking advantage of a health care FSA, you can actually reduce your taxable income and reduce your out-of-pocket expenses when you use your FSA to pay for health care services and products you'd purchase anyway.

copyright 2024 • www.isolvedbenefitservices.com

isolved

Is an FSA right for me?

An FSA is a great way to pay for expenses with pre-tax dollars. A Health Care FSA could save you money if you or your dependents:

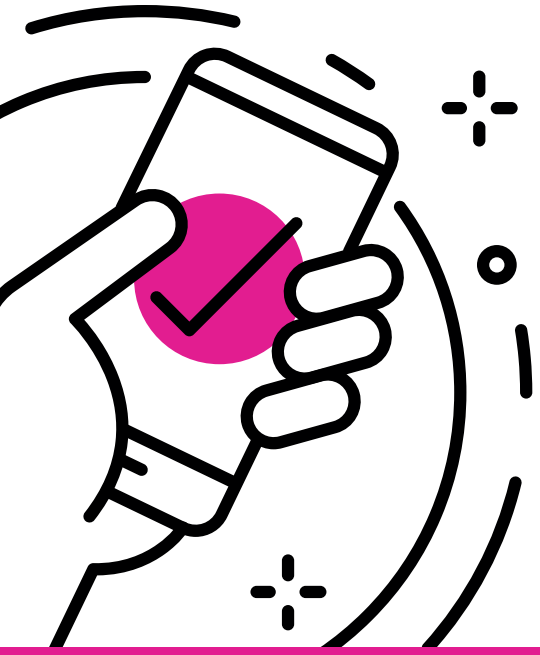
- Have out-of-pocket expenses like **co-pays, coinsurance, or deductibles** for health, prescription, dental or vision plans
- Have a **health condition that requires the purchase of prescription medications** on an ongoing basis
- Wear **glasses or contact lenses** or are planning **LASIK surgery**
- Need **orthodontia care, such as braces,** or have dental expenses not covered by your insurance

A Dependent Care FSA provides pre-tax reimbursement of out-of-pocket expenses related to dependent care. This benefit may make sense if you (and your spouse, if married) are working or in school, and:

- Your **dependent children under age 13 attend day care, after-school care** or **summer day camp**
- You **provide care for a person of any age who you claim as a dependent on your federal income tax return** and who is mentally or physically incapable of caring for himself or herself

An FSA is a great way to pay for expenses with pre-tax dollars.

- Enjoy significant tax savings with pre-tax contributions and tax-free distributions used for qualified plan expenses
- Quickly and easily access funds using the prepaid benefits card at point of sale, or request to have funds directly deposited to your bank account via online or mobile app
- Reduce filing hassles and paperwork by using your prepaid benefits card
- Enjoy secure access to accounts using a convenient Consumer Portal available 24/7/365
- Manage your FSA "on the go" with an easy-to-use mobile app
- File claims easily online (when required) and let the system determine approval based on eligibility and availability of funds
- Stay up to date on balances and action required with automated email alert and convenient portal and mobile home page messages
- Get one-click answers to benefits questions



With the convenience of a mobile device, you can see your available balance anywhere, anytime, as well as file claims and upload receipts.

Plan Ahead

Before you enroll, you must first decide how much you want to contribute to your account(s). You will want to spend some time estimating your anticipated eligible medical and dependent care expenses for the calendar year.

The U.S. Treasury Department modified its Health Flexible Spending Account (FSA) Use-or-Lose rule to allow up to a speficied carryover of Health FSA funds. The carryover option is based solely on your employer's plan design. Not every company allows a carryover. Some employer plans may establish a lower maximum limit than allowed, but it must be uniformly applied to all eligible participants. The carryover is applicable only to Health FSAs (not to Dependent Care FSAs). Any unused amount above the carryover limit is subject to forfeiture and cannot be cashed out or transferred to other taxable or nontaxable benefits (e.g., HSAs). Please review our guide - Contribution Limits - for the carryover amount maximum allowed for each plan year.

For questions, contact us at: **FSA@isolvedhcm.com** or **800-300-3838**

Transforming employee experience for a better today and a better tomorrow.

copyright 2024 • www.isolvedbene itservices.com

isolved

isolved Benefit Services

Know Your Eligible and Ineligible Expenses

Estimated unreimbursed health care expenses

Eligible Expenses

Baby/Child to age 13
- Lactation consultant
- Lead-based paint removal*
- Special formula*
- Tuition: special school/teacher for disability or learning disability
- Well baby/well child care

Dental
- Dental x-rays
- Dentures and bridges
- Exams and teeth cleaning
- Extractions and fillings
- Oral surgery
- Orthodontia
- Periodontal services

Eyes
- Eye exams
- Eyeglasses and contact lenses
- Laser eye surgeries
- Prescription sunglasses
- Radial keratotomy

