G&W Equipment, Inc.

Benefits

Enrollment Guide

Plan Year
1/1/2022 – 12/31/2022

Who is Eligible?

Benefit	Full-Time Employees working 30+ Hours Per Week	Pre-tax Deduction
Medical and Prescription Drug	✔	✔
Health Savings Account	✔	✔
Dental	✔	✔
Vision	✔	✔
Group Term Life & Accidental Death (AD&D)	✔	
Voluntary Term Life & Accidental Death (AD&D)	✔	
Long Term Disability	✔	
Critical Illness	✔	
Flexible Spending Account	✔	✔

Eligibility Date
All benefits are available to full-time employees working 30 hours or more weekly. You are eligible 1st of the month following 30 days from your full-time date of hire. Employees may make benefit changes during Annual Enrollment each year or within 30-days of a qualifying event.

Eligible Dependents
Other members of your family may be eligible for coverage under Medical, Dental, Vision, Group Term Life/AD&D and Voluntary Life/AD&D. Your eligible dependents include your legal spouse and dependent child(ren).

Medical	Up to age 26 - regardless of student status and marital status
Dental	Up to age 26 - regardless of student status
Vision	Up to age 26 - regardless of student status
Group Term Life	Up to age 26 - regardless of student status
Voluntary Life	Up to age 26 - regardless of student status

How Do I Enroll?

Enrollment is handled via online enrollment through Paycom. Using your employee Paycom app, login and enroll or verify your coverage for the plan year for yourself and each family member.

How/ When to Make Changes?

Unless you have a qualifying life event, you cannot make changes to the benefits you elect until the next annual enrollment period. Qualifying life events include: marriage, divorce, legal separation, birth or adoption of a child, change in child's dependent status, death of spouse, child or other qualified dependent, change in residence due to an employment transfer for you or your spouse, or a change in spouse's benefits or employment status. **You have 30 days from the date of the qualifying life event to notify Human Resources of any changes to your benefit elections.**

What If I Need Help?

If you have general benefit questions or need guidance, you may contact G&W Human Resources or one of the Mountcastle Insurance's representatives below:

Human Resources	(704) 394-6316	hr@gwequip.com
Johanna Barthle	(980) 321-4607	
Liliana Garzon	(980) 321-4616	
Kim Meltzer	(980) 321-4656	
Jody Spivey Mountcastle Insurance	(336) 313-2946	jspivey@mountcastleinsurance.com
Pete Schantz Mountcastle Insurance	(336) 777-8500	Pschantz@mountcastleinsurance.com

This benefit guide is intended to be a brief overview only. Policy contracts are available by contacting Human Resources. In the event that the information in this guide varies from the information in the policy contracts, the provisions outlined in the contracts will govern.

Identification Cards

You will receive identification cards when you enroll for the benefits listed below. See pictures below.

Medical/Prescription Drug HSA or PPO Plan	If you enroll in the HSA or PPO Medical / Prescription Drug plan, you will receive a personalized ID card from BCBS for you and each covered dependent on the plan. You may request additional cards by contacting BCBS Customer Service at 1 (877) 258-3334.
Health Savings Account (HSA) Base Plan Only Debit Card	If you enroll, you will receive a Purple debit card from Health Equity. You may request additional cards by contacting Health Equity Customer Service at 1 (866) 346-5800.
Flexible Spending Account (FSA) Debit Card	If you enroll, you will receive a Blue Debit Card from Health Equity. You may request additional cards by contacting Health Equity Customer Service at 1 (866) 346-5800
Dental	Dental cards are plan specific and are not required for use with the plan. If you enroll, a generic card will be provided to you upon request.
Vision	If you enroll, you will receive up to 2 ID cards from CIGNA for your family to use. You may request additional cards by contacting CIGNA Customer Service at 1 (800) 997-1654.

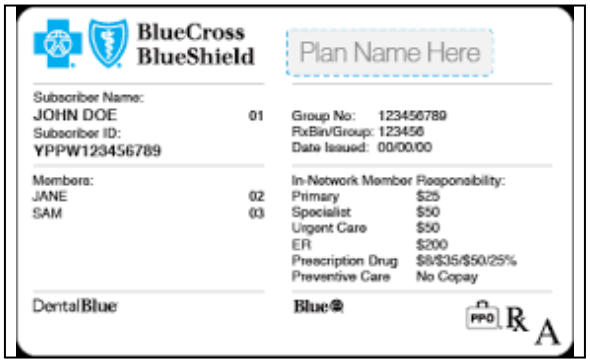
Sample Insurance Cards

Below are samples of the identification cards. Based on your benefit enrollment selection, you will receive the following cards. Contact HR if you don't receive them within the first week of your enrollment month.

Flexible Spending Account (FSA) Debit Card - PPO Medical Plan

Health Savings Account (HSA) Base Plan Only Debit Card – HSA Medical Plan

Medical/Prescription Drug HSA or PPO Plan



Cigna Dental Plan

Cigna Vision Plan

Carrier Contacts

BCBSNC
Medical and Prescription Drug Plan – HSA or PPO
1 (877) 258-3334
www.bluecrossnc.com

CIGNA
Dental and Vision
Group or Voluntary Life / AD&D Plan
Long Term Disability Plan
Critical Illness Plan
1 (888) 842-4462
www.CIGNA.com

Health Equity
Health Savings Account
Flexible Spending Account
1 (866) 346-5800
www.HealthEquity.com

Telehealth Services
MDLive
1 (888) 910-9722
mdlive.bcbsnc.com

Employee Premiums
(Per Bi-weekly Pay Period)

Medical Insurance HSA Base Plan			
Employee	**Employee + Spouse**	**Employee + Child(ren)**	**Employee + Family**
$38.00	**$146.00**	**$107.00**	**$260.00**
Medical Insurance PPO Buy-Up Plan			
Employee	**Employee + Spouse**	**Employee + Child(ren)**	**Employee + Family**
$51.00	**$213.00**	**$170.00**	**$329.00**
Dental Insurance			
Employee	**Employee + Spouse**	**Employee + Child(ren)**	**Employee + Family**
$6.61	**$ 14.08**	**$ 17.76**	**$ 27.01**
Vision Insurance			
Employee	**Employee + Spouse**	**Employee + Child(ren)**	**Employee + Family**
$1.56	**$3.11**	**$3.14**	**$5.01**

