SHELLY & SANDS

Employee Benefits *e.Guide*

2022 PLAN YEAR

Welcome to your 2022 Employee Benefits!

SHELLY & SANDS

Shelly & Sands recognizes the demands employees have when it comes to balancing the requirements of work and family, that is why we are pleased to offer a comprehensive array of quality benefits to protect your health, your family and your way of life.

Employee benefits are an important part of your overall compensation, and this guide was created to answer some of the questions you may have and provide the tools and resources you will need to take full advantage of the programs and plans being offered. Please read it carefully along with any supplemental materials you receive.

If you have any questions or concerns, please do not hesitate to call Dana Bowling in Human Resources at **740-252-5046 or e-mail d.bowling@shellyandsands.com** Available Monday through Friday, 8:00 am to 4:30 pm EST.

AssuredPartners

There are two ways to view this enrollment *eguide*:

- Use the links to navigate the guide like a website; or
- Read the pages like a printed document.

This enrollment guide is best viewed on a desktop computer using the latest version of Adobe Acrobat Reader. To download this application, visit **https://get.adobe.com/reader**.

How to Navigate

- Click on the topics listed on the menu to the right or use the back and next buttons at the bottom of every page.
- Click on links that are **bold/underlined** to open a browser window and be directed to topic-specific information on the Internet. *Note: If an underlined link is an email address, your email program will launch after you click that link.*

Enrollment Instructions

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Open Enrollment

December 1, 2021, through December 15, 2021, for a January 1, 2022 effective date.

Questions?

If you have any questions please contact Dana Bowling in Human Resources at 740-252-5046 or e-mail **d.bowling@shellyandsands.com** for all your benefit related questions.

How to Enroll

The **Open Enrollment period** is beginning **December 15, 2021, through December 15, 2021,** for changes effective January 1, 2022.

Employees wishing to make changes of your election under the group health plan may do so by completing an enrollment form. Contributions will automatically be deducted from your gross pay before taxes are withheld and are based on the level of pay group. You may elect to pay them on an after-tax basis by completing a waiver of election form. Forms can be obtained from Dana Bowling.

Decisions made during the Open Enrollment Period remain in effect during the following 12-month period unless the employee or dependent incurs a "life event". When a change in family status occurs, participants can revoke their existing election and make a new election for the remainder of the coverage period. Election changes must be consistent with the "life event" change and requests for change **must be made within 30 days** of the "life event."

Eligibility

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Shelly & Sands shares in the cost by paying for most of the employee and dependent health insurance costs. Dependents are eligible to participate in the health & welfare plan. Your completed enrollment serves as a request for coverage and authorizes any payroll deductions necessary to pay for that coverage.

Who is eligible for benefits

For eligible employees working 30 hours per week, benefits begin on the 31st day of employment. 401(k) is the 1st of the month following 30 days of employment.

Eligible Dependents

Your eligible dependents include*:

- A spouse to whom you are legally married.
- A dependent child under age 26. Coverage will terminate at the end of the month of the dependent's 26th birthday. Coverage may be extended past the age of 26 for disabled dependents. Dependent children can include natural and adopted children and stepchildren.

Coverage for eligible dependents generally begins on the same day your coverage is effective.

**Additional carrier conditions may apply.*

Please note: If you cover an individual on your benefit plan who is not an eligible dependent, this is considered fraud and theft. Claims may be reprocessed and become your responsibility. Providing false statements regarding tobacco usage is against company policy. Anyone found providing false statements will be subject to discipline up to and including termination of employment.

Pre-Tax Benefits: IRS Code Section 125

Shelly & Sands benefit plans utilize Section 125. This enables you to elect to pay premiums for health, dental, vision and flexible spending account coverage on a pre-tax basis. When you use pretax dollars, you will reduce your taxable income and have fewer taxes taken out of your paycheck. Under Section 125, you can actually have more spendable income than if the same deductions were taken on an after-tax basis.

Pre-tax Note: When you pay for your dependent's benefits on a pre-tax basis you are certifying that the dependent meets the IRS' definition of a dependent. [IRC §§ 152, 21 (b)(1) and 105(b)]. Children/spouses that do not satisfy the IRS' definition will result in a tax liability to you, such as changing that dependent's election to a post- tax election or receiving imputed income on your W-2 for the dependent's coverage that should not have been taken on a pre-tax basis.

Benefit Change in Status

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The benefit elections you make during Open Enrollment or as a new hire will remain in effect for the entire plan year. You will not be able to change or revoke your elections once they have been made unless a Qualifying Life Event (status change) occurs. For purposes of health, dental and vision, you will be deemed to have a Status Change if:

- your marital status changes through marriage, the death of your spouse, divorce, legal separation, or annulment;
- your number of dependents changes through birth, adoption, placement for adoption, or death of a dependent;
- you, your spouse or dependents terminate or begin employment;
- your dependent is no longer eligible due to attainment of age;
- you, your spouse or dependents experience an increase; or reduction in hours of employment (including a switch between part-time and full-time employment; strike or lock-out; commencement of or return from an unpaid leave of absence);

- gain or loss of eligibility under a plan offered by your employer or your spouse's employer; and
- a change in residence for you, your spouse or your dependent resulting in a gain or loss of eligibility.

In order to be permitted to make a change of election relating to your health or dental coverage due to a Qualifying Life Event, the Life Event Change must result in you, your spouse or dependent gaining or losing eligibility for health, dental or vision coverage under this plan or a plan sponsored by another employer by whom you, your spouse, or dependent are employed. The election change must correspond with that gain or loss of eligibility.

You may also be permitted to change your elections for health coverage under the following circumstances:

- a court order requires that your child receive accident or health coverage under this plan or a former spouse's plan;
- you, your spouse or dependent become entitled to Medicare or Medicaid;
- you have a Special Enrollment Right; and
- there is a significant change in the cost or coverage for you or your spouse attributable to your spouse employment.

For purposes of all other benefits under the Plan, you will be deemed to have a Status Change if the change is on account of and consistent with a change in status, as determined by the Plan Administrator, in its discretion, under applicable law and the plan provisions.

You must notify Dana Bowling in Human Resources at 740-252-5046 or e-mail d.bowling@shellyandsands.com within 30 days from the status change in order to make a change in your benefit selections.

Change in Status *continued...*

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- If an employee experiences an approved life event throughout the year, he/she may be permitted to make changes to his/her benefit elections, subject to plan rules. The employee must submit permitted benefit changes within ***30 days*** of a qualifying life event.
- Employees must alert Human Resources when a life event occurs.
- Failure to submit the enrollment form and Life Event documentation timely will nullify their request for enrollment and they will **not** be permitted to make the change(s) until the next open enrollment.
- The summary of events that allow an employee to make benefit changes and instructions for processing his/her life event changes via Shelly & Sands benefit program are below:

Family Status Change		
Event	**Action Required**	**Results If Action Not Taken**
New Hire:	Make elections within 30 days of hire date. Documentation is required.	You and your dependents are not eligible until the next annual Open Enrollment.
Marriage:	Add your new spouse to your elections within 30 days of the marriage date. A copy of the marriage certificate must be presented.	Your spouse is not eligible until the next annual Open Enrollment period.
Divorce:	Remove the former spouse within 30 days of the divorce. Proof of the divorce will be required. A copy of the divorce decree must be presented.	Benefits are not available for the divorced spouse and will be recouped if paid erroneously.
Birth or adoption of a child:	Enroll the new dependent in your elections within 30 days of the adoption, even if you already have family coverage. A copy the birth certificate, footprints, or hospital discharge papers must be presented. Once you receive the child's Social Security Number, be sure to contact HR to update your child's insurance information record.	The new dependent will not be covered on your birth or insurance until the next annual Open Enrollment period
Death of a spouse or dependent:	Remove the dependent from your elections within 30 days from the date of death. Death certificate must be presented.	You could pay a higher premium than required and you may be overpaying for coverage.
Your spouse gains or loses employment that provides health benefits:	Add or drop health benefits from your elections within 30 days of the event date. A letter from the employer or insurance company must be presented.	You need to wait until the next annual Open Enrollment period to make any change.
Loss of coverage with a spouse:	Change your elections within 30 days from the loss of coverage. A letter from the employer must be provided.	You will be unable to enroll in the benefits until the next annual Open Enrollment period.
Changing from full-time to part-time employment (without benefits) or from part-time to full-time (with benefits):	Change your elections within 30 days from the employment status change in order to receive COBRA information or to enroll in benefits as a full-time employee. Documentation from the employer must be provided.	Benefits may not be available to you or your dependents if you wait to enroll in COBRA. Full-time employees will have to wait until the annual Open Enrollment period.

