

ADVISORS EXCEL

2026-2027

BENEFITS GUIDEBOOK

WHO TO CONTACT

The quickest way to find answers to your benefit questions is to go directly to the source. This contact list includes web addresses and phone numbers for the administrators of each of our benefit plans. The insurance company can verify benefits and coverage or copayment information. We suggest you contact the insurance company prior to seeking care should you have any questions in regard to your benefits.

Coverage / Carrier	Phone Number	Website or Email
Medical and Prescription		
<i>Blue Cross and Blue Shield of Kansas</i>	785.291.4180 (in Topeka) 800.438.1565 (toll-free)	www.bcbsks.com
<i>Amwell Telemedicine</i>	800.733.3627	www.bcbsks.com/telemed
Dental		
<i>Delta Dental of Kansas</i>	800.234.3375	www.deltadentalks.com
Vision		
<i>Ameritas</i>	800.659.2223	www.ameritas.com/vision
<i>EyeMed</i>	866.289.0614	www.eyemed.com
<i>VSP</i>	800.877.7195	www.vsp.com
Life and AD&D, Voluntary Life and AD&D, Disability, Voluntary Accident, Critical Illness, Cancer, Hospital Indemnity Plans		
<i>Symetra</i>		www.symetra.com
Flexible Spending Account		
<i>Surency</i>	866.818.8805	www.surency.com
401(k) Retirement Plan		
<i>Empower Retirement</i>	888.411.4015	www.empowermyretirement.com
Financial Wellness		
<i>Two West</i>	913.825.1722	twowestadvisors.com info@twowestadvisors.com
Employee Assistance Programs		
<i>ComPsych®</i>	888.327.9573	guidanceresources.com
<i>CFCC</i>	785.272.0778	www.christfirstcounseling.com
Legal and Identity Theft		
<i>MetLife</i>	800.821.6400	info.legalplans.com
HR/Benefits Contacts		
<i>Laura Moyer, HR Manager</i>	866.363.9595	laura.moyer@advisorsexcel.com
<i>Sarah Saenz, Sr. HR Generalist</i>	866.363.9595	sarah.saenz@advisorsexcel.com
<i>Candice Beightel, HR Generalist</i>	866.363.9595	candice.beightel@advisorsexcel.com



ADVISORS[®] EXCEL

JUNE 1, 2026 - MAY 31, 2027

*We expect a lot from the people who work at Advisors Excel.
We're prepared to give them a lot in return.*

We can't create the ultimate client experience for our advisors unless every one of us remains focused every day on going above and beyond in every interaction. It's as simple as that. There are no "unimportant" positions on our team — any one of us could be the deciding factor in whether an advisor chooses to join us, stay with us or leave us. We need to attract the very best, so we work hard to provide competitive salaries and top-notch benefits, including medical, vision and dental insurance, life and disability coverage, a matching 401(k) plan, flexible spending accounts, immediate vacation time, annual increases and more.

The health and well-being of all our team members and their families is a primary concern to Advisors Excel. That's why AE is committed to offering a competitive rewards program that is aligned with our business objectives and values, and inspires employees to drive innovation and improve company performance.

This booklet contains valuable information about your benefits. Please take time to review this 2026-2027 Benefits Guide carefully. If you have questions regarding any of the information presented, or require additional information about AE's benefits, please contact HR in the Employee Experience Department.



For all benefits, except retirement, you must sign up within 30 days from your date of hire. You will receive an email from Paycor regarding benefit enrollment after your first day of employment.

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ELIGIBILITY

Employees: Active employees who are regularly scheduled to work 30 hours a week over a period of time are eligible to participate in medical, dental, vision, life and disability plans, and additional benefits.

Dependents: In addition to enrolling yourself, you may also enroll any eligible dependents in the medical, dental, vision and supplemental life insurance. Eligible dependents are defined below:

Spouse (including same-sex spouse): A person to whom you are legally married. Such a person remains a spouse until a decree or divorce is issued.

Child: A child who is yours or your spouse's by birth or legal adoption; one whose medical care is the legal obligation of you or your spouse as per a court order or court-approved requirement; the subject of a child support order that recognizes the right of that person to receive benefits under your medical coverage; your grandchild in the court-ordered custody of you or your spouse; a child who is your dependent and who is in the guardianship of you or your spouse; a legal dependent child under the age of 26. Coverage will cease at the end of the month in which the dependent reaches age 26.

Disabled Dependent: A child who is dependent on you or your spouse as a result of mental or physical incapacity; a child who is disabled prior to reaching the maximum age allowed under the plan.

Domestic Partner: Have chosen to live together in a committed relationship and who have agreed to be jointly responsible for living expenses incurred during the domestic partnership.

Your quick path to personalized benefits

This year, choose your benefits with confidence.

Nayya Choose makes it easy to pick the best-fit plans for your unique needs.



Step 1

Access Nayya once you receive your link

Step 2

Answer a few questions about yourself and your family through Nayya's secure survey*



Step 3

Get matched with a benefits package customized to your needs and budget



Step 4

Continue onto your company's benefits administration platform to enroll

*Our promise: Nayya will never share your personal information with your employer or anyone else.



HIPAA compliant | SOC2+HITRUST certified

Learn more at support.nayya.com

Choose: Frequently asked questions

What is Nayya Choose and who can use it?

Nayya Choose offers benefits guidance so you feel confident in your plan choices. Through a quick, easy-to-understand survey, Choose asks you a few questions before recommending the best benefits for you based on your individual health, finances, and preferences. Because the recommendations are hyper-personalized to each individual employee, everyone can benefit from the tool.

88% of employees who used Nayya Choose indicated that their benefits decision was made easier!¹

How does Nayya Choose work?

Nayya Choose is quick and easy to use:

- 01 Access Nayya once you receive your link
- 02 Answer a few questions about yourself and your family through Nayya's secure survey
- 03 Get matched with a benefits package customized to your needs and budget
- 04 Continue to enrollment

Why should I use Nayya Choose before enrolling in my employee-sponsored benefits?

Selecting the best benefits for you and your family can be daunting. You want to maximize value while avoiding unnecessary costs, but it can be tough to determine which benefits to choose and why.

Nayya Choose empowers you to feel confident in your benefits choices before you make your elections. By providing personalized guidance that balances protection and affordability, you can rest assured that you'll be recommended the best fit coverage for your unique needs.

What types of questions can Nayya Choose help me answer?

Nayya Choose is a benefits guidance tool that helps you feel confident in your plan choices. Through a quick, easy-to-understand survey, Choose asks you a few questions before recommending the best benefits for you based on your individual health, finances, and preferences. Because the recommendations are hyper-personalized to each individual employee, everyone can benefit from the tool. If you're looking to:

- Confirm whether the plans you want to enroll in are appropriate for yourself and your family, vision, OB/GYN)
- Save money on your benefits while ensuring the right coverage,
- Understand whether you should add extra coverage
- Decide how much to contribute to your retirement or other tax-advantaged plans
- Learn more about all of the benefits available to you through their employer,

Then Nayya Choose is a great tool for you!

How does Nayya protect my data, including sensitive health, financial, and wellness information?

We have a SOC2+HITRUST certification and are HIPAA compliant, meaning all sensitive data is handled with care. All user data is accessed with the employee's permission and is kept confidential. Your employer has no access to any of your personal data or information, and we will never sell your information. Your responses to the questions in the survey are only used to personalize your benefits recommendation.

Why does Nayya Choose ask for my financial information?

We analyze your financial information – only with your explicit permission – to make smarter, more personalized benefits recommendations. By knowing details like your home equity, mortgage payments, and outstanding debts, we can better recommend the right amount of coverage to keep you and your family protected. This information also determines whether enrolling in voluntary benefits coverage, such as life or accident insurance, is right for you.



HIPAA compliant | SOC2+HITRUST certified

Patent: www.nayya.com/patent

CHANGING YOUR BENEFITS DURING THE YEAR

As you make your benefit elections, please keep in mind that these elections and the related payroll deductions generally cannot be canceled or changed until your next Open Enrollment period. However, you may request to make a change in your coverage if (1) you, your spouse or your dependent experience a qualified change-in-status event, and (2) the change-in-status event affects you, your spouse's or your dependent's eligibility for coverage under this plan or another employer's plan.

If you experience one of these life events, please contact HR in the Employee Experience Department as soon as possible; you only have 30 days from the date of the status change to make changes.

Allowable events include:

- Marriage
- Registering a domestic partnership
- Divorce
- Birth
- Adoption
- Death
- Change in number of dependents
- Change in employment status — beginning or end of employment for you or your spouse/domestic partner; going from benefits ineligible to benefits eligible

- Dependent losing eligibility — reaches maximum age of 26
- Change in health coverage — significant change in health care coverage or cost for you or your eligible dependent
- Retirement
- Moving into or out of a medical plan's service area

Other situations that allow you to make a change in your benefit elections are listed below:

- Entitlement to a special enrollment right
- Taking leave under the Family Medical Leave Act
- Complying with a judgment, decree or order that requires you, a former spouse or another living individual to obtain health coverage for a child who is your dependent
- Entitlement to coverage or loss of eligibility for coverage under Medicare or Medicaid for you, your spouse or your dependent
- An election change or change under your spouse/domestic partner or dependent's employer's plan during an Open Enrollment period that does not correspond with this plan's Open Enrollment period

Coverage will begin on the first of the month following the qualified change-in-status event, unless the change is due to the birth, adoption or placement for adoption of a child, in which case the coverage is effective on the date of birth, adoption or placement for adoption.

Advisors Excel, LLC believes the Blue Cross and Blue Shield of Kansas Triple Option Comprehensive Medical Program and High Deductible Health Plans are "grandfathered health plans" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Triple Option Comprehensive Medical Program and High Deductible Health Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator, Matt Beier, Director of Employee Initiatives at Advisors Excel, LLC. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1.866.444.3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.



The benefits plan year runs June 1 through May 31. The elections you make will remain in effect through May 31, 2027, unless you, your spouse or your dependent child(ren) experience a qualified change-in-status event.

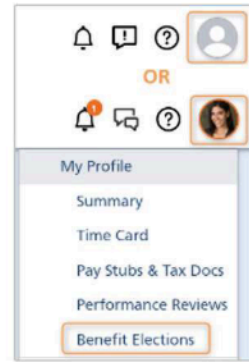
ACCESSING YOUR ONLINE BENEFITS PORTAL

Log in to Paycor.