Medical & Prescription Drug
HSA Base Plan

Physician Services	BCBSNC Member Pays In-Network
Primary Care Physician Office Visit	Deductible then Covered at 80%
Specialist Office Visit	Deductible then Covered at 80%
Preventative Medical Services	0% (Plan covers 100%)
Telehealth Services	Deductible then Covered at 100%
Hospital/Emergency	
Emergency Room	Deductible then Covered at 80%
Urgent Care	Deductible then Covered at 80%
Lab, X-Ray and Diagnostic- Outpatient	Deductible then Covered at 80%
Major Diagnostic and Imagining –Outpatient	Deductible then Covered at 80%
Inpatient Hospitalization Services	Deductible then Covered at 80%
Outpatient Facility & Physician Charges	Deductible then Covered at 80%
Prescription Drugs (Based on BCBS RX Formulary for the year)	
Generic / Tier 1	Deductible then Covered at 80%
Preferred Brand Name / Tier 2	Deductible then Covered at 80%
Non-Preferred Brand Name / Tier 3	Deductible then Covered at 80%
Specialty / Self-Injectables / Tier 4	Deductible then Covered at 80%
Specialty / Self-Injectables / Tier 5	Deductible then Covered at 80%
Deductibles and Maximums	
Individual Annual Deductible	$2,800
Individual Annual Out-of-Pocket Maximum	$5,000
Family Annual Deductible	$5,600
Family Annual Out-of-Pocket Maximum	$10,000

Out of Network benefits are available

The Health Savings Account (HSA) is available for those enrolled on this plan only.

Medical & Prescription Drug
HSA Base Plan

Your Health Savings Account is set up through Health Equity

- **G&W contributes to your HSA:**
  - **Employee only Non-Vaccinated - $750 annually**
  - **Employee only Vaccinated - $1,500**
  - **Employee, Spouse or Children Non-Vaccinated -$1,250 annually**
  - **Employee Spouse or Children Vaccinated - $2,500**

What is a Health Savings Account (H.S.A)?

A health savings account (HSA) is an account funded to help you save for future medical expenses. There are certain advantages to putting money into these accounts, including favorable tax treatment

Who Can Have an HSA?
Any adult can have an HSA if you:

- Have coverage under an HSA-qualified, high deductible health plan(HDHP)
- Have no other health coverage (certain types of insurance, such as specific injury or accident, disability, dental care, vision care or long-term care, are permitted)
- Are not enrolled in Medicare- Contributions to the account must stop once you are enrolled in Medicare. However, you can still use your HSA funds to pay for medical expenses tax-free.
- Cannot be claimed as a dependent on someone else's tax return

Contributions:
Contributions to your HSA can be made by you, your employer or both. However, the total contributions are limited annually. If you make a contribution, you can deduct the contributions (even if you do not itemize deductions) when completing your federal income tax return.

You can make a contribution to your HSA each year that you are eligible. You can contribute no more than:

- Single coverage: $3,650 for 2022
- Family coverage: $7,300 for 2022

Individuals ages 55 and older can also make additional "catch-up" contributions of up to $1,000 annually.

Using Your HSA:
You can use money in your HSA to pay for any qualified medical expense permitted under federal tax law. This includes most medical care and services, dental and vision care. You can use your HSA to pay for medical expenses for yourself, your spouse or your dependent children, even if your dependents are not covered by your HDHP. Any amounts used for purposes other than to pay for qualified medical expenses are taxable as income and subject to an additional 20% penalty.

Medical & Prescription Drug PPO Buy-Up Plan

Physician Services	BCBSNC Member Pays In-Network
Primary Care Physician Office Visit	$35
Specialist Office Visit	$70
Preventative Medical Services	0% (Plan covers 100%)
Telehealth Services	$0
Hospital/Emergency	
Emergency Room	$500 (Waived if admitted)
Urgent Care	$70
Lab, X-Ray- Outpatient	Deductible then Covered at 80%
Major Diagnostic and Imagining –Outpatient	Deductible then Covered at 80%
Inpatient Hospitalization Services	Deductible then Covered at 80%
Outpatient Facility & Physician Charges	Deductible then Covered at 80%
Prescription Drugs (Based on BCBS RX Formulary for the year)	
Generic / Tier 1	$10
Preferred Brand Name / Tier 2	25% up to $100
Non-Preferred Brand Name / Tier 3	50% up to $100
Specialty / Self-Injectables / Tier 4	25% up to $500
Specialty / Self-Injectables / Tier 5	25% up to $500
Deductibles and Maximums	
Individual Annual Deductible	$2,500
Individual Annual Out-of-Pocket Maximum	$7,000
Family Annual Deductible	$5,000
Family Annual Out-of-Pocket Maximum	$14,000

Out of Network Benefits are available

Flexible Spending Account (FSA)

- **Your Flexible Spending Account is set up through HealthEquity**
- **G&W contributes to your FSA if you enroll in the G&W Medical PPO Plan:**
    - **Employee only Non-Vaccinated - $500 annually**
    - **Employee only Vaccinated - $1,000**
    - **Employee, Spouse or Children Non-Vaccinated - $750 annually**
    - **Employee, Spouse or Children Vaccinated - $1,500**

Flexible spending accounts, or FSAs, provide you with an important tax advantage that can help you pay health care and dependent care expenses on a pre-tax basis. By anticipating your family's health care and dependent care costs for the next plan year, you can lower your taxable income.

Essentially, the Internal Revenue Service (IRS) set up FSAs as a means to provide a tax break to employees. As an employee, you agree to set aside a portion of your pre-tax salary in an account, and that money is deducted from your paycheck over the course of the year. The amount you contribute to the FSA is not subject to social security (FICA), federal, state or local income taxes—effectively adjusting your annual taxable salary.