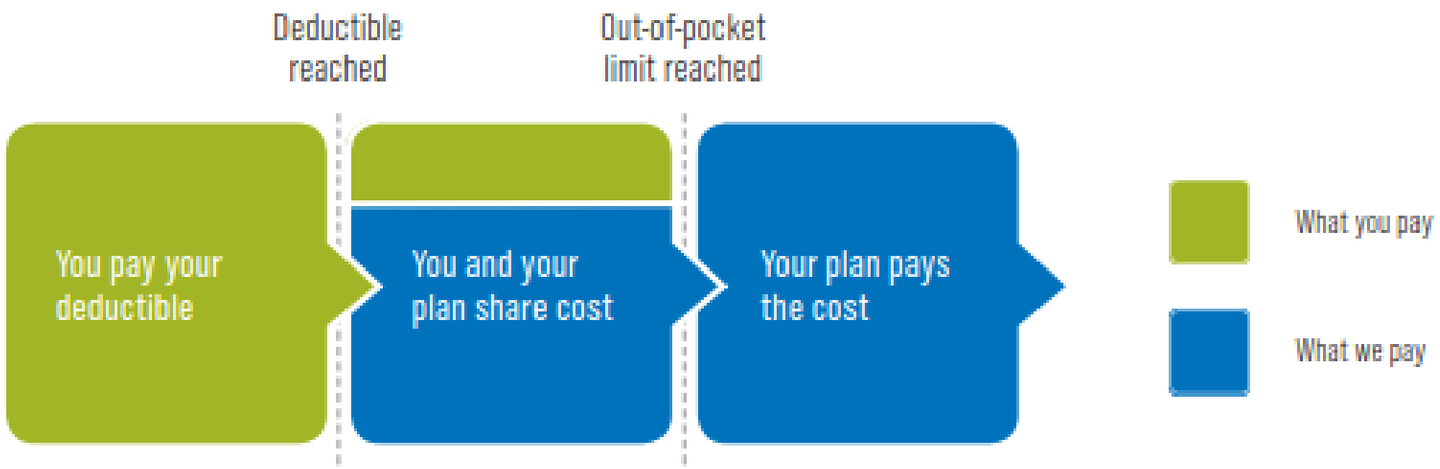
Documentation is needed to validate a change in family status event.

If you have a Change in Family Status event, please promptly notify Human Resources: 740-453-0721 or e-mail Dana Bowling at **d.bowling@shellyandsands.com**

The basics explained

Before we dive into the plan details, it may be helpful to review some health benefit basics.

What you pay and what your plan pays



This chart is only an example. Your actual cost share will depend on your plan, the service you get and the doctor you choose. Check your plan details to see your actual share of the cost.

The basics explained

Before we dive into the plan details, it may be helpful to review some health benefit basics.

Words that are helpful to know

We can help you crack the code of health insurance lingo. Here are the meanings of some common terms:

Deductible:

A set amount you pay each year for covered services before your plan starts to pay for covered health care costs.

Copay:

A flat fee you pay for covered services like doctor visits.

Coinsurance:

Once you've met your deductible, you and your health plan share the cost of covered health care services. The coinsurance is your share of the costs, usually a percent of the cost of care. Your plan details show what portion of the cost you'll pay.

Out-of-pocket limit:

This is the most you have to pay out of your own pocket each year for covered services. This amount may include your deductible and your percentage of the costs, depending on your plan. And some plans may still have you pay a copay at the time of service.

Premium:

The premium, also called a monthly payment, is what you pay for the plan. It's the money that comes out of your paycheck. Think of it like a membership fee that's separate from what you pay when you get care.

2022 Medical Mutual Plan Summary & Cost

Schedule of Benefits	Network	Non-Network
Deductible (Single / Family)	$400 / $800	$800 / $1,600
Out-Of-Pocket Max (Single / Family) Includes Deductible	$4,000 / $8,000	$7,000 / $14,000
Physician Office Services	$0 Telemedicine / $20 PCP / $40 SCP	Deductible + 40%
Preventative Services	No Cost Share	Deductible + 40%
Routine Vision Examinations	No Cost Share	Deductible + 40%
Emergency Room Services	$150 copay per visit	$150 copay per visit
Urgent Care Services	$35 copay per visit	Deductible + 40%
Inpatient & Outpatient Professional Services	Deductible + 20%	Deductible + 40%
Outpatient Surgery Hospital / Alternative Care Facility	Deductible + 20%	Deductible + 40%
Outpatient Therapy Services PT/OT/ST	$40 SCP	Deductible + 40%
Prescription Drugs Retail with Express Scripts (Network Pharmacy)	$10 / $30 / $60 30 Day Supply	
Prescription Drugs Mail Order with Express Scripts (Network Pharmacy)	$20 / $60 / $120 / 20% to $250 (Specialty only 30-day supply) 90 Day Supply	

Coverage Level	Level 1	Level 2	Level 3
Employee Only	$15.00 per week	$20.00 per week	$25.00 per week
Employee Plus Spouse	$32.69 per week	$43.59 per week	$54.49 per week
Employee Plus Child(ren)	$25.32 per week	$33.76 per week	$42.21 per week
Family	$45.23 per week	$60.30 per week	$75.39 per week

Medicare Part D: Shelly & Sands has determined that the prescription drug coverage offered is considered Creditable Coverage.

Embedded Deductibles / Out of pocket maximums: All medical plans have embedded deductibles and out of pocket maximums. An embedded deductible means that each individual member on the insurance shall meet his or her individual deductible and then the insurance plan (co-insurance) shall pay (80% in network) for the remainder of the calendar year until the out-of-pocket maximum is met. Copays will accumulate toward the out-of-pocket maximum after the deductible is met.

PCP = Primary Care Physician, SCP = Specialty Care Physician, PT = Physical Therapy, OT=Occupational Therapy, ST = Speech Therapy

This Summary is for informational purposes only. For specific benefit information, please refer to the applicable Insurance Contract.

Questions? Contact Dana Bowling in Human Resources at 740-252-5046 or e-mail **d.bowling@shellyandsands.com**

Group ID: 898472

Register for My Health Plan

1-800-362-4700

MEDICAL MUTUAL

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FACTS ABOUT GENERIC DRUGS

Today, nearly **8 in 10** prescriptions filled in the U.S. are for generic drugs.

- FDA requires generic drugs to have the **same active ingredient**, **strength**, **dosage form**, and **route of administration** as the brand-name drug.
- The generic manufacturer **must prove its drug is the same** (bioequivalent) as the brand-name drug.
- All manufacturing, packaging, and testing sites **must pass the same quality standards** as those of brand-name drugs.
- Many generic drugs are made in the same manufacturing plants as the brand-name drugs.

ALL FDA-APPROVED GENERIC DRUGS MUST BE EQUIVALENT TO THE BRAND-NAME DRUG.

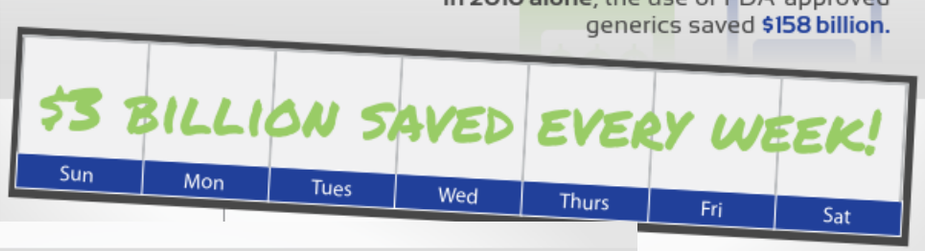
Any generic drug modeled after a single, brand name drug must perform approximately the same in the body as the brand name drug. There will always be a slight, but not medically important, level of natural variability just as there is for one batch of brand name drug compared to the next batch of brand name product.

