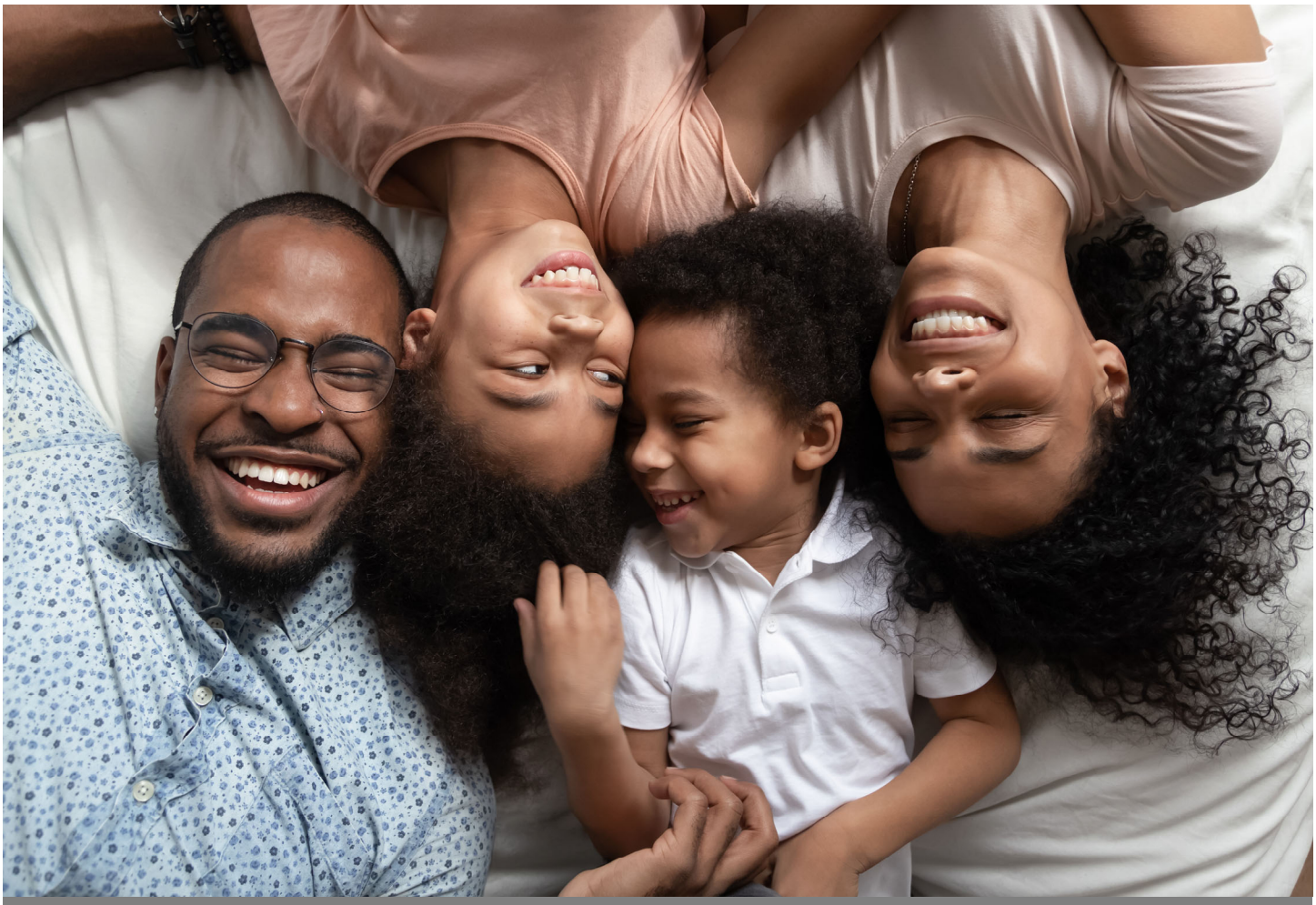

2024

Benefit Summary

SGMC HEALTH

CONTENTS & CONTACT INFORMATION

HUMAN RESOURCES

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Table of Contents

BENEFIT INFORMATION

Your Benefits Plan

SGMC offers a variety of benefits allowing you the opportunity to customize a benefits package that meets your personal needs.

In the following pages, you'll learn more about the benefits offered. You'll also see how choosing the right combination of benefits can help protect you and your family's health and finances – and your family's future.

Benefit	Who pays the cost?
Medical	Full-Time and Part-Time eligible employees: SGMC pays a portion of the medical premium and the remainder is deducted from your paycheck over the course of the year.
Dental	Full-Time eligible employees: SGMC pays a portion of the dental premium and the remainder is deducted from your paycheck. Part-Time eligible employees: SGMC offers dental coverage on a voluntary basis so the full dental premium amount will be deducted from your paycheck over the course of the year.
Vision	Full-Time and Part-Time eligible employees: SGMC offers vision coverage on a voluntary basis so the full vision premium amount will be deducted from your paycheck over the course of the year.
Basic Life & Basic Disability	Full-Time employees: SGMC covers 100% of the cost of your basic life and basic long-term disability.
Supplemental Life & Disability	Full-Time employees: SGMC offers supplemental life and disability insurance along with spouse and child life on a voluntary basis. So the full cost of the premium will be deducted from your paycheck over the course of the year.
Voluntary Benefits	Full-Time employees: SGMC offers accident, cancer, universal/whole life insurance and other worksite benefits on a voluntary basis. So the full cost of the premium will be deducted from your paycheck over the course of the year.

PRE-TAX BENEFITS

Choosing Your Benefits

The premium for elected coverages are taken from your paycheck automatically. There are two ways that the money can be taken out, pre-tax or post – tax.

Why do I pay for Benefits with Pretax Money?

There is a definite advantage to paying for some benefits with pre-tax money. Taking the money out before your taxes are calculated lowers the amount of your pay that is taxable. Therefore, you pay less in taxes.

Which benefit premiums are taken before tax?

PRE tax
Medical, Dental, and Vision

POST tax
Voluntary Life and Worksite

ELIGIBILITY

All regular full-time employees are eligible to enroll in benefits as soon as they are hired. All benefits, including the 401k, will begin the first of the month following the date of hire. “Regular Full-Time Employees” must be regularly scheduled and working at least 30 hours per week in a fulltime status. You may also enroll your dependents in benefits when you enroll.