The Health Care FSA

The health care FSA lets you pay for certain IRS-approved medical care expenses not covered by your insurance plan with pre-tax dollars. For example, cash that you now spend on deductibles, copayments or other out-of-pocket medical expenses can instead be placed in the health care reimbursement FSA pre-tax. Eligible health care expenses for the health care reimbursement FSA include more than just your deductible and copayments. You can also reimburse items such as prescription drugs, dental expenses, eye glasses and contacts, certain medical equipment and many more items. For more information about eligible medical expenses, please refer to IRS Publication 502, Medical and Dental Expenses, available at www.irs.gov/publications/p502/index.html. **The annual maximum contribution to the health care reimbursement FSA is $2,850.**

Health FSAs employ a "**use-it-or-lose-it"** model. If you do not use the funds that you contribute to your FSA within the end of the year, you will have to forfeit those funds. However, you have available to you a carryover up to $500 of unused funds from one year to the next. In addition, any amount that is carried over does not count toward the maximum contribution limit.

The Dependent Care FSA

The Dependent Care FSA lets you use pre-tax dollars toward qualified dependent care. The annual maximum amount you may contribute is $5,000 (or $2,500 if married and filing separately) per calendar year. If you elect to contribute to the dependent care FSA, you may be reimbursed for:

- The cost of child or adult dependentcare
- The cost for an individual to provide care either in or out of yourhouse
- Nursery schools and preschools (excluding kindergarten)

Eligible Expenses for Dependent Care

In order for dependent care services to be eligible, they must be for the care of a tax-dependent child under age 13 who lives with you, or a tax-dependent parent, spouse or child who lives with you and is incapable of caring for himself or herself. The care must be needed so that you and your spouse (if applicable) can go to work.

Telehealth Services Program
(Included with both Medical Plans)

BCBS provides access to MDLive for BCBS telehealth services as part of your medical insurance plans. BCBS Telehealth Connection lets you get the care you need – including most prescriptions – for a wide range of minor conditions. Now you can connect with a board-certified doctor via secure video chat or phone, without leaving your home or office.

Choose when: Day or night, weekdays, weekends and holidays.
Choose where: Home, work or on the go.
Choose how: Phone or video chat.

You can use Telehealth for any of the following minor conditions:

- ✓ Sore throat
- ✓ Headache
- ✓ Stomachache
- ✓ Fever
- ✓ Cold and Flu
- ✓ Allergies
- ✓ Rash
- ✓ Acne
- ✓ UTIs and more

If you have not previously registered, sign up today so you'll be ready to use a telehealth service when and where you need it.

mdlive.bcbsnc.com
1(888) 910-9722

This is available to those enrolled on either of the medical plans at no additional cost.

There is no copay when you use the Telehealth program with MDLIVE. The $55 copay is paid by G&W Equipment.

Dental Plan

Policy # 3343404

Plan Design	Total Cigna DPPO	Out-of-Network
Calendar Year Maximum	Progressive Plan	
(Class I, II, III Expenses)	Class I applies	Class I applies
	Year 1: $1,500	Year 1: $1,500
	Year 2: $1,750	Year 2: $1,750
	Year 3: $2,000	Year 3: $2,000
	Year 4: $2,250	Year 4: $2,250
Calendar Year Deductible		
Individual	$50	$50
Family	$150	$150
Class I Expenses - Preventive & Diagnostic Care		
Oral Exams Cleanings Routine X- rays	100%, No Deductible	100%, No Deductible
Fluoride Application Sealants		
Space Maintainers (limited to non-orthodontic treatment) Non-Routine X-rays		
Emergency Care to Relieve Pain		
Class II Expenses - Basic Restorative Care		
Fillings (Amalgam and composite on all teeth) Oral Surgery - Simple Extractions	100%, After Deductible	80%, After Deductible
Oral Surgery - All Except Simple Extraction/ Surgical Extraction of Impacted Teeth/ Minor Periodontics		
Major Periodontics		
Root Canal Therapy / Endodontics/ Brush Biopsy		
Class III Expenses - Major Restorative Care		
Anesthetics	60%, After Deductible	50%, After Deductible
Relines, Rebases, and Adjustments Repairs - Bridges, Crowns, and Inlays Repairs - Dentures Crowns/Inlays/On-lays		
Stainless Steel/Resin Crowns/Dentures		
Bridges		
Class IV Expenses – Orthodontia		
Eligible Children Only/Lifetime Maximum	50%, No Ortho Deductible/$1,500	
Dental Plan Reimbursement Levels	Based on negotiated contract fees	90th Percentile
Additional Member Responsibility in excess of Coinsurance	None	Yes, the difference between Billed Charges and the plan reimbursement

Vision Plan

Policy # 3343404

Coverage	VSP In-Network Benefit***	Out-of-Network Benefit	Frequency Period **
Exam Copay	$10	N/A	12 months
Exam Allowance (once per frequency period)	Covered 100% after Copay	Up to $45	12 months
Materials Copay	$20	N/A	12 months
Eyeglass Lenses Allowances: (one pair per frequency period) Single Vision Lined Bifocal Lined Trifocal Lenticular	 Covered 100% after Copay Covered 100% after Copay Covered 100% after Copay Covered 100% after Copay	 Up to $32 Up to $55 Up to $65 Up to $80	 12 months 12 months 12 months 12 months
Contact Lenses Allowances: (one pair or single purchase per frequency period) Elective Therapeutic	Up to $130 Covered 100%	Up to $105 Up to $210	12 months 12 months
Frame Retail Allowance (one per frequency period)	Up to $130	Up to $71	24 months

** Your Frequency Period begins on January 1 (Calendar year basis)

In-Network Coverage Includes***:

· One vision and eye health evaluation including but not limited to eye health examination, dilation, refraction, and prescription for glasses;

·One pair of standard prescription plastic or glass lenses, all ranges of prescriptions (powers and prisms) o Polycarbonate lenses for children under 19 years of age

o Oversize lenses

o Rose #1 and #2 solid tints

o Minimum 20% savings* on all additional lens enhancements you choose for your lenses, including but not limited to: scratch/ultraviolet/anti-reflective coatings; polycarbonate (adults); all tints/photochromic (glass or plastic); and lens styles. o Progressive lenses covered up to bifocal lens amount with 20% savings on the difference;

One frame for prescription lenses – frame of choice covered up to retail plan allowance, plus a 20% savings on amount that exceeds frame allowance;

·One pair of contact lenses or a single purchase of a supply of contact lenses – in lieu of lenses and frame benefit, (may not receive contact lenses and frames in same benefit year). Allowance applied towards cost of supplemental contact lens professional services (including the fitting and evaluation) and contact lens materials

* Provider participation is 100% voluntary; please check with your Eye Care Professional for any offered discounts.