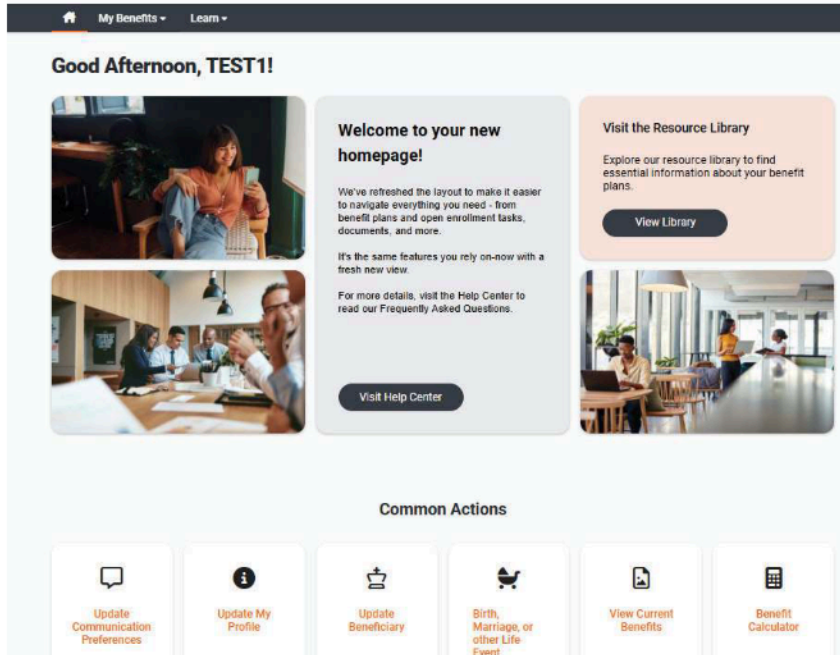
In the upper right corner, click on the circle Profile Menu.

Click on Benefit Elections.

On the home screen, select Start Your Enrollment.



You will then be directed to your Benefits Home screen:



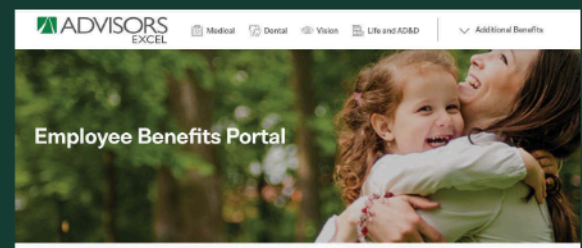
Be sure to visit SharePoint to review details of every benefit offered. Scan the QR code or visit our [SharePoint site](#).



Employee Experience

Home Welcome to AE! Human Resources

We encourage you and your family to become familiar with this website. Inside, you will find detailed information about your employee benefits program including benefit summaries, claim forms, administrative forms, customer service numbers, provider directories and direct links to the insurance carriers. You will also find helpful information regarding each benefit product so you can choose a benefit package that's right for you and your family. <https://advisorexcel.millercare.com/>



HEALTH INSURANCE RATES - SEMI-MONTHLY



Advisors Excel's medical plans are self-funded through Blue Cross and Blue Shield of Kansas. While we access the Blue Cross network, Advisors Excel assumes the direct risk for payment of claims. Below are the semi-monthly medical rates, which are broken down by employee share, employer contribution and semi-monthly total.

Option 1	Employee	Employer	Total
Employee Only	\$53.81	\$298.79	\$352.60
Employee + Child(ren)	\$159.50	\$580.58	\$740.08
Employee + Spouse/ Domestic Partner*	\$170.26	\$587.83	\$758.09
Family	\$275.15	\$870.41	\$1,145.56
Option 2	Employee	Employer	Total
Employee Only	\$47.36	\$294.35	\$341.71
Employee + Child(ren)	\$145.32	\$572.99	\$718.31
Employee + Spouse/ Domestic Partner*	\$156.03	\$580.31	\$736.34
Family	\$254.57	\$858.34	\$1,112.91
Option 3	Employee	Employer	Total
Employee Only	\$42.26	\$290.74	\$333.00
Employee + Child(ren)	\$134.98	\$565.93	\$700.91
Employee + Spouse/ Domestic Partner*	\$144.54	\$572.21	\$716.75
Family	\$236.57	\$848.03	\$1,084.60
Option 4	Employee	Employer	Total
Employee Only	\$25.78	\$277.80	\$303.58
Employee + Child(ren)	\$98.76	\$535.93	\$634.69
Employee + Spouse/ Domestic Partner*	\$106.32	\$546.24	\$652.56
Family	\$178.61	\$805.38	\$983.99

* A portion of the health care premium contributions for domestic partners are deducted on an after-tax basis unless the domestic partner qualifies as the employee's dependent under federal tax laws. Even though domestic partner premiums are not deducted on a pre-tax basis, the same restrictions for adding or dropping coverage still apply to domestic partners when a qualifying change in status occurs. If you wish to cover your domestic partner, contact the HR department to obtain additional enrollment information.

Summary of Benefits and Coverage (SBC)

As required by The Patient Protection and Affordable Care Act, Advisors Excel is required to provide each employee a summary of benefits and coverage (SBC) in a standardized format. The SBC is also available upon request by contacting HR in the Employee Experience Department.

GRANDFATHERED: TRIPLE OPTION COMPREHENSIVE MAJOR MEDICAL PROGRAM

Maximum benefits are available when services are received from Blue Choice providers. Your financial responsibility is based on the provider network you select:

Non-Blue Choice & Non-CAP: Difference between the payment allowance and provider charge, additional 20% coinsurance, deductible, coinsurance, or copay amount. **CAP (Non-Blue Choice):** Additional 20% coinsurance amount,* deductible, coinsurance or copay amount.

*Limited to a combined \$2,000 per person, \$4,000 two or more persons (family) each benefit period.

In-Network Benefits	Option 1	Option 2	Option 3
Deductible: Individual/Family ¹	\$500/\$1,000	\$1,000/\$2,000	\$1,500/\$3,000
Annual Out-of-Pocket Maximum: Individual/Family ²	\$1,500/\$3,000	\$2,000/\$4,000	\$2,500/\$5,000
Coinsurance Responsibility: Member/Blue Cross	20%/80% (of allowed amounts after deductible has been met); up to \$1,000/\$2,000 (individual/ family)		
Doctor's Office Visits (includes Telehealth, hearing and eye exams)	\$25 office visit copay Does not apply toward deductible/OOP max		
Surgery — inpatient and outpatient Maternity Care Inpatient Hospitalization ³ Outpatient Hospitalization Freestanding Outpatient Facilities (ex: surgery/renal dialysis) Medical Equipment/Disposable Supplies/Breast Pump Supplies Short-Term Therapies: PT, OT, ST, Respiratory and Cardiac Ambulance Services Inpatient Mental Health & Substance Use Disorders ⁴ Electronically Operated Appliances or Devices Residential Treatment Centers Wig/Hair prosthesis to a max of \$750 Infertility Services to a lifetime max of \$10,000 Accupuncture/Accupressure	Deductible then coinsurance		
Preventive Care — includes annual physicals, well-baby & well-child visits, immunizations, routine physicals/ screenings, well-woman visits/screenings, breastfeeding support, counseling, and supplies (limit one pump per lifetime), contraceptives, Cologuard [®] Breast pumps up to \$250 after ACA benefit	Covered at 100%**		
Outpatient Radiology & Lab Services/Advanced Imaging	Pays at 100% of the allowable charge to a combined maximum of \$300 per person each benefit period, then subject to deductible then coinsurance		
Accidental Injury Services	Pays at 100% up to \$1,000 per person each benefit period, then subject to deductible then coinsurance		
Emergency Room Services ⁵	\$100 copay per incident, then subject to deductible then coinsurance		
Prescription Drug			
BlueRx Card — Retail Services: ⁶ Generic/Brand Formulary/Brand Non-Formulary	The quantity per prescription shall be the greater of a 34-day supply or 100-unit dosage, if defined as a maintenance drug. \$15/\$35/\$50 copay Does not apply towards deductible/OOP max		
BlueRx Mail Order (90-day supply): Generic/Brand Formulary/Brand Non-Formulary	\$37.50/\$87.50/\$125 copay (Note: prior authorization and quantity limits may apply) Does not apply toward deductible/OOP max		

**If not coded as preventive, subject to coinsurance and deductible.

¹Family Aggregate — no one family member may contribute more than the individual deductible amount toward the family coverage maximum.

²Includes deductible; after the annual out-of-pocket amount has been reached (deductible), eligible benefits will be paid at 100% of the allowed amount for the remainder of the benefit period.

³Pre-admission certification required for all planned inpatient admissions at 1.800.782.4437.

⁴Pre-admission certification required for inpatient mental health and substance use disorder admissions at 1.800.952.5906.

⁵If admitted to the hospital as an inpatient within 24 hours of initial visit, copay is waived and benefits are provided subject to deductible then coinsurance.

⁶Diabetic supplies are covered.

GRANDFATHERED: HIGH DEDUCTIBLE HEALTH PLAN

Maximum benefits are available when services are received from Blue Choice providers. Your financial responsibility is based on the provider network you select:

Non-Blue Choice & Non-CAP: Difference between the payment allowance and provider charge, additional 20% coinsurance amount, deductible, coinsurance or copay amount. **CAP (Non-Blue Choice):** Additional 20% coinsurance amount,* deductible, coinsurance or copay amount.

**Limited to a combined \$2,000 per person, \$4,000 two or more persons (family) each benefit period.*

In-Network Benefits	Option 4
Deductible: Individual/Family ¹	\$3,400 / \$6,800
Annual Out-of-Pocket Maximum: Individual/Family ²	\$3,400 / \$6,800
Doctor's Office Visits (includes hearing and eye exams, Telehealth) Surgery: Inpatient and outpatient Maternity Care Inpatient Hospital ³ Accidental Injury Services Ambulance Services Outpatient Hospital Emergency Room Services ⁴ Freestanding Outpatient Facilities (ex: surgery, renal dialysis) Medical Equipment/Disposable Supplies Short-Term Therapies — Physical, Speech and Occupational, Respiratory and Cardiac Outpatient Radiology & Lab Services Inpatient Mental Health & Substance Use Disorders ⁵ Electronically Operated Appliance or Devices Residential Treatment Centers Wig/Hair prosthesis to a max of \$750 Infertility Services to a lifetime max of \$10,000	Subject to Deductible
Preventive Care — includes annual physicals, well-baby & well-child visits, immunizations, routine physicals/screenings, well-woman visits/screenings, breastfeeding support, counseling, and supplies (limit one pump per lifetime), contraceptives, Cologuard [®]	Covered at 100%**
Amwell Telehealth	\$49 Billed Charge
Prescription Drug	
BlueRX Card - Integrated Benefit ⁶	Subject to Deductible

***If not coded as preventative, subject to coinsurance and deductible.*

¹Family Aggregate — no one family member may contribute more than the individual deductible amount toward the family coverage maximum.

²Includes deductible; after the annual out-of-pocket amount has been reached (deductible), eligible benefits will be paid at 100% of the allowed amount for the remainder of the benefit period.

³Pre-admission certification required for all planned inpatient admissions at 1.800.782.4437.

⁴If admitted to the hospital as an inpatient within 24 hours of initial visit, copay is waived and benefits are provided subject to deductible then coinsurance.

⁵Pre-admission certification required for inpatient mental health and substance use disorder admissions at 1.800.952.5906.

⁶The quantity per prescription shall be the greater of a 34-day supply or 100-unit dosage, if defined as a maintenance drug. (Note: prior authorization and quantity limits may apply.)

TELEMEDICINE



Telemedicine connects you with a doctor anytime, anywhere.

With Blue Cross and Blue Shield of Kansas coverage, you can have a live visit on your computer or mobile device with a doctor at a time that works for you.

Blue Cross provides telemedicine services through American Well® (Amwell). With Amwell, registration is FREE. It's easy to use, affordable, private and secure.

HOW TO USE AMWELL

You can easily register for a telemedicine visit and connect with a board-certified doctor in your area.