All part-time employees working 20 hours per week regularly are eligible to enroll in Medical, Dental and Vision benefits first of the month following date of hire. You may also enroll your dependents in benefits when you enroll.

Who is an eligible dependent?

- Your legal spouse
- Your married or unmarried natural children, step-children living with you, legally adopted child(ren) and any other child(ren) for whom you have legal guardianship, up to age 26.

When can you enroll?

You can sign up for Benefits at any of the following times:

- As a new hire, at your initial eligibility date.
- During the annual open enrollment period, each year.
- Within 30 days of a qualified family-status change.

If you do not enroll at one of the above times, you may enroll during the next annual open enrollment period.

MAKING CHANGES

Generally, you can only change your benefit elections during the annual benefits enrollment period. However, you may be able to change your benefit elections during the plan year if you have a change in status including:

- Your marriage or divorce
- Birth or adoption of an eligible child
- Death of your spouse or covered child
- Change in your spouse’s work status that affects your benefits
- Change in your work status that affects your benefits
- Change in residence that affects your eligibility for coverage
- Change in your child’s eligibility for benefits
- Receiving Qualified Medical Child Support Order (QMCSO)

You must notify and provide SGMC with the necessary documentation within 30 days from the life event. The IRS allows changes to be made within 60 days for those eligible for Medicaid or CHIPRA under HIPAA Special Enrollment Rights.

If you fail to do so you will be required to wait until the next annual enrollment period to make benefit changes unless you have another family status change.

WHEN DOES COVERAGE END?

Coverage will end at the end of the month following termination or change to a non-benefit eligible status.

MEDICAL INSURANCE

SGMC offers both a PPO plan and a high-deductible health plan. While a high deductible health plan offers up front savings on premiums as well as additional (pre-tax) Health Savings Account (HSA) contribution options, it may not be the best option for everyone. So, which plan is right for you? Compare your options using the chart on the following page.

MEDICAL INSURANCE (cont'd)

PLAN	PPO Plan			HDHP		
DEDUCTIBLE	**SGMC Provider**	**In-Network**	**Out of Network**	**SGMC Provider**	**In-Network**	**Out of Network**
Single	$500	$2,000	$7,000	$2,000	$3,500	$7,000
Family	$1,000	$4,000	$14,000	$4,000	$7,000	$14,000
MAXIMUM OUT-OF-POCKET						
Single/Family	$6,600/$13,200	$8,550/$17,100	Unlimited	$6,000/$12,000	$7,000/$14,000	Unlimited
Maximum Out-of-Pocket Includes: Deductible, Coinsurance & Copayments (including prescription copays)						
WELLNESS						
Wellness, Immunizations, & Mammography/Colonoscopy	Covered 100% as part of an annual wellness screening					
COPAYMENTS						
Primary Care	$30 copay	$30 copay	50%	Deductible and Co-insurance		
Specialist	$60 copay	$60 copay	50%	Deductible and Co-insurance		
Urgent Care	$30 copay	$75 copay	50%	Deductible and Co-insurance		
Emergency Department (copay applies to facility, copay waived if admitted within 24 hours).	100% after $250 copay ($500 copay if non-emergency			90% after Deductible		
DIAGNOSTIC SERVICES (outpatient)						
Lab	90% after $30 copay	80% after deductible	50% after deductible	90% after deductible	80% after deductible	50% after deductible
X-Ray	90% after $30 copay	80% after deductible	50% after deductible	90% after deductible	80% after deductible	50% after deductible
Major	90% after $200 copay	80% after $400 copay	50% after deductible	90% after deductible	80% after deductible	50% after deductible
PRESCRIPTIONS						
Rx Deductible (Single/Family)	$50/$100			$2,000/$4,000 (medical and Rx combined)		
RETAIL						
Generic	$10 copay	80% after deductible	50% after deductible	90% after deductible	80% after deductible	Not covered
Formulary (Brand Name)	Greater of $25 or 20% (max of $100)	80% after deductible	50% after deductible	90% after deductible	80% after deductible	Not covered
Non-Formulary	90% after $200 copay	80% after $400 copay	50% after deductible	90% after deductible	80% after deductible	Not covered
Specialty Drugs	20% coinsurance up to $200 max	Not covered	Not covered	90% after deductible	80% after deductible	Not covered

Deductible and Out of Pocket Max for tiers 1 and 2 (SGMC's Domestic Network and the Anthem BCBS Network) cross accumulate. Tier 3 does not cross accumulate. Deductible for the High Deductible Health Plan is non-embedded. SGMC Pharmacy also offers Walmart price match for certain drugs ($4 for 30-day supply, $10 for 90-day supply)

WHAT YOU WILL PAY FOR COVERAGE (per pay period)

PPO Plan

	Full-Time		Part-Time	
	Non-tobacco rates	Tobacco rates	Non-tobacco rates	Tobacco rates
Employee Only*	$62.96	$132.19	$125.92	$195.15
Employee + Child(ren)*	$104.82	$174.05	$209.64	$278.87
Employee + Spouse*	$141.89	$211.12	$283.78	$353.01
Family*	$189.24	$258.47	$378.48	$447.71

High Deductible Health Plan

	Full-Time		Part-Time	
	Non-tobacco rates	Tobacco rates	Non-tobacco rates	Tobacco rates
Employee Only*	$43.57	$50.00	$87.14	$156.37
Employee + Child(ren)*	$83.92	$153.15	$167.84	$237.07
Employee + Spouse*	$124.77	$194.00	$249.54	$318.77
Family*	$172.55	$241.78	$345.10	$414.33

* Tobacco users subject to $75 surcharge (per-pay-period). If your spouse has other coverage available there is a $75 surcharge (per-pay-period).
If any discrepancy exists between this communication and the official plan document, the plan document will prevail.

CVS caremark™

Your prescriptions

Get the most from your medication.

Taking your medication as directed helps you get and stay as healthy as possible. These tips can keep you on track.

Fill your prescriptions on time. We offer convenient options for filling your medication so you never run out. Choose the one that's right for you.

- **Pick up your refills at any CVS Pharmacy®.** With more than 9,900 locations, there's always one nearby
- **Have refills delivered to your door.** You'll pay just one copay* for a 90-day supply with no-cost shipping from CVS Caremark® Mail Service Pharmacy
- **Let us manage your refills.** Sign up for automatic refills at **Caremark.com** or in our mobile app

Stick to the schedule prescribed by your doctor. This helps your medication do its job and prevents hospital visits. Talk to your doctor or pharmacist if you have questions.