This amount of difference would be expected and acceptable, whether for one batch of brand name drug tested against another batch of the same brand, or for a generic tested against a brand name drug.

80-85% LESS

Average cost of a generic drug vs. its brand-name counterpart

In 2010 alone, the use of FDA-approved generics saved **$158 billion.**



Express Scripts Pharmacy Plan

Rx Bin: 610014 RXPCN: COPAY Rx GRP: MMODRUG

Register for Mail Order Delivery

1-800-471-1961

THE LOWER PRICE DOESN'T MEAN INFERIOR.

Generic manufacturers are able to sell their products for lower prices because they are not required to repeat the costly clinical trials of new drugs and generally do not pay for costly advertising, marketing, and promotion In addition, multiple generic companies apply to FDA to approve a generic for the same brand name drugs. Multiple generic companies are often approved to market a single product. Competition in the market place, often results in lower prices.

FDA MONITORS ADVERSE EVENTS REPORTS FOR GENERIC DRUGS.

The monitoring of adverse events for all drug products, including generic drugs, is one aspect of the overall FDA effort to evaluate the safety of drugs after approval. Many times, reports of adverse events describe a known reaction to the active drug ingredient.

Reports are monitored and investigated, when appropriate. Investigations may lead to changes in how a product is used or manufactured.

MEDICAL MUTUAL EXPRESS SCRIPTS

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Medical Mutual Nurse Line

Speak with a trained nurse to help you determine the care you need

24/7 Medical Mutual Nurse Line: **1-888-912-0636**

Your coverage with Medical Mutual provides access to highly-trained and experienced nurses available 24/7 to help you:

- Advise you personally, no matter the size of the concern
- Provide easy-to-understand explanations about medical tests and results
- Talk you through self-care for treating minor medical conditions at home
- Help determine if you need to visit your doctor, an urgent care clinic or the emergency room
- Use nationally accredited guidelines to assess symptoms
- Connect you with your primary care provider (PCP), specialist or in-network emergency room if necessary
- Connect you with a nursing home or alternate point of care
- Schedule next-day appointments with your PCP if needed
- Stay on the line until you feel you understand next steps

Highly trained and experienced nurses to take your call

Call toll-free to speak with a medically trained, compassionate nurse anytime, day or night, whenever you have a health concern to help you understand your situation and determine next steps.

Health counseling, education and help with symptom identification

The nurse will evaluate your symptoms, provide an assessment and help you take the most appropriate action. Medical Mutual's Nurse Line staff will help you make the most informed decisions about how to handle a wide variety of health and wellness concerns and connect you with the appropriate resources. If it's an emergency, the nurse will tell you what steps to take immediately and will follow up later to see how you're feeling.

Nurse Line is a valuable health benefit

Nurse Line is available 24/7 to help you address a wide range of health concerns. There is no added charge and you will always speak with a live nurse first without being triaged or put on hold.

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Group ID: 898472-101

Register for My Health Plan

1-800-362-4700

Questions? Contact Dana Bowling in Human Resources at 740-252-5046 or e-mail d.bowling@shellyandsands.com

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Cost differences between types of care

NURSE LINE

$$$$$

No Charge

Available 24/7
Speak to a trained nurse to help you determine the care you need.

Use the Nurse line for:
- Assistance with understanding medical tests and results
- Help with symptom identification
- Connect you with your primary care provider (PCP) specialist or in-network emergency room if necessary

They are very knowledgeable and are there to help you make a better decision on deciding whether to go to your Primary Care Physician, Urgent Care or Emergency Room.

VIRTUAL VISITS

$$$$$

$0 copay

Care at your fingertips for common conditions such as:

- Colds and flu
- Upper respiratory infections
- Rashes
- Allergies
- Bug bites
- Poison Ivy

Cleveland Clinic Express Care® Online is available 24/7. No appointment is needed and is usually less than a 5 minute wait to speak to a physician. Download in the App Store.

Google Play App Store

PRIMARY CARE

$$$$$

$20 copay

Your Primary Care Doctor (PCP) is your first line of defense in managing overall health.

Use routine care, such as:
- Yearly checkups and screenings
- Flu shots
- Sickness or injury that is not an emergency

If you don't have a Primary Care Physician call 1-800-362-4700 or visit www.medmutual.com to search for a doctor in your area.

WALK-IN CLINICS

$$$$$

$20 copay

Treatment inside local CVS Minute Clinics or other network Convenience Clinics for minor illnesses and injuries such as:

- Colds, flu, or fever
- Allergies
- Upper respiratory infections
- Urinary tract infections
- Sports physicals

Average wait time at a Convenience Clinic is 10-20 minutes. Also, in some locations you can set an appointment ahead of time.

URGENT CARE

$$$$$

$35 copay

Immediate care for conditions that are not life-threatening, such as:

- Colds, flu or fever
- Minor strains, sprains or breaks
- Minor lacerations
- Vomiting
- Diarrhea

Average wait time at Urgent Care is 20 minutes.

EMERGENCY ROOM

$$$$$

$150 copay

Approximately 71% of Emergency Room visits are unnecessary or could have been avoided.

For serious and life-threatening conditions such as:
- Heart attack
- Chest pain
- Coughing up or vomiting blood
- High fever with stiff neck, mental confusion or difficulty breathing
- Injury to head, neck or spine

Average wait time to be seen in the ER is 2-3 hours.

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Group ID: 898472-101
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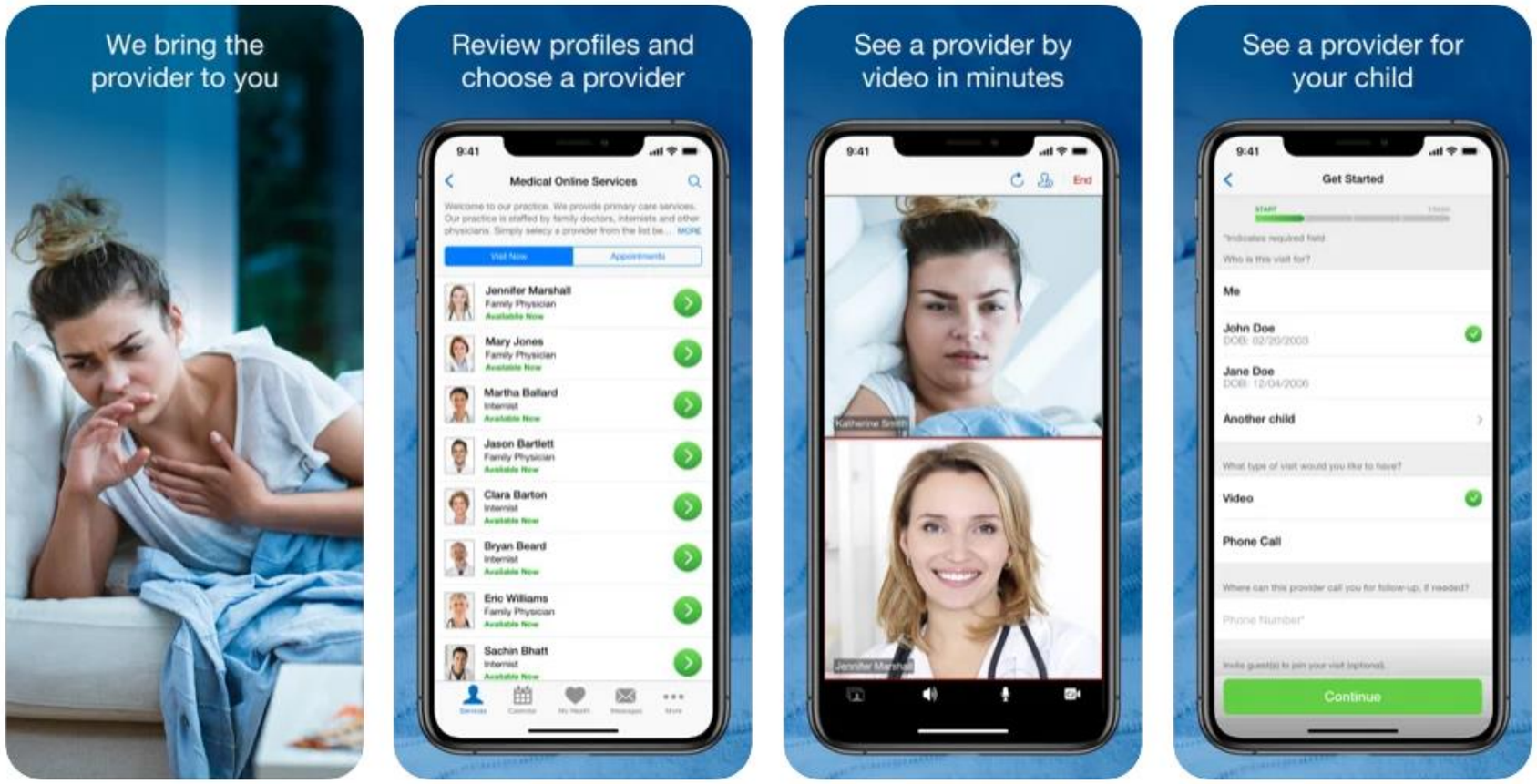
1-800-362-4700