Hearing
- Hearing aids and batteries
- Hearing exams

Lab Exams/Tests
- Blood tests and Metabolism tests
- Body scans
- Cardiograms
- Laboratory fees
- X-rays

Medications
- Insulin
- Prescription drugs

Medical Equipment/Supplies
- Air purification equipment*
- Arches and other orthotic inserts
- Contraceptive devices
- Crutches, walkers, wheel chairs
- Exercise equipment*
- Hospital beds*
- Mattresses*
- Medic alert bracelet or necklace
- Nebulizers
- Orthopedic shoes*
- Oxygen
- Personal Protective Equipment (PPE)
- Post-mastectomy clothing
- Prosthetics
- Syringes
- Wigs*

Obstetrics
- Doulas*
- Lamaze class
- OB/GYN exams
- OB/GYN prepaid maternity fees (reimbursable after date of birth)
- Pre- and post-natal treatments

Practitioners
- Allergist
- Chiropracter
- Christian Science Practitioner
- Dermatologist
- Homeopath
- Naturopath*
- Osteopath
- Physician
- Psychiatrist or Psychologist

Therapy
- Alcohol and Drug addiction
- Counseling (must be treating a medical condition)
- Exercise programs*
- Hypnosis*
- Massage*
- Occupational
- Physical
-Smoking cessation programs
- Speech
- Weight loss programs

Medical Procedures/Services
- Acupuncture
- Alcohol and drug/substance abuse (inpatient treatment and outpatient care)
- Ambulance
- Fertility enhancement and treatment
- Hair loss treatment*
- Hospital services
- Immunization
- In vitro fertilization
- Personal trainers*
- Physical examination (not employment-related)
- Reconstructive surgery (due to a congenital defect, accident or medical treatment)
- Service animals
- Sterilization/sterilization reversal
- Transplants (including organ donor)
- Transportation*

This list is not meant to be all-inclusive, as other expenses not specifically mentioned may also qualify. Also, expenses marked with an asterisk (*) are “potentially eligible expenses” that require a note of medical necessity from your health care provider to qualify for reimbursement. For additional information, check your Summary Plan Document or contact isolved Benefit Services.

Over-the-Counter (OTC) Medicines, purchased on or after January 1, 2020, were reinstated with the passage of the CARES Act (COVID-3 Stimulus Bill) for HSAs, FSAs and Archer MSAs (unless your plan excludes OTC items). OTC items can be purchased with funds from eligible accounts without needing a prescription. Additionally, the bill expanded OTC items to include menstrual care products.

Eligible Over-the-Counter Items

Note: Product categories are listed in bold face; common examples of products are listed in regular face.

The following is a high-level list of over-the-counter (OTC) items that are not medicine or drugs and are eligible for purchase with Health Care FSA dollars. You can use your benefits card for these items

Antiseptics, wound cleaners
Alcohol, peroxide, Epsom salt

Baby electrolytes
Pedialyte, Enfalyte

Denture adhesives, repair and cleansers
PoliGrip, Benzodent, Efferdent

Diabetes testing and aids
Insulin, Ascencia, One Touch, Diabetic Tussin, insulin syringes, glucose products

Sunscreen (SPF 15 and over)

Diagnostic products
Thermometers, blood pressure monitors, cholesterol testing

Elastics/athletic treatments
ACE, Futuro, elastic bandages, braces, hot/cold therapy, orthopedic supports, rib belts

Eye care
Contact lens care

Family planning
Pregnancy and ovulation kits

First aid dressings and supplies
Band Aid, 3M Nexcare, non-sport tapes

Hearing aid/medical batteries

Incontinence products
Attends, Depend, GoodNites for juvenile incontinence

Ineligible Expenses

Note: This list is not meant to be all-inclusive

The IRS does not allow the following expenses to be reimbursed the FSA, as they are not prescribed by a physician for a specific ailment.

Contact lens or eyeglass insurance

Cosmetic surgery/procedures

Electrolysis

Marriage or career counseling

Swimming lessons

Sunscreen
(SPF less than 15 needs RX)

isolved Benefit Services

Dependent Care FSA

FAQ's

A Dependent Care FSA provides pre-tax reimbursement of out-of-pocket expenses related to dependent care. It's a great option for employees who have dependent children under the age of 13 who attend day care, after-school care or summer day camp, and/or provide care for a person of any age who is claimed as a dependent on the federal income tax return and who is mentally or physically incapable of caring for himself or herself.

Who is a qualified dependent under the Dependent Care FSA?

- Dependent under the age of 13
- Dependent or spouse of employee who is mentally or physically disabled and whom the employee claims as a dependent on their federal income tax return

Can an adult be a qualified dependent?

Yes, an adult may qualify as a dependent provided that the employee is providing more than half of that individual's support for the year and the dependent lives with the employee.

Do I have to use a day care facility?

No. You can be reimbursed for expenses of an individual providing care for your dependent in your home as long as the expenses are incurred for you and your spouse (if married), to work, look for work or attend school full time.