*** Coverage may vary at participating discount retail and membership club optical locations, please contact Customer Service for specific coverage information.

Vision Plan

Policy # 3343404

Coverage for Therapeutic contact lenses will be provided when visual acuity cannot be corrected to 20/70 in the better eye with eyeglasses and the fitting of the contact lenses would obtain this level of visual acuity; and in certain cases of anisometropia, keratoconus, or aphakis; as determined and documented by your Vision eye care professional. Contact lenses fitted for other therapeutic purposes or the narrowing of visual fields due to high minus or plus correction will be covered in accordance with the Elective contact lens coverage shown on the Schedule of
Benefits.

Healthy Rewards® - Vision Network Savings Program:
When you see a Cigna Vision Network Eye Care Professional*, you can save 20% (or more) on additional frames and/or lenses, including lens options, with a valid prescription. This savings does not apply to contact lens materials. See your Cigna Vision Network Eye Care Professional for details.

How to use your Cigna Vision Benefits

Finding a VSP Doctor

There are three ways to find a quality eye doctor in your area:

- Log into myCigna.com; "Coverage"; Select Vision page; Click on Visit Cigna Vision; Then select "Find a Cigna Vision Network Eye Care Professional" to search the Cigna Vision Directory.
- Don't have access to myCigna.com? Go to Cigna.com; at the top of the page select "Find A Doctor, Dentist or Facility"; click Cigna Vision Directory under Additional Directories.
- Prefer the phone? Call the toll-free number found on your Cigna insurance card andtalk with a Cigna Vision customer service representative.

Schedule an Appointment

Identify yourself as a Cigna Vision customer when scheduling an appointment. Present your Cigna or Cigna Vision ID card at the time of your appointment, which will quickly assist the doctor's office with accessing your plan details and verifying your eligibility.

Out-of-network Plan Reimbursement for Cigna Vision Benefits

Send a completed Cigna Vision claim form and itemized receipt to:
Cigna Vision, Claims Department, PO Box 385018, Birmingham, AL 35238-5018.

To get a Cigna Vision claim form:

- Go to Cigna.com and go to Forms, Vision Forms
- Go to myCigna.com and go to your vision coverage page
- Cigna Vision will pay for covered expenses within ten business days of receiving the completed claim form and itemized receipt."

Group Term Life/AD&D

Policy # FLX969434

Group Term Life /Accidental Death & Dismemberment underwritten by CIGNA

100% Paid by G&W Equipment

Who Is Eligible for Coverage?

- You: All active, Full-Time Employees of the Employer classified as Other regularly working a minimum of 30 hours per week in the United States
- Your Spouse: Up to age 70
- Your Child(ren): Birth to 26

Available Coverage:

Benefit Amount Maximum	
Employee	$50,000
Spouse	$10,000
Child	15 days to age 26 $2,000 (Up to 14 days $500)

Additional Features:

- **Continuation of Disability** – If your active service ends due to disability, at age 60 or over, your life insurance coverage will continue while you are disabled. Benefits will remain in force until the earliest of: the date you are no longer disabled, the date the policy terminates, the date you are Disabled for 12 consecutive months, or the day after the last period for which premiums are paid. You are considered disabled if, because of injury or sickness, you are unable to perform all the material duties of your Regular Occupation, or you are receiving disability benefits under your Employer's plan.

- **Extended Death Benefit with Waiver of Premium** – The extended death benefit continues your coverage without payment of premium, before you're eligible to qualify for Waiver of Premium, if you are continuously Disabled for 9 months prior to age 60. "Disabled" means, because of injury or sickness, you are unable to perform all the material duties of your regular occupation, or you are receiving disability benefits under a program sponsored by your Employer. Regular Occupation means the occupation you routinely performed at the time your Disability began. We/the insurance company will consider the duties of your occupations as those that are normally performed in the general labor market in the national economy. If you qualify for this benefit and have insured your spouse or children, the insurance company will also extend their coverage if applicable.

- **Waiver of Premium** – If you become Disabled prior to age 60, and you remain Disabled continuously for a 9- month period and thereafter, you won't need to pay premiums for your life insurance coverage, provided we/the Insurance Company determine(s) you are Disabled. "Disabled" for this coverage means, because of injury or sickness, you are unable to perform the material duties of your regular occupation, or are receiving disability benefits under a program sponsored by your employer, for the first 12 months after your Disability began. Thereafter, you must be unable to perform the material duties of any occupation that you are or may reasonably become qualified based on your education, training or experience. If you qualify for this coverage and have insured your spouse or children, the insurance company will also waive their premium if applicable.

Group Term Life/AD&D

Policy # FLX969434

- **Accelerated Death Benefit** – Terminal Illness – if two unaffiliated doctors diagnose you or your spouse as terminally ill while the coverage is active, with a life expectancy of 12 months or less, the benefit for Terminal Illness provides up to: Employee: 75% of your Term Life Insurance coverage amount or $37,500, whichever is less. Spouse: 75% of your Term Life Insurance coverage amount or $7,500, whichever is less.

- **Portability** – If your employment is terminated, you can continue your life insurance on a direct-bill basis. Coverage may also be continued for your spouse/children. Premiums will increase at this time. Coverage can be continued to age 70, unless the insurance company terminates portability for all insured persons. Refer to your certificate for details.

- **Conversion** – To convert, you must apply for the conversion policy and pay the first premium payment within 31 days after your group coverage ends. For Questions, please call 1-800-423-1282, 8:00 a.m. to 4:30 p.m., CST.