MEDICAL MUTUAL

Questions? Contact Dana Bowling in Human Resources at 740-252-5046 or e-mail d.bowling@shellyandsands.com

Cleveland Clinic Express Care



Cleveland Clinic Express Care® Online offers 24/7 care from anywhere via your smartphone or tablet. During your virtual visit, a healthcare provider can offer a diagnosis, treatment, and medication if appropriate – no appointment needed.

How can Express Care Online benefit me?

- Connect in minutes to a healthcare provider – save time vs. an in-person visit
- Can be used by your entire family, ages 2 and up
- $55 or less per visit, with many insurance plans accepted
- All visits are secure and confidential.
- We treat many common conditions, including cough and cold, sinus infections, allergies, rash, and pink eye
- Many Cleveland Clinic providers also offer virtual follow-up visits to select patients

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Register for My Health Plan

1-800-362-4700

If you use Apple Health, you can choose to share your health information with the provider during your virtual video visit, such as heart rate, blood pressure, body temperature, blood glucose levels, weight, nutritional information, and respiratory rate.

Questions? Contact Dana Bowling in Human Resources at 740-252-5046 or e-mail **d.bowling@shellyandsands.com**

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Understanding Your Insurance Card

For members living in the Medical Mutual SuperMed® Service Area

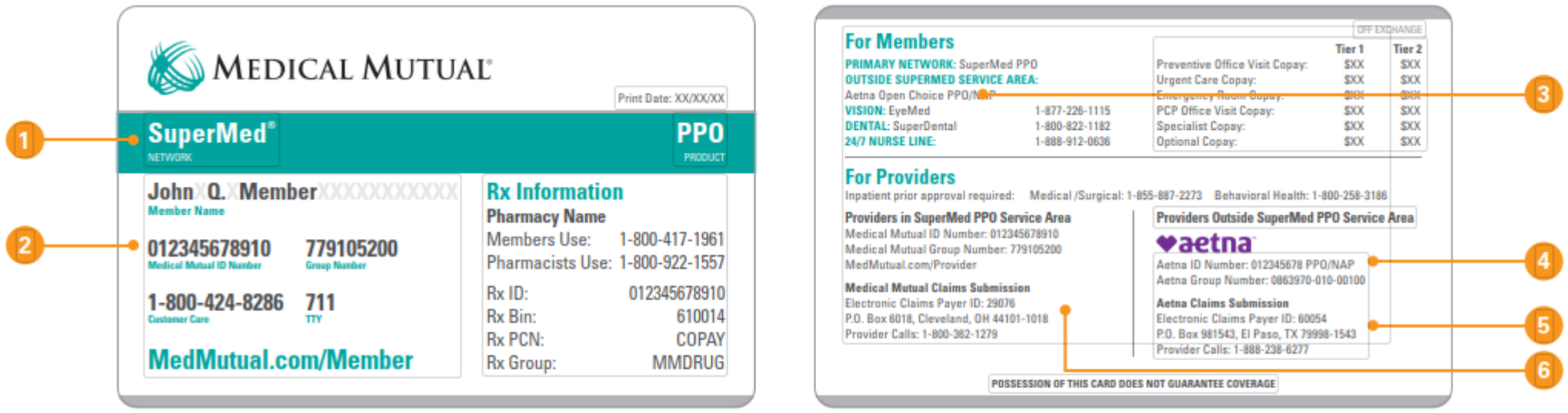
Get to Know Your Network

Medical Mutual members have access to the Aetna® Open Choice® PPO network when they live, travel or spend significant time outside of the SuperMed® PPO network service area. The SuperMed service area includes the state of Ohio, as well as Boone, Campbell and Kenton counties in Kentucky.

Your member ID card will identify your primary network, which is where you should receive most of your care.

Inside-the-Service-Area ID Card

If you live inside the Medical Mutual SuperMed PPO service area, your ID card will look like this:



1. Your primary network
2. Your Medical Mutual ID number
3. Your national network
4. Your Aetna ID number
5. Aetna claims submission address
6. Medical Mutual claims submission address

All dental and vision claims should be sent to *Medical Mutual* for processing.

Group ID: 898472

Register for My Health Plan

1-800-362-4700

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Frequently Asked Questions

For members living in the Medical Mutual SuperMed® Service Area

How do I know which network to use?
In most cases, you will use the network that is indicated on the front of your member ID card.

How can my provider verify eligibility?
Aetna providers should use the Aetna ID number listed on the card to verify eligibility. Medical Mutual providers should use the Medical Mutual ID number listed on the card to verify eligibility.

How will my provider know where to send my claims?
Providers should send claims to the address listed on the back of the ID card. The address will vary based on whether you receive care inside or outside the SuperMed service area.

What if I live inside the Medical Mutual SuperMed service area, but I need medical care while I am traveling out of state?
If you travel outside the SuperMed service area and you need medical care, you can visit an Aetna Open Choice PPO provider to receive care.

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Aetna Open Choice PPO Provider Search

Register for My Health Plan by clicking on the link here.

How to Access Your National Network

For members living outside the Medical Mutual SuperMed® Service Area

What is the SuperMed PPO network?

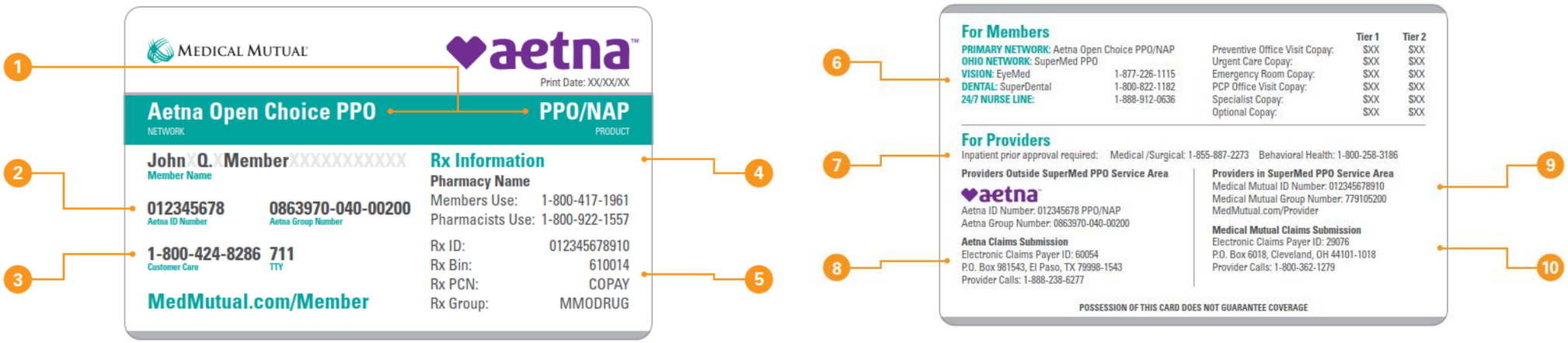
Medical Mutual is a regional health insurer with our corporate headquarters located in Cleveland, Ohio. Our SuperMed® PPO network is one of the largest provider networks in Ohio. The SuperMed PPO service area includes the state of Ohio, as well as Boone, Campbell and Kenton counties in Kentucky.