Does my day care provider have to be licensed?

No. However, you are required to submit their Tax Identification Number or Social Security Number when filing your federal income tax return.

My child attends camp during the summer. Is this eligible?

Generally, no. However, if the camp is a day camp and your dependent attends to allow you and your spouse (if married) to work, look for work or attend school full time, then yes, this would be an eligible expense. Overnight camps are specifically excluded.

Does my day care provider have to be 18?

No, but the individual must claim the money as income on their tax return.

copyright 2020 • www.isolvedbenefitservices.com

isolved

When can I be reimbursed for dependent day care expenses?

Expenses are eligible for reimbursement when they have been incurred, not when you are billed or when you pay for the services.

Example: Your day care provider requires you to pay for the month of September on September 1. You can be reimbursed as the services are incurred, not when you paid for the services. You can submit claims after each week, every week or on October 1.

What support documentation must I file with each Dependent Care claim?

Complete the Dependent Care section of the Request for Reimbursement Form and have your day care provider sign and date. The receipt must include the following information:

- Name and address of provider
- From/through dates of service
- Amount of charge

Can I submit claims for dependent care expenses that are greater than the current balance of my Dependent Care FSA?

Yes. However, you will only receive reimbursement for the amount that you have contributed to your Dependent Care FSA. For example, if you contribute $150 each month to your Dependent Care FSA, then you will only receive $150 in reimbursement each month. The excess amount of expenses will be pended and automatically paid to you as contributions are posted to your account.

What happens if a claim exceeds the amount currently available in my Dependent Care FSA?

The claim will be processed and approved. The amount that is currently available will be disbursed and the remaining portion will be pended until you make another contribution.

copyright 2020 • www.isolvedbenefitservices.com

isolved

WARE GROUP
GENERAL AGENCIES

Area Substance Abuse Council

Supplemental Benefits for

Administered by Assurity

Area Substance Abuse Council offers supplemental benefits through Assurity. These benefits are designed to address financial vulnerabilities that may arise due to injuries, illnesses, surgeries, or pregnancies affecting you or a covered loved one. Assurity provides accident, critical illness, and hospital indemnity benefits to team members. All these benefits offer cash payments directly to you, which can be used for various purposes such as deductibles, everyday living expenses, childcare, treatment-related travel expenses, or any other needs you may have.

You can find your benefit summaries at the URL provided below, along with a URL and QR code to access an educational video about these plans. If you have any questions, please reach out to your agent. For filing a claim, please contact your claims advocate, whose details are also listed below.

Locate your benefit summaries visit link below:
http://bit.ly/asacsupplementalbrochures

Locate your education video visit link below or scan the QR code
http://bit.ly/asacsupplementaleducation

Contact Information

Agent
MATT REDNOUR
563-265-0122
Matt@waregroupga.com

Claims Advocate
JADE WOOD
855-535-4231 Ext. 213
Jade@waregroupga.com

Assurity Accident Expense Overview

OVERVIEW	Accident insurance provides a cash benefit that can be used for any purpose, not limited to deductibles, out-of-pocket maximums, or everyday living expenses, when an employee or their covered loved one experiences an injury due to an off-the-job accident. There are many examples such as sports injuries, slips and falls, burns, dislocations, and more. To qualify for benefits, seek treatment at a physician's office, urgent care, or emergency room; thereafter, it pays cash benefits for the specific injury, treatments, services, and more. Please contact your claims advocate for assistance with filing a claim. This plan is portable, meaning you can take it with you upon leaving employment, and it does not require any networks; benefits will be paid directly to you. Please refer to your benefit summaries for full plan details.	
WELLNESS	Pays $50 once per date, up to two times per calendar year per person and four times family maximum which will reset every January 1st. Applicable screenings or exams you may submit are blood screening for triglycerides, cholesterol, HDL, LDL, fasting blood glucose, annual physical exam, routine eye exam, and immunization.	
EMERGENCY CARE	Physician's Office for Accident: $150 Urgent Care for Accident: $150 Emergency Room for Accident: $300 Telemedicine Treatment: $60 Ambulance Ground/Air: $300/$900	X-Ray: $300 Diagnostic Exams: $150 Blood/Plasma/Platelets: $900 ER Observation: $150
SUPPORTIVE & SPECIFIC INJURY CARE	Follow-Up Treatment: $100 Physical/Occup./Speech Therapy: $60 Chiropractic/Acupuncture: $60 Epidural Pain Management: $100 Medication or Medical Supplies: $10	Appliance: $250 Prosthetic Devices: $1,000 Residence or Vehicle Modification: $1,000 Transportation Ground/Air: $200/$500 Lodging: $200
SPECIFIC INJURY CARE	Burns: $1,125 Burns Skin Graft: 50% of Burn Benefit Child Organized Sports: Up to $1,000 Coma: $22,500 Concussion: $56.25 Dental Emergency Crown/Extraction: $225 Dislocation/Fracture Closed/Open Reduction: $2,250/$4,500	Ear/Eye Injury: $225 Gunshot Wound: $1,125 Laceration: $112.50 Paralysis: $16,875 Poisoning: $56.25 PTSD: $450 Traumatic Brain Injury: $675
HOSPITAL ADMISSION CARE	Hospital Admission: $1,000 Hospital Confinement: $200 Intensive Care Unit: $400	Sub-Acute Intensive Care Unit: $300 Rehabilitation Unit: $200 Hospital Confinement-Child Care: $40

