



2024

BENEFITS

IMPORTANT NOTICE: READ CAREFULLY

This benefits guide briefly describes your benefit choices and your options to enroll. All benefits, and your eligibility for benefits, are subject to the terms and conditions of the benefit plans, including group insurance contracts. This guide is not intended to be a complete description of the benefit plans and it is not a summary plan description or plan document. In the event of any conflict or discrepancy between this guide and the plan documents, the plan documents will govern. The Plan Sponsor reserves the right to modify or terminate any of the described benefits at any time and for any reason. This guide is not a guarantee of current or future employment or benefits.

A MESSAGE FROM USA

Dear Valued Employee,

USA knows that our most important asset is the dedicated employees that work hard to deliver the quality service that our clients have come to expect. Knowing that, we are committed to providing quality health benefits to our valued employees and their eligible dependents.

As you are aware, the cost of healthcare has continued to rise at double digit levels over the past decade. It is now one of the nation's largest issues. USA has worked hard to create a solution that will control the rising cost to the company as well as our employees.

We urge you to read this benefit guide carefully and keep it for future reference. If you are well informed you will be in a better position to make the appropriate choices and take full advantage of your benefits as a valued member of our team.

We encourage you to contact Human Resources or the SolV Independent Insurance Associates Benefits Advocacy Line at 833.4.SOLVIT or BAT@solvins.com if you should have any questions regarding your employee benefits package.

Sincerely,

USA

Human Resources

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ELIGIBILITY & ENROLLMENT

ELIGIBILITY

In order to be eligible for benefits you must work a minimum of 30 hours per week in a regular full-time position. Coverage will begin on the first day of the month following 60 days from your hire date.

If you are not currently eligible for benefits, but in the future your employment status changes to an eligible class, you will be allowed to join the plan on the first of the month following 30 days of your status change.

HOW TO ENROLL

You can enroll for coverage within 30 days of your date of hire, or during the annual open enrollment period. All enrollments and changes must be completed through MyHealthBenefits at www.myhealthbenefits.com (see page 11 for more details).

ELIGIBLE DEPENDENTS

Our benefit plans are available to you and your family members. You can enroll yourself, your legal spouse, domestic partner and eligible children. Eligible children under the plan include biological, adopted, or step- child(ren) up to the age of 26. If your child is disabled before the age of 26, they may be eligible for continued coverage while disabled beyond age 26.

WAIVING COVERAGE

If you elect to waive your coverage options through USA, you still must act. You must provide a reason for waiving coverage in your MyHealthBenefits portal. Please keep in mind that you will not be allowed to enroll in any of the offered plans if you later change your mind unless you experience a qualified event (see the next page). You will be allowed to enroll during the next Open Enrollment period if you are still eligible.

NEARING MEDICARE ELIGIBILITY?

Are you or your spouse nearing Medicare eligibility age? If so, there are important things you should know about how your employer-sponsored plans integrate with Medicare. Reach out to your HR department or the SolV Benefits Advocacy Team (BAT) for more information about what steps you should take if you are, or will be, eligible for Medicare.

ELIGIBILITY & CHANGES

MAKING CHANGES

If you experience a qualifying event such as marriage, divorce, birth/adoption of a child or you lose other group coverage you have 31 days to notify Human Resources and make changes to your elections.

HIPAA SPECIAL ENROLLMENT RIGHTS

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides employees additional opportunities to enroll in a group health plan if they experience a loss of other coverage or certain life events.

If you are declining coverage at this time for either yourself or your eligible dependents, you may be able to enroll yourself and/or your eligible dependents in coverage at a later date if there is a loss of other coverage. You must enroll and provide the required supporting documentation within 31 days of the date your other coverage ends.

In addition, you may be able to enroll yourself and your eligible dependents if you have a qualifying life event (e.g. change in your marital status, birth or adoption of a child, death of dependent or change in employment status.) You must enroll and provide the applicable required supporting documentation within 31 days of the qualifying life event.

For additional information regarding your rights under HIPAA, please visit the US Department of Labor website at: http://www.dol.gov/ebsa/faqs/faq_consumer_hipaa.html

REDUCTION OF HOURS

If you experience a loss in hours and you are not regularly working the required 30 hours per week to maintain eligibility, you will lose coverage. You will be eligible for continuation of coverage when applicable.