Group Term Life and AD&D Reduction Schedule	
Percent Reduction	At Age
Reduces to 65%	65
Reduces to 50%	70

Voluntary Term Life/AD&D

Cigna Policy #OK970869

- 100% paid by Employee through payroll deductions
- Who Is Eligible for Coverage?
    - You: All active, Full-Time Employees of the Employer regularly working a minimum of 30hours
    - Your Spouse: Up to age 70, as long as you apply for and are approved for coverageyourself.
    - Your Child(ren): Birth to 26, as long as you apply for and are approved for coverage yourself.
- During the Annual Enrollment Period, an Employee currently insured may increase his or her Voluntary Life Insurance Benefits by up to two units of $25,000, up to the Guaranteed Issue, without an evidence of insurability form. A covered spouse's coverage may be increased by 50% of the Employee's Voluntary Life election, without an evidence of insurability form.
- Benefit Reduction Schedule - If you are still employed, your benefits and your spouse's benefits will reduce to 65% at age 65 and 50% at age 70.
- If you apply for coverage for yourself more than 31 days from the date you become eligible to elect coverage under this plan, the Guaranteed Issue Amount will not apply, unless Guaranteed Issue has been approved by your employer for a specific period of time. Coverage will not be issued until the insurance company approves acceptable proof of good health.

	Benefit Amount	Maximum	Guaranteed Issue
Employee	Increments of $25,000	$150,000	$100,000
Spouse	50% of the Employee's Insured Amount	50% of the Employee's Insured Amount up to a maximum of $75,000	$25,000
Children	Units of $5,000	$10,000; under 6 Months old $500	All amounts

Waiver of Premium

If you become Disabled prior to age 60, and you remain Disabled continuously for a 9-month period and thereafter, you won't need to pay premiums for your life insurance coverage, provided we/the Insurance Company determine(s) you are Disabled. "Disabled" for this coverage means, because of injury or sickness, you are unable to perform the material duties of your regular occupation, or are receiving disability benefits under a program sponsored by your employer, for the first 12 months after your Disability began. Thereafter, you must be unable to perform the material duties of any occupation that you are or may reasonably become qualified based on your education, training or experience. If you qualify for this coverage and have insured your spouse or children, the insurance company will also waive their premium if applicable.

Accelerated Death Benefit

Terminal Illness – if two unaffiliated doctors diagnose you or your spouse as terminally ill while the coverage is active, with a life expectancy of 12 months or less, the benefit for Terminal Illness provides up to:
Employee: 75% of your Term Life Insurance coverage amount or $112,500, whichever is less. Spouse: 75% of your Term Life Insurance coverage amount or $56,250, whichever is less.

Portability

If your employment is terminated, you can continue your life insurance on a direct-bill basis. Coverage may also be continued for your spouse/children. Premiums will increase at this time. Coverage can be continued to age 70, unless the insurance company terminates portability for all insured persons. Refer to your certificate for details.

Conversion

To convert, you must apply for the conversion policy and pay the first premium payment within 31 days after your group coverage ends. For Questions, please call 1-800-423-1282, 8:00 a.m. to 4:30 p.m., CST.

Long Term Disability

Policy # LK966254

Underwritten by CIGNA
100% Paid by G&W Equipment

If you had an unexpected illness or injury and were unable to work, how long would you be able to pay your bills? Long-term disability pays a portion of your salary if you're unable to work due to a covered disability.

- Benefit amount is 60% of insured's monthly covered earnings to a maximumof $5,000.
- Benefit is payable beginning after 90 days of being deemed disabled according to the contract.
- How Long Benefits Last - Once you qualify for benefits under this plan, you continue to receive them until the end of the benefit or until you no longer qualify for benefits, whichever occurs first. Should you remain Disabled, your benefits continue according to the later of your Social Security Normal Retirement Age, or the following schedule, depending on your age at the time you become Disabled.

Age at Disability	Age 62 or younger	63	64	65	66	67	68	69+
Duration of Payments (months)	To age 65 or the date the 42nd monthly benefit is payable, if later.	36	30	24	21	18	15	12

Disability
"Disability" or "Disabled" means that, solely because of a covered injury or sickness, you are unable to perform the material duties of your regular occupation/regular job and you are unable to earn 80% or more of your indexed earnings from working in your regular occupation/regular job. After benefits have been payable for 24 months, you are considered disabled if solely due to your injury or sickness, you are unable to perform the material duties of any occupation for which you are (or may reasonably become) qualified by education, training or experience, and you are unable to earn 60% or more of your indexed earnings.

Covered Earnings
Covered Earnings means your wages or salary, not including overtime pay, bonuses, commissions, and other extra compensation.

Pre-existing Condition Limitation
Benefits are not payable for medical conditions for which you incurred expenses, took prescription drugs, received medical treatment, care or services (including diagnostic measures), during the 3 months just prior to the most recent effective date of insurance. Benefits are not payable for any disability resulting from a pre-existing condition unless the disability occurs after you have been insured under this plan for at least 12 months after your most recent effective date of insurance. Benefits are not payable for any disability resulting from a pre-existing condition unless the disability occurs after you have been insured under this plan for at least 12 months after your most recent effective date of insurance. recent effective date of insurance.

Critical Illness

Policy # CI961403

Underwritten by CIGNA
100% Paid by G&W Equipment

Critical Illness insurance provides a cash benefit when a Covered Person is diagnosed with a covered critical illness or event after coverage is in effect.

Benefit Amount		
Employee	$1,000	
Covered Conditions	**Benefit Amount**	
Cancer Conditions		
Skin Cancer*	$250 1x per lifetime	
Covered Conditions	**Initial Benefit Amount %**	**Recurrence % of Initial Benefit Amount**
Invasive Cancer	100%	100%
Carcinoma in Situ	25%	25%
Vascular Conditions		
Heart Attack	100%	100%
Stroke	100%	100%
Coronary Artery Disease	25%	25%
Nervous System Conditions		
Advanced Alzheimer's Disease	25%	Not Available
Amyotrophic Lateral Sclerosis (ALS)	25%	Not Available
Parkinson's Disease	25%	Not Available
Multiple Sclerosis	25%	Not Available
Other Specified Conditions		
Benign Brain Tumor	100%	100%
Blindness	100%	Not Available
Coma	25%	25%
End-Stage Renal (Kidney) Disease	100%	100%
Major Organ Failure	100%	100%
Paralysis	100%	100%

Initial Critical Illness Benefit
Benefit for a diagnosis made after the effective date of coverage for each Covered Condition shown above. The amount payable per Covered Condition is the Initial Benefit Amount multiplied by the applicable percentage shown. Each Covered Condition will be payable one time per Covered Person. A 180 days separation period between the dates of diagnosis is required.