What if I live outside of the SuperMed PPO service area?

Many of our customers have employees located throughout the country. That's why Medical Mutual members have access to the Aetna® Open Choice® PPO network when they live, travel or spend significant time outside of the Medical Mutual SuperMed PPO service area.

How do I access care through my national network?

Review the sample ID card below and the frequently asked questions on the back of this flyer for valuable information that will help you access care when you need it.*



Card Front

1. Your Primary Network and Product
2. Your Aetna ID Number
3. Your Customer Care Phone Number
4. Your Rx Information
5. Your Rx Benefit Management Detail

Card Back

6. Your Vision and Dental Networks
7. Prior Authorization Phone Numbers
8. Aetna Claims Submission Information
9. Your Medical Mutual ID Number
10. Medical Mutual Claims Submission Information

All dental and vision claims should be sent to *Medical Mutual* for processing.

Group ID: 0863970-040-00200

Register for My Health Plan

1-800-362-4700

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Frequently Asked Questions

For members living outside the Medical Mutual SuperMed® Service Area

What is the relationship between Medical Mutual and Aetna?
Medical Mutual is the company that provides your healthcare coverage. Your Medical Mutual coverage includes access to the Aetna® Open Choice® PPO network.

When should I use the Aetna ID number on the front of my card?
You should use your Aetna ID number when you visit an Aetna Open Choice PPO provider for medical services or procedures.

When should I use the Medical Mutual ID number on the back of my card?
You should use your Medical Mutual ID number if you have dental or vision benefits with Medical Mutual, or if you visit a SuperMed PPO provider for medical services or procedures.

How can I find an in-network provider?
To find an in-network provider, please refer to our online provider directory at ProviderSearch.MedMutual.com or log in to My Health Plan and use the Find a Provider tool.

How can my provider verify eligibility?
Providers can verify eligibility by using an online system called Availity. Or they can follow these instructions to verify eligibility by phone: Aetna Open Choice PPO providers should call 1-888-238-6277 and use the Aetna ID number listed on the front of your ID card to verify eligibility. Medical Mutual SuperMed PPO providers should call 1-800-362-1279 and use the Medical Mutual ID number listed on the back of your ID card to verify eligibility.

Where should my provider submit claims for payment?
Providers should submit claims as instructed below:

- Aetna Open Choice PPO providers should submit claims to the Aetna address listed on the back of your ID card.
- Medical Mutual SuperMed PPO providers should submit claims to the Medical Mutual address listed on the back of your ID card.

Where should my provider call to obtain prior authorization?
Providers should contact Medical Mutual for prior authorization using the phone numbers listed on the back of your ID card.

How does this affect my dental or vision coverage?
If you have dental and/or vision coverage through Medical Mutual, this does not affect your claims or your network for standard dental or vision procedures. To find an in-network provider, please refer to our online provider directory at ProviderSearch.MedMutual.com. Providers should call the phone number for dental or vision that is listed on your ID card to find out where to submit claims for payment.

Who can I call if I have questions about my national network?
Call Medical Mutual Customer Care at the number listed on your ID card.

Aetna Open Choice PPO Provider Search

Register for My Health Plan by clicking on the link here.

Group ID: 0863970-040-00200
Register for My Health Plan
1-800-362-4700

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Medical Mutual Dental Insurance Coverage

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Regular dental checkups can help find early warning signs of certain health problems, which means you can get the care you need to get healthy. So, don't skimp on your dental care, good oral care can mean better overall health!

Dental Schedule

Annual Deductible	$50 Single / $150 Family
Calendar Year Maximum Benefit (all services except Orthodontia)	$1,000
Preventive Services (Exams, Cleanings and Bitewing X-rays)	100%
Essential Services (Routine fillings, simple extractions, endodontics, periodontics)	50%
Complex Services (Crowns, dentures and bridges)	50%
Dependent Children	Child less than 26 years of age
Orthodontic Services • Dependent Children under age 19	50%
Orthodontia Lifetime Maximum	$750
Predetermination of Benefits	Required for any course of treatment exceeding $200 or involving major restorations.
Coverage Level	**Cost if you ONLY elect dental coverage without the medical plan. Cost of dental is included in medical cost share.**
Employee	$5.00 per month
Employee Plus One or More	$15.00 per month

Dependents of an Employee include the Employee's spouse and unmarried children to age 26.
This Summary is for informational purposes only. For specific benefit information, please refer to the applicable Insurance Contract.

MEDICAL MUTUAL

Group ID: 898472

For questions or to locate a participating provider, call or visit:

MMO - Find a dental provider and register for My Health Plan

1-888-336-8251

Medical Mutual Claims Submission:
Electronic Claims Payer ID: 29076
P.O. Box 6018,
Cleveland, OH 44101-1018

Medical Mutual Preventive Eye Exam and VSP Vision Savings Pass

The Preventive Eye Exam Benefit through your **Medical Mutual Health Plan Benefits** when utilizing a Network Provider under your Medical Plan the exam is covered at 100% per benefit period.

VSP® Vision Savings Pass is a discount program that offers immediate savings on eye care and eyewear.

The **VSP® Vision Savings Pass** is a discount program that offers immediate savings on eye care and eyewear.

VSP® Vision Savings Pass	
WellVision Exam®	• $50 with purchase of a complete pair of prescription glasses. • 20% without purchase • Once every calendar year
Retinal Screening	Guaranteed pricing with WellVision Exam® not to exceed $39.
Prescription Glasses	With purchase of a complete pair of prescription glasses: • Single Vision: $40 • Lined Bifocal: $60 • Lined Trifocal: $75 • Polycarbonate for children: $0
Frame	25% savings when a complete pair of prescription glasses is purchased.
Lenses	Single vision, lined bifocal, and lined trifocal lenses every 12 months
Contacts instead of glasses	15% savings on contact lens exam (fitting and evaluation)
Extra Savings	• 20-25% average savings on lens enhancements. • 15% off regular price for laser vision correction

MEDICAL MUTUAL

VSP Vision care for life

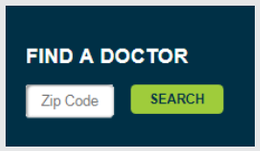
How to use your VSP Vision Savings Pass:

1. Find a VSP Doctor at www.vsp.com or call 1-800-877-7195

2. Save immediately on eyewear and contacts

Provider Look-Up

www.vsp.com, type in desired zip code and search in Find a Doctor field:



SHELLY & SANDS

Medical Mutual Life and AD&D Insurance

Basic Life and AD&D Insurance

Shelly & Sands provides Life and Accidental Death & Dismemberment insurance. There is no cost to you for this coverage. Benefits reduce to 50% at age 70 and terminates at retirement.

Other AD&D Features

- Seat Belt Benefit
- Air Bag Benefit
- Repatriation Benefit
- Dependent Education Benefit
- Exposure and Disappearance Benefit
- Coma Benefit

Conversion of Life Insurance

You may convert to an individual policy of life insurance if your life insurance or a portion of it ceases because:

1. You are no longer employed by the policyholder; or
2. You are no longer in a class which is eligible for life insurance.

You have 30 days in which to request the conversion.

SHELLY & SANDS

MEDICAL MUTUAL

Remember to update your beneficiary!!

Group ID: 898472

Claims@MedMutualLife.com

1-866-925-2542

Family Medical Leave (FMLA)

Family Medical Leave Act of 1993

FMLA provides up to 12 weeks of unpaid, job protected leave to "eligible" employees for certain family and medical reasons. You are eligible if you have worked for Shelly & Sands for at least one year and worked 1,250 hours over the previous 12 months.

Reasons for Taking Leave

Unpaid leave must be granted for any of the following reasons:

- To care for your child after birth, or placement for adoption or foster care.
- To care for your spouse, son, daughter or parent who has a serious health condition.
- For a serious health condition that makes you unable to perform your job.
- In situations of qualifying exigency to be with an employee's spouse, parent or child if said person is an active service member or has an impending call to active duty in support of a contingency operation.
- For the care of an injured service member if the service member is the employee's spouse, child, parent, or "next of kin." This type of FMLA can be elected to be taken for up to 26 weeks in a 12-month period.