IF YOU LEAVE YOUR JOB

In the event that your employment with your employer ends, qualified beneficiaries will be offered COBRA continuation coverage. You will receive election paperwork and be given the opportunity to continue to cover yourself or your previously enrolled dependents on the plan.

MEDICARE INFORMATION & FAQs

Our Team at SolV includes a Medicare expert who can work with our employees personally to help you understand Medicare, when and how to enroll, and your best coverage options for healthcare services and medications. You're welcome to reach out directly as follows:



Helen Ornellas (CA Lic#0D63358)
Email: Helen@OrnellasInsurance.com
Phone Number: 916.804.9888

FREQUENTLY ASKED QUESTIONS

Who is eligible for Medicare?

Medicare is a health insurance program for people age 65 and older, people under 65 with certain disabilities, and people of all ages with End-Stage Renal Disease (ESRD).

What is original Medicare?

Part A (Hospital Insurance — no cost): Helps cover inpatient care in hospitals, skilled nursing facility care, hospice care, and home health care.

Part B (Medical Insurance — premium applicable): Helps cover services from doctors and other health care providers, outpatient care, home health care, durable medical equipment (like wheelchairs, walkers, hospital beds, and other equipment), many preventive services (like screenings, shots or vaccines, and yearly "Wellness" visits).

Medicare Advantage (also known as Part C— premium applicable): Medicare Advantage is Medicare-approved plan from a private company that offers an alternative to Original Medical (Part A & B) for your health and drug coverage. These "bundled" plans include Part A, Part B, and usually Part D. In most cases, you'll need to use doctors who are in the plan's network. Plans may have lower out-of-pocket costs than Original Medicare. Plans may offer some extra benefits that Original Medicare doesn't cover—like vision, hearing, and dental services.

Part D (Drug coverage— premium applicable): Helps cover the cost of prescription drugs (including many recommended shots or vaccines). You join a Medicare drug plan in addition to Original Medicare, or you get it by joining a Medicare Advantage Plan with drug coverage. Plans that offer Medicare drug coverage are run by private insurance companies that follow rules set by Medicare.

Medicare Supplemental Insurance (Medigap —premium applicable): Extra insurance you can buy from a private company that helps pay your share of costs in Original Medicare. Policies are standardized, and in most states named by letters, like Plan G or Plan K. The benefits in each lettered plan are the same, no matter which insurance company sells it.

Where to enroll?

Medicare Website: <https://www.medicare.gov/basics/get-started-with-medicare/sign-up/ready-to-sign-up-for-part-a-part-b>

Social Security: <https://www.ssa.gov/medicare/sign-up>

MEDICARE FREQUENTLY ASKED QUESTIONS

Why enroll?

You can potentially save money in out-of-pocket costs. Medicare benefits are geared toward Medicare age recipients. Plans can include dental, vision, and hearing coverage for no extra charge. With Advantage plans you may choose an HMO or PPO Network. Finally, with Supplemental plans you have the freedom to go to any doctor(s) that accept Medicare.

When to enroll?

You should sign up when you're first eligible for Part A (Hospital Insurance) and Part B (Medical Insurance). Generally, you're first eligible to sign up for Part A and Part B starting 3 months before you turn 65 and ending 3 months after the month you turn 65. If you don't enroll onto Medicare during your initial enrollment opportunity (when you turn 65), you must wait to sign up during Open Enrollment (Jan 1– Mar 31) and will be given a July 1st effective date. To supplement Parts A & B you will have several times during the year in which you can enroll onto Advantage (Part C), Supplemental Plans (Medigap) or a Stand-alone-prescription plan (Part D).

If I am retiring soon, what are my next steps?

If you're going to obtain retirement benefits from Social Security at least 4 months before you turn 65, you'll automatically get Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) when you turn 65.

What do Social Security benefits have to do with enrolling onto Medicare?

Before you turn 65: If you apply to start receiving retirement benefits from Social Security (or the Railroad Retirement Board) at least 4 months before you turn 65, you'll automatically get Part A (Hospital Insurance) and Part B (Medical Insurance) when you turn 65. You'll still need to make important decisions about how you get your coverage, including adding drug coverage. If you want to enroll in Medicare when you turn 65 but aren't planning to take retirement benefits at that time, you'll need to initiate the enrollment process for Medicare.