Start a reminder system. Set your mobile device or computer to tell you when it's time to take your medication. Writing reminders on sticky notes or your calendar works, too.

Get help for side effects.

If you experience side effects, don't stop taking your medication. Call your doctor, talk to a pharmacist at CVS Pharmacy or contact a pharmacist with the *Ask a Pharmacist tool* at **Caremark.com**.

For savings opportunities and personalized support, visit Caremark.com (after your benefits begin).

*Copayment, copay or coinsurance means the amount a member is required to pay for a prescription in accordance with a Plan, which may be a deductible, a percentage of the prescription price, a fixed amount or other charge, with the balance, if any, paid by a Plan.
Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.
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HEALTH SAVINGS ACCOUNT (HSA)

What is a HDHP?

A High Deductible Health Plan or HDHP is a health plan that has a lower premium cost and pays no benefit until a higher annual deductible is met. Once the annual deductible is met, you will be responsible for copays and coinsurance until you reach the out- of-pocket maximum. You must be enrolled in a qualified HDHP in order to have an HSA.

What is an HSA and how does it work?

An HSA, is a bank account that can be used to pay for out of pocket health expenses. You will receive a debit card to pay for eligible expenses or you may submit receipts for reimbursement. You can make pre-tax contributions via payroll deduction.

Money in your HSA can be used to pay any out-of-pocket expenses incurred prior to your medical plan's annual deductible being met or other eligible health, vision, or dental expenses.

unlike an FSA, you can change your payroll deductions for the HSA during the year. For 2024, combined employee contributions cannot exceed $4,150 for individuals or $8,300 for families. Anyone over age 55 can add an additional $1,000 for catch-up contributions.

What expenses apply toward my plan deductible?

Even though HSA funds can be used for other qualified expenses (for example, orthodontia) only medical expenses covered by your medical plan apply towards your plan deductible.

Who verifies that my HSA was used for qualified expenses?

Save your receipts - in the event of an IRS audit, you are responsible for providing documentation to the IRS.

Do doctors require payment at the time of service?

Most network physicians will bill luminare Health first and then bill you for your adjusted costs.

What happens to my HSA if I never withdraw funds, change jobs, or retire?

Funds in your HSA are yours, even if you change employers or retire. The less that you spend on current medical expenses, the more money that stays in your account accumulating interest. Under IRS guidelines, HSAs are treated like IRAs. HSA funds are never taxed or penalized if they are used for qualified medical expenses. Funds can be withdrawn for any reason, without penalty, once you reach age 65.

Can I have an HSA and an FSA?

You cannot have an HSA and Health Care FSA;
however, you can have a dependent care FSA and an HSA .

Key Features:

You decide how and when to use the money in your HSA: pay for the qualified expenses during the year, save it for future needs or open an investment account.

SGMC Contributes the first $500 for individuals, and $1,000 for those with dependents on the high deductible health plan.

SGMC's contribution will be available following the first pay day of 2024, individual contributions are available as they are deducted.

FLEX SPENDING ACCOUNT (FSA)

A Flexible Spending Account (FSA) is a smart way to manage your share of the costs for healthcare and dependent care expenses.

SGMC offers Flexible Spending Accounts (FSA) administered by Luminare Health for all benefit eligible employees. When you establish an FSA, you set aside pre-tax dollars to pay for certain expenses. This reduces your taxable income and you can request reimbursement as you incur eligible expenses.

You may contribute up to $3,200 per calendar year to pay for out-of-pocket medical, prescription, drug, dental, and vision care expenses for yourself and your eligible family members - even if you do not cover your family members under the SGMC health plan. You can also use this FSA to pay expenses such as orthodontia expenses not covered by your dental plan, prescription drugs, prescription glasses and contact lenses, as well as laser eye surgery.

Healthcare Flex Spending accounts are pre-funded by SGMC, the funds are available at the beginning of the plan year and contributions are deducted from each payroll.

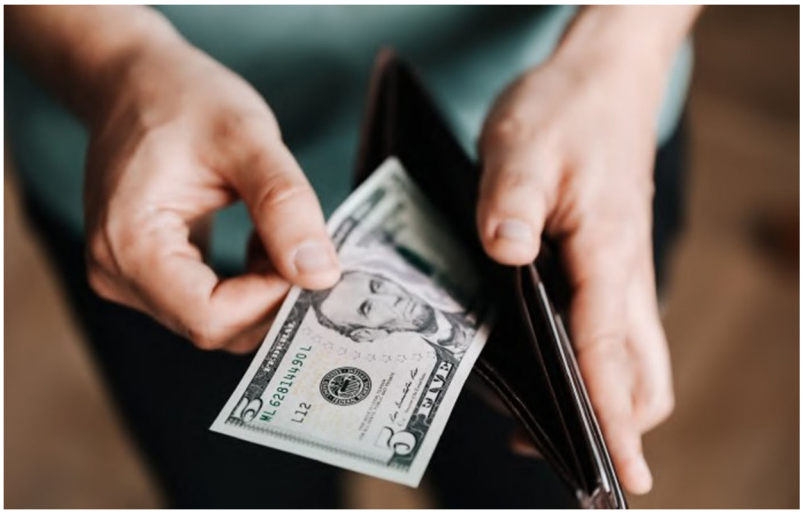
Please note: Due to IRS regulations the Healthcare FSA is not available to employees enrolled in the HSA.

A full description of qualified FSA expenditures can be found in IRS Publication 502 and is located on the web at www.irs.gov/pub/irs-pdf/p502.pdf

DEPENDENT CARE SPENDING ACCOUNT

The Dependent Care Spending Account is a pre-tax account for elder care and childcare expenses. You may set aside up to $5,000 pre-tax to pay for eligible dependent care expenses ($2,500 if you are married filing taxes separately). The child or elder care provider must declare the income on his/her tax return for dependent care services provided. You may use the dependent care spending account only to pay for dependent care that is required to allow you and your spouse to be gainfully employed.

If you enroll, payroll deductions will occur for the prorated amount each pay period. Money that you contribute to your FSA is considered pre-tax and is not subject to social security, federal, and in most cases, state income tax.



Use it or lose it!