Assurity Accident Expense Overview

SURGICAL CARE	Open Abdominal/Thoracic/Cranial Surgery: $1,500 Tendon/Ligament/Rotator Cuff/Knee Cartilage Surgery: $750 Ruptured Disc Surgery: $750		Hernia Surgery: $375 Exploratory Surgery: $375 Misc Outpatient Surgery: $150 Anesthesia: $150
ACCIDENT, DEATH & DISMEMBERMENT	Employee: $40,000 If Seatbelt Was Used: +$10,000 Common Carrier: $100,000	Spouse: $20,000 If Seatbelt Was Used: +$5,000 Common Carrier: $50,000	Child(ren): $10,000 If Seatbelt Was Used: +$2,500 Common Carrier: $25,000

Semi-Monthly Rates	Plan 1
EMPLOYEE	**$6.98**
EMPLOYEE + SPOUSE	**$12.17**
EMPLOYEE + CHILD(REN)	**$15.26**
FAMILY	**$22.42**

Assurity Critical Illness Benefits Overview

OVERVIEW	Critical illness insurance provides a cash benefit for a range of covered serious illnesses such as cancer, stroke, and heart attack, in addition to the conditions your medical insurance may cover. Payments can be used for any purpose, not limited to deductibles, out-of-pocket maximums, or everyday living expenses. If you or a covered loved one is diagnosed with one of the covered illnesses listed below while coverage is in force, please contact your claims advocate to assist you in filing a claim. This plan is portable, meaning you can take it with you upon leaving employment, and it does not require any networks; benefits will be paid directly to you. Please refer to your benefit summaries for full plan details.

	Employee Coverage Options	Spouse Coverage	Child(ren) Coverage
MULTIPLES OF MINIMUM ELECTION **GUARANTEE ISSUE** **MAXIMUM ELECTION**	$10,000 $10,000 $30,000 $30,000	50% of Employee's Amount	25% of Employee's Amount (coverage is automatically included when employee coverage is elected)
COVERED CRITICAL ILLNESSES ***Percents Shown Reflect Percent of Lump Sum Benefit**	Heart Attack: 100% Stroke: 100% Invasive Cancer: 100% Kidney Failure: 100% Major Organ Transplant: 100% Alzheimer's Disease: 100% Coma: 100% Paralysis: 100%	Loss of Sight: 100% Loss of Speech: 100% Loss of Hearing: 100% Parkinson's Disease: 100% ALS: 100% Benign Brain Tumor: 100% Occupational HIV: 100% Severe Burns: 100%	Bone Marrow Transplant: 100% Multiple Sclerosis: 50% Coronary Bypass Surgery: 25% Sudden Cardiac Arrest: 25% Angioplasty: 10% Non-Invasive Cancer: 25% Skin Cancer: $250/cal yr Loss of Independent Living: 25% Schizophrenia: 10% TIA: 10%
Cardiopulmonary Rider ***Percents Shown Reflect Percent of Lump Sum Benefit**	**Cardiopulmonary Rider** Mitral Valve Replacement or Repair 50% Aortic Valve Replacement or Repair 50% Surgical Treatment of Abdominal Aortic Aneurysm 50% Pulmonary Embolism 25% Idiopathic Pulmonary Fibrosis 25% Angio Jet Clot Busting 10%	**Cardiopulmonary Rider** Atherectomy 10% Stent Implementation 10% Cardiac Catheterization 10% Automatic Implantable Cardioverter Defibrillator 10% Pacemaker Placement 10% Valvuloplasty 10%	

Assurity Critical Illness Benefits Overview

PRE-EXISTING CONDITIONS	Assurity will not pay benefits for a specified critical illness that is caused by a pre-existing condition unless the specified critical illness starts after the coverage has been in force for 12 months from the issue date. Pre-existing condition means a sickness or physical condition for which, during the 12 months before the issue date, the insured person had symptoms which would cause an ordinary prudent person to seek diagnosis, care of treatment, or received medical consultation, advice or treatment from a physician or had taken prescribed medication. The pre-existing condition clause will be waived during the initial enrollment for new hires. Late entrant employees enrolling during the annual re-enrollment will be subject to the normal pre-existing condition clause.