After you turn 65: You'll have to contact Social Security when you're ready to sign up for Medicare or enroll online. Depending on your employment situation and if you have health coverage through your employer, you may want to wait to sign up for Medicare Part B.

Can I stay on my employer's medical insurance if I am over the age of 65 and not retiring?

You and/or your spouse should enroll onto Medicare Parts A & B when you or your spouse first become eligible. If you choose to defer your enrollment in Part B and remain on USA's medical plan, you may do so without penalty. When you experience a qualifying event (i.e., retire, reduction of hours, terminated) this will create a Special Enrollment Period (SEP) for you onto Medicare.

Is there a penalty if I don't sign up for Medicare when I am first eligible?

Yes, a penalty may apply if you do not enroll when you are initially eligible. Penalties may be avoided if you/or your spouse are enrolled in other group coverage. You might also pay a monthly penalty for as long as you don't have Part B or creditable coverage. The penalty increases the longer you wait to sign up.

MEDICAL INSURANCE

USA offers three medical plans that are administered by Benefit & Risk Management Services (BRMS). They are all open access plans that allow you the freedom and flexibility to select a provider of your choosing. For California employees, you have access to the Networks by Design network of providers that are recommended for this plan design. For more information about Networks by Design providers for California, see page 9.

Below is a brief description of the components that make up your USA medical arrangement.



Benefit & Risk Management Services (BRMS) is the Third-Party Administrator (TPA) for the USA medical plan. BRMS provides the following for USA employees:

- Customer service for ALL medical plan related questions
- Medical management administration
- MyHealthBenefits Portal
- Medical ID cards
- Explanation of Benefits (EOB) documentation
- Pre-certifications (see page 11 for details)
- Case Management (see page 10 for details)



USA is partnering with ClaimDoc to assist you with reviewing and evaluating every claim to ensure your healthcare costs are paid at a fair and reasonable price. ClaimDoc provides claim review, member support and advocacy, and expert legal services. If you ever receive a bill that does not match the EOB from BRMS, contact BRMS and they will connect you to ClaimDoc for help. One of their dedicated Member Service Advocates will work with you through the resolution of your billing issue.



MagellanRx is the Prescription Benefits Manager for the USA health plan. The Magellan pharmacy network consists of independent and retail pharmacies. Please visit magellanrx.com/member/find-a-pharmacy to access the Network Pharmacy Locator Tool.

MEDICAL

	BRMS Traditional HRA Medical Plan	BRMS Alternative HRA Medical Plan
GENERAL PLAN PROVISIONS	MEMBER RESPONSIBILITY	MEMBER RESPONSIBILITY
Deductible Individual/Family	\$3,000 / \$6,000	\$3,000 / \$6,000
Calendar Year Out-of-Pocket Limit Individual/Family	\$3,500 / \$7,000	\$3,500 / \$7,000
USA HRA Annual Contribution* Individual/Family	\$1,500 / \$3,000	\$1,000 / \$2,500
Deductible Accumulation	Embedded	Embedded
OUTPATIENT SERVICES		
Physician & Specialist Office Visit	No cost after deductible	\$50
Teladoc Physician Visit	No cost	No cost
Preventive Care	No cost	No cost
Lab & X-Ray	No cost after deductible	No cost after deductible
Outpatient Surgery in Facility	No cost after deductible	No cost after deductible
INPATIENT SERVICES		
Hospitalization	No cost after deductible	No cost after deductible
EMERGENCY & URGENT SERVICES		
Emergency Room	No cost after deductible	No cost after deductible
Urgent Care	No cost after deductible	No cost after deductible
PRESCRIPTION DRUGS – Liviniti	30-DAY SUPPLY	30-DAY SUPPLY
Generic	\$10 after deductible	\$10
Brand – Preferred	\$30 after deductible	\$30 after deductible
Brand – Non-Preferred	\$50 after deductible	\$50 after deductible
Specialty Medication	\$50 after deductible	\$50 after deductible
Cost	Per Pay Period – Weekly	Per Pay Period – Weekly
Employee Only	\$50	\$39
Employee + Spouse	\$94	\$90
Employee + Child(ren)	\$85	\$80
Employee + Family	\$139	\$132

*** Note:** Each year up to half of the medical deductible of unused HRA funds from the current plan year will be rolled over to the next calendar year. HRA funds are pro-rated for new participants effective after the beginning of the calendar year.