1. Download the Amwell app on any mobile device. (AppStore, Google Play)
2. On a computer?
Sign up at bcbsks.com/telemed.
Simply fill in the contact information and set up a username and password.

WHY USE AMWELL?

- Choose Your Own Physician: You select a physician for your visit from a list of U.S. board-certified doctor and therapist profiles. All profiles include physician certifications, licenses and online patient ratings.
- Available nationwide, 24/7/365
- Convenient Prescriptions: If a medication is prescribed, all prescriptions can be picked up at your local pharmacy.
- Easy Payment: Pay for the visit with credit, debit or FSA cards.
- Record Storage: A complete record of each visit is securely maintained and can be accessed by the patient.

HOW MUCH DOES AMWELL COST?

The out-of-pocket cost of an Amwell doctor or therapist visit depends on your plan type. Participants in Options 1, 2 or 3 will have a \$25 co-pay. High Deductible Health Plan Participants will have a \$49 charge for the service.

WHEN TO USE AMWELL?

As an innovative patient consultation service, telemedicine lets you interact with a doctor at your convenience for common conditions such as:

- cold
- sinus infection
- flu
- rash
- pink eye
- ear infection
- fever

Also offering behavioral health and counseling services, known as teletherapy, Amwell's licensed therapists will provide treatment for several conditions, including:

- anxiety
- attention deficit hyperactivity disorder (ADHD)
- stress
- bereavement
- obsessive-compulsive disorder (OCD)
- panic attacks
- depression
- trauma/post-traumatic stress disorder

Therapists will be available on demand or by appointment from 6 a.m. to 10 p.m. Central, 7 days a week.

CAN MY FAMILY USE AMWELL?

If your spouse and/or children are covered under your BCBSKS plan, they are eligible for telemedicine services. Your spouse should create their own Amwell account, but children or dependents under age 18 can be added to your account and have doctor visits on your behalf. You need to register first, and then the child or dependent can be added to the account. Dependents over the age of 18 must create their own Amwell account.

For more information, visit bcbsks.com/telemed or call 844-SEE-DOCS (844-733-3627).

Welcome to BlueAccess®

Our secure online member portal is the gateway to your health information

Access your information – quickly and securely

Our secure online member portal allows you to:

- View benefits, including eligibility and deductible/coinsurance information
- Check your claims
- View, download and monitor medical expenses through your Explanation of Benefits (EOBs)
- View, download or print your digital ID card

Registration is quick and simple

If you already have a BlueAccess account, log in to view your health plan information. If you don't have an account, registration is easy.

- 1 Go to bcbsks.com/blueaccess.
- 2 Click *Register for a BlueAccess account*.
- 3 Have your ID card handy and follow the step-by-step instructions.



- 1 **Manage My Account** | Edit and manage your preferences and go paperless.
- 2 **Forms** | Order a new ID card, find authorization forms and other forms related to your health insurance coverage.

- 3 **Summary of Benefits and Coverage (SBC) and Contract/Certificate** | View details about your coverage and contract.
 - View your copay, deductible and coinsurance amounts
 - Common medical coverage information
 - Coverage for specific tests or treatments
- 4 **Strive, powered by WebMD ONE** | Use this health and wellness platform to take a Health Assessment and generate a personalized health plan to reach your well-being goals.
- 5 **Blue365®** | Exclusive health and fitness deals and discounts.

Visit us at bcbsks.com



MC371 01/21



1133 SW Topeka Blvd, Topeka, KS 66629

An independent licensee of the Blue Cross Blue Shield Association.

ID PROTECTION PLAN

Employees enrolled in our BCBS plan are eligible for Experian IdentityWorksSM services



Protecting you when you are most vulnerable. Our services monitor a variety of channels to provide comprehensive protection.



If you become a victim of identity theft, we work to resolve it. Experian® will do the work to help recover your financial losses and restore your credit file.



Protection at no cost to you. Our identity restoration services are available to you free as an eligible member.

Experian IdentityWorks

Experian IdentityWorks offers more protection and the option to enroll at any time — also at no cost to you. Once you enroll in IdentityWorks, you will have access to:

- **Experian credit report at signup:** See what information is associated with your credit file*.
- **Credit Monitoring:** Actively monitors your Experian credit file for indicators of identity theft.
- **Internet Surveillance:** Technology searches the web, chat rooms and bulletin boards 24/7 to identify trading or selling of your personal information on the Dark Web.
- **Identity Restoration:** Identity Restoration Specialists are immediately available to help you address credit and non-credit related identity theft.
- **Up to \$1 Million Identity Theft Insurance**:** Provides coverage for certain costs and unauthorized electronic fund transfers.
- **Lost Wallet:** Assistance with canceling/replacing lost or stolen credit, debit, and medical cards.
- **Child Monitoring:** For up to 10 children up to 18 years old, Internet Surveillance and monitoring to determine whether enrolled minors in your household have an Experian credit file are available. Also included are Identity Restoration and up to \$1M Identity Theft Insurance**.
- **Experian IdentityWorks ExtendCARE™:** You receive the same high-level of Identity Restoration support even after your Experian IdentityWorks membership has expired.

Enrollment is required.

Members must provide their personal information to enroll online or via phone. To start monitoring your personal information, please follow the steps below:

- 1 Visit the Experian IdentityWorks website to enroll: www.experianidworks.com/bcbsks
- 2 Click “Get Started” and enter code: **KANSAS26**
- 3 Complete the enrollment process.

How Experian Identity Restoration Works

If you become a victim of identity theft, a dedicated Identity Restoration Specialist from Experian will act as your guide and advocate from start to finish by initiating the dispute process, and help ensure that your identity returns to its pre-identity theft state***.

If you have questions about protecting your identity or if you suspect that your identity has been stolen:

- 1 Call the Experian customer support team at **1-855-272-6796**
- 2 Provide the engagement number **B151540**

* Offline members will be eligible to call for additional reports quarterly after enrolling.

**The Identity Theft Insurance is underwritten and administered by American Bankers Insurance Company of Florida, an Assurant company. Please refer to the actual policies for terms, conditions, and exclusions of coverage. Coverage may not be available in all jurisdictions.

***You may be asked to provide a limited power of attorney to facilitate any Identity Restoration related work on your behalf.

Summary of Dental Plan Benefits BASE PLAN - \$1,500 Maximum Benefit

MAXIMUM BENEFIT(S) PER PERSON:	Benefit % Paid				
	Delta Dental PPO	Delta Dental Premier	Out-of-Network		
The Maximum Benefit for all Covered Services for each Enrollee in any one Contract Year is: One Thousand Five Hundred Dollars (\$1,500.00).	100%	100%	100%	DIAGNOSTIC & PREVENTIVE (Not Subject to Deductible)	
The Maximum Benefit for Orthodontic Services for each Enrollee is: One Thousand Five Hundred Dollars (\$1,500.00) during such person's lifetime. Payment for the Orthodontic Services shall not be included in determining the Maximum Benefit for each Contract Year.	100%	100%	100%	Diagnostic:	Includes the following procedures necessary to evaluate existing dental conditions and the dental care required: <ul style="list-style-type: none"> • <u>Oral evaluations</u> – two (2) times per Contract Year. • <u>Bitewing x-rays</u> – bitewings two (2) times per Contract Year for dependents under age eighteen (18) and once (1) each twelve (12) months for adults age eighteen (18) and over. • <u>Full mouth or panoramic x-rays</u> – once (1) each five (5) years.
The Maximum Benefit for Implant Services for each Enrollee is: One Thousand Dollars (\$1,000.00) per arch during such person's lifetime. Payment for Implant Services shall not be included in determining the Maximum Benefit for each Contract Year.	100%	100%	100%	Preventive:	Provides for the following: <ul style="list-style-type: none"> • <u>Prophylaxis</u> (Cleanings) – unlimited. • <u>Topical Fluoride</u> – two (2) times per Contract Year for dependent children under age nineteen (19). • <u>Space Maintainers</u> – for dependent children under age fourteen (14) and only for premature loss of primary molars. • <u>Sealants</u> – once (1) per tooth per lifetime for dependent children under age sixteen (16) when applied only to permanent molars with no caries (decay) or restorations on the occlusal surface and with the occlusal surface intact.
DEDUCTIBLE LIMITATIONS: Coverage for Diagnostic and Preventive Services are not subject to any Deductible amount. For all other covered benefits, the Contract Year Deductible is: \$25x3	80%	80%	80%	BASIC (Subject to Deductible)	
RIGHT START 4 KIDSSM (RS4K): Kids 12 and under receive coverage at 100% for all services covered under the plan. Not subject to deductible. Excludes orthodontics. Subject to plan's Annual Maximum, frequencies and limitations apply. Must see an in-network dentist or the plan's underlying contract applies including waiting periods, deductibles and coinsurance levels.	80%	80%	80%	Ancillary:	Provides for one (1) emergency examination per plan year by the Dentist for the relief of pain.
	80%	80%	80%	Oral Surgery:	Provides for extractions and other oral surgery including pre and post-operative care.
	80%	80%	80%	Regular Restorative:	Provides amalgam (silver) restorations; composite (white) resin restorations on all teeth; and stainless steel crowns for dependents under age twelve (12).
	80%	80%	80%	Endodontics:	Includes procedures for root canal treatments and root canal fillings. When covered, payment for root canal therapy is limited to only once (1) in any twenty-four (24) month period, per tooth.
ELIGIBLE CHILDREN AGES: Children are eligible for coverage to age twenty-six (26).	80%	80%	80%	Periodontics:	a. Includes procedures for the treatment of diseases of the tissues supporting the teeth. Periodontal maintenance, including evaluation, is counted toward the frequency limitation for prophylaxis cleanings. b. Surgical periodontal procedures.
	80%	80%	80%	MAJOR (Subject to Deductible)	
	50%	50%	50%	Special Restorative:	When teeth cannot be restored with a filling material listed in Regular Restorative Dentistry, provides for individual crowns.
	50%	50%	50%	Prosthodontics:	a. Includes bridges, partial and complete dentures. b. Repairs and adjustments of bridges and dentures. c. Implants
	50%	50%	50%	ORTHODONTICS (Subject to Deductible)	
	50%	50%	50%	Orthodontics:	Includes orthodontic appliances and treatment, interceptive and corrective, for dependent children under age nineteen (19).

This is a summary of benefits only and does not bind Delta Dental of Kansas to any coverage. Subscribers are encouraged to familiarize themselves with the details of their individual plan benefits. Subscribers are responsible for any required copayments, deductibles, or fees for services not covered by their plan at the time services are performed. Please refer to the Description of Dental Care Coverage ("Benefits Booklet") for complete coverage information, including but not limited to any applicable exclusions and limitations. Coverage as described in the employer group's dental benefits contract with Delta Dental of Kansas is binding on all parties and supersedes all other written or oral communications.