Advance Notice and Medical Certification

You may be required to provide advance leave notice and medical certification. Taking leave may be denied if requirements are not met:

- You ordinarily must provide 30 days advance notice when the leave is foreseeable.
- Shelly & Sands requires medical certification to support a request for leave because of a serious health condition and may require second or third opinions (at the employer's expense) and a fitness-for-duty report to return to work.

Job Benefits and Protection

- For the duration of FMLA leave, Shelly & Sands must maintain your health coverage under any "group health plan." You will continue to be responsible for your portion of the cost sharing of the premium payments.
- Upon return from FMLA leave, employees must be restored to their original or equivalent positions with equivalent pay, benefits and other employment terms.
- The use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

What You Should Do

When needing to miss work due to one of the stated reasons for taking leave:

- Contact Dana Bowling at 740-252-5046 or e-mail at d.bowling@shellyandsands.com in Human Resources regarding your need for leave.

401(K) Savings Plan

SHELLY & SANDS

Shelly & Sands 401(K) provides a 401(k) Plan with a matching contribution.

Employees must be **18 years** of age and have satisfied their new hire waiting period which is the first of the month following 30 days of service to be eligible to begin participation. However, an immediate roll-over may be processed into the plan upon hire.

You are automatically enrolled to defer 4% of your pay as of the date you become a participant in the plan, unless you choose a different percentage, or you choose not to defer (see Part 1). Your 401(k) elective deferral contributions will be pre-tax elective deferral contributions unless you designate all or a portion as Roth elective deferral contributions by completing an elective deferral agreement.

Our matching contributions give you an additional return on the amount you defer. We will make a matching contribution equal to 50% of your 401(k) elective deferral contributions. 401(k) elective deferrals over 4% of your pay are not matched.

401(k) contribution limit is $20,500 in 2022. If you are age 50 or over, the catch-up contribution limit is $6,500 in 2022. Employer match or profit-sharing contributions aren't included in these limits

Remember to update your beneficiary!!

Principal℠

For more information on the Principal 401(k) plan and portfolio options visit **www.InvictaCapitalAdvisors.com** or call

Rex W. Linkenbach at
Phone: 419-566-8364
Fax: 419-525-0098
Linkenbach.Rex@InvctaCapitalAdvisors.com
Mailing Address:
1592 Bridgewater Way S
Mansfield, OH 44906-3577

Medical Mutual Value-Added Services

(Included at no additional charge for employees)

SHELLY & SANDS

My Health Plan

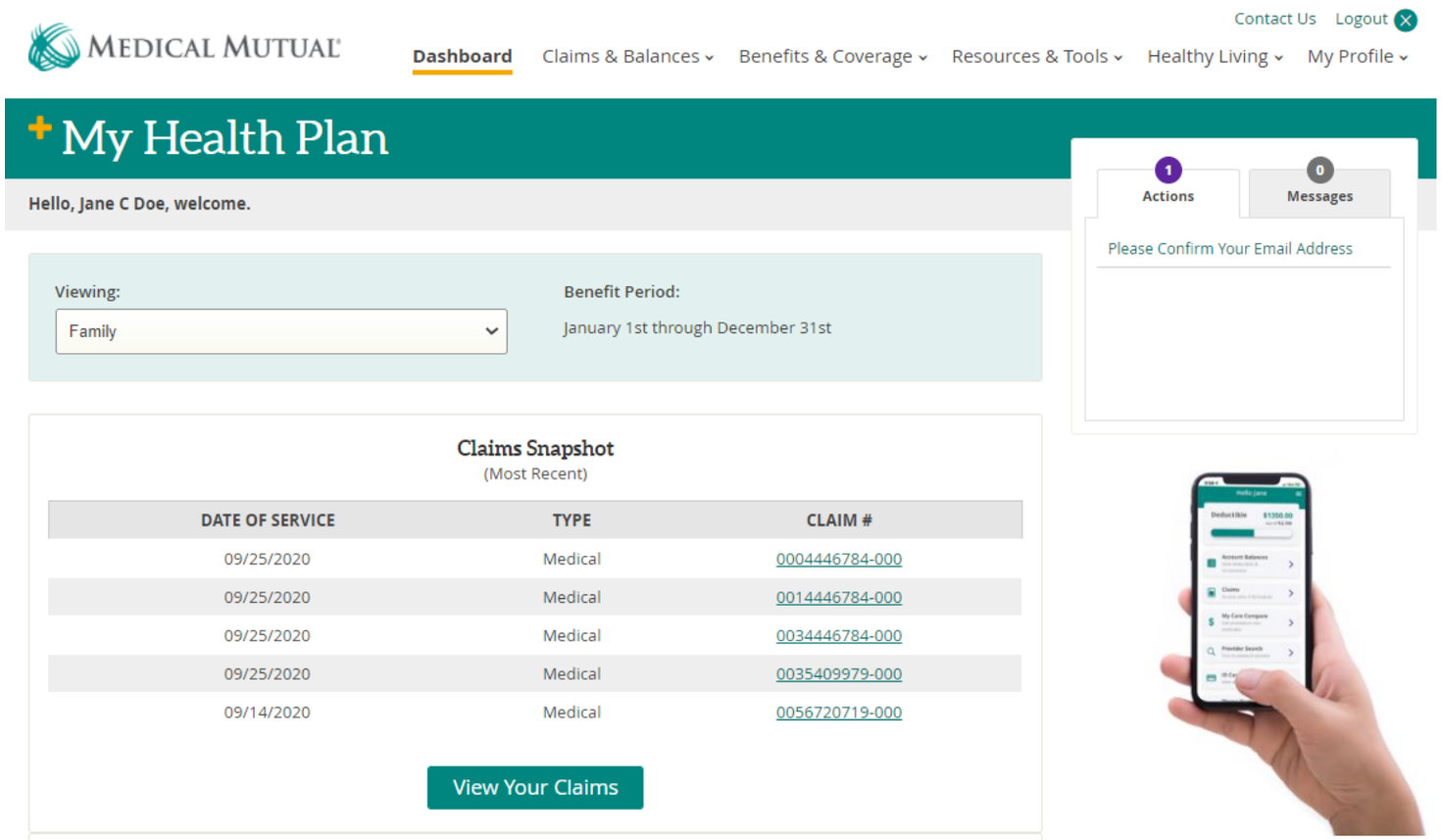
Access your claims 24/7 by registering at www.member.medmutual.com and setting up an account.

You can access many resources on this site such as:

- Tools to Find a Provider or search the Rx Formulary
- MyCare Compare cost estimator for medical services and Rx Cost Estimator
- Download the My Health Plan Mobile App to access your ID Card, Find a Provider or view your claims
- Access to My Health Assessment that will help evaluate your overall health and wellness

Download on the App Store

GET IT ON Google Play



MEDICAL MUTUAL

Group ID: 898472

Register for My Health Plan

1-800-362-4700

EXPRESS SCRIPTS

Express Scripts Pharmacy Plan

Rx Bin: 610014 RXPCN: COPAY Rx GRP: MMODRUG

Register for Mail Order Delivery

1-800-471-1961

Have the Member App?

Get your health plan information any time, any place. Get the free MedMutual app for your iPhone or Android

Questions? Contact Dana Bowling in Human Resources at 740-252-5046 or e-mail **d.bowling@shellyandsands.com**

Back **23 Next**

Medical Mutual Value-Added Services *continued*

(Included at no additional charge for employees)

SHELLY & SANDS

Healthy Living

- **Health Awareness:** Articles to help make informed healthcare decisions. Learn about essential topics such as nutrition, fitness, stress reduction and more.
- **Healthy Outlooks:** Newsletter that keeps you up to date on health and wellness trends and topics to help you navigate through the world of healthcare. Topics such as "Preventing Drug Interactions" and "A Harmful Trend on Vaping" are some of the topics discussed.
- **Fitness:** Program Discounts for Curves and Global Fit
- **Preventive Care:** Reminders about age-appropriate preventive care screenings.
- **QuitLine:** Tobacco Cessation Program available at no additional cost to members. Just call 1-866-845-7702 to enroll.
- **WW (formerly Weight Watchers):** Enrollment in the program is simple.