BRMS Copay Medical Plan	
GENERAL PLAN PROVISIONS	MEMBER RESPONSIBILITY
Deductible Individual/Family	\$1,500 / \$3,000
Calendar Year Out-of-Pocket Limit Individual/Family	\$3,500 / \$7,000
Deductible Accumulation	Embedded
OUTPATIENT SERVICES	
Physician Office Visit	\$30
Specialist Office Visit	\$50
Teladoc Physician Visit	No cost
Preventive Care	No cost
Lab & X-Ray	\$50
Outpatient Surgery in Facility	20% after deductible
INPATIENT SERVICES	
Hospitalization	20% after deductible
EMERGENCY & URGENT SERVICES	
Emergency Room	20% after deductible
Urgent Care	\$50
PRESCRIPTION DRUGS – Livinit	30-DAY SUPPLY
Generic	\$10
Brand – Preferred	\$30
Brand – Non-Preferred	\$50 after deductible
Specialty Medication	\$50 after deductible
Cost	Per Pay Period – Weekly
Employee Only	\$23
Employee + Spouse	\$82
Employee + Child(ren)	\$72
Employee + Family	\$124

MEDICAL – FIND A RECOMMENDED CA PROVIDER



NETWORKS BY DESIGN

Attention: Employees that reside in California - USA will continue to partner with Networks by Design (NBD) to offer you a selection of in-network medical providers in your area.

Before scheduling an appointment, follow these steps:

1. Visit www.NetByD.com
2. Click on the "Find a Doctor or Facility" tab located at the top of the page below NBD's logo
3. Click on "Group Health" under the Product Line section

Find a Doctor or Facility

Last Name:

Facility:

City:

Product Line: ☒ Group Health
☐ Workers Compensation

Specialties:

Primary Care

Acupuncture

Acute Care Hospital

Acute Care Referral Hospital

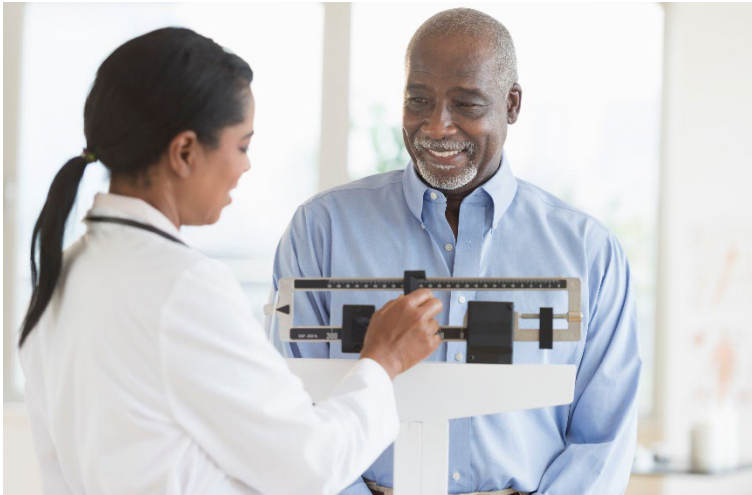
County:

Language:

4. Enter the minimum search criteria
 - Name of Provider and/or Specialty
 - Location
5. Click Search

If your California provider is not within the NBD network, you may click on "Nominate a Provider", complete the form and click "Submit". Networks by Design will receive your nomination and notify you via e-mail of the Recruitment Specialist who will personally be contacting the provider. You are invited to contact the Recruitment Specialist to obtain status of a nominated provider.

Attention: Employees that reside in Nevada - Your providers and facilities (hospitals and outpatient surgery centers for example) are "open access", meaning you may visit any provider or facility and receive in-network benefits. You can disregard these instructions and see page 10 for more information.



MEDICAL – OPEN ACCESS PROVIDERS & FACILITIES



For California/Nevada facilities and Nevada providers you have the freedom to choose any provider you wish! All medical plan options through USA do not utilize a specific network, other than Networks by Design for California Doctors.