Semi-Monthly Attained Age Rates	**Employee Only and Employee + Children Rates Below**			**Employee + Spouse and Employee + Family Rates Below**		
Benefit Amounts	$10,000	$20,000	$30,000	$10,000	$20,000	$30,000
18-24	**$1.33**	**$2.63**	**$3.94**	**$1.94**	**$3.86**	**$5.78**
25-29	**$1.70**	**$3.36**	**$5.04**	**$2.46**	**$4.88**	**$7.31**
30-34	**$2.25**	**$4.47**	**$6.70**	**$3.31**	**$6.56**	**$9.82**
35-39	**$3.06**	**$6.06**	**$9.09**	**$4.52**	**$8.95**	**$13.40**
40-44	**$4.11**	**$8.16**	**$12.22**	**$6.12**	**$12.11**	**$18.11**
45-49	**$5.95**	**$11.80**	**$17.66**	**$8.91**	**$17.62**	**$26.35**
50-54	**$9.21**	**$18.29**	**$27.36**	**$13.84**	**$27.40**	**$40.96**
55-59	**$14.85**	**$29.48**	**$44.12**	**$22.35**	**$44.27**	**$66.21**
60-64	**$19.01**	**$37.79**	**$56.59**	**$28.62**	**$56.78**	**$84.95**
65-69	**$26.18**	**$52.11**	**$78.05**	**$39.38**	**$78.29**	**$117.19**
70+	**$76.21**	**$151.86**	**$227.50**	**$114.60**	**$228.06**	**$341.54**

IMPORTANT: This is a fixed indemnity policy,

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** 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) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.

Assurity Hospital Indemnity Benefits Overview

OVERVIEW	Hospital Indemnity insurance provides a cash benefit for hospital admissions, not limited to deductibles, out-of-pocket maximums, or everyday living expenses. If you or a covered loved one is admitted to the hospital for the duration described below due to an injury, illness, surgery, or pregnancy, please contact your claims advocate to assist you in filing a claim. This plan is portable, meaning you can take it with you upon leaving employment, and it does not require any networks; benefits will be paid directly to you. Please refer to your benefit summaries for full plan details.		
ADMISSION & DAILY CONFINEMENT BENEFITS	Plan 1 20 + Hours Hospital Admission: $1,000 Plan 2 20 + Hours Hospital Admission: $2,000	Both Plans 1 & 2 Hospital Confinement: $100 per day (Up to 30 days) ICU Confinement: $200 per day (Up to 10 days)	
NOTE	Confinement means the assignment to a bed as a resident inpatient as prescribed by a physician for a period of at least 20 hours. Only one type of confinement benefits if payable for a given day. If confinement continues in an ICU, Sub-Acute ICU or Rehabilitation Unit beyond the maximum benefit period shown, the Hospital Confinement benefit will be payable until that benefit period is also exhausted.		
PRE-EXISTING CONDITIONS & PREGNANCY	Assurity will not pay benefits concerning a pre-existing condition until after coverage has been in force for 12 months from the issue date. Pre-existing condition means a covered sickness or physical condition for which, during the 12 months before the issue date, the insured person received medical consultation, diagnosis, advice or treatment from a Physician or had taken prescribed medication . The pre-existing condition clause and 10-month pregnancy exclusion will be waived during the initial enrollment and for new hires. Late entrant employees enrolling during the annual re-enrollment will be subject to the normal pre-existing condition and 10-month pregnancy exclusion.		

Semi-Monthly Rates	Plan 1	Plan 2
EMPLOYEE	**$7.87**	**$12.39**
EMPLOYEE + SPOUSE	**$15.96**	**$25.23**
EMPLOYEE + CHILD(REN)	**$14.98**	**$23.44**
FAMILY	**$23.07**	**$36.28**

MetLife | Pet Insurance

Ready to roam?

Unleash the power of pet insurance.

MetLife Pet Insurance can help cover the costs of unexpected accidents, illnesses and routine care. Help protect your pet's health and your wallet.

You asked. We answered.

Why sign up for pet insurance? Find out with some FAQs.

What is pet insurance?

A. Pet insurance works much like other types of insurance. For a monthly fee (also called a premium), you'll have coverage that can help reduce the financial impact of expected and unexpected veterinary care.

Why MetLife Pet Insurance?

A. With MetLife Pet, you have the power of choice to customize your pet insurance to meet both your pet's needs and your budget. You can take advantage of benefits like:

- **The freedom to visit any U.S. licensed vet, emergency clinic or specialist –** Exam fees are covered for accidents and illnesses.
- **Flexible coverage with no breed exclusions.**
- **Family plans –** One policy covers up to three dogs and cats with one shared deductible.[1]
- **Preventive care coverage (optional) for dogs and cats –** For common routine wellness expenses.

How does MetLife Pet Insurance work?

A. Our process is simple and straightforward. Take your pet to the vet and pay the bill, then send us your claim documents. You can file using our mobile app, online portal, email, fax or mail, and we process most claims within five days[2]. You'll receive reimbursement[3] by check or direct deposit if the claim expense is covered under the policy.