  Step 1: Contact Medical Mutual at **WeightWatchers@MedMutual.com** or by phone at 1-800-251-2583, any time, seven days a week. Please leave a detailed message that includes: Your first and last name, Full date of birth, Medical Mutual member ID number (found on your ID card) Street address, city, state and ZIP code, Email address, & Phone number.
  Step 2: Medical Mutual will confirm your eligibility and enter your information into the WW portal. You will receive confirmation within 3 business days.
  Step 3: Follow the remaining instructions on the **Enrollment Guide** to receive discounted pricing today. Questions about the program? Check out our **Frequently Asked Questions** and **WW Program brochure** for answers.
  †For members participating in an employer's Workshops in the Workplace program, we require three statements to be reimbursed $50 and four statements to be reimbursed $75. To request reimbursement, please complete this **Form**.
  WW is a registered trademark of WW International, Inc.

- **Member Discounts:** American Fitness.net, Safe Beginnings, Beltone™ Hearing Aids, YOGAccessories and Vitamix: **Click here for details**

Cleveland Clinic Express Care® Online (Telemedicine)

To talk to a healthcare provider online whenever and wherever you want using your cell phone, tablet or computer.

10-Minute Visit. Anytime 24/7. No appointment needed. Visit **www.clevelandclinic.org/eco**

Try Cleveland Clinic Express Care® Online when you have:

- Asthma
- Bronchitis
- Cough and cold symptoms
- Earaches
- Minor back and shoulder pain
- Minor Trauma, burns or cuts
- Minor medical concerns
- Seasonal allergies
- Sinus infections
- Urinary tract infections
- Yeast infections

Download on the App Store

GET IT ON Google Play

MEDICAL MUTUAL

Cost: $0 Ages 2 and older. Patients 17 years and younger must be accompanied by a parent or legal guardian during the visit.

Chronic Condition Management Program

(Included at no additional charge for employees)

SHELLY & SANDS

Medical Mutual has made significant enhancements to our Chronic Condition Management program, formerly referred to as our Disease Management program. Members will be transitioned into one of the following programs designed to engage, motivate and support them across their health continuum.

Digital Health Programs

Medical Mutual has added two new digital health programs to assist members with managing their chronic condition and meeting their health goals through digital platforms instead of telephonic-based coaching.

Chronic Condition Coaching through Lark Health

This program provides personalized daily health coaching interactions via text messages to help members achieve their health goals. The program also integrates connected devices, such as wireless glucometers, blood pressure cuffs, and digital scales to monitor progress.

Self-monitoring through Emmi Solutions

Members with a consistent pattern of properly managing their condition can report their progress via an automated telephone or text message survey.

Members in the digital programs still have the option to call the Medical Mutual Chronic Condition Management team for additional support. In addition, our team may reach out to members to follow up on specific risks identified through their interactions with the digital programs.

MEDICAL MUTUAL

Telephonic Support

Medical Mutual is transitioning members from telephonic support with Optum to an enhanced Medical Mutual team. There are two levels of support members may receive, depending on their care plan.

Chronic Condition Management

This program is for members with a chronic condition who have a care plan that requires monthly telephonic interaction with a nurse care manager to help them manage their condition.

Complex Case Management

This program is for members with more advanced health conditions who may require multiple telephonic interactions each month, as well as support with recent hospitalizations.

Advanced Home Monitoring

Medical Mutual has partnered with regional health systems around the state of Ohio to provide more advanced home monitoring capabilities for high-risk members with conditions such as heart disease and pulmonary disease. Members will transition from Optum's device monitoring program to this enhanced program later this year.

Group ID: 898472

Register for My Health Plan

1-800-362-4700

Aflac Voluntary Benefit Options

SHELLY & SANDS

You work hard for your paycheck, and Aflac would like to help you protect it.

Aflac knows that life is a balancing act. It's about standing up to the expected and unexpected every day. For more than 60 years, Aflac has been dedicated to helping people protect their financial security and peace of mind when they've needed it most.

While you can't possibly foresee everything that can come your way, you can make smart choices so you are better prepared for things life can throw at you. Aflac is different from health insurance; it's insurance for daily living.

While major medical insurance pays doctors and hospitals, Aflac pays cash benefits directly to you[1] . Aflac provides prompt service and fast payment of claims to help you pay your bills. While you're focusing on your health, we focus on getting you cash as quickly as possible."

Benefit options:

- **Short-Term Disability**: Up to 60% income replacement. Provides a source of income if you are unable to work due to a sickness or off the job injury. Also provides coverage for Maternity leave. Customizable options for your financial needs.
- **Accident:** Coverage for emergency treatment, hospital admission, intensive care unit, ambulance transportation and many other medical costs. This coverage has a *$50 wellness screening benefit*.
- **Hospital Indemnity:** If you are confined to the hospital this plan is designed to pay cash benefits for hospital confinement, hospital admission, intensive care, intensive care step-down unit and more.
- **Critical Illness:** This coverage pays a lump sum cash benefit to help cover the costs of a covered critical illness, such as heart attack or stroke. This plan has a *$50 wellness screening benefit*.

Group# 22260

Carrie Carter
Carrie_Carter@US.Aflac.com
330-844-6825

Aflac.

[1] Benefits are paid directly to you, unless assigned otherwise. [2] One Day Pay SM is available for certain individual claims submitted online through the Aflac SmartClaim® process. Claims may be eligible for One Day Pay processing if submitted online thorough Aflac SmartClaim, including all required documentation, by 3 p.m. ET. Documentation requirements vary by type of claim; please review requirements for your claim(s) carefully. Aflac SmartClaim is available for claims on most individual Accident, Cancer, Hospital, Specified Health and Intensive Care policies. Most other claims are processed within four days. Processing time is based on business days after all required documentation needed to render a decision is received and no further validation and/or research is required. Individual Company Statistic, 2017.

Individual coverage is underwritten by American Family Life Assurance Company of Columbus. In New York, coverage is underwritten by American Family Life Assurance Company of New York. Worldwide Headquarters | 1932 Wynnton Road | Columbus, Georgia 31999

What Happens to my Benefits Upon Separation?

Benefit	What happens to this benefit upon separation?
	If you participated in the medical and dental plan on your last day of active employment you may continue this plan through COBRA, if you elect to do so. COBRA is administered through the Shelly & Sands Human Resources Department. For details on how long you may remain on COBRA, refer to the paperwork that will be provided by Dana Bowling in Human Resources. Contact Dana Bowling in Human Resources at 740-455-3144 or e-mail at d.bowling@shellyandsands.com.
Medical / Dental	Coverage ends at the **end of the month** but is eligible for COBRA Continuation. Contact Dana Bowling in Human Resources at 740-252-3144 or e-mail at d.bowling@shellyandsands.com.
Life Insurance	Coverage ends on the date of termination.
401(k)	Plan participation ends on the date of termination. You may stay in the plan or rollover to an IRA or another group 401(k) plan.
AFLAC	Plan participation ends at the end of the month. You can keep your policies and pay AFLAC direct.

SHELLY & SANDS

Shelly & Sands Carrier Contacts

SHELLY & SANDS

Coverage	Carrier	Group #	Website	Phone / E-mail
Medical **Rx / Pharmacy**	Medical Mutual Express Scripts	Medical: #898472-101 Rx Bin: 610014 RXPCN: COPAY Rx GRP: MMODRUG	**www.medmutual.com**	**1-800-362-4700** See back of ID Card 1-800-471-1961
Value Added Services Cleveland Clinic Express Care® Online Chronic Condition Management Nurseline Quit Line WW: Weight Watchers	Medical Mutual	#898472-101	**www.medmutual.com**	**Download App from the App Store:** **Apple / Android** **1-800-362-4700** **1-888-912-0636** **1-866-845-7702** **1-800-251-2583**
Dental (MMO Super Dental)	Medical Mutual	#898472-101	**wwww.medmutual.com**	**1-888-336-8251**
Vision Exam with MMO & VSP Vision Savings Pass	Medical Mutual / VSP	#898472-101	**wwww.medmutual.com**	**MMOH: 1-800-362-4700** See back of ID Card **VSP: 1-800-877-7195**
Life / AD&D Insurance (Employer Paid)	Medical Mutual	#898472	**wwww.medmutuallife.com**	Dana Bowling: 740-453-0721 **d.bowling@shellyandsands.com**
401(k) Savings	Principal Invicta Capital, LLC	#8-2225	**www.principal.com** **www.InvicaCapitalAdvisors.com** **Linkenbach.Rex@InvictaCapitalAdvisors.com**	Rex W. Linkenbach 419-566-8364
AFLAC	AFLAC Carrie Carter	#22260	**www.Aflac.com** **Carrie_Carter@Us.Aflac.com**	1-800-992-3522 330-844-6825
Erie Insurance	Supplemental Life Insurance		Jeff Dennis	**740-982-3091** **jeff@dennisnelsoninsurance.com**
COBRA Administration	Shelly & Sands	N/A	N/A	Dana Bowling: 740-453-0721 **d.bowling@shellyandsands.com**