Summary of Dental Plan Benefits Buy Up Plan - \$2,000 Maximum Benefit

MAXIMUM BENEFIT(S) PER PERSON:	Benefit % Paid				
	Delta Dental PPO	Delta Dental Premier	Out-of-Network		
The Maximum Benefit for all Covered Services, excluding Diagnostic & Preventive Services, for each Enrollee in any one Contract Year is: Two Thousand Dollars (\$2,000.00).	100%	100%	100%	DIAGNOSTIC & PREVENTIVE (Not Subject to Deductible or Maximum)	
The Maximum Benefit for Orthodontic Services for each Enrollee is: Two Thousand Dollars (\$2,000.00) during such person's lifetime. Payment for the Orthodontic Services shall not be included in determining the Maximum Benefit for each Contract Year.	100%	100%	100%	Diagnostic:	Includes the following procedures necessary to evaluate existing dental conditions and the dental care required: <ul style="list-style-type: none"> • <u>Oral evaluations</u> – two (2) times per Contract Year. • <u>Bitewing x-rays</u> – bitewings two (2) times per Contract Year for dependents under age eighteen (18) and once (1) each twelve (12) months for adults age eighteen (18) and over. • <u>Full mouth or panoramic x-rays</u> – once (1) each five (5) years.
The Maximum Benefit for Implant Services for each Enrollee is: One Thousand Dollars (\$1,000.00) per arch during such person's lifetime. Payment for Implant Services shall not be included in determining the Maximum Benefit for each Contract Year.				Preventive:	Provides for the following: <ul style="list-style-type: none"> • <u>Prophylaxis (Cleanings)</u> – unlimited. • <u>Topical Fluoride</u> – two (2) times per Contract Year for dependent children under age nineteen (19). • <u>Space Maintainers</u> – for dependent children under age fourteen (14) and only for premature loss of primary molars. • <u>Sealants</u> – once (1) per tooth per lifetime for dependent children under age sixteen (16) when applied only to permanent molars with no caries (decay) or restorations on the occlusal surface and with the occlusal surface intact.
DEDUCTIBLE LIMITATIONS: Coverage for Diagnostic and Preventive Services are not subject to any Deductible amount. For all other covered benefits, the Contract Year Deductible is: \$25x3	90%	80%	80%	BASIC (Subject to Deductible)	
RIGHT START 4 KIDSSM (RS4K): Kids 12 and under receive coverage at 100% for all services covered under the plan. Not subject to deductible. Excludes orthodontics. Subject to plan's Annual Maximum, frequencies and limitations apply. Must see an in-network dentist or the plan's underlying contract applies including waiting periods, deductibles and coinsurance levels.	90%	80%	80%	Ancillary:	Provides for one (1) emergency examination per plan year by the Dentist for the relief of pain.
	90%	80%	80%	Oral Surgery:	Provides for extractions and other oral surgery including pre and post-operative care.
	90%	80%	80%	Regular Restorative:	Provides amalgam (silver) restorations; composite (white) resin restorations on all teeth; and stainless steel crowns for dependents under age twelve (12).
	90%	80%	80%	Endodontics:	Includes procedures for root canal treatments and root canal fillings. When covered, payment for root canal therapy is limited to only once (1) in any twenty-four (24) month period, per tooth.
	90%	80%	80%	Periodontics:	a. Includes procedures for the treatment of diseases of the tissues supporting the teeth. Periodontal maintenance, including evaluation, is counted toward the frequency limitation for prophylaxis cleanings. b. Surgical periodontal procedures.
ELIGIBLE CHILDREN AGES: Children are eligible for coverage to age twenty-six (26).	60%	50%	50%	MAJOR (Subject to Deductible)	
	60%	50%	50%	Special Restorative:	When teeth cannot be restored with a filling material listed in Regular Restorative Dentistry, provides for individual crowns.
	60%	50%	50%	Prosthodontics:	a. Includes bridges, partial and complete dentures. b. Repairs and adjustments of bridges and dentures. c. Implants
	60%	50%	50%		
	50%	50%	50%	ORTHODONTICS (Subject to Deductible)	
				Orthodontics:	Includes orthodontic appliances and treatment, interceptive and corrective, for adults and dependent children under age twenty-six (26).

This is a summary of benefits only and does not bind Delta Dental of Kansas to any coverage. Subscribers are encouraged to familiarize themselves with the details of their individual plan benefits. Subscribers are responsible for any required copayments, deductibles, or fees for services not covered by their plan at the time services are performed. Please refer to the Description of Dental Care Coverage ("Benefits Booklet") for complete coverage information, including but not limited to any applicable exclusions and limitations. Coverage as described in the employer group's dental benefits contract with Delta Dental of Kansas is binding on all parties and supersedes all other written or oral communications.

Preventive Plus Program

Included with Buy Up Plan Only

BENEFITS THAT GO FURTHER

Preventive Plus allows those enrolled in the Buy-Up Plan to receive preventive care without it counting towards the overall annual maximum - incentivizing you to keep up on preventive care and saving money. Through regular cleanings and exams, employees can find disease early and prevent it from occurring.

PREVENTIVE PLUS PROGRAM DETAILS

Here are some important things to know:

Diagnostic & Preventive Care services don't count towards your annual maximum - services like exams, cleanings, X-rays, sealants and more don't count towards how much the plan will pay towards covered services.

Underlying contract applies including frequency limitations, exclusions, waiting periods, deductibles, and coinsurance levels.

HOW DOES IT WORK?

Example of a plan with and without Preventive Plus*.

With Preventive Plus 2 exams, 2 cleanings, X-rays (claims cost \$450)			Without Preventive Plus 2 exams, 2 cleanings, X-rays (claims cost \$450)		
Delta Dental pays up to \$1,500 (plan's annual maximum)			Delta Dental pays up to \$1,500 (plan's annual maximum)		
Delta Dental Pays	Member Pays	Max Remaining	Delta Dental Pays	Member Pays	Max Remaining
\$450	\$0	\$1,500	\$450	\$0	\$1,050
(100% coverage for in-network preventive care)	(100% coverage for in-network preventive care)	(\$1,500 - \$0, claims payment is NOT applied to max)	(100% coverage for in-network preventive care)	(100% coverage for in-network preventive care)	(\$1,500 - \$450, claims payment applied to max)

*Savings amounts and annual maximums in the example are provided by Delta Dental of Kansas (DDKS) for illustrative purposes only.

Coverage will vary based on your specific plan's contract.



Delta Dental of Kansas

DeltaDentalKS.com | 800-264-9462

Delta Dental of Kansas

With Delta Dental of Kansas you receive the expertise of the largest, most experienced dental benefits carrier in the nation, paired with our unparalleled customer service. With your employer, we have designed a dental benefit plan to help protect you and your family’s oral health. Regular, preventive dental care is fundamental to making your smile last, and a healthy mouth contributes to your overall wellbeing.

CHOOSING A DENTIST

You are free to go to any dentist of your choice, but there may be a difference in the amount you pay if the dentist is not a Delta Dental in-network dentist. It is to your advantage to choose a Delta Dental PPO™ or Delta Dental Premier® network dentist. Nearly 4 out of 5 dentists nationwide participate with Delta Dental, so chances are excellent your dentist is already in-network. You can search for an in-network dentist at DeltaDentalKS.com, on the Delta Dental mobile app or by contacting our customer service team at 800.234.3375.

MANAGING MY BENEFITS

At DeltaDentalKS.com, you can log in to your member account to:

- Print your member ID card
- Review your eligibility and benefit information
- See how your claims paid
- Estimate your out-of-pocket costs*
- Sign-up to receive your Explanation of Benefits (EOBs) electronically
- Access member-only discounts
- And more!

Through Delta Dental’s mobile app, you can:

- Use your mobile ID card
- Find a dentist
- Estimate your out-of-pocket costs*
- Review your coverage and claims
- Take an oral health risk assessment
- Use the toothbrush timer
- And more!



*The Dental Care Cost Estimator provides an estimate and does not guarantee the exact fees for dental procedures, what your dental benefits plan will cover or your out-of-pocket costs. Estimates should not be construed as financial or medical advice. For more detailed information on your actual dental care costs, please consult your dentist and call Delta Dental of Kansas at 800-234-3375.

Semi-Monthly Rates

Dental Base Plan	Employee	Employer	Total
Employee Only	\$7.06	\$15.68	\$22.74
Employee + Child(ren)	\$21.41	\$22.39	\$43.80
Employee + Spouse/Domestic Partner*	\$23.38	\$21.61	\$44.99
Family	\$36.52	\$38.11	\$74.63
Dental Buy-Up Plan	Employee	Employer	Total
Employee Only	\$8.20	\$18.18	\$26.38
Employee + Child(ren)	\$26.47	\$27.66	\$54.13
Employee + Spouse/Domestic Partner*	\$27.13	\$25.08	\$52.21
Family	\$45.14	\$47.09	\$92.23

*A portion of the dental premium contributions for domestic partners is deducted on an after-tax basis until the DP qualifies as the employee’s dependent under federal tax laws. Even though DP premiums are not deducted on a pre-tax basis, the same restrictions for adding or dropping coverage still apply to domestic partners when a qualifying change in status occurs. If you wish to cover your DP, contact the HR department to obtain additional enrollment information.

FLEXIBLE SPENDING ACCOUNTS



Flexible spending accounts (FSA) allow you to reduce your taxable income by setting aside pre-tax dollars from each paycheck to pay for eligible out-of-pocket health care and dependent care expenses for you and your family. There are two types of FSAs: Health Care FSA and Dependent Care FSA. You can elect to participate in one or both accounts. The FSAs are administered by Surency Flex.

In order to participate in the FSA, you must enroll each year. Your annual contribution stays in effect during the entire year (June 1 through May 31). The only time you can change your election is during Open Enrollment or if you experience a qualified change-in-status event.

USING YOUR FSA

Surency Flex Benefits Card: Use your Surency Flex Benefits Card whenever you are purchasing an eligible expense. Most doctors' offices, pharmacies, and some retailers will accept your card when paying as "credit" at checkout. Your purchase may need to be substantiated later on, so make sure to keep your receipts!

Pay With Personal Funds and Request Reimbursement: Pay using your own personal credit card, cash or check and keep your itemized receipt as documentation. Then log on to your online account to file for reimbursement and upload documentation.

Online and Mobile App: You can quickly and easily submit payment requests, check your account balance and view payment status online or on your mobile device.

HEALTH CARE FSA

Health Care FSAs help you stretch your budget for health care expenses for you and your dependents by allowing you to pay for these expenses using tax-free dollars. Employees may set aside up to \$3,400 annually, which is deducted out of your pay throughout the year on a pre-tax basis. Funds can be used to

pay for qualified health care expenses such as deductibles, medical and prescription copays, dental expenses and vision expenses.

You can use the FSA for expenses for yourself, your spouse and your dependent children — even if they are not covered under your medical or dental plan. When you submit a claim, you can be reimbursed up to your full annual election.

If you don't use it, you won't lose it!

Didn't use all of your funds this year? Don't worry — you can carry over up to \$680 to use in the next plan year. Funds over \$680 will be forfeited.

DEPENDENT CARE FSA

The Dependent Care FSA allows you to pay for eligible dependent care expenses with tax-free dollars while you are at work. You may set aside up to \$7,500 annually in pre-tax dollars, if you are married filing jointly or are single; \$3,750 if you are married and file taxes separately from your spouse. If you have a stay-at-home spouse, you should not enroll in a DC FSA.