When does coverage start?

A. MetLife Pet Insurance wait periods are among the shortest for accident and illness coverage.[4] Accident coverage and optional preventive care coverage begin on the effective date of your policy. Illness coverage begins 14 days later.

What's covered?

A. Coverage includes:

- Accidental injuries
- Illnesses
- Exam fees
- Surgeries
- Medications
- Ultrasounds
- Hospital stays
- X-rays/diagnostic tests
- Hereditary conditions
- Congenital conditions
- Chronic conditions
- Holistic therapies and much more!

What's not covered?

A. **Pre-existing conditions may not be covered**—to learn more about what's not covered, visit metlifepetinsurance.com/coverage-exclusions.

How much pet insurance do I need?

A. Every individual and their pet has unique needs—we provide the ability to customize your coverage. Coverage is flexible and customizable, so you can choose the plan that works for you. Options include:

- Levels of coverage from **$500–unlimited**[5]
- **$0–$2,500** deductible options[6]
- Reimbursement percentages of **50%, 70%, 80% and 90%**[3]

How much will it cost?

A. Each pet's premium will be unique based on your pet's age, breed and location, as well as your selected coverage amount.

But how much can you save? If you're claim-free for a policy year, we'll automatically decrease your deductible by $50 with our healthy pet incentive.[7] Plus, MetLife Pet offers an Automatic Policy Limit Increase[8].

Are there any discounts?

A. A variety of additional discounts may be available,[9] including:

- Military, Veteran, First Responder and Healthcare Workers Discount[10]
- Animal Care Discount[10]
- Multi-policy Discount[11] (5% for the 2nd pet policy and 10% for each additional policy)

How do I pay for my coverage?

A. **You can set up an automatic payment** via credit card through the online portal or call center. ACH (electronic bank-to-bank payment) is available exclusively in our call center. Payroll deduction may be available.

Is my coverage portable if I leave my employer?

A. **Yes. Your Pet Insurance policy will automatically remain in effect after you leave your employer.** If your employer was deducting premiums, you will now be responsible for paying them directly to MetLife Pet Insurance and you will need to contact MetLife Pet to update your payment plan. However, if your employer was not deducting premiums, your Pet Insurance policy will automatically remain in effect after you leave your employer and no action will be necessary on your part to continue your policy.

Access your pet insurance account anywhere, anytime with the MetLife Pet app

Download and use the app to easily:

- Submit and track claims
- Manage your pet's health records
- Talk to an expert with 24/7 live vet chat[12]
- Find nearby pet services

Get a Quote or Enroll Today
www.metlife.com/getpetquote

Questions? Call MetLife Customer Service at 1-800-GET-MET8 (800-438-6388)

1. Coverage options may be limited for certain ages.
2. Most claims are processed in 5-10 days, but processing may take longer in some cases.
3. Reimbursement options include: 50%, 70%, 80% and 90%. Restrictions apply.
4. Based on a January 2025 review of publicly available summary information of top competitors. Competitors did not furnish copies of their policies for review. If you have questions about a particular competitor's policy or coverage, please contact them or their representative directly.
5. Annual limit options range from $500 - $25,000 in $1,000 increments or unlimited benefit option also available. Restrictions apply.
6. Deductible options range include: $0 - $750 in $50 increments and $1,000, $1,250, $1,500, $2,000 and $2,500. Restrictions apply.
7. Your policy deductible decreases by $50 each policy year that you don't receive a claim reimbursement. Deductible reverts on renewal if claim reimbursement for claims other than preventive care have been made. Restrictions apply.
8. For policies with annual limits greater than $5,000 and at least $1,000 of unused benefits remaining at the end of policy year, the annual limit will be increased by $500 at no additional cost. Restrictions apply. May not be available in all states.
9. When combining discounts, restrictions apply. Must be eligible for applicable discounts. Each discount may not be available in all states.
10. Must be eligible for discount. Not available in NY.
11. Multi-policy discount is not available with Family Plans.
12. Virtual veterinary services are available through the MetLife Pet app and are provided entirely by AskVet, a third-party partner; MetLife is not responsible for any pet guidance or advice provided or taken. Veterinarians providing virtual veterinary services cannot prescribe medication or answer questions about the pet policy.

Pet Insurance coverage issued by Metropolitan General Insurance Company, a Rhode Island insurance company headquartered at 700 Quaker Lane, Warwick, RI 02886. Coverage subject to restrictions, exclusions and limitations and application is subject to underwriting. See policy or contact MetLife Pet Insurance Solutions LLC ("MetLife Pet") for details. MetLife Pet is the policy administrator. It may operate under an alternate or fictitious name in certain jurisdictions, including MetLife Pet Insurance Services LLC (New York and Minnesota) and MetLife Pet Insurance Solutions Agency LLC (Illinois).