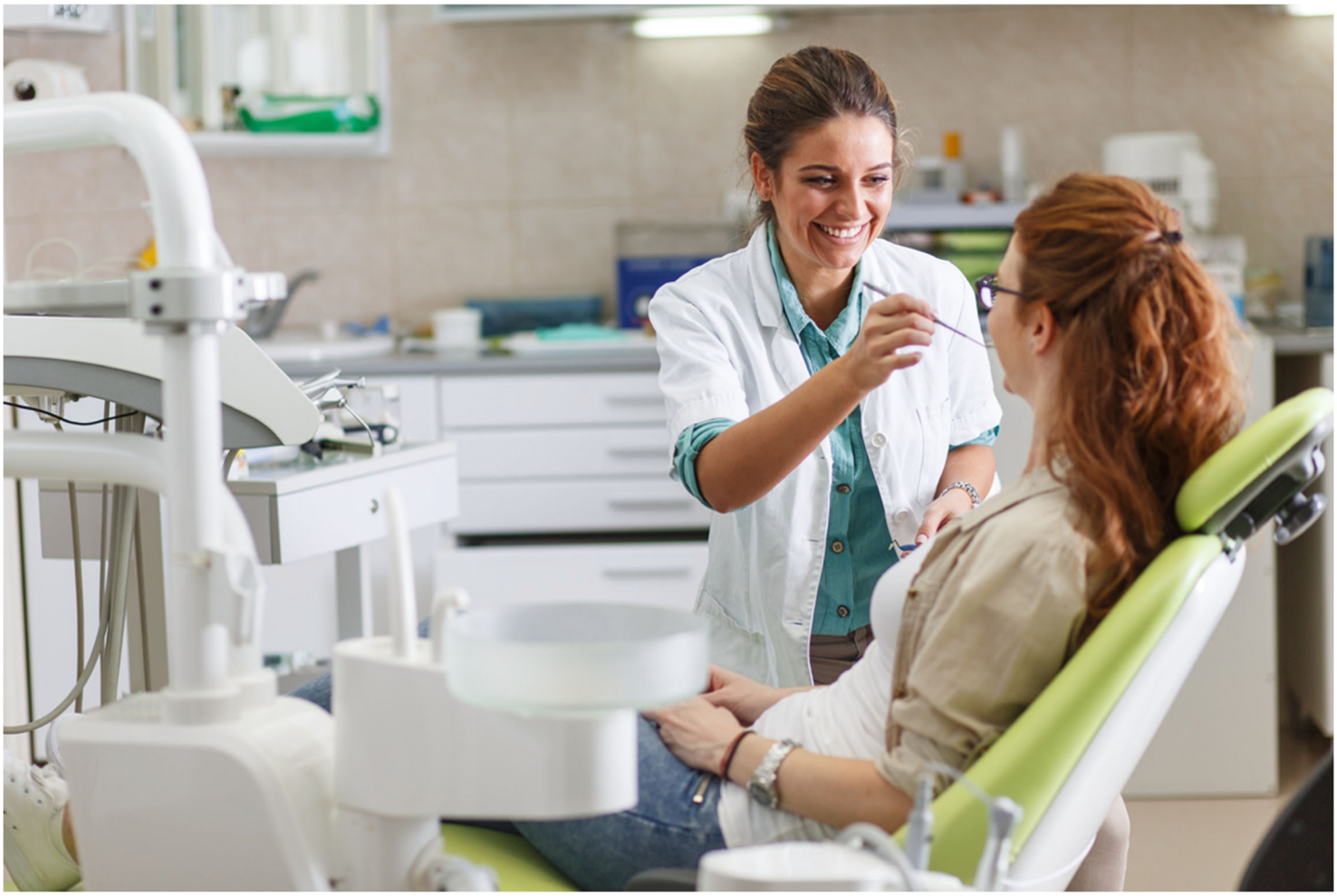
It's important to consider your expenses when determining your annual contribution amount. Any unused funds in your FSA at the end of the year do not roll over to the next.

DENTAL INSURANCE

Guardian offers the choice between two dental options. The High Dental Plan provides an annual maximum of $2000 and includes Orthodontia coverage. The Low Dental Plan offers an annual maximum of $1,000, and does not include orthodontia. Both plans allow you to use in-network and out-of-network benefits. If out-of-network dentists are used, you will be responsible for the difference between Guardian's allowed amount and what the dentist may charge, also known as “balance billing”. The charts on the following pages provide a brief overview of the plans.

Full Time Rates (per Pay period)		
	Dental Low	Dental High
Employee Only	$10.56	$15.55
Employee + 1	$21.10	$31.05
Employee + Family	$34.89	$51.34

Part Time Rates (per Pay period)		
	Dental Low	Dental High
Employee Only	$11.46	$16.86
Employee + 1	$22.83	$33.59
Employee + Family	$37.70	$55.48



Guardian®

Your dental coverage

Option 1 or 2: PPO plan, you'll have access to one of the largest networks of dentists with two reimbursement levels that give you more control over savings. You will always save money with any dentist in Guardian's network and when they belong to a tier in the Tier 1 reimbursement level you will maximize your savings. Reimbursement for covered services received from a non-contracted dentist will be based on a percentile of the prevailing fee data for the dentist's zip code.

Your Dental Plan	**Option 1: PPO**		**Option 2: PPO**	
	Tier 1	Tier 2	Tier 1	Tier 2
Your Network is DentalGuard Preferred Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Calendar year deductible	*Tier 1*	*Tier 2*	*Tier 1*	*Tier 2*
Individual	$50	$50	$50	$50
Family limit	3 per family (applies to all levels)		3 per family (applies to all levels)	
Waived for	Preventive	Preventive	Preventive	Preventive
Charges covered for you (co-insurance)	*Tier 1*	*Tier 2*	*Tier 1*	*Tier 2*
Preventive Care	100%	100%	100%	100%
Basic Care	80%	80%	80%	80%
Major Care	50%	50%	50%	50%
Orthodontia	50%	50%	Not Covered (applies to all levels)	
Annual Maximum Benefit	$2000 (applies to all levels)		$1000 (applies to all levels)	
Maximum Rollover	Yes (applies to all levels)		Yes (applies to all levels)	
Rollover Threshold	$800		$500	
Rollover Amount	$400		$250	
Rollover Account Limit	$1500		$1000	
Lifetime Orthodontia Maximum	$1500 (applies to all levels)		Not Applicable (applies to all levels)	
Dependent Age Limits	26 (applies to all levels)		26 (applies to all levels)	