Eligible expenses include those listed below:

- Care for your dependent child who is under the age of 13 who you can claim as a dependent for tax purposes
- Care for your dependent child who resides with you and who is physically or mentally incapable of caring for him/herself
- Care for your spouse or parent who is physically or mentally incapable of caring for him/herself

Any money left unspent in your Dependent Care FSA at the plan year-end is forfeited.

Once you enroll, you will receive detailed instructions for accessing your account through the Surency Flex secure online portal.

www.surency.com

PO Box 789773

Wichita, KS 67278-9773

866.818.8805

Ameritas provides access to both VSP and EyeMed vision networks. VSP has the largest network of independent doctors nationwide, while EyeMed has access to five of the top six retail chains, including LensCrafters, Pearle Vision and Target Optical, allowing you to choose the right network to fit your needs.

In-Network Benefits	VSP Low Plan	VSP High Plan	EyeMed Access Plan
Copays			
Eye Exam	\$10 copay	\$10 copay	\$10 copay
Materials	\$25 copay	\$25 copay	\$25 copay
Contact Lens Fit & Follow-up Exam	Member cost up to \$60	Member cost up to \$60	Member cost up to \$55
Frames	\$130 allowance; 20% off remaining balance	\$180 allowance; 20% off remaining balance	\$130 allowance; 20% off remaining balance
Lenses			
Single Vision	Covered in full	Covered in full	Covered in full
Bifocal	Covered in full	Covered in full	Covered in full
Trifocal	Covered in full	Covered in full	Covered in full
Lenticular	Covered in full	Covered in full	20% discount
Progressive	Up to contracted fee for bifocal lenses; member responsible for difference	Covered in full	Standard: \$65 + lens deductible Premium: lens cost - 20% discount - \$120 allowance + Standard Progressive cost
Lens Options:			
Standard Polycarbonate	\$33 copay; covered in full for dependent children	\$33 copay; covered in full for dependent children	\$40 copay
Scratch Resistant Coating	\$17-\$33 copay	Covered in full	\$15 copay
Anti-Reflective Coating	\$43-\$85 copay	Covered in full	\$45 copay
Ultraviolet Coating	\$16 copay	\$16 copay	\$15 copay
Contact Lenses			
Medically Necessary	Covered in full	Covered in full	Covered in full
Disposable	\$130 allowance	\$180 allowance	\$130 allowance
Frequency			
Exam	Every 12 months	Every 12 months	Every 12 months
Lenses or Contact Lenses	Every 12 months	Every 12 months	Every 12 months
Frames	Every 24 months	Every 12 months	Every 24 months

Semi-Monthly Rates — Employee Pays 100% of the Premium

The employee's share of premium cost are made through payroll deductions on a pre-tax basis.*

Tier	VSP Low Plan	VSP High Plan	EyeMed Plan
Employee Only	\$4.22	\$7.30	\$4.38
Employee + Child(ren)	\$7.18	\$13.02	\$7.40
Employee + Spouse/Domestic Partner*	\$6.76	\$14.40	\$6.98
Family	\$11.10	\$20.12	\$11.36

*A portion of the vision plan premium contributions for domestic partners is deducted on an after-tax basis unless the domestic partner qualifies as the employee's dependent under federal tax laws. Even though domestic partner premiums are not deducted on a pre-tax basis, the same restrictions for adding or dropping coverage still apply to domestic partners when a qualifying change in status occurs. If you wish to cover your domestic partner, contact the HR department to obtain additional enrollment information.

DISABILITY AND LIFE



Life insurance helps protect your family from financial risk and sudden loss of income in the event of your death. Accidental death and dismemberment (AD&D) insurance provides an additional benefit if you lose your life, sight, hearing, speech or limbs in an accident. Advisors Excel provides \$50,000 in basic life and AD&D insurance.

For extra insurance protection, you have the option of buying supplemental life and AD&D for yourself, your spouse and dependent children.

Short-Term Disability (STD) and Long-Term Disability (LTD) benefits are provided at no cost should you become unable to work due to pregnancy/childbirth, injury or illness. Enrollment is automatic for eligible employees.

SHORT-TERM DISABILITY

Employer Pays 100% of the Premium

<i>Benefit Details</i>	
Benefits Percentage	66.67% of employee's salary
Elimination Period	Injury — 7 days Illness — 7 days
Benefit Duration	Up to 12 weeks
Minimum Weekly Benefit	\$25
Maximum Weekly Benefit	\$1,500
Pre-Existing Condition Duration	None

LONG-TERM DISABILITY

Employer Pays 100% of the Premium

<i>Benefit Details</i>	
Benefits Percentage	60% of employee's salary
Elimination Period	90 days
Benefit Duration	Greater of Age 65 or Social Security Full Retirement Age
Minimum Monthly Benefit	Greater of \$100 or 0% of Gross Monthly Benefit
Maximum Monthly Benefit	\$10,000
Pre-Existing Condition Duration	3/12

GROUP LIFE AND AD&D

Employer Pays 100% of the Premium

<i>Benefit Details</i>	
Basic Life and AD&D Amount	\$50,000
Age Reduction Schedule	Reduce to 65% at age 65; 40% at age 70; 20% at age 75
Value Added Services	Emergency Travel Assistance, ID Theft Protection, Beneficiary Companion Program, and Estate Planning Services

VOLUNTARY LIFE AND AD&D



Employee Pays 100% of the Premium

<i>Employee Benefit Details</i>	
Voluntary Life and AD&D Amount	Minimum: \$0 / Maximum: The Lesser of Five Times Annual Salary or \$500,000; Available in \$10,000 increments. Basic & Supplemental amounts cannot exceed a combined maximum of Seven Times Earnings.
Guarantee Issue	\$350,000
Age Reduction Schedule	Reduce to 45% at age 70; 30% at age 75; 20% at age 80; 15% at age 85; 10% at age 90
Accelerated Benefit	An amount equal to 75% of the death benefit subject to a maximum benefit of \$500,000.
<i>Spouse Benefit Details</i>	
Voluntary Life and AD&D Amount	\$5,000 to \$250,000; Limited to 50% of employee amount; Increments of \$5,000
Guarantee Issue	\$50,000
<i>Dependent Child(ren) Benefit Details</i>	
Voluntary Life and AD&D Guaranteed Issue Amount	\$10,000 Cannot exceed 100% of employee amount Child(ren) must primarily depend on employee for 50% or more of their support
Minimum Age	Birth
Maximum Age	Age 26

Employee & Spouse Monthly Rates By Age per \$1,000 of Benefit

Min Age	Max Age	Life/AD&D
0	29	\$0.06
30	34	\$0.07
35	39	\$0.11
40	44	\$0.17
45	49	\$0.25
50	54	\$0.41
55	59	\$0.65
60	64	\$0.83
65	69	\$1.42
70	999	\$3.72

Dependent Child(ren) Monthly Rate

Option	Life/AD&D
\$10,000	\$2.00

LEGAL/ID PROTECTION PLAN

Legal experts on your side, whenever you need them

For \$24 a month fee, you, your spouse and dependents get legal assistance for some of the most frequently needed personal legal matters – with no waiting periods, no deductibles and no claim forms, when using a network attorney for a covered matter. You can choose one from our network of prequalified attorneys, or use an attorney outside of our network and be reimbursed some of the cost.¹

Money Matters	<ul style="list-style-type: none"> Debt Collection Defense Identity Theft Defense LifeStages Identity Restoration Services² 	<ul style="list-style-type: none"> LifeStages Premium Identity Protection & Restoration² Negotiations with Creditors Personal Bankruptcy 	<ul style="list-style-type: none"> Promissory Notes Tax Audit Representation Tax Collection Defense
Home & Real Estate	<ul style="list-style-type: none"> Boundary & Title Disputes Deeds Eviction Defense Foreclosure 	<ul style="list-style-type: none"> Home Equity Loans Mortgages Property Tax Assessments Refinancing of Home 	<ul style="list-style-type: none"> Sale or Purchase of Home Security Deposit Assistance Tenant Negotiations Zoning Applications
Estate Planning	<ul style="list-style-type: none"> Codicils Complex Wills Healthcare Proxies Living Wills 	<ul style="list-style-type: none"> Powers of Attorney (Healthcare, Financial, Childcare, Immigration) 	<ul style="list-style-type: none"> Revocable & Irrevocable Trusts Simple Wills
Family & Personal	<ul style="list-style-type: none"> Adoption Affidavits Conservatorship Demand Letters Garnishment Defense Guardianship Immigration Assistance 	<ul style="list-style-type: none"> Juvenile Court Defense, Including Criminal Matters Name Change Parental Responsibility Matters Personal Property Protection Prenuptial Agreement 	<ul style="list-style-type: none"> Protection from Domestic Violence Review of ANY Personal Legal Document School Hearings
Civil Lawsuits	<ul style="list-style-type: none"> Administrative Hearings Civil Litigation Defense 	<ul style="list-style-type: none"> Disputes Over Consumer Goods & Services Incompetency Defense 	<ul style="list-style-type: none"> Pet Liabilities Small Claims Assistance
Elder-Care Issues	<ul style="list-style-type: none"> Consultation & Document Review for your parents: Deeds Leases 	<ul style="list-style-type: none"> Medicaid Medicare Notes Nursing Home Agreements 	<ul style="list-style-type: none"> Powers of Attorney Prescription Plans Wills
Vehicle & Driving	<ul style="list-style-type: none"> Defense of Traffic Tickets³ Driving Privileges Restoration 	<ul style="list-style-type: none"> License Suspension Due to DUI 	<ul style="list-style-type: none"> Repossession

Estate planning at your fingertips

Our website provides you with the ability to create wills, living wills and powers of attorney online in as little as 15 minutes. Answer a few questions about yourself, your family and your assets to create these documents instantly. In states where available, you also have access to sign and notarize your documents online through our video notary feature.⁴

To learn more about your coverages, view our attorney network, or grant your dependents access, create an account at members.legalplans.com or call 800.821.6400 Monday – Friday 8:00 am to 8:00 pm (ET).

- The Participant will be reimbursed according to the set fee schedule, the lesser of the maximum reimbursement amount or the attorney's actual charge. You will be responsible to pay the difference, if any, between the plan's payment and the non-plan attorney's charge for services. MetLife Legal Plans is not responsible for legal work performed by out-of-network attorneys.
- These benefits provide the Participant with access to LifeStages Identity Restoration Services and LifeStages Premium Identity Protection & Restoration provided by IdentityForce, A TransUnion® Brand. IdentityForce is not a corporate affiliate of MetLife Legal Plans.
- Does not cover DUI.
- Digital notary and signing is not available in all states.

