staab construction corporation

100% EMPLOYEE OWNED

Employee Benefits Guide

January - December 2024

The information in this enrollment guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancies between this guide and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your guide, contact Human Resources.

Benefit Option Organizer

Line of Coverage	Benefit Partner	Contribution
Mental Wellness	ERC	Staab
Direct Primary Care	Anovia	Staab
Dependent Care Flexible Spending Account (DCFSA)	Diversified Benefit Services (DBS)	You Staab
Medical Insurance	Allegiance	You Staab
Care Advocacy	Alithias	Staab
Healthcare Incentive Program	Alithias	Staab
TeleHealth	Recuro (formerly Wellvia)	Staab
Health Savings Account (HSA)	bank of choice	You
Dental Insurance	Delta	Staab
Short-term Disability	The Standard	Staab
Long-term Disability	The Standard	Staab
Group Life/AD&D	The Standard	Staab

*Any benefit deductions from your paycheck would be taken on a pre-tax basis.

Benefit Eligibility & Enrollment

Who is eligible...

Full-time employees working 30+ hours per week with Staab Construction Corporation are eligible to enroll in the benefits outlined in this guide. In addition, dependents (spouse, domestic partner, natural or adopted child, grandchild, or child for whom you have legal guardianship) may be eligible for these benefits.

How to enroll...

The first step in determining which benefits to elect is reviewing existing lines of coverage. Evaluate life changes - did you move or recently get married? Are you expecting a child?

Verify all personal demographic information is accurate and make applicable changes.

Once the above is complete, evaluate the benefit options available and make your elections for the upcoming year. Benefit decisions made when first eligible or during annual enrollment have a significant impact on your life (and finances) so weigh the options carefully.

When to enroll...

All benefits must be selected for you and eligible dependents within 30 days of being newly eligible, or during the designated annual enrollment period.

Benefits elected now will be in effect until the next annual enrollment, unless you experience an IRS qualified event.

How to make changes...

Unless you experience an IRS qualified event, you are not able to make changes to benefit elections until the next annual enrollment period.

An IRS qualified event would include:

- A loss of eligibility for other health coverage
- Termination of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP)
- Acquisition of a dependent - marriage, birth, adoption or placement for adoption
- Becoming eligible for a premium assistance subsidy under Medicaid or a state CHIP

In the case of a qualified event, you have 30 days to make changes to benefit elections.

Mental Health Support Services

Employer-Paid Services

ERC

COUNSELORS & CONSULTANTS

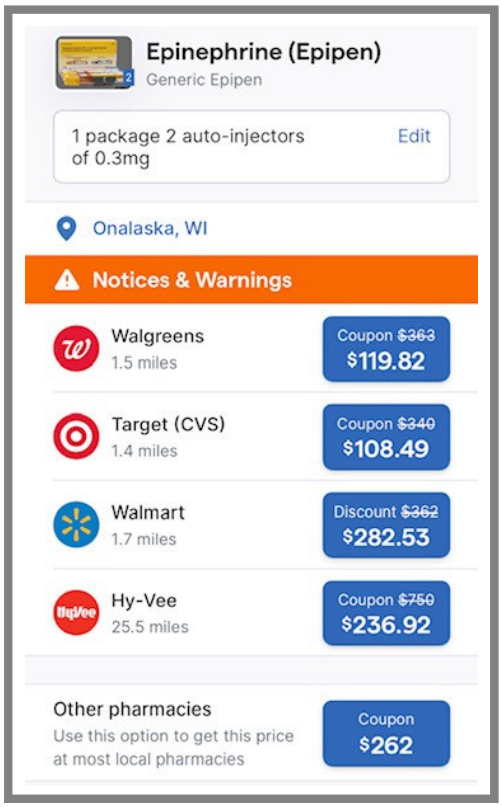
ERCincorp.com | 1-800-222-8590

The EAP helps lift the mental health burdens that hold employees and their families back from their full potential. Call to schedule a free and confidential appointment with an EAP counselor.

Prescription Drug Savings Tips

Why we pay so much for our prescriptions

Prices for prescription drugs vary widely between pharmacies. U.S. drug prices are neither fixed, nor regulated.



How can GoodRx help me?

Every week, GoodRx collects millions of prices and discounts from pharmacies and drug manufacturers, which allows users to find the lowest cost for their prescriptions.

How does it work?

GoodRX allows users to search for prescriptions at pharmacies nearby and compare prices. If choosing to proceed with GoodRX, notify the pharmacist when picking up your prescription to apply the applicable discount.

No cost!

GoodRx is 100% free. Discounts are available for every family member, even if not covered by insurance. Pets included! No quantity limits.

www.GoodRx.com

Available on the App Store

GET IT ON Google Play

NOTE: Using the GoodRx coupon bypasses your health insurance. Money spent on prescriptions using GoodRX does not apply to your deductible and/or out-of-pocket maximum; however, may still be considered an HSA eligible expense.

HealthCARE at no cost to you!

ANOVIA HEALTH

www.anoviahealth.com

Clinic Hours	Appleton	Antigo	Clintonville	DePere
8:00 am - 4:00 pm Monday - Friday extended hours available by appointment only	59 Park Place Ste 100 Appleton 920.764.8677	510 Ackley St Ste 2 Antigo 715.500.4651	270 N Main St Clintonville 715.468.6098	1200 Enterprise Dr DePere 920.289.4206
Marshfield	**Merrill***	**Rhinelander***	**Stevens Point**	**Weston**
203 W Upham St Marshfield 715.506.5328	2402 E Main St Ste 3 Merrill 715.500.4651	580 Shepard St Rhinelander 715.500.4651	2417 Post Road Stevens Point 715.883.3200	7402 Stone Ridge Dr Weston 715.636.0590

*Care provided by affiliated Priority Medical Partners (PMP) branded clinics

Services provided are NO COST to all employees AND their dependents (age 2+)

What can Anovia help me with?