Guardian®

Your dental coverage

A Sample of Services Covered by Your Plan:

		Option 1: PPO *Plan pays (on average)*		Option 2: PPO *Plan pays (on average)*	
		Tier 1	Tier 2	Tier 1	Tier 2
Preventive Care	Cleaning (prophylaxis)	100%	100%	100%	100%
	Frequency:	2 per calendar year (applies to all levels)		2 per calendar year (applies to all levels)	
	Fluoride Treatments	100%	100%	100%	100%
	Limits:	Under Age 19 (applies to all levels)		Under Age 19 (applies to all levels)	
	Oral Exams	100%	100%	100%	100%
	Sealants (per tooth)	100%	100%	100%	100%
	X-rays	100%	100%	100%	100%
Basic Care	Anesthesia*	80%	80%	80%	80%
	Fillings‡	80%	80%	80%	80%
	Perio Surgery	80%	80%	50%	50%
	Periodontal Maintenance	80%	80%	80%	80%
	Frequency:	2 per calendar year (applies to all levels)		2 per calendar year (applies to all levels)	
	Root Canal	80%	80%	80%	80%
	Scaling & Root Planing (per quadrant)	80%	80%	80%	80%
	Simple Extractions	80%	80%	80%	80%
	Surgical Extractions	80%	80%	50%	50%
Major Care	Bridges and Dentures	50%	50%	50%	50%
	Dental Implants	50%	50%	50%	50%
	Inlays, Onlays, Veneers**	50%	50%	50%	50%
	Repair & Maintenance of Crowns, Bridges & Dentures	50%	50%	50%	50%
	Single Crowns	50%	50%	50%	50%
Orthodontia	Orthodontia	50%	50%	Not Covered	
	Limits:	Adults & Child(ren) (applies to all levels)		(applies to all levels)	

Guardian's Preferred Provider Organization consists of Dentists in the DentalGuard Preferred ("DGP") network. These tiers represent specific benefit levels as described in Your Schedule of Benefits. Network access varies by geographic location and zip code. Please visit www.Guardianlife.com to confirm your Dentist's tiered participation.

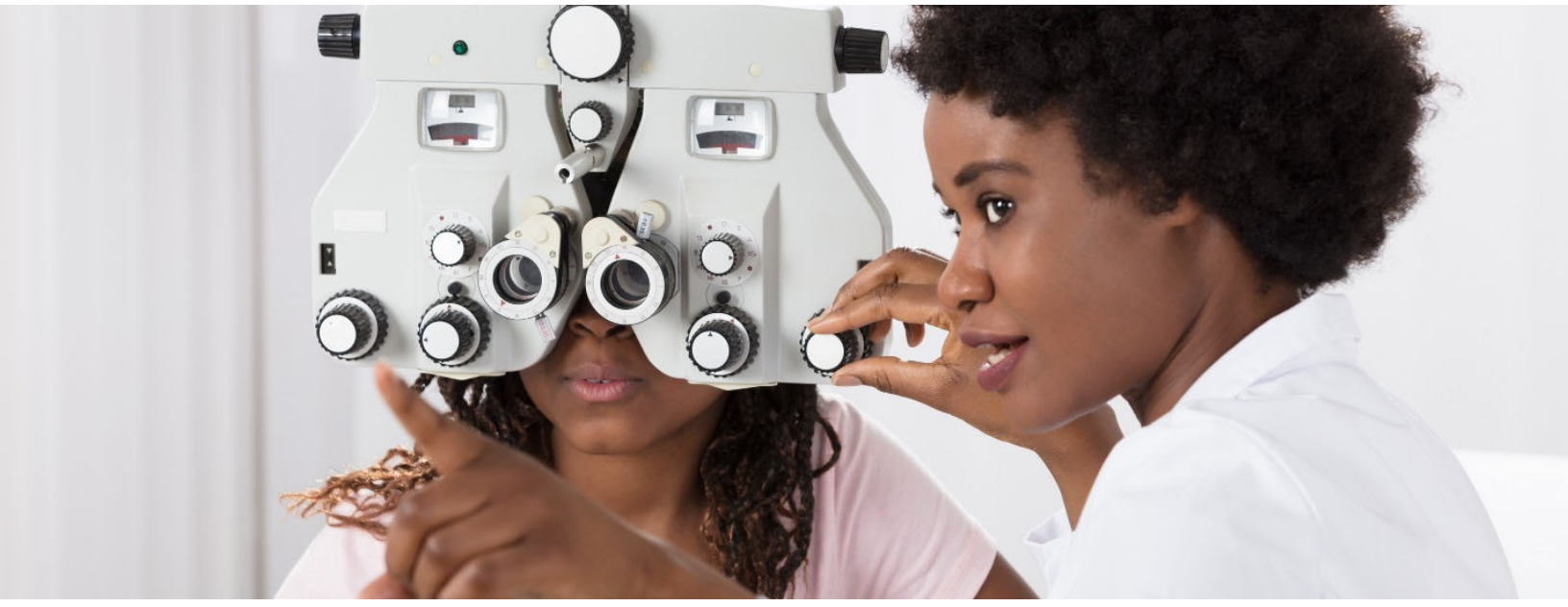
This is only a partial list of dental services. Your certificate of benefits will show exactly what is covered and excluded. **For PPO and or Indemnity members, Crowns, Inlays, Onlays and Labial Veneers are covered only when needed because of decay or injury or other pathology when the tooth cannot be restored with amalgam or composite filing material. When Orthodontia coverage is for "Child(ren)" only, the orthodontic appliance must be placed prior to the age limit set by your plan; If full-time status is required by your plan in order to remain insured after a certain age; then orthodontic maintenance may continue as long as full-time student status is maintained. If Orthodontia coverage is for "Adults and Child(ren)" this limitation does not apply. *General Anesthesia – restrictions apply. ‡For PPO and or Indemnity members, Fillings – restrictions may apply to composite fillings.

VISION INSURANCE

SGMC has partnered with Guardian for vision insurance, their national network of both independent and retail optometrists, ophthalmologists, and opticians makes it easy to find the right provider for your eye care needs.

To find a provider go to guardiananytime.com/registration/ and click on “Provider Search” at the top of the page. Choose to search by Location, Office, or individual doctors.