Group legal plans are administered by MetLife Legal Plans, Inc., Cleveland, Ohio. In California, this entity operates under the name MetLife Legal Insurance Services. In certain states, group legal plans are provided through insurance coverage underwritten by Metropolitan General Insurance Company, Warwick, RI. For costs and complete details of the coverage, call or write the company. Some services not available in all states. No service, including consultations, will be provided for: 1) employment-related matters, including company or statutory benefits; 2) matters involving the employer, MetLife and affiliates and plan attorneys; 3) matters in which there is a conflict of interest between the employee and spouse or dependents in which case services are excluded for the spouse and dependents; 4) appeals and class actions; 5) farm and business matters, including rental issues when the participant is the landlord; 6) patent, trademark and copyright matters; 7) costs and fines; 8) frivolous or unethical matters; 9) matters for which an attorney client relationship exists prior to the participant becoming eligible for plan benefits. Coverage for defense of criminal matters is excluded from insurance coverage for individuals located in New York. For all other personal legal matters, an advice and consultation benefit is provided. Additional representation is also included for certain matters. Please see your plan description for details. [MLP3&CM]

Navigating life together

MetLife Legal Plans, Inc. | 111 Superior Avenue, Suite 800 | Cleveland, OH 44114

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 **ADVISORS**
EXCEL

2950

401(K) RETIREMENT PLAN

YOUR CONTRIBUTIONS

Employees are eligible for participation if they are full-time and at least 21 years of age on the first day of the month following original date of hire. Employees may contribute up to a combined 100% of eligible earnings on a pre-tax and/or after-tax basis subject to the IRS limits: for 2026 up to \$24,000 if you are younger than age 50; if you are 50 or older you can add an extra \$8,000 in “catch-up” contributions. Starting in 2025, if you fall within the age range of 60-63 by the end of the year, you can contribute an extra \$11,250 for an “enhanced catch-up” contribution. If you are 50 or older and earned more than \$150k in the previous year, catch-up contributions must be made on a Roth basis. You are always 100% vested in your contributions. You are 100% vested in the company match after six years of service.

TRADITIONAL PRE-TAX CONTRIBUTIONS

If you elect to make pre-tax deferrals, your taxable income is reduced by the deferral contributions, so you pay less in federal income taxes. Later, when the plan distributes the deferrals and earnings, you will pay the taxes on those deferrals and the earnings. Therefore, with a pre-tax deferral, federal income taxes on the deferral contributions and on the earnings are only postponed. Eventually, you will have to pay taxes on these amounts.

ROTH 401(K) POST-TAX CONTRIBUTIONS

If you elect to make Roth deferrals, the deferrals are subject to federal income taxes in the year of deferral. However, the deferrals and, in certain cases, the earnings on the deferrals are not subject to federal income taxes when distributed to you. In order for the earnings to be tax-free, you must meet certain conditions.

EMPLOYER MATCHING CONTRIBUTIONS



Advisors Excel also contributes to your retirement savings by offering an employer match. The match is 100% on the first 3% of employee contribution and 50% up to 8% of employee contribution. The employer match begins the first of the month following three months of employment. There is an \$8,000 annual limit on the match.

EMPOWER RETIREMENT

Empower Retirement’s website provides resources and tools to help you research investment options, 401(k) plan information, educational resources and many other financial resources for free.



To enroll or log in, go to:
participant.empower-retirement.com

If you need assistance, call a Participant Service Representative at 1.888.411.4015

Vesting Schedule

YEARS OF SERVICE	VESTED PERCENTAGE
1	0%
2	20%
3	40%
4	60%
5	80%
6	100%

Need Help?
Contact Empower Retirement at 800.338.4015



TWO WEST
MONEY SIMPLIFIED

Retirement Planning Services



One-On-One Financial Coaching

Access to unlimited one-on-one financial coaching!

- ✓ Retirement
- ✓ Debt management
- ✓ Savings goals
- ✓ Investments
- ✓ Spending analysis

Visit us at
[www.TwoWestAdvisors.com/
Financial-Planning-Resources](http://www.TwoWestAdvisors.com/Financial-Planning-Resources)
to schedule a time today!

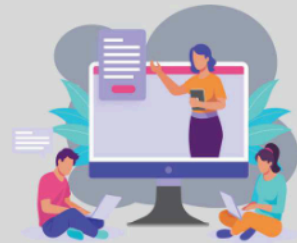
Join us monthly for our live financial education workshop!



Scan or click the QR code to sign up for a session!

Unable to join live? All workshops are recorded and available in the Workshop Library. [Click here to check it out!](#)

Financial Education Workshops



Five Minute Financial Plan



Get a personalized five-minute financial plan to get a jump start on your financial goals!

To get started...

1. Click or scan the QR code
2. Complete the questionnaire
3. Wait for your results to be emailed to you
4. Schedule a time with a coach to review!



Money Simplified.

EMPLOYEE ASSISTANCE PROGRAM - EAP



Employee Assistance Program

Helping you cope with the present and plan for the future



When life gets tough, it's helpful to have someone in your corner to listen, offer advice and point you in the right direction for additional help. That's what you get from DisabilityGuidanceSM—an Employee Assistance Program that offers confidential counseling when you need it most.

Your Employee Assistance Program

We're available 24/7 to assist you.

Call: 1-888-327-9573

TDD: 1-800-697-0353

Online: guidanceresources.com

Web ID: SYMETRA

When talking on the phone, mention Symetra as your employer sponsor.

Program Highlights

You and eligible family members can meet face-to-face with a counselor, financial planner or attorney for expert, confidential information and guidance.¹ Your household is eligible for a total of five sessions per calendar year, plus an additional five with a covered disability claim.² These services are included in the overall premium, so no additional payment is required to use the program.

Confidential Counseling

Trained counselors with a master's or doctorate degree are just a phone call away—and completely confidential. They'll listen to your concerns and quickly refer you to appropriate resources and providers for:

- Stress, anxiety and depression
- Credit card or loan problems
- Difficulties with children
- Job pressures
- Grief and loss
- Substance abuse

Financial Information and Resources

Contact a certified public accountant or certified financial planner for financial information and guidance, including:

- Getting out of debt
- Credit card or loan problems
- Tax questions
- Retirement planning
- Estate planning
- Saving for college

Legal Support

Talk to an attorney about:

- Divorce and family law
- Debt and bankruptcy
- Landlord/tenant issues
- Real estate transactions
- Civil and criminal actions
- Contracts

Need Legal Representation?

A guidance consultant will refer you to a qualified attorney in your area for a free 30-minute consultation. Any customary legal fees after that are reduced by 25%.

Your DisabilityGuidanceSM Employee Assistance Program

Access Anytime

Call: 1-888-327-9573

TDD: 1-800-697-0353

Online: guidanceresources.com

Web ID: SYMETRA

When talking on the phone, mention Symetra as your employer sponsor.



Confidential support, information and resources for all of life's challenges.
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EMPLOYEE ASSISTANCE PROGRAM - EAP



SERVICES AVAILABLE TO YOU!

The CFCC System of Care is defined by high quality, compassionate care delivered within a multi-disciplinary, integrated network of committed professionals.

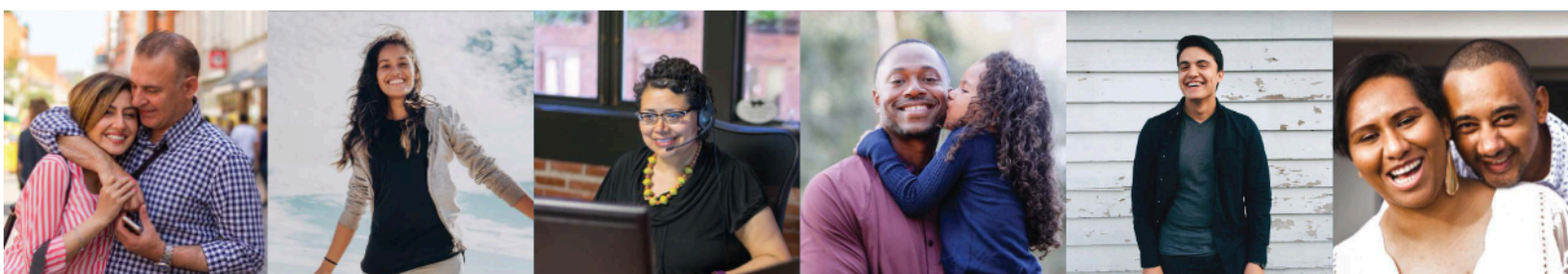
CFCC is dedicated to strengthening individuals, couples, families, and communities. At CFCC, you can receive counseling services related to a wide variety of mental health issues. Everyone deals with the many facets of life stressors. You may be dealing with a major life issue or just simply are wanting to remove all obstacles to becoming your best! Employees may receive up to five sessions per issue, per person, per calendar year.

We believe that no one should navigate life alone and we are here to help! We have 8 locations to serve you and your family. CALL TODAY! 785-272-0778

SERVICES INCLUDE:

Individual Therapy
Coping with loss, grief, or chronic illness, and life transitions
Couples Therapy
Anxiety, depression, job pressures, feelings of failure and guilt

Family Therapy
Spiritual guidance
Stress, anger & conflict management
Premarital counseling
Addiction issues
Military deployment and family reintegration



A COMPASSIONATE MINISTRY FOR HOPE AND HEALING FOR ALL PEOPLE

2000 SW Gage Blvd., Topeka, KS 66604 • 785-272-0778 (phone) • 785-272-2056 (fax) • christfirstcounseling.com

VOLUNTARY BENEFITS

Accident, Critical Illness, and Hospital Indemnity Insurance are the voluntary insurance plans available to employees and dependents through Symetra.

PLAN OPTIONS

Accident

Accidents can happen to anyone, at any time. Could you afford the financial impact if one happened to you or someone in your family? With accident insurance, you can be better prepared for the unexpected.

Accident insurance can cover out-of-pocket medical expenses related to an accidental injury. Benefits are paid for injuries resulting from an accident, and they don't interfere or coordinate with your major medical plan.

Even with major medical insurance, your out-of-pocket health care costs can be substantial. Accident insurance can help you offset your deductible, copay or coinsurance requirements while paying little to nothing from your own pocket. Benefits can also be used to pay for other expenses that may follow an accident, such as medical supplies, help with childcare or anything else you may need.

Hospital

If you end up in the hospital, you probably want to focus more on your recovery, not your medical bills. Hospital indemnity insurance can help with the cost of your stay, giving you and your family some financial peace of mind.

Hospital indemnity insurance pays a fixed dollar amount per day for services and supplies you receive during a hospital stay, up to a maximum number of days each year. Stays in a mental health, substance abuse or nursing facility are also covered. There are no pre-existing condition limitations, no health questions to answer and no medical tests to take. You're paid the full per-day benefit no matter what other insurance you have.

Pays a fixed dollar amount for each day of a hospital stay lasting 24 hours or more. Benefits are paid until you reach the maximum number of days stated in your policy. Your plan also has an initial day confinement benefit (admission benefit), which pays a higher benefit amount for your first day of a hospitalization. In addition to hospitals, benefits are paid for stays in other eligible facilities. Each facility has its own per-day benefit and calendar-year maximum.

Newborn benefit If you have a baby while you're covered under the hospital indemnity plan, not only is your hospital stay covered, but your newborn is automatically covered under this plan from birth through the first 31 days of life.

Critical Illness/ Cancer

Critical illness insurance can provide some financial relief during a serious medical condition or life event. Benefits can be used for anything - whether it's transportation, childcare or other expenses - helping you focus on your recovery rather than your finances.

If you are diagnosed with a covered condition after the policy is in effect, you will receive a lump-sum benefit payment based on the terms of your policy and the diagnosis. Benefits are paid directly to you, regardless of any other insurance coverage you may have.