- Abdominal Pain
- Acid indigestion/reflux
- Acne
- Allergies
- Anxiety
- Asthma
- Athlete's foot
- Back pain
- Boils
- Bowel issues
- Blood work
- Broken bones
- Bronchitis
- Cold symptoms
- COVID testing
- Depression
- Diabetes
- DOT exams
- Drug screening/testing
- Ear infection/wax removal
- Eczema
- Emphysema
- Eye injuries/issues
- Hearing tests
- Head lice
- Hepatitis B
- High blood pressure
- High cholesterol
- Hives
- I.V. Therapy
- Impetigo
- Influenza
- Lacerations
- Minor burns
- Mole checks/removal
- Mono
- Nebulizer treatments
- Physicals/sports physicals
- Preemployment screening
- Poison Ivy, Oak, Sumac
- Primary care
- Rashes
- Respiratory screening
- Ringworm
- Scabies
- Shingles
- Sinus infections
- Skin infections/irritations
- Sprains/strains
- STD testing
- Strep throat
- Suture removal
- TB skin tests
- Thyroid disorders
- Tick/insect bites
- Upper respiratory
- UTI's
- Wart removals
- Wellness exams
- Vaginal infections/issues

Please Note: Anovia Health does not offer chiropractic, physical therapy, or massage therapy

Dependent Care Flexible Spending Account (DCFSA)

Dependent Care

Plan Highlights

Dependent Care FSA Plan Year
January 1st - December 31st
*no carryover option available

Runout Period
90 days
*Any amounts remaining in your DCFSA account at the end of the plan year after all timely claims have been paid will be forfeited.

Contribution Amounts
Single/Married, filing jointly = $5,000
Married, filing separately = $2,500

What is a Dependent Care Flexible Spending Account?

A Dependent Care Flexible Spending Account (DCFSA) is used for expenses incurred for the care of children under the age of 13 and for certain dependent adult care expenses.

With dependent care expenses, you can be reimbursed up to the amount that has already been deducted from your paycheck. Reimbursements cannot be made for future dates of service.

When using a DCFSA, you will need to file Form 2441 with your income tax returns and you cannot apply the Federal Tax Credit for dependent care expenses.

Diversified Benefit Services (DBS) administers the DCFSA available through Staab.

Example...

The example to the right demonstrates two families at Staab who have the same income and childcare expenses.

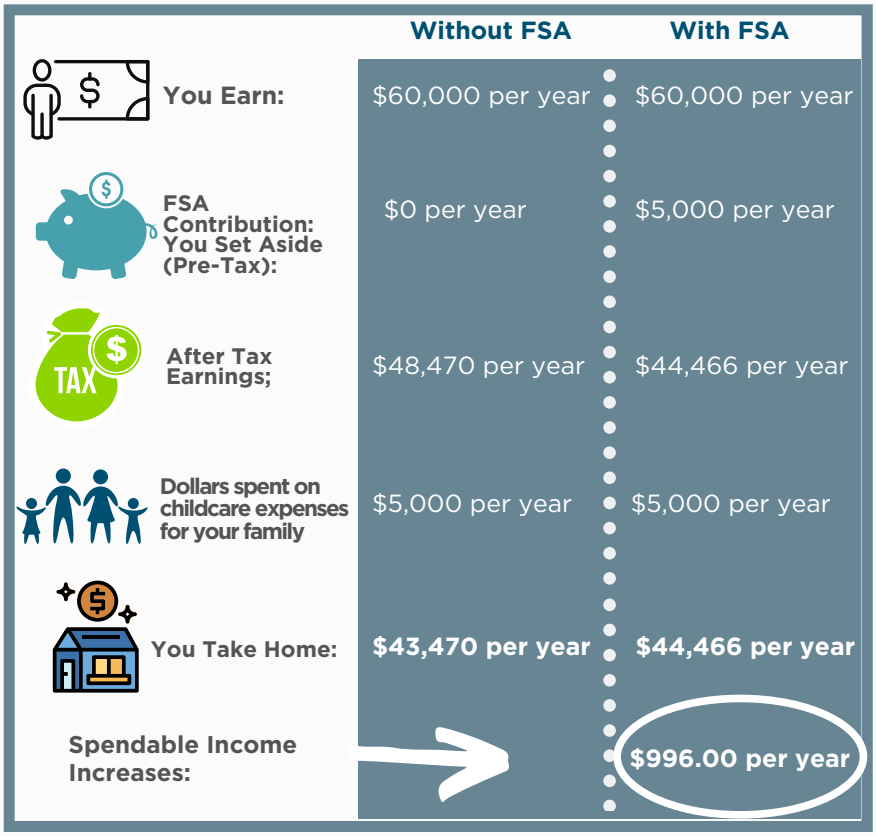
Bob and Jane Smart have chosen to take advantage of the pre-tax DCFSA available to them.

- Bob and Jane have a combined income of $60,000
- Bob and Jane have two children under the age of five
- Bob and Jane file their income taxes jointly

Since Bob and Jane expect to spend at least $5,000 in childcare expenses throughout 2024, they elect to contribute the maximum allowance of $5,000 to their DCFSA.