Legal Notices

These notices are required by various government agencies as they affect your health plan coverage. Please review and let us know if you have any questions.

Newborn and Mothers Health Protection Act of 1996

Under the Newborn and Mothers Health Protection Act of 1996, Group Health Plans that provide benefits for childbirth must annually notify all participants of this act. Mothers and their newborn children are permitted to remain in the hospital for 48 hours after a normal delivery or 96 hours following a cesarean section. However, an attending provider may discharge a mother or her newborn earlier than 48 hours, or 96 hours in the case of a cesarean section, if he or she makes this decision in consultation with the mother.

Under the Newborn and Mothers Health Protection Act provisions, the time limits affecting the stay begin at the time of delivery, if the delivery occurs in a hospital. If a delivery occurs outside the hospital, the stay begins when the mother or newborn is admitted in connection with the childbirth. Whether the admission is in connection with childbirth is a medical decision to be made by the attending provider. A health plan may not require that a health care provider obtain authorization from the plan for all or part of the hospital stay required under the Newborn and Mothers Health Protection Act provisions. But, the rules do provide that plans may require pre-certification for the entire length of the hospital stay. Under the Newborn and Mothers Health Protection Act, an attending provider is defined as an individual who is licensed under applicable state law to provide maternity or pediatric care to a mother or newborn child. Therefore, attending providers could include physicians, nurse midwives, and physician's assistants. Attending providers do not include health plans, hospitals, and managed care organizations.

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance 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 another employer stops contributing toward your or your dependents' other coverage). Should you choose to do this, you must request enrollment within 31 days* after your or your dependents' other coverage ends (or after the other employer stops contributing toward the coverage). If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. Should you choose to do this, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

The Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act of 1998 was passed into law on October 21,1998 amending the Employee Retirement Income Security Act of 1974 (ERISA). The law requires plans which provide mastectomy coverage to provide notice to individuals of their rights to benefits for breast reconstruction following a mastectomy.

Your Plan currently provides coverage for a mastectomy and reconstructive breast surgery following a mastectomy. Benefits for medical and surgical treatment for reconstruction in connection with a mastectomy are further clarified as follows according to the requirements of the Women's Health and Cancer Rights Act of 1998:

1) Reconstruction of the breast on which the mastectomy has been performed;
2) Surgery and reconstruction of the other breast to produce symmetrical appearance; and
3) Coverage for prostheses and physical complications of all stages of mastectomy, including lymphedema in a manner determined in consultation with the attending physician and the patient.

These benefits will be paid at the same benefit level as other benefits payable under the Plan.

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums. If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can 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, you can 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, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.
Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**.

COBRA Continuation Coverage

A federal law known as The Consolidated Omnibus Reconciliation Act (COBRA) requires that most employers sponsoring group healthcare plans offer employees and their families the opportunity for a temporary extension of healthcare coverage (called continuation coverage) at group rates in certain instances where coverage under the terms of the plan would otherwise end. This notice is intended to inform you of your rights and obligations under the continuation coverage provisions of the law.

If you are an employee of G&W Equipment, Inc. and are covered by its group healthcare plan, you have a right to choose this continuation coverage if you lose your group healthcare coverage under the terms of the plan because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part). If you are the spouse of an employee and are covered by the group healthcare plan, you have the right to choose this continuation coverage if you lose your group healthcare coverage under the terms of the healthcare plan for any of the following reasons:

- The death of your spouse.
- A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment.
- Divorce or legal separation from yourspouse.
- Your spouse becomes entitled toMedicare.

In the case of dependent children of an employee covered by the group healthcare plan, they have the right to continuation coverage if group healthcare coverage under the terms of the healthcare plan is lost for any of the following reasons:

- The death of a parent.
- A termination of a parent's employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment.
- Parent's divorce or legal separation.
- A parent becomes entitled to Medicare.
- The dependent ceases to be a dependent child under the terms of the health plan.

Individuals described above who are entitled to COBRA continuation coverage are called qualified beneficiaries. If a child is born to a covered employee or if a child is, before age 18, adopted by or placed for adoption with a covered employee

during the period of COBRA continuation coverage, the newborn or adopted child is a qualified beneficiary. These new dependents can be added to COBRA coverage upon timely notification to the Plan Administrator in accordance with the terms of the group healthcare plan. Under the law, the employee or a family member has the responsibility to inform the Plan Administrator of a divorce, legal separation or a child losing dependent status under the terms of the healthcare plan.

This information must be provided within 60 days of the later of the event or the date on which coverage would end under the terms of the Plan because of the event. If the information is not provided within 60 days, rights to continuation coverage under COBRA will end. The employer has the responsibility to notify the Plan Administrator of the employee's death, termination of employment or reduction in hours or Medicare entitlement.

When the Plan Administrator is notified that one of these events has happened, the Plan Administrator will in turn notify you that you have the right to choose continuation coverage. Under the law, you have 60 days from the later of the date you are notified of your rights or the date you would lose coverage because of one of the events described above to inform the Plan Administrator that you want continuation coverage. If you do not choose continuation coverage in a timely manner, your group healthcare coverage will end. COBRA continuation coverage is not available to any covered individual if coverage is lost due to termination of employment for gross misconduct. If you choose continuation coverage, the employer is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated employees or family members. Any changes made to the healthcare plan for similarly situated employees or family members will also apply to the individual who chooses COBRA continuation coverage. The terms of the coverage are governed by the plan documentation, which is available upon request from the Plan Administrator in the event you have misplaced your documentation. The law requires that you be given the opportunity to maintain continuation coverage for up to three years unless you lost group healthcare coverage because of your termination of employment (except for gross misconduct) or reduction of hours. If such termination or reduction of hours is the reason for your loss of coverage, the required continuation coverage period is up to 18 months.