A critical medical event usually leads to unknown and unexpected costs. And many of these - such as additional needs for transportation, childcare, help around the house and more - aren't covered by health insurance. Critical Illness Insurance can help pay for these additional expenses while you focus on your recovery.

HOSPITAL INDEMNITY WHAT'S COVERED



Once your coverage goes into effect, you can file a claim for covered conditions diagnosed after your insurance plan's effective date.

COVERAGE DETAILS		
	Low	High
Confinement Benefits		
First Day Hospital	\$500 per confinement period	\$1,000 per confinement period
Hospital Confinement	\$100/day up to 90 days	\$200/day up to 90 days
ICU Confinement	\$200/day, up to 30 days	\$400/day, up to 30 days
Covered Conditions		
Mental Nervous/ Substance Abuse	\$100/day, up to 30 days	\$200/day, up to 30 days
Healthy Newborn Nursery Confinement	Covered, Same as Mother	Covered, Same as Mother
Health Questions	Not Required	Not Required
Pre-existing Condition Limitation	None	None
Plan Highlights		
Portability	Included at same rates, even if master contract terms	
Child Eligibility Ages	From birth to 26 years	

SEMI-MONTHLY RATES		
Coverage	Low	High
Employee	\$4.93	\$8.94
Employee + Spouse/DP	\$10.12	\$18.90
Employee + Child	\$8.26	\$15.19
Family	\$13.86	\$25.15

FOR ALL PLAN DETAILS SEE SHAREPOINT [HERE](#)

ACCIDENT WHAT'S COVERED



Once your coverage goes into effect, you can file a claim for covered conditions diagnosed after your insurance plan's effective date.

COVERAGE DETAILS		
	Low	High
Initial Care		
Emergency Room	\$250	\$400
Urgent Care	\$200	\$250
X-ray	\$50	\$100
Hospitalization		
Admission	\$2,000	\$2,500
Confinement	\$400/day up to 365 days	\$500/day up to 365 days
ICU Admission	\$4,000	\$5,000
ICU Confinement	\$800/day up to 30 days	\$1,000/day up to 30 days
Rehabilitation	\$150/day up to 90 days	\$200/day up to 90 days
Surgery		
Cranial, Open Abdominal, Thoracic	\$1,500	\$2,500
Repair of Tendon, Ligament, Rotator Cuff	\$500 for 1 / \$1,000 for 2+	\$750 for 1 / \$1,500 for 2+
Exploratory/Arthroscopic	\$150	\$250
Life and Dismemberment Losses		
Employee	\$50,000	\$100,000
Spouse	\$25,000	\$50,000
Child	\$12,500	\$25,000
ONE hand, foot or eye	\$25,000	\$50,000
BOTH hands, feet or eyes	\$50,000	\$100,000
Speech or Hearing (both ears)	\$25,000	\$50,000
Thumb or Index Finger – same hand	\$2,500	\$5,000
Multiple fingers or toes – same hand/foot	\$10,000	\$20,000
Paralysis		
Quadriplegia	\$20,000	\$20,000
Paraplegia	\$12,500	\$20,000

FOR ALL PLAN DETAILS SEE [SHAREPOINT HERE](#)

ACCIDENT WHAT'S COVERED



COVERAGE DETAILS		
	Low	High
Other Benefits		
Appliances (wheelchairs, crutches, etc.)	\$400	\$500
Burns 2 nd /3 rd degree burns	2nd Degree: 20 - 100 square cm - \$200 2nd Degree: 101 - 225 square cm - \$600 2nd Degree: More than 225 square cm - \$1,000 3rd Degree: 20 - 100 square cms - \$500 3rd Degree: 101 - 225 square cm - \$3,000 3rd Degree: More than 225 square cm - \$15,000	2nd Degree: 20 - 100 square cm - \$400 2nd Degree: 101 - 225 square cm - \$1,200 2nd Degree: More than 225 square cm - \$2,000 3rd Degree: 20 - 100 square cms - \$1,000 3rd Degree: 101 - 225 square cm - \$6,000 3rd Degree: More than 225 square cm - \$20,000
Coma	\$15,000	\$20,000
Concussions	\$150	\$200
Dislocations (non-surgical/surgical)	Open: \$200 to \$6,000 Closed: \$100 to \$3,000	Open: \$250 to \$8,000 Closed: \$125 to \$4,000
Crowns	\$100	\$200
Extractions	\$30	\$65
Eye Injury (foreign object/surgical repair)	\$125	\$125
Fractures (non-surgical/surgical)	Open: \$200 to \$5,000 Closed: \$100 to \$2,500	Open: \$250 to \$8,000 Closed: \$200 to \$3,750
Lacerations	Not requiring sutures - \$40 Under 3 inches, required sutures - \$75 3 to 6 inches, requires sutures - \$250 Over 6 inches, requires sutures - \$500	Not requiring sutures - \$70 Under 3 inches, required sutures - \$125 3 to 6 inches, requires sutures - \$500 Over 6 inches, requires sutures - \$1,000
Lodging	\$50	\$100
Major Diagnostic Exams	\$100	\$200
Physical Therapy	\$50/visit up to 10 visits	\$75/visit up to 10 visits
Prosthetics (One/Two or more)	\$500, one per accident	\$1,000, one per accident
Transportation	\$250 per trip, up to 3 trips	\$500 per trip, up to 3 trips
Ambulance	\$400	\$600
Air Ambulance	\$1,500	\$2,000
Wellness	\$100	\$100

COVERAGE	SEMI-MONTHLY COST	
	Low Plan	High Plan
Employee	\$5.74	\$7.95
Employee + Spouse/DP	\$9.66	\$13.31
Employee + Child	\$11.15	\$15.25
Family	\$15.85	\$21.65

FOR ALL PLAN DETAILS SEE SHAREPOINT [HERE](#)

CRITICAL ILLNESS WHAT'S COVERED



Once your coverage goes into effect, you can file a claim for covered conditions diagnosed after your insurance plan's effective date.

COVERAGE DETAILS	
Core conditions	Invasive Cancer: 100%, Minor Cancer (in Situ): 50% Skin Cancer: \$1,000 Heart Attack: 100% Stroke: 100% Coronary Artery Disease Needing Surgery or Angioplasty: 25% Major Organ Failure: 100% Occupational HIV: 100% End-Stage Renal Failure: 100% Loss of Sight: 100% Loss of Speech: 100% Loss of Hearing: 100% Paralysis: 100% (Covers Sickness and Accident) Severe Burns: 100% Stem Cell Transplant: 100%
Neurological Conditions	ALS/Other Motor Neuron Disease: 100% Advanced Alzheimer's: 100% Parkinson's Disease: 25% Coma: 100% (Covers Accident & Sickness) Benign Brain Tumor: 100%
Childhood Conditions	Major Congenital Structural Anomaly: 100% Congenital Metabolic Disorder: 100% Congenital Chromosomal Abnormality: 100% Chronic Medical Condition Commonly Diagnosed in Childhood: 100%
Other Benefits	Type II Diabetes: 10% Complications from Type II Diabetes: 50% Occupational Hepatitis: 100%
Additional Occurrences	If you are diagnosed with a Covered Critical Illness, and you are then, at least one day later, diagnosed with a different Covered Critical Illness, we will also pay the additional Critical Illness benefit for the second covered condition.
Health Screening Benefit	Pays an annual benefit amount of \$50 for x-ray and laboratory tests only incurred by the employee, spouse, or child.
Recurrence Benefit	Pays an additional benefit of 100% of the critical illness benefit when a specific critical illness recurs more than 6 month(s) after the first diagnosis. Each condition is payable an unlimited number of times unless otherwise specified in the certificate.

FOR ALL PLAN DETAILS SEE [SHAREPOINT HERE](#)

CRITICAL ILLNESS – SEMI-MONTHLY RATES



Employee Semi-Monthly Rates

Coverage	<29	30-39	40-49	50-59	60-69	70+
\$10,000	1.63	2.28	4.58	80.28	16.10	35.25
\$20,000	3.25	4.55	9.15	16.55	32.20	70.50
\$30,000	4.88	6.83	13.73	24.83	48.30	105.75
\$40,000	6.50	9.10	18.30	33.10	64.40	141.00
\$50,000	8.13	11.38	22.88	41.38	80.50	176.25

Spouse/Domestic Partner Semi-Monthly Rates

Coverage	<29	30-39	40-49	50-59	60-69	70+
\$10,000	1.63	2.28	4.58	80.28	16.10	35.25
\$20,000	3.25	4.55	9.15	16.55	32.20	70.50
\$30,000	4.88	6.83	13.73	24.83	48.30	105.75
\$40,000	6.50	9.10	18.30	33.10	64.40	141.00
\$50,000	8.13	11.38	22.88	41.38	80.50	176.25

Child Semi-Monthly Rates

Coverage	<29
\$5,000	0.17
\$10,000	0.33
\$15,000	0.50
\$20,000	0.66
\$25,000	0.83

For details
on all the
Symetra
Voluntary
Plans



Please visit
SharePoint
HERE

ADDITIONAL BENEFITS

PAID TIME OFF*

Full-Time Employees with Less Than One Full Year of Service Prior to Jan. 1

For the purposes of PTO, a new employee hired on or before the 15th of the month will be considered to have been hired in that month; a new employee hired the 16th of the month or after will be considered to have been hired in the following month.

Month of Hire	Number of PTO Hours
January	120
February	110
March	100
April	90
May	80
June	70
July	60
August	50
September	40
October	30
November	20
December	10

Full Years of Completed Service Prior to Jan. 1

Each completed year worked by an employee from Jan. 1 of one year to December 31 of that year is considered a completed year of service for PTO purposes.

Full Years of Service * Prior to January 1	Number of PTO Hours
Less than 1 year completed service, but more than one month	120 Hours (15 Days)
At least 1 year, but less than 2 years	136 Hours (17 Days)
At least 2 years, but less than 3 years	152 Hours (19 Days)
At least 3 years, but less than 4 years	168 Hours (21 Days)
At least 4 years, but less than 5 years	184 Hours (23 Days)
At least 5 years, but less than 6 years	200 Hours (25 Days) 5 weeks cap

*Employees can carry over a maximum of 80 hours per year. Carryover/Cap rules may vary based on residing state.

HOLIDAYS/ BIRTHDAY

- New Year's Day
- Martin Luther King Jr. Day
- Memorial Day
- Juneteenth
- Independence Day
- Labor Day
- Thanksgiving Day
- Friday After Thanksgiving
- Christmas Eve
- Christmas Day

• Your Birthday
(Submitted as PTO request; timing arranged with your supervisor)

AEWM holiday schedule is subject to market availability requirements.

EVENTS

Incentive Trip As a reward for hitting our annual stretch goals set by the founders, all Advisors Excel employees and their significant others are taken on an all-inclusive, company-wide vacation! An employee's date of hire may affect eligibility.

FUNC = THE FUN COMMITTEE

Over 30 AE employees volunteer their time to dream up and deliver awesome events—whether it's family fun, friendly competition, or all-employee get-together. We're talking bingo showdowns, sports tournaments, craft nights, pool parties, and so much more. If it's fun, FUNC is probably behind it!