All benefits are paid at the same benefit level and there are no out-of-network penalties. As long as your provider agrees to submit claims to BRMS (your plan administrator), you are only responsible for your applicable co-pays, deductibles and co-insurance.

INTRODUCING THE PLAN TO YOUR PROVIDERS

In order to avoid confusion or issues surrounding access, please allow a ClaimDOC Member Advocate to contact your providers BEFORE your first appointment by submitting a Provider Nomination Form to ClaimDOC via phone, email or online.



Call a Member Advocate
1-888-330-7295



Email your form
membersupport@claim-doc.com



Submit an online form
portal.claim-doc.com/guest
PIN: TL95242

Present your ID card at the medical office and say "I have benefits and my plan will pay!". The representative should take a copy of your card and locate the claims submission address and Electronic Payor ID for claims processing. If you run into any issues, please have the providers office call 888-330-7295 to speak with a ClaimDOC representative.



DID YOU RECEIVE A BALANCE BILL?

A balance bill is any amount a provider is billing you that is more than what your Explanation of Benefits (EOB) from BRMS says you are responsible for, after the insurance has paid.

Follow the steps below for assistance!

Step 1

If you have a provider or billing issue, call ClaimDOC at 888-330-7295 or email balancebills@claim-doc.com

Step 2

ClaimDOC will collect your information, have you sign proper documentation granting ClaimDOC authorization to handle the bill on your behalf

Step 3

A ClaimDOC Support Specialist will be assigned to your case

Step 4

ClaimDOC will work with the provider and your employer to resolve the issue

Ongoing Communication

You will be provided updates throughout the process and upon resolution. If you continue to receive balance bills or receive any other communications, let ClaimDOC know immediately.



BRMS BENEFITS PORTAL

With MyHealthBenefits from BRMS, you are able to do much more than enroll in benefits. The platform allows you to add or remove dependents, modify beneficiary designations and access a comprehensive resource library with important information about your plan. The system is available year-round to check your benefit information or record a family status change.

To login or register, visit www.myhealthbenefits.com. All new users will be required to go through the registration process to create a new username and password. To register for an account, click "Create New Account". Complete the registration and validation process then you'll be taken to your benefits dashboard.

BRMS – MEMBER ADVOCATE CONCIERGE SERVICE

USA has partnered with BRMS to provide you with a resource to help you understand your benefits and your financial responsibility after utilizing the medical plan. Here's how it works:

1. After BRMS receives & processes a claim they will send you an Explanation of Benefits (EOB), as well as an HRA Statement & a copy of an HRA check paid to the provider if HRA funds were available to use. The information explains what was covered & what your financial responsibility is for the services.
2. For claims with billed amounts over \$250, BRMS will follow up the above mailing with a phone call to you*, approximately 7-10 days after the above mailing, asking if you have any questions regarding your claim or the information sent.
3. If the advocate does not reach you live, they will leave you a voice message and include a toll-free phone number to call if you would like to discuss.
4. We recommend adding BRMS' phone number to your contacts so if you do get a call from them, you will recognize it. The BRMS phone number to add to your contacts is (916) 467-1400

***Be sure to complete the one-page BRMS 'HIPAA Consent Form/Release of Information' so that the BRMS Employee Advocate Concierge representative can call you. By law they cannot contact you unless this form is on file for each family member.**

BRMS – CASE MANAGEMENT

Medical Case Management will continue to be mandatory in 2024. Medical Case Management will provide you with tools, information, and the necessary people to help you stay healthy. If you have a condition that requires the medical case management team to become engaged, you will receive a call from the dedicated nurse team at BRMS. **Should you decide NOT to participate in the case management program, you will forfeit your coverage and will no longer be eligible for benefits under the Plan.** The coverage termination process will commence following a specified number of contact attempts by the case management department if no response is made within a timely fashion. This program allows us to ensure you are receiving the best care for your condition.

BRMS – PRE-CERTIFICATION

Your medical plan requires that certain procedures be pre-certified before they are performed. Precertification helps determine if the course of treatment you will receive is both medically necessary and cost effective. Pre-certification services are provided by BRMS.

Most often the ordering physicians will coordinate the pre-certification, however, it is up to you as the member to ensure that your physician has completed the proper steps to pre-certify the procedure. Should you undergo the procedure without prior approval on file, the allowed charges on the claim will be reduced by \$500 and you will be responsible for payment of the part of the charge that is not paid by the plan. Since this is considered a penalty, it will not apply to the deductible or out-of-pocket maximum.