The chart to the right illustrates the savings Bob and Jane Smart will recognize over coworkers who chose to pay childcare expenses with post-tax dollars.

NOTE: Filing claims is the responsibility of each employee. Claims for the DCFSA must be filed directly with DBS.



Your personal income and tax savings may vary based on income, tax rate, and the amount you contribute to your FSA account. This example is for illustration purposes only.

DIVERSIFIED BENEFIT SERVICES, INC.

Excellence in Benefit Management Solutions

Claims Filing
Options that meet your needs.

Why file online?

- **Fast**
  There's no quicker way to get reimbursed for your FSA or HRA claims.
- **Convenient**
  Day or night, on your favorite device, go online and get account information.
- **Safe**
  You have encrypted Internet access to the site, which is protected and Verisign secured.
- **Comprehensive**
  View account balance and activity.

DBSbenefits.com

Diversified Benefit Services, Inc.
P.O. Box 260
Hartland, WI 53029
(800) 234-1229

File Online—it's fast, convenient and secure

Using your laptop or PC, you can submit your claims online 24/7. DBS's exclusive A.S.A.P.® (Advanced Strategic Administration Program) is a safe and quick way to see claim information and get reimbursed from your Health Care FSA (HCFSA), Dependent Care FSA (DCFSA), Limited Purpose FSA (LPFSA), or Health Reimbursement Arrangement (HRA).

1. Login to your online account at DBSbenefits.com
2. Select the Benefit Plan Type (FSA, HRA)
3. Select "Claims > Claims View/Submit > Submit"
4. Complete the required information
5. Attach an image with supporting documentation (.pdf or .jpg)
6. Submit

File on the go—use our Mobile Phone App

Filing using your smartphone or tablet is simple.

1. Login using your A.S.A.P.® name and password, click "File a Claim"
2. Take a picture or use an existing photo, click "Attach Image"
3. Select the Benefit Plan Type
4. Enter dollar amount, answer questions, click "Submit"

Visit your favorite app store to download.

ANDROID APP ON Google play

Available on the App Store

File via mail or fax

More traditional filing is available, too.

1. Download a claim form at DBSbenefits.com
2. Select the "Participant Resources Tab > Forms"
3. Complete the form and attach copies of your documentation
4. Mail to Diversified Benefit Services, P.O. Box 260, Hartland, WI 53029
5. Or fax to 262-367-5938

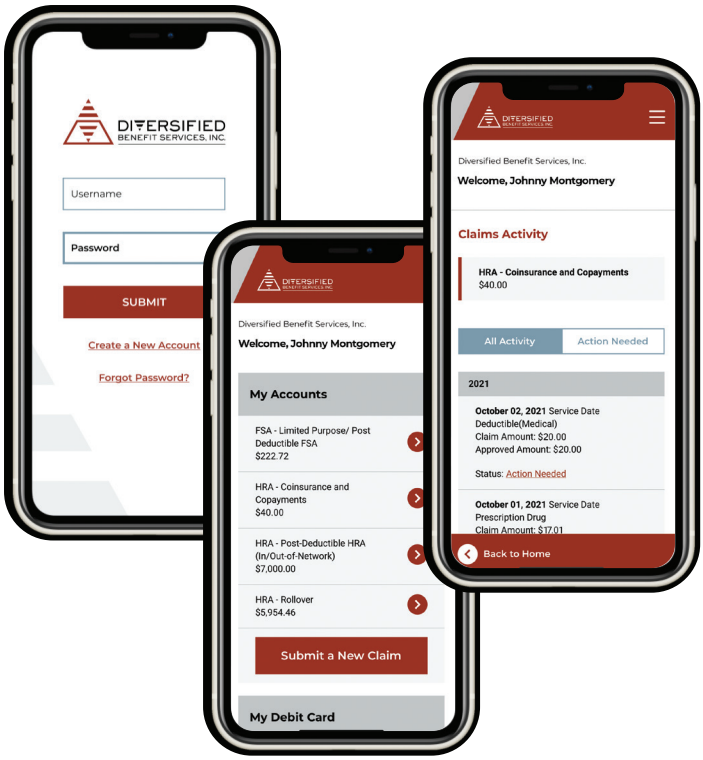
For assistance, please call DBS at **(800) 234-1229**
or visit **DBSbenefits.com**

ENHANCED DBS MOBILE APP

There's no easier way to submit claims and review account information than with the latest version of our mobile app. Day or night, you have convenient and secure access to account activity from your mobile phone.

NEW APP FEATURES:

- View account balances
- Submit new claims and view claim status
- Submit supporting documentation
- Manage debit card transactions
- Create a new account or reset your password



Download the updated app to begin using the new features today!

GET IT ON Google Play

Download on the App Store

P.O. Box 260 Hartland, WI 53029
Toll Free: (800) 234-1229
Phone: (262) 367-3300
DBSbenefits.com

DIVERSIFIED BENEFIT SERVICES, INC.