© 2025 MetLife Services and Solutions, LLC, New York, NY 10166 — All Rights Reserved © 2025 Peanuts Worldwide LLC

L4543573[exp0627][All States and][DC]

MetLife | Pet Insurance

Therapist. Comedian. Best friend for life.

Help give them protection with MetLife Pet Insurance.

MetLife Pet Insurance helps cover the costs of unexpected accidents or illnesses, so nothing gets in the way of caring for your pet when they need it most.

Coverage that's a breed apart

With MetLife Pet Insurance, you can count on:

The freedom to visit any U.S. veterinarian. Exam fees are covered for accidents and illnesses.

Flexible plans with no breed exclusions. Find coverage that fits your pet's needs and your budget.

Extra savings with value-driven policies, options and discounts.

- **Multi-pet policy**[1] – 5% for the 2nd policy and 10% for each additional policy
- **Family Plans option**[2] – One policy and a shared deductible for up to three dogs and cats
- **Discounts of up to 30%**[3] – And additional savings on pet care, where available

Preventive care coverage (optional) for dogs and cats – Save on routine wellness expenses.

How does MetLife Pet Insurance work?

Choose the coverage that's right coverage for you and your pet, and download our mobile app

Visit any U.S. licensed veterinarian or emergency clinic

Pay the bill within 90 days and send it with your claim documents to us via our mobile app, online portal, email, fax or mail

Get a percentage of your money reimbursed[4] by check or direct deposit if the claim expense is covered under the policy

You'll have **the power of choice** to customize your coverage

With our flexible plans, you can select the plan that fits your pet's needs and your finances. Here are just some of the treatments and conditions we cover:

- Accidental injuries
- Illnesses
- Exam fees
- Surgeries
  Medications
- Ultrasounds
- Hospital stays
- X-rays and diagnostic tests
- Hereditary conditions
- Congenital conditions
- Alternative therapies
- And more!

Preventive care coverage (optional) for dogs and cats such as:

- Vaccinations
- Flea/tick medications
- Wellness visits
- Teeth cleaning
- Deworming
- And more!

Explore other plan benefits (where available)

- **24/7 live vet chat**[5] – for when things come up after hours
- **Healthy pet incentive**[6] – your pet's deductible automatically decreases by $50 each policy year that you don't receive a claim reimbursement
- **Automatic coverage increases annually**[7] – if you have an unused amount of $1,000 or more at the end of the policy period
- **Loss or theft coverage for dogs and cats** – receive up to $500 if your pet is stolen or goes missing during the policy period and is not found within 60 days
- **Mortality benefits** – in the sad event of your pet's death, receive up to $500 for cremation or burial expenses, or any combination of cremation and burial
- **And more!**

Enroll at metlife.com/getpetquote.

Scan Now

Questions? Call MetLife Customer Service at 1-800-GET-MET8 (800-438-6388)

1. Multi-policy discount is not available with Family Plans.
2. Coverage options may be limited for certain ages.
3. When combining discounts, restrictions apply. Must be eligible for applicable discounts. Each discount may not be available in all states.
4. Reimbursement options include: 50%, 70%, 80% and 90%. Restrictions apply.
5. Virtual veterinary services are available through the MetLife Pet app and are provided entirely by AskVet, a third-party partner; MetLife is not responsible for any pet guidance or advice provided or taken. Veterinarians providing virtual veterinary services cannot prescribe medication or answer questions about the pet policy.
6. Your policy deductible decreases by $50 each policy year that you don't receive a claim reimbursement. Deductible reverts on renewal if claim reimbursement for claims other than preventive care have been made. Restrictions apply.
7. For policies with annual limits greater than $5,000 and at least $1,000 of unused benefits remaining at the end of policy year, the annual limit will be increased by $500 at no additional cost. Restrictions apply. May not be available in all states.

Pet Insurance coverage issued by Metropolitan General Insurance Company, a Rhode Island insurance company headquartered at 700 Quaker Lane, Warwick, RI 02886. Coverage subject to restrictions, exclusions and limitations and application is subject to underwriting. See policy or contact MetLife Pet Insurance Solutions LLC ("MetLife Pet") for details. MetLife Pet is the policy administrator. It may operate under an alternate or fictitious name in certain jurisdictions, including MetLife Pet Insurance Services LLC (New York and Minnesota) and MetLife Pet Insurance Solutions Agency LLC (Illinois).

L4535276[exp0627][All States and][DC]

© 2025 MetLife Services and Solutions, LLC, New York, NY 10166. All Rights Reserved © 2025 Peanuts Worldwide LLC

Trying to make sense of

Medicare?

Will you be Medicare eligible soon?

Are you nearing retirement age?

Are you 65+ and continuing to work?

Do you have a family member who needs help with their Medicare coverage?