Please familiarize yourself with the list of services that are required to be pre-certified.

- Inpatient Hospitalization
- Transplant Candidacy Evaluation and Transplant (organ and/or tissue)
- All outpatient procedures not performed in a physician's office, including freestanding Ambulatory Surgical Centers (ASC)
- Chemotherapy
- Radiation Therapy
- Durable Medical Equipment greater than \$500 MRI
- MRA, CT, CTA, PET, PECT CT, Arthrogram
- Nuclear Imaging Cardiac
- Rehabilitation
- Therapy: Physical, occupational and speech therapy IV
- Therapy
- Home Healthcare
- Hospice
- Intensive Outpatient Program for Mental Health Partial
- Hospitalization Program for Mental Health

PRESCRIPTION BENEFITS WITH MAGELLAN RX

Your prescriptions will continue to be administered through MagellanRx. The Magellan pharmacy network consists of independent and retail pharmacies. Please visit magellanrx.com/member/find-a-pharmacy to access the Network Pharmacy Locator Tool.

Did you know you can register on the MagellanRx portal to view your plan and pharmacy information?

By registering with MagellanRx's secure online Pharmacy Benefit Services, you are able to:

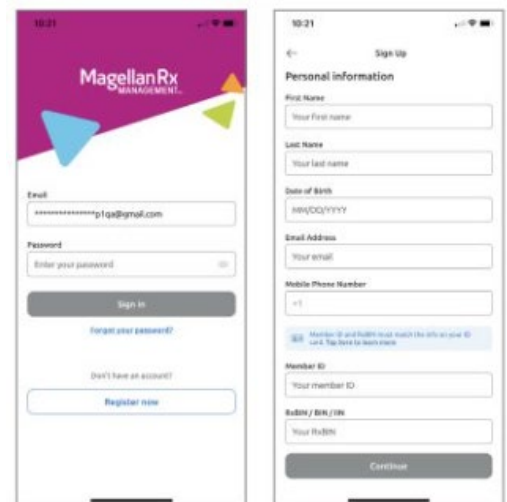
- View Benefit and Copay Information – Access information about your prescription drug benefits, including copay information for retail and mail orders
- Locate Network Pharmacies using the Network Pharmacy Locator Tool
- View Medication History – Including drug and quantity, copay amount and the date the prescription was filled

To register with MagellanRx, follow these steps:

1. Visit www.MagellanRx.com/member/login
2. Click "Register"
3. Complete the secure online registration form. Please note: you must have your member ID to register. Your member ID can be found on your medical ID card.

You can also access MagellanRx via Mobile App!

Log into the mobile app using your Magellan Rx member web portal email and password. If it is your first time using a Magellan Rx portal, create an account with us through the mobile app by tapping the "Register now" button.

Two screenshots of the MagellanRx mobile app. The left screenshot shows the login screen with fields for Email, Password, and a 'Sign in' button. Below the 'Sign in' button are links for 'forgot your password?' and 'don't have an account?'. At the bottom is a 'Register now' button. The right screenshot shows the 'Sign Up' screen with fields for First Name, Last Name, Date of Birth, Email Address, Mobile Phone Number, Member ID, and RxID / BIN / IDN. A 'Continue' button is at the bottom.



PRINCIPAL DENTAL PLANS

The Principal dental plan options provide you in and out-of-network benefits, providing you the freedom to choose any provider. However, you will pay less out of pocket when you choose a network provider. Locate a Principal network provider here: principal.com/dentist, Principal POS Plan network. You may have access to higher discounts if you visit an EPO provider.

The table below summarizes the key features of the Principal dental plan options. The coinsurance amounts listed reflect the amount you pay.