What you will pay for Vision Coverage (per Pay period)	
Full time and Part-time Eligible rates	
Employee Only	$4.05
Employee + 1	$6.25
Employee + Family	$8.57



Guardian®

Your vision coverage

Option 1: Significant out-of-pocket savings available with your **Full Feature** plan by visiting one of VSP's network locations, including one of the largest private practice provider networks, Visionworks and contracted Pearle Vision locations.

Your Vision Plan	**Full Feature**	
Your Network is	VSP Choice Network	
Copay		
Exams Copay	$ 10	
Materials Copay *(waived for elective contact lenses)*	$ 20	
Sample of Covered Services	*You pay (after copay if applicable):*	
	In-network	*Out-of-network*
Eye Exams	$0	Amount over $39
Single Vision Lenses	$0	Amount over $23
Lined Bifocal Lenses	$0	Amount over $37
Lined Trifocal Lenses	$0	Amount over $49
Lenticular Lenses	$0	Amount over $64
Frames	80% of amount over $200[1]	Amount over $46
Costco, Walmart and Sam's Club Frame Allowance	Amount over $110	
Contact Lenses *(Elective)*	Amount over $200	Amount over $100
Contact Lenses *(Medically Necessary)*	$0	Amount over $210
Contact Lenses *(Evaluation and fitting)*	15% off UCR	No discounts
Cosmetic Extras	Avg. 20-25% off retail price	No discounts
Glasses *(Additional pair of frames and lenses)*	20% off retail price**	No discounts
Laser Correction Surgery Discount	Up to 15% off the usual charge or 5% off promotional price	No discounts
Service Frequencies		
Exams	Every calendar year	
Lenses *(for glasses or contact lenses)*‡‡	Every calendar year	
Frames	Every two calendar years‡‡‡	
Network discounts *(glasses and contact lens professional service)*	Limitless within 12 months of exam.	
Dependent Age Limits	26	
To Find a Provider:	Register at VSP.com to find a participating provider.	

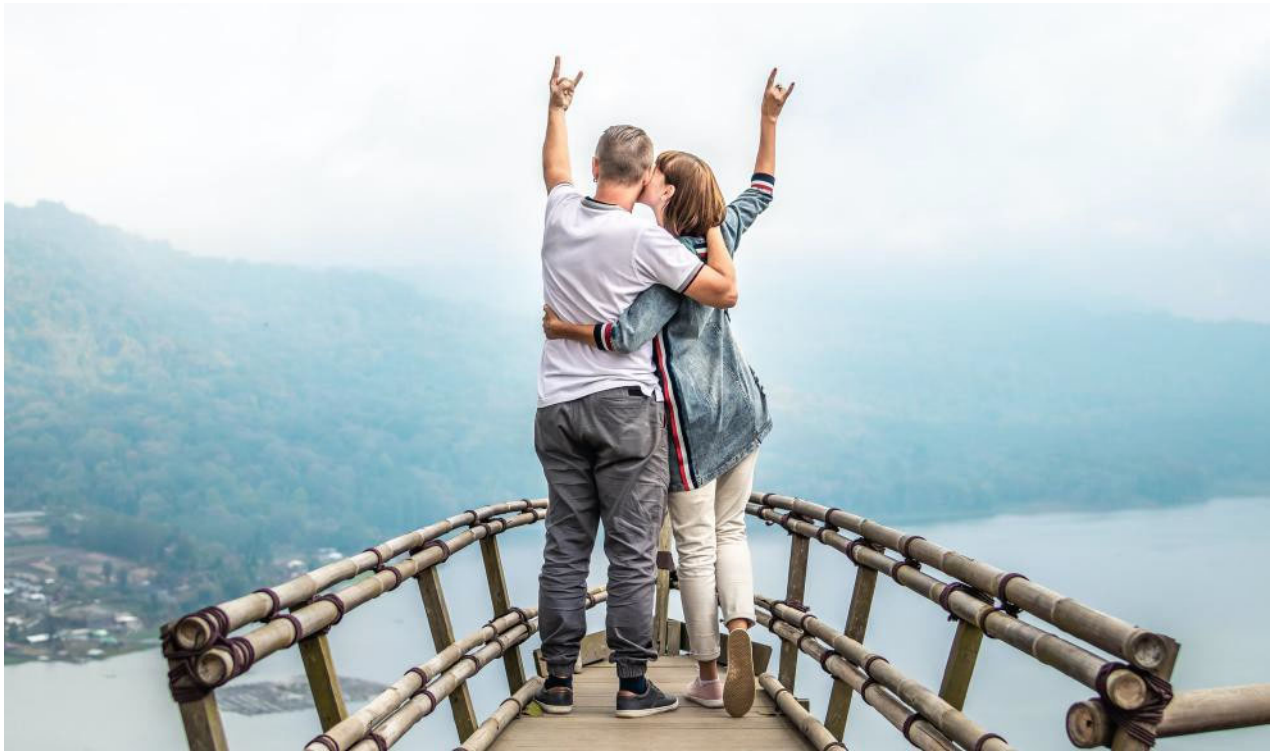
VSP

- ‡‡Benefit includes coverage for glasses or contact lenses, not both.
- ** For the discount to apply your purchase must be made within 12 months of the eye exam.

LIFE AND DISABILITY INSURANCE

Nothing is more important than family. That is why SGMC wants to ensure that your family is protected in every situation. SGMC provides all full-time and part-time employees with basic life insurance equal to 2x your base salary* beginning on the first of month after date of hire. SGMC pays 100% of all enrollment costs. You name the beneficiary of your choosing and change it as needed.

You may also elect to purchase additional term life and AD&D insurance for yourself as well as your eligible dependents. Employees can purchase 2 x salary to a maximum of $800,000.00. You can elect one of the spouse options, $25,000 or $50,00 and dependent children $10,000.



EMPLOYEE

How much Life Insurance can I purchase?

You may purchase additional life insurance at either 2x your base salary with additional AD&D up to $800,000.

What's Guarantee Issue?

Guarantee Issue (GI) is the amount you can purchase as a newly eligible employee without having to provide evidence of good heath (aka Evidence of Insurability, or EOI). The GI is $300,000 for both basic and supplemental insurance,

*Basic life insurance is calculated off of base salary, excluding any overtime or bonus pay. Policy limits apply.

When would I need to show evidence of good health to get life insurance?