This 18-month period may be extended to 36 months if other events (such as death, divorce or the employee's Medicare entitlement) occur during the 18-month period. If the covered employee becomes entitled to Medicare less than 18 months before a qualifying event that is termination of employment or reduction of hours, then qualified beneficiaries other than the covered employee may receive continuation coverage for up to 36 months measured from the covered employee's Medicare entitlement.

The 18-month continuation coverage period applicable to termination (except for gross misconduct) or to reduction of hours may be extended to up to 29 months if a qualified beneficiary is determined to be disabled by the Social Security Administration and before the end of the 18-month continuation period. If the above requirements are satisfied, the continuation coverage for all qualified beneficiaries may be continued for up to an additional

11 months beyond the end of the initial 18-month period. A higher monthly premium (150 percent of the applicable premium used to determine regular COBRA rates) will be required. The Plan Administrator also must be notified within 30 days after the date of any final determination of the Social Security Administration that the disability no longer exists, if such a determination is made before the end of the 29-month continuation coverage period.

Continuation coverage will be cut short for any of the following reasons:

- The employer no longer provides group healthcare coverage to any of its employees.
- The premium for your continuation coverage is not made on time.
- You become covered under another group healthcare plan that does not contain any exclusion or limitation with respect to any pre-existing condition you have.
- You become entitled to Medicare.
- In the case of the 29-month continuation coverage period for the disabled, the cessation of disability.

You do not have to show that you are insurable to choose continuation coverage. However, continuation coverage under COBRA is provided subject to your eligibility for coverage. The Plan Administrator reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible.

Under the law, you may have to pay all or part of the premium, plus a 2 percent administration fee, for your continuation coverage. As explained above, higher rates apply to the 11-month extension due to disability. There is a grace period of 30 days for payment of the regularly scheduled premium. In addition, upon the expiration of the 18-month or 36-month continuation coverage periods, you will be allowed to enroll in an individual conversion plan if conversion is provided.

Glossary of Health Coverage and Medical Terms

- This glossary defines many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan or health insurance policy. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- Underlined text indicates a term defined in this Glossary.
- See page 6 for an example showing how deductibles, coinsurance and out-of-pocket limits work together ina real life situation.

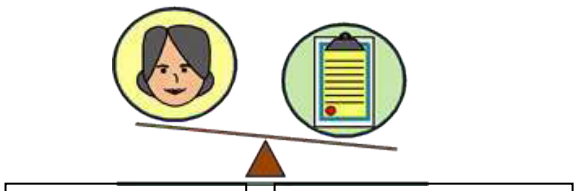
Allowed Amount This is the maximum payment the plan will pay for a covered health care service. May also be called "eligible expense," "payment allowance," or "negotiated rate."

Appeal A request that your health insurer or plan review a decision that denies a benefit or payment (either in whole or in part).

Balance Billing When a provider bills you for the balance remaining on the bill that your plan doesn't cover. This amount is the difference between the actual billed amount and the allowed amount. For example, if the provider's charge is $200 and the allowed amount is $110, the provider may bill you for the remaining $90. This happens most often when you see an out-of-network provider (non-preferred provider). A network provider (preferred provider) may not bill you for covered services.

Claim A request for a benefit (including reimbursement of a health care expense) made by you or your health care provider to your health insurer or plan for items or services you think are covered.

Coinsurance Your share of the costs of a covered health care service, calculated as a percentage (for example 20%) of the allowed amount for the service. You generally pay coinsurance plus any deductibles you owe. (For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.)



(See example page)

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

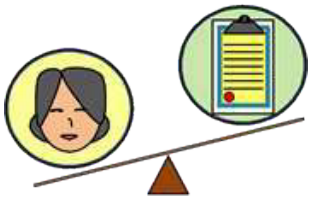
Glossary of Health Coverage and Medical Terms

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

Cost Sharing Your share of costs for services that a plan covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of cost sharing are the copayments, deductibles, and coinsurance. Family cost sharing is the share of the cost for deductibles and out-of-pocket costs you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your premiums, penalties you may have to pay, or the cost of care a plan doesn't cover usually aren't considered cost sharing.

Cost-sharing Reductions Discounts that reduce the amount you pay for certain services covered by an individual plan you buy through the Marketplace. You may get a discount if your income is below a certain level, and you choose a Silver level health plan or if you're a member of a federally-recognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation.

Deductible An amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles. (For example, if your deductible is $1,000 your plan won't pay anything until you've met your $1,000 deductible for covered health care services subject to the deductible.)



Jane Pays 100% | Her plan pays 0%

(See example page)

Diagnostic Test Tests to figure out what your health problem is. For example, an x-ray can be a diagnostic test to see if you have a broken bone.

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

Emergency Medical Condition An illness, injury, symptom (including severe pain), or condition severe enough to risk serious danger to your health if you didn't get medical attention right away. If you didn't get immediate medical attention you could reasonably expect one of the following: 1) Your health would be put in serious danger; or 2) You would have serious problems with your bodily functions; or 3) You would have serious damage to any part or organ of your body.

Glossary of Health Coverage and Medical Terms

Emergency Medical Transportation Ambulance services for an emergency medical condition. Types of emergency medical transportation may include transportation by air, land, or sea. Your plan may not cover all types of emergency medical transportation, or may pay less for certain types.

Emergency Room Care/Emergency Services Services to check for an emergency medical condition and treat you to keep an emergency medical condition from getting worse. These services may be provided in a licensed hospital's emergency room or other place that provides care for emergency medical conditions.

Excluded Services Health care services that your plan doesn't pay for or cover.

Formulary A list of drugs your plan covers. A formulary may include how much your share of the cost is for each drug. Your plan may put drugs in different cost sharing levels or tiers. For example, a formulary may include generic drug and brand name drug tiers and different cost sharing amounts will apply to each tier.

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

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

Health Insurance A contract that requires a health insurer to pay some or all of your health care costs in exchange for a premium. A health insurance contract may also be called a "policy" or "plan."

Home Health Care Health care services and supplies you get in your home under your doctor's orders. Services may be provided by nurses, therapists, social workers, or other licensed health care providers. Home health care usually doesn't include help with non-medical tasks, such as cooking, cleaning, or driving.

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

Hospitalization Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Some plans may consider an overnight stay for observation as outpatient care instead of inpatient care.
Hospital Outpatient Care Care in a hospital that usually doesn't require an overnight stay.