Dental PPO - High Plan			Dental PPO - Low Plan	
GENERAL PLAN PROVISIONS	EPO & In-Network	Non-Network	EPO & In-Network	Non-Network
Deductible Individual/Family	\$50/\$150		\$50/\$150	
Calendar Year Maximum	\$2,500 per person (\$500 carryover)		\$1,500 per person (\$500 carryover)	
Preventive Services	No cost	No cost	No cost	No cost
Basic Services	20% after deductible	20% after deductible	20% after deductible	20% after deductible
Major Services	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Orthodontics Adult & Dependent Children	50%	50%	Not covered	
Orthodontics Lifetime Maximum	\$1,500		N/A	
Cost	Per Pay Period – Weekly		Per Pay Period – Weekly	
Employee Only	\$8.50		\$6.50	
Employee + Spouse	\$17.00		\$13.50	
Employee + Child(ren)	\$21.00		\$13.50	
Employee + Family	\$31.00		\$23.00	

VISION

VISION PLAN

USA has partnered with Vision Service Plan (VSP) to offer a comprehensive vision plan. Plan features are listed below.

To find a vision provider, visit www.vsp.com, click find a Doctor, enter your zip code and search.



VSP Choice PPO

GENERAL PLAN PROVISIONS

In Network

Eye Exam

\$20

\$130 frame allowance + 20% savings on the amount over your allowance

Frames

\$150 Featured Frame Brands allowance

\$130 Walmart/Sam's Club frame allowance

\$70 Costco frame allowance

Lenses

Single vision, lined bifocal, and lined trifocal lenses. Impact-resistant lenses for dependent children.

\$20

Contact Lenses (in lieu of frames)

\$130 Allowance

FREQUENCY

Exams

Once every 12 months

Lenses

One pair every 12 months

Frames

One frame every 24 months

Cost

Per Pay Period – Weekly

Employee Only

\$1.50

Employee + Spouse

\$3.00

Employee + Child(ren)

\$3.00

Employee + Family

\$5.00

LIFE INSURANCE

BASIC LIFE AND AD&D INSURANCE

Life and accidental death and dismemberment (AD&D) insurance is an important element of your income protection planning, especially for those who depend on you for financial security. For your peace of mind, USA provides **complimentary, no cost** basic life and AD&D insurance through Principal to all regular full-time employees.

Please be sure to review your beneficiary information and update if needed through the MyHealthBenefits portal. A beneficiary is the person (or people, estate, trust, etc.) to whom benefits will be paid to in the event of your death. You may change your beneficiary at any time during the plan year.

Principal Life/AD&D Insurance	
BENEFITS	
Life Insurance	\$30,000
AD&D Insurance	\$30,000
AGE REDUCTIONS	
At Age 65	Reduced by 35% of original benefit
At Age 70	Reduced by an additional 15%

VOLUNTARY LIFE INSURANCE

USA provides you the option to purchase supplemental life and AD&D insurance for yourself, your spouse, and your dependent children through Principal. You must purchase supplemental coverage for yourself in order to purchase coverage for your spouse and/or dependents.

If you elect supplemental coverage when you're first eligible to enroll, you may purchase up to the guaranteed issue amount(s) without completing a statement of health (EOI: evidence of insurability). Coverage will not take effect until approved by Principal.

- **Employee:** \$10,000 increments up to \$500,000; Guarantee Issue: \$150,000 (if older than 70: \$10,000)
- **Spouse:** \$5,000 increments up to \$200,000, not to exceed 100% of the employee's election; Guarantee Issue: \$30,000 (if older than 70: \$10,000)
- **Dependent children:** \$10,000 (if under 14 days old: \$1,000); Guarantee Issue: \$10,000

Please log into your MyHealthBenefits portal to view the cost of coverage.

EMOTIONAL HEALTH SUPPORT LINE

Get help when you're feeling overwhelmed or need support. You, your spouse, and dependent children can call this free, confidential support line 24/7 at 800-424-4612 to reach licensed behavioral health clinicians who can provide emotional support, tips for coping, and referrals to local resources.

ADDITIONAL BENEFITS

TRAVEL ASSISTANCE

Ease some of the worries of traveling—whether in the U.S. or internationally. You, your spouse, and dependent children have access to a variety of benefits provided through AXA Assistance. These services include travel and medical assistance plus emergency medical evacuation benefits. Assistance is available for travel 100+ miles away from home for up to 120 consecutive days. principal.com/travelassistance

WILL & LEGAL DOCUMENT CENTER

Consider preparing your simple legal documents online. These online resources and tools, provided by ARAG, are easy-to-use. You and your spouse can prepare, print, and store essential legal documents—such as a will, living will, healthcare power of attorney, durable power of attorney, and medical treatment authorization for minors. Plus, you can access estate planning tools and resources, and a personal information organizer. principal.araggroup.com

NATIONWIDE PET INSURANCE

You now have access to obtain insurance for your four-legged family members through Nationwide preferred pricing Pet Protection program. My Pet Protection is available in two reimbursement options (50% and 70%) so you can find coverage that fits your budget. All plans have a \$250 annual deductible and \$7,500 maximum annual benefit.