GIVING BACK

We understand how incredibly blessed we've been as an organization, and we regularly seek opportunities to give back. Each year, the company contributes financially to a variety of causes and organizations—but we're committed to being more than just financial benefactors. We believe our greatest resource is our talented team of more than 1,000 employees, and we strive to make a real difference in the community by volunteering our time and skills.



HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

General Information

The Health Insurance Marketplace offers individuals that qualify a way to buy health insurance other than through an employer-sponsored plan. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment-based health coverage offered by your employer.

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 tax credit that lowers your monthly premium right away. Open enrollment for health insurance through the Marketplace begins in November for coverage starting on January 1.

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% of your household income for the plan 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.

The group health plan offered by your employer to full-time employees satisfies the minimum value standard, and the cost is intended to be affordable based on employee wages.

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.

Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact your Human Resources Department.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its costs. Please visit [Healthcare.gov](https://www.healthcare.gov) for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: INFORMATION ABOUT HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Advisors Excel, LLC		4. Employer Identification Number (EIN) 20111111	
5. Employer address 2950 SW McClure Road		6. Employer phone number 866-363-9595	
7. City Topeka	8. State KS	9. ZIP code 66614	
10. Who can we contact about employee health coverage at this job? Laura Moyer			
11. Phone number (if different from above)		12. Email address laura.moyer@advisorsexcel.com	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

- ✗ All employees. Eligible employees are working 30 hours or more per week and are eligible the first of the month following date of hire.

- Some employees.

- With respect to dependents:

- ✗ We do offer coverage. Eligible dependents are: *Lawful spouse, domestic partner, handicapped child(ren), children by birth, step-children (must be under age 26); grandchild(ren) with court-ordered custody; adopted child or placement for adoption may be eligible.*

- We do not offer coverage.

- ✗ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

*** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.*

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Above is the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

LEGAL & SPECIAL ENROLLMENT NOTICES

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the 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.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT (NMHPA)

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

the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

HIPAA PRIVACY NOTICE

Advisors Excel is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about the uses of protected health information (PHI) and your privacy rights. PHI use and disclosure by Advisors Excel plan is regulated by federal law known as HIPAA (the Health Insurance Portability and Accountability Act). A full description of our HIPAA Privacy Practices is available on request from the Human Resources department.

SPECIAL ENROLLMENT NOTICE

This notice is being provided to ensure that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive coverage at this time.

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, 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 you and your dependents other coverage). However, you must request enrollment within 30 days after you or your dependents other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoptions or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. To request special enrollment or obtain more information, contact the Human Resources department.

Laura Moyer
866.363.9595
laura.moyer@advisorsexcel.com

LEGAL NOTICES

RIGHT TO DESIGNATE PRIMARY CARE PROVIDER

Blue Cross and Blue Shield of Kansas generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, go to www.bcbsks.com.

You do not need prior authorization from Blue Cross and Blue Shield of Kansas or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

For a list of participating health care professionals who specialize in obstetrics or gynecology, visit Blue Cross and Blue Shield of Kansas at www.bcbsks.com.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This includes BCBS, Delta Dental, Ameritas, CFCC & Associates EAP and on-site mental health services. **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.**

In general, COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end, such as when you leave an employer. **You may also have other options available to you when you lose group health coverage**, such as enrolling in another group health plan or buying an individual plan through the Health Insurance Marketplace.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of changes in your life known as qualifying events (which are listed below). 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 a qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay the premiums for it.

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

- The employee dies;
- The employee's hours of employment are reduced;
- The employee's employment ends for any reason other than their gross misconduct;
- The employee becomes entitled to Medicare benefits (under Part A, Part B or both); or
- The employee becomes divorced or legally separated from their spouse.

In addition, dependent children will become qualified beneficiaries if they lose coverage due to a change in dependent status.

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

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; 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. You must provide this notice to the Human Resources department.

Once the Plan Administrator receives notice of a qualifying event, continuation coverage will be offered to all qualified beneficiaries, each of which will have an independent right to elect COBRA 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.

HOW LONG CAN I STAY ON COBRA?

COBRA is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. 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 able to extend your COBRA coverage up to an additional 11 months, for a maximum of 29 months. The disability would have to have started before the 60th day of COBRA coverage and must last at least until the end of the 18-month period of COBRA coverage.

Second qualifying event extension – If your family experiences a second 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: 1) the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B or both), or gets divorced or legally separated; or 2) 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, you and your family could get coverage through the Health Insurance Marketplace, Medicaid or another group health plan coverage (such as a spouse's plan) through what is called a "special enrollment period." 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). You can learn more about many of these options at www.healthcare.gov.

IF YOU HAVE QUESTIONS

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), COBRA, the Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the Employee Benefits Security Administration (EBSA) or visit www.dol.gov/ebsa.

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

Laura Moyer
laura.moyer@advisorsexcel.com
866.363.9595

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, 2025. Contact your State for more information on eligibility –

ALABAMA - Medicaid

Website: <http://myalhipp.com/>
Phone: 1-855-692-5447

ALASKA - Medicaid

The AK Health Insurance Premium Payment Program Website:
<http://myakhipp.com/>
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: <http://health.alaska.gov/dpa/Pages/default.aspx>

ARKANSAS - Medicaid

Website: <http://myarhipp.com/>
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA - Medicaid

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+)

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>
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

FLORIDA – Medicaid

Website: <https://www.flmedicaidplrecovery.com/flmedicaidplrecovery.com/hipp/index.html>
Phone: 1-877-357-3268

GEORGIA – 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

INDIANA - Medicaid

Health Insurance Premium Payment Program
All other Medicaid
Website: <http://www.in.gov/medicaid/>
<https://www.in.gov/fssa/dfr/>
Family and Social Services Administration

Phone: 1-800-403-0864

Member Services Phone: 1-800-457-4584

IOWA - Medicaid and CHIP (Hawki)

Medicaid Website: [iowa Medicaid | Health & Human Services](http://iowa.Medicaid.IHealth&HumanServices)
Medicaid Phone: 1-800-338-8366
Hawki Website: [Hawki - Healthy and Well Kids in Iowa | Health & Human Services](http://Hawki-HealthyandWellKidsinIowa.IHealth&HumanServices)
Hawki Phone: 1-800-257-8563
HIPP Website: [Health Insurance Premium Payment \(HIPP\) | Health & Human Services \(iowa.gov\)](http://HealthInsurancePremiumPayment(HIPP)|Health&HumanServices(iowa.gov))
HIPP Phone: 1-888-346-9562

KANSAS - Medicaid

Website: <https://www.kancare.ks.gov/>
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY - 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: KIHIPPPROGRAM@ky.gov
KCHIP Website: <https://kynect.ky.gov>
Phone: 1-877-524-4718
Kentucky Medicaid Website: <https://chfs.ky.gov/agencies/dms>

LOUISIANA - Medicaid

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

Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US
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

MASSACHUSETTS - Medicaid AND CHIP

Website: <https://www.mass.gov/masshealth/pa>
Phone: 1-800-862-4840 TTY: 711
Email: masspreassistance@accenture.com

MINNESOTA - Medicaid

Website: <https://mn.gov/dhs/health-care-coverage/>
Phone: 1-800-657-3672

MISSOURI - Medicaid

Website: <http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>
Phone: 573-751-2005

MONTANA - Medicaid

Website: <http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>
 Phone: 1-800-694-3084
 Email: HSHIPPProgram@mt.gov

NEBRASKA - Medicaid

Website: <http://www.ACCESSNebraska.ne.gov>
 Phone: (855) 632-7633
 Lincoln: (402) 473-7000
 Omaha: (402) 595-1178

NEVADA - Medicaid

Medicaid Website: <https://dhcfp.nv.gov>
 Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

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 15218
 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP

Medicaid Website: <https://www.state.nj.us/humanservices/dmahs/clients/medicaid/>
 Phone: 1-800-356-1561
 CHIP Premium Assistance Phone: 609-631-2392
 CHIP Website: <http://www.njfamilycare.org/index.html>
 CHIP Phone: 1-800-701-0710 (TTY: 711)

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/
 Phone: 1-800-541-2831

NORTH CAROLINA - Medicaid

Website: <https://medicaid.ncdhhs.gov/>
 Phone: 919-855-4100

NORTH DAKOTA - Medicaid

Website: <https://www.hhs.nd.gov/healthcare>
 Phone: 1-844-854-4825

OKLAHOMA - Medicaid and CHIP

Website: <http://www.insureoklahoma.org>
 Phone: 1-888-365-3742

OREGON - Medicaid

Website: <http://healthcare.oregon.gov/Pages/index.aspx>
 Phone: 1-800-699-9075

PENNSYLVANIA - Medicaid and CHIP

Website: <https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html>
 Phone: 1-800-692-7462
 CHIP Website: [Children's Health Insurance Program \(CHIP\) \(pa.gov\)](http://www.dhs.pa.gov/childrens-health-insurance-program-chip)
 CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND - Medicaid and CHIP

Website: <http://www.eohhs.ri.gov/>
 Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line)

SOUTH CAROLINA - Medicaid

Website: <https://www.scdhhs.gov>
 Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid

Website: <http://dss.sd.gov>
 Phone: 1-888-828-0059

TEXAS - Medicaid

Website: [Health Insurance Premium Payment \(HIPP\) Program | Texas Health and Human Services](http://www.hhs.texas.gov/health-insurance-premium-payment-hipp-program)
 Phone: 1-800-440-0493

UTAH - Medicaid and CHIP

Utah's Premium Partnership for Health Insurance (UPP) Medicaid
 Website: <https://medicaid.utah.gov/upp/>

Email: upp@utah.gov

Phone: 1-888-222-2542

Adult Expansion Website: <https://medicaid.utah.gov/expansion/>

Utah Medicaid Buyout Program Website: <https://medicaid.utah.gov/buyout-program/>

CHIP Website: <https://chip.utah.gov/>

VERMONT - Medicaid

Website: [Health Insurance Premium Payment \(HIPP\) Program | Department of Vermont Health Access](http://www.vermont.gov/health-access)
 Phone: 1-800-250-8427

VIRGINIA - Medicaid and CHIP

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

Website: <https://www.hca.wa.gov/>
 Phone: 1-800-562-3022

WEST VIRGINIA - Medicaid and CHIP

Website: <https://dhr.wv.gov/bms/>

HIPP: <http://mywvhipp.com/>

Medicaid Phone: 304-558-1700

CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN - Medicaid and CHIP

Website: <https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm>
 Phone: 1-800-362-3002

WYOMING - Medicaid

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, 2025, 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

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 have to 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 balance 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 never required to give up your protections 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 entity responsible for enforcing the federal and/or state balance or surprise billing protection laws. Visit <https://www.commonwealthfund.org/publications/maps-and-interactives/2022/feb/map-no-surprises-act#map> for information and to view the No Surprises Act Map.

For more information about the impact of the No Surprises Act on consumers, including how to file complaints, please refer to the Centers for Medicaid and Medicare Services' [No Surprises Act Consumer FAQ page](#).

Visit <https://www.cms.gov/nosurprises/policies-and-resources/overview-of-rules-fact-sheets> for more information about your rights under federal law.

Visit <https://www.ncsl.org/health/surprise-and-balance-billing-state-policy-options> for more information about your rights under state law.

To contact state regulators regarding the No Surprises Act, please [click here](#) for agency websites.

The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.



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