Our Senior and Individual Solutions can help explore options and compare Medicare to the benefits available through employer sponsored plans:

- If you're continuing to work beyond age 65, comparing your employer's plan to Medicare Supplements and Medicare Advantage plans will help determine the best solution for you.
- The differences in Part A, Part B, Medicare Supplements, Part D, and Medicare Advantage. Which ones do you need?
- How do you purchase Dental and Vision plans along with Medicare?
- How does Medicare work with your employer's plan? What are the differences when working for an employer with under 20 employees or over 20 employees?

Interested in learning more? ***Contact Joe today!***

Joe Engel
Medicare/Individual Advisor
joe_engel@ajg.com

402-889-0009 or 319-731-0515

Currently we represent seven organizations which offer over 100 products in your area. You can always contact Medicare.gov, 1-800- MEDICARE, or your local state health insurance program for help with plan choices.

Health Benefits Terminology

The world of health insurance can be confusing. Understanding your costs and benefits becomes much easier once you are able to make sense of the terminology.

Health Insurance: Arrangement with an insurance company to help protect you from the high costs of health care and improve access to health care services. Health insurance works by spreading the cost of care among large groups of people. Insurance premiums paid by one person helps pay for the care of others.

Deductible: Amount you owe for health care services each year before the insurance company begins to pay.

Embedded deductible: Embedded deductibles have two components: individual deductibles for each family member and a combined family deductible. When a family member meets his or her individual deductible, the insurance company will begin paying according to the plan's coverage for that member. When the total amount the family has paid towards individual deductibles reaches the family deductible, the insurance company will then begin paying according to the plan's coverage for all family members.

> *For example: Olivia and Tyler have a family health plan that has a $1,500 individual deductible and a $3,000 family deductible that covers them and their three children. Olivia meets her $1,500 deductible after giving birth to their youngest child in February. Son Sam breaks his leg and also meets his $1,500 individual deductible in March, which means the family deductible of $3,000 has now been met. When Tyler needs carpal tunnel surgery later in the year, he does not have to satisfy a deductible before the plan begins to pay.*

Non-embedded deductible: Non-embedded, or aggregate, deductible is simpler than an embedded deductible. With a non-embedded deductible, there is only a family deductible. All family members' out-of-pocket expenses count toward the family deductible until it is met, and then they are all covered with the health plan's usual copays or coinsurance. It doesn't matter if one person incurs all the expenses that meet the deductible or if two or more family members contribute toward meeting the family deductible.

> *For example: Antonio and his family have a health plan with a nonembedded deductible. The family deductible is $2,600. Daughter Isabella had acute appendicitis that required surgery costing $2,300. Antonio sprained his ankle and medical care cost $400. The combined out-of-pocket expenses from Isabella's and Antonio's medical treatments met the family deductible; any further medical care for anyone in the family will be covered by the insurance company according to the plan benefits.*

Coinsurance: Your percentage share of the allowed costs for a covered health care service.

> *For example: Joe's surgery costs $8,000. Because he has a $1,500 annual deductible, Joe is responsible for the first $1,500 of the surgery. After that, he has met his deductible and his carrier will cover 70 percent of the remaining cost, a total of $4,550. Joe will still be responsible for 30 percent, or $1,950, of the remaining cost. Therefore, the total Joe must pay for his surgery is $3,450.*

Out-of-Pocket Maximum (OOPM or OPM): An OPM protects you from very high medical expenses. It is the most you should have to pay for your health care during a year, excluding the monthly premium. After you reach the OPM, your plan begins to pay 100 percent of the allowed amount for covered services for the rest of the year.

Copayment: A copayment, or copay, is a fixed amount you pay for a covered health care service, usually when you get the service. Deductibles often will not apply when a copay is assigned to a service.

Preventive care: Proactive, comprehensive care emphasizing prevention, early detection, and early treatment of conditions. Generally includes routine physical exams, immunizations and well-person care.

Office visit: Services provided in a physician's office.

Urgent care center: Health care facility whose primary purpose is the provision of immediate, short-term medical care for minor but urgent medical conditions. Serves as an alternative to the hospital emergency room.

Emergency services: Services provided for an unforeseen acute illness or injury that requires immediate medical attention.

Telemedicine (telehealth): Technology-based visits that allows a doctor and patient to communicate without being in the same physical space. Serves as another alternative to emergency care as well as to urgent care or office visits. Telemedicine is not a complete replacement for direct patient care, but it can be used to evaluate, diagnose and prescribe treatments for many common illnesses for lower costs and at times when primary care physicians are not available or open.

Participating provider (In-Network Provider): Health care provider (clinic, hospital, doctor, laboratory, health care practitioner or pharmacy) who has contracted with a particular insurance carrier or health plan to provide health care services to its members.

Primary care physician (PCP): Physician who is responsible for monitoring and coordinating a patient's overall health care, and refers the patient to appropriate specialists when necessary. Many managed care plans require members to choose a PCP as part of their strategy to increase quality of care and control costs.

This benefit summary prepared by

Insurance | Risk Management | Consulting

© 20xx Gallagher Benefit Services, Inc. All rights reserved.