- 24/7 access to veterinary experts (\$110 value)
- Available via phone, chat and email
- Unlimited help for everything from general pet questions to identifying urgent care needs



- Save time and money by filling pet prescriptions at participating in-store retail pharmacies across the U.S.
- Rx claims submitted directly to Nationwide
- More than 4,700 pharmacy locations

Enroll at any time throughout the year!

There are three simple ways for employees to sign up for their new pet insurance voluntary benefit:

1. Go directly to the dedicated URL we've created for your company: <http://benefits.petinsurance.com/tigerlines>
2. Call 877-738-7874 and mention that you're an employee of USA to receive preferred pricing
3. Visit PetsNationwide.com or scan the QR code below, and enter your company name



CONTACT INFORMATION

Plan	Group #	Telephone #	Website
MEDICAL			
Benefit & Risk Management Services (BRMS)			
Third Party Administrator (TPA)	10898	844.317.9331	www.myhealthbenefits.com
Health Reimbursement Account (HRA)			
ClaimDOC			
Reference Based Pricing Vendor		888.330.7295	claim-doc.com/members
Networks by Design			
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GLOSSARY OF TERMS

AD&D (Accidental Death & Dismemberment)	A plan that provides benefits in the event of an accidental death or dismemberment (generally, an accident that results in death, loss of part of the body, or the loss of the use of part of the body).
Beneficiary	A person designated by a participant, or by the terms of an employee benefit plan, which is or may become entitled to a benefit under the plan.
COBRA	Federal law (Consolidated Omnibus Budget Reconciliation Act of 1985) requiring certain employers that offer group health plans to provide continuation coverage to employees and their dependents who incur certain qualifying events.
Co-Insurance or Cost Sharing	The portion of covered health care costs for which you are financially responsible. Coinsurance does not include deductibles or copays.
Co-Payment or Copay	A set amount you pay out of pocket for a particular service. The plan pays the balance.
Deductible	The out-of-pocket amount you must pay each plan year before the plan pays for eligible benefits.
Evidence of Insurability (EOI)	Many insurance companies require prospective clients/ individuals to prove that they are in good health and are therefore good insurance risks before the company will cover them.
Explanation of Benefits (EOB)	A statement from a plan explaining what portion of a claim was paid.
Generic	Your prescription drug copay depends on the class or group of your prescribed medication. A generic drug generally has the lowest copay level. A generic drug is one that is no longer produced only under a brand name. Once a drug's patent expires, many companies can begin to manufacture "generic" versions of a previously brand-name-only drug. Generic drugs are identical to brand-name drugs in chemical makeup ("active ingredients"), usage, strength and dosage. They are regulated and approved by the FDA just like brand-name drugs; however, they are much less expensive.
HIPAA Authorization	Under HIPAA, a document that authorizes the use or disclosure of an individual's Protected Health Information by a Covered Entity for any purpose described in the document and meets specific requirements.
Negotiated rates	The costs for health care services negotiated between the insurance carrier and in-network health care providers. Negotiated rates are usually less than usual, customary and reasonable (UCR) charges.
Non-preferred brand	Your prescription drug copay depends on the class or group of your prescribed medication. A non-preferred brand-name drug generally has the highest copay level because it is not on the plan's list of preferred drugs. You can find out how different drugs are classified by your plan by visiting the plan's Web site.
Out-of-Pocket Expenses	Copays, deductibles, and other expenses that are not covered by the health plan.
Qualifying Life Event	Certain events which may allow you to make allowable changes to your benefits. Qualifying events include: marriage, divorce, death, birth, adoption or placement for adoption, and significant change in employment.
Reasonable and Customary (R&C) or Usual, Reasonable & Customary (UCR)	A term used in many health plans, defined as the price at or below which the majority of health-care professionals of similar expertise charge for similar procedures within a specific geographic area.



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