If you elect a benefit over GI, a benefit outside of your newly eligible period, or an increase to your current benefit for you and/or your spouse you will be required to provide a Statement of Health (SOH). Completed SOHs should be submitted directly to Guardian.

If you elect voluntary life coverage for yourself, you may also purchase voluntary life insurance for your spouse and/or child(ren).

SPOUSE

How much life insurance can I purchase for my spouse?

You may purchase either $25,000 or $50,000 of coverage.

What's Guarantee Issue?

Guarantee Issue (GI) is the amount you can purchase as a newly eligible employee without having to provide evidence of good health (aka Evidence of Insurability or Statement of Health). The GI is $25,000 for spouses.

CHILD(REN)

How much life insurance can I purchase for my children?

You may purchase a benefit of $10,000 at a fixed rate of $0.61 per pay period.

If you elect life coverage for a child you must cover all eligible children, the cost to cover one child is the same for multiple children.

LIFE AND DISABILITY (cont'd)

SHORT TERM DISABILITY

SGMC offers a choice of two Short-Term Disability plans, one with a 7-day waiting period the other with a 14-day waiting period. Short-Term Disability provides income replacement if you are unable to work due to Accident, Injury, or Illness.

	How it Works	Who Pays for the Benefit
Short-term Disability Option 1	You receive 60%% of your income up to $1,300 per week. Benefits begin on 8th calendar days for Accident/Sickness of absence from work and continue for up to 25 weeks.	Employee
Short-term Disability Option 2	You receive 60%% of your income up to $1,300 per week. Benefits begin on 15th calendar days for Accident/Sickness of absence from work and continue for up to 24 weeks.	Employee

LONG TERM DISABILITY

Long Term Disability (LTD) provides income replacement if you are unable to work due to Accident, Injury, or Illness and covers you until age 65 or Social Security Normal Retirement Age.

SGMC offers a CORE LTD plan and a BUY-UP LTD Plan. SGMC covers the cost of the CORE Plan while giving employees the option to purchase the BUY-UP LTD Plan.

The CORE LTD plan provides a benefit percentage of 40% of your pre-disability monthly earnings after you meet the 90 day elimination period. The BUY-UP LTD plan provides a benefit percentage of 60% of your pre-disability monthly earnings after a 90 day elimination period.

Pre-Existing Conditions

You may not be eligible for disability benefits if you have received treatment for a condition within 3 months prior to your effective date under this policy until you have been covered under the policy for 6 months.

	How it Works	Who Pays for the Benefit
Core LTD	You receive 40% of your income up to $12,000 per month. Benefits begin after 90 calendar days of absence from work and continue until you reach the Social Security Normal Retirement Age or later of age 65.	Company
BUY-UP LTD	You receive 60% of your income up to $12,000 per month. Benefits begin after 90 calendar days of absence from work and continue until you reach the Social Security Normal Retirement Age or later of age 65.	Employee

RETIREMENT

401k

SGMC has partnered with Fidelity Investments to offer a 401k with an employer match of 50% up to the first 4% that you contribute. Full-time benefit eligible employees can begin contributing to the 401k as soon as the first of the month following their date of hire.

SGMC's employer match is vested at 20% per year, employees are 100% vested at five years. Visit netbenefits.com or call 800-343-0860 to begin contributing today.

457b

SGMC also offers a 457b which allows additional tax deferred contributions. The 457b has no employer match and is subject to certain IRS contribution limits. Email benefits@ sgmc.org or call 229-259-4704/4714 for more information.

Both the 401k and 457b are subject to IRS Defined Contribution plan limits and thresholds which may change from year-to-year. For the 2024 calendar year employees may defer a maximum of $23,000 to both the 401k and 457b. Those 50 and older can contribute an additional $7,500 "catch-up" contribution.

WORKSITE

The below benefits are offered to you through Taylor Insurance. These benefits are available to you on a voluntary basis, with the premium deducted from your paycheck. If you enroll in these plans you'll have the opportunity to enroll your spouse and/or child (ren). Premiums vary by employee and policies selected.

Critical Illness

Critical Illness insurance offers the protection you need to focus on what is most important: your treatment, care, and recovery. Conditions covered under this program include heart attack, stroke, cancer, bypass surgery, a $100 wellness benefit, advanced Alzheimer's, major organ transplant, end stage renal failure, advanced Parkinson's disease, benign brain tumor, complete blindness, complete loss of hearing, and paralysis. Benefits are paid tax- free in a lump sum and can choose a benefit of $10,000, $20,000, or $30,000.

GAP Insurance

GAP Insurance provides coverage that fills in the gaps left by health insurance and for all in-patient ($2,000) and out-patient ($1,000) covered events, excluding doctor's office visit co-pays and Rx charges. Benefits are typically paid directly to the provider based on the out-of-pocket expenses according to the EOB.

Whole Life Insurance

Allstate Benefits Whole Life Insurance provides a lump sum benefit upon death. The coverage offers fully guaranteed premiums payable to age 95 and cash value that can be used along the way. Plus, included policy riders provide coverage for terminal illness, premium waiver for total disability, long-term care and more.

- Coverage is available up to $250,000
- Fund value accumulation allows for loans when needed
- Family coverage is available
- Portable—take it with you if you leave SGMC or retire

Accident Insurance

Accident Insurance helps lessen the financial pain of deductibles, co-pays and out-of-pocket costs related to an accidental injury.

- Benefits are paid to you in addition to other coverage you may have
- Benefits cover injuries that result from accidents that happen on or off the job
- Coverage includes a benefit for office visits and wellness visits
- Two options to choose from – High or Low.

Cancer Insurance

Being diagnosed with cancer or a specified disease can be difficult on anyone, both emotionally and financially. Having the right coverage to help when sickness occurs or when undergoing treatments for cancer is important. Cancer coverage can help provide added financial security when it is needed most. Allstate Benefits group voluntary cancer coverage provides cash benefits for cancer and 29 specified diseases. This coverage can help cover the costs of specific and specified disease treatments and expenses as they happen.