Annual Notices

Health Insurance Portability and Accountability Act (HIPAA)

For purposes of the health benefits offered under the Plan, the Plan uses and discloses health information about you and any covered dependents only as needed to administer the Plan. To protect the privacy of health information, access to your health information is limited to such purposes. The health plan options offered under the Plan will comply with the applicable health information privacy requirements of federal Regulations issued by the Department of Health and Human Services. The Plan's privacy policies are described in more detail in the Plan's Notice of Health Information Privacy Practices or Privacy Notice. For any insured health coverage, the insurance issuer is responsible for providing its own Privacy Notice, so you should contact the insurer if you need a copy of the insurer's Privacy Notice.

HIPAA Special Enrollment Rights Notice

If you are waiving enrollment in the medical plan for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in the medical plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Genetic Nondiscrimination

The Genetic Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting, or requiring, genetic information of an individual or family member of the individual, except as specifically allowed by this law. Genetic information, as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents (including spouse) for up to 24 months while in the military. Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions for pre-existing conditions except for service-connected injuries or illness.

WHCRA Notice

In compliance with the Women's Health and Cancer Rights Act of 1998, the plan provides the following benefits to all participants who elect breast reconstruction in connection with a mastectomy, to the extent that the benefits otherwise meet the requirements for coverage under the plan:

- Reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Coverage for prostheses and physical complications of all stages of the mastectomy, including lymphedemas.

The benefits shall be provided in a manner determined in consultation with the attending physician and the patient. Plan terms such as deductibles or coinsurance apply to these benefits.

Pre-Existing Conditions

Under current law, health insurance companies can't refuse to cover you or charge you more just because you have a "pre-existing condition" – that is, a health problem you had before the date that new health coverage starts. These rules went into effect for plan years beginning on or after January 1, 2014.

Health insurers can no longer charge more or deny coverage to you or your child because of a pre-existing condition like asthma, diabetes, or cancer. They cannot limit benefits for that condition either. Once you have insurance, they can't refuse to cover treatment for your pre-existing condition.

The pre-existing coverage rule does not apply to "grandfathered" individual health insurance policies. A grandfathered individual health insurance policy is a policy that you bought for yourself or your family on or before March 23, 2010, that has not been changed in certain specific ways that reduce benefits or increase costs to consumers.

Notice of Patient Protections

You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. To find a primary care provider in your plan's network, log in to My Health Plan at AultCare Member Portal Login and click Provider Search. You can also call **Customer Care** at 330-363-6360 to make any changes to your personal information.

COBRA

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, COBRA qualified beneficiaries (QBs) generally are eligible for group coverage during a maximum of 18 months for qualifying events due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

COBRA coverage is not extended to those terminated for gross misconduct. Upon termination, or other COBRA qualifying event, the former employee and other QBs will receive COBRA enrollment information.

Qualifying events for employees include voluntary/ involuntary termination of employment, and the reduction in the number of hours of employment. Qualifying events for spouses/ same-sex domestic partners or dependent children include those events above, plus, the covered employee becoming entitled to Medicare; divorce or legal separation of the covered employee; death of the covered employee; and the loss of dependent status under the plan rules.

If a QB chooses to continue group benefits under COBRA, they must complete an enrollment form and return it to the Plan Administrator with the appropriate premium due. Upon receipt of the premium payment and enrollment form, the coverage will be reinstated.

Thereafter, premiums are due on the 1st of the month. If premium payments are not received in a timely manner, Federal law stipulates that your coverage will be canceled after a 30-day grace period. If you have any questions about COBRA or the Plan, please contact the Plan Administrator.

Please note, if the terms of the Plan and any response you receive from the Plan Administrator's representative conflict, the Plan document will control.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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

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

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

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

Special Enrollment Rights CHIPRA – Children's Health Insurance Plan

You and your dependents who are eligible for coverage, but have not enrolled, have the right to elect coverage during the plan year under two circumstances:

- You or your dependent's state Medicaid or CHIP coverage terminated because you ceased to be eligible.
- You become eligible for a CHIP premium assistance subsidy under state Medicaid or CHIP.

You must request special enrollment within 60 days of the loss of coverage and/or within 60 days of when eligibility is determined for the premium subsidy

Glossary of Terms

This glossary has many commonly used terms, but it is not a full list. Those can be found in your insurance policy or contract.

Allowed Amount: Maximum amount on which payment is based for covered health care services. This may be called “eligible expense,” “payment allowance” or “negotiated rate.” If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Appeal: A request for your health insurer or plan to review a decision or a grievance again.

Balance Billing: When a provider bills you for the difference between the provider’s charge and the allowed amount. For example, if the provider’s charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you.

Co-insurance: Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co- insurance plus any deductibles you owe. For example, if the health insurance or plan’s allowed amount for an office visit is $100 and you’ve met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount. (Jane pays 20%, her plan pays 80%.)

Complications of Pregnancy: Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency cesarean section aren’t complications of pregnancy.

Co-payment: A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible: The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won’t pay anything until you’ve met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services. (Jane pays 100%, her plan pays 0%.)

Durable Medical Equipment (DME): Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include oxygen equipment, wheelchairs, crutches, or blood testing strips for diabetics.

Emergency Medical Condition: An illness, injury, symptom, or condition so serious that a reasonable person would seek care right away to avoid severe harm. Emergency Medical Transportation Ambulance services for an emergency medical condition.

Emergency Room Care: Emergency services received in an emergency room.

Emergency Services: Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

Excluded Services: Health care services that your health insurance or plan doesn’t pay for or cover.

Grievance: A complaint that you communicate to your health insurer or plan.

Habilitation Services: Health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn’t walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Glossary of Terms continued…

Health Insurance: A contract that requires your health insurer to pay some or all your health care costs in exchange for a premium.

Home Health Care: Health care services a person receives at home.

Hospice Services: Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization: Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care: Care in a hospital that usually doesn't require an overnight stay.

In-network Co-insurance: The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network co-insurance usually costs you less than out-of-network co-insurance.

In-network Co-payment: A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network co-payments usually are less than out-of-network co-payments.

Medically Necessary: Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, disease, or its symptoms and that meet accepted standards of medicine.

Network: The facilities, providers, and suppliers your health insurer or plan has contracted with to provide health care services.

Non-Preferred Provider: A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non- preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.

Out-of-Network Co-insurance: The percent (for example, 40%) you pay of the allowed amount for covered health care services to providers who do not contract with your health insurance or plan. Out-of-network co-insurance usually costs you more than in-network co-insurance.

Out-of-Network Co-payment: A fixed amount (for example, $30) you pay for covered health care services from providers who do not contract with your health insurance or plan. Out-of-network co-payments usually are more than in-network copayments.

Out-of-Pocket Limit: The most you pay during policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges, or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit. (Jane pays 0%, her plan pays 100%.)

Physician Services: Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan: A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Preauthorization: A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval, or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Glossary of Terms continued…

Preferred Provider: A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium: The amount that must be paid for your health insurance or plan. You and or your employer usually pay it yearly.

Prescription Drug Coverage: Health insurance or plan that helps pay for prescription drugs and medications.

Prescription Drugs: Drugs and medications that by law require a prescription.

Primary Care Physician: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Provider: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified, or accredited as required by state law.

Reconstructive Surgery: Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, or medical conditions.

Rehabilitation Services: Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care: Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist: A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

UCR (Usual, Customary and Reasonable): The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care: Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.