Navigating HealthCARE

Guide for choosing appropriate care for your situation

	Nurse Line	Direct Primary Care	Virtual Visit	Primary Care	Urgent Care	Emergency Care
What is it?	A phone call with a nurse to provide guidance for urgent but non-emergency medical conditions	Quality medical care provided by accredited doctors at local clinics	An on-demand appointment with a provider via smartphone, tablet, or computer	Regular, in-person care with your provider by appointment	In-person, walk-in care at designated locations, usually with extended hours	In-person care when help is needed right away to prevent an adverse outcome
Hours?	24/7	Varies by clinic	24/7	Clinic hours	Extended hours	24/7
Cost?	FREE!	FREE!	FREE!	$129+	$200+	$600+
When should I use it?	• Triaging minor illness & injury • Help identifying next steps for medical care	• Primary & urgent medical care • Illness & injury • Annual exams (including school or sports physicals) • Vaccinations • Labs & x-rays	• Allergies • Cold & flu • Rashes • Cough • Headache • Nausea • Sore throat	• Primary medical care • Medical monitoring • Referrals to specialty care • Illness & injury • Annual exams • Vaccinations • Labs & x-rays	• Urgent medical care • Illness & injury • Cuts, scrapes, & bruises • Sprains & strains • Ear pain/infection • Rashes & bites • Sore throat	• Emergent medical care • Traumatic illness & injury • Chest pains • Numbness or weakness • Shortness of breath

ANOVIA HEALTH

RECURO CARE

Medical Benefit Partners

Medical Networks

The Alliance/Trilogy Networks

*network utilized within the state of Wisconsin

www.the-alliance.org

Mayo Direct

*no directory necessary as any Mayo provider will be in network

CIGNA

*network utilized outside the state of Wisconsin, Winona, Houston, Wabasha MN)

www.Cigna.com

Choose: OAP/Open Access Plus, OA Plus, Choice Fund OA Plus

Care Advocacy

alithias

Call: 855-270-2850

askme@careadvocacycenter.com

Let the alithias team assist with any benefit questions, EOB explanation, billing questions, verifying in-network providers, and most importantly - navigating through non-emergent services to find the highest quality, lowest cost providers for services such as:

- MRI/CT scans
- Colonoscopies
- At home sleep studies
- Breast biopsy/hysterectomy
- Orthopedic procedures
- Outpatient surgeries

***see full list of services and incentive payouts on the following pages**

Prescriptions

Customer Support
866-333-2757
www.Navitus.com

Mail Order
800-481-4940
www.serve-you-rx.com

Prescription Drug Benefits are provided through Navitus Health Solutions.

Any Specialty Drugs must be purchased through Lumicera Specialty Pharmacy, 855-847-3553.

Preventative drugs are covered by the plan before reaching the deductible. Please refer to the health plan document (SPD) for details.

TPA
(Third Party Administrator)

Allegiance® a Cigna Company

Medical Claims Processor

In coordination with alithias, the Allegiance team assists with navigating your healthcare needs:

- **Locating in-network providers**
- **Claims questions or concerns**
- **Requesting a copy of your medical ID card**
- **Obtaining a copy of your Explanation of Benefits (EOB)**
- **Pre-authorization requirements**
- **Case management**

Call: 800-877-1122
www.askallegiance.com

Medical Insurance

Allegiance: Plan 1 HSA

	In-Network	Out-of-Network
Deductible *non-embedded	$2,500 / individual $5,000 / family	$7,500 / individual $15,000 / family
Coinsurance	20%	40%
Maximum Out of Pocket *non-embedded	$4,500 / individual $9,000 / family	$13,000 / individual $26,000 / family
Preventive Care	paid at 100% *must be billed as preventive care	deductible + coinsurance
Primary Care Visit	deductible + coinsurance	deductible + coinsurance
Specialist Visit	deductible + coinsurance	deductible + coinsurance
Urgent Care	deductible + coinsurance	deductible + coinsurance
Emergency Room	deductible + coinsurance	
Prescription Drug **Advantage Prescription Drug List (PDL)**	Tier 1: deductible + coinsurance Tier 2: deductible + coinsurance Tier 3: deductible + coinsurance Tier 4: deductible + coinsurance	

REMINDER

Ask the pharmacy to also run prescriptions through GoodRx to help determine what makes the most sense for your situation.

Website = fad.the-alliance.org
Customer Service = 855.270.2850

or scan the QR code!

In-network providers

Utilizing in-network providers maximizes the benefits available on the medical plan and protects members from balance billing. Contact Alithias for verification of in-network providers.

Employee cost:

Employee Only	Employee + 1	Family
$ 1,003.30 / month	$ 2,006.60 / month	$ 2,708.91 / month
+ $ 30 / weekly payroll deduction	+ $ 57 / weekly payroll deduction	+ $ 82 / weekly payroll deduction

Monthly premium to be deducted from your employee benefit account.

DISCLAIMER: Employees in this plan will have a pre-tax deduction from their paycheck in addition to the monthly deduction from their benefit account. If any adjustments are needed with the deduction, the SCC Payroll Department will communicate with the affected employee on a case by case basis.

Medical Insurance

Allegiance: Plan 2 HSA

	In-Network	Out-of-Network
Deductible *non-embedded	$5,000 / individual $10,000 / family	$7,500 / individual $15,000 / family
Coinsurance	20%	40%
Maximum Out of Pocket *non-embedded	$7,000 / individual $14,000 / family	$13,000 / individual $26,000 / family
Preventive Care	paid at 100% *must be billed as preventive care	deductible + coinsurance
Primary Care Visit	deductible + coinsurance	deductible + coinsurance
Specialist Visit	deductible + coinsurance	deductible + coinsurance
Urgent Care	deductible + coinsurance	deductible + coinsurance
Emergency Room	deductible + coinsurance	
Prescription Drug Advantage Prescription Drug List (PDL)	Tier 1: deductible + coinsurance Tier 2: deductible + coinsurance Tier 3: deductible + coinsurance Tier 4: deductible + coinsurance	

REMINDER

Ask the pharmacy to also run prescriptions through GoodRx to help determine what makes the most sense for your situation.

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Customer Service = 855.270.2850

or scan the QR code!

In-network providers

Utilizing in-network providers maximizes the benefits available on the medical plan and protects members from balance billing. Contact Alithias for verification of in-network providers.

Employee cost:

Employee Only	Employee + 1	Family
$ 871.19	$ 1,758.89	$ 2,352.22

Monthly premium to be deducted from your employee benefit account.

DISCLAIMER: Although employees in this plan generally will not have a pre-tax deduction from their paycheck, there are cases (long layoff or extended time away from work) when a pre-tax deduction could be needed for employees. In those situations, the SCC Payroll Department will communicate with the affected employee on a case by case basis.

2024 Alithias Incentive Offerings

Procedures		Standard Incentive Amount	Midwest Estimated Cost Range	
			Low Cost	High Cost
Mayo Complex Care Program for Complex Diagnosis Procedures: Medical Review and Second Opinion for Cancer, Neck, Back & Spine, Transplants, etc. →		100% Covered		
Infusions: OSMS Green Bay/GI Associates of Milwaukee or SmartScan Rituxan, Orencia, Actemra, Simponi Aria: Example Remicaid		$750	$6,500	>$13,000
Women's Health	Breast Biopsy	$250	$1,500	$8,500
	Hysterectomy	$1,000	$11,500	$34,855
Gastro-Intestinal Colonoscopy (Screening and/or Polyp Removal)		$350	$2,000	>$20,000
Cologuard Screening		$500		
Upper GI (endoscopy with or w/o biopsy)		$350	$1,500	>$10,000
Diagnostic Imaging/Radiology	All CT Scans	$350	$600	$4,600
	MRIs at High-Value Locations- Sensible MRI, SMT, Smart Scan, and many more	$600	$450	$5,400
	Ultrasound	$50	$250	$800
	X-Ray	$50	$70	$250
Ear, Nose and Throat	Nasal/Sinus Septoplasty	$500	$4,400	$17,381
	Sleep Study (at home)	$250	$250	$800
	Sleep Study (in clinic)	$250	$1,400	$4,100
	Tonsilectomy/Adenoids	$500	$4,200	$9,850
	Tympanostomy/Myringotomy (Ear Tubes)	$500	$2,850	$12,891
Allergy/Asthma	Allergy/Asthma Complete Workup	$150	$1,900	$4,550
Cardiology	ECG, ECG with tracing and report	$50	$30	$130
	Doppler ECG	$50	$30	$130
	Cardiovascular Stress Test	$250	$950	$2,680
General Surgery	Gallbladder Removal	$1,000	$9,500	$24,972
	Groin-Hernia Repair>5 years and older	$1,000	$3,900	$19,827
Orthopedics Hand Surgery (Carpal Tunnel)		$500	$3,500	$12,300
Knee Shaving and Debridement (Arthroscopy)		$500	$6,250	$18,430
Knee Meniscus/Cartilage Repair		$500	$6,500	$18,430
Knee Ligament Repair		$1,000	$12,500	$29,000
Shoulder Rotator Cuff		$1,000	$16,500	$39,309
Total Hip Replacement		$3,000	$27,500	>$80,000
Total Knee Replacement		$3,000	$27,500	>$80,000
Spine/Level 1 or 2 Cervical Fusion or Disc Arthroplasty		$3,000	$26,500	>$80,000
Second Opinion for Shoulder/Hip/Knee/Spine done with a Center of Excellence		$500		
Spine Lumbar Fusion		$3,000	$26,500	>$80,000
Urology Kidney Stones-Lithotripsy		$1,000	$9,950	$24,375

**This is not an all-inclusive list of incentive offerings. If the high value option(s) being offered provides a nominal savings opportunity, additional incentives may be offered. Approval of such, required by employer.

Alithias: finding Money30 providers

Step 1

If, you have not already found a Provider or Specialist reach out to Alithias to find an In-network provider to obtain the order or referral.

Step 2

Ask your provider to send a copy of the order to Alithias.
Providers can fax order or referral to: **855-843-8783**
Email the order or referral to:
askme@careadvocacycenter.com

Step 3

Call **855-270-2850** and speak with a Care Advocate to make sure we received the order or referral.
Research can take 1-3 business days to complete, once we have the order or referral.

Step 4

Review your options. You will get an email with your Care Option Report.
Call your Care Advocate if you have any additional questions.
Make a decision and notify Alithias by email or phone.

Step 5

Call Alithias to do survey over phone or submit your survey online. If you are awaiting an incentive, this step will help forward the information to your HR

THE Insurance CENTER

Health Savings Account

(HSA)

A Health Savings Account (HSA) is an employee-owned account meant to pay for healthcare expenses. To maximize the tax benefits of this account, HSA funds must be used for qualified medical, prescription, dental, and/or vision expenses.

Your money rolls over each year and GROWS over time

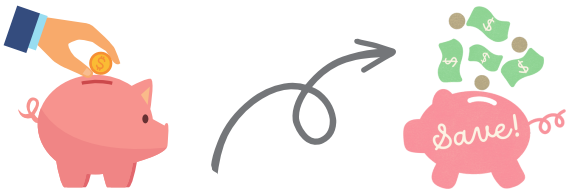
Triple tax benefits...

1. Make contributions to the account (tax-free)
2. Earn interest annually on the account (tax-free)
3. Pay for healthcare expenses (tax-free)

F - L - E - X - I - B - I - L - I - T - Y

to adjust contribution amounts throughout the year

Lower your contribution when you're tight on cash



Increase your contribution when you have more disposable income available

Annual Contribution Allowances

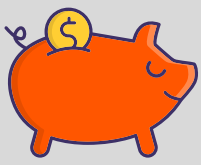
Individual Maximum
2023 = $3,850 / 2024 = $4,150

Family (2+) Maximum
2023 = $7,750 / 2024 = $8,300

Catch-Up Contribution
additional $1,000 for ages 55+

Financial Institution
bank of choice

Take your HSA with you into Retirement



Health Savings Account

OR

Investments/ Mutual Funds

Spend your money on:	That money is:	When can you use it? (without penalty)
Qualified Medical Expenses	TAX FREE	ANYTIME
	TAXED INCOME	AGE 65+

Care Services

Virtual Urgent Care

Getting Started

INTRODUCTION

Access board-certified physicians 24/7, 365 days a year for urgent medical needs. Doctors will discuss your symptoms, confirm a diagnosis, and prescribe any needed medication. Video and telephone-based visits are available, with an average wait time of just ten minutes.

HOW TO ACCESS

01	Sign up with the Recuro Care app or visit the webpage below to access: "member.recurohealth.com"
02	Enter your Allegiance member ID
03	Create your username and password
04	Complete your medical history
05	Schedule your consult

*Registering your account is not required to use the service, you can call 855.6RECURO anytime for 24/7 access to doctors.

Example Conditions Treated

- Acne / Rash
- Allergies
- Cold / Flu
- GI Issues
- Ear Problems
- Fever
- Insect Bites
- Nausea
- Pink Eye
- Respiratory
- UTI's
- And More...

WELLVIA
A RECURO HEALTH COMPANY

customerservice@recurohealth.com | 855.6RECURO | Scan QR Code to Download

Mayo Clinic Complex Care Program

MAYO CLINIC

If you are facing complex health challenges, you may be eligible for care at Mayo Clinic with travel and lodging paid for by your employer.

The Mayo Clinic Complex Care Program is an enhanced health care benefit for:

- Cancer
- Spine health
- Transplant (solid organ and bone marrow transplant)
- Undiagnosed/diagnostic odyssey – conditions for which you've been unable to find answers from other medical providers

STEP 1. Get started

Call Alithias Care Navigators at 855-270-2850 for full details, help with collecting your medical records and to get connected with Mayo Clinic.

STEP 2. Medical review

A Mayo Clinic specialist will review your medical records and determine if you would benefit from care at Mayo Clinic.

STEP 3. Travel to Mayo Clinic for care

Mayo Clinic will call you to coordinate your travel, lodging and appointment itinerary for you and a caregiver.

STEP 4. Return home

After you return home, your local medical provider and Mayo Clinic will work closely to coordinate your ongoing care.

Dental Insurance

Delta

	PPO	Premier
Deductible	$25 / individual $75 / family	$50 / individual $150 / family
Annual Maximum (per person)	$1,000	$1,000
Preventive & Diagnostic Services	100%	100%
Basic Restorative Services	80%, after deductible	80%, after deductible
Major Restorative Services	50%, after deductible	50%, after deductible
Orthodontia (up to age 19)	50% up to $1,000 lifetime maximum	50% up to $1,000 lifetime maximum

Website = www.deltadental.com
Customer Service = 800.236.3712

or scan the QR code!

Preventative Services: Cleanings (prophylaxis), fluoride treatments, space maintainers, sealants, evaluation, bitewing x-rays, and full-mouth x-rays.

Basic Services: Emergency treatment to relieve pain, fillings, simple extractions

Major Services: Oral surgery, crowns, inlays, bridges, dentures, implants

NOTE: Delta Dental offers two networks; PPO and Premier...BOTH save you money! PPO providers offer the lowest agreed upon fees. Premier providers also agree to discounts, just not as deep as the PPO providers; however, the Premier network of providers is much broader. Seeing either a PPO or Premier provider will ensure no balance billing can occur. Balance billing occurs is when you seek treatment from a provider who chooses not to contract with Delta, meaning they are not willing to offer discounted services. If you visit an out of network provider, you will be responsible for the difference between the provider's charges and the amount your plan pays. 9 out of 10 dentists contract with Delta Dental.

Employee cost:

Employee Only	Family
$ 28.24	$ 90.05

Monthly premium to be deducted from your employee benefit account.

Short-Term Disability

The Standard

Coverage is 100% paid for by the employer.

Plan Highlights

Elimination Period
14 days accident
14 days disabling illness

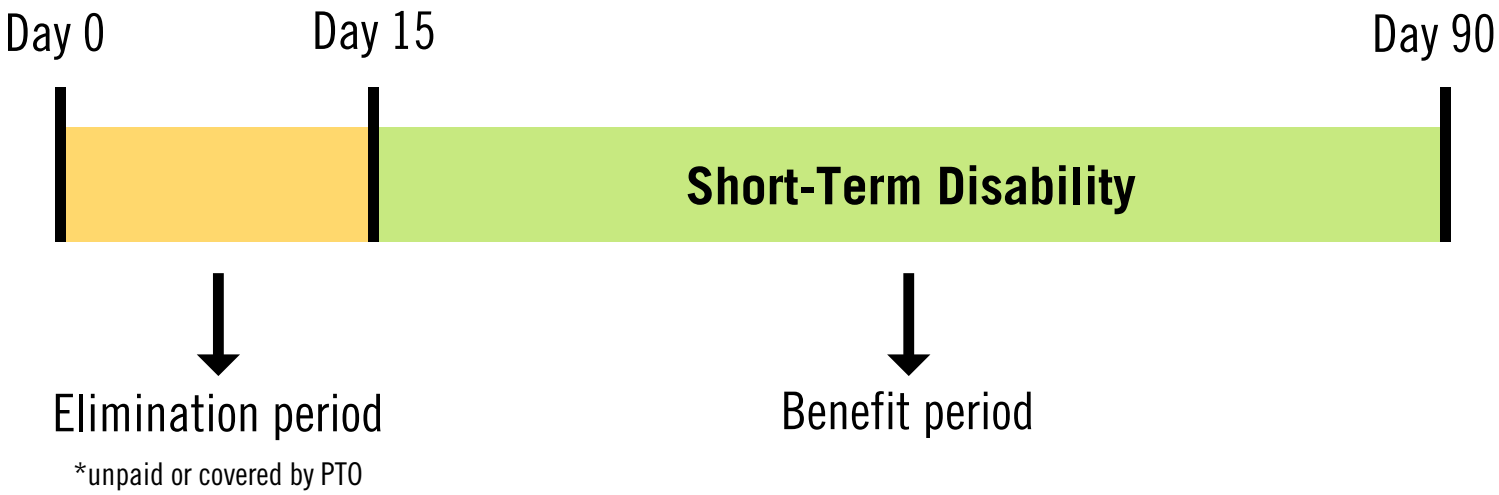
Benefit Payable
70% of pre-disability earnings up to $1,500 per week
*excludes bonuses and overtime

Benefit Duration
up to 90 days

Financial Protection

If you are unable to work due to accident or illness, financial burdens do not take leaves of absences alongside you. Paid time off and short-term disability will help offset loss of income until you're able to return to work or the short-term disability benefit ends.

The plan provides a weekly cash benefit to help maintain expenses such as groceries, utilities, rent/mortgage, vehicle payments, ongoing healthcare, childcare, etc. while you focus on your recovery.



Long-Term Disability

The Standard

Coverage is 100% paid for by the employer.

Plan Highlights

Elimination Period
90 days

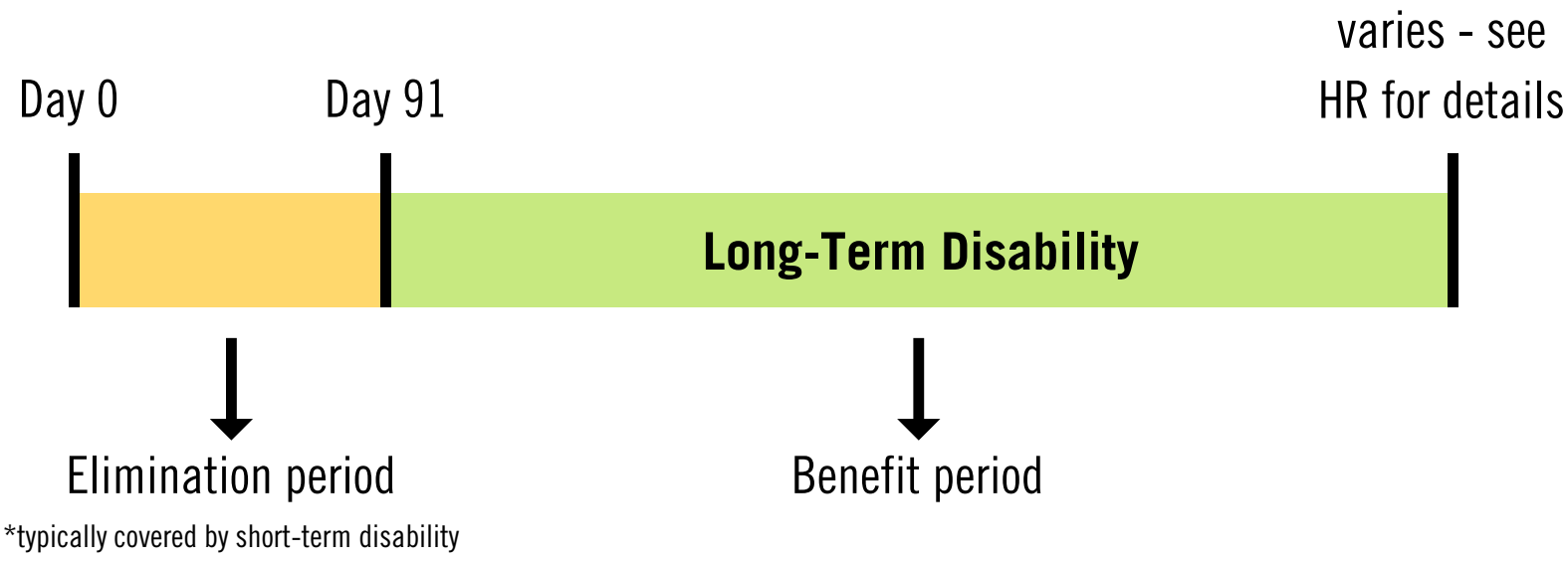
Benefit Payable
60% of pre-disability earnings up to $7,658 per month
*excludes bonuses and overtime

Benefit Duration
varies - see HR for details

Financial Protection

If you are unable to work due to accident or illness, financial burdens do not take leaves of absences alongside you. Long-term disability extends financial assistance beyond the short-term disability benefit duration.

The plan provides a monthly cash benefit to help maintain expenses such as groceries, utilities, rent/mortgage, vehicle payments, ongoing healthcare, childcare, etc. while you focus on your recovery.



*typically covered by short-term disability

Basic Life and AD&D
Employer-Paid Policy

Plan Features

Benefit Amount
$40,000 - employee
$2,000 - spouse
$2,000 - child(ren) through age 20

Age Reduction Schedule
65% of benefit @ age 65
50% of benefit @ age 70+

Accelerated Benefit
This benefit provides an advanced payout of benefits for covered persons who are terminally ill and not expected to live for more than one year. The benefit may be taxable.

Compliance

2024 Government Notices

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS
** CONTINUATION COVERAGE RIGHTS UNDER COBRA**

Note: *Federal COBRA applies to group health plans maintained by private-sector, state, and local government employer with 20 or more employees. Group health plans sponsored by the federal government or churches are exempt from COBRA. For Wisconsin employers, State Continuation applies to insured group health plans providing medical/hospital coverage. Dental, vision, and prescription drug benefits are not subject to state continuation if they are offered as separate policies. Employer self-funded plans are not subject to these requirements. Outside of Wisconsin -refer to your state specific laws or carrier for further information.*

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

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

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage?
COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage may be required to pay for COBRA continuation coverage. Your employer will provide you with the information should you experience a qualifying event.

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

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

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

- Your spouse dies.
- Your spouse's hours of employment are reduced.
- Your spouse's employment ends for any reason other than his or her gross misconduct.
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.
- Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:
- The parent-employee dies.
- The parent-employees' hours of employment are reduced.
- The parent-employee's employment ends for any reason other than his or her gross misconduct.
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both).
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

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

- The end of employment or reduction of hours of employment.
- Death of the employee.
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

How is COBRA Continuation coverage provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. There are also ways in which this 18-month period of COBRA continuation coverage can be extended.

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

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

Are there other coverage options besides COBRA Continuation coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Can I enroll in Medicare instead of COBRA Continuation coverage after my group health plan coverage ends?
In general, if you do not enroll in Medicare Part A or B when are you first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group plan health coverage based on current employment ends

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer), and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare. For more information visit https://www.medicare.gov/medicare-and-you.

Questions concerning your Plan, or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of Address Changes: To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information: Your employer's Human Resource Department or individual in charge of Benefits Administration within your organization.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

Enrollment Notice
If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator for more information.

NOTICE OF PATIENT PROTECTIONS

Under the ACA, group health plans and issuers that require the designation of a participating primary care provider must permit each participant, beneficiary and enrollee to designate any available participating primary care provider (including a pediatrician for children). Additionally, plans and issuers that provide obstetrical/gynecological care and require a designation of a participating primary care provider may not require preauthorization or referral for such care. If a health plan requires participants to designate a participating primary care provider, the plan or issuer must provide a notice of these patient protections whenever the SPD or similar description of benefits is provided to a participant. If your employer's plan is subject to this notice requirement, they will provide this information in the open enrollment materials and/or the Summary Plan Description (SPD).

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2022. Contact your State for more information on eligibility –

IOWA – Medicaid Website: http://dhs.iowa.gov/ime/members Phone: 1-800-338-8366 **CHIP (Hawki):** http://dhs.iowa.gov/Hawki Phone: 1-800-257-8563. HPP Website https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562

WISCONSIN – Medicaid and CHIP Website: https: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

MINNESOTA – Medicaid Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

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

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

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137. Expires 01/31/2023

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE:

When key parts of the health care law took effect in 2014, there is a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace.

What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. The open enrollment period each year for health insurance coverage through the Marketplace runs from Nov. 1 through Dec. 15 of the preceding year. After the open enrollment period ends, you can get coverage through the Marketplace only if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP).

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 8.39% (2024) of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

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

HIPAA PRIVACY INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.

This *simplified notice* describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated
- You can complain if you feel we have violated your rights by contacting your HR Department
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **ww.hhs.gov/ocr/privacy/hipaa/complaints**

We will not retaliate against you for filing a complaint.

Our Uses and Disclosures:
Help manage the health care treatment you receive:
We can use your health information and share it with professionals who are treating you. *Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*

Run Our Organization:
We can use and disclose your information to run our organization and contact you when necessary. We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. *Example: We use health information about you to develop better services and plan design for our company.*

Pay for Your Health Services:
We can use and disclose your health information as we pay for your health services. *Example: We share information about you with your dental plan to coordinate payment for your dental work.*

Administer your Plan:
We may disclose your health information to your health plan sponsor for plan administration. *Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

How Else can we use or Share your Health Information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Our Responsibilities:

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice: We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, or you can request we mail a copy to you. This is a summary of information only.

CONSOLIDATED APPROPRIATIONS ACT DISCLOSURE FOR PLAN MEMBERS

The Consolidated Appropriations Act (CAA) is a comprehensive set of laws that include the No Surprises Act (NSA) and transparency provisions. Plan Sponsors are required to post an NSA Notice in a prominent location in the workplace and/or post a link to the NSA Notice on the searchable home page of their websites. The Department of Labor (DOL) has provided a model notice, which should be used for plan years beginning on or after January 1, 2022.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "Balance Billing" (sometimes called "surprise billing")?
When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or must pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay, and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in- network facility but are unexpectedly treated by an out-of-network provider.

You are Protected from Balance Billing for:
Emergency Services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain Services at an In-Network Hospital or Ambulatory Surgical Center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.
If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're <u>never</u> required to give up your protection from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When Balance Billing isn't Allowed, you also have the Following Protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  Cover emergency services by out-of-network providers.
  Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the Department of Health and Human Services to reach the entity responsible for enforcing the federal balance or surprise billing protection laws at 1-800-985-3059.
Visit https://www.cms.gov/nosurprises for more information about your rights under federal law.

staab construction corporation

100% EMPLOYEE OWNED