- Select Silver, Gold or Platinum coverage levels
- Benefit is paid at the initial diagnosis of cancer and with a treatment reimbursement schedule
- $100 Annual Wellness Benefit – payable even without a cancer diagnosis
- Optional ICU coverage (included in Platinum plan) pays $600 per day when in ICU

Legal Notices

Women's Health & Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan. Therefore, the following deductibles and coinsurance apply:

Plan 1: PPO Plan (Individual: 20% coinsurance and $2,000 deductible; Family: 20% coinsurance and $4,000 deductible)

Plan 2: HDHP (Individual: 20% coinsurance and $3,500 deductible; Family: 20% coinsurance and $7,000 deductible)

If you would like more information on WHCRA benefits, please call your Plan Administrator at 229-259-4744 or Ashley.Romadka@sgmc.org.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-54477	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/ flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=enUS Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health care/medicaid/ Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP)(pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP)Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 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

HIPAA Notice of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights
SGMC is committed to the privacy of your health information. The administrators of the SGMC Health Plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Ashley Romadka - Director at 229-259-4744 or Ashley.Romadka@sgmc.org.

HIPAA Special Enrollment Rights

SGMC Health Plan Notice of Your HIPAA Special Enrollment Rights

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

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

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

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

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

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

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Ashley Romadka - Director at 229-259-4744 or Ashley.Romadka@sgmc.org.

Important Warning

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

Notice of Creditable Coverage

Important Notice from SGMC

About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with SGMC and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **SGMC has determined that the prescription drug coverage offered by the medical plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current SGMC coverage will not be affected. You can keep this coverage and it will coordinate with Part D coverage. If you do decide to join a Medicare drug plan and drop your current SGMC coverage, be aware that you and your dependents will be able to get this coverage back during open enrollment or in the case of a special enrollment opportunity.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with SGMC and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through SGMC changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage Notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	**January 01, 2024**
Name of Entity/Sender:	**SGMC**
Contact—Position/Office:	**Ashley Romadka - Director**
Office Address:	**2501 N Patterson St**
	Valdosta, Georgia 31602-1735
	United States
Phone Number:	**229-259-4744**

Continuation Required by Federal Law for You & Your Dependents (COBRA)

The continuation required by Federal Law does not apply to any benefits for loss of life, dismemberment or loss of income. Federal law enables you or your dependent to continue health insurance if coverage would cease due to a reduction of your work hours or your termination of employment (other than gross misconduct). Federal law also enables your dependents to continue health insurance if their coverage ceases due to your health, divorce, or legal separation, or with respect to a dependent child, failure to continue to qualify as a dependent. Continuation must be elected in accordance with the rules of your Employer's group health plan(s) and is subject to federal law, regulations and interpretations.

Our Uses & Disclosures

- We may use and share your information as we:
- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Our Responsibilities

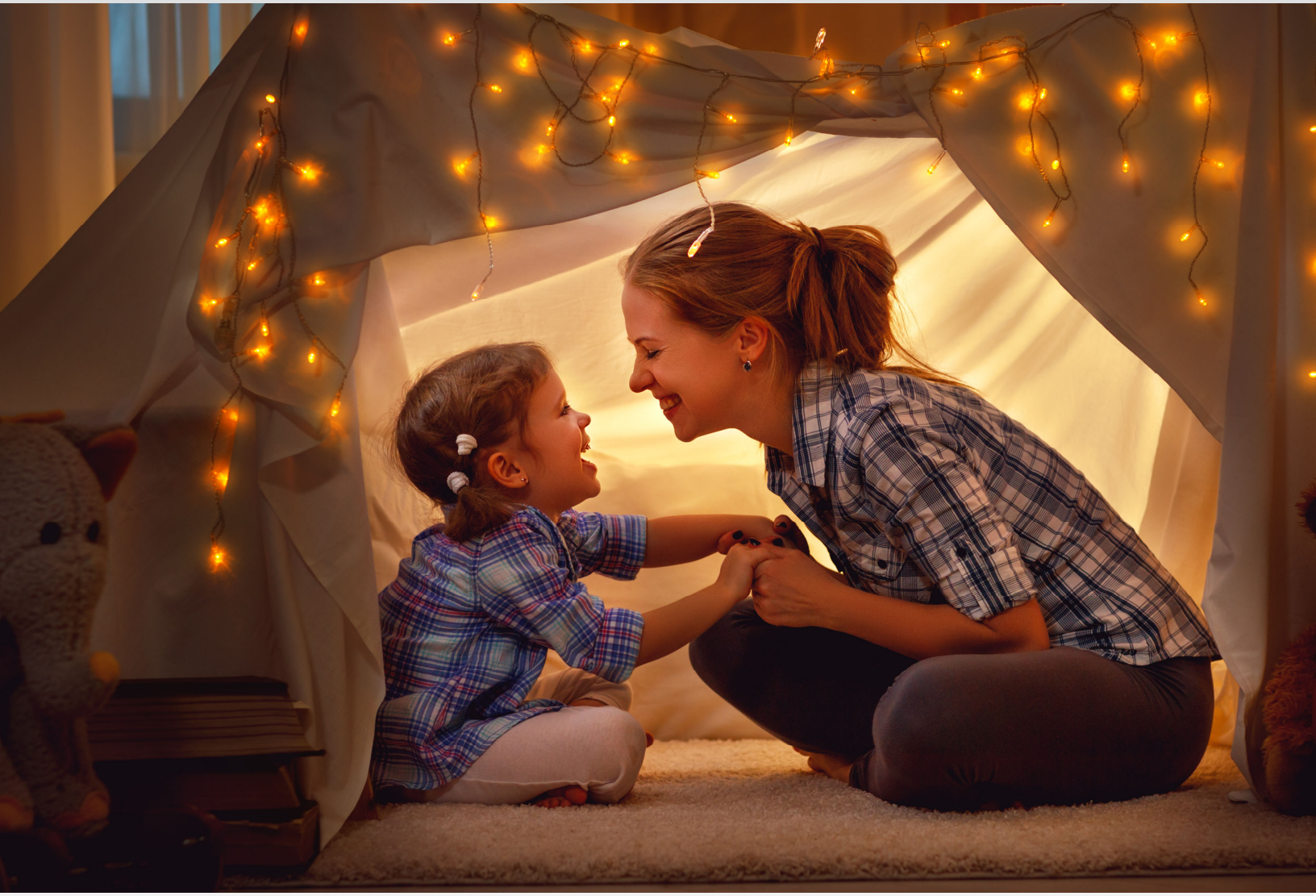
We are required by law to maintain the privacy and security of your protected health information.

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.

Notes

Notes



This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.

This benefit summary prepared by

Gallagher

Insurance | Risk Management | Consulting