Individual Responsibility Requirement Sometimes called the "individual mandate", the duty you may have to be enrolled in health coverage that provides minimum essential coverage. If you don't have minimum essential coverage, you may have to pay a penalty when you file your federal income tax return unless you qualify for a health coverage exemption.

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

Marketplace A marketplace for health insurance where individuals, families and small businesses can learn about their plan options; compare plans based on costs, benefits and other important features; apply for and receive financial help with premiums and cost sharing base on income; and choose a plan and enroll in coverage.

Glossary of Health Coverage and Medical Terms

Maximum Out-of-pocket Limit Yearly amount the federal government sets as the most each individual or family can be required to pay in cost sharing during the plan year for covered, in-network services. Applies to most types of health plans and insurance. This amount may be higher than the out-of-pocket limits stated for your plan.

Medically Necessary Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease, or its symptoms, including habilitation, and that meet accepted standards ofmedicine.

Minimum Essential Coverage Health coverage that will meet the individual responsibility requirement. Minimum essential coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverages.

Minimum Value Standard A basic standard to measure the percent of permitted costs the plan covers. If you're offered an employer plan that pays for at least 60% of the total allowed costs of benefits, the plan offers minimum value and you may not qualify for premium tax credits and cost sharing reductions to buy a plan from the Marketplace.

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

Network Provider (Preferred Provider) A provider who has a contract with your health insurer or plan who has agreed to provide services to members of a plan. You will pay less if you see a provider in the network. Also called "preferred provider" or "participating provider".

Orthotics and Prosthetics Leg, arm, back and neck braces, artificial legs, arms and eyes, and external breast prostheses after mastectomy. These services include: adjustment, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition.

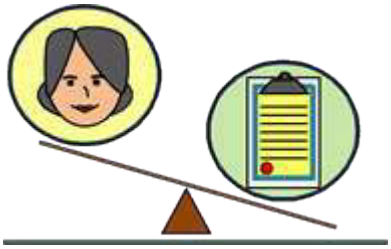
Out-of-network Coinsurance Your share (for example 40%) of the allowed amount for covered health care services to providers who don't contract with your health insurance or plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.

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

Out-of-network Provider (Non-Preferred Provider) A provider who doesn't have a contract with your plan to provide services. If your plan covers out-of-network services, you'll usually pay more to see an out-of-network provider than a preferred provider. Your policy will explain what those costs may be. May also be called "non- preferred" or "non-participating" instead of "out-of-network provider".

Glossary of Health Coverage and Medical Terms

Out-of-pocket Limit The most you *could* pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit the plan will usually pay 100% of the allowed amount. This limit helps you plan for health care costs. This limit never includes your premium, balance-billed charges or health care your plan doesn't cover. Some plans don't count all of your copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.



Jane Pays 0%

Her plan pays 100%

(See Example Page)

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

Plan Health coverage issued to you directly (individual plan) or through an employer, union or other group sponsor (employer group plan) that provides coverage for certain health care costs. Also called "health insurance plan", "policy", "health insurance policy", or "health insurance".

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

Premium The amount that must be paid for your health insurance or plan. You and/or your employer usually pay in monthly, quarterly, or yearly.

Premium Tax Credits Financial help that lowers your taxes to help you and your family pay for private health insurance. You can get this help if you get health insurance through the Marketplace and your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly premium costs.

Prescription Drug Coverage Coverage under a plan that helps pay for prescription drugs. If the plan's formulary uses "tiers" (levels), prescription drugs are grouped together by type or cost. The amount you'll pay in cost sharing will be different for each "tier" of covered prescription drugs.

Glossary of Health Coverage and Medical Terms

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

Preventive Care (Preventive Service) Routine health care, including screenings, check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

Primary Care Physician A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), who provides or coordinates a range of health care services for you.

Primary Care Provider A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law and the terms of the plan, who provides, coordinates, or helps you access a range of health care services.

Provider And individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The plan may require the provider to be licensed, certified, or accredited as required by law.

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

Referral A written order from your primary care provider for you to see a specialist or get certain health care services. In many health maintenance organizations (HMOs), you need to get a referral before you can get health care services from anyone except your primary care provider. If you don't get a referral first, the plan may not pay for the services.

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

Screening A type of preventive care that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs, or prevailing medical history of a disease or condition.

Skilled Nursing Care Services performed or supervised by licensed nurses in your home or in a nursing home. Skilled nursing care is ***not*** the same as "skilled care services", which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.

Specialist A provider focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

Specialty Drug A type of prescription drug that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a formulary.

Glossary of Health Coverage and Medical Terms

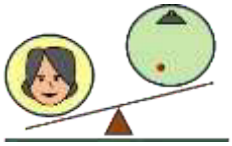
UCR (Usual, Customary and Reasonable) The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

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

How You and Your Insurer Share Costs-Example

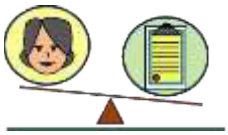
Jane's Plan Deductible: $1,500 Coinsurance: 20% Out-of-Pocket Limit: $5,000

Beginning of Coverage Period:January 1st End of Coverage Period: December31st



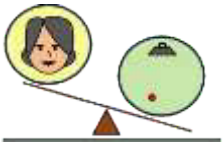
Jane pays 100%
Her plan pays 0%

Jane hasn't reached her $1,500 deductible yet. Her plan doesn't pay any of the costs. Office visit costs: $125, Jane pays: $125, Her plan pays: $0.



Jane pays 20%
Her plan pays 80%

Jane reaches her $1,500 deductible, coinsurance begins. Jane has seen a doctor several times and paid $1,500 in total, reaching her deductible. So her plan pays some of the costs for her next visit. Office visit costs: $125, Jane pays: 20% of $125 = $25, Her plan pays: 80% of $125 = $100.



Jane pays 0%
Her plan pays 100%

Jane reaches her $5,000 out-of-pocket limit. Jane has seen the doctor often and paid $5,000 total. Her plan pays the full cost of her covered health care services for the rest of the year. Office visit costs: $125, Jane pays $0, Her plan pays